In the Inquest Touching the Death of Oskar Miles Nash

Factual Findings and Conclusions

Mr Richard Travers
H.M. Senior Coroner for the County of Surrey
10th September 2021

Introduction

1. This has been the inquest into the death of Oskar Miles Nash. For ease, I will refer to Oskar Nash simply as "Oskar", as we have done in the course of the inquest.

2. The Interested Persons ("IPs") in this inquest are :

   (i) Mrs Natalia Nash, Oskar's mother, represented by Angela Patrick of counsel,
   (ii) Surrey County Council, represented by Malcolm Fortune of counsel,
   (iii) Surrey and Borders Partnership NHS Foundation Trust, represented by Rachel Gourley of counsel,
   (iv) Relate West Surrey, represented by Virginia Hayton of counsel,
   (v) The Chief Constable of Surrey Police, represented by Daniel Frier of counsel,
   (vi) Cobham Free School, represented by Andrew Banks, Solicitor,
   (vii) St. Dominic's School, represented by Thomas Mallon of counsel, and
   (viii) The Independent Office for Police Conduct.

3. At a pre-inquest stage I ruled that the inquest must satisfy the procedural requirements of Article 2 of the European Convention on Human Rights. The

purpose of this inquest is, therefore, as laid out in section 5 (1) and (2) of the Coroners and Justice Act 2009, which provides that I must ascertain who the deceased person was and when, where and how (meaning by what means and in what circumstances) he came by his death.

4. In order to answer those questions I have received and admitted oral and written evidence, over the course of four weeks, from Oskar's family and friends, from post mortem investigations and from the investigation conducted by the British Transport Police (including CCTV), from two of the schools he attended, and from the other IPs. I have also had the benefit of evidence from an independent expert. Unless I have stated otherwise below, I have found the witnesses to be honest and to have endeavoured to assist me in this investigation.

5. Set out below are my findings of fact concerning Oskar and his death, all of which have been reached on the balance of probabilities, as well as my conclusion as to his death. Reference is made below to some of the evidence I have heard but it is not intended to be, and is not, a comprehensive review of all the evidence before me. Rather, my intention is to explain, by reference to parts only of the evidence, why I have reached my findings of fact and conclusion. However, in reaching my findings and conclusion I have taken account of all the evidence I received, both oral and written. If a piece of evidence is not expressly mentioned, it does not mean that I have not considered and taken full account of it.

Background

6. Oskar was born on the 18th April 2005 in Chertsey and he died, at the age of 14 years, on the 9th January 2020. He was the elder, by 18 months, of the two sons of his mother, Natalia Nash, and his father, Mark Nash, whom came originally from Poland and USA respectively. Oskar's parents separated when he was three years old and, a few months later, his father died. Subsequently, Natalia raised her sons as a single parent.

7. When Oskar was four years of age, he was diagnosed as having Asperger's Syndrome, which is a form of autism; as I will come to below, this diagnosis was of great significance, but Natalia Nash gave evidence which provided a fuller picture; she described Oskar as a very intelligent and creative child who was curious about the world. By way of examples, she said that by the age three years he had worked out how their heating system worked, and when he was only 10 years' old, he used proper tools to construct a garden bench. She said, "He was never happier than when he was able to create, explore

nature and spend time with his dog." Mrs Nash also told me that Oskar was able to take part in activities with others, and she described his successes in the children's section of St. John's Ambulance, as well as happy trips they had taken as a family with their church. She said,

"*Oskar was at heart a very caring, sensitive, helpful and loving boy. This was his essential character and when things were going well and he was calm, this caring nature was very apparent indeed. Most people who met Oskar loved him and found him to be polite and always willing to help*."

Mrs Nash went on to say, however, that Oskar's "smile could quickly turn to tears" when things did not make sense to him, and he could become extremely anxious and distressed; this was because of his autism. Oskar's behaviour could then change and become very challenging, and if people around him did not fully understand, they could react in ways which made matters worse. She said that although Oskar was intelligent and could act in a mature way when he felt supported and understood, his lack of maturity and vulnerability were soon apparent when he could no longer cope with his environment.

8. There are three further matters which I note, at this stage, from what Natalia Nash told me about Oskar. The first is that Oskar missed his father very much and, from a young age and for many years, he suffered extreme separation anxiety when apart from his mother. Secondly, that it was not easy to communicate with Oskar and, because he found it challenging, he would often simply say what he thought the other person wanted to hear, even if he did not mean it. Thirdly, that Oskar was never able to come to terms with his autism diagnosis and its consequences and he hated being labelled as different to others; significantly, he resisted being assessed and supported, and he could become very distressed if people discussed his condition.

Oskar's Diagnosis and Its Effects

9. Natalia Nash said that it was apparent that Oskar was "different" from a very early age and, because of his behaviour at home and at nursery school, he was referred by the Community Nursery Nurse for developmental assessment.

10. Dr Francesca Tennant told me that she worked as part of the Developmental Paediatric Service in Surrey and she saw Oskar in 2009 when he was three years' old. Engagement with Oskar was difficult as he had high levels of self-direction and low tolerance to adult direction, and it was recorded that, "He didn't want to interact … and when he was extremely angry at the end of the

session, and screaming and crying, he shouted at his mum in Polish, and at the paediatrician in English."

11. Dr Tennant said that, even before she diagnosed Oskar, she was concerned about his emotional and mental state; she wrote to the Child and Adolescent Mental Health Service ("CAMHS"), which was operated by Surrey and Borders Partnership NHS Foundation Trust, in the following terms :

"Oskar is a complex child. He is described by his carers as delightful, difficult, able, articulate and unpredictable. He is likely to present a high level of challenge to his teachers when he starts school. His problems can be summed up as, first, he has an unusually strong bond with his mother, with significant separation anxiety, including prolonged screaming when separated. Secondly, Oskar becomes very anxious in unfamiliar situations, and those with a large number of people. Third, Oskar has some unusual features of social interaction. Fourth, Oskar has a high level of mental rigidity. He does not like change. He likes things to be just right. He tends to develop very strong interests, usually around mechanical, engineering subjects. Fifthly, Oskar finds it difficult to tolerate adult direction, but will work with an adult if it suits his agenda. Six, Oskar has very strong emotional responses. He has severe tantrums and is very difficult to calm down when upset. He will have tantrums if told what to do or told off. And seven, Oskar's father has been seriously ill and unfortunately died in February this year. Although Oskar's pattern of development was unusual before his father became ill, this may have contributed to his high levels of anxiety. Oskar has many features suggestive of autistic spectrum disorder. However, some of this may be accounted for by his need to control situations to avoid anxiety, and by his father's illness. And we would be grateful for your help in three areas. Managing Oskar's very high levels of anxiety as he starts school. Supporting mother as she copes with this very difficult child. Helping the family with coping with their bereavement. … I am hoping to review Oskar's diagnosis in around six months, in a joint assessment with Jan Sebestik, at his social communication clinic. Although autism seems likely, his ability to use his social skills to control others, and his high levels of anxiety, look like Pathological Demand Avoidance."

Dr Tennant explained that there is a high correlation between autism and certain psychiatric conditions including anxiety and depression (and I note that this accords with the NICE Guidance for Diagnosing and Supporting Children with Autism which indicates that around 70% of people with autism also meet diagnostic criteria for at least one other, often unrecognised, psychiatric disorder which further impairs their psychosocial functioning). Dr Tennant said, however, that very few children would be referred to CAMHS at the diagnostic stage; she referred Oskar because she was very worried about his level of anxiety. She said she was seeking CAMHS' more specialised psychological assessment and support and she was hoping they

would work with Oskar in relation to his mental health needs, and to provide bereavement support; she indicated that early intervention is often the most effective. Dr Tennant said she assumed that CAMHS would provide this help, but she did not know whether, in fact, they had done so.

12. Subsequently, in December 2009, Dr Tennant saw Oskar again, although this was at his school rather than in Dr Sebestik's specialist clinic as previously planned. She recorded that Oskar "meets the criteria for a diagnosis of Autistic Spectrum Disorder / Asperger's Syndrome." She explained that this was her formal diagnosis of Oskar.

13. I have had benefit of written evidence from an independent expert who has provided evidence about the nature of autism and its effects. The evidence came from Dr John McKeown, a Chartered Practitioner and Educational Psychologist. As regards the three conditions which Dr Tennant had mentioned in relation to Oskar, he wrote :

    (i) People with Asperger's Syndrome appreciate the world, in terms of seeing, listening and feeling, differently from other people. It is not a disease and cannot be 'cured'. It is sometimes indicated that the "cognitive wiring" is just different from so-called "neurotypical" individuals. Children … with Asperger's Syndrome do not have significant language and learning disabilities and function cognitively within the broad average range – in some cases they can function at very high levels of cognitive abilities. … Difficulties will be in the area of social functioning, social communication and repetitive patterns of behaviour. With appropriate support a high proportion of individuals with Asperger's Syndrome can function educationally and occupationally adequately - and pursue a good deal of independence. An important characteristic is a tendency to interpret information literally due to the difficulty they have with certain aspects of "reading the minds of others",

    (ii) Individuals with Autistic Spectrum Disorder, a broader term which is now used to include those with Asperger's Syndrome, show some of or all the following everyday functional difficulties:

- Engaging in reciprocal social interaction
- Understanding non-verbal social cues
- Repetitive and restricted interests and activities
- Sensory processing difficulties and sensory sensitivity, and
- Atypical language processing and communication,

(iii) The characteristics of Pathological Demand Avoidance are :

- Resists and avoids the ordinary demands of life
- Uses social strategies as part of avoidance, for example, distracting, giving excuses
- Appears sociable, but lacks some understanding – (Surface Sociability)
- Experiences excessive mood swings and impulsivity
- Appears comfortable in role play and pretence (unlike others with ASD)
- Displays obsessive behaviour that is often focused on other people.

The key factor for PDA is that individuals with this profile appear excessively controlling and demanding, especially when they feel anxious. The management of anxiety therefore is a key factor in helping them to cope with everyday demands such as that necessary for learning in a school environment and co-operation in everyday life. Children demonstrating social, emotional and mental health difficulties (SEMH) can also be evident within this presentation and can cause problems in relation to appropriate school placement and support.

14. Dr McKeown wrote in his report that other features associated with autism include variability in cognitive abilities and physical coordination, tactile defensiveness, noise sensitivity, anxiety management, and social competence in relating to others. He said that although the above terms are used, each autistic child will have his own individual profile; for example, it may be ASD with PDA traits. He wrote, "There will be a range of perceived differences between one individual and another - so that a formulation of individual difficulties is often more important for practical intervention purposes than the diagnostic category itself". Consequently, it is important that an autistic child is understood as an individual, as they may not fit fully in to a "typical" presentation.

15. Dr McKeown noted too that, (i) coping with independent functioning as the individual moves from childhood to adolescence and on to adulthood can be extraordinarily challenging, and even high functioning adults may need significant amounts of care and assistance to cope with everyday life, (ii) if high levels of stress and conflict due to their disability are experienced in adolescence, the potential for self-medication through alcohol and drugs will

increase and they will be vulnerable to exploitation and they may become more disturbed in the aftermath of their experimentations, (iii) The inflexibility associated with ASD and particularly PDA presentations have severe negative consequences in the case of traditional more authoritarian approaches taken by adults who expect compliance without negotiation, and (iv) as referenced in the NICE Guidance, there is a high prevalence of autism in the cohort of those who self-harm or commit suicide.

Events from 2009 to February 2017

16. Natalia Nash told me that following Oskar's diagnosis, she was provided with very little information about autism and its ramifications. Dr Tennant did not provide any advice as to how to manage Oskar's difficult behaviour; on the contrary, she said that she did not know how Mrs Nash could make him do anything, as her experienced team were unable to gain his compliance. There was no medical follow-up and Natalia Nash said that over the following months and years she read many books, spoke to other parents, and attended parenting classes, all in an effort to understand and manage Oskar's condition.

17. So far as Oskar's educational needs were concerned, it seems there was an expectation that Oskar would require specialist support at school. In August 2009, Dr Tennant had recorded her views as follows,

    "Oskar will require a carefully thought out environment to minimise his levels of anxiety. He is likely to benefit from strategies used with children with autistic spectrum disorder, … he'll require support when in groups with large numbers of other children, … and would benefit from having his own space to retreat to, a quiet workstation and he will need support to develop his ability to take adult direction."

    Mrs Nash told me that Dr Tennant said Oskar's school would take the lead in ensuring that a "Statement of Special Educational Needs" was put in place (although this did not, in fact, happen until six years later).

18. I heard evidence about the statutory obligations upon a Local Education Authority, in Oskar's case Surrey County Council ("SCC"), in relation to the education of children with special educational needs. I heard from Julie Beckett who, since April 2019, has been the Service Manager for SCC's Special Educational Needs ("SEN") services in the Northwest area of Surrey. She explained that :

(i) There is a statutory framework in place, covered by a Code of Practice, under which a Local Authority must, if asked to do so, consider assessing a child to see whether he has special educational needs. Requests for assessment usually come from a child's family or school. An assessment is not automatically triggered by a child receiving an autism diagnosis,

(ii) The Code specifies that, "A child or young person has special educational needs if they have a learning difficulty or a disability which calls for special educational provision to be made for him or her." If relevant needs are identified, then the Local Authority must issue and maintain what used to be called a Statement of Special Educational Needs, and is now called an Education, Health and Care Plan ("EHCP"),

(iii) As the name suggests, an EHCP must set out the child's educational, health and care needs, together with planned outcomes, and the specific provision which must be provided to meet those needs and achieve those outcomes; the focus will be on the provision needed in an educational setting. The provision identified is, in effect, the support and/or reasonable adjustments needed to enable the child's effective access to education,

(iv) So far as identified health needs are concerned, the provision required to address those needs may include medical treatment or specific therapeutic support; if so, it must be decided whether the provision is principally for educational purposes, in which case it must be specified in section F of the EHCP and will be funded by the Local Education Authority, or whether the provision is principally for health purposes, in which case it must be specified in section G of the EHCP and will be funded by the local Clinical Commissioning Group. Provision which is required to address emotional or mental health difficulties, such as anxiety or depression for example, may therefore be placed in either section F or G of an EHCP, depending on the specific circumstances of the child,

(v) Following its issue, an EHCP must be reviewed at least annually and further reviews may be triggered by certain events, and

(vi) A pupil with an EHCP may be placed in a mainstream school or a special school; either way, he must receive the provision identified in the Plan.

19. In September 2009 Oskar started at Our Lady of the Rosary Primary School. Julie Beckett confirmed that initially Oskar's primary school would have been expected to provide any additional support he needed to meet his needs out of their "school action plus" funding. Mrs Nash told me that she contacted Freemantle School in Woking, which specialised in autism, and asked them to advise Oskar's primary school as to necessary adjustments and strategies to manage his behaviour; they made recommendations but she felt the school did not follow them properly; she said they continued to treat Oskar the same as the other pupils and consequently Oskar's needs were not met.

20. A very significant problem in Oskar's early years was his distress when separated from his mother. Mrs Nash consulted the family General Practitioner, Dr Renal Patel, who made a further referral to CAMHS in October 2010, stating that Oskar was increasingly anxious at being left at school and was angry when he returned home, and his mother was struggling to cope. Dr Patel considered that, in the context of his Asperger's, Oskar needed specialist clinical management which was beyond her own expertise.

21. Oskar and his mother were seen by CAMHS on the 1st December 2010, but the outcome was simply that the school should be reminded of Freemantle's advice and that Mrs Nash should attend a parenting course. Oskar did not receive the direct assessment and support which Natalia Nash believed he needed, and which the GP had requested (as had Dr Tennant, 18 months earlier). Mrs Nash told me that CAMHS had said that Oskar had found contact with them too distressing.

22. Natalia Nash said that she remained concerned and so she sought an alternative primary school; she found a small school, which Oskar started to attend in April 2011 but, unfortunately, it soon amalgamated with other schools to become Riverbridge Primary School ("Riverbridge"), and it became much bigger, which was not helpful for Oskar. Mrs Nash said that subsequently Oskar's problems steadily grew.

23. In November 2011, when Oskar was aged six and a half, Mrs Nash reported to a doctor at the GP practice that she had been having problems getting Oskar to attend school and that he had "threatened to put a knife through his chest on a couple of occasions"; on the evidence, this appears to be the first recorded threat of self-harm or suicidal ideation. However, it seems that a CAMHS referral was not made because matters "had settled".

24. Julie Beckett told me that, in early 2012, Riverbridge sought and received advice about managing Oskar from SCC's Specialist Teachers for Inclusive Practice Team ("STIPS"), which was an early intervention service; this had a

positive effect but Mrs Nash said that Oskar still did not receive the specialist support he needed and, even though he was apparently coping at school, there was a significant consequential impact on his behaviour at home with which she struggled to cope.

25. In June 2013, when Oskar was 8 years' old, there was a further referral to CAMHS by the GP, Dr. Patel, this time because Oskar was finding it hard to manage his anger and "Mother was at the end of her tether". Dr Patel told me that although the concerns were about Oskar's behaviour, a referral to CAMHS was needed so that any diagnoses of "other background conditions" could be made and appropriate "psychological support and intervention" could be offered.

26. Natalia Nash attended a CAMHS' assessment without Oskar, because of the distress he had suffered when he attended previously. She expressed her concern about his difficulty in controlling his feelings and with peer relationships, his anger to his younger brother, and his anxiety; she said he was coping at school but "acts out his stress at home". CAMHS recorded,

    "*Although Natalia is a devoted mother who is using good behaviour management strategies, she feels the strain of Oskar's special needs and would like further support for him in managing himself.*"

27. In August 2013 Mrs Nash attended CAMHS with Oskar, although he made it plain that he did not want to be there; in CAMHS' risk assessment it was noted that Oskar had "talked of killing himself in the past and wanting to be dead. This has now stopped." Meetings at school and further appointments followed, and Mrs Nash was offered parenting advice. However, there was no active response by CAMHS in relation to Oskar himself, and this was apparently because his school, Riverbridge, had indicated that all was well there. From CAMHS' records it is apparent that, at this time, the school were reporting that their concerns lay with Mrs Nash, and her health, rather than with Oskar himself. Mrs Nash told me that, in her view, the school and CAMHS did not fully appreciate that the problems at home, and her difficulties in coping, were connected to the impact on Oskar of his school life. In this regard, I note a review written by the Salesian School, albeit at a much later date on the 17th June 2016, which stated,

    "*Since 2011 Oskar has received a significant amount of support from agencies and his school. His mother has tirelessly sought support across the board, for support both at home and in school. Oskar's behaviour at home is typical of an ASD child that is under immense pressure all day in school. Once at home he relaxes and becomes aggressive and oppositional.*"

28. By mid-October 2013, Mrs Nash was reporting that she could no longer cope with Oskar and she had contacted SCC's Children's Services Department. At this stage I will note in brief what I heard about the structure and powers of that Department. Elaine Andrews, who has been the Service Manager of the Department's Assessment Service for the Northwest area of Surrey since September 2019, told me that,

    (i) All referrals to Children's Services are made via a central point, known previously as the Multi Agency Safeguarding Hub, or "MASH", and later as the Children - Single Point of Access, or "C-SPA". Staff within this central unit conduct an initial triage to decide whether progress of the referral is warranted,

    (ii) Local authorities have a duty to provide a level and range of services to safeguard children and promote their welfare. There are a number of teams which can provide intervention and support; of relevance to the inquest I note that –

        (a) There are "early help" teams, which are concerned with issues which are at an early stage of seriousness (although support can be provided over a long period); this is known as Level 2 work,

        (b) There are "targeted support" teams, which sit within the early help "umbrella" but are concerned with issues which need a more focussed period of support; this is known as Level 3 work, and

        (c) There is the Intervention Service under which Registered Social Workers are concerned with more serious issues, including statutory child protection; this is known as Level 4 work,

    (iii) Whilst Registered Social Workers may sit within the Level 2 and 3 teams, it is only at Level 4 that a child must be allocated a Social Worker,

    (iv) The statutory interventions which are available to a Local Authority for child protection purposes include :

        (a) Section 17 of the Children Act 1989 which creates a general duty to safeguard and promote the welfare of children within the area who are in need; a Child and Family Assessment is conducted and may lead to the child being designated as a "Child in Need" and a Child

in Need Plan being made to ensure effective support from professionals, including medical professionals if appropriate, and others,

(b) Section 20 of the Children Act 1989, under which, with the agreement of a child's parents, a child may be accommodated elsewhere, and

(c) Section 47 of the Children Act 1989, which sets out the requirement to investigate a child's circumstances where they have "reasonable cause to suspect that a child … is suffering, or is likely to suffer, significant harm" and thereafter to take action to safeguard or promote the child's welfare, as necessary. If necessary, the child may become a "Looked After Child", and

(v) All work undertaken by Children's Services is governed or guided by relevant statutes, the "Working Together to Safeguard Children" Guidance, and SCC's internal protocols.

29. Elaine Andrews confirmed that Working Together to Safeguard Children is a national guidance document which requires all public and voluntary bodies to work collaboratively to safeguard children, including through effective communications and information sharing. It states,

"Nothing is more important than children's welfare. Children who need help and protection deserve high quality and effective support as soon as the need is identified. We want a system that responds to the needs and interests of children and families, not the other way round. In such a system, practitioners will be clear about what is required of them individually and how they need to work together in partnership with others. Whilst it is parents and carers who have primary care for their children, local authorities working with partner organisations and agencies have specific duties to safeguard and promote the welfare of all children in their area."

Elaine Andrews agreed that the guidance placed an emphasis on communicating effectively with the child and family, and that if the child had a communication difficulty, there is an obligation on the Local Authority to make reasonable adjustments in order to ensure that the child can effectively access its services. The importance of information sharing is also highlighted :

"Everyone who works with children has a responsibility for keeping them safe. No single practitioner can have a full picture of a child's needs and circumstances and if

children and families are to receive the right help at the right time everyone who comes in contact with them has a role to play in identifying concerns, sharing information and taking prompt action. In order that organisations, agencies and practitioners collaborate effectively, it is vital that everyone working with children and families, including those who work with parents and carers understands the role they should play and the role of other practitioners. …Effective information sharing between practitioners, local organisations and agencies is essential for the early identification of need, assessment, and service provision to keep children safe. Serious case reviews have highlighted that missed opportunities to record, understand the significance of and share information in a timely manner can have severe consequences for the safety and welfare of children."

And later,

"Where a child has other assessments, whether it is by CAMHS or whether it is by your own SEN team, it is important that these are coordinated so that the child does not become lost between the different organisational procedures."

30. As stated above, on the 17th October 2013, Natalia Nash telephoned Children's Services to ask for help. It is recorded that,

"Mother ringing to say that she can no longer cope with Oskar (8) and has told Oskar she is not going to pick him up from school today. Oskar has Asperger's and Mother said he just doesn't want to listen to her, and is disrespectful, calling her names and saying she is not his mother. Mother said Oskar thinks he is older than he really is. In the last few months, he thinks he can rule the house, won't go to bed when told. Mother feels he doesn't find home good enough for him. Father passed away four years ago. … Oskar is coping well at school … Oskar has seen CAMHS on Monday, and … they told her to be strict with him … but Mother said she just doesn't know how to cope with him any longer."

Elaine Andrews told me that this information did raise safeguarding concerns given Mrs Nash's apparent inability to cope. In response to Mrs Nash's call, the Children's Services hub spoke to the Head Teacher at Riverbridge, who said that, "Oskar does have autistic tendencies but doesn't need help, otherwise he would be statemented", and suggested that the problem lay with Mrs Nash who was "almost wanting him to have issues". On that basis alone, and without obtaining Natalia Nash's response, it was decided that the referral should be closed. It is noteworthy that the brief enquiries made by Children's Services had not elicited Oskar's history of suicidal ideation; when Elaine Andrews was asked about this, she said that if that history had been known, Children's Services would have wanted to know more.

31. In December 2013, Natalia Nash telephoned CAMHS again and informed them that, amongst other things, Oskar was "making negative comments about himself and voicing ideas about killing himself, like eating to excess … or getting a knife". It is recorded that she was "given advice on managing these behaviours" and invited to go on the "123 Magic Parenting" course, which she did. This contact with CAMHS was then closed. Mrs Nash said the parenting course was helpful but did not address how she should recognise, assess and manage the risk of suicide in an autistic child; indeed, Mrs Nash voiced to me her view that she did not understand how any parent could be expected to deal with such matters in relation to her own child.

32. The Summer and Autumn of 2015, when Oskar was 10 years old, brought a further period of crisis for the family. In July, Mrs Nash reported to Surrey Police, for the first time, that Oskar was missing, and on the 21st July she contacted Children's Services, again seeking support. She said that Oskar was,

    "… defiant and can be aggressive towards both her and his younger brother. Natalia feels that Oskar is becoming beyond her control and wants urgent intervention from Social Services in order to prevent this. Natalia was tearful at times during the call. … she cannot control Oskar anymore and is struggling with Oskar's behaviour. … he has been in a lot of trouble at school. Natalia advised that the school told her they would be contacting Children's Services as Oskar hit another child and he received a detention. … Oskar's behaviour has been getting worse over the last month … and yesterday he threw something at her."

    Natalia Nash told Children's Services that Riverbridge had recently referred Oskar to CAMHS but he had not met their threshold; she wanted SCC to "carry out a psychological assessment of Oskar" and was advised that she would need to go to her GP for Oskar to be referred again to CAMHS for that. An "Early Help Assessment" was suggested "for September when school restarts", and Mrs Nash is recorded as being "open to this" but indicating that she would not cope with the summer. The record finishes by stating,

    "No safeguarding concerns raised. Mother does not know how to manage Oskar's behaviour but said she has a friend who is a Special Needs teacher who can assist her in setting boundaries, and advice has been given. No role for Surrey Children's Services."

33. In September 2015, Oskar's behaviour at school was noted to have deteriorated; Mrs Nash said that Oskar was anxious about his autism diagnosis and about transferring to secondary school. She said that it was at

this time that Riverbridge "started to take Oskar's needs seriously". Jan Ronicle, the school's Inclusion Lead, became involved and took three steps; importantly, she applied to SCC's SEN Team for Oskar to have an EHCP assessment, and I shall come to that a little later. Additionally, Ms Ronicle made further referrals to both Children's Services and to CAMHS, and I shall consider those now.

34. Ms Ronicle made a referral to Children's Services on the 10th September 2015, stating,

"Oskar has a diagnosis of ASD and his behaviour can be particularly challenging, especially at home. Ms Nash has been struggling to manage Oskar's behaviour for some months, and there has been a breakdown in the relationship. The family have reached crisis point now. … Over the last few years Oskar has shown increasingly oppositional and aggressive behaviour that Mrs Nash is finding very difficult to manage. The whole family have reached crisis point, where both boys are very unhappy, with [Oskar's brother] being fearful of his brother."

In response, Children's Services decided that a Child and Family Assessment was required under s. 17 of the Children Act, to assess whether Oskar should be designated as a Child in Need. The target date for completion of the assessment was the 24th September 2015, but it was not in fact completed until late January 2016.

35. As part of the Child and Family Assessment, the allocated Social Worker visited Oskar at home on the 18th November 2015. She recorded that Oskar was trying to be polite but that it was obvious that he did not want to talk to her. Oskar indicated that he did not think he had any special needs or autism; he also said he was happy at home and had no problems there, although he accepted that he upset his mother. Of particular note in relation to this home visit is that, the following day, Oskar became very upset at school. An internal school "child protection expression of concern" form recorded that,

"Oskar started ripping his work from his book. AM removed books. Oskar became upset. Sat in cloakroom with a coat over his head crying. … After 20 minutes ON returned to seating in classroom. Continually said, "I hate my life. I'm going to commit suicide. I'm going to burn my birth certificate. I should never have been born. It is God's fault for making me be born. It's going to happen tonight. I will commit suicide." ON said, "I don't have special needs. I don't need social workers coming to my house. If they come again they're for it." ON worked for a short period, becoming angry for no reason (meaning without triggers), and would suddenly throw a pen or kick a table repeating the above. ON became angry, and on reaching down to

the data sheet for medical needs, ON thumped the cloakroom wall saying, "This sheet is going on the fire. I hate my life."

36. As a result of what happened at school, Jan Ronicle rang Children's Services that day, and they recorded that she stated that,

    "Oskar was disruptive in class today, stating that he does not need a social worker to visit him and he has no special needs. Jan reported that he became upset by tearing his worksheet and got very agitated. Jan stated they had to let him go home. His mother was called about his behaviour in school. Jan stated Oskar talks about killing himself and he has been asking his mother how to kill himself. Jan stated she did not think it would meet the threshold for CAMHS referral, so they have not made a referral. Jan advised that they are having a meeting tomorrow about a planned move to a short stay school for six weeks. She stated that it's a therapeutic setting. I told Jan that I will contact mother to advise her to contact the emergency services, if Oskar's behaviour became erratic and is endangering his life."

    Elaine Andrews was asked about the suggestion that this behaviour "would not meet the threshold for CAMHS" and why the Social Worker had not herself make a referral to CAMHS, and she said she would have liked to have seen that done. She acknowledged that there definitely had been a need to investigate what had triggered Oskar's behaviour in order to monitor his future risk. However, she confirmed that this had not happened and, indeed, that there had been no further contact between Children's Services and the family until January 2016. Ms Andrews also agreed that there was no evidence of the Social Worker having liaised with CAMHS to gather information for the purpose of the Child and Family Assessment, as she was required to do, and that consequently Oskar's earlier history of suicidal ideation, which was recorded in CAMHS' records, was not reflected in her Child and Family Assessment at all.

37. On the 13th January 2016, the Social Worker telephoned Natalia Nash to ask whether she still required support and Mrs Nash indicated that she did, and so on the 27th January 2016, she completed the Child and Family Assessment. It is noteworthy that the assessment made no mention of his history of suicidal ideation, and that there was a one line reference only to his expression of suicidal intent on the 19th November 2015, and this appeared in a section concerning "parenting of the child". Further, the only direct risk to Oskar which was identified was from his mother's parenting; no risk from his own emotional or mental state was recognised. Elaine Andrews agreed that, given the information available, the latter ought to have been identified as a specific risk.

38. Nevertheless, the Social Worker did recommend that Oskar should be managed as a Child in Need because he was a "child whose health or development will be significantly impaired without the provision of services"; she recommended "for mother and boys to receive support regarding Oskar's challenging behaviour in respect of his Asperger's". A "Child in Need Plan" was made which recognised the risk of family breakdown due to Oskar's behaviour and proposed to address this risk by supporting him, "… to appropriately control his emotions and for Oskar to learn positive aspects about people with Asperger's". The Plan stated that this support was to be provided through one-to-one direct work with Oskar himself, by a Social Worker or Family Support Worker. Ms Andrews said that if Oskar's risk of self-harm and suicidal ideation had been recognised (which it was not), she would have expected the Plan to include some support linked to that risk also. It is recorded that in response to the Plan,

    "Oskar has stated that he has not Asperger's and he does not want any help."

    The Child in Need Plan also proposed to provide two weeks of one-to-one work with Mrs Nash, addressing "parenting strategies in respect of children with Asperger's condition".

39. On the 17th February 2016, the Social Worker visited the family at home, together with a Senior Family Support Worker, Jessica Shields-Porter. Her record of the visit includes the following account :

    "When we knocked on the door there was delayed answering, you could see many locks were being opened, and we were told towards the end of the visit that Oskar had done this prior to us getting there to stop us coming in. Once we were in the house we sat down, brother and Natalia, mother, greeted us. Oskar came out of the kitchen and said that he wanted us to leave. He stood by the kitchen with his head down not making eye contact. He said he wanted us to leave, he said, "I don't want you talking about me." He went back into the kitchen, we tried to get him to come and join in the meeting and he kept saying, "No" and that he doesn't care. Oskar went up the stairs, kept shouting, "Stop talking about me, I can hear you, stop." Oskar started to shoot bullets from his Nerf gun down the stairs, but not aimed at anyone. He carried on shouting for us to leave. Natalia tried to reason with Oskar and explained that we were talking about the whole family, not just him. Oskar said, he didn't care he just wanted us to go. Oskar came down the stairs continued to say he wanted us to leave. He went to the front door, opened it and kept saying, "Leave." We left, mum said she would come out in five minutes to meet us and when we left the door slammed. Victoria and I were walking down the road, we saw Natalia run out of the house and hide behind a car. Oskar also ran out of the house and shouted at us to leave. Natalia came and spoke to Victoria and I in the car, she spoke about Oskar can be like this

when he thinks people are there to talk or help him. He struggles to understand that he suffers from autism. Natalia spoke about Oskar saying he wants to die and kill himself. He often asks Natalia how he could do it. We spoke about having a consultation with CAMHS, we also discussed Oskar's internet usage and the access he may have. It was agreed that the Child in Need plan would work around [Oskar's brother] and Natalia due to Oskar not wanting to engage with professionals … ."

As a result of this, the intervention and support proposed for Mrs Nash and Oskar's brother proceeded, but the planned direct one-to-one work with Oskar, which had been recognised as necessary, did not take place at this time.

40. Subsequently, on the 4th March 2016, a meeting to review the Child in Need Plan was held at Oskar's school, during which Natalia Nash informed Children's Services that the day after their visit, Oskar had said, "I should have gone under a train". It was recorded that this "hit Natalia hard because there is a train line close to their house". She also reported that Oskar had said similar things in the past, such as, "Don't worry about my secondary school, I'll be dead by then anyway". Mrs Nash also told them that after their home visit Oskar had "ripped up every document that he could come across about him". At the meeting it was noted that CAMHS had previously worked with Oskar at school but this had stopped due to his lack of engagement, and that Oskar was currently undergoing the EHCP process and that a medical report from a paediatrician was awaited. At the end of the meeting the Child in Need Plan, in its original form, was handed out, even though it was apparent that Oskar would not engage with the proposed one-to-one work. The school's note of the meeting recorded that the Social Worker and Jessica Shields-Porter were "pressed" for some longer-term intervention for Oskar as "the difficulties within the family stem from Oskar's needs", and the root of the family breakdown "is not being addressed." No response to this is recorded. A further Child in Need review meeting was arranged for the 18th April 2016, with an indication that the case was likely to be stepped down to a "Team Around the Family" led by the school.

41. In September 2015, Jan Ronicle, the Inclusion Lead at Riverbridge, had also made a referral to CAMHS. No action by CAMHS in response, over the following six months, is apparent, but on the 12th April 2016 a meeting took place between CAMHS and Children's Services. Ian Matthews, the then Service Manager for the Northwest Surrey CAMHS team, told me that the meeting was attended by Emily Burnham, who was not a clinician but a Social Worker recruited by SCC and seconded to CAMHS, Jessica Shields-Porter of Children's Services, and some of their colleagues. CAMHS' notes of the meeting record that,

"Jessica expressed her concerns for Oskar as he has been expressing that he "wants to kill himself". Oskar's mother has also expressed that she feels she doesn't have the necessary skills to respond appropriately when this happens. Mrs Nash has been in receipt of various parenting support programmes in the past. Jessica explained that Oskar appears to have a lot of control within the family home (for a child) and maintains the view that appropriate on-going support for the family is primarily associated with making sure that Oskar's mum has the appropriate parenting skills. During the consultation it was agreed CAMHS assessment would be offered in regard to Oskar expressing that he wants to kill himself. There have been no reported incidents of self-harm and no other risk type behaviours reported. CAMHS will offer an assessment to ascertain mental health issues / difficulties."

Further, in a CAMHS' Social Work Consultation Form, also dated the 12th April 2016, Emily Burnham wrote,

"Oskar has told Natalia that she does not need to worry about secondary school because he will be dead by then. Natalia does not feel that Oskar is trying to get a reaction from her, because she does not give him one. Oskar told Natalia that he will run under a train. Oskar lives very close to the railway line. Oskar has previously spoken about committing suicide at school to his support teacher. Natalia has said that Oskar has previously self-harmed, he would bite himself and leave marks when people did not listen to him."

An appointment for Oskar to be assessed by CAMHS was made for the 5th May 2016 at Ashford Hospital. Ian Matthews explained that this was an appropriate way forward because, in view of what was known, Oskar did need a clinical assessment. He said the outcome would have been considered in the next Post Assessment Meeting, chaired by a Consultant Psychiatrist, and a plan for Oskar's ongoing care, which could have included further assessment by a Registered Mental Health Nurse or a Psychiatrist, would have been made.

42. A further meeting to review the Child in Need Plan took place at school on the 18th April 2016. In the Children's Services' records it was noted that,

"Natalia spoke about a recent incident where Oskar was hanging out of the window saying he was going to jump. Natalia believes it is because of school and he is constantly saying he is going to kill himself. We discussed CAMHS and how it was a voluntary service, and if Oskar refused to engage, we were unable to make him. CAMHS do not want to stress out Oskar further. Natalia feels this is the problem. No one wants to stress out Oskar, meaning he is not ever seen. Oskar just wants to be like everyone else. Natalia said that Oskar will not turn up to the CAMHS

appointment, and asked for Oskar to be seen in school, which may be a better approach. Jessica to have a conversation with CAMHS in regard to this."

Elaine Andrews agreed that the reference to Oskar "hanging out of a window" was a serious development as he had clearly acted on his suicidal ideation. In that context, she was asked about Mrs Nash being told that CAMHS was a "voluntary" service and that Oskar could not be forced to undergo clinical assessment. Ms Andrews agreed that was incorrect, and said that she would have expected a creative approach to have been taken to seeing Oskar for clinical assessment, for example, by seeing him at a different location (as suggested by Mrs Nash); Ms Andrews also agreed that, if necessary, an Approved Mental Health Practitioner could have been involved in order to facilitate a Mental Health Act assessment.

43. At the meeting on the 18th April, a discussion also took place about contacting a psychiatric team, and it was recognised that Oskar needed therapy. Jessica Shields-Porter suggested a referral to the "Extended Hours Service", which was part of Children's Services; this was because the family was at risk of breakdown, and the Extended Hours Service had specialists on the team, such as family therapists and CAMHS workers (although Ian Matthews told me that only one member of the team had a clinical qualification). Elaine Andrews said that she could not see any evidence of Jessica Shields-Porter, who was a Senior Family Support Worker, having discussed the appropriateness of a referral to the Extended Hours Team with a manager; nevertheless, the referral was made on the 27th April 2016.

44. As stated above, Jessica Shields-Porter had been asked to liaise with CAMHS to see whether, on the 5th May 2016, they could conduct their assessment of Oskar at school, rather than at the hospital, but she did not ring them until the day of the appointment itself. Emily Burnham noted, "Jessica explained that Ms Nash has said that she will not be able to get Oskar to attend the appointment with CAMHS today and was requesting the assessment takes place at school. I explained that this unfortunately would not be possible." (Ian Matthews told me that, in fact, an assessment at school would have been possible, although it would have taken time to make the arrangements.) Ms Burnham went on to note that Jessica Shields-Porter had said that she would discuss the planned CAMHS assessment with the Extended Hours Team, who were now involved, and let her know the outcome. Under "Risk", Ms Burnham recorded,

"Jessica described … that Oskar continues to say to his mum that he is going to jump in front of the train. Jessica did not report that these comments has [sic] increased in frequency and has said that the Extended Hours Service are aware of these concerns.

Jessica has said that she will liaise further with the Extended Hours Team re these concerns and get back to me. … I will liaise with my supervisor."

In her records, Jessica Shields-Porter noted that it was agreed that it was unnecessary for Mrs Nash to attend the appointment alone and that the appointment would be stood down.

45. Following cancellation of the 5th May appointment, CAMHS did not, in fact, have any further contact with Oskar or Mrs Nash and his case was formally closed on the 1st July 2016, without Oskar having undergone any clinical assessment. Elaine Andrews agreed that this had been a significant interference with Mrs Nash's access to the CAMHS team, and she told me that, as a Family Support Worker, Ms Shields-Porter did not have authority to interfere with the agreed clinical appointment in this way; she was not the allocated case holder, and she could not see any record of any discussion between her and the case holder. On behalf of CAMHS, Ian Mathews said that, following the cancellation of the appointment on the 5th May, he would have expected Emily Burnham to have reported this to CAMHS' clinical team to assess the risks arising, together with the outcome of the Extended Hours Service's assessment, if it happened, but he could see no evidence in the records of any contact between Ms Burnham and her supervisor in this regard. He said the plan appeared to have been for Christian Fleischer, who was a CAMHS' Primary Mental Health Team worker seconded to Children's Services' Extended Hours Service, to make a clinical assessment of Oskar, and then report to CAMHS' Post Assessment Meeting, but he never did so. Mr Matthews confirmed that the referral which had been made to CAMHS should not have been closed without "a wider, multi-disciplinary team consideration within CAMHS", but that it was closed on the 1st July 2016 without that consideration, and without Oskar having undergone any clinical assessment.

46. On the 16th May 2016, at a further meeting to review the Child in Need Plan, its management was transferred to the Extended Hours Service. Support was provided to the family by this Team from June 2016, and continued until Oskar was eventually placed at a secondary school in February 2017. Although there was no clinical assessment by Christian Fleischer, Oskar did receive regular one-to-one support from Helen Thompson, a Resource Worker, to whom he responded well; this support was successful, as was his home schooling; Oskar was not expressing suicidal ideation at this time and matters were much calmer at home. Mrs Nash also received one-to-one support and, after Oskar started school again, she indicated that he was "… a different boy to who he was six months ago", and that she was happy for the

support to come to an end; and on the 14th March 2017, the Child in Need Plan, and Children's Services' involvement, were formally closed.

47. As stated above, in September 2015 Jan Ronicle had also applied to SCC's SEN Team for Oskar to have an EHCP assessment and that application progressed in parallel to the referrals to Children's Services and CAMHS which I have just considered. Initially, the SEN Team refused to assess Oskar, and only did so following a challenge by Ms Ronicle, who indicated that Oskar was at risk of exclusion as a result of his behaviour at school.

48. Julie Beckett told me that following the assessment, the SEN Team agreed to issue an EHCP. She explained that an EHCP has a standard format with the child's needs being set out in different sections of the Plan; she said that a draft EHCP is usually written by the SEN case officer, on the basis of evidence gathered from different professionals. This includes medical advice addressing any physical or mental health needs. She said that the medical adviser would be expected to obtain and share any information CAMHS may have about the child. In Oskar's case, the medical advice was obtained from Dr Tennant, who provided a report which was dated the 29th February 2016, and which was counter-signed by Dr Lisa Wall on the 7th March 2016.

49. Dr Lisa Wall is a Consultant Developmental Paediatrician who, like Dr Tennant, was then working for Children and Family Health Surrey (a service now run by Surrey and Borders Partnership NHS Foundation Trust). She told me that the purpose of the medical advice was to identify the child's physical, emotional, neurodevelopmental, and mental health conditions and how they impacted on his functioning in any setting, including at school and at home; this is because the EHCP must record these conditions, the needs arising from them, the intended outcomes for the child, and precisely what provision must be provided to achieve those outcomes. Dr Wall said that the medical adviser must specify the precise provision required to meet health needs, if it lay within their expertise to do so; if it did not, the adviser ought to spell out the need for more specialist input; for example, if Speech and Language Therapy was clearly needed, the medical adviser would not be able to identify the precise nature and extent of the therapy required, but should state that a SALT assessment must be obtained for that purpose.

50. Dr Tennant said that an appointment had been made for her to see Oskar for the preparation of her medical adviser report, but he was very challenged and uncomfortable about the process, and would not participate, and so the appointment was cut short; she said she did not make an adjustment for Oskar in this regard, for example by arranging to see him in a different

environment, because the health advice is a "small and insignificant" part of the EHCP. Information was, therefore, gathered by her from Mrs Nash alone. Dr Tennant recorded, under the heading "Behaviour and Emotional Development" that,

"*Oskar has had a very difficult time at school. He wants to be treated just the same as the rest of the children and cannot make the link between his very difficult behaviour and his having extra help. Oskar's a lovely boy when he is relaxed and not anxious. He's polite and helpful. When Oskar becomes stressed, he will try to leave the school site, he has kicked and hit other children and has pushed furniture. Oskar likes to have friends but his friendships can be obsessive. … He's often unsettled after lunchtime, because things have gone wrong.*"

Dr Tennant said that she "was worried about him. I felt he was a very unhappy little boy who was finding school and life very challenging." As for the cause of his problems, she said, "I think it was directly his diagnosis but also the anxiety and the low mood that he was having from being in a school environment which can be very challenging for a child on the autism spectrum." She explained that low mood is a separate condition from the autism, but there is vulnerability to suffering low mood due to the autism. In her advisory report for the EHCP process, Dr Tennant wrote,

"*Oskar is an able boy with autistic spectrum disorder, Asperger's, with high anxiety. He has difficulties with coping with change, peer relationships, develops obsessive friendships. Managing gentle touch, he can get upset if people brush past him. Coping with noise levels at school. Following adult direction. Becomes extremely oppositional when anxious. Coping with meeting new adults. Challenging behaviour when anxious including hurting other children and trying to leave the premises. Dislike of other people discussing him. Dislike of being different but not able to control his behaviour so that he can be treated the same as his peers and low mood.*"

However, despite the above, when it came to identifying his specific health needs for the EHCP, under the heading "Non-educational Health Needs", she wrote only,

"Management of enuresis.
Oskar has discussed taking his own life. He may require an urgent referral to CAMHS if these threats are thought to be serious."

51. Given that Oskar had voiced suicidal ideation, Dr Tennant was asked why she did not make a referral to CAMHS herself and she said this was because Oskar was not her patient at that time; she agreed that it was, therefore, left to Mrs Nash to seek help from the family's GP if she felt the threats of suicide

were "serious". However, when Dr Tennant was asked how the seriousness of any threat should be assessed, she said that was beyond her level of expertise and would be a matter for a psychiatrist to assess; in other words, that the assessment of Oskar's risk of suicide was a matter for specialist psychiatric evaluation. When pressed as to the appropriateness of leaving the responsibility for making that assessment to Mrs Nash, Dr Tennant conceded,

"possibly I should have done things differently, looking back on the situation, maybe if it happened again, I would do things differently."

52. Dr Tennant also agreed that her advisory report to the SEN Team was not specific as to the support which Oskar needed in relation to his emotional and mental health needs, even though the EHCP Code makes it plain that the purpose of an EHCP is to set out specific needs and how, precisely, those needs are to be met. When asked about this, Dr Tennant said,

"I am not allowed to specify what other organisations provide. So, I can't put recommendations for speech therapy, occupational therapy, CAMHS or anything else. …we have very specific training on how we are supposed to write these reports, and we would not be expected to put in a report something that the CCG needed to fulfil without that being referred to the CCG."

53. Dr Wall was critical of Dr Tennant's report and preparation. She said Dr Tennant should have made a referral to CAMHS herself and then liaised with them. Further, she said that the advice given in the report should have ensured that Oskar's history of low mood, anxiety and suicidal ideation was fully reflected in the EHCP, and it should have made it plain that a specialist CAMHS assessment must be obtained in order to identify the provision he required to meet his consequential needs. She said that the outcome of the report, that his needs were, "Management of enuresis. Oskar has discussed taking his own life. He may require an urgent referral to CAMHS if these threats are thought to be serious", was not appropriate. Dr Wall recognised that she had counter-signed the report which, she said, was to "quality assure that what Dr Tennant had put in was not inappropriate"; but she could not recall whether she had fully read it or discussed it with Dr Tennant before doing so. When asked about the facts that Oskar became a Child in Need, and that Children's Services were liaising with CAMHS, before the EHCP was drafted by the SEN Team, Dr Wall said she would have "hoped" that Dr Tennant would have been told about these developments, but there was no evidence that she had been. Nor, apparently, were Mrs Nash's concerns about the final draft provided to her for review.

54. Julie Beckett explained that Oskar's EHCP was drafted by the SEN case worker, in June 2016, on the basis of the evidence gathered in early 2016; this included input from an Educational Psychologist and a Speech and Language therapist. On the basis of Dr Tennant's report, the only information included in the draft EHCP concerning Oskar's health needs (including his history of suicidal ideation and mental health), was in the "Non-educational Health Needs" section, and it read,

"Management of enuresis.
Oskar has discussed taking his own life. He may require an urgent referral to CAMHS if these threats are thought to be serious."

55. The SEN Team proposed that Oskar's needs could be met by placement in a mainstream school with 28 hours' extra support per week, and there was discussion about placement at the Salesian School. However, Jan Ronicle expressed real concern about this proposal, as follows :

- He won't cope with the amount of staff changes and movement around the building
- He has the potential to be aggressive towards staff
- He has been aggressive towards children
- He will not accept his diagnosis
- He is resistant to support
- He will not engage with any outside agencies (he tore up Orla's notes on one occasion [Orla being the SCC Educational Psychologist]
- He is threatening to kill himself but will not engage with CAMHS
- He is paranoid
- He misreads situations
- He is very manipulative of friendships
- Ros Poole (Callum Centre) felt that the Callum Centre would not work for Oskar [Callum Centre being an autistic unit within a mainstream school]
- Dr Tennant suggested Unstead House as an appropriate placement to mum
- Oskar was going to be placed in the Secondary PRU [Pupil Referral Unit] but his placement had to be withdrawn due to other issues

56. Further, on the 9th May 2016, Jan Ronicle wrote a long letter directly to the SEN case officer, expressing similar concerns. She emphasised that Oskar was experiencing very significant and wide-ranging problems at school and that, "During term time his anxiety is incredibly high", and that this was impacting so greatly on relationships at home that there was a risk of family breakdown.

She said that placement in a mainstream school would be, "setting him up to fail" and that the Educational Psychologist had said that he must have "a calm, low arousal environment with staff trained in meeting the needs of children with social communication difficulties".

57. In June 2016, Natalia Nash sent an email to the SEN case officer in which she too indicated that Oskar needed to go to a special school. Additionally, Mrs Nash objected to the draft EHCP on the basis that the special education provision included in section F was not specific and was not quantified, and that it did not describe what kind of therapist would deliver the support Oskar needed. Julie Beckett was asked about this and, in particular, the importance of the EHCP reflecting sufficiently Oskar's emotional and mental health needs, and the provision he required to address those needs. She accepted that the further information provided by Jan Ronicle, including in relation to Oskar's risk of suicide, did make clear that his mental health needs were relevant to his educational setting and, therefore, they needed to be apparent in the EHCP. She said that in view of the information from Ms Ronicle, she would have expected the case officer to seek an updated report from Dr Tennant, but this did not happen, and the original draft of the EHCP (from June 2016) was finalised in February 2017 without further amendment, save for naming in section I the school in which Oskar was then placed.

58. It is noteworthy, therefore, that the only reference to Oskar's emotional and mental health needs, and his extensive and significant history of suicidal ideation, in the final EHCP, remained the one-line entry from Dr Tennant's report, and this remained in section G; no relevant entry was ever made in section F of the EHCP, under "social, emotional, and mental health needs".

59. The SEN Team agreed to Oskar's placement at a special school. I heard that the SCC's Educational Psychologist had identified Oskar's "presenting needs" (most significant behavioural difficulties) as "SEMH", meaning "Social, Emotional and Mental Health" needs, rather than "ASD" (autistic spectrum disorder) needs, and that SCC's specialist Panel, which dealt with placements in special schools, considered that Oskar should be considered for placement in an "SEMH special school". From the records available, Julie Beckett could not assist me with why this had not occurred.

60. Oskar left primary school in July 2016, and an appropriate special school placement was not identified until February 2017. He was, therefore, out of school for six months. As stated above, during this period, he received education at home, and one-to-one support, from a team provided by SCC, and he did well and was calmer and happier.

Comments and Findings

61. The first thing that strikes me about the evidence I have reviewed above, is that from a very early age Oskar was recognised to be a very complex child, with not only a diagnosis of autism, but very probably other diagnosable mental health conditions also. Whether these were limited to the low mood and extreme anxiety which were noted many times, or whether they also included issues arising from his father's death or other matters, is impossible to know in the absence of clinical assessment. However, what is plain, is that as a result, Oskar suffered periods of extreme distress and suicidal ideation. It is shocking to read that Oskar had thoughts of self-harm from the age of six, and that by the time he was eight he was regularly discussing, with different people, suicide by a number of different methods. It is important to note, however, that his suicidal ideation was not constant; when he was away from the demands of school, and was being home schooled with one-to-one support, Oskar was calm and happy, and "a different boy".

62. It is patently clear that Oskar needed his emotional and mental health to be fully assessed, by a clinician with appropriate expertise, so that effective treatment, monitoring and support could be put in place. By September 2015, six referrals had been made to CAMHS by Natalia Nash, Dr Tennant, Dr Patel and others. However, despite having knowledge of Oskar's extensive history of suicidal ideation, no clinical assessment took place. I consider there were clear failures by CAMHS, not only in May 2016 but at earlier stages also, to ensure that Oskar was clinically assessed. These missed opportunities, in Oskar's early years, were of particular significance given that, as I was told in evidence, intervention at an early stage is well-recognised to be the most effective.

63. I consider that Oskar's resistance to assessment and support was allowed too often to act as a barrier to his receiving the services he needed, even though that resistance stemmed from the very conditions which needed to be addressed professionally. Instead of grappling, head on, with Oskar's complex issues, too often an emphasis was placed by both Children's Services and CAMHS, on his mother's parenting skills.

64. In my view, there was also delay in seeking and putting in place the specialist support that Oskar clearly needed at school. When an EHCP was eventually issued, it failed properly to address Oskar's emotional and mental health, his significant history of suicidal ideation, and the provision he required to meet his consequential needs. In this regard there were significant failures by the medical adviser team to provide sufficient advice, but also a clear a very significant failure by the SEN Team to obtain sufficient evidence,

even in the face of the relevant and very concerning information about Oskar's condition and risks being supplied directly to the SEN Team. Mrs Nash's concerns about the draft EHCP were, I find, well founded. Given the importance of the EHCP as a vehicle for key information about Oskar, and the risks he faced, this was a failure with real ramifications, as I shall come to below.

Events from February 2017 to March 2019

65. I heard evidence from Dr Kirsty Glaysher, the Lead for Integrated Services at St. Dominic's School. She explained that in 2016 the school was a non-maintained independent special needs school which was able to meet the needs of autistic spectrum disorder children who were academically able, through a "needs-led curriculum". Class sizes were very small, about eight pupils, and there was "in-house" speech and language therapists, occupational therapists, counsellors, and "Emotional Literacy Support Assistants".

66. In November 2016 Oskar had attended for a four-day assessment, after which the school concluded it could meet his needs, and it offered him a place in a letter in which his specific requirements for therapy were identified. This placement was subsequently approved by the SEN Team and Oskar started at the school on the 8th February 2017.

67. Dr Glaysher was asked what further information the school received about Oskar in advance of his arrival. She said the school would have seen the EHCP, but his records from his primary school were not received until after he had started; it was not, therefore, until then that the school knew of the real extent of Oskar's history of suicidal ideation, although she said that Oskar would have been offered a place in any event. It is noteworthy, though, that his primary school safeguarding records were accessed by some members of St. Dominic's staff only, and Oskar's risk of self-harm and suicide were never reflected in St. Dominic's own risk assessment documentation.

68. Dr Galysher described Oskar as a bright boy academically, whose main struggles were in relation to meeting the demands of school life, including his anxiety and difficulty in following instructions. His first months went well but, by the Summer Term, there were some negative behavioural incidents, albeit minor in nature. Dr Glaysher explained that it was not unusual for their pupils to have a "honeymoon period" as, initially, they can feel relief at being more understood, but later face the realisation that there are still demands of school life to be met.

69. A teacher at the school, Hector Alonso Martinez, summarised Oskar's progress at the school as follows :

"Oskar fitted in well with his peers when he joined. He was initially a calm and cheerful student who engaged well and responded to instructions. I would say that we had a good relationship and that he felt able to talk to me about most things. However, as time went on his behaviour changed. He became demanding and wanted things his own way. Initially his response would be to shut down and not engage, but then, in 2018, he started to become more angry and vocal. He was a very articulate boy, but he went from quietly expressing his views to swearing and shouting at times. He kept saying that he wanted to be in mainstream school, and I think that he did not see himself as the same as his peers. He became increasingly focused on this wish, and he started to abscond from St Dominic's, and was eventually subject to two exclusions towards the end of 2018 because of his aggressive behaviour, particularly towards staff."

70. I heard evidence from Liz Godfrey, who was the school's Key Stage 3 Co-ordinator; she had responsibility for monitoring Oskar's progress. She said that a special school was essential for Oskar and the placement was appropriate. She said that Oskar was a lovely, kind boy and, initially, he was calm and well-behaved, and had a good group of friends. It was expected that he would stay at the school until at least the age of 16 years and that he would complete his GCSEs. Ms Godfrey said that on the 12th October 2017 the first review of his EHCP took place. The therapy and one-to-one support which Oskar was receiving were noted in the review paperwork, and it was recorded that he had settled well, although there had been some recent disruption from his having changed groups. It was recorded though, that,

"Oskar struggles to accept his diagnoses and essentially he considers that he is not like his peers and he perceives many to have more severe needs than him and he feels he should be in a mainstream school.", and

"Oskar can lose trust in adults when he perceives that a situation has not been handled in the way he would like. It can take time to recover these relationships and Oskar needs a lot of prompting and support towards recovering a relationship. When he is anxious, he needs lots of support and prompting to make good choices about his behaviour to ensure he is in the right place and at the right time."

Julie Beckett confirmed that the SEN Team were invited to the review of the EHCP but did not attend. She said this was not unusual as long as matters were going well, although "if a young person is at a transition point, or there are difficulties with the placement, then often a case officer and/or an

Educational Psychologist may be involved at that point." She agreed that although the review set out the precise therapy and support Oskar was receiving, the EHCP was not amended to reflect this. She agreed too that it was not apparent on the face of the EHCP that the review had taken place; she said the paperwork from the review would simply be "appended to" the Plan.

71. Over the Summer Term 2018 a safeguarding concern arose in relation to Oskar self-harming; and in July 2018 it was recorded that Oskar stated that he felt like hurting himself, but this was not linked by staff to his history of suicidal ideation (about which they may not have known) and there is no record of any plan having been made in response. Subsequently, in October 2018, another pupil reported that Oskar was cutting himself. Dr Glaysher accepted that, given Oskar's history of suicidal ideation, that ought to have triggered a call to CAMHS, but that did not happen.

72. Dr Glaysher said that in the Autumn Term 2018, Oskar "told a trusted member of staff that he was comparing himself unfavourably with his brother, who was in mainstream, and that's when we think … he started to become more disengaged." On the 11th October 2018, a further review of his EHCP took place. It was recorded that Oskar now had a strong desire to move to mainstream and that Mrs Nash felt he would be able to manage in a small mainstream school. Ms Godfrey said that efforts had been made, through the school's therapists, to help Oskar understand and accept his diagnosis, but he would not accept it. She said Oskar felt that a move to mainstream would solve all his problems, including his own inability to manage his behaviour; he became focussed on this and, she believed, this became the key cause of the further deterioration in his behaviour. When asked for her view of the proposed transfer to a mainstream school, Liz Godfrey stated,

    "I honestly felt that mainstream was not an appropriate placement for him unless it was somewhere with a Callum Centre, which the two schools I investigated had … or a very small school with small classes".

    I heard that a "Callum Centre" is a unit within a mainstream school which can support autistic pupils.

73. Despite Ms Godfrey's reservations, a Transition Plan for the proposed transfer to mainstream was made and this included proposals that (i) a re-assessment of Oskar's needs by an Educational Psychologist should be arranged by the SEN Team, and (ii) the school should arrange "taster" day visits to a local mainstream school with a Callum Centre (Rodborough School). Liz Godfrey said the planned taster sessions were important because,

she believed at the time, they would "make him think twice", or act as a reality check for Oskar; and she said the Educational Psychologist re-assessment was required to ensure that his current needs, and the provision he would require in mainstream school, were set out in an updated EHCP. In fact, neither happened and when the witness was asked at the inquest whether she was concerned about Oskar moving to mainstream school without the planned preparations, she said that she was, because,

"*Oskar struggled, as do many ASD children, with change, and, as I have already said, I think he thought that this would solve every single problem that he had, and he needed to know that it was not going to be this halcyon place that he anticipated, that there would still be demands made upon him, and that he would still need to conform to expectations within an educational environment, even though it was a mainstream school. I don't think he really understood that.*"

74. Julie Beckett confirmed that the SEN Team were invited to, but did not attend, the October 2018 review of Oskar's EHCP. She said this may have been because they had not been alerted in advance to the proposed changes which were afoot, but she accepted that the Team would have become aware of the proposed move to mainstream when the school's review documentation and Transition Plan were received following the review. She accepted that the SEN Team were then under an obligation to respond and she said she "would expect the case officer to prompt the educational psychology service and also the school to have that discussion", but she could not see any evidence of the SEN Team taking any action. Ms Beckett was asked whether the SEN Team ever questioned or investigated the merits of the proposed move to mainstream and she said that, as it was a parental preference, they did not. She was asked whether the SEN Team ought to have questioned the proposal, given Oskar's inability to cope in a mainstream setting only two years earlier and the apparent breaking down of the special school placement. Ms Beckett answered, "In an ideal world, yes", and said that she would have liked to have seen a decision-making panel considering all the evidence. She said, too, that obtaining an Educational Psychologist's view, although not necessarily a full re-assessment, would have been appropriate, but this did not happen.

75. On the 13th November 2018, Oskar began to refuse to attend school. The records note that, "Oskar has refused to attend school this week. Mrs Nash is very concerned about his recent change in behaviour and is seeking help from the school." Ms Godfrey said that Mrs Nash was emotional and reported that she could no longer cope with Oskar at home, and that an immediate referral to Children's Services was, therefore, made. She told them, in summary, that Oskar had,

"… not been in school for two days prior to this referral, and Mother described his behaviour as noncompliant, with regards to him being verbally abusive, and stating he is doing his own thing. Not only are there concerns that Mother is struggling to manage his behaviour, there are concerns that his behaviour and the choices that he is making is putting him at risk. Oskar is going out in the dark, in the evening, with other children in the local area, and Mother does not approve of this. This could pose a risk to his physical safety. His ASD could mean that Mother needs additional support to meet his behavioural and emotional needs associated with this, and Mother is requesting that support."

76. Dr Galysher confirmed that Oskar's behaviour at school continued to deteriorate and there were a growing number of incidents involving non-compliance, rudeness and swearing, and some damage to property; by the end, Oskar had 49 negative behavioural incidents on his records. There were then two incidents which were viewed by the school as serious. On the 20th November 2018 another student said in class that a weapon could be made by sharpening the end of a ruler and a pupil said, "That's good to know for Morton", with Oskar then stating, "We can make a shank and use it on Morton if he tries to kill us." Mr Morton was a member of staff in the school's Behaviour and Inclusion Team. Dr Glaysher said that Oskar was "going along with" the other boys and noted that he was placed at that time with a "tricky" group of students whose behaviour was "agitated". Nevertheless, Oskar was excluded from school for two days. Liz Godfrey contacted Children's Services again to inform them of this development; further, Surrey Police were informed and an officer subsequently sent a "SCARF", which is a child safeguarding information-sharing form, to SCC's MASH.

77. When Oskar returned to school there was further disruptive behaviour and, on the 6th December 2018, a second incident; Oskar refused to leave a class room where he should not have been, matters escalated, and Oskar was physically restrained by staff; in the course of the melee that followed, three members of the staff were injured. This incident resulted in Oskar being excluded from school for five days and the Police being informed. Children's Services were also informed, and their records show that Mrs Nash was saying that she could no longer cope with Oskar and would like him to be taken into care.

78. On the 7th December 2018, it was noted on the school records that the SEN Team had been alerted that a change of placement was needed "to avoid permanent exclusion". Dr Glaysher said the incident was,

"..strong communication from Oskar that he didn't want to be here … he told us he wanted to go to mainstream school, and he was indicating that he didn't want to be at

St. Dominic's, using his speech and other communication. And I think it was also a recognition that he isn't in the right place, that things weren't working for him … it was clear our provision wasn't meeting his needs."

Dr Glaysher said that the alert to the SEN Team ought to have triggered an emergency EHCP review meeting, but that did not take place. That evening, Natalia Nash rang the Police to report that Oskar had left home and was now missing. He returned home at about 10.15 pm and officers attended and found him in bed. PC Hysen completed a SCARF which stated,

"This 13 year old male has left home address at around 20:00 hours on a Friday night. He did not speak to his mum or tell anyone where he was going, and so mum reported him missing. Male has returned home of his own accord around three hours after leaving. No injuries and no allegations. … Male has Asperger's but no other known learning difficulties or mental health issues. … Male stated he left the house to see his friend. He then got the bus with her to Hounslow, dropped her off at her dad's. He then got the bus back to his home address. Mum is concerned that the male does not appear to listen to authority and is having issues at school. … Mum believes the female he has been seeing is a year or two older than him and often smokes and drinks. Concern that she is a bad influence on the male and could be making issues worse. The male, Oskar, feels he can do whatever he likes without consequence, and this is concerning if his behaviour escalates. Mum is struggling to manage and cope with his behaviour and feels like she needs assistance. … Male has recently been becoming more distanced from his family, and has withdrawn from hobbies he was previously doing, such as piano. Male has recently been involved in an incident where he has lashed out at teachers at school and been excluded. This is likely to mess up any chance he had of moving schools. It is unknown if this is deliberate or not. Mum states the male wanted to move into mainstream schooling and was due to visit a school on Monday to see how it went. Concern this could be related to his current behaviour."

79. On the 9th December 2018, Mrs Nash telephoned Surrey Police again. DC Thomas stated,

"Natalia NASH had called in reporting that her son, Oskar NASH, who was 13 years old at the time, had been shouting and swearing at her. He had previously gone missing and he was trying to leave the house on this occasion as well. I recall that Oskar had left the address before I had arrived, therefore I was looking out for him as I was turning in on the road. I saw a boy walking away from the road, so I have stopped him … he didn't want to go back, but then did agree to go home. … Natalia was struggling with Oskar's behaviour, and Social Services had previously been in contact … it was agreed a further referral would be made to Social Services, and a word of warning would be given to Oskar. I remember being stern with Oskar as it didn't appear that he

understood what he had done was wrong. … Oskar was warned if he went missing again that police would look for him, find him and bring him back home. … I submitted a referral to Social Services [meaning a SCARF], *which I risk assessed as red, which is the highest rating. In the referral I justify my assessment due to his recent violent behaviour at school, which in turn might escalate to violence at home. I also raised concerns that Oskar had gone missing recently and had tried to leave again today, so Oskar may continue to go missing in the future."*

80. PC Williams told me that, on the 13th December 2018, he telephoned Mrs Nash in relation to events of the 7th December, and she told him that Oskar and the girl he had been with were smoking cannabis;

"…they had taken a bus to Hounslow also in the company of two other persons but their identity was not known. Natalia stated that her son's behaviour changed over the previous weeks and he had become intimidating and would swear at her a lot. Natalia informed me that she had attended the home address of the girl involved and spoken to her parents regarding this issue. She informed them that Oskar is not allowed to travel alone and she should be informed by them if they see him. They exchanged numbers to facilitate this. I then added the girl's details to the occurrence and I submitted Child Protection paperwork [a SCARF] for the attention of Social Services."

81. Elaine Andrews confirmed that following the school's referral of Oskar to Children's Services in Mid-November 2018, the early help Family Services Team (subsequently called the Targeted Support Team) had been involved. However, as the Department received further information concerning Oskar's developing situation, including his exclusions from school and missing episodes, it was decided that a Social Worker, Shivani Rohith, should be allocated to conduct a Child and Family Assessment under s. 17 of the Children Act (a level 4 response).

82. On the 13th December 2018, a "Team Around the Family" meeting took place. The Children's Services' notes record that Matthew Bell, who was the school SENCO, told the meeting that the school could no longer meet Oskar's needs; he said the school were not saying he could not return but that, if he did, he would be at risk of permanent exclusion which would hinder his choice of future school. It was recorded that the SENCO had spoken to Oskar's SEN case worker, and her manager, and they had advised that they would help with a managed move to an alternative placement. St. Dominic's agreed to put in place "a robust transition" to support the move. There was discussion about potential placement in a residential school with in-house psychological support, and Mrs Nash expressed her view that Oskar would need that support. The "Actions" agreed at the end of the meeting included for the Social Worker to liaise with the school and to contact Oskar's SEN case worker.

83. Shivani Rohith, the allocated Social Worker, visited the family home on the 14th December 2018. Ms Rohith recorded that Oskar was seen to engage with his mother and they had been able to discuss the incident at school. Despite Oskar having been diagnosed with Asperger's Syndrome and complex needs nine years earlier, she wrote,

"Oskar is borderline autistic, and small classes at school caused him to be frustrated. He feels he is not challenged enough in the standard of work taught to him. Natalia has been supporting with learning by ensuring he has extra tuition."

Ms Rohith wrote that Oskar, whom she described as having "behaviour traits similar to someone on the ASD spectrum", spoke about the incident at school on the 6th December, saying that his teachers had said he was misbehaving by not being where he should have been and he had "wanted to show what it meant to misbehave by testing them in this case", and that he had tried to free himself from the subsequent restraint and had not wanted to hurt anyone. Oskar also indicated that he had gone off with a 15 year old girl on the 7th December because he was "of the view that mum and school were against him at the time after he said that he had not done anything wrong". It is noted that Mrs Nash said that Oskar was more open and compliant since the involvement of the Police and that, although the girl with whom Oskar had spent time was suspected to use alcohol and drugs, she was not aware of Oskar having done so.

84. On the 19th December 2018, Natalia Nash contacted Liz Godfrey and reported that although Oskar had settled at home, she had found him self-harming the previous evening; Ms Godfrey passed this information to Children's Services who recorded that Mrs Nash had found Oskar in his bedroom with a concealed blade "and there was blood". It was noted that Mrs Nash, who was "tearful and upset", had been advised to contact her GP to obtain a CAMHS appointment. Dr Patel, the GP, confirmed that Mrs Nash had telephoned the practice that day and had spoken to one of her colleagues, who recorded that Mum found Oskar "has cut his chest with a knife, won't let her look at it. Reports from school that this may be happening on off, previously." Oskar's attendance at the GP practice the next day was engineered under the pretext of a discussion about his bed-wetting, but when the topic of the self-harm came up, Oskar would not talk about it and he left the consultation. It is recorded that Mrs Nash was advised to go to the A & E Department or call the police if Oskar needs sectioning, but, Dr Patel said, there was no record of a referral to CAMHS being made or even discussed; she agreed that a referral ought to have been pursued.

85. Subsequently, on the 25th January 2019, Ms Rohith completed the Child and Family Assessment in which she reviewed the information available, adding that there had been a further home visit on the 18th January 2019 at which Oskar had not expressed his views, but was clearly upset that his mother had shared the fact of his self-harming. It was also recorded that Oskar had refused to see the GP, and that,

"Oskar has seen his father's death certificate and is therefore aware of the circumstances (heart attack and drug abuse) and has verbally expressed his anger at how selfish he feels his father had been. Mrs Nash advised that Oskar was receiving bereavement counselling, however the counsellor stopped after only the first couple of sessions because she was not comfortable with Oskar's behaviour and demeanour and did not feel safe."

It was recorded that Mrs Nash said Oskar was calmer since being out of school and at home and that her main concern currently was Oskar being placed in a school which could meet his needs; she said she was engaging with the SEN Team and that residential placements had been discussed, including schools (eg Brown's) where there are on-site psychologists.

86. The conclusion of the Child and Family Assessment was that Oskar did not meet the threshold for being designated as a Child in Need; this was on the basis that his "Needs are being met by others"; it was noted that Mrs Nash had obtained advice from the National Autistic Society, but also,

"There is currently no CAMHS support as Oskar had not engaged previously, however Mrs Nash has been advised to seek support from the GP if needed. … The SEN Team are currently providing intervention to ensure Oskar is provided with appropriate school placement able to meet his social, emotional and learning needs."

Consequently, Oskar's case was closed to Children's Services on the 29th January 2019 with no further action being taken.

87. Although the exclusion from school was for five days only, Oskar never returned to St. Dominic's School. Dr Glaysher accepted that he remained on the role and that the school continued to have responsibility for Oskar's education, but she said that he did not return because he did not want to be at the school any longer and it was not thought appropriate to put pressure on him to attend. When asked about the weight given to Oskar's views about leaving the school and moving to mainstream, Dr Glaysher said this was a decision which she thought he was competent to have a view upon, given his intelligence and ability levels. However, she did agree that Oskar's desire to

be at a mainstream school was driven very much by his unwillingness to accept his diagnosis and the fact that he needed support; she said,

"*I think when things were, in inverted commas, going well for him, we very much could see him in a mainstream setting, maybe with some additional support.*" But that, "*using his behaviour to communicate his … unhappiness with his placement, that made it clear that he was still a boy very much with special educational needs. However, if he was refusing to engage with the school safely, and then ultimately engage with the school, full stop, forcing him to attend is unachievable.*"

88. As stated above, although Oskar stayed on the role of St. Dominic's School until March 2019, he did not attend that school again and the school had little further contact with him. Ms Godfrey said that he may have been provided with some work (although there was no evidence of this), but he certainly did not receive his usual therapy, and he was not visited at home because of his negative feelings about the school. Dr Glaysher said that it was for the SEN Team and the family to identify the next placement. She said the school's role would then be to liaise with potential placements to share information; she said his behavioural records and risk assessments could have been shared, but a child's safeguarding file would not be shared until he had started at the new school. When asked how, then, any potential school would obtain the full picture in order to assess whether it could meet the child's needs, she said "the EHCP is the go-to document that should contain everything about that pupil".

89. Mrs Nash and the SEN Team identified a number of potential further placements, and there was some discussion concerning residential school, which Natalia Nash considered may assist the family greatly in coping with Oskar's adolescence. However, when, in February 2019, a place became available at Cobham Free School ("CFS"), a school which had been identified by Mrs Nash, that was the only "option on the table".

90. I heard evidence from Laura Newman, the Deputy Head for Inclusion at CFS, who described it as a mainstream school with 72 pupils in each year group of its secondary provision, and with about 26 pupils per class. The teaching staff did not undergo compulsory training in relation to autism, but there were Learning Support Assistants who supported pupils with EHCPs, and they had three half-day training sessions on the subject per year. The school had no in-house Speech and Language or Occupational Therapists, but it did have trained Emotional Literacy Support Assistants.

91. Laura Newman said that CFS was first approached about Oskar by Mrs Nash in October 2018, when she had provided Oskar's EHCP; the school had also

received a copy of an introductory letter dated the 26th September 2018 and written by St. Dominic's School, which contained general information about Oskar but did not provide details of his difficulties at the school. Ms Newman said that CFS had no further information or involvement until late February 2019, when a place became available.

92. CFS did not see or assess Oskar, but between the 1st and 5th March 2019 assessed whether the school could meet his needs on the basis of his EHCP, and oral information received from Mrs Nash and Ms Godfrey only. Laura Newman spoke on the telephone to Liz Godfrey on the 4th March 2019; Ms Godfrey agreed that she probably told Ms Newman that Oskar had become involved with a bad crowd and needed a fresh start, that she had no concerns about his ability to cope academically, and that she felt he would manage in mainstream with support. Ms Newman said that on the basis of the limited information obtained from the school and Mrs Nash, she was under the impression that there had been only two incidents of bad behaviour and that Oskar had left St Dominic's in December 2018 in order to be home schooled; she did not know of his history of suicidal ideation beyond the one line entry in the EHCP, nor did she know of the unfulfilled Transition Plan. CFS did not request any documentation from St. Dominic's School, although it could have done so, and it did not, therefore, see Oskar's behaviour records (with the 49 incidents) and risk assessments, nor the documentation relating to the two EHCP reviews (which were not supplied by the SEN Team).

93. Laura Newman told me that, having now seen all the records which existed, including those from Riverbridge Primary School,

"Had I had all of that information, as a school, I think it's highly unlikely we would have felt we could have met his needs."

She stated, in particular, that she would have been concerned about Oskar's move back to mainstream given that he had experienced suicidal ideation when last in a mainstream school but not in the specialist setting; she highlighted that the staff at CFS were not trained to monitor the risk of suicide in autistic students. She added,

"And in particular, as well in Oskar's case, he had a background of adverse childhood experiences which, coupled with the autism, made him very high risk for suicide, which we weren't particularly looking for."

94. Having decided that they could meet Oskar's needs, CFS contacted Oskar's case officer in the SEN Team to indicate they were willing to offer Oskar a place. Julie Beckett told me that the SEN Team were content to agree to placing Oskar at CFS, because the school had indicated that it could meet his needs. However, she accepted that the school's indication was based on insufficient information, given that the EHCP provided to them was as originally drafted nearly three years earlier, and had not been updated to reflect any of the subsequent changes and events. When asked how it could be that a pupil from a special school could transfer to a mainstream school without the new school first seeing and considering the contents of his previous school records, Ms Beckett said that she could not answer that question and that information sharing between schools is not a matter for which the SEN Team is responsible. She was asked whether it was not the SEN Team's responsibility to be assured that the new school had "the full picture of what they are taking on", and she said it was not. She did agree that, consequently, the SEN Team could not have been confident that the placement was suitable and she said, again, that Oskar's placement had progressed on the basis of parental preference which was, at that time, viewed as very difficult to challenge. Julie Beckett also accepted that, contrary to the SEN Code, his EHCP was not amended following Oskar's placement at CFS in order to name that school in section I of the Plan.

Comments and Findings

95. Having considered all the evidence I have no doubt that Laura Newman was right to say that Oskar's move to CFS was inappropriate and the school could not meet his needs, and it seems to me that the move resulted from a series of failures. Before turning to the SEN Team, I have to say that I have found it astonishing to learn that a child with Oskar's complex needs should be permitted to change schools, indeed to move from a special school to a mainstream school, without provision between the schools of his records, and full information sharing as to his history, needs, and current situation. It is very surprising that CFS did not insist on seeing them, and very concerning that St. Dominic's School took no steps to provide them or to ensure CFS had the whole picture; the information sharing, which was necessary to safeguard Oskar, simply did not take place. I consider that St. Dominic's School very readily stepped back from its responsibilities to Oskar following his second exclusion in December 2018, despite the fact that he remained on their role until March 2019; it does not seem to me that Oskar's reluctance to continue at the school is a sufficient explanation for the almost total absence of contact between the school and their pupil. St. Dominic's did not support a robust transition process, as it had indicated it would, and, despite clear reservations about the appropriateness of the proposed move to a mainstream school, it

did not ensure that the Transition Plan was acted upon, nor that CFS were fully in the picture about Oskar's needs and risks before offering him a place.

96. Turning to the SEN Team, it was their responsibility to ensure that CFS could meet Oskar's needs before they placed him there and, in my view, they did not do so. The SEN Team failed to attend the reviews of the EHCP and to update the Plan to reflect the many developments since June 2016 when it had been drafted, they failed to implement the Transition Plan, in particular to obtain the Educational Psychologist's re-assessment, they failed to provide sufficient information to CFS, and they failed to consider, at all, CFS's ability to meet Oskar's needs. These are highly significant failures and the fact that the move represented "parental preference" is not, in my view, an acceptable explanation for the inappropriate placement being made, given the very real risks to Oskar when he was insufficiently supported at school, of which the SEN Team were well aware.

97. In addition to the above, and in what seems to me to be a striking example of a failure to meet the Working Together principles, the referral to Children's Services in this period, and the s. 17 assessment, were closed without support being provided to Oskar, not because he did not need support as a Child in Need, but on the basis that the SEN Team were ensuring that his needs were to be met by an appropriate school placement, which of course did not happen.

Events of March to November 2019

98. Laura Newman told me that initially the SEN Team said that the placement would be with a reduced level of support, but she challenged this and the SEN Panel then agreed to a temporary period of funding for full time (32 hours') support. Oskar then started to attend CFS on Monday, the 8th March 2019.

99. PC Williams of Surrey Police recorded that, on the 19th March 2019, he attended Oskar's home following a report from Mrs Nash that just after midnight she had found him in his bedroom with a bladed instrument, self-harming. He said that Oskar stated that "he was unhappy with his life" and Natalia Nash,

"disclosed that something had happened with Oskar at school today but he would not disclose. … Natalia has disclosed concerns that Oskar is watching videos of self-harm on his phone. She stated that his behaviour has declined since the summer of 2018. He is unhappy at school, Cobham Free School. He is easily misled by friends and his

behaviour changed. He started to become aggressive, telling her he hates her and he doesn't want to live there anymore. He states he cannot trust her and that she always tells the school about him and stops him doing what he wants. Natalia states that Oskar has Asperger's and had to deal with his father's passing at a young age. Natalia states that she is very stressed and needs support dealing with her son. … I have then spoken to Oskar. He refused to engage or disclose any details to the police. He stated that he was having some issues at school. He denied he was being bullied. … I have then asked to see if he had caused injuries to himself this evening. He has shown me a number of scratch marks to his left forearm, the same consistency as cat scratches. When asked why he did this he stated he had had a bad day. He disclosed that he had previously self-harmed around a month ago but was not caught so thought he would do it again. Oskar has then at my request retrieved the bladed instrument from his room. This was a small miniature razor which was probably taken from a pencil sharpener. He provided two of these … Natalia told me she is aware and willing for support from Social Services to help deal with these ongoing issues and she is really starting to struggle. I then returned to the police station and completed the necessary documentation for a Child Protection incident and Social Services were informed of this incident."

100. On the 20th March 2019, the school learned from Children's Services that Mrs Nash had contacted the Police because Oskar had self-harmed with a razor blade. Ms Newman said she understood this to be the first time this had happened and described it as very concerning; as a result, Oskar was placed on the school's "additional needs register", on a red "RAG" rating, meaning he was to be monitored with the highest level of concern. She said the school sought further information from Children's Services about Oskar's history, but this was not forthcoming.

101. Helen Cottingham was a SENCO at CFS with responsibility for the 19 pupils in the senior school who has EHCPs; she said that about half of them had an autism diagnosis and noted that it was very common for them also to have a vulnerability to emotional or mental health problems. She said she had no previous experience of a child moving from a special school to a mainstream school,

"*So we were obviously keen to understand and know a little bit more about him, specifically meeting him in person, and obviously ensuring that we put in place what was in E and F* [in the EHCP*], when he joined us."*

She said that the support provided to Oskar at CFS was, a Learning Support Assistant being present for all his lessons, an Emotional Literacy Support Assistant should he need it, and a couple of designated members of staff. He

was placed in the bottom streamed set, to reflect both his academic ability and his need for LSA support.

102. At first Oskar initially settled and did well. Helen Cottingham said he was initially "an exemplary student … his uniform was excellent, he came into the classroom appropriately, got on with tasks appropriately, accepted support from myself in lessons, from learning support assistants." Ms Newman said he was coping academically, was perfectly behaved in every way, was polite, respectful, and he made a very nice group of friends with whom he was visibly happy. This was supported by evidence I heard from some of Oskar's friends at CFS; his close friend, Joe, described him as "probably one of the most liked people in the school", and Abigail said he was "funny and laid back". An annual review of Oskar's EHCP was conducted in June 2019 (which was, in reality after only a few weeks at the school) and it was recorded that things were going well and that "his teachers have been really encouraged by his attitude to learning, and his end of year exam results", and that, "Oskar has coped well, although he continues to be challenging for Mum at home."

103. In June 2019, a pupil in Oskar's year group at CFS attempted suicide; Ms Newman told me that Oskar knew, but was not especially close to, this student and Ms Cottingham said he declined an offer of ELSA support. However, in July 2019, a 14 year old boy from another local school, Sam Connor, who was known to Oskar, died after deliberately placing himself on to a railway track and into the path of train. Oskar attended Sam Connor's funeral with his family and it is not clear, from the evidence, what impact this may have had on Oskar; Mrs Nash does not believe that Oskar had been in contact with Sam in the period prior to his death, and nothing was found on Oskar's telephone to suggest that he was, but I do note that some of Oskar's friends at CFS said that Oskar had described Sam as a close friend.

104. Following the summer holidays, on the 10th September 2019, Mrs Nash consulted the family's GP, Dr Patel, again. She made an appointment in her own name, although the consultation was about Oskar. Mrs Nash's medical notes record,

"Problem with son's behaviour, defiant, not listening, goes out, does not tell her where he's going. She has had to call the police on him. When she challenges him he swears, throws things around. Yesterday threw water around the kitchen and tossed frying pan with dinner in it all over the hob. Upsetting for younger brother too. Single, bereaved mother, has always tried to do her best for the boys but feels she has no control over his behaviour. Puts on headphones and walks away. He has not said that he is suicidal or self-harming."

105. Dr Patel told me that she decided that a referral to CAMHS was required because of the escalation of events and the danger to Mrs Nash, to Oskar and to his brother, with "hot water being tossed around the kitchen and things like that"; she agreed that her note had not referred to "hot" water, but that was her recollection of what Mrs Nash had described. Dr Patel said that Oskar's "autism and … lack of awareness of danger" triggered the referral. She sent a referral letter to "CAMHS one-stop", which stated,

"Please can you see this boy urgently. He is known to CAMHS in the past. He has a diagnosis of Asperger's. He is becoming more and more defiant of his mother, refuses to listen to her. At times he can be verbally aggressive towards her, swearing and shouting a lot. He goes out without telling her of his whereabouts. She has had to call the police on several occasions. She is worried about his welfare. When she tries to discipline him, he puts his headphones on and refuses to listen. He has at times been physically threatening, throwing water in the kitchen, tossing pan of dinner all over the hob thus ruining the family meal. His father died when he was young. He has a younger brother. The mother, in my opinion, seems very sensible in the parenting style that she tells me she adopts, but she seems to be unable to engage with Oskar which is likely to be due to his Asperger's. Now, I really feel this family need input for the wellbeing of Oskar but also his little brother. Therefore, I would appreciate your prompt intervention. Thanks."

Dr Patel sent a letter, rather than completing CAMHS' on-line form, because she found the latter "clunky to use" and detrimental to the flow of conversation in a consultation. She accepted that she had not mentioned suicide or self-harm in her letter and said that she should have included reference to Oskar's history in this regard; she said, though, that she had reminded CAMHS that Oskar was known to them and they would, therefore, be aware of his history. She said that if CAMHS had needed more information and had requested it, she would have obtained and supplied it, but she had never known them to do this. Dr Patel told me that by seeking an urgent appointment she was hoping Oskar would be seen within two to three weeks, as this would have been "a sensible response time".

106. On the 11th September 2019, Helen Cottingham made an entry in Oskar's safeguarding file following a call from Mrs Nash, as follows :

"I have just taken a call from Mrs Nash who was deeply distressed. Oskar has taken her laptop, mobile phone in retaliation towards her taking his phone. Oskar is refusing to come to school until his phone has been returned to him. She said he has been aggressive towards her. He says things like she isn't his mother, that she isn't

providing enough for him. She said he has spent the whole summer in his bedroom on his phone. He doesn't communicate with her or his brother. She is worried about the impact his behaviour is having on her other son. She did go to see her GP yesterday. They said they could make a referral to CAMHS for her but it would take months. In Mrs Nash's words, "I don't have months"."

107. Dr Patel's referral went to CAMHS-SPA (Single Point of Access), a team for which Dr Caroline Dibnah, a Clinical Psychologist, was the Clinical Lead. Olivia Biancardi conducted the initial triage. She was a Registered Counsellor, but not clinically qualified. She said she would spend on average 15 to 30 minutes triaging a referral into one of three categories :

(i) Crisis : Meaning a response was required within four hours by the CAMHS' crisis nurse,

(ii) Urgent : Meaning the child should be seen within five working days, usually by a nurse or a CAMHS community team, or

(iii) Routine : Meaning the referral would be in a queue for further triage, which may result in the child being seen by a CAMHS community team, but typically would lead to a referral on to a partner agency; further triage was supposed to take place within ten working days but the volume of referrals meant the wait was much longer at the time.

Ms Biancardi said that a referral would be triaged as crisis or urgent only if it referenced a current risk of suicide or self-harm, psychosis, or an eating disorder; all other referrals were to be triaged as routine; these were the strict criteria she was required to apply. She said a referral could be classed as a "priority" in certain circumstances, including if the child had an allocated Social Worker, and this would result in it coming to the attention of an Assistant Psychologist on the team.

108. Olivia Biancardi said that she triaged the referral made by Dr Patel as "routine" because none of the above criteria was met; she said the fact that Dr Patel judged the situation to be urgent was not relevant, although she agreed that it was concerning that 70% of GP referrals were marked in that way but were nevertheless triaged as routine unless CAMHS' criteria were met. Ms Biancardi relied solely on the GP's letter and she did not look at CAMHS' own records, even though Dr Patel had noted that he was known to the service; she said this was the usual practice (although Dr Dibnah said she expected the records to be viewed). Ms Biancardi accepted that the notes from Oskar's last contact with CAMHS revealed that he was then a Child in Need with current and historic suicidal ideation, and that this information was

relevant to his current risk level but, she said, she would have classed the referral as routine even if she had seen that information.

109. Ms Biancardi explained that following her triage, a standard letter dated the 16th September 2019 was sent to Mrs Nash, and copied to Dr Patel, which stated that CAMHS had "screened your referral for safety and risk, and we will notify you of the next steps once clinical triage has been completed"; it also advised further contact if there were new or increased concerns. The witness accepted that the screening for "safety and risk" which had taken place was for current suicidality, psychosis and eating disorder only, and that no individual assessment for other potential risks had been undertaken. She said, though, that a clinical triage ought to have followed within 10 working days. As I shall come to below, Oskar's referral was not, in fact, considered again by CAMHS until the 6th December 2019, nearly three months later. Dr Dibnah was asked for the reason for this delay and said it was, "the number of referrals we received compared to the number of staff to process them". She accepted that CAMHS had no system in place to assess the risks to the children who were waiting to be further triaged and that no assessment was made of the nature or extent of Oskar's risks.

110. Despite the problems at home, it seems that Oskar had not displayed any significant problems at school in the first half of the Autumn Term 2019. After the October 2019 half-term, however, Oskar's behaviour at school changed dramatically. Mrs Nash described it as follows :

"*Until that time he had been attending school every day and had a good group of friends and enjoyed it, even though his behaviour at home was very challenging. Oskar suddenly decided that he was no longer going to go to school after the half-term break. When I asked him about his friends he said, "What friends?" I also believe he split up from a girlfriend he may have met through Instagram around that time. He wouldn't tell me what had happened, but Oskar would often misunderstand things or take offence due to his Asperger's, which caused difficulties in his relationship with friends.*"

Events of November 2019 to the 9th January 2020

111. The first school day after half term was the 4th November 2019 and Oskar refused to attend. I heard evidence from Isabelle Chessar, who had responsibility for monitoring pupil attendance at CFS and supporting the work of the safeguarding team in investigating and addressing, as necessary, the reason for non-attendance. She told me that she had only a little training in relation to special needs and that she was not, herself, a designated

safeguarding lead; as such, she had no knowledge of Oskar's history of suicidal ideation and self-harm (save for the March 2019 incident); she emphasised that she was not a decision-maker and that she filled a support role only. She said that on the 4th November 2019 she raised a safeguarding concern following Mrs Nash contacting the school to say he was refusing to go to school and "will just walk out of the house".

112. Oskar again refused to attend on the following days, although he attended on the Friday (the 8th November) which Mrs Nash said was "to get his mobile back". Isabelle Chessar spoke to Natalia Nash who said she was open to a referral to Children's Services and wanted, in particular, some-one who could talk to Oskar as had happened, successfully, when he had been schooled at home. On the 12th November 2019, Mrs Nash described verbal and physical abuse by Oskar, and on the 14th November Isabelle Chessar made a referral to Children's Services to seek support for the family. After setting out that Oskar was refusing to attend school, she wrote,

"He goes out without permission and she is not sure where he is going. Mum has overheard telephone conversations where she thinks Oskar is blackmailing people and conversations where he is telling someone he doesn't want to do something. Mum has called the police during an aggressive incident in the past. In a school meeting with Mum, Mum also raised that the situation at home is having a detrimental effect on his sibling. … At our recent meeting Mum said she would be "happy for Oskar to go into care". … It is very clear that the situation at home has completely broken down and Mum believes that Oskar is in danger. There is an urgent need for behaviour support in the home. Oskar needs a mentor / support worker outside of school. Mum needs support in her relationship with Oskar – she has been referred to Talking Teens in the short term".

113. When asked about the contents of this referral, and the developments since Children's Services' last involvement in January 2019, including the references to risks outside the home, Elaine Andrews said that it had "a different dynamic in terms of what we refer to as contextualised safeguarding". She agreed that if a child is in danger in the community and the parent cannot keep them safe from that danger, that can that be a basis for judging them to be at risk of harm even though they are safe within the home itself. Ms Andrews confirmed that the referral was triaged as requiring a level 3 response and was allocated to the Targeted Youth Service ("TYS"). When asked why this referral warranted a level 3 response when, previously, Oskar had been allocated a Social Worker under a level 4 response and matters now appeared more serious, Ms Andrews said that the TYS Team had "specific expertise working with the adolescents and, therefore, were very well matched

to work with children who are at risk of contextualised safeguarding". She said the triage was in accordance with SCC's internal guidance.

114. I heard evidence from Alexis Hynds, a Registered Social Worker and the TYS Team Manager. Her team consisted of a further Social Worker, a Senior Targeted Youth Support Worker, and four Targeted Youth Support Workers. Ms Hynds told me that she did not have a case load herself. All members of the team had some qualification for working with young people, but there was no mandatory training in relation to skills required for communication with autistic children, although training on autism was available on a voluntary basis. The witness said that the team were not able to refuse an allocation by the Early Help Hub, and were "expected to carry on and to try what we can at level 3, to avoid a social care response initially". She said that the team could provide a range of support for young people and their families. It was part of her role to "review thresholds to see whether we need to escalate".

115. On the 19th November 2019, Ms Hynds allocated Oskar's case to Laurianne Harrison, who was a Targeted Youth Support Worker. Ms Harrison told me she had a degree in Youth Studies and had received some training from SCC, but her knowledge of autism came mainly from a one-day course and her own research. The witness was asked specific questions about her knowledge of autism and its effects by Ms Patrick. In answer, she said that she was not aware at the time that there was evidence of a high prevalence of children with a neuro disability in the cohort of children who take their own lives. It is also noteworthy that Ms Harrison said she had no training for communicating with a child or a young person with autism, nor upon -

"… how to assess risk, including self-harm, harm to others, self-neglect, breakdown of family or … exploitation or abuse of other and how to develop a risk management plan, … particularly for children with autism".

Ms Harrison was directed to complete an "Early Help Assessment" within 20 working days, which was by the 17th December 2019; the outcome of the assessment would then inform what support was required. The witness said she looked at Oskar's Early Help and Children's Services records, although only the more recent notes. There was no marker to indicate that Oskar had a history of suicidal ideation and she did not learn of this history. She knew Oskar had an EHCP but she did not obtain a copy from the SEN team, although she accepted she should have done so. She was not aware that there was an open referral to CAMHS; Ms Harrison said she needed Mrs Nash's permission to obtain those records, but she agreed that she did not seek it.

116. On the 20th November 2019, Mrs Nash called the Police because Oskar was missing. She told PC Mostyn that she had located an e-cigarette in Oskar's bedroom and confiscated it; Oskar became very angry, smashed a glass container and a mirror whilst arguing with her before packing a bag and leaving. The officer stated that whilst searching Oskar's bedroom, he found a small sharp kitchen knife on his desk. Mrs Nash told the officer of Oskar's previous self-harm and that he had only attended school three or four times over the past three weeks because "he is convinced that he is going to start his own business online, and therefore does not need to study for his GCSEs". Oskar returned home at about midnight and refused to give any information about where he had been or who he had seen. Mrs Nash was saying that, "He lives in his own world which he has created in his head and cannot see reason or reality". Surrey Police sent a SCARF to Children's Services.

117. Oskar had continued to attend school only intermittently. On Friday, the 22nd November, Isabelle Chessar visited Oskar at home but he refused to speak to her. That evening, Natalia Nash called the Police again after Oskar left home; he returned late at night and PC Vasilova attended with a colleague to conduct a Return Home Interview. In a SCARF provided to MASH, it was said that,

"Oskar … was in bed in his bedroom. When SC Barbridge entered Oskar refused to sit up or acknowledge the officer initially. … He blanked the officer and continued to type on his mobile phone. He was still fully clothed … the bed cover obscured below his chest. Oskar would not answer questions as to where he had been, anyone he had been with and whether he had been with school friends, who he was in contact with on the phone, why he had run away, why he had not been in contact with Mum, any reason why he was running away. Oskar said, "It's shit here, I'd rather be with my mates". He would not elaborate on who his mates were. It was explained that his mates are not his guardians and not in a position to look after him ...Oskar said he didn't want Mum knowing where I am because she would just send the police to come and get me, and I don't want the police turning up around my mates. … It was explained to Oskar that he's 14 and … when he goes missing it becomes our responsibility to find him … to ensure his safety …and that since he has now been missing on multiple occasions there is the possibility that he will be taken into police protection, and that he could be placed in a secure, juvenile home, which could be anywhere in the UK, which has a place free. He didn't seem concerned about being taken into police protection but he did appear surprised that he could be taken far away from his mates. Having spoken with Mother, Natalia, she had no objection to Oskar being into police protection and agreed that as a temporary measure it would be beneficial for Oskar to go into secure police protection should the police deem it necessary. … Oskar has had it explained that if he carries on going missing, he will be taken away from his mother and he will not see his family. Oskar appeared totally oblivious as to what attending officers were trying to tell him."

DI Emmerson of Surrey Police was asked about the Special Constable's exchanges with Oskar; he said that the talk of Oskar going into police protection and a secure care home was inappropriate as it was "way off the mark because we were so far from that".

118. On Saturday, the 23rd November 2019, Surrey Police were called again by Mrs Nash after Oskar had left the house at about 5pm, saying he was going to see friends. PC Tamang stated,

"… we spoke to him on the phone in which he said he was in Staines but would not tell us the exact location. … We then got a phone call from his mother saying that he was standing on Staines bridge. We attended the bridge and started talking to Oskar who was not happy that we were called. He said he was fine and has not done anything wrong. … He did not appear in distress and did not make any threats to jump off the bridge. Then eventually he agreed to walk back home with my colleague, PC Nicholas, and his mother. When we reached his home address, we carried out a Missing Person Return interview. He did not have much to say but it was clear that mother and son were not getting along well. He wanted to go to his grandparents in the USA but his mother said that they are in their 90s, therefore this was not possible. We left the address after giving words of advice to both parties."

He later added that Oskar had been alone on the bridge and had been "pleasant and engaging" when spoken to. A further record also noted that Oskar had been with "two female friends, Nicola and Gabriella.… There was no indication of any harm coming to the misper or any risk in relation to child criminal or sexual exploitation. … There is likelihood that Oskar will come to the police notice soon as he was not listening to any advice given by the police. He was not happy that he was taken home by the police."

119. Natalia Nash told me that when Oskar had returned home, he had "smelt of alcohol". She said she was very concerned about the group of friends Oskar had apparently become involved with; although he would not identify them to her or to the police, she believed they were pupils from a local school, the Magna Carta School. She said she was,

"*… worried they were getting him involved in drug dealing and other dangerous activities. Police officers interviewed Oskar after he had returned home and spoke again about the possibility of Oskar being taken into police protection. I was completely at my wits' end and recall saying that I was happy for the police to do whatever would help Oskar, as I felt I was not receiving any help from anyone. I felt that someone getting involved and engaging Oskar in conversation about his behaviour was the only way forward.*"

At this point it is worth my noting that the evidence I heard at the inquest showed that Mrs Nash was correct to suspect that Oskar had started to spend time with pupils from the Magna Carta School and that he had become involved in drug use. I heard oral evidence from a pupil from that school, Megan, who stated that Oskar had started to spend time with her, and some of her friends, in late October 2019, and this continued until his death. She said they would meet regularly after school, often at a local park, and would communicate by "Snapchat". She said Oskar usually seemed happy but sometimes spoke of feeling low and killing himself; most of the group discouraged this although one girl would "wind him up about it". As for drug use, the witness said that members of the group used cannabis and cocaine and she had seen Oskar using both; sometimes Oskar would bring cannabis, but the cocaine was provided to the group for free by "Ricky". (DS Tate of Surrey Police told me that Ricky, also known as Ginger Ricky, is a vulnerable adult, who is autistic and suffers mental health problems with suicidal ideation; he has many convictions and has been known to the police for supplying drugs to schoolchildren, particularly pupils from the Magna Carta School, since at least January 2019, when a Community Protection Notice warning letter was issued to him. She said also that shortly after Oskar's death, the police received intelligence indicating that Ricky had caused a child to shoplift on his behalf.) The picture painted by Megan was supported by evidence from Oskar's friends at CFS; Abigail said that although Oskar had previously been "funny and laid back", a time came when he seemed to change, and he became more aggressive and angry; she said he had trouble sleeping, he self-harmed every few days, he drank and used drugs with his Magna Carta friends, and he was "constantly feeling down and out of pace in general".

120. On Monday, the 25th November, Isabelle Chessar made a note in the school records, which included :

"Oskar is still refusing to come to school today. … Mum is also very worried about his mental wellbeing. He has very low self-esteem. He has burnt old photos and thrown old objects away, some pottery that he made and had been proud of. Mum thinks he is really struggling with his identity. … Oskar found it difficult transitioning from the special needs school and convinced himself that everyone would think he was the same as the kids from that school. He was scared and ashamed that people would see him the same way. Mum thinks that Oskar has built something up in his head in the same way, but cannot talk to anyone about it."

It seems that Mrs Short, Oskar's Year Leader, was talking to him but Laura Newman said that, overall, the school could not identify what appeared to be

troubling Oskar; she wondered whether it was because he was concerned about his GSCEs, a concern which Natalia Nash had also voiced, but she did not know.

121. Children's Services were informed of the missing episodes and Laurianne Harrison was given responsibility for conducting a "Return Home Interview". She visited Oskar at home on the 25th November 2019 but Oskar refused to come downstairs, so she went to his bedroom and tried to speak to him but he would not engage; he did not make any eye contact and had his headphones on; she had stayed in his room for "probably about a minute". She said she spoke then to Mrs Nash who told her that she was concerned that she could not keep Oskar safe and Ms Harrison said she would try again to speak to Oskar, by phone or through another visit, perhaps with support from "other professionals who had already established a relationship with Oskar". Mrs Nash told me that she explained that it was very unlikely Oskar would engage initially due to his Asperger's and that a relationship of trust would have to be built up more gradually for him to engage; she felt this was completely disregarded and no real effort was made to build a relationship with him. "Overall, I was extremely disappointed by the efforts that Social Services made to engage with Oskar", she said.

122. Laurianne Harrison explained that she did telephone Oskar the next day, but he did not answer. She spoke also to Mrs Nash who said Oskar had refused to attend school and had left the house, and she did not know where he was. Ms Harrison told me that Natalia Nash asked for Oskar to be removed from home but that she told Mrs Nash that she did not think that would be possible, and that "there wouldn't be a removal from home unless there was a real threat of violence" at home, or something along those lines. Ms Harrison was asked about her knowledge of s. 20 of the Children Act and she said she was unfamiliar with it.

123. Laurianne Harrison said she was concerned about whether Oskar's case was sitting at the right level with Targeted Youth Support and whether it ought to go to level 4. She said she spoke to Michelle Beirne about this, but she did not make a note and could not now remember when the conversation took place, nor what Ms Beirne's response had been.

124. The fact that Oskar had been reported as missing on three occasions prompted further action within Surrey Police, in that, on the 25th November 2019, he was referred to their Child Exploitation and Missing Unit ("CEMU"). DI Craig Emmerson told me that CEMU is part of Surrey Police's Safeguarding Unit and its role is to identify and safeguard children and young people at risk of criminal and sexual exploitation. He explained that

some children who go missing are brought to the attention of CEMU because of the inherent risk that a missing child may face an emerging or actual risk of exploitation. It is important to discover why they have gone missing, where they have been, and who they have been with, so as to help locate them, should they go missing again, and for the assessment of risk. DI Emmerson said the officers in CEMU gather information in order to protect the child, including by identifying, disrupting and prosecuting perpetrators. Each child referred to CEMU has an officer allocated as a single point of contact, or "SPOC", whose role is to maintain contact with the child and his family, to identify any exploitation offences, and to work with investigators to disrupt activities and prosecute perpetrators. The SPOC also attends multiagency meetings (including Risk Management Meetings, which consider certain children following risk assessment by Children's Services) and works with partner agencies to ensure that the best support for the child is in place. DI Emmerson said, though, that if the investigation establishes that the child is not at risk of exploitation, then the police will probably step away; for example, "… if the episodes are purely mental health related, my view is that we shouldn't be the agency responding to that, and we can make our assessment and feed in any concerns we have, but then, no, we shouldn't be carrying on if that's the sole concern in terms of the missing episodes". He further explained that,

"…the SPOC's role is specific to a policing purpose, and whilst there is a degree of overlap, the SPOC does not seek to assume responsibilities for social care, health, education or parenting".

125. DI Emmerson was asked about information gathering from the child and a SPOC's training for this. He said that more often than not a child will not be forthcoming, initially, and so the SPOC will seek to build a relationship of trust, but, "if we're really not getting any engagement, it may be that we'd go to meet them with a teacher or with someone from Children's Services, the child's social worker, to potentially bridge that communication gap". He confirmed that SPOCs, and police officers in general, do not have any training for communicating, specifically, with autistic children; they would not know how to adjust their approach to the needs of an autistic child, nor what impact a conversation may have upon the child. He said that the training provided by Surrey Police was in line with the recommendations of the College of Policing, but that the College of Policing has acknowledged that there is a gap in training in this respect and that a "wider input" is needed in the future.

126. PC Paul Tyson was appointed to act as the SPOC for Oskar and his family. He said the role "… is around relationship building with the family and child and we work closely with our partner agencies as well, information

sharing with them". He said a key aspect of the work was intelligence gathering from the child, from the family, and from others. He agreed that some of the children reported as missing were resistant to communicating and co-operating with the Police and so the officers took a relaxed and informal approach, wearing t-shirt and jeans, and offering to meet and talk in McDonalds, for example; he said,

"… we try to meet them on their level, you know, we try to remove that position of authority in order to gain their trust. Ultimately, it is about safeguarding".

PC Tyson said he was a very experienced officer and he had been trained in Public Protection and Safeguarding but, when he joined CEMU, he did not receive any specific training in relation to managing and communicating with children. Further, he had received no training on autism, save for a mention of it within an on-line training course on mental health. He was not trained on, or familiar with, either the National Autistic Society's guidance prepared for police forces or the Working Together national guidance.

127. PC Tyson told me that he read all the information held by the police on Oskar but had no access to records of other agencies and he was not aware that Oskar had an EHCP. On the 28th November 2019, he went, with DS Egan, to see Oskar at home to introduce himself. They went at 11 am and found Oskar still in bed, but he got up and spoke to them. He could not give a reason for not going to school, but said he "doesn't like school, he's not particularly good at any of the subjects". As for going missing, the officer recorded that, "Oskar didn't consider that he was missing. He would go out to meet with friends and his mother knew where he was. We told him that this wasn't the case. … Oskar refused to give us details of any friends saying that police would visit them if he was reported missing." PC Tyson said he asked Oskar about self-harm and he admitted to cutting his arms, but he could not provide a reason for doing this. He said that Oskar agreed that he would go back to school on the 29th November. He said Oskar's problem seemed to be that he was angry with his mother because she would not let him do as he wanted, which was not unusual for a teenager; he said,

"Again, it came back to, from reading the reports from the other officers, Oskar's disclosures to the officers about the family dynamic it,… I appreciate that he did have autism, albeit I didn't know to what extent, and again, how that manifested itself, because he didn't present necessarily as he had autism. … he didn't look me in the eyes necessarily but a lot of children I work with don't look us in the eyes, because we're police officers. So, apart from that I, it was nothing obvious to identify any huge vulnerabilities around him. So, for me it came back again to around the family dynamic was the concern there".

128. Early the following morning, which was Tuesday the 29th November 2019, Natalia Nash went to Staines Police Station to see PC Tyson. He recalled that,

"Oskar's mum in tears. … Oskar had taken her phone. She had confiscated his and so he did the same to her. She said that she wanted to sign him over to child services as she could no longer cope with him. His behaviour has deteriorated recently, he walks out of the house whenever he wants, has no respect for her and she played me an audio clip from her other son's phone where Oskar was swearing about her, calling her names. She said that last night he was pushing her out of his room and he often swears at her. She says that she can no longer cope with him."

The witness told me that his conversation with Mrs Nash had "really disturbed" him and he was really concerned; he said it "hit home that she was at her wits ends, you know, that distraught that she was considering signing him over to child services". As a result, he said, he submitted a SCARF reflecting the above, and he gave it a red risk marking, which meant it went through to Children's Services immediately as a priority, and he then telephoned Laurianne Harrison and her manager, Alexis Hynds, and left her a voice mail. He said he would have continued to contact Children's Services until he spoke to someone but, shortly after this, he found out there was to be a "s.47 strategy meeting" about Oskar that afternoon and so he made himself available for that.

129. On the 29th November 2019 there were in fact two formal meetings in relation to Oskar. First, in the morning, a meeting took place at school which was attended by Isabelle Chessar, an Education Welfare Officer, Natalia Nash, and Oskar. The school had made a referral to SCC's Education Welfare Service (now the Inclusion Service), because of Oskar's non-attendance. Ms Chessar said the Inclusion Officer explained to Oskar the importance of his attending school, but Oskar did not really speak at all. Mrs Nash was required to sign an "Attendance Agreement" undertaking to ensure Oskar's attendance at school or explain his non-attendance, and to alert the service to any further problems so that support could be provided. Julie Beckett was asked about this and agreed that there was no evidence to suggest that Natalia Nash was not, already, doing her best to facilitate Oskar's attendance at school but, she said, this was the standard first step which the Inclusion Officer was obliged to take. Ms Beckett also agreed that Mrs Nash complied fully with this agreement, sending text messages to Kate Hall on an almost daily basis thereafter; she said, though, that she could see no evidence of any support being provided to Mrs Nash by the Inclusion Service.

130. The second meeting on the 29th November 2019 took place in the afternoon. It was a "strategy meeting" under section 47 of the Children Act 1989. The meeting had been triggered by SCC's procedures because Oskar had gone missing on three occasions within a 90-day period. Elaine Andrews was asked about the rationale for this and explained that "from a safeguarding perspective, children that go missing can be at high risk of harm in the community". She said the purpose of a s .47 strategy meeting is to apply the statutory test (namely, whether there is reasonable cause to suspect that the child is suffering or is likely to suffer significant harm) to consider whether the Local Authority had a duty to investigate further; it was not for the strategy meeting to decide what, if any, further action may follow after further investigation. She said that a parent may be informed of the meeting but would not necessarily be invited, because concerns may relate to the parent. She explained that the process was for all pertinent information to be gathered by the person convening the meeting and circulated to invitees before the meeting; it is then the responsibility of the Chair to gather more information from attendees and from SCC's own records. If insufficient information is available at the meeting, a follow up strategy discussion can be held subsequently. Ms Andrews stated that all participants should be asked for their view as to whether the statutory threshold is or is not met, but that ultimately the decision lies with the Chair of the meeting on behalf of Children's Services, who could disagree with all other views. Ms Andrews also explained that if the statutory threshold is judged not to be met, there should, nevertheless, be a discussion about next steps; the child may still have needs which require Social Worker involvement, for example, to conduct a Child and Family Assessment.

131. It was Alexis Hynds of the TYS who requested the s. 47 strategy meeting for Oskar. She said it was the TYS Team's responsibility to put together sufficient history to help guide the Chair and the other professionals attending, although she also expected the Chair to have done some background reading and those attending to come prepared. She completed an electronic referral form in which she set out a brief history of Oskar's previous contacts with Children's Services, a brief review of the three recent missing episodes, and the following :

"On all occasions mother has highlighted that she feels that Oskar is socialising near Staines Bridge … with two females called Gabriella and Nicola who are Polish and both 14 years old and attend Magna Carta school. Oskar's mother has no idea what Oskar is doing when he leaves the home. Oskar become verbally abusive towards his mother when he wants to leave the home or does not want to attend school. Oskar's

mother feels that Oskar is putting himself at risk and is vulnerable as he is out late at night.

Oskar also attends Cobham Free School however Oskar has not been attending school and refuses to go in. This is due to Oskar feeling he does not need education and would prefer to start a business selling phone cases.

There are a lot of unknowns as we do not know what Oskar is doing or who he is actually associating with when out missing. Mum is clearly struggling to manage his behaviour which has been a concern from previous involvement by Children's Services.

"Mum is clearly not coping and is seeking support. Oskar is a vulnerable young person due to his diagnosis of ASD and this could further impact on the risk to him. Whilst Oskar's family have only recently been referred to TYS, his engagement so far has been limited, as he is not responding to calls made by the worker. … School report that Oskar is quiet and does not engage with school."

132. Ms Hynds accepted that the form also had a section which was headed, "Are there concerns that a child may be at risk of any of the following factors ?", the purpose of which was to highlight identified risk factors, if they were relevant to the child in question, to draw them to the attention of the decision maker; the witness accepted that the only risk she had identified had been Oskar's "3 missing episodes in 90 days"; she had not ticked the boxes which referred to risk from alcohol misuse, drug misuse, mental health concerns, learning disability, child exploitation, or self-harm, all of which should have been highlighted as risks to Oskar, for the benefit of the Chair of the meeting.

133. The s. 47 meeting was originally arranged for the 27th November 2019, and the invitees (who were representatives of the police, health, the TYS, and CFS) were provided with the information set out above. Laurianne Harrison, as the allocated Support Worker, was due to attend on behalf of the TYS. An invitation was not sent to Mrs Nash (who was not aware of the meeting), and neither the Inclusion Team nor the SEN Team were invited, a situation which Julie Beckett described as "very concerning". Further, the GP practice were not consulted or invited. The meeting could not proceed on the 27th November, because a Chair was not available; and so subsequently, Alexis Hynds asked Bekezela Sibanda to Chair the meeting on the 29th November instead.

134. Bekezela Sibanda told me that he is a Registered Social Worker and a Team Manager in SCC's Children's Services. He thought that it was on the 29th November 2019 itself that he was asked by Alexis Hynds to Chair the s. 47

strategy meeting; he said, SCC held up to six s. 47 meetings a day and short notice was "usual". Mr Sibanda said that in advance of the meeting he was provided with the referral form, but he did not look at Oskar's records or gather any further information. He conducted the meeting, which he thought may have lasted for about 20 minutes, from his office with all attendees joining by telephone; there was a minute-taker present with him, who made notes on a laptop. Mr Sibanda told me in his oral evidence that the attendees were (i) PC Tyson and DS Michail on behalf of Surrey Police, (i) Nicola Steadman, an NHS Health Advisor, (iii) Michelle Beirne for the TYS, in place of Laurianne Harrison who was on leave, and (iv) Isabelle Chessar from CFS. Mr. Sibanda said that at the start of the meeting he checked everyone had read the circulated information and he then invited their updates.

135. The recorded contributions were as follows :

(i) PC Tyson read out the contents of the SCARF he had completed earlier that day (as set out above),

(ii) Nicola Steadman stated, "Oskar has had bereavement counselling and anger management. Oskar struggles with anxiety and low self-esteem. Refer to CAMHS?" (Ms Steadman having said she was unsure whether Oskar has been referred to CAMHS or not),

(iii) Michelle Beirne stated, "Natalia, Oskar's mother, does not know where Oskar is going or who he is meeting. Oskar's behaviour is deteriorating and he is becoming more disruptive in the home, swearing, refusing to go to school, becoming physical with his mother, Natalia, pushing her. TYS received a referral from Cobham Free School on 20th November regarding their concerns. Oskar is in school today, as he was spoken to by Paul Tyson, his SPOC officer and has a meeting with the school Inclusion Officer.

(Elaine Andrews agreed that the TYS ought to have informed the meeting of Oskar's history of suicidal ideation and of Mrs Nash's report that she had heard Oskar having worrying telephone conversations), and

(iv) Isabelle Chessar stated, "Oskar has not been in school since 20th November, however he is in today. We think that is due to speaking to his SPOC, Officer Paul Tyson, and having a meeting with the Inclusion Officer. School has met with Natalia and offered counselling which has been turned down. Usually Oskar is well behaved and works well in

class. School hopes that Oskar will engage and we will continue to support him and Natalia".

Mr Sibanda, when pressed, agreed that the information before the meeting was insufficient. He did not know about the extent of Oskar's self-harming or the reason for it, he did not know whether Oskar had been referred to CAMHS and he had no details of his mental health history. Mr Sibanda accepted this was relevant information which he ought to have had before reaching a decision. He was asked why he had not adjourned to make further enquiries and said he was focusing on the three missing episodes and thought we had sufficient information to cover the risks associated with Oskar going missing.

136. Bekezela Sibanda said that at the end of the meeting he asked for the views of all attendees and all agreed that the threshold for further enquiries had not been met. The witness decided that no further action was needed by Children's Services. His reasons were recorded as:

"All agreed that threshold for s.47 was not met.
The Strategy discussion was as a result of 3 missing episodes in 90 days.
All missing episodes have been for a few hours. It was also noted that Oskar has not come to any harm whilst he has been out and that he is not interacting with people that are known to the police. There is no evidence of Oskar being exploited.
Oskar's relationship with mother is strained and he is not adhering to any boundaries. There is a risk that Oskar will repeatedly go missing as he refuses to tell mother where he is.
Oskar is working with TYS and the view is that TYS will continue to support the family – putting and maintaining boundaries and doing direct work with Oskar around the risks of going missing and using alcohol and drugs."

137. Mr Sibanda was challenged about aspects of his reasoning. He accepted that the fact that the missing episodes had been for a few hours only did not preclude the risk of significant harm; and that the information available was insufficient to enable him to assess, one way or the other, whether Oskar had come to harm, was interacting with people who were known to the police (which, in fact, he was), or was being exploited (a question which the Police's Child Exploitation and Missing Unit had not yet answered). He said, though, that he "…needed to have evidence for me to come to a conclusive decision in terms of whether he was suffering significant harm". It was put to the witness that this was not the correct test, as he ought to have considered whether there was reason to suspect significant harm and he answered, "My professional judgment at that point was no". As for the

suggestion that Oskar was "working with" TYS, Mr Sibanda said, "I was led to believe in the meeting that there was already a plan by TYS – a plan of intervention". The witness also accepted that his reasons did not take account of Oskar's autism, which he agreed increased his vulnerability and undermined his ability to keep himself safe, nor the fact that he was refusing to attend school. Finally, he was asked about Mrs Nash's position; he said he had concluded that she was "…doing everything that would be reasonably expected of her" and that there was, therefore, no evidence that mother was failing to safeguard Oskar; it was put to him that the fact that Mrs Nash was saying that she could not control Oskar or keep him safe was a significant risk factor and the witness said that his "…conclusion was that this was a child in need of support".

138. So far as the plan for future support was concerned, the Record of the Meeting noted, under the heading, "What needs to happen":

"School to continue supporting Oskar and Natalia.
Paul Tyson and Police to continue supporting Oskar and Natalia.
Social Services to continue supporting Oskar and Natalia.
Referral sent to CAMHS."

Mr Sibanda said that it was his view that Oskar's case was "correctly pitched at level 3" but that it would have been open to Alexis Hynds to allocate the case to a more senior support worker, or to a Social Worker within the TYS Team. It was his expectation that it would be the TYS who would contact CAMHS to establish whether a referral had been made.

139. I also heard evidence from three other of the attendees at the meeting. First, PC Tyson said that although it was not his role to express a view on behalf of Surrey Police as to whether the statutory threshold was met, he may have conveyed his view that Oskar was not at risk of significant harm; he was of that opinion, he said, because "… at the time there was no indication that he was likely to be at risk of being exploited … I've no serious concerns around his mental health. I appreciate that he had autism … but when he wasn't at school he appeared to be at home in a safe environment, and no information has been shared with me to really make me concerned about his immediate welfare". However, when questioned, he agreed that in fact what ought to have been concluded was that there was not yet enough information to know whether Oskar was or was not at risk of significant harm; there were information gaps which were still to be investigated and the Police did not know, for example, who he was mixing with or who was supplying him with drugs. He also agreed that he did not then know anything about Oskar's

history of suicidal ideation which, he said, was significant information as it would have made him a high risk missing person; he said he would have expected Children's Services and Health to have informed the meeting of the suicidal ideation history.

140. PC Tyson said he understood the outcome of the meeting was that he would continue working with Oskar and he planned to liaise with Laurianne Harrison the following Wednesday (which would have been the 4th December), when she returned to work, and to see Oskar at school. However, he accepted that, in fact, he had no further contact with Oskar, or his mother, until the 30th December; he said that this was due to the pressure of other work. He agreed therefore, that although the s. 47 meeting had concluded that Oskar's needs were already being met with support from TYS and the Police, he did not take any steps to provide support to Oskar or investigate further where he was, and who he was with, when he was not at home or at school.

141. Secondly, A/DS Michail said she formally represented Surrey Police. She told me that the first she knew about Oskar, and the meeting, was about an hour before it took place; this was not unusual and she was sometimes given only 10 minutes' notice. She was notified by PC Tyson because she was the Duty Sergeant. A/DS Michail was asked whether an understanding had been gained at the meeting as to why it was that Oskar was going missing and she said that, "the main understanding was that he had a fractious relationship at home with his mother and the missing episodes were due to wanting to get away but also that he wanted to be with his friends. The missing episodes as such weren't for a long duration of time" whereas "…the children that we deal with [in CEMU] tend to go missing for quite a substantive amount of time … for three, four days at a time and that's where the risk for us is incredibly high, because that's where the risk of exploitation, alarm bells are ringing for us". She accepted, though, that further investigations had to be made in order to assess whether Oskar was or was not at risk of exploitation, and that she did not know whether Oskar was currently self-harming, and, therefore, that she could have required more information before giving her view as to whether the s. 47 threshold was met, but she did not do so; on the basis of the evidence available at the meeting she concluded that there was not enough to suggest that Oskar was at risk of any significant harm.

142. Thirdly, Isabelle Chessar attended this meeting on behalf of CFS. She said that Laura Newman was due to attend but was not available when the meeting was re-arranged; she was asked to attend at the last minute, probably after her morning meeting with Mrs Nash; she thought she would simply need to update the meeting as to the school's interventions. Ms Chessar said

that, "other than that it was a multiagency meeting concerning Oskar's situation", she had had no understanding of "section 47" or the purpose of the meeting. She said she could not recall what was said at the meeting, adding that "it was quite a difficult conference to follow. It was badly sounded, so that everyone was hard to hear." She agreed that what she told the meeting probably underplayed the seriousness of Oskar's non-attendance at school and that, so far as the recorded note is concerned, she portrayed Mrs Nash's response to an offer of counselling in an inaccurate and negative way. She also agreed that she did not inform the meeting of Mrs Nash's concerns for Oskar's mental health, nor of the outstanding CAMHS referral. Overall, she agreed that she had probably not given a full and accurate description of Oskar's situation, as known to her. Ms Chessar said there was no real discussion at the meeting which had been "a tick box" exercise. She said that she was asked to express her view as to whether the "s. 47 threshold had been met" and that she "indicated that she was in agreement with the other parties"; but, she said, in fact she probably did not know what the threshold was. When asked whether, in the light of the information which was available to the school, she could have properly concluded that Oskar was not at risk of significant harm, she agreed that she could not have done so. Isabelle Chessar said that she could now see that the s. 47 meeting was one she was not qualified to attend.

143. In view of Isabelle Chessar's evidence, Laura Newman was recalled. She accepted that Isabelle Chessar ought not to have been asked to represent the school at the meeting but, she said, if she had attended the meeting, she too would have concluded that the s. 47 threshold had not been met. She was pressed on this and asked to consider how, in view of the many factors which were escalating risk, and the matters which were still unknown, she would have been able to reach that conclusion and she accepted that she could not have done so.

144. Following the s. 47 meeting, Alexis Hynds spoke to Michelle Beirne on the telephone about the outcome and the plan. She said she was given to understand that Oskar's case was left with TYS because "…we had only just started to try and engage with Oskar. … So it was felt that there was more opportunity for us to try and engage him and encourage him to access our support rather than escalating straightaway to Children's Services at this time". When asked about Oskar's history of non-engagement she told me that she acknowledged that "… we didn't fully check the social care records as fully as we could have done". As for the plan, so far as TYS was concerned this was, in effect, for Laurianne Harrison to continue with the Early Help Assessment; she was not made aware of any requirement to contact CAMHS.

145. Ms Hynds was asked whether the further information which had become apparent ought to have triggered a review of Children's Services' records in order to get a fuller picture of Oskar's history and she accepted that it should have done, and that such a review would have revealed very significant information, including his significant history of suicidal ideation which could apparently be triggered in the face of professionals trying to help him. She accepted, also, that she did not take any steps to speed up completion of the Early Help Assessment.

146. When Laurianne Harrison returned to work on the 4th December 2019, she said the plan which was recorded in their notes, was,

"Efforts to be made to encourage Oskar to attend school every day. Mum to call police if Oskar does not return home by curfew time or is behaving in a violent or aggressive manner within the home. Mum to take Oskar to A&E if he self-harms/shows sign of emotional distress. PC Tyson to visit Oskar in school next week. Professionals meeting to be held in two weeks' time. To be discussed again if Oskar continuously goes missing or any other significant events arise."

She said that, in addition to completing the Early Help Assessment, her tasks were to convey the plan to Mrs Nash and to arrange the "professionals' meeting" in two weeks' time, but she was not asked to contact CAMHS. She did speak to Mrs Nash and found that the situation had not improved. When questioned, she agreed that the suggestion that Oskar should be permitted to go out without Mrs Nash knowing where he was, and that she should report this to the Police only if he failed to return by a curfew time, was not safe or appropriate, given his age, his autism, and his vulnerabilities.

147. Laurianne Harrison had also received an email from Isabelle Chessar which stated,

"Hi, Laurianne, I'm not sure when you're back from leave, but we are very worried about Oskar. He has not made it into school all week and from the email from mum below, we're very concerned for Oskar's mental health. We are hoping to do a home visit ourselves tomorrow, but it would be good to have a catch up when you're back."

Ms Harrison responded by writing,

"I am aware that Oskar has not been attending school. Oskar will not talk to me so I have been in contact with the police officer who took him to school last week to see whether he can do a joint home visit with me as Oskar spoke to him a little bit. I have spoken to my manager regarding Oskar and the plan at the moment is to do a joint home visit with the police, or even someone he has a relationship with in school, and

also arrange a TAF [Team Around the Family] in school. In terms of Oskar's mental health, mum can take Oskar to CYP Haven which is at Leacroft Tuesdays and Wednesdays four to 8pm and Saturday 12 to six. She can also take him to the GP. Hope this helps and I do hope Oskar will open up to someone about what is going on."

The witness said she could not remember whether she spoke to Mrs Nash herself to convey this advice about how Oskar's mental health should be addressed; it was Mrs Nash's recollection that she had not done so.

148. On the 6th December 2019, there was a second home visit by CFS; Isabelle Chessar and Mrs Short spoke to Oskar and he responded a little, describing, in effect, a breakdown of his relationship with his mother. There was then intermittent attendance at school until the end of term. An emergency review of his EHCP was planned for the 9th December 2019 with James Cotton (SEN Team) in order to discuss Oskar's absenteeism, possible alternative ways to support his education (such as on-line learning), and whether change of placement was required; Ms Cottingham said that James Cotton had also raised the possibility of a residential placement to be arranged by social care. However, the planned review meeting did not go ahead on that date and no further action was taken by the SEN Team prior to Oskar's death.

149. Also on the 6th December 2019, Natalia Nash rang CAMHS in response to a letter she had received from them. As I have set out above, after Olivia Biancardi's initial triage of Dr Patel's referral, CAMHS had written to Mrs Nash on the 16th September indicating that a clinical triage would follow, but this had not happened. Rather, on the 22nd November 2019, an administrator at CAMHS had sent a standard letter to Mrs Nash and had closed the case. The letter read,

"We are sorry it has taken some time to get back to you about your referral to our service. We know that for some young people emotional and mental health needs can persist, but for others they get better with time. There is strong research evidence which indicates that time is a healer. Now that some time has passed, we wonder if a mental health assessment is still needed. Could you please let us know if an assessment is still required, and you can do this by contacting us on [telephone number for CAMHS SPA given] and we will gather some more recent information from you and progress your referral. If we do not hear from you by the 16th of December, we will assume your needs have now resolved, so we will not contact you for an assessment. If your needs have subsided but later re-emerge, please don't hesitate to seek a re-referral through your GP or school."

Dr Dibnah, the Clinical Lead for CAMHS-SPA, told me that this system had been introduced because of the significant backlog of cases. She could not identify the "strong research evidence" referred to in the standard letter.

150. Natalia Nash's call to CAMHS on the 6th December was answered by Rachel McPherson, who was on duty as a Triage and Assessment Assistant Psychologist. She said she knew nothing at all about Oskar, or his referral, when she spoke to Mrs Nash. Ms McPherson told me that she could remember the call very well. She said that Mrs Nash initially provided her new address and the witness updated Oskar's electronic records accordingly. She then saw that the referral had been closed on the above basis and so she asked Mrs Nash if Oskar still required support from CAMHS, Mrs Nash said he did, and so she reopened the case. The witness' record of the call made no reference to any further conversation with Mrs Nash and it was Natalia Nash's recollection that the call had lasted for a short time only. Ms McPherson was, therefore, asked why she had not taken the opportunity to obtain information as to Oskar's current presentation and risks, given that Dr Patel's referral was now three months old and that she now had to decide how the re-opened referral was to be managed; in particular, she had the responsibility to undertake a clinical assessment in order to decide whether to pass Oskar to one of CAMHS' clinical teams or to refer him on to a partner agency, the latter being appropriate for less serious cases. Ms McPherson told me that she had asked for further information from Mrs Nash. She said, "Mrs Nash mentioned that he was still being aggressive towards her and she's had to call the police numerous times. She did not say why … so I assumed it was to do with the aggression. … There were no additional concerns that were raised. The main issue that was raised was to do with aggression which is the same as what was in the referral". The witness said they spoke for 15 to 20 minutes, and "I remember building a rapport with Mrs Nash and I was speaking to her at length as well in regards to Oskar" but, she said, nothing was mentioned "that would cause me to refer on to the CAMHS community team or anything". She said she did not make any note of what was said probably because "it wasn't any different to what was in the referral". When questioned by Ms Patrick the witness agreed that she had not asked Mrs Nash any of the questions suggested in CAMHS' manual in order to establish a child's needs. The witness said that Natalia Nash did not tell her that Oskar had stopped going to school, that the police were called because he was going missing, that there was evidence of him using alcohol and drugs, nor that she considered she could not keep him safe and had asked for him to be taken into care; she did not learn about the involvement of Children's Services and the Targeted Youth Support Worker. The witness was asked how it could be that she had not learned of any of these matters if she had spoken to Mrs Nash for 15 minutes to obtain the current situation, and she said that Natalia

Nash was very emotional and there was "a language barrier … I think her accent kind of prohibited her from obviously explaining what she wanted to explain at the time". She said, "I did do my best to reassure her that CAMHS would do the best that we could as a team to get the case reallocated … and refer to the best possible service for Oskar".

151. Following completion of Rachel McPherson's evidence, I was provided by Mrs Nash with a copy of her telephone records which showed that the telephone call had lasted for only 2 minutes 16 seconds. Ms McPherson was recalled and it was put to her that, after introductions, finding Oskar's records, recording the family's new address, and establishing that the service was still needed, there was little or no time for any conversation about Oskar's current situation. Ms McPherson said that her evidence, that she had spoken to Mrs Nash for 15 minutes or so and had built a rapport with Mrs Nash, had been "an error"; but, she said, she had been telling the truth and had not exaggerated her evidence. I do not accept that Ms McPherson's initial account was in error, and I find that it was untruthful, and that she had, in fact, made no real enquiry as to Oskar's current situation.

152. On any view, Rachel McPherson failed to obtain the further information as to Oskar's current situation which Mrs Nash could readily have provided. In addition, she accepted that she did not contact any other agency to obtain further information about Oskar, although, she said, "that is something that I would do in normal practice", and that she did not review CAMHS' own records (even though, Dr Dibnah told me, this was an expectation); as a result she did not read his history of suicidal ideation and his being a Child in Need; she said that "could have been relevant" to his current risk, but "we were taught to just focus on the current referral".

153. On the 7th December 2019 Rachel McPherson referred Oskar on to one of CAMHS' partner agencies, Relate West Surrey ("Relate"), which is a counselling service which could "provide six to eight sessions of counselling". She also closed his case to CAMHS meaning, she said, that "the referral was taken off the CAMHS-SPA caseload and put onto the Relate caseload". The witness agreed she had not recorded anywhere her reasons for making the referral to Relate. She said it was not CAMHS' practice to record reasons although she accepted, when taken to it, that CAMHS' manual directed employees to "Ensure you provide a rationale for your clinical decision as to where to signpost and any further information you gather". In evidence she said that her reasons were, "…because the main issue from the referral was aggression … and I felt that Oskar would benefit from some counselling sessions with a partner agency team and also they would … be able to provide him with some bereavement support as well, as bereavement was

also mentioned in the referral". The witness was asked whether she had any understanding of why it was that Oskar had started to become aggressive and she said, "No, but I assumed it was to do with his autism diagnosis". She accepted that Oskar's problems could be resulting from a mental health condition and that he required a mental health assessment, but she said that she did not have information to warrant that. She said, she did not think his autism was a risk factor and, "I know that Relate also have people trained in autism, so I think that was the reasoning behind my decision in referring him to Relate as well". She was not aware of the timescale for Oskar being seen by Relate.

154. Ms McPherson said that she did not contact Relate to discuss Oskar but simply sent to them a short, standard form. Other than personal and contact details, the form said only,

"Reason for Referral : YP is aggressive towards his mother
Known Risk : [Blank]
Other Information : YP's dad died when he was young"

She did not forward Dr Patel's referral letter as, she said, it was not CAMHS' practice to do so, and she did not inform Relate that Oskar was autistic. She said she did not know whether Relate did or did not have access CAMHS's records relating to Oskar. A letter was then sent to Mrs Nash, and copied to Dr Patel, which referenced Relate and stated,

"We have made a referral under this service on your child's behalf. The service will be in touch in due course with regards to setting up an initial appointment. Please be aware that there is often a waiting time for the service due to the amount of young people needing to access support and your patience is appreciated. If your child's circumstances change, including worsening, or you do not wish to access the service please contact the service directly."

When asked who it was, within CAMHS, who had responsibility for subsequently assessing whether Relate's input had been effective in assisting Oskar with the problems for which he had been referred, she said, "I don't believe there is any follow-up from CAMHS".

155. Dr Patel was asked about the referral on to Relate and said she could have referred to Relate herself, but had felt that CAMHS were needed. Nevertheless, she said,

"The fact that the mother hadn't come back for, with escalation of problems and the fact that the referral had been triaged by CAMHS, I trusted that they were making

the choice or the decision that they made with the information and on the conversation that they may have had with the mother."

However, Dr Patel said she would have been concerned that Oskar had not been seen for clinical assessment by CAMHS if she had had the full picture, which was far more serious than she had appreciated, but which she gained only after Oskar's death; prior to his death the GP practice was dependent on Mrs Nash for information and had no access to CAMHS, Children's Services, or SEN Team records, nor Oskar's EHCP.

156. Relate received the referral and triaged it quite quickly. Christina Powell told me that she is a Counsellor and Supervisor within Relate and in December 2019 it was her role to view new cases passed by CAMHS in order to assess, first, whether the referral was suitable for their service and, secondly, if it was, whether the child needed to be seen urgently. She was asked about Relate's remit and said, "…we would accept anxiety, panic, anger, inter-personal issues within a family, within a school context, with friendships. So those would be the main issues we would see and work well with". Ms Powell said that it was not unusual to receive a referral in terms as brief as the one relating to Oskar. Jill Rawling, the CEO of Relate West Surrey, was asked about the sufficiency of the information provided, and she explained that they did not have the resources to "go back and query lack of information" in each case, although the issue had been raised with CAMHS; when asked why Relate accepted referrals on the basis of inadequate information she said,

"Because we were a new partner in a new contract we accepted, probably wrongly now, in retrospect that the information we were given was relevant, up to date, included any issues of concern. I think we were wrong to accept what we were given".

Ms Powell told me that, when triaging Oskar's referral, she too assumed that CAMHS had conducted a full risk assessment. The referral, she said, appeared to relate to aggression in the context of bereavement, and so she accepted it and saw no reason to treat it as urgent. Consequently, Oskar was placed in the queue to be seen, with a waiting period, at that time, of possibly four to six months. Significantly, however, Christina Powell told me that had she seen Dr Patel's referral letter, and known about Oskar's autism, she would have rejected the referral and sent it back to CAMHS. She said that she and her colleagues were not clinicians, were not able to undertake mental health assessments, and had no training in relation to autistic children. Despite that lack of training, she said,

"We know that there is a higher risk impulsivity in autistic boys in particular. We know aggression is very relevant when we work with them. We know if there is self-harm, a suicidal ideation, there is a higher risk.

She said that the further information of which she was now aware, of his going missing and being under the Police's Child Exploitation and Missing Unit, involvement with drugs and drinking, his mother considering him to be out of her control, and the involvement of the Targeted Youth Service would have only added to her view that this was not an appropriate referral to Relate.

157. On the 9th December 2019, Laurianne Harrison contacted Isabelle Chessar enquiring about the outcome of the SEN meeting and asking whether Mrs Short, or someone from the school, could conduct a joint home visit with her on Friday 11th December; Ms Chessar replied saying that the SEN meeting was cancelled and the home visit would not be possible as the 11th December was the last day of term.

158. On the 11th December 2019, Laurianne Harrison received a text message from Natalia Nash which read,

"Good morning. I hope you are well. I would like to request signing off my son Oskar into care of Social Services."

Ms Harrison said she discussed this request with her supervisor, Michelle Beirne, who said something "…along the lines that … we don't have enough evidence of what's going on within the home". Ms Harrison then contacted Mrs Nash and recorded in the notes that,

"I called Natalia regarding the text message that she sent me. I informed Natalia that Oskar did not meet the threshold when we had the strategy discussion last week, so therefore Oskar would not be able to go into care. I asked whether Oskar had been missing lately. Natalia said that he goes out and does text her to let her know, but she does not know where he is, so he is missing. I explored this with Natalia and asked whether Oskar comes back home at the time of his curfew and she said yes. Natalia said that Oskar is still refusing to go to school. I explained that this is something the school will have to look into. Natalia said that Oskar is not speaking to her. I explained to Natalia that I have tried to arrange a joint home visit with someone from school that Oskar talks to, but they were unable to do it this week, and won't be able to do it until after Christmas. I also explained that I have tried to arrange a joint home visit with PC Tyson. I explained to Natalia that I would do a home visit to the family on Monday the 16th December, and hopefully Oskar will talk to me. If not then, I will arrange a joint visit with the school. Natalia explained that Oskar does not really talk

to anyone. I explained that I would try, however, most services will close to a young person who does not want to talk, as we aim to work with the young person and their parents. Natalia said that she really needs the support, and I explained that I will try my best for Oskar to engage with our services. I spoke to Natalia about a parenting course, and she informed me that she attended one in Walton for teenagers, and I spoke to her about doing this one, one-to-one. Natalia got really upset on the phone and said that she had to go."

Mrs Nash's recollection of the call was that,

"After Ms Harrison's first visit I recall the next contact I had with her was a phone call when she explained Social Services could not offer any further support as they could not continue speaking only to me and not to Oskar. I believe this was in early December. Ms Harrison said Social Services had concluded that Oskar was safe, but I kept repeating to her that he absolutely was not. Although I provided a safe environment at home, I felt very strongly that he was not safe. I felt he was depressed and I was very worried about him. I had no idea what would happen to him or what he might do as he was isolating himself from me, spending a lot of time on his phone in a dark room or going out to meet people I did not know. As such I made very clear that my view was that Oskar was definitely not safe. When Ms Harrison told me that Social Services intended to close the case I burst into tears as I was so upset this was happening again. Because I was so upset, I believe Ms Harrison agreed to keep the case open and to meet me and Oskar again. However, by the time she visited again too much time had passed and she was not able to get Oskar to engage with her. The visits had to be more regular for there to be any prospect of gaining Oskar's trust."

When questioned by Mr Fortune, Mrs Nash said she asked Ms Harrison, "If you cannot help me, please tell me who can help me."

159. Laurianne Harrison did attend the family home again, as arranged, on the 16th December 2019; she went alone. Mrs Nash asked Oskar to come downstairs, which he did, but he immediately left the house when he saw Ms Harrison, saying he did not want to talk. Ms Harrison said her plan then was to call Oskar the next day, to investigate one-to-one parenting support for Natalia, and to arrange another home visit, with PC Tyson or Mrs Short from school. The witness said that, on reflection, she could have arranged to see Oskar with her manager, rather than relying on others from outside the service. She said that she did ring Oskar the next day, on the 17th December, and told him she was worried that he was not attending school and wanted to know what was happening. She said,

"Oskar said that he does not want any support; does not want to talk to anyone. I suggested to Oskar that he can have a think about it, and if I can make contact with him again after Christmas holiday, and he said that's okay."

160. The 17th December 2019 was also the deadline for Ms Harrison to complete the Early Help Assessment, which she had not done. Alexis Hynds said that this was because Oskar had not been willing to engage. When asked whether there should not therefore have been consideration of escalation to a Social Worker, potentially for a s.17 assessment, she agreed that there should. Ms Hynds said that around the time that the assessment was due, and recognising that it had not been completed, she had discussed the situation with Michelle Beirne and Laurianne Harrison and they had, together, decided "to work with either … Esther Short or PC Tyson to do a joint visit because they'd secured a level of engagement" (although the witness accepted that PC Tyson's contact with Oskar had, in fact, been less than she then believed it to be). The witness said a new deadline for completion of the assessment was not set, and one should have been. She also accepted that no written record was made of this conversation, or two other key conversations, and she added,

"Yes, and I think that's an omission on my part, … there is a lack of robust, frequent management oversight, even from the point of allocation through to key conversations, I completely recognise that".

161. Alexis Hynds also accepted that the Manager of the Safeguarding Adolescent Team (a Level 4 team) could have been consulted about the possibility of escalation but she did not consider that option at the time; she said if she had known what she knows now, she would definitely have progressed that consultation but, she said, there was usually a "challenging conversation" about whether SCC's internal criteria for level 4 involvement were met and "push-back" for more to be done at level 3. Ms Hynds agreed that SCC's internal guidance included very serious risk factors at level 3, and she said that the fixed criteria in the guidance were used as the driver for management of cases, saying, "It is regularly used in conversation between colleagues, both within our team and in terms of escalating up and down".

162. On the 20th December 2019, Laurianne Harrison recorded in her notes that she had telephoned Mrs Nash to inform her "that I was off during Christmas. I therefore gave her the Emergency Duty Team. I also reminded her to contact the police if Oskar goes missing." Ms Harrison acknowledged that the 17th December had been the deadline for completion of the Early Help Assessment, which she had not completed. She accepted that more information, which was concerning and relevant to risk, had been received

since the school's referral a month earlier, including Oskar going missing and his mother asking for him to be taken into care, and that he was continuing to go out without permission, with no-one knowing where he was or who he was with. She was asked whether she was, therefore, concerned that no support had been put in place and the plan was simply for further contact after the Christmas holidays; she said she was not concerned because she knew "that PC Tyson was going to be in contact with the family during the Christmas period … I knew that there were going to be home visits". After Christmas, Ms Harrison exchanged messages with Isabelle Chessar about arranging a meeting at school in the new year, with Ms Chessar writing, on the 5th January 2020, "Fingers crossed the holidays have gone okay and he comes to school on Tuesday".

163. Natalia Nash told me that there were ongoing concerns over the Christmas holidays and that she found marijuana and money in Oskar's jacket. PC Tyson told me that on the 30th December 2019 he received a text message from Mrs Nash, with photographs of a small amount of cannabis, empty snap bags, the remainder of a joint, and a £10 note in his wallet (for which Mrs Nash could not account). The officer said that Mrs Nash asked him to visit Oskar to speak to him about drug usage. She was at work, but said he could visit without her being present and she asked him not to mention that she had told given him this information, as her relationship with Oskar was already quite fractured and any confrontation with her could spark off a missing episode. PC Tyson said he agreed to visit Oskar at home, with DS Egan, later that morning. The officer was asked whether, before visiting Oskar, he updated himself at to what had been happening since their last contact on the 29th November, and as to Oskar's emotional and mental health state, and he said that he had not. He said that Oskar presented as high functioning and he equated that with a lesser level of risk. He had not seen the National Autistic Society's guidance to the police which stated, particularly, "Just because a person has good spoken language it does not mean that they have an equally good understanding of what is being said to them. Make sure an autistic person is always treated as vulnerable, regardless of how able they may outwardly appear".

164. PC Tyson said the purpose of the visit was to challenge Oskar about the presence of the drugs and to establish whether he was using drugs of his own volition or whether he was being exploited. He said if Oskar had supplied information as to the source of the drugs, then they could have taken the matter forward as a criminal investigation. The two officers went to see Oskar at about 11.30 am and found him still in bed. He would not come down to speak to them and so they went upstairs to his bedroom. Oskar recorded part of what was said on his telephone and this recording was played at the

inquest. Both DS Egan and PC Tyson accepted that their approach, and the content and tone of some of what was said to Oskar, was inappropriate. PC Tyson said that, after hearing the tape, he felt that he had been overbearing with Oskar; he said, "I mean he has been in possession of a controlled substance which is an offence and there are consequences. He's over the age of criminal responsibility so I needed to get to the bottom of how he has come into that,… but I felt my method was overbearing". He said the threats to Oskar, of "doing it the hard way", of his being searched when he left home, and of his being arrested and receiving a criminal record, were made to provoke disclosure of the identity of the person who was supplying the drugs, and also to discourage him from further involvement with drugs. The officer accepted that telling Oskar that he was "hearing his name" in relation to drugs was said to give Oskar the false impression that the source was someone other than his mother but, he said, he was "prepared to take a hit on my relationship building with Oskar for the benefit of maintaining his relationship with his mother". He accepted that the exchanges may have left Oskar with the impression that he was under investigation for possessing and supplying drugs, although that was not the case. PC Tyson said that he would not usually speak to a child in this way; when asked why he did so on this occasion, he could not fully explain that, but said "I suppose we identified that there was an issue with him being in possession of cannabis and he wasn't responding as we've hoped".

165. PC Tyson accepted that he did not have any understanding of what impact an authoritarian approach such as this might have on Oskar by reason of his autism; he said he was not aware at the time of Oskar having any complex needs. He did not understand that autism could cause a child to take matters literally, to have a heightened sense of injustice, to find it difficult to cope with an authoritarian approach. PC Tyson said that he did not know that there was a high incidence of autism in the cohort of children who self-harm and take their own lives, and he said that if he had known of Oskar's history of suicidal ideation, including episodes where he had spoken of suicide following being visited at home by Social Workers who were trying to help him, "I would have adjusted my approach considerably". PC Tyson also accepted that, following Oskar's indication that he was taking cannabis, "to feel better", he had not explored this further with Oskar, for example by asking what he needed to feel better about, and he had not passed this disclosure on to Oskar's mother, the TYS, or his GP.

166. So far as information concerning the supplier of drugs to Oskar, and his risk of exploitation, was concerned, PC Tyson was asked about the information provided by Oskar, namely that he was receiving drugs from an adult he met in the community. PC Tyson said that this information alone was

insufficient to enable him to identify the supplier. He explained that, after Oskar's death, it was discovered that Oskar had associated with "Ginger Ricky" and the officer said that Ginger Ricky had been known to him since at least September 2019 as an adult who supplied drugs to Magna Carta school pupils; however, he had not made the link between him and Oskar before Oskar's death, as Ricky was only one of a hundred potential suppliers.

167. PC Tyson did suggest that, after the recording of the conversation ended, the two officers "spent about another ten, 15, probably 20 minutes with him just having a chat just generally. I can't remember exactly what about, but it was a much lighter mood and we left him laughing and on good terms", although he accepted that Oskar was certainly not laughing and joking on the recording; he recalled DS Egan showing Oskar a video clip which made him laugh, but DS Egan had a clear recollection of that video being shown on their first visit, and I prefer his evidence.

168. DI Emmerson was asked about the recorded conversation and said that, in parts, the officers' approach was "ill-judged though well-meaning"; he said it was inappropriate to have given Oskar the false impression that he was being discussed "on the streets" in relation to drugs, and to have threatened him with search and arrest when there was no question of that happening, and he accepted that the officers had failed to consider what impact the exchanges may have on Oskar. The witness recognised that there was a risk of inadvertent damage being caused to a child, by a conversation such as this being conducted by officers who had not been trained on autism, but he said this had to be balanced with the need to speak to the child to ensure he was safe. DI Emmerson was asked by Ms Patrick about the specific guidance available to the police around interviewing victims, witnesses or suspects who have autism and he accepted that it included guidance to seek advice from those who know the child and that "it may also be necessary to seek the advice of a psychologist or a social worker who specialises in autism". DI Emmerson was also asked whether there was a tension in the role of a SPOC which was illustrated by this interview, and whether it was appropriate for an officer who was intended to have a supportive role (the SPOC), also to question the child as a potential offender himself, as a potential victim of crime, and as a potential informant and witness. Such "tension" appeared to have been recognised by A/DS Michail who told me, "If the child finds out that the SPOC is involved in a criminal investigation then they may see that as a betrayal of their trust in the information that they have provided. So, we try and keep the SPOC role completely separate to any investigation". In response to this question, DI Emmerson answered, "Probably not in one go. I think there should have been more of a focus on the safeguarding and keeping him safe, making sure he was okay, and trying to build that

relationship, given that it was only their second meeting", and he said that "possibly" there was a tension in the role. He agreed that he did sometimes see evidence of other agencies overestimating the extent to which the SPOC should be seen as a fulfilling a welfare role, rather than having a policing purpose. He noted the plan made at the s. 47 Strategy Meeting took assurance from the involvement of the SPOC which went beyond that role to some extent. He said, "I'd have rather seen probably a joint approach in terms of addressing Oskar's other needs, and us still trying to limit that risk that was coming to him when he was going missing."

169. Oskar's movements and state of mind in the early days of January 2020 are revealed partly by messages found, following his death, on his two mobile telephones. The newer telephone had been in use since the 27th December 2019 only; there were some noteworthy texts messages, including the following :

(i) On the 3rd January 2020 Oskar exchanged messages with a friend who had also gone missing from home and Oskar wrote, "Shit then, mate. Now you're going to be under police investigation just like me", which would seem to suggest that Oskar did perceive that he was under investigation by the police, probably as a result of the visit and conversation which had taken place on the 30th December,

(ii) On the 4th January 2020 Oskar was in contact with a drug supplier in an unsuccessful effort to buy drugs (a £10 bag of cannabis), and

(iii) On the 5th and 6th January 2020 Oskar exchanged messages with a friend about buying and using drugs and, on the 5th January 2020, he arranged to meet a friend in the park, saying he was smoking a joint (of cannabis).

170. Oskar did not attend school on the first day of term, Tuesday 7th January 2020; Mrs Nash emailed the school saying he was refusing. She told CFS that over the holidays she found out that he was upset that his friends were dating people they had met without him, and that Oskar thinks he is not going to pass his GCSEs "because he said he was dumb." Laurianne Harrison was informed of his non-attendance and her notes record, on the 7th January,

"Today I called Natalia. I asked Natalia how their Christmas was. She said that their Christmas was good. I asked Natalia how Oskar had been. She said he'd been fine. She said he went out a few times but came home. Also informed me that Paul TYSON came to see Oskar over the Christmas, and the plan was for myself and Paul to see Oskar next week. I also informed Natalia that I'd been in contact with his

school and await a date for the meeting, and that I will contact Paul with a date next week for us to meet with Oskar."

The following day she contacted PC Tyson asking for an update and saying, "I was also wondering what the plan will be going forward for Oskar, as I am not sure whether he will engage with TYS." This was the final step taken by Ms Harrison and Children's Services before Oskar's death.

171. Oskar attended school on Wednesday 8th January and Helen Cottingham told me that she taught him that day; she deliberately placed him next to a more animated student, and Oskar responded well, and was laughing and joking with him. However, one of Oskar's friends at school stated in evidence that Oskar told her that day that he would, "jump in front of a train"; she said that he passed this off as a joke and she did not take it seriously.

172. I heard from Kerry Wilson, the Office Manager from Relate, that on the 8th January 2020 she telephoned Mrs Nash, on the number provided by CAMHS, to find out whether Relate's services were still needed; this was "because quite often by the time they get to us they've been on a list somewhere for goodness knows how long, 'cause they will say we've been waiting for this for a year, maybe. So, quite often people come to us and say, "No, young person's fine now"". She said the number given for Mrs Nash was unobtainable and it was Relate's practice to write to the child's parents asking them to confirm, within 10 to 14 days, whether counselling was still required, and if confirmation was not received, to close the case. She said that on the 10th January 2020 (the day Oskar's body was found), in her absence, a letter was sent in her name to Mrs Nash, stating,

"Following a referral for Oskar from CAMHS One Stop for counselling, we've tried to contact you on [number] without success. If you would like Oskar to have counselling, please call us on [number] to discuss availability of our working Stanwell and Ashford offices. If we do not hear from you by Friday the 17th of January we will work on the basis that counselling is no longer required and refer back to your GP."

Ms Wilson said the letter would have been sent second class and she could not explain why such a short period for response had been specified; she had never seen that before. However, she did say that this was a standard letter for Relate to send to all parents of children who were subject to referrals, if oral confirmation that the referral was still needed had not been obtained, and that it was standard practice for the referral then to be closed if a response was not received.

Comments and Findings

173. Before turning to the events of 9th January 2020, I will record my comments and findings concerning Oskar's time at CFS.

174. Oskar's move to a mainstream school had been driven by his refusal to accept his diagnosis and his condition; his clear imperative was to be a "normal" boy. As had been predicted, he was bright enough to cope academically, and it is clear that he had managed to join a group of friends who clearly liked him. However, I find that the reality was that the demands this placed on Oskar were too great, especially as he did not have in place sufficient specialist support and adjustments. There was, as there had been at St. Dominic's School, a "honeymoon" period, although the impact of the strain Oskar felt was apparent almost immediately, with a recorded incident of self-harm soon after he started. In truth, however, his time at school was short before his inability to cope there became obvious. His reluctance and refusal to attend school from early November 2019 onwards, was the first obvious sign that he was entering a period of increased risk; over the following weeks there were further clear signs that his risk levels were escalating; including his missing episodes and his use of alcohol and drugs. In my view, when Oskar's presentation at this time is viewed in the context of his autism and his very significant history of periodic suicidal ideation, his raised risk of suicide is readily apparent. CAMHS, Children's Services, and Surrey Police all became directly involved in Oskar's safeguarding in this period and I shall consider these agencies in turn.

175. Oskar was referred to CAMHS, as he had been many times before, in September 2019. The referral was triaged quickly and I can understand why, on the basis of the information provided by Dr Patel, it was not immediately triaged as requiring a response within 4 hours, or even five days. However, I have received no satisfactory explanation of why it was not then looked at again for nearly three months, nor why it was never risk assessed. When it was further reviewed, following Mrs Nash's call to the service, the key decision as to how it was to be managed was made on a wholly inadequate basis. By the 6th and 7th December 2019, Dr Patel's letter was nearly 3 months old and I find it difficult to comprehend why the decision maker did not take the opportunity, when Mrs Nash was on the telephone, to obtain a full update on Oskar's condition and situation. It is clear that Ms McPherson made no real effort to do so, not only because of the length of the call, but also because the evidence shows that Mrs Nash was both willing and able to provide state agencies with relevant information, and yet, Ms McPherson admitted, she knew nothing of the significant developments since September 2019. She also

failed to review, at all, CAMHS' own medical records, and to obtain any information from other agencies, particularly Children's Services. Any one of those enquiries would have revealed that Oskar's risk levels had risen greatly since Dr Patel's letter. I am in no doubt that a review of the information which was readily available and ought to have been gathered and considered, would have made it plain not only that a referral on to a counselling service was wholly inadequate and inappropriate, but also that Oskar was in urgent need of a clinical assessment; and as he was still over a month away from his death, there would have been sufficient time for that to have taken place. In my view, CAMHS' failures to risk assess the referral and to see and assess Oskar before his death, are serious failures.

176. I consider that the response of Children's Services to the final referral they received was also inadequate; in my view, it too was marked by insufficient review of records held by the service and information gathering from others, insufficient liaison with other agencies (especially CAMHS), and a lack of appreciation of the level of risk Oskar was facing. On the basis of the evidence I received, I do not fully understand why the initial triage resulted in Oskar being referred to a level 3 service when he had previously, in arguably less concerning circumstances, been dealt with at level 4. Further, given his history and current situation, it is also difficult to understand why the management of his case was allocated to a Targeted Youth Support Worker rather than a more senior member of the team. That worker failed, in the many weeks available, to complete the assessments (including the Early Help Assessment) which were required, and her managers were well aware of this, and no effective interventions or support were ever put in place for Oskar or his family. In my view, it is no answer to point to Oskar's reluctance to engage; this was a well-documented consequence of his disability and it was incumbent on the service to overcome that communication barrier, as had proved possible previously.

177. I consider that it is equally concerning, however, that Oskar's case remained throughout with the Targeted Youth Support Worker who, in my view, was without sufficient training or expertise to deal with such a complex case and to communicate effectively with such a complex child; a situation reflected in Ms Harrison's own request for the matter to be escalated. There were several clear opportunities to review and escalate the management of the referral, most particularly the s. 47 meeting. The decision making at that meeting took place, I find, on the basis of insufficient information gathering and sharing; it is striking that the decision making proceeded without information from CAMHS or the SEN Team and without account being taken of Oskar's autism and his history of suicidal ideation. Even if, as may be the

case, the conclusion of the meeting and the Chair, that the threshold for a full s. 47 investigation had not been reached was reasonable, I am in no doubt that a proper review of the information which could readily have been obtained would have revealed a clear need for the management of the referral to be escalated to a Registered Social Worker. I have no doubt, given the evidence of Ms Hynds, that a full review by a Registered Social Worker of the information which was available would have resulted in action being taken to put in place sufficient support to have reduced Oskar's escalating level of risk; again, there was time before his death for this to have occurred. I note too that there were further, missed, opportunities to review and escalate the case, for example when Mrs Nash asked for Oskar to be taken into care (a request which was not seen as a risk factor in itself, when it ought to have been), and when it was realised that the Early Help Assessment had not been completed in the required timeframe because of Ms Harrison's lack of success in communicating with Oskar.

178. In the above circumstances, although I am satisfied that, at earlier stages, effective support had been provided to Oskar and his family, I find that Children's Services' response to the crisis period from November 2019 onwards, reflected a marked failure to recognise, or acknowledge and act upon, the seriousness of Oskar's situation and the risks he faced. In the two months between the school's referral of Oskar to Children's Services and his death, the service provided no effective support whatever to Oskar or his mother.

179. As for the involvement of Surrey Police, I am concerned about the lack of clarity as to the nature of the role of the CEMU SPOC so far as the welfare of the child is concerned. I consider that there is some tension between policing purposes and safeguarding from exploitation, on the one hand, and the provision of welfare and support through a personal relationship of trust, on the other. Seeking to gather information from a child which may be relevant to the investigation and prosecution of perpetrators may, foreseeably, have a detrimental impact, especially if the child is autistic. I consider that the inappropriate conversation which took place on the 30th December 2019 resulted, in part, from this tension, and in part from the officers' almost complete lack of training upon and understanding of autism. I was told by one of the officers that he equated Oskar's high functioning level to there being a lower risk, whereas, in fact, the opposite is true because his cognitive ability heightened his awareness of his differences. I consider too that the lack of clarity as to the role of the SPOC resulted in an inappropriate level of reliance by Children's Services on the police's involvement, so far as keeping Oskar safe was concerned.

The Events of 9th January 2020 and the Cause of Death

180. Natalia Nash told me that, on the morning of the 9th January 2020, she went to work but found out from Oskar's brother that Oskar had not gone to school. She exchanged texts with Oskar, telling him to go to school. She also indicated to him that the family were to move to Poland; this was not in fact being planned and, she told me, was said to put pressure on Oskar to go to school and to try to get through to him; Oskar indicated that he would not go to live in Poland and I note that, in a subsequent text to a friend, he wrote, "I think she's bluffing". Mrs Nash said that she returned home at lunch-time and found Oskar still at home. She told me that, at the time, she did not suspect that he had been drinking alcohol. She again said he must go to school and she confiscated Oskar's mobile telephone, saying that he could have it back when he started going to school. She said that Oskar was very angry with her about that. She then left to return to work.

181. Oskar's movements following his exchanges with his mother at lunch-time can be pieced together from evidence I heard from DS Gerry Griffin of the British Transport Police, on the basis of their investigation of his death, as well as from evidence from Megan and Nikola. I heard that :

(i) Oskar left home at about 3.00 pm and met Megan and Nikola at about 3.30 pm, after they came out of school. Megan said he was drunk; he was unsteady on his feet and slurring his words and he said he had been drinking alcohol since lunch-time; Megan described Oskar having a bottle of vodka, which was about two-thirds empty, which she took from him and put in the bin "for his safety",

(ii) Oskar went with Megan and Nikola to Staines; they met "Ginger Ricky" on the way and the four of them went to McDonald's in Staines. CCTV shows them arriving at 16.16 hours, and I was told that they stayed for 30 minutes. Megan told me that they went there to use the free wi-fi. I have viewed the CCTV (which provides video only and no audio) and agree with DS Griffin's assessment that all four appear to be in good spirits, talking and laughing together. At one point, Oskar falls from his seat and is helped up. I can see no evidence of any unpleasant exchanges or events, although Megan did tell me that Oskar was still angry with Nikola in relation to the comments she had made on snapchat about him killing himself. However, she said that Oskar was not upset or distressed at any time,

(iii) Oskar, Megan, Nikola and Ricky all left McDonald's at 16.41 hours and then went their separate ways. Oskar told the girls that he was going home to "sober up"; Megan said they were not worried about him at this time, as he was joking with her and he seemed fine,

(iv) Oskar then set off in the direction of his home, which was about half a mile away. He can be seen for the last time on CCTV at 16.46 hours, which was about 20 minutes before his death. It is then thought that he made his away, alone, to the railway track where he died. There was sufficient time for him to first go to his home, which was quite close, but there is no evidence at all to suggest that he in fact did so,

(v) In any event, it is clear Oskar gained access to an area beside the railway track which is not readily accessible by the public. It is not apparent from the evidence whether he did so by walking along the track side from the Thorpe Lane Level Crossing in Egham, or whether he climbed over the railway boundary wall, which was easily traversable at several points from Railway Terrace. However it was that Oskar gained access, it is clear that it was a deliberate act on his part. He ended up beside the tracks at a point which was approximately 80 metres from the Level Crossing and it is apparent that he hung his jacket on a post in this vicinity, and

(vi) Oskar was struck and killed by a non-stopping train which passed this location at about 17.06 hours. It was dark and the train driver did not see Oskar and would not have felt any impact from the collision.

182. When Natalia Nash came home from work on the afternoon of the 9th January, Oskar was not there but she found that he had caused a very considerable amount of damage to the house and items within it; he had also written angry messages on the doors and walls. She reported to the Police that he was missing and a missing person investigation was instigated by Surrey Police, although Oskar was, in fact, already dead. It is noteworthy that when, as part of the investigation, an officer viewed Oskar's bedroom, he found a photograph of his father on his bed.

183. Oskar's body was found on the morning of the 10th January 2020, following a call to the Police from a member of the public. I heard evidence from DS Griffin, and other police officers, about the circumstances in which Oskar's body was found and the apparent nature of his injuries. I also received evidence from Dr Palm, a Consultant Paediatric Pathologist who conducted an autopsy. So far as the cause of his death was concerned, Dr Palm found that Oskar had suffered multiple traumatic injuries consistent

with being struck by a train, and from which he would have died instantaneously. From the position in which Oskar's body was found, and the precise nature of the fatal injuries suffered, I am satisfied that, as DS Griffin suggested to me, it is likely that these were consistent with Oskar having placed his neck on the railway track and I find, as a fact, that he did so. In this regard, I should record that footage from the train's forward-facing camera was available to me and to all the IPs; I viewed it but, as I have made plain, I was unable to discern anything of assistance (and, consequently, it was agreed that the footage need not be played at the inquest). I did receive evidence from DS Griffin as to his impression that an upright figure could be seen moving towards the train, but he confirmed that the timing was such as to leave sufficient time for Oskar then to have laid down on the track.

184. The post mortem evidence also revealed two further matters of interest. First, the pathologist, Dr Palm, found some marks on the body which she described as a longitudinal scar on the right proximal forearm, multiple superficial scars to the medial aspect of the left proximal forearm, an oblique scar to the lateral aspect of the right hip, and three parallel scars to the lateral aspect of the right proximal thigh; I am satisfied that these are likely to have been marks caused by acts of self-harm by Oskar when he was alive. Secondly, post mortem toxicological testing was also performed and this revealed what Dr Palm described as a "low moderate" level of alcohol in Oskar's blood and urine; the reading was over the driving limit and at a level which could be associated with drunkenness. The testing revealed no drugs in Oskar's body at the time of his death, although cannabis metabolites were found in his urine (which indicates previous use of cannabis). Further, subsequent analysis of Oskar's hair, by Dr Rosa Cordero, a Senior Toxicologist, revealed that Oskar had been "exposed to cocaine" prior to his death. Dr Cordero gave oral evidence to the inquest, and explained that the hair was not heavily contaminated and the reading could be explained either by Oskar having ingested small quantities of cocaine, or having been exposed to an environment of cocaine powder, smoke or cocaine-contaminated goods, at some time or times in the course of the eight months prior to his death.

Conclusions as to the Death

185. At the conclusion of the evidence I received written legal submissions from counsel for the IPs which address the possible conclusions available to me. I have considered and taken full account of all the submissions.

186. I have first considered whether the short-form conclusion of Suicide is available to me and ought to be recorded. In order to reach this conclusion, I

must be satisfied, on the balance of probabilities, that Oskar died as a result of his own deliberate act and that he intended that act to end his life. On the evidence, I am entirely satisfied that this is the case. Oskar had a very significant history of suicidal ideation and had spoken, in particular, of killing himself on a railway line a number of times, including to a friend at school shortly before his death. Further, the nature of the deliberate act which led to his death was such that Oskar could have had no doubt about the inevitable fatal consequences. I have taken account of the fact that he had consumed alcohol, but I do not consider that he was affected to such an extent as to undermine my conclusion. I will, therefore, record that he died as a result of suicide.

187. Secondly, I have considered whether there is any proper basis for concluding that Oskar's death was contributed to by neglect. According to the Court of Appeal's ruling in *R (Jamieson) v HM Coroner for North Humberside* [1995] QB 1, this conclusion may be appropriate where there is evidence of a gross failure (meaning a very serious failure) to provide or procure basic medical attention for someone in a dependent position, in the face of an obvious need for such attention. There must be a clear and direct causal connection between that failure and the death; the causal connection is satisfied if the failure represented an opportunity to render care which would have prevented the death (see, *R (Khan) v HM Coroner for West Hertfordshire* [2002] EWHC 302 (Admin)).

188. I have concluded that the conclusion of Neglect is of potential relevance only in relation to the final referral, made in September 2019, to CAMHS. For the reasons I have already set out above, I am satisfied that there were gross failings by CAMHS in their management of this referral. Whilst I have accepted that the initial triage was reasonable, there were the following failures: (i) a failure to conduct the further triage in an acceptable timeframe, (ii) alternatively, in the absence of timely review, a failure to undertake a risk assessment, and (iii) in any event, on the 6th and 7th December 2019, a failure to gather and review any of the extensive information which was available concerning Oskar's history, and his current presentation and situation, before deciding how to allocate the case, and then allocating the case to a Relate West Surrey; these were all gross failures individually and cumulatively. The system in place and the decision making, appear to be more concerned with managing and reducing CAMHS lengthy waiting list, rather than addressing the needs of a child who had been referred, by a medical professional on an urgent basis, for the specialist assessment and care the service exists to provide. As I have also indicated above, I have no doubt that a proper review of the information available ought to have resulted in Oskar's case being passed for clinical assessment and I am satisfied that there was sufficient time

available, before Oskar's death, for that to have taken place. I must, however, consider whether I can properly find, on the balance of probabilities, that had Oskar been clinically assessed, and provided with the care and support he needed, his death would probably have been prevented. I have considered this very carefully and I have taken particular account of the fact that his suicidal ideation was periodic and was capable of being minimised by appropriate support. I am satisfied that timely and expert clinical intervention, following the September 2019 referral to CAMHS, would more likely than not, have minimised his level of suicidal ideation and avoided his death in January 2020.

189. Finally, as this inquest has been one in which the procedural obligation under Article 2 of the ECHR is engaged, I must consider whether Oskar's death was caused or more than minimally contributed to by any acts or omissions on the part of any one or more of the state agencies concerned with protecting Oskar in the course of his life. It is for me to identify the central issues. I am required to identify probable causes of Oskar's death in the Record of Inquest, that is to say those matters which are more likely than not to have caused or more than minimally contributed to his death. I also have a discretion to record matters which are possible (that is, more than speculative) but not probable causes of the death.

190. In considering this question I have reviewed the failures by the state agencies, and the schools Oskar was placed in by the state following the issue of his EHCP, as set out above. In my consideration of those failures, and their causative link, if any, to Oskar's death, I have borne in mind that the issues arising must be approached fairly and without the benefit of hindsight. I have noted too the reference, in the legal submissions made on behalf of Surrey County Council, to the fact that Natalia Nash retained parental responsibility for Oskar at all times. I am well aware of that fact but will take this opportunity to say that, in my view, the evidence shows that she did her very best to meet her responsibilities to Oskar, through her own direct parenting and by seeking, for his benefit and protection, the support he needed to remain safe and well. Oskar was undoubtedly a child with extremely complex needs who, by reason of his autism exhibited very challenging behaviour and the strain of coping with Oskar, and doing so alone following his father's death, should not be underestimated. Oskar was a child in need of skilled, professional support, which he did not receive and, for the avoidance of doubt, I will say expressly that I do not consider that his problems, or his death, were caused or contributed to by any failure on the part of his mother to meet her parental responsibilities.

191. I must consider whether the failures I have found, or any of them, probably or possibly more than minimally contributed to Oskar's death. For the reasons set out below, I have concluded that the following failures have done so :

(i) By Surrey and Borders Partnership NHS Foundation Trust's Child and Adolescent Mental Health Service :

A failure 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.

I am satisfied that this failure probably more than minimally contributed to his death. Reasons : The need for assessment was recognised repeatedly by medical and other professionals and referrals were made on the basis not only that expert clinical assessment was needed, but also with an expectation that effective steps could and would be taken to diagnose, treat, monitor and support Oskar. Oskar's need for this input was recognised over 10 years before his death. Had suitable intervention taken place, especially from a young age and thereafter, as necessary, I am satisfied that it would have minimised his risk of suicide.

(ii) By Surrey County Council's Special Educational Needs Department :

(a) A failure 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) A failure to place Oskar in an appropriate school, rather than the inappropriate placement in a mainstream school which did not have the facilities or expertise sufficiently to meet his complex needs.

I am satisfied that these failures probably more than minimally contributed to his death. Reasons : The insufficiency of Oskar's EHCP so far as his emotional and mental health, and history of suicidal ideation, was concerned, resulted in these vital aspects of his needs not coming to the attention of others. Most particularly, the EHCP did not convey to Cobham Free School Oskar's needs in this regard and this

resulted in the school offering Oskar a place when, had they been in possession of the full picture, they would not have done so. In my view, the placement of Oskar in Cobham Free School placed him in an environment which led to the crisis which emerged in November 2019. Given Oskar's history at his earlier schools, this was entirely foreseeable, and proper review of the information which was readily available, would have made it clear that Oskar would not cope, and that the risk of suicidal ideation would consequently re-emerge.

(iii) By Surrey County Council's Children's Services Department :

(a) A failure by the Targeted Youth Support Team, following Oskar's referral in early November 2019, to complete the required assessments and to provide any effective intervention or support, and

(b) Following escalation of Oskar's risk level in the course of November 2019, a failure to reallocate the management of his case to a Registered Social Worker.

I am satisfied that these failures probably more than minimally contributed to his death. Reasons : I am satisfied that it ought to have been plain to Children's Services that Oskar required support and some intervention to protect him, including from his well-documented risk of suicidal ideation. Previous support provided by Children's Services had been effective and successful and, given the time available, I am satisfied that had the seriousness of Oskar's crisis been recognised and addressed by a sufficiently qualified professional, which it ought to have been, support which would have minimised his risk of suicide, could have been put in place.

(iv) By St. Dominic's School and Cobham Free School :

Failures 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 am satisfied that these failures probably more than minimally contributed to his death. Reasons : There was some information sharing between the two schools prior to Oskar's transfer, but it is clear that it was not sufficient to convey the full picture about his history,

special needs and current situation. Given the importance of this information to enable a proper decision to be made about the mainstream school's ability to meet Oskar's needs, the full picture ought to have been requested and provided. If it had been, the evidence suggests that Cobham Free School would not have offered him a place. His placement at the School, which was an environment which could not fully meet his needs and which led to the crisis which emerged in November 2019, would have been avoided.

Record of Inquest

I shall, therefore, record the following on the Record of Inquest :

Box 1 :

Oskar Miles Nash

Box 2 :

Ia Multiple Traumatic Injuries

Box 3 :

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.

Details of these and other failings are set out in the Factual Findings and Conclusions.

On the 9th January 2020 Oskar Nash gained access to an area of railway track which was approximately 80 metres from the Thorpe Lane Level Crossing in Egham, Surrey, and a short time later, at about 17.06 hours, he deliberately moved on to the track and was struck and fatally injured by a train. His body was found the following morning.

Box 4 :

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.

Box 5 :

(a) 18th April 2005 in Chertsey

(b) Oskar Miles Nash

(c) Male

(d) -

(e) 9th January 2020 on the railway line close to Thorpe Lane Level Crossing, Egham, Surrey

(f) Schoolboy

Before closing the inquest I would like to record my thanks to counsel for their work and assistance, which I have appreciated, and to pass my very sincere condolences to Natalia Nash who has attended the inquest with great dignity throughout.

Richard Travers

HM Senior Coroner for Surrey

10th September 2021