Richard Travers
HM Senior Coroner for Surrey
Sent via email

Leadership Office
Woodhatch Place
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Reigate, Surrey
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25 March 2022

Dear Mr Travers

Inquest touching the death of the late Oskar Nash

I write in response to your Regulation 28 Report dated 31 January 2022 and thank you for the same.

Each of the concerns directed to Surrey County Council has been fully considered. I set out below the response to each concern in turn.

Concern 6
The evidence at the inquest revealed that the staff in the Education / SEN Department, including SEN caseworkers, had insufficient understanding of Autism, its links to co-morbid mental health conditions, self-harm, and suicidal ideation, and how to communicate with an autistic child. I am concerned that there continues to be no requirement for the staff to undertake relevant Autism training on a mandatory basis.

Response:
On 30 November 2021 the Executive Director for Children Families, Lifelong Learning and Culture wrote to all staff in the Directorate setting out the Autism Awareness Training offer available for all staff in the Directorate.

The training is now mandatory for all staff working directly with children and young people and must be completed by 31 March 2022. The uptake of the training is being monitored for each individual. The awareness training must also be completed by all new starters as they join as a part of their mandatory training.

The training captures:

- **information on autism diagnoses, how the condition impacts the individual and the challenges for people who work with or care for people with autism.**
- **key issues such as the autistic spectrum, the causes of autism, autism and social communication issues, autism and body language, facial expressions and tone of voice, mind blindness, sensory issues, coping methods and the positives of autism.**
- **the different effects of the condition for those on the autistic spectrum and how to support someone with dealing with those effects.**

- **the potential link to mental health issues, anxiety, and self-harming.**

The training does not currently capture fully the link between autism and self harm or suicidal ideation, and the associated risks. The SCC Children's Academy is currently in the process of reviewing the training required in order to equip all frontline workers to recognise this risk and is in the process of identifying the most appropriate further training package for relevant staff to broaden understanding around this. SCC is committed to rolling out this further training package at the very earliest opportunity.

As part of the SCC All Age Autism strategy, significant additional funding has been secured to raise awareness and understanding of staff around autism generally.

Concern 7
The evidence at the inquest showed that, in the months before his death, Oskar Nash was moved from a special needs school and placed into a mainstream school which did not have the facilities or expertise sufficiently to meet his complex needs. I found that the inappropriate placement, by SCC, of Oskar into the mainstream school contributed to his death.

Prior to the placement, the mainstream school had been provided with Oskar's Educational, Health and Care Plan, but this failed adequately to identify and record his mental and emotional health concerns, his risk of suicidal ideation, his consequential needs, and the provision required to meet those needs, and it had not been updated to reflect a series of subsequent reviews of the Plan and significant subsequent events. The mainstream school was not provided with any of the extensive and informative records from the special needs school from which he was being moved.

I was told by the mainstream school that, had they seen the records held by his special needs school, they would have recognised their inability to meet his needs and informed the SEN Department accordingly.

At the prevention of future deaths hearing, I was told that it continues to be the case that a prospective school will usually be provided by the SEN Department with the child's EHCP only. Further, it was apparent that there is a lack of clarity as to the extent to which a current school may or should provide records or information to a prospective school.

I am concerned that there is an ongoing risk that placements of children with EHCPs are being made on the basis of inadequate information and record sharing.
On the evidence before me, it was clear that, even if an EHCP were comprehensive and fully updated (which may not be the case), it is unlikely to contain all matters of relevance to the question of a prospective school's ability to meet the child's needs.

I was given no good reason why fuller information and record sharing, sufficient to ensure that the prospective school can properly assess its ability to meet the child's needs, should not take place before any child with an EHCP is placed in a new school. I am concerned that there is no system in place, locally or nationally, to ensure this is achieved by the relevant SEN department for every child with an EHCP. I am also concerned that there is an ongoing lack of clarity as to schools' powers and duties to share information and documents, and any data protection ramifications this may have.

Response:
When a change of school placement is being considered, the Council's SEND department is required to share a comprehensive and accurate up to date EHCP

(including, where relevant, supporting information that is considered important) for the prospective school to consider. This could include supporting assessments and information resulting from the most recent annual review. These documents combined should provide a clear picture of the current needs of the child or young person and the arrangements needed to support their learning, meet their needs, and secure the planned outcomes.

SEND Code of Practice para 9.82 states that advice from schools, colleges and other education or training providers will contribute to the development of an EHCP to ensure that it meets the child or young person's needs, the outcomes they want to achieve and the aspirations they are aiming for. SCC complies with this national requirement. The intention is for the EHCP to contain all necessary information.

Steps have been taken to better train SEND officers with a view to ensuring EHCPs are drawn properly with advice from the wide range of professionals named. Significant improvements in the quality of EHCPs have resulted. These EHCPs can then be relied upon to share all necessary information.

There is no national requirement for the local authority to share child protection files or to require schools to do so.

Keeping Children Safe in Education (DfE) 2021 paragraphs 105-113 sets out guidance to education providers on the subject of information sharing.

At 110. KCSiE states:
110. The Data Protection Act 2018 and UK GDPR do not prevent the sharing of information for the purposes of keeping children safe. Fears about sharing information must not be allowed to stand in the way of the need to safeguard and promote the welfare and protect the safety of children.

To this end, any school wishing to seek further information from the current/prior school can request such information and the school receiving that request can make a decision about whether it is suitable to share such information in line with the guidance. This is a matter of professional judgment on a case by case basis.

Given the sensitive nature of safeguarding files and child protection information, SCC does not consider that a blanket system of sharing such information for all children with an EHCP is necessary or appropriate in relation to the placement of a child in school. However, where a school considers that they require further information they can make this request by exception.

Safeguarding concerns and/or child protection concerns should not form the basis of a decision of an educational provider as to its suitability to meet a child's need. It is a national expectation that all educational providers will be able to support children with concerns around self-harm and/or suicidal ideation including where this is co-morbid with other conditions, including autism. Any child or young person could experience or develop suicidal ideation or self-harm at any time. This is, very sadly, a common occurrence and systems of support should be in place in every educational provider to support children in school with, where appropriate, the help of partners eg. mental health services. This national expectation and approach is set out in the Department for Education publication Promoting Children and Young People's Mental Health and Well Being published 21 September 2021 (first published in 2015) and the referenced Public Health England Guidance published September 2021.

SCC is in the process of reviewing its guidance to educational providers and has committed to incorporating in that guidance clearer information around the parameters within which information can be shared between educational providers and to highlight

that schools can, where considered appropriate, request additional information from a current/previous school. SCC is committed to concluding the review by May 2022.

The SEND Code of Practice paragraph 9.89 states that mainstream education cannot be refused by a local authority on the grounds that it is not suitable. A local authority can rely on the exception of incompatibility with the efficient education of others in relation to maintained nursery schools, mainstream schools or mainstream post-16 institutions taken as a whole only if it can show that there are no reasonable steps it could take to prevent that incompatibility.

In paragraph 9.90 the Code of Practice further sets out that, where the local authority considers a particular mainstream place to be incompatible with the efficient education of others, it must demonstrate, in relation to maintained nursery schools, mainstream schools or mainstream post-16 institutions in its area taken as a whole, that there are no reasonable steps that it, or the school or college, could take to prevent that incompatibility. Efficient education means providing for each child or young person a suitable, appropriate education in terms of their age, ability, aptitude and any special educational needs they may have. Where a local authority is considering whether mainstream education is appropriate (as opposed to considering the appropriateness of an individual institution) the term 'others' means the children or young people with whom the child or young person with an EHCP would be likely to come into contact on a regular day-to-day basis. Where a parent or young person has expressed a preference for mainstream education and it would not be incompatible with the efficient education of others, the local authority has a duty to secure that provision.

Concern 8

The evidence at the inquest revealed that the staff in SCC's Children's Services Department, including Social Workers and other Team members, had insufficient understanding of Autism, its links to co-morbid mental health conditions, self-harm and suicidal ideation, and how to communicate with an autistic child. I am concerned that there continues to be no requirement for the staff to undertake relevant Autism training on a mandatory basis.

Response:

The Coroner is respectfully referred to the response to Concern 6 above. The communication from the Executive Director for Children, Families, Lifelong Learning and Culture of 30 November 2021 was sent to all staff within the Directorate. This includes both staff within the Education department and those within the Children's Services Department.

Equally, the further training to be offered addressing more specifically the link between autism and self-harm or suicidal ideation and the associated risks, will be rolled out to all relevant staff within both the Education department and the Children's Services Department. SCC is fully committed to ensuring that all relevant staff receive appropriate training around autism and the associated risks.

Concern 9

At the inquest I found that following Oskar Nash's final referral to SCC's Children's Services Department, which was made approximately two months before his death, there was a failure to appreciate the seriousness of his situation and the risks arising, and a consequential failure to allocate his case appropriately. I found that this contributed to his death. The inappropriate allocation resulted, in part, from the application of SCC's then "threshold of needs" document, which was used to inform the level at which support should be provided.

At the prevention of future deaths hearing, I heard evidence about SCC's revised "threshold of needs" document, as well as the recent guidance (including a "toolbox") in relation to suicidality, which has been introduced since Oskar's death.

Despite these changes, I remain concerned that the "threshold of needs" document does not adequately and clearly reflect the known risks of mental health difficulties, self-harm, and suicidal ideation for autistic children (given their prevalence in this group of children) and that, consequentially, there is an ongoing risk that an autistic child in these circumstances will be allocated an insufficient level of support, as was the case for Oskar.

Response:
In light of the concern raised, there has been a further review of the current 'Effective Family Resilience' document undertaken and careful consideration of the need to make changes to that document. At the current time, we do not believe there is a need to update the document in the level of need descriptions with additional definitions or criteria. However, we have reflected that adding some wording within the section on page 8 (as outlined below) draws attention to the need to consider aggravating factors of mental health, suicidal ideation and autism which should weigh more on the assessment and need / risk grading rather than simply the initial referral trigger.

'The windscreen cannot replace professional curiosity, judgement or decision making and should not be used as a checklist or an assessment of need. The indicators of need are suggestions of the types of need a child and family may have. Sometimes their needs may include indicators from each of the levels, however combined, they may cause additional strain on the family (for example the impact of additional factors related to emotional wellbeing, mental health and or self-harm upon a child who has a diagnosis of autism) and following discussion with the family may indicate a higher level of support needed. Equally, there may be family strengths that are mitigating factors for the indicators'

We intend to update the 'Effective Family Resilience' document to expand this paragraph and include the wording above in red. This change cannot be unilaterally made but will be subject to the agreement of the Surrey Safeguarding Children Partnership and will need the approval of the Surrey Safeguarding Children's Board. We anticipate that agreement will be forthcoming and the document will then be amended accordingly.

Concern 10
At the prevention of future deaths hearing, I heard evidence concerning the post-death reviews conducted into Oskar Nash's death by the Surrey Child Death Review Partnership Team and the Surrey Safeguarding Children Partnership. The evidence showed that neither process resulted in a sufficient or effective investigation of the death; I consider that the evidence shows 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.

Ineffective review by the child death review processes results in the risk of further deaths in similar circumstances and I am concerned 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.

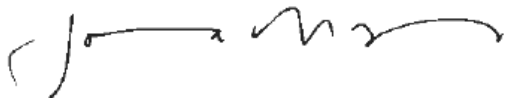
Response:
The Coroner's concern is respectfully noted. In terms of post-death reviews, SCC follows the national guidance set out in Working Together 2018. This gives flexibility for the local

safeguarding partnership to decide how learning may be best generated and disseminated. Even if the criteria are met, it is not an automatic requirement to hold a Local Children's Safeguarding Practice Review "*It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice*" (HM Government 2028:87). It is ultimately most important that local safeguarding partners respond to any death in a proportionate and appropriate way.

In respect of the post-death review into Oskar's death, SCC followed national guidance and took appropriate steps by way of a Thematic Review which was accepted by the National Panel.

SCC is aware that the Chair of the National Panel is also considering the Coroner's concern and will be providing a response to the same. SCC remains committed to following national guidance and will readily adopt changes in practice, if any, recommended by the National Panel.

Yours sincerely



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Chief Executive
Surrey County Council