The Children's Trust

Response to Regulation 28 Report
Issued by HM Senior Coroner, Professor Fiona J Wilcox
Following the Death of Raihana Oluwadamilola Awolaja

Acknowledgement of Loss and Coroner's Findings

We would like to express our deepest sympathy to the family and loved ones of Raihana Oluwadamilola Awolaja. Raihana was a much-loved young person whose tragic death has had a profound impact on our team and the way we care for, support, and involve the children and families we work with today at The Children's Trust.
We recognise the serious concerns raised by the coroner and are committed to addressing each of them fully. Raihana's death has prompted significant reflection, change, and action across our organisation.

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1. Safe Staffing and One-to-One Care

Coroner's Concerns:

- Children like Raihana are not always receiving the level of one-to-one care and supervision they require.
- Staff may lack clarity or training in what one-to-one care looks like in practice.
- Administrative duties may be prioritised over care.

Actions Taken:

- **Mandatory Training**: All care giving staff now receive mandatory, specific training on our monitoring and observation policy, including clear guidance on what one-to-one care entails at The Children's Trust. This training covers essential aspects such as proximity, engagement, and supervision.
- **Floating Staff Role Introduced**: We have introduced a flexible "floating" staff role available 24 hours a day. This role ensures that additional support can be provided promptly whenever needed, guaranteeing that children and young people consistently receive the appropriate level of care and supervision without interruption.
- **Dedicated Administrative Support**: Each house has been allocated a dedicated administrator, allowing care staff to focus on their primary caregiving responsibilities without being unduly distracted by administrative tasks.
- **Role Clarity**: We have clarified staff roles to ensure that direct care is prioritised over administrative duties. Staff have been formally instructed on this expectation.
- **Improved Handover Protocols**: Shift handovers now follow a standardised, structured protocol supported by clear tools to ensure comprehensive transfer of information between teams, reducing the risk of important details being missed.

- **Clinical Site Management**: A Clinical Site Manager, a senior nurse, is now present on site 24 hours a day. This role allows immediate response to any clinical issues or escalations, enhancing clinical oversight and quality of care.
- **Routine Audits**: In addition to regular monitoring and observation audits, Clinical Site Managers conduct routine overnight audits. These are systematically reviewed to maintain high standards of care.
- **Delegation Policy**: As part of our revised Delegation Policy, The Children's Trust now requires that every staff member allocated to provide one-to-one care for a child or young person, formally sign at the start of each shift to confirm their understanding of that individual's care, monitoring, and observation needs; furthermore, they must seek approval from the shift leader before stepping away at any time during the shift, including for breaks, and must obtain permission to leave at the end of their shift to ensure safe and continuous care with no gaps during handovers.

In Progress:

- We are in the process of embedding a revised evidence-based staffing model aligned with national standards. This model aims to continue to ensure the appropriate number and mix of staff are available according to the individual needs of each child.

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2. Incident Investigation and Accountability

Coroner's Concerns:

- A flawed investigation shifted blame onto an individual, failing to address broader systemic issues.
- A flawed investigation risks missing key lessons that could prevent future harm.

Response:

- We accept that the initial external investigation was inadequate and did not sufficiently explore systemic factors. We later identified and reported these issues in our Serious Incident Report and undertook further work.
- A revised internal investigation led by our Risk and Legal team provided a more comprehensive understanding and drove meaningful changes.

Actions Taken:

- **Incident Management Policies and Processes**: We have developed and implemented a revised incident management policy and process that incorporates national best practice standards to ensure robust and consistent handling of all incidents
- **Clinical Governance Framework**: Significant investment has been made in strengthening our clinical governance framework. This enhancement enables us to better identify and respond to recurring themes and trends, promoting continuous organisational learning and improvement.

- **PSIRF Implementation**: We have fully implemented the national Patient Safety Incident Response Framework (PSIRF) to guide all incident investigations, ensuring a consistent, transparent, and learning-focused approach.
- **Multidisciplinary Panels**: All incidents are now reviewed by multidisciplinary panels comprising of representatives from across the organisation, facilitating a comprehensive and collaborative review process.
- **Internal Oversight of External Reviews**: Investigations commissioned externally are now subject to additional internal oversight through our governance procedures. This internal review ensures that external findings are scrutinised rigorously and challenged appropriately to maintain high standards of accountability.

Additional Review:

- An independent review is currently underway to examine how we managed the investigation and disciplinary process related to this case. This review, due for completion by 30 June 2025, will also evaluate governance arrangements, equality considerations, and the potential influence that the PSIRF framework might have had at the time.

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3. Communication with Families and Local Authorities

Coroner's Concerns:

- Raihana's mother and the local authority were not informed about key developments, such as disciplinary proceedings.
- This lack of communication increases risks to vulnerable children.

Actions Taken:

- **New Communication Protocols**: We have implemented new communication protocols to ensure that all serious care or safeguarding concerns are promptly and transparently shared with the child's family and the relevant local authority. This is done in accordance with the Patient Safety Incident Response Framework (PSIRF) and our updated incident management policy and procedures.
- **Governance Oversight**: To ensure accountability and transparency, all such communications are systematically recorded and reviewed by our governance teams. These processes have also been independently reviewed by external regulators, confirming their effectiveness.

System-Level Improvements:

- **Risk Summit**: In November 2024, we convened a Risk Summit involving NHS England, regulatory bodies, health and social care partners, and commissioners. This summit

focused on improving access to specialist NHS services and reviewing our monitoring and observation policies to enhance the safety and quality of care provided.

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4. Listening to Families and Handling Complaints

Coroner's Concerns:

- Families were not always listened to or taken seriously.
- Complaints may have been dismissed without thorough investigation.

Actions Taken:

- **Family Satisfaction Surveys**: We have introduced quarterly Family Satisfaction Surveys, which families can complete anonymously if they wish. Feedback from these surveys is carefully reviewed and acted upon. Outcomes are escalated through our governance structure to ensure they directly influence service improvements and decision-making.
- **Monthly Family Forum**: A Monthly Family Forum has been established, attended by senior leaders including the Head Teacher and Chief Executive Officer. This forum provides a protected and supportive environment where parents, families, and carers can provide feedback, ask questions, and raise concerns. Discussions and themes from these meetings are formally documented, with agreed actions monitored and followed up at subsequent forums.
- **Increased Resource**: To strengthen the organisation's responsiveness, we have created a dedicated Clinical Governance Department. This department includes a senior role (Band 8a) specifically responsible for championing the experiences and perspectives of children, young people, and their families. This role ensures that their voices are embedded at every level of the organisation, with concerns and feedback escalated consistently and with appropriate oversight.

In Progress:

- **Revised Complaints Policy**: We are currently revising our Complaints Policy and process. This work involves a thorough review across the organisation to identify and address any gaps, ensuring the process is robust and aligned with national best practice standards.
- **Modified Martha's Rule**: We are introducing a modified escalation procedure, often referred to as "Martha's Rule," which will provide families with a clear and accessible route to request a second opinion or further review when they have concerns about the care provided.

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5. Internal Communication and Planning

Coroner's Concerns:

- Information shared in planning or safeguarding meetings wasn't always passed on to the frontline staff delivering care.

Actions Taken:

- **Standardised Handover Protocols**: We have introduced standardised handover protocols to ensure that all shift handovers consistently include relevant updates from planning and safeguarding meetings. These handovers follow a structured format that is regularly audited to maintain compliance and effectiveness.
- **Electronic Patient Records**: All care decisions and updates are now recorded within a comprehensive electronic patient records system. This system ensures that care staff have real-time access to accurate and up-to-date information, supporting continuity and quality of care across the organisation.

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6. Organisational Culture and Staff Confidence

Coroner's Concerns:

- Concerns were raised that staff might feel unable to speak up or challenge poor practice.

Actions Taken:

- **Nursing and Care / Clinical Governance Restructure**: We have undertaken a significant restructure within our largest directorate, Nursing and Care. This restructure strengthens clinical governance, risk management, clinical education, and operational leadership across the site to ensure improved oversight and quality of care.
- **Freedom to Speak Up**: In February 2025, we adopted the NHS-aligned Freedom to Speak Up framework and appointed an independent Guardian to support staff in raising concerns safely and confidentially. This represents a major commitment for our organisation, which is a smaller, non-NHS provider, but we believe it is essential to provide a safe, independent route for staff to raise concerns and ensure they are addressed with full organisational accountability.
- **Psychological Safety**: To promote psychological safety, we hold regular reflective safeguarding sessions and learning forums. These initiatives foster a culture of openness, transparency, and continuous improvement among staff. In addition, we are currently training 30 of our most senior staff and 53 first line managers in relation to psychological safety as part of a wider leadership development programme launched in 2025.
- **Thematic Reviews**: We conduct thematic reviews of all serious incidents to identify recurring issues. The findings from these reviews directly inform staff training and ongoing service improvements.

- **Culture and Values**: Our culture and values underpin everything we do and our organisational 'promises' – to put children first, to care deeply, to aim high, to be open, and to own it – developed in collaboration with our staff, volunteers, partners and children, young people and families, always guide us in the way we work and the decisions we make everyday.

Ongoing Commitment

We remain committed to embedding these improvements in a sustainable way, ensuring they are not one-off responses but part of a systemic shift in how we deliver care, learn from harm, and work with families and professionals.

We are confident that our current systems, informed by the national Patient Safety Incident Response Framework, are significantly more robust and responsive than at the time of Raihana's death. However, we also remain humble in our approach and open to continued challenge and oversight.

We also acknowledge that the issues raised in Raihana's case do not exist in isolation. The safety and wellbeing of children with complex needs requires a coordinated and transparent approach across the wider health and social care system. As such, we continue to work closely with our NHS and local authority partners to ensure risks are shared, escalated, and addressed collaboratively.

Our continued progress is subject to internal audit, external regulatory inspection from both OFSTED Care and the Care Quality Commission, and multi-agency oversight. In October 2024, we were rated as 'Good' by OFSTED Care who also inspected in January 2025 with no change to our rating. Both the Care Quality Commission and OFSTED Care have conducted targeted inspections over the last 12 months covering the areas detailed within this response providing us with significant assurance that this improvement work is embedded within practice.

Conclusion

Raihana's death has been a catalyst for fundamental change across The Children's Trust. We recognise that serious and avoidable failures occurred, and we are resolute in our commitment to improvement.

We take the coroner's concerns extremely seriously and have acted swiftly and extensively. We are confident that the measures we have already introduced will strengthen safety, communication, and trust across our services, and we know there is still more to do. We remain focused on our duty to every child in our care, and on ensuring that Raihana's legacy is one of learning, accountability, and lasting change.