NHS
Surrey Heartlands
Clinical Commissioning Group

Mr Richard Travers
Senior Coroner
HM Coroner's Court
Station Approach, Woking
Surrey GU22 7AP

58 Church Street
Weybridge
Surrey
KT13 8DP

[redacted]

28 March 2022

Re: Regulation 28 Report- Prevention of Future deaths- Oskar Nash

Dear Mr Travers,

Thank you for your Regulation 28 Report to prevent future deaths dated 31 January 2022 concerning the death of Oskar Nash on 10 January 2020. On behalf of Surrey Heartlands Clinical Commissioning Group (CCG), I want to express our deepest condolences to Oskar's family.

Following the prevention of future death hearing you raised a concern in your Regulation 28 report to prevent future deaths to the Chief Executive Officer of Surrey Heartlands CCG regarding the post death review process:

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 the 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 process 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.

I would like to assure HM Coroner and the family that we have taken the issues raised in the report very seriously, they have been carefully and thoroughly considered at every level of the organisation and we have begun taking steps to address the issues raised.

On 17 March 2022, the Surrey CDR team met with Professor [redacted], Professor of Infant Health & Developmental Physiology, University of Bristol and an academic at

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the National Childhood Mortality Database (NCMD) to discuss the CDR process in Surrey. NCMD are currently undertaking a review of Joint Agency responses nationally (which include Surrey cases) to improve, strengthen and review the process. Any recommendations from this review will be fully implemented in Surrey.

Additionally, we are asking the National Team to undertake a review of the Surrey CDR process. This will provide an independent view of our CDR process, identifying any areas of improvement and/or assurance. We would be pleased to share this, and any resultant action plan for improvement with you.

The Child Death Review (CDR) following Oskar's death is still open and is being completed in line with Statutory Process as outlined within the National Statutory Guidelines: Child death review: statutory and operational guidance (England). The review at the Child Death Overview Panel (CDOP) has not yet taken place, as CDOP do not consider any case until all investigations are completed, including the Coroner's Inquest and any further investigations, like a PFD hearing, as these are an integral part of the CDR process. This is to ensure that every opportunity to capture learning is taken up before the CDOP review.

The CDR is the process to be followed when responding to, investigating, and reviewing the death of any child under the age of 18, from any cause. It runs from the moment of a child's death to the completion of the review by the CDOP.

This is intended to be the final, independent scrutiny of a child's death by professionals who have had no responsibility for the child during their life. It is at this point in the process that all learning from Oskar's death is collated and includes information from parallel investigations, such as Coronial Investigation/Inquest, Joint Agency Response, Criminal Investigation, Serious Incident (SI) Investigation) into the final standardised report to NCMD to allow our local learning to influence national learning and future direction.

The CDR Team accept that the reporting forms (Form B's) received were minimally completed. The CDR Team do not have direct access to any agency records and rely on professional accountability and integrity when completing the Reporting Form B. However, we will take forward this learning to ensure when forms are received providing minimal information, we go back and request greater detail from agencies to ensure we have a complete account of their involvement in that child's life. In addition, a learning event has been arranged to support and provide guidance to professionals when completing a Form B.

Surrey CDR team have arranged a meeting with national colleagues in the NCMD to discuss the learning identified in relation to the completion of reporting form B's and improvements needed to the Child Death Review processes.

Working Together to Safeguard Children (2018 p.103) states – "All practitioners participating in the child death review process should notify, report, and scrutinise child deaths using the standardised templates". The templates are nationally agreed and available from the website www.gov.uk/government/publications/child-death-reviews-forms-for-reporting-child-deaths. The NCMD have replicated these templates for use within the electronic reporting system used in most areas across England, including Surrey (eCDOP). The majority of the boxes are direct questions with multiple choice answers, some provide free text. The format of the forms is nationally agreed, therefore, Surrey CDR team are not able to amend these forms at a local level. However, we will raise the issues identified with the NCMD to identify future improvements in processes.

In addition to the CDR process, to identify learning from a number of deaths from probable suicide and to help prevent future deaths, the CDR and the SSCP team undertook a thematic review in 2020**.** In response to concerns raised by parents, who reported that they had struggled to find information of where to access help and support**,** a Suicide Prevention Toolbox was developed. This is designed to be a living document which will be reviewed and updated as required. The Thematic Review was well received both locally and nationally and was used to challenge and influence the development of the design and offer of the new services in Mindworks Surrey. The action taken to date to prevent future similar deaths is as follows:

Dissemination of learning from the thematic review:

- In October 2020, over 200 participants attended one of four online sessions on 'Probable Suicide by Children and Young People in Surrey Thematic Review Learning Event' which was accredited for CPD by the Faculty of Public Health.
- The Learning from the Thematic Review and Suicide Prevention Toolbox was presented at dedicated webinars (Awareness of Autistic Spectrum Disorder (ASD); Management of self-harm; Prevention of alcohol and substance misuse; Parent support; Work across the County to mitigate Adverse Childhood Experiences (ACEs); Timely support for children and young people in crisis, Support for completing effective referrals; Implementing a Surrey Healthy Schools Approach)
- The Thematic Review and the Suicide Prevention Toolbox were published and shared at a national level with the National Safeguarding Panel and presented regionally at NHS England (NHSEI) and National Child Mortality Database meetings.
- Learning from thematic review and development of Suicide Prevention Toolbox has also been presented locally at:
  - monthly lunch & learn sessions which are attended by practitioners from all agencies across Surrey
  - GP safeguarding sessions
  - Incorporated in Surrey Children Services' academy training

An Action Plan was developed in response to learning from the Thematic review

- A multi-agency Task & Finish Group was established to develop an action plan based on the learning and opportunities not to be missed that were identified in the thematic review.
- It was identified that as part of the Surrey Suicide Prevention Partnership, while there is an established adult subgroup (with a delivery workplan to monitor progress of actions to meet the priorities outlined in the Surrey Suicide Prevention Strategy) there was not a specific children and young person subgroup.
- Following the completion of the Task and Finish group, a children and young person subgroup of the Surrey Suicide Prevention Partnership was established in September 2021 to develop a delivery work plan and continue the monitoring and progression of the action plan developed by the Task and Finish Group.

Oskar's death, including all information gathered throughout the CDR process, will be presented at the next suicide themed CDOP meeting; any additional learning and action required from Oskar's death will be shared across services/multi-professionals in Surrey and nationally via NCMD. We have transitioned to holding themed panels on a repeating cycle which allows for better identification of themes. This will also allow an opportunity to review whether prior learning has been embedded in practice and identify any ongoing areas of concern.

While there is still ongoing work to be done, I hope this response provides assurance that the CDR Team at Surrey Heartlands CCG are committed to working with national colleagues to address concerns related to CDR processes highlighted in the Regulation 28 Report to prevent future deaths and we thank you for the opportunity to further reflect on learning following the sad death of Oskar.

Yours sincerely,

Professor [redacted]
Interim Accountable Officer