DECISION

Appeal No:	09-01215
Appeal By:	Mr and Mrs M
Against Decision of:	East Sussex County Council
Concerning:	C (born 5 March 1998)
Hearing Date:	20 July 2009 and 11 September 2009
Tribunal Panel:	Mr Anthony Davies (Tribunal Judge) Miss Judith Wade Mr John Dunford

Appeal

Mr and Mrs M appeal under Section 326 Education Act 1996 against the contents of a statement of special educational needs made by East Sussex County Council (LA) in respect of their son C.

Attendance

Mr Silas, Solicitor, represented Mr and Mrs M who both attended the hearing. Mr Silas was supported by his supporter, Ms Patel. Mr and Mrs M's witnesses were Ms RB, independent Educational Psychologist, Mr Y, independent Social Worker and Ms F, head of therapies at SM School.

Ms Scolding, Barrister, represented the LA. Its witnesses were Mrs Ford, Principal Educational Psychologist. Mrs Clark, Headteacher of GP School, attended the hearing on 20 July 2009 but was unwell at the hearing on 15 September 2009 and was replaced by Miss Palmer, LA officer. This was agreed by both representatives.

Preliminary matters

1. We accepted a number of items of late evidence at the first hearing. There was no objection by either party to this. We accepted a report by Mrs Ford dated 16 July 2009, a report by East Sussex School Improvement Partners regarding GP School dated 16th June 2009, a letter from Dr C, Consultant Paediatrician, dated 3 July 2009, a report from Winchester Autism and Asperger`s and Assessment Clinic by Dr JM dated 16 July 2009 and the report from the Annual Review of 9 March 2009 from SM School.

2. Unfortunately, the Tribunal ran out of time on the day of the first hearing before discussing all the issues raised by the parties. The Tribunal had no alternative but to adjourn the hearing until the first convenient date, 15 September 2009. Directions were issued and the parties produced a working document setting out the terms regarding the amendments to C`s statement that had been agreed, both before and during the first hearing. The parties also submitted a written submission regarding the issue of costs of the proposed placements and the legal principles involved in the case.

Facts

1. C has a complex range of difficulties. He has a rare diagnosis of balanced reciprocal translocation of long arms of chromosome 15 and 18 and the deletion of the long arm of chromosome 8. He has a diagnosis of autistic spectrum disorder, dyspraxia, Duane's syndrome (damaged cranial nerve), mild conductive hearing loss and a diagnosis of Pathological Demand Avoidance Disorder (PDA). He presents with significant learning difficulties concerning physical, cognitive, behavioural and educational issues and these also affect his communication and social abilities.

2. C had attended GP School, a LA maintained special school, for a period of only two weeks in 2006. However, his parents withdrew him from that school as they did not feel that the school was meeting his needs or was able to fulfil the requirements of the statement and they therefore placed him at SM School, Bexhill on Sea, a non-maintained special school for children with speech, language and social communication difficulties. He remains at that school as a day pupil funded by his parents and the school remains his parents`s preferred school for C. Mr and Mrs M now wish for C to attend as a residential pupil and contended that there was an educational reason for him to receive a residential education. The LA had not intended to issue an amended statement when C became of secondary school age as his statement named GP School, an all age special school. However, on 30 April 2009, following judicial review proceedings taken by Mr and Mrs M, the LA issued an amended statement of special educational needs which named placement at GP School in Part 4. Mr and Mrs M therefore appealed against Parts 2, 3 and 4 of the statement. The LA objected to parental preference for SM School mainly on the ground that it would be an unreasonable use of public expenditure for C to attend the school when appropriate provision could be made at less expense by his attendance at GP School. The LA also had reservations regarding the therapeutic approach adopted at SM School.

3. The cost of a day placement at SM School is £28,489 per annum with transport costs of £950 a year making a total additional cost to the LA of £29,399 per annum. The annual cost of a residential placement at SM School is £43,512, together with transport costs of £1900, making a total additional cost to the LA of

£45,412 per annum. There was disagreement as to the additional cost to the LA of a place at GP School. The LA argued that placement is pre-funded and therefore there is no additional cost to the LA if C attended the school. Speech and language therapy costs were stated to be £30 per hour by the LA making a total of £4920 per annum if the parental amendments sought were agreed. Occupational therapy is calculated at £60 per hour making a further additional cost of £7,860 if the parental amendments were agreed. Physiotherapy would be a nil additional cost, there would be a small cost of a sound field system of £453 and transport costs would be £3800 per annum. The LA submitted that the additional cost of GP School would be £17,033 a year.

4. Mr Silas argued at the first hearing that Mrs Clark had stated that there was already a maximum number of 80 pupils on roll and C would be the 81st pupil, over the pre-funded number of pupils. He argued that a previous Tribunal Decision in March 2006 stated that the cost of one hour of direct therapy would be between £5000 and £7000 a year. He therefore argued that this would be the cost for each individual therapy and that the total cost of C`s placement at GP School with transport would therefore be at a minimum of approximately £25000 per annum. He argued that for a similar amount of cost, the provision that C would receive SM School is far more than would be available to him at GP School and the Tribunal also needed to take into account that C would find a change of school to GP School extremely difficult.

5. Following the first hearing, the parties' representatives produced a working document showing the agreements that had been reached. The issues regarding Part 2 of C`s statement had been discussed at the first hearing and the only outstanding matters that remained in Part 2 following further agreements reached related to a statement that C is interested in peers and will indulge in role play sometimes unsure of what is real and what is fantasy. His parents submitted that this is unusual and different to a child diagnosed with ASD. They also wanted stating that C remains a vulnerable child, that his diagnoses of ASD together with PDA have necessitated a very unique approach to teaching. The issues outstanding in Part 3 of the statement related to the provision of the three therapies, the experience/qualifications of staff in PDA/behavioural issues, an appropriate peer group, the need for specially adapted classrooms and the need for a sound field system and the need for a waking day curriculum.

6. At the annual review in 2009, C was said to be working towards Level 1C in reading, Level P7 in mathematics and Level P8 in science. C had been assessed by Educational Psychologists in 2002 and 2005. Assessments using the Lieter scale in 2007 indicated that C has significant learning difficulties with his non-verbal skills. However, the Clinical Psychologist stated that because of C's avoidance behaviours, it is difficult to be definitive about his exact level of current functioning as regards his intellectual skills. Ms RB had attempted to carry out an assessment with C in February 2009. Using the BAS11, C was quite cooperative on the verbal comprehension sub-test and at a chronological

age of 10.8 years, he scored an age equivalent of 3.4 years but became confused by more complex instructions. C became resistant and oppositional on the Pictures and Similarities sub- test and Ms RB had stated that this was due to being asked to do something that was not to his own agenda. With a teacher sitting with him he managed to score at an age equivalent of 4.7 years. Ms RB felt that C did have the potential to learn once his non-compliance could be harnessed. Ms RB concluded that is not clear what C`s cognitive ability is and the greatest challenge for him is not his cognitive difficulties but his attitude and behaviour.

7. The 2009 Annual Review stated that his parents had been pleased with the progress that C and made over the past year. His class teacher stated that his levels have improved dramatically. Mrs Ford's report stated that she had observed C in July 2009. She had stated that it was unusual for a child's anxiety to rise within the context of a school environment which operates an integrated therapeutic approach specifically geared towards mediating a child`s sensory overload. She felt that it was unfortunate that the school had not adopted elements of the TEACCH approach which previously had proved successful in building up C's confidence.

8. Regarding communication, C is generally able to communicate his needs by speech, gesture and pointing. He has relatively good social skills but has poor social communication skills. His level of play skills are variable. Ms F agreed that he does engage in fantasy and there are times when the school has to draw a line. Other children with ASD do not exhibit this and the school does not have to draw such boundaries. Mrs Ford disagreed and said this was typical of a child with ASD.

9. Ms RB had observed C in class and in the playground. C did not immediately understand the difference between real and make-believe during a game in the playground. She had felt that C is one of the most complex children she has observed and assessed over the years. His school see him as being towards the lower end of the moderate learning difficulties range and not in the severe learning difficulties range. She had concluded that his indulgence in role play, sometimes unsure of what is real and what is fantasy, is unusual and different for a child diagnosed with ASD. He is adept at social mimicry.

10. The LA had originally not agreed with the diagnosis of PDA. However, the existence of this diagnosis was agreed at the first hearing. Nevertheless, Mrs Ford still felt that PDA is generally associated with children who have a higher level of cognitive ability than C. C had been seen by Dr B, Consultant Paediatrician, in February 2009. She noted C will become distressed and angry if he is misunderstood. He is occasionally impulsive and can unknowingly hurt others and can be a danger to himself. Dr B had set out a plan of action in her report and felt that C needed a comprehensive assessment of his behaviours by a Child Psychiatrist in the area of behavioural difficulties in the context of

disability and learning difficulties. She was to contact the local community paediatric team in this regard. She was also mindful that parents would benefit from input from Social Services, particularly with regard to respite. We have not been presented with any further report by the child psychiatrist and it appears that no respite has been agreed for Mr and Mrs M.

11. C was seen by Dr JM, associate specialist in neuro-developmental paediatrics who works within the Child and Adolescent Mental Health Service. The report by her from the Winchester Autism and Asperger`s Assessment Clinic in July 2009 and admitted as late evidence noted that a play based assessment is a helpful way of assessing how a child is functioning in terms of social interactions and imaginative play skills. The play assessment with C lasted 50 minutes. Dr JM said that C`s social mimicry is consistent with a diagnosis of PDA. Under the diagnosis of ASD it is now recognised that there are a group of disorders rather than a single disorder. PDA is in this group. She stated that by appreciating C's strengths in role play, strategies that would not ordinarily be used for pupils with ASD can be employed. She concluded that C does have difficulties on the autistic spectrum which are best described by the defining criteria of PDA. An article by Phil Christie, Director of Children`s Services within Nottinghamshire Regional Society for Children and Adults with Autism had spelt out some of the strategies to be used in teaching children with PDA.

12. Regarding C remaining a very vulnerable child, Mr Y had assessed C and his family. He had concluded that C is exceptionally vulnerable other than in the very watchful company of his parents. This vulnerability is rarely exposed because of the protection afforded him by his parents. C is a child who has problems with enuresis and is prone to fungal infections as a consequence. He requires regular medical oversight. He has a pattern of sleeplessness.

13. The report from SM School in March 2009 noted that since admission C had made slow progress in language, physical, academic skills and social communication but that these remain severely impaired for his chronological age. The non-directive approach has proved to be essential in ensuring C's cooperation and ability to access teaching and therapy. He has received an appropriately differentiated curriculum delivered in a total communication environment and has shown an increase in his confidence and motivation. It is essential for C to build good relationships with people before he is able to communicate effectively with them. The report said that the approach adopted is supported by the writings of Professor Newsom and relate to the trust and relationship between staff and child and also an indirect approach. Experience has shown that withdrawing C from class for individual therapy sessions and skills training is not successful. He is unable to incorporate what he has learnt into another situation. Teaching of therapy has taken place in functional settings using indirect methods and learning by imitation of peers.

14. Mrs Ford`s report said that the initial assessment of SM School noted the

perception of C having underlying behavioural issues and that it could be that this influenced initial management strategies. She said that C`s developmental history up until this time had highlighted his underlying levels of anxiety and his difficulties in coping with change. He was also known to prefer to be a passive observer initially when placed in a new context needing time and reassurance before building up the confidence to engage. She felt the assessment process of SM School would have proved taxing for him and judgments could have been made about his behaviour which subsequently influenced the management approach.

15. Regarding C's communication needs and requirements for direct speech and language therapy, C presents with significant speech and language difficulties and continues to function at around the 3 year level. He has progressed with his understanding of concepts from an age equivalent of 2 years 10 months in 2006 to 4.01 years. Currently C sentences can be at a 7-8 word level. His receptive vocabulary remains a profound area of difficulty and he does not use signing to accompany his language. He is generally able to convey his needs without this.

16. JF, independent speech and language therapist, had assessed C in March 2009. C was very non-compliant in formal assessment. Observation by her showed that C has relatively good situational understanding although there was evidence of difficulty in following relatively simple language. She said that Signed English is essential for C in order to support his comprehension. She recommended that in order to support C's weak receptive language, he needs a consistent environment where signing is used across the curriculum and into the waking day. This needs to be a gramatically based signing system and not just a basic signing vocabulary system such as Makaton.

17. Ms F said that this signing was required to aid comprehension and develop concepts and to develop expressive language. C needs to develop grammatical construction. Mrs Ford, however said that C is reluctant to sign and progress was very limited. There was a need to differentiate signs at his level and there needs to be more checks to ascertain if C has understood. Ms F said that C`s speech is reasonably clear and the only reason signing would be used would be to address his word finding difficulties. As C is starting to use words such as "his", the method being used is working. Because of his hearing loss he often misses out on the endings of words and therefore signing helps with that difficulty.

18. Mr and Mrs M wanted C taught in classrooms adapted to accommodate children with either hearing difficulties or sensory integration difficulties and teachers and staff need to wear a transmitter for a sound field system. The LA recommended an auditory processing assessment by the teacher for the hearing impaired. A sound field system brings the teacher`s voice to a level where it is the dominant sound and Ms F said that this makes a huge difference. SM

School has this in place. C had an audiological assessment in March 2009 revealing a mild hearing loss. The report stated that a sound field system makes a significant difference to C`s ability to access the curriculum and improve his acoustic environment. Sensory integration may be affecting his auditory awareness and he may well be hypersensitive to auditory stimulus. Mrs Clark said that GP School does not use a sound field system. However the school is a modern school, purpose built in 2007. There is one child with a hearing impairment who has hearing aids and uses sign supported language. At SM School, the majority of rooms are adapted.

19. Regarding speech and language therapy, the LA had not presented any updated speech and language therapist report. At GP School, speech and language therapists support all children across the school. The full time therapist spends one day a week in a class. Programmes are put in place and delivered by school staff. There is also a speech and language therapy assistant available once a week and there are trained teaching assistants. No child receives direct therapy. JF had reported that C has difficulty being withdrawn for therapy because of his PDA. At SM School, a lot of work is done in class through small group work and in lessons differentiated with assistance from the speech and language therapist and occupational therapist. Speech and language therapist sometimes works specifically with C although in his class. For example, the therapist runs a Maths Circle class and some DT classes. The therapist needs to be there at the time because of C's PDA and the therapist needs to know why he is failing in any particular issue. The school has 8 full-time speech and language therapists and 1 speech and language therapy assistant. There is a multi-disciplinary meeting once a week.

20. Mrs Ford did not feel there was evidence of significant progress in terms of language. She pointed to the speech and language report in 2005 stating that C could "understand and use language at the 3 key word level". The annual review from SM School said that C made a good attempt to follow 4 word level instructions. She stated that there that was no evidence that the intensive approach had resulted in a major difference. In expressive language the annual review report 2005 said that C was able to use simple 4-5 word sentences. SM School report that C had shown good progress in his sentence length, use of vocabulary and grammatical development.

21. JF recommended intensive daily speech and language therapy planned and delivered by a therapist across the curriculum and into the waking day. She did not feel the programmes delivered primarily by other staff allowed for the in-depth knowledge that is necessary to plan appropriately and keep amending and updating targets. He needs speech and language therapy in individual, small group and classroom based therapy with an integrated approach. The minimum amount of time each week would be 2 hours.

22. Regarding occupational therapy, C had been assessed in February 2009

by SW for a joint independent occupational therapy and physiotherapy assessment. Firstly, she had felt that it is imperative that C continues to have access to a learning environment that has a sound field system. It was agreed that C continues to have significant attention, behavioural and sensory processing difficulties which impact on his functioning and performance across all areas affecting his ability to participate in the curriculum. His sensory integration difficulties affect his ability to access learning. He has a tendency to become overloaded by variety of auditory, visual and tactile stimulation and displays tactile sensitivity and has difficulties with body awareness. The LA had not arranged an occupational assessment for C. At GP School, occupational therapy is bought in at present for 4 children from a private clinic. VR, PCT Occupational Therapist, had replied to the LA by e-mail, never having observed or assessed C. However, twice weekly direct occupational therapy was offered by her for C together with 30 minutes per year and an annual assessment and monitoring. She had found it difficult to understand why C required direct occupational therapy. SW commented that it is questionable whether C would have made the amount of progress in the areas of fine motor skills and visual processing without the level of therapy intervention he has received while SM.

23. There are 2 physiotherapists at GP School. One is there for 1 day a week and the other for 2 days a week with the physiotherapy assistant there for 4 days a week supplied by the PCT. The amount of direct therapy was agreed at 30 minutes 1:1 physiotherapy each week. Parents want this to move towards a block of daily sessions together with 6 sessions of 30 minutes each year for training, a session for annual assessment and further specificity for monitoring, for equipment and contributing towards the IEP and liaison with a total time specified each year for the physiotherapist and occupational therapist.

24. Miss F said that there are weekly meetings at SM between the therapists who plan for the next week's lessons and how to differentiate for children. It is important to plan for success for C as he can shut down. Mr and Mrs M stated that C leans towards adults. He likes slapstick e.g. such as Dad`s Army or Fawlty Towers and will indulge in role play regarding this. He believes he is a character from these programmes. The PDA diagnosis has helped them understand his difficulties. His anxieties need to be managed. He is becoming bigger and stronger and more aggressive and more defiant and more isolated from them and his siblings. They have to hide things away such as lighters and keys. They feel they have reached the limit as to what they can do to influence him. After attending the 3-day residential assessment at SM he was calmer and played cards and a board game. The TEACCH approach is not suitable for him.

25. Mrs M had reservations regarding the peer group at GP School. There are only 4 children she felt who had reciprocal speech. There was a lot of coming and going in the classroom. C could not concentrate. The suspension equipment at the school was put into the main hall which was totally inappropriate. Mrs Clark said there were no children at GP school with PDA.

Some children are manipulative and who have sensory overload and refuse to cooperate. The school caters for children with complex learning needs. The school would not use a TEACCH approach if C did not respond. C would have an Individual Behaviour Plan and all staff are trained in addressing the needs of children with ASD. Staff do not know enough about PDA but there are children who have similar behaviours. Mrs RB argued that the multi-professional approach adopted in SM school works for C. Failure for C is and would be catastrophic.

26. There are 79 pupils in total at GP School, with 39 being of secondary age. There would be 7 children in year 7 with C at GP School. There is a year 7 inclusion class which would spend 75% of the time in the mainstream school. The school is physically located on a mainstream site although is separate and uses a different entrance as regards the lower part of the school. The school is a single storey building which has a multipurpose hall, a food technology room, soft playroom, splash pool area, Ball pool, library, sensory room, and autistic facility. The building also has a therapy room. The 2008 Ofsted report stated that the school provides a satisfactory quality of education. There is a good specialist autistic resource meeting the needs of pupils with autism. There would be 79 pupils on roll with C being with 2 boys and 4 girls. The profiles of the peer group were given to us in detail. There are 2 ASD children. One has limited social communication and is able to initiate questions and talk in phrases. Both ASD children are able to generate 3 to 4 word sentences. There is a child with learning difficulties who can initiate 4 word sentences. Another learning difficulties child has a 2 word expressive level and there is a year 8 Down's child with severe learning difficult and another girl also with significant learning difficulties who is able to understand a 4 word sentence. Reading ages range from around the 5 year level to above the 9 year level. 5 children have 4 word expressive language.

27. The Year 7 teacher has hearing impaired teaching experience and BSL experience. Signed Supported English can be used. There are 2 full-time equivalent teaching assistants in the group. The school has signed up for the accreditation scheme with the National Autistic Society. There is online training for ASD and 2 staff are taking an ASD diploma and all staff have TEACCH training. The ASD outreach teacher was based at the school until 9 months ago. About a third of children have ASD diagnosis. We were told that has been change in peer groups since 2006 with new entries in year 7 and year 6.

28. We were told that behaviour is not a major issue. Positive handling is used and staff are trained in how to de-escalate difficulties. There is a distraction free area with workstations where children can be withdrawn and can work individually. A school nurse is available for 3 days a week. All staff have had some sensory processing training. There is suspended equipment and a music therapist and weekly input from the Educational Psychologist and the school does run after-school clubs.

29. Ms RB said that at the time of the Ofsted report the school was still establishing itself. It is an emerging and developing school. Children go into the playground and at lunch and the inclusion class may well be there. At assemblies and whole school situations C`s peer group would not be limited to his class. This is important as playtime is a learning experience for him. There appears to be no transition programme in place. SM School needed time for him to adapt to the new environment. The class was not a low stimulation environment. The TEACCH programme is not appropriate. 2 of the group have limited social communication. Mrs M said that when she was at the school she saw little evidence of signing.

30. Regarding the need for a waking day curriculum. Ms RB said that the indirect approach has worked. With the school day there are constant flashpoints due to C's PDA which have potential to escalate. C avoids work and therefore that opportunity for learning has gone. If this happens consistently throughout day he needs time to make up what is missed. This time is would normally be given to children by way of home work. C does not have the opportunity to make up lost time. In after-school activities learning takes place C because the education is not so stringent. Teaching and learning should involve constant checking to see if C`s skills have been generalised to other contexts. Learning for C takes place best in functional contexts. She felt that he could make more progress.

31. C had an assessment at SM School in March 2009 and the multi-professional team believe that his progress to date, together with his complex needs now place C in a position where a waking day curriculum is necessary in order to progress his skills to functional levels in all areas. The assessment concluded that C's should be educated in an environment where the multi-professional team work with C to embed their skills into all functional settings. A waking day curriculum is therefore essential to increase his skills, particularly to develop his communication skills, his problem solving, social communication and his activities of daily living. The report gave details of programmes that would be used in communication, personal social, literacy and numeracy, physical, information technology and independence. The report recommended opportunities to transfer and generalise C`s learning. These programmes should be consistently implemented both in school and in residential settings so that continuity is achieved. The learning goals set in care, therapy and education environments need to be implemented by staff who collaborate regularly and who use the same teaching styles and approaches during the day. C needs consistent boundaries and routines, with clear expectations and time to adjust to new plans and added staff support at times of change. We heard that SM School does not employ strategies or staff to encourage consistency of approach into the home environment. We were told that staff at GP School would do this and if necessary visit the home environment.

32. Mr Y said that C is a vulnerable child. He gravitates towards adults and can withdraw totally. He felt he was at a significant risk. He has holistic needs and it is impossible to single out what is education. He did not see how the objectives in the statement could met without him being a residential student. Mr and Mrs M said that C now spends one night a week at SM. Programmes addressing issues such as washing and dressing, money management or independent travel are implemented.

33. The LA's reservations regarding SM school related to C being taught in a group, children have higher cognitive abilities and C`s peer group are more socially aware. It had concerns that play programmes were not educational programmes. Mrs Ford had concerns that C's avoidance behaviour was entrenched and that there was no evidence that the regime at SM School is working as he had not made this progress in basic attainment skills. Any progress in speech and language was due to C becoming older. She had concerns regarding his self-esteem as he has to strive to keep up with other children.

34. Ms RB replied that the peer group has changed at SM School. C`s P levels between 2007 and 2009 had shown progress. Ms F said that there was not just group teaching at SM School as there is some withdrawal. C is withdrawn for speech and language sessions, one with the occupational therapist and with the physiotherapist. Ms F gave us details of the year 7 group. There is a child with acquired brain injury whose BPVS score is 9.4, with speaking and listening at level 2A, an Asperger`s syndrome child whose BPVS score was 8.1, with speaking and listening at Level 3, a cerebral palsy child whose BPVS score is 5.10 with speaking and listening at Level 1C, a girl whose speaking and listening is at Level P8, a boy with Downs Syndrome whose BPVS score is 4.0 with speaking and listening at Level 1C, a boy with severe speech and language difficulties with a BPVS of 3.3 and speaking and listening at Level P6 and a child with Worcester Drought syndrome, similar to cerebral palsy, whose BPVS score is 3.3. The speech and language therapists feel that C has made very good progress. The LA had never expressed any concern regarding C's progress since he had been placed at the school.

35. Mr Silas said that Mrs Ford first denied the diagnosis of PDA which now appears to be accepted. GP school had no child with this diagnosis. There was no transition plan, no occupational therapy available and no integrated therapy. Mr and Mrs M felt the previous Tribunal had been misled regarding the provision that was available. Mr Silas went through the statement stating that GP School would be unable to offer a holistic approach, generalisation or a total communication environment or occupational therapy and physiotherapy integrated into the curriculum or a consistent approach. He reminded the Tribunal that it had to rely on evidence presented to it. The LA had not produced any reports from a speech and language therapist and physiotherapist and the PCT occupational therapist had not met C. There was a need for specificity even

within the LA special school as therapists were not on the school staff. He reminded the Tribunal of what is education under the Bromley judgment.

36. Ms Scolding's summary stated that generalisation of skills and liaison and consistency do not automatically require a residential school setting. She argued that there is potential for as much fragmentation within a residential setting as within the home setting with dedicated parents. C`s behavioural difficulties are not of the extent and nature as to having required the engagement of social services to any meaningful degree. The Tribunal has no power to order a residential placement on the basis of social care concerns. Mr Y's report noted that C is well nurtured and cared for. He also has self-care skills developed by his parents. The term "special educational needs" did not encompass every activity where therapy which could achieve some benefits. The parents' argument is that anything which helps the child learn to do was educational. If that was correct, there would, in reality, be no cases where children required their skills to be generalised which would not inevitably lead to a residential placement.

Tribunal's conclusions, with reasons

We carefully considered the written evidence submitted to the Tribunal in advance and the evidence given to us at the hearing. We also took account of the Code of Practice and the relevant sections of the Education Act 1996 and the Special Educational Needs and Disability Act 2001.

Our conclusions are:

A. Parts 2 and 3 of the statement dated 30 April 2009 should be amended by the terms of the draft amended statement annexed to this Decision, subject to the following conclusions and order of the Tribunal.

B. Regarding the remaining issues in Part 2 of the statement, we concluded as follows:

1. Mr and Mrs M wanted an amendment that C's indulgence in role play and being sometimes unsure of what is real and fantasy is unusual and different to a child diagnosed with ASD. They referred to the report of Ms RB regarding this. We concluded that the autistic spectrum is a wide spectrum where childrens` difficulties and functioning can vary considerably. We were therefore not convinced that the statement should emphatically state that this particular aspect of C is unusual and different to a child diagnosed with ASD.

2. As to whether C remains a very vulnerable child with genuine worries for his future well-being, we regard this statement as ambiguous. It is not clear

whether it is meant that C has genuine worries or whether other people have worries about his future well-being. If it is the latter, which we suspect, then we regard the statement as tautologous. The description of C in his statement would lead to an inevitable conclusion that he is a very vulnerable child and therefore there must be worries over his future well-being. We can see no benefit including this obvious statement.

3. C`s parents wanted the fact that the diagnoses of ASD and PDA means that this has necessitated a very unique approach to teaching. We regard this amendment, if required, as provision and should be dealt with under Part 3.

C. Regarding the remaining issues in Part 3 of the statement, we concluded as follows

1. Mr and Mrs M now require C to have a waking day curriculum. SM School supports this. Ms RB also provided evidence to support this contention. Ms RB said that there was an educational need for this as C will inevitably miss much of the curriculum due to his behaviour and avoidance. He also needs to generalise skills learnt across a number of contexts. We were not persuaded with Ms RB's first argument that there is an element of "catch up" required in the need for a waking day curriculum. Many children unfortunately miss out on the curriculum due to difficulties and we would not regard this as a reason to order a residential education. Consistency of approach for C is agreed as being of benefit to him. Clearly, some element of consistency in communication and in approaches to managing his behaviour will be of benefit. There is an argument state that for C, education for him consists of him being able to communicate and being able to manage his behaviour as it seems that these difficulties do impact on his access to the curriculum. However, Mr and Mrs M have not had full social services involvement. Instead, they wish to pursue a residential education for C. We can see no reason why a consistent approach could not be encouraged by C attending as a day pupil at a school provided there is sufficient liaison between home and school and/or respite environment. It does not appear that this has been meaningfully attempted to date. We heard that SM School had not made any home/school input. GP School encourages this liaison. We therefore concluded that although a consistent approach would benefit C, that requirement falls short of requiring C to receive a residential education in order to achieve that consistency. We therefore also concluded that is not educationally essential that C is educated in an environment where a multi professional team can work with C in all functional settings.

2. Mr and Mrs M wanted C to have use of Sign Supported English, being a gramatically based signing system. Mrs Ford had observed C at SM School and noted that he did select symbols, although he was unable to build on this in the same way as his peers. There appears to be conflicting evidence regarding the need for this. There is a question as to whether C is of sufficient cognitive level to progress using a grammatical based signing system and whether this would

be successful, given his reluctance to use this at school. We were therefore concluded that given this conflicting evidence, the statement should not be emphatic in requiring the use of this and that the statement should merely refer to the use of signing across the curriculum.

3. Regarding the need for specificity of speech and language therapy and whether there should be given across the waking day, we have some difficulty in accepting that the speech and language therapist should recommend a waking day curriculum. The statement already provides for intensive daily speech and language therapy. The original statement had been specific in giving two sessions per week of direct therapy either individually, or in a small group or in the classroom with an integrated approach. We find the amendments sought by the parents to be extremely prescriptive and restrictive within the special school environment. They state that the therapist should necessarily work within the classroom for at least 3 hours per week. The argument is that C does not respond well to withdrawal. However, we do not feel that it is unreasonable to allow a specialist speech and language therapist within the special school environment to make professional decisions as to where the therapy should be delivered. Although statements are required to be clear and unambiguous in the provision made, there does come a point where specificity becomes too presciptive. The reason for placement within the special school environment is to take advantage of specialist and professional input and it appears to us that the amendments sought may unreasonably fetter professional discretion and judgement.

4. Mr and Mrs M wanted a statement saying that if C is placed in a school where his social confidence was stifled, his overall confidence would be adversely affected. We regard this as a negative statement and does not state what C needs by way of provision and should therefore be deleted.

5. Mr and Mrs M want C to have nurture-type activities and friendship development training through professionally trained staff and time to develop relationships with staff. This is a vague statement. It merely states that staff should encourage friendship with other peers and should form a good relationship with staff which would be attempted in any event in any special school. We can see no benefit in its inclusion.

6. Regarding the physiotherapy and occupational therapy amendments, for the reasons stated in our conclusions regarding speech and language therapy, we regard the very detailed specific amendments as too prescriptive in a special school environment where therapies are delivered on-site. The statement agreed by the LA does make provision for specific input from the occupational therapist. The timings requested are extremely specific e.g. 15 minutes for checking equipment, 30 minutes for annual assessment, 15 minutes for IEP contribution and 20 minutes liaison with other professionals. Despite the evidence from SW associates, we do not feel that this restriction should be contained in the

statement and that the statement should be so specific. There is a requirement sought for an expert and experienced physiotherapist. We do not regard it necessary to include the words "expert and experienced" as a physiotherapist will be qualified to carry out the necessary therapy. There is a requirement for regular 1:1 sessions aimed at addressing C' sensory integration difficulties. There does not appear to be any evidence to refute the requirement for this and we therefore agree this should remain as requested. We have amended the provision for therapies to reflect the parents` desire for more specificity and the evidence presented whilst respecting that the therapists will require some discretion in making their input.

7. There were amendments sought that C needs to learn in the context of a group of similarly able children. This was advised by SW associates, joined occupational/physiotherapy assessment. We have reservations as to the qualifications of a therapist to make such recommendations which are to be included in a statement. This would appear to be the domain of an educational psychologist in advising on this if it is a requirement for Part 3 of the statement. We therefore could not agree for this to be included. The statement had already made provision for placing C with peers of at least a similar level of verbal ability which we conclude is appropriate for him.

8. The need for occupational therapy appears in a number of places in Part 3 of the statement. We have therefore tried to rearrange this to put the occupational therapy provision together.

9. The audiological report recommended a Sound Field system. The need for this did not appear to be too much in dispute. We therefore agree for its provision and can see the benefit of this. However, we do not agree that C necessarily requires classrooms specifically adapted to accommodate children with hearing difficulties. At worst he appears to have a mild hearing loss. We also do not agree that the classrooms should be specifically adapted for children with sensory integration difficulties. The occupational therapist will be able to advise regarding sensory integration problems and how best to deal with them.

10. Mr and Mrs M wanted staff to be experienced in dealing with PDA. There is only one report which offered the diagnosis of PDA and this is the report from Dr JM which was admitted as late evidence. The LA had previously disagreed with this diagnosis. Dr B had recommended a further referral to the child psychiatrist regarding C' behavioural difficulties and it does not appear that this has been effected. The report by Dr JM, which followed only a one off 50 minute assessment, is the only report that has stated that C has difficulties which are consistent with the criteria for PDA. Even at SM School, they only have experience of one other child with PDA. We consider that this requirement for staff to be experienced in dealing with PDA is unrealistic. We prefer wording that staff should demonstrate that they understand the behavioural issues which arise in teaching children with a diagnosis of PDA. The requirement for a

multidisciplinary meeting is sensible. However, that this to be on a weekly basis is very prescriptive. We were not persuaded that, in reality, this is an educational necessity. We therefore concluded that the requirement for a weekly meeting should be deleted.

11. Mr and Mrs M also wanted the child psychiatrist to have an understanding and experience of PDA. We do not feel that the statement can make this requirement and should the child psychiatrist have limitations, he will be able to refer the matter on. Dr B had recommended that C be seen by a child psychiatrist who has understanding of these behavioural difficulties and we would wish for a report from such a person to be available before we can order this requirement to be put in the child's statement.

D. Regarding Part 4 of the statement, we concluded as follows:

1. There does appear to be a significant discrepancy in the costs of the 2 placements. For the reasons stated in the preceding paragraphs, we have concluded that a residential placement is not necessary. Regarding a placement at GP School, the evidence we heard is that C would be the 79th pupil and the school is pre-funded by the LA for 80 pupils. The additional cost of the placement at GP School to the LA would therefore be nil. Even if the total therapy provision that the parents sought had been ordered, we conclude that the cost of these will be substantially below the cost of the day placement at SM School of £28,000 per annum. There is a physiotherapist on-site at GP School who realistically would be able to provide the physiotherapy ordered . Occupational therapy would have to be bought in. It would appear that speech and language therapy can be provided at GP School but even if a small amount had to be purchased, the total cost will be well below the day placement at SM School.

2. It is therefore necessary for us to consider whether GP School would be an appropriate placement for C. From the evidence given to us, the provision offered at GP School may appear to be suitable. C would be educated in a small group. He would receive specialist tuition. Therapies are available either through on-site therapists or they would be bought in for him. There would be some peers who would be able to vocalise with him, although these are restricted. However, the report presented as late evidence Dr JM had raised the diagnosis of PDA. The LA had been rushed into issuing a new statement by judicial review proceedings and by the parents requirement for an expedited hearing. It had not been possible for there to be a proper investigation into this diagnosis. Although the LA had appeared to accept this diagnosis at the hearing, Mrs Ford still had reservations and she felt that PDA is generally shown to be present with children of a higher cognitive level than C.

3. Dr B had recommended a plan of action following a report in February 2009. She noted the diagnosis of autism but was unsure as to the diagnosis

regarding his behaviours and felt C required a comprehensive assessment of his behaviours by a child psychiatrist. Such an assessment does not appear to have taken place. The article and report produced as late evidence showed that provision normally used with children with autistic spectrum disorders may not always be appropriate for PDA children. We feel that there is now lack of clarity around C` presenting features and therefore there is difficulty in deciding the appropriate education for him. In particular, it would appear that although there is emphasis on the diagnosis of PDA, it would seem from the report from Dr JM that this is recognised as being within the group of disorders under the umbrella of the ASD. It is difficult for us to be sure as to the significance of the effect of such a diagnosis.

4. The LA had some reservations regarding SM School and the therapeutic approach adopted by it. They also had reservations as to whether C was making progress in such an environment. We understand these reservations and have some concerns that the education appears to be therapy led. Progress by C does appear to be limited if Mrs Ford`s evidence is accepted in this regard. However, it does seem that C is settled at the school. His demands and behaviour are being contained within the school staff. There is academic opinion that this approach is beneficial to children with PDA. In light of this, we do have concerns over placing him within GP School which appears to have no experience of children with such a diagnosis. There are other reservations regarding GP School in that it is situated on more than one site as stated in the Ofsted report. It is located in a mainstream school site. We do have concerns over C mixing with mainstream pupils at unstructured times. There are only a small number of secondary age pupils and a small number of girls. In his group there would only be limited contact with peers of similar verbal ability. GP School is a developing and emerging school. The report from Phil Christie had referred to the writings of Professor Newsom and had had recommended the appointment of a key worker. It does not appear that this would be readily available at GP school.

5. We therefore have some reservations in naming either school proposed, as it is uncertain to us as to whether C has PDA, despite the diagnosis from Dr JM and what the effects of this are on his education. One choice for us is to further adjourn the case for further investigations to take place as recommended by Dr B. However, the case has been already adjourned. We consider that this would be very uncertain as to C' placement and not in his interest and would cause even more distress within the family. We have therefore concluded that our reservations over GP School make a placement there inappropriate at this time, given our uncertainty over C` diagnosis. In view of the fact that C is settled at SM School, we concluded that he should continue to attend the school. However, we also concluded that it would be beneficial if further investigations as recommended by Dr B took place and therefore, the annual review of the statement should be brought forward to consider all the further evidence and the continuing suitability of the placement. The review should take place by 31 March 2010. This will give an opportunity for the parties to consider any ongoing

assessment of C, in particular in the light of the recommendations from Dr B. The annual review would therefore consider all the advices from school and professionals working with him and other advice obtained as a result of continuing assessment and monitoring. We also considered that it would be expedient for the Appendix to the statement to include the more recent medical and educational and psychological assessment reports received during 2009. We note that this had been requested by the parents and agree with this.

Order

The LA to amend Parts 2, 3 and 4 of the statement dated 30 April 2009 by substituting the terms of Parts 2, 3 and 4 of the statement annexed to this Decision

Dated 14 October 2009

Signed:

Tribunal Judge Anthony Davies