

28 March 2022

Private and Confidential

Mr Richard Travers  
HM Senior Coroner for Surrey

[REDACTED]  
[REDACTED] Chief Executive

Chief Executive's Office  
Surrey and Borders Partnership NHS Foundation Trust  
Third Floor  
Leatherhead House  
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Leatherhead  
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Dear Mr Travers,

**Oskar Miles Nash (deceased)**

**Regulation 28 Report to Prevent Future Deaths**

**Response from Surrey and Borders Partnership NHS Foundation Trust ("the Trust")**

Thank you for the Regulation 28 Report to Prevent Future Deaths ("the Report") dated 31<sup>st</sup> January 2022. I have considered the Report carefully, together with senior colleagues from our Children and Young People's Service (CYPS). I have outlined below the steps that we have taken or intend to take, to address the concerns you have raised.

**Concern 1**

*The evidence at the inquest revealed that the staff responsible for the triage of referrals to child mental health services 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 have been told that the triaging process is now undertaken by an "Access and Advice Team" but I am concerned that there continues to be no requirement for the staff in that Team to undertake relevant Autism training on a mandatory basis.*

**Our response**

A new "Autism Awareness" half-day training course, provided by the Association for Psychological Therapies (APT), has been added to the mandatory training matrix for all CYPS staff. The course is designed to raise staff's knowledge and awareness of the importance of autism and covers issues such as:

- What causes autism
- What effect autism has on the person living with it, and their friends and family
- What the most helpful responses to autism are

The first training session was held on the 24<sup>th</sup> March 2022. The training is initially being offered on a priority basis to staff in the Access and Advice Team.

As an interim measure, while the “Autism Awareness” training is being rolled out, the document “Supporting autistic children and young people through crisis” (see **Appendix 1**) has been shared with all CYPS staff in the Trust. It is mandatory for all CYPS staff to sign to confirm they have read this document. The document is also going to be shared across the Alliance and a method is being developed to collect assurance that all Alliance staff have read it.

### **Concern 2**

*The evidence at the inquest revealed that, despite a series of referrals to child mental health services over many years, Oskar Nash never received the clinical assessment he needed. I have been told that the system now in place ought to result in a child such as Oskar being seen and assessed by a clinical team. I am satisfied that the introduction of the Access and Advice Team, in the context of the new Mindworks service, is intended to ensure that a referred child’s needs are properly identified and met.*

*However, on the basis of the evidence I heard at the prevention of future deaths hearing, including from a special needs school which has experience of referring its pupils, I am concerned that there is an ongoing risk that some referrals may be inappropriately closed (for example because the child, at an early stage, declines to engage) or inappropriately referred to non-clinical partner agencies. In this context, I am concerned that there is a lack of specific monitoring of what proportion of referred children reach a clinical team and the extent to which the outcomes match the expectations of the referrers (so that any ongoing “barriers” in the system, which may be preventing proper access to the clinical teams, can then be identified and eliminated).*

### **Concern 3**

*The evidence showed that a referral to the child mental health services is triaged initially as being crisis, urgent, priority or routine. The criteria for crisis, urgent and priority referrals are specific and narrow and, consequently, the great majority of referrals are categorised as routine. I have been told that the routine referrals are automatically categorised as “low risk”. I am concerned about this as it is clear from the evidence that a child may not meet the criteria crisis, urgent or priority but, like Oskar Nash, may nevertheless be at a high or medium risk of harm. The Trust is currently receiving a high volume of referrals and so there is a considerable waiting time for its “routine” cases to be addressed. It seems inevitable, therefore, that there are children in this category who have been wrongly assumed to be at low risk of harm but who, in fact, face a high risk of harm which is currently unrecognised and unmanaged.*

### **Response**

Concerns 2 & 3 are addressed below. A summary of the referral process is provided, followed by responses to specific concerns raised above.

#### Summary of how the Access and Advice Team process referrals

The Trust’s Access and Advice Team (AAT) provides a point of access to Mindworks Surrey and ensures that there is consistency of referral management, clinical screening and triage services. Referrals (now called ‘requests for support’) can be made by any professional working with a child or young person.

All referrals into the AAT are screened within one hour of receipt (during AAT operational hours) to ensure the urgency of referrals is identified and fit within the AAT's criteria. It is at the point of screening that the referrals are categorised as emergency, urgent or routine. The Trust recognises and is keen to impress that "routine" or "low risk" referrals do not mean "no risk" – all referrals will have associated risk, and the decision to screen a referral as "routine" is not taken lightly.

Routine referrals are then triaged; it is at triage that the referral is processed and allocated to a suitable provider. It is the Trust's aspiration that routine referrals are triaged within ten days of screening, however due to the volume of referrals received by the service, this target is currently not being met. As part of the triage process, a 'discovery conversation' is held with the child / young person and their family. Discovery conversations are a semi structured approach to identifying concerns, risks and goals from the child / young person's point of view and where their needs might be best met.

If a routine referral has been waiting for over four weeks to be triaged, then it is now subject to a harm review. The child/young person and/or their family will be contacted as part of this, and there will be a conversation about what the current situation is and whether there are any increased risks. Following this review, the referral will either be categorised as being suitable and safe to remain in the routine referral waiting list, with safety netting advice being provided. Alternatively, if the risks have escalated, the referral will be triaged immediately and then referred on to an appropriate service.

If the referral remains on the routine waiting list to be triaged, then it will be reviewed every four weeks, until the referral is triaged. Routine referrals are currently typically triaged within five to eight weeks. At times of high demand, additional weekend hours are being offered to clinicians who can assist with processing routine referrals.

The screening and triage of referrals is undertaken by a team of experienced clinicians who look at a number of factors including the expectations of the referrer and the information in the referral. They then cross check this back with the family and/or referrer when they are planning how the referral will be processed.

The workforce is structured to provide a supportive, multi-disciplinary team approach with shared accountability and responsibility for clinical case management. Clinical advice is sought from senior clinical and medical colleagues, clinical specialists and community team clinicians to further support the clinical integrity of triage decision making where required.

Where a child or young person doesn't want to engage with treatment this presents a challenge, particularly where the care and treatment cannot be provided without the engagement of the child or young person. Overriding a child or young person's refusal needs to be carefully weighed against the benefits of treatment and developing a therapeutic relationship or preventing the child or young person from becoming mistrustful of professionals.

Where appropriate, the Trust can employ its Assertive Outreach Team to support difficult to engage young people. The Trust can also reach out to schools, parents and other system wide partners. Joint

working arrangements mean that where a child or young person receives care from a partner agency, support can also be provided by CAMHS if this is indicated.

The CYPS Standard Operating Procedures are being reviewed to ensure that staff are guided to consider safeguarding and liaising with the Surrey County Council c-SPA where children refuse to engage with care and treatment, record their competence and capacity (where applicable) to consent, and consider if the threshold for providing treatment in their best interests or under the auspices of the Mental Health Act is met; and that this is recorded in their records.

Consideration of risks identified in other areas of the system is essential as risks escalating in other parts of the system can elevate the overall risk and might support more paternalistic decision making. The AAT are now able to access the Surrey Care Record, this provides an opportunity for wider sharing of risk information.

*Some referrals may be inappropriately closed*

Referrals will only be closed to the AAT without providing an onward referral in exceptional circumstances. This would typically be where the parent or carer does not engage in the triage process. Before a referral is closed a letter is sent to the parent / carer and the child / young person's GP, this provides the number to call should they wish to continue with the triage process, or if their circumstances change. Therefore, no referral is closed without the Trust having engagement with the GP and providing the parent / carer with information on how to get support if their circumstances change. Where there is no engagement from the parent or carer, a safeguarding referral must be considered.

If a child / young person doesn't engage in the triage process the AAT will liaise with their parent / carer and partner agencies (for example their school) to gain further information and establish the best way to support their needs. If there are no risks identified after making these enquiries, and speaking to the referrer, that indicate that assertive outreach support or a Mental Health Act assessment is required, it is likely the referral would be closed at that stage.

It is important that referrals are not held open indefinitely while attempts to contact parents are made, as this can create an inaccurate perception that the person is receiving support from secondary mental health services.

There is also clinical oversight of the decision making provided by staff in the AAT, which is provided by the Service Manager and Lead Clinician. Staff are supported to raise queries or concerns during the working day and also through supervision.

*Some referrals may be inappropriately referred to non-clinical partner agencies*

The significant changes that have been made to the AAT triage process (for example discovery conversations) will significantly reduce the risk of an inappropriate referrals being made.

If a referral is made to a partner agency and the circumstances of the child / young person have changed, or the partner agency does not feel able to meet the child / young person's needs, the referral can then be sent back to the AAT to be re-screened.

Where there is an escalating need identified by a partner agency there is also a professionals' line, which allows the partner to call the CAMHS community team duty worker directly for advice. Where appropriate, the child/young person can then be opened to the community team directly.

*There is a lack of specific monitoring of what proportion of referred children reach a clinical team*

'Clinical team' is understood to refer to a CAMHS service provided by the Trust.

The Trust monitors the total number of referrals that are received by the AAT and the number of referrals that are subsequently referred onto clinical teams, these are:

- Neurodevelopmental Pathway
- Community CAMHS and Primary Mental Health Teams
- Crisis Intervention Services including Hope and Extended Hope
- Learning Disability Service
- Eating Disorder Service
- Care Experienced Services

In addition, in the monthly Executive Finance, Contracts, Quality and Performance Accountability Committee, all referral activity to both clinical and non-clinical teams is reviewed.

*There is a lack of specific monitoring of the extent to which the outcomes match the expectations of the referrers*

When referrals are made, the referrer and family will have expectations of what treatment should be provided. Through triage, we refine our understanding and match our support in line with the child / young person's emerging need(s). Treatment goals are then established and the effectiveness of interventions are measured against outcome measures.

An example case study of this is provided below:

## Anonymised example of Goal Based Outcomes report for CYP

### GBOs - Goal Based Outcomes

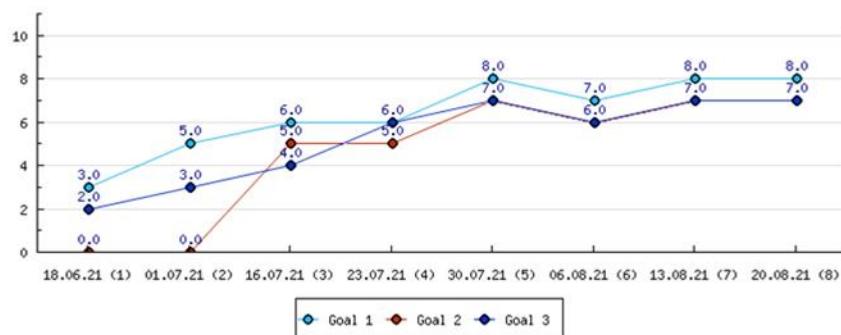
#### GBOs current rating

Goal Score

1. To wash my hands less often 8
2. To go out on my inflatable boat 7
3. To be able to go back to school 7

#### Graphic representation of GBOs progress towards goals

Min = 0 ("Goal not at all met") Max = 10 ("Goal reached")



## Case Study

### April to September 2021 – Wellbeing Coordinator support

The young person was referred to the Community Wellbeing Team in April 2021 from the Access and Advice Team to receive support with anxiety, feeling overwhelmed with emotions, struggling to cope with change, feeling different and insecure. After an initial discovery conversation with Mum via Zoom and then a further conversation with Mum and the young person face to face, it was identified that longer-term emotional wellbeing support was needed. The young person and their parents were presented with the different support options available to them, and they chose a referral to the Y's Girls mentoring programme and one to one sessions with a Wellbeing Coordinator whilst waiting for the mentoring to start.

One to one sessions started in June 2021 and these sessions covered a number of different areas such as friendships, asking for help and making mistakes, emotional regulation, negative thinking and managing uncomfortable thoughts and feelings. 'Bear Feelings Cards' were used to explore emotions; a story about worries and a 'traffic light toolkit' for managing emotions, affirmations and activities to boost self-esteem. During the penultimate session, the young person said that she has "become better at coping with things" and feels "more confident." She said that she felt "nervous and overwhelmed before" but now she feels "better at handling things." She will shortly transition to support from a Y's Girls mentor for approximately 12 months.

Throughout the treatment process staff endeavour to provide the referrer and GP with updates on the child and young person's progress. When treatment is completed the referrer and the GP are provided with a summary of the treatment provided and the outcome.

The Trust also receives feedback from the child / young person and their parent / carer through its Patient Advice and Liaison Service in the form of compliments and complaints, Your Views Matter (this is a feedback questionnaire that can be provided for completion at any point in a person's treatment journey, feedback is reviewed bi-annually at the Quality and Operations Board), and Family Voices Surrey (who obtain feedback from families with children who have a neurodevelopmental need and are stakeholders in commissioning and contract review for the MindWorks Alliance).

*I have been told that the routine referrals are automatically categorised as “low risk”. ... It seems inevitable, therefore, that there are children in this category who have been wrongly assumed to be at low risk of harm but who, in fact, face a high risk of harm which is currently unrecognised and unmanaged.*

The AAT Triage Scale definitions are currently based on the [Mental Health Triage Scale](#). The term low risk is adopted from this and is commonly used nationally in Children and Young People's services.

The MindWorks Standard Operating Procedure manual provides guidance to staff on how to grade referrals. It is only where the child / young person has been assessed as being at low risk of serious self harm or suicide, and there are clear protective factors in place, that referrals are screened as being ‘Routine / Low Risk’.

Harm reviews are undertaken every four weeks for referrals that have not yet been triaged and families are given advice on how to inform the AAT if they have any concerns or their circumstances have changed. In addition to this, should further information be received at any time, this will cause the priority of the referral to be reviewed.

NHS England is currently reviewing risk assessment and is intending to develop a best practice guide for clinical risk assessment by the end of 2022.

#### **Concern 4**

*I was told that the Standard Operating Procedure manual for the triage of referrals to children's mental health services is to be updated to reflect the Trust's new working practices but that this has not yet been done. I am concerned that important changes to the system of work (for example, the vital requirement that a referred child's records are reviewed before any triaging decision is made and the child/family are spoken to) are not yet established in written guidance.*

#### **Response**

The Trust's Standard Operating Procedure manual has been updated to reflect the new working practices; this was signed off on the 15<sup>th</sup> March 2022.

#### **Concern 5**

*The evidence at the inquest showed that the clinicians who were responsible for ensuring that Oskar Nash's medical conditions, including his risk of self-harm and suicide, and his consequential needs, were properly and sufficiently recorded in his Education, Health and Care Plan, failed to do so; this was in part because they did not fully understand their role and obligations in this regard.*

*On the basis of the evidence at the prevention of future deaths hearing, I am concerned that there continues to be a lack of understanding amongst the clinicians currently providing medical advice as part of the EHCP process as to their role in that process. I am further concerned that there is in place no programme for the training or monitoring of these clinicians in relation to these responsibilities.*

## **Response**

### **Summary**

Any healthcare professional can be asked to provide medical advice for EHCPs. Advice sought from the Trust can be provided by clinicians from Developmental Paediatrics and / or CAMHS.

### **Training**

All Developmental Paediatrics new starters have induction on EHCP advice. CPD sessions are then provided on a monthly basis and these will include training on EHCPs where there are changes or learning to be shared.

All CAMHS staff are provided with regular training / refreshers on the completion of EHCPs. The opportunities include weekly team business meetings, MDT discussions, case discussions and supervision, management supervision provided to doctors, monthly CAMHS doctors meetings. In addition to this the Designated Clinical Officers (DCOs) provide ad-hoc training opportunities for staff.

### **Monitoring**

Local Authority DCOs are employed by Clinical Commissioning Groups (CCGs) and have a specific role focused on special educational needs (SEN). They help CCGs oversee the care and treatment that is given to SEN children and give guidance on completion of EHCP documents and support EHCP tribunals.

These DCOs meet with the Trust's medical advisors (who provide quality assurance) regularly (every 2-3 months) to disseminate new guidance and help resolve any local challenges or queries in relation to EHCP requests. There is a good relationship between the DCOs and medical advisors, any more urgent matters can be raised outside of this forum.

In addition, medical advisors sit within Developmental Paediatrics and offer support where there are urgent queries arising about what to include in an EHCP.

I trust that the above information addresses the concerns that you have raised, and assures you that the Trust has taken further additional steps to prevent a similar death occurring in the future. However if you have any queries or questions, please do not hesitate to contact me.

Yours sincerely,



[REDACTED]  
**Chief Executive**