25 March 2022

Child Safeguarding
Practice Review Panel

Dear Mr Travers,

Oskar Miles Nash, Deceased - Regulation 28 report to prevent future deaths

I am writing further to your Regulation 28 report in relation to Oskar Miles Nash. We note with concern your conclusion that Oskar died as a result of Suicide contributed to by neglect on the part of Surrey and Borders Partnership NHS Foundation Trust's Child and Adolescent Mental Health Service, and that his death was more than minimally contributed to by the various failures of: Surrey and Borders Partnership NHS Foundation Trust's Child and Adolescent Mental Health Service; Surrey County Council's Special Educational Needs Department; Surrey County Council's Children's Services Department and Targeted Youth Support Team; and St Dominic's School and Cobham Free School, as outlined in your report.

We note your finding in Concern 10 that neither of the post-death reviews conducted into Oscar Nash's death by the Surrey Child Death Review Partnership Team and the Surrey Safeguarding Children Partnership resulted in a sufficient or effective investigation of the death; that fact finding was superficial, there was no meaningful analysis of the part played by statutory agencies in the causation of his death, and only very limited learning was identified.

We agree with your conclusion that 'ineffective review by the child death review processes results in the risk of further deaths in similar circumstances', and note your concern that 'the local and/or national process, guidance and oversight are insufficient to ensure that an effective post-death investigation, which should not be dependent on the inquest process, is achieved in all cases'.

In our response to your report, we will outline the steps we have taken and continue to take, in conjunction with the Department for Education, local Safeguarding Partners and with other national and local stakeholders to improve the quality and effectiveness of the child safeguarding practice review process. We restrict our response to those areas which come within our purview as the National Child Safeguarding Practice Review Panel.

We note the finding expressed within Concern 10 in relation to the child death review process, and note that responsibility for those processes rests with the Department for Health and Social Care, the National Child Mortality Database

team, and with the local Child Death Review Partners. While this is outside our remit, we recognise there are nevertheless considerable areas of overlap and we seek to work in collaboration with those responsible on areas of mutual interest so as to improve learning and reduce the risks of future death or harm to children.

The purpose and remit of the National Child Safeguarding Practice Review Panel

The National Child Safeguarding Practice Review Panel (hereafter the Panel) was established in 2018 as part of wider reforms to interagency working to safeguard children, as specified in the Children Act 2004 and amended by the Children and Social Work Act 2017. The purpose and remit of the Panel and the wider processes of local and national reviews are outlined in Chapter 4 of Working Together 2018.

The purpose of reviews of serious child safeguarding cases is 'to identify improvements to be made to safeguard and promote the welfare of children'. Working Together 2018 stipulates that 'Reviews should seek to prevent or reduce the risk of recurrence of similar incidents'. It goes on to state that they 'are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose'. As such, these reviews are not intended to be investigations into the cause or circumstances of the death or serious harm, nor to determine whether any individual, organisation or agency was culpable. Nevertheless, at all stages of the safeguarding practice review process, both the local Safeguarding Partners, and we as a national Panel, seek to identify and learn lessons with a view to improving practice and better safeguarding and promoting the welfare of children.

Working Together 2018 specifies that the responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Panel and at a local level with the Safeguarding Partners. As a Panel, we are responsible for identifying and overseeing the review of serious child safeguarding cases which raise issues that are complex or of national importance, and to maintain oversight of the system of national and local reviews and how effectively it is operating.

The remit of the Panel and of the safeguarding practice review system is limited to reviewing serious child safeguarding cases which are defined as those in which:

- abuse or neglect of a child is known or suspected **and**
- the child has died or been seriously harmed.

The death of a child in which abuse or neglect is not known or suspected would therefore not come within the Panel's remit, and responsibility for any review of such deaths sits with the child death review partners. Such cases may at times come to the notice of the Panel when, for example, it is not clear whether abuse or neglect may have contributed, or where there is nevertheless potential for learning in relation to safeguarding children.

Where a local authority in England is aware of a serious child safeguarding case that meets the above criteria, they must notify the Panel and the local safeguarding partners within five working days. On receiving notification of a serious child safeguarding case, the safeguarding partners should promptly undertake a rapid review of the case. The aim of this rapid review is to:

- gather the facts about the case, as far as they can be readily established at the time;
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately;
- consider the potential for identifying improvements to safeguard and promote the welfare of children; and
- decide what steps to take next, including whether or not to undertake a child safeguarding practice review.

The Panel's expectation is that these rapid reviews will be completed and submitted to the Panel within 15 working days. It is important to note that the timeframes for these rapid reviews are tight, so as to ensure that any learning coming out of the review process is not delayed and that the system of learning proceeds promptly and efficiently. This means, however, that any fact finding will, necessarily, be limited and the rapid review is geared towards identifying immediate learning. Should the rapid review identify the potential for further learning, then the expectation is that this will be explored through a Local Child Safeguarding Practice Review (LCSPR).

The LCSPR is a more in-depth review, commissioned by the safeguarding partners, where they determine that there is potential for further learning to identify improvements to practice. These reviews should take a thorough and systematic approach to learning from the case, and should seek to involve the family as well as relevant practitioners and managers. They should be completed within six months, published and submitted to the Panel. The reviews should be carried out by an independent reviewer, using principles of systems methodology and in a way that enables the review to look at and analyse frontline practice as well as organisational structures and learning. The reviews should be proportionate to the circumstances of the case, focus on potential learning, and establish and explain the reasons why the events occurred as they did.

Local Safeguarding Partners have a duty to ensure that the review is of satisfactory quality. The Safeguarding Partners also have a responsibility to disseminate learning from the review and to take appropriate action in response to the findings.

As part of its remit to maintain oversight of the system and how effectively it is operating, the Panel receives and appraises all rapid reviews and LCSPRs. We provide feedback to the local Safeguarding Partners on the quality of both rapid reviews and LCSPRs, and identify, collate and disseminate learning arising from these reviews.

Actions taken to date to improve learning

Since its inception, the Panel has been sent over 1500 rapid reviews and we have seen the publication of more than 100 LCSPRs. In 2021 there were a total of 398 rapid reviews, of which 156 related to fatal cases and 242 to non-fatal serious harm. In 125 cases (31%), the local Safeguarding Partners decided to commission an LCSPR.

As a Panel we have had significant concerns about both the quality and timeliness of both the rapid reviews and the LCSPRs. While we have seen some excellent examples of high-quality review and learning submitted within the specified timeframes, we have also seen rapid reviews and LCSPRs that are tardy, unfocused and insufficiently analytic. We recognise that some of this has been due to Safeguarding Partners and reviewers getting used to the new system of reviews. In addition, the Covid-19 pandemic and consequent lockdowns had a particular impact on the ability of Safeguarding Partners to complete both rapid reviews and LCSPRs in a timely manner. Nevertheless, we remain concerned that, too often, the reviews are not of sufficient rigour and quality to identify meaningful learning and to drive relevant improvements to children's safeguarding.

In 2018 the Panel produced detailed practice guidance which outlined the process of reviews and our expectations for what makes for good quality reviews. We are in the process of updating this guidance in light of our learning since 2018.

In response to each rapid review and LCSPR which we receive as a Panel, we write to the Safeguarding Partners, providing feedback on the content and quality of the review, any learning arising from it, and actions we are taking as a Panel in response to any national issues identified. While initially much of this feedback was focused on the process and criteria for reviews, we have increasingly been more detailed and focused on issues of quality and learning. In cases which are particularly complex, or where we as a Panel have particular concerns about the quality of the review, we will often engage directly with the Safeguarding Partners through telephone calls or online or face-to-face meetings, offering advice, guidance and support. Where we deem a review to be of insufficient quality, we may ask the Safeguarding Partners to amend the report, or take further action to achieve more meaningful learning, or ask for evidence of implementation and impact of action in response to any recommendations.

Over the past two years we have sought to improve our communication with Safeguarding Partners in order to improve the quality of and learning from the review process. We have instituted a system of regional working with individual Panel members assigned as leads to each of the nine government regions. This has been backed up by a series of regional webinars, in which we have explored learning coming from both local and national reviews as well as issues of quality and process.

In addition to our oversight of the system of local reviews, as a Panel we are

responsible for commissioning national reviews into cases which raise issues of national importance. To date we have completed and published three national reviews, each of which has been a thematic review, drawing on a number of cases relating to a particular theme: sudden unexpected death in infancy (SUDI); child criminal exploitation; and non-accidental injury in infants aged under one. Each of these thematic national reviews has sought to identify relevant learning to inform practice and system improvement within the relevant area. While the Panel has no immediate plans to announce a national review into suicide it remains a theme in which we have a very keen interest and we will continue to analyse the cases which we see to consider if a practice briefing or more detailed piece of thematic work in this space would aid system learning.

Ongoing and planned actions to improve learning

As a Panel we have noted improvements in both the timeliness and quality of rapid reviews over the past year. We continue to feedback to local Safeguarding Partners on the content and quality of their rapid reviews. We are now also receiving significant numbers of completed LCSPRs. To date, very few of these have been completed within the required timeframe of six months, and many have been delayed by a year or more. We consider this unacceptable and are working with Safeguarding Partners to ensure that they take a more streamlined and focused approach to learning through the LCSPRs, but we are aware that there is still a long way to go.

In recognition of the ongoing issues around timeliness and quality, and taking note of your expressed concerns regarding the Oskar Nash rapid review, we are currently updating our practice guidance, with a much greater focus on issues of quality and learning in the reviews. We are planning also to publish some anonymised examples of good quality rapid reviews as exemplars of good practice.

We continue to monitor the learning from all rapid reviews and LCSPRs and are in the process of developing an observatory function to provide up-to-date data and information on all serious safeguarding cases, along with a case tracking system to enable us to monitor and report on the progress of reviews. We have, to date, and will continue to commission national analyses of the learning from rapid reviews and LCSPRs, and both of these pieces of work include some analysis of the quality of those reviews. We publish the findings of these analyses as part of our annual report.

We continue to commission national thematic reviews and currently are undertaking a review of domestic abuse which we intend to publish shortly. In addition, we are carrying out two case-specific national reviews – one into the deaths of Arthur Labinjo-Hughes and Star Hobson, and one into safeguarding children with disabilities and complex health needs in residential settings - both of which will report later this year.

Conclusion

We note that the rapid review on Oskar Nash was undertaken in January 2020. A lot has happened since then, and it is our impression that there have been significant improvements in the quality of both rapid reviews and LCSPRs over that time. We recognise, however, that there is still a lot to be done to ensure that the system of safeguarding practice reviews is more fit for purpose. We welcome this Regulation 28 report as a stimulus both for us as a Panel and for all local Safeguarding Partners to improve the quality of reviews and the overall learning coming from them.

I hope that this letter provides you with relevant and helpful information about the national system of reviews of the circumstances around the deaths of children as a result of abuse or neglect.

Yours sincerely,

[redacted], Chair – Child Safeguarding Practice Review Panel