Re : OSKAR MILES NASH, DECEASED

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Chief Executive Officer of Surrey and Borders Partnership NHS Foundation Trust [in relation to Concerns 1 to 5 below]** 2. **Chief Executive Officer of Surrey County Council [in relation to Concerns 6 to 10 below]** 3. **Chief Executive Officer of Surrey Heartlands Clinical Commissioning Group [in relation to Concern 10 below]** 4. **The Chair of the National Child Safeguarding Review Panel [in relation to Concern 10 below]** 5. **Secretary of State for Education [in relation to Concerns 7, 10, 11 and 12 below]** 6. **Secretary of State for Health and Social Care [in relation to Concerns 10 and 12 below]**
1	**CORONER** I am Richard Travers, HM Senior Coroner for Surrey.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

3	**INVESTIGATION and INQUEST** I commenced an investigation into the death of Oskar Miles Nash. The inquest concluded on the 10th September 2021 when I found that the medical cause of death was - Ia Multiple Traumatic Injuries and my conclusion as to the death was that - Oskar Nash 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. Oskar Nash's death was more than minimally contributed to by the failures of : (i) Surrey and Borders Partnership NHS Foundation Trust's Child and Adolescent Mental Health Service : To undertake a clinical assessment of Oskar's mental and emotional health at any stage, despite a series of requests for them to do so, and a consequential failure to diagnose, treat, monitor and otherwise support Oskar as necessary, in order to minimise his risk of suicide. (ii) Surrey County Council's Special Educational Needs Department : (a) To ensure that Oskar's Educational, Health and Care Plan contained sufficient and updated information about his mental and emotional health needs and his risk of suicidal ideation, and the provision required to meet those needs, and (b) To place Oskar in an appropriate school, rather than in March 2019 his inappropriate placement in a mainstream school which did not have the facilities or expertise sufficiently to meet his complex needs. (iii) Surrey County Council's Children's Services Department and Targeted Youth Support Team : (a) To complete the required assessments following Oskar's referral in November 2019, and to provide any effective intervention or support, and (b) To reallocate the management of his case to a Registered Social Worker following escalation of Oskar's risk level in the course of November 2019. (iv) St. Dominic's School and Cobham Free School : To ensure that there was a sufficient sharing of information about Oskar's history, special needs and current situation, prior to his

	transfer from a special needs school to a mainstream school in March 2019. I subsequently held a hearing to receive evidence relating to the prevention of future deaths and this was concluded on the 7th December 2021, with time allowed subsequently for written submissions.
4	**CIRCUMSTANCES OF THE DEATH** Oskar Nash was 14 years old when he died. He had been diagnosed with autism at the age of 4 years and he suffered associated high anxiety throughout his life. It is likely that he also had one or more undiagnosed emotional or mental health condition(s). Oskar had a very significant history of periodic suicidal ideation and a history of self-harm, the risk of both of which receded when his needs were sufficiently supported. Oskar was well known to the Child and Adolescent Mental Health Service and to Children's Services, having been the subject of a number of referrals to both. His education was managed by the Special Educational Needs Department of his local authority as he had been issued with an Educational, Health and Care Plan. All state agencies concerned with Oskar had knowledge of his history of suicidal ideation. In March 2019 Oskar transferred from a special needs school to a mainstream school. Initially he appeared to cope, but from early November 2019 onwards, he regularly refused to attend school and a period of escalating risk followed. Referrals were made to CAMHS and Children's Services but Oskar did not receive any effective support. On the 9th January 2020, Oskar Nash gained access to an area of [redacted] and, a short time later, at about 17.06 hours, he deliberately moved [redacted]. His body was found the following morning. **Full details of the events and failings which lead to Oskar Nash's death are set out in my "Factual Findings and Conclusions" document, a copy of which is sent with this report.**
5	**<u>CORONER'S CONCERNS</u>** The evidence heard at the inquest revealed many matters giving rise to concern. The evidence received at the prevention of future deaths hearing showed that many of those concerns have been addressed.

However, in my opinion the following concerns remain and give rise to a continuing risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows :

A. Surrey and Borders Partnership NHS Foundation Trust

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.

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.

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.

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.

B. Surrey County Council (and National)

(i) Education and Special Educational Needs Department

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 <u>mandatory</u> basis.

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.

(ii) Children's Services Department

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.

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.

C. Surrey County Council and Surrey Heartlands Clinical Commissioning Group (and National)

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.

D. National Issues

Concern 11

From the evidence I heard at the inquest and the prevention of future deaths hearing, it was apparent that the national "Working Together" guidance focuses on children who are in need of safeguarding by reason of risks within the home or from other parental failures to keep the child safe. It was apparent that the consequential approach tends to look critically at the child's family and parent(s) and their parenting skills, and that this is likely to be inappropriate if the child is in need through disability. I consider that this had a detrimental impact on the approach of agencies to Oskar and his family.

I am concerned that "Working Together" does not provide clearer guidance specifically for the safeguarding of children with disabilities, including Autism, and the approach to be taken by agencies to parents and families.

Concern 12

The evidence at the inquest revealed a widespread lack of knowledge and understanding of Autism, its links to co-morbid mental health conditions, self-harm and suicidal ideation, and how to communicate with an autistic child. There was a lack of training across all the state agencies from which I heard. At the prevention of future deaths hearing, I heard evidence of more training being available, but also of an ongoing absence of comprehensive, relevant and mandatory training.

I was told that the National Autism Strategy does not currently include a timetabled commitment for relevant mandatory Autism training to be provided to all state agencies working directly with autistic adults and children.

I am concerned that this poses an ongoing risk to autistic children and their ability to access the services they require for their support, welfare, and safeguarding.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by addressing the concerns set out above and I believe your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **by the 28th March 2022**. I, as coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner, to the following Interested Persons and to the other organisations listed below which may find it useful or of interest: [redacted] The Chief Constable of Surrey Police The Independent Office for Police Conduct College of Policing (FAO the Autism Lead) Cobham Free School St. Dominic's School Relate West Surrey Relate British Transport Police I am also under a duty to send a copy of your response to the Chief Coroner. I may also send a copy of your response to any other person who I believe may find it useful or of interest.

	The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**31st January 2022** **Richard Travers**