OVERVIEW REPORT FOR THE SERIOUS CASE REVIEW OF YOUNG PERSON A

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Independent Author – David Byford

A LINCOLNSHIRE SAFEGUARDING CHILDREN BOARD COMMISSION

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Overview Report

Introduction

1. This Serious Case Review (SCR) was commissioned by Lincolnshire Safeguarding Children Board (LSCB) following a notification of the death of Young Person A, referred to as YPA. He was a seventeen year old male, who committed suicide on 17 December 2013, having been found drowned on a beach in another area. The suicide took his family, friends and professionals by surprise. There had been no previous information, concerns or threats of YPA committing suicide or self-harming known which could have stimulated an intervention.

2. The SCR is an opportunity to understand the life experiences of YPA and his involvement with services and the interaction with key professionals and agencies that provided those services. To learn from his story, may effect change to help prevent a similar occurrence happening to others. More importantly, it is an opportunity for the LSCB, the Independent Overview Author and multi-agency partners within the SCR process, to express sincere condolences to YPA's family after the tragic event that led to the death of a young person, sorely missed by those who were closest to him.

Initiation of the Serious Case Review

3. Following a recommendation from Lincolnshire Safeguarding Children Board the Independent Chair, Chris Cook of the LSCB took the decision to commission a Serious Case Review on the 3 July 2014 as the circumstances met the criteria in accordance with Section 5 (2) (a) and (b) (I) LSCB Regulations 2006[1] and Working Together to Safeguard Children 2013 and Chapter 10 of the Lincolnshire Safeguarding Board Procedures[2].

- *"Abuse or neglect of a child or young person is known or suspected and*
- *The child or young person has died or been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child or young person".*

4. The Department for Education and the National Serious Case Review Panel were informed by the LSCB who requested additional time to conduct the SCR due to the complexity of the review, which was agreed.

[1] Local Safeguarding Children Board Regulations, 2006 Section 5 (2) (a) and (b) (i).
[2] http://lincolnshirescb.proceduresonline.com/index.htm

5. Period under Review and Terms of Reference

6. The Terms of Reference (TOR) requested information from birth to the date of YPA's death. This assisted in understanding the background history of YPA as a final draft of the TOR timeline was appropriately changed from 1 January 2010 until 17 December 2013.

7. The purpose of the Serious Case Review is to:

- Identify improvements which are needed and to consolidate good practice.
- Translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

8. The summarised Terms of Reference and specific questions identified to be addressed by Agencies are:

1) Were practitioners aware of and sensitive to the timely identification of YPA's needs and appropriate intervention put in place and if not why not?
2) Were his needs reviewed holistically and approved in a timely way?
3) Did his Statement of Educational Needs identify wider issues beyond his education?
4) Was there effective and timely communication and information sharing between the respective partner agencies when the family moved?
5) What were the key relevant points/opportunities for assessment in this case in relation to the young person and the whole family unit?
6) Were appropriate services offered, provided and accepted and were appropriate enquiries made in the light of assessments and if not why not?
7) Did the policies and procedures of agencies reflect the relevant legislation and guidance available at that time, and were they adhered to?
8) Was YPA's voice heard and was he listened to?
9) Are partner agencies alert and proactive to the risk associated with bullying, including electronic and the impact it can have on children and young people?

9. Other standardised questions within the terms of reference were recorded for consideration of the ANR authors within their agency responses.

10. Membership and Conduct of the SCR Panel

11. The Independent Chair for the SCR is Leila Barron. Advisers to the SCRP were Lincolnshire SCB Legal Adviser and Safeguarding Business Manager.

12. The Independent Overview Author - David Byford was appointed to carry out the SCR on the 27 July 2014 and has met all deadlines set by Lincolnshire Safeguarding Children Board (see Appendix 1 for Biographical summary for the Independent Chair and Overview Author).

13. Both Ms Barron and Mr Byford have no operational involvement, connection or conflict of interest with the case of YPA.

14. All Agency Narrative Report Authors including the NHS Overview Report Author have demonstrated their independence within their agency responses to the SCR.

15. The Serious Case Review Panel (SCRP) consisted of the Independent Chair and Senior Representatives from:

- Lincolnshire County Council Education,

- Lincolnshire County Council Children's Services,
- Lincolnshire Police,
- Clinical Commissioning Groups,
- North East Lincolnshire Education,
- Northern Lincolnshire and Goole NHS Foundation Trust,
- Dudley Children Services,
- Lancashire County Council, Directorate for Children and Young People.

16. The SCRP have met on a number of occasions and on a second scoping meeting on the 21 October 2014 agreed, that the most appropriate methodology for this SCR, based on the nature of agency involvement, is that a mixed methodology be used which includes, agency narrative reports, chronology, staff interviews and family interviews. The panel met on the following occasions:

13 August 2014 - Scoping meeting

21 October 2014 - Scoping meeting

19 November 2014 - Authors briefing meeting

2 February 2015 - Presentation to SCR Author.

27 March 2015 - SCR Author report briefing day with Author, SCR Chair, LSCB Business Manager and Legal Adviser.

28 July 2015 – SCR Authors report presentation day.

17. Agency Narrative Reports (ANR) and Summary Reports

18. The following Agencies were asked and provided a chronology and an Agency Narrative Report or Summary Report for their agencies involvement with YPA as follows:

1) Lancashire Police Summary Report.
2) Lincolnshire Children's Services Summary Report.
3) Lincolnshire Police ANR.
4) Humberside Police ANR.
5) Dudley Children's Services ANR.
6) North East Lincolnshire Education ANR.
7) Lincolnshire Education ANR.
8) Northern Lincolnshire and Goole NHS Foundation Trust ANR.
9) Dudley Clinical Commissioning Group ANR.
10) Lancashire County Council, Directorate for Children and Young People, ANR.
11) East Lindsay Summary Report.
12) Rotherham, Doncaster and South Humberside CCG ANR.
13) North Lincolnshire Children's Services ANR.
14) North East Lincolnshire Children's Services ANR.
15) Blackpool Teaching Hospitals MHS Foundation Trust ANR.
16) Lincolnshire Clinical Commissioning Group ANR (linked to Dudley CCG ANR).
17) Dudley West Midlands Police ANR
18) Dudley Education Service ANR.

19. A NHS Overview Report and revised report was completed by Jan Gunter, Designated Consultant Nurse for Safeguarding Children and Adults South West Lincolnshire Clinical Commissioning Group, on behalf of all the four health clinical commissioning bodies to the SCR: West Lincolnshire Clinical

Commissioning Group; Lincolnshire East Clinical Commissioning Group; South Lincolnshire Clinical Commissioning Group; South West Lincolnshire Clinical Commissioning Group.

20. Family

Subject:

Young Person A (YPA).

Other relevant family members:

YPA's Mother.

YPA's Father.

YPA's Brother - Young Person B (YPB).

Paternal Aunt.

Half Brother – RC, son of YPA's Father.

Significant Others:

Young Person C - Ex-Girlfriend.

Young Person D - Assailant.

21. Methodology

22. Statutory guidance provided by the Department of Education[3] requires serious case reviews to be conducted in a way which:

- *Recognises the complex circumstances in which professionals work together to safeguard children;*
- *Seeks to understand precisely who did what and the underlying reasons that led to individuals and organisations to act as they did;*
- *Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;*
- *Is transparent about the way data was collected and analysed; and*
- *Makes use of relevant research and case evidence to inform findings.*

23. Lincolnshire Safeguarding Children Board (LSCB) agreed a mixed methodology to understand professional practice contextually, to identify factors that influenced agency and professionals in the quality and nature of working together with family.

24. The terms of reference and timescales set for this review have been limited to Agency Narrative Reports, Summary Reports and chronologies. The Independent Overview Author identified at the chronology stage some omissions of outcomes and requested updates which, were predominately provided within the ANR's when submitted. Significant case notes and documentation, particularly the report to the Coroner and the statements of witnesses were requested and obtained for direct analysis and comparison. Interviews of key practitioners were carried out by ANR authors and the family contact and interviews were conducted by the SCR author in conjunction with the LSCB Safeguarding Business Manager. Every effort has been made to ensure accuracy, openness,

[3] Working Together to Safeguard Children, 2013 Chapter 4.

transparency, comprehensiveness and challenge of the information provided to the SCR process in completing this overview report.

25. Inhibitors to the process:

- The SCR author did not receive the majority of ANR's or Summary Reports on time even with the commissioners actively chasing up submissions. This is however, in some cases, understandable when you accept the difficulty expressed to obtain information. The late submissions also impacted on the NHS Overview Report being understandably delayed and further revised submissions, tightened the timescale for this author and required comment.

- Requests for family to participate were not successful until the eleventh hour when importantly both parents agreed to meet with the SCR Independent Overview Author and LSCB Business Manager and their response was appreciated. This was after the date of the first draft Overview Report and reflected further change.

- Other significant persons to the SCR, for reasons unknown, did not contribute towards the SCR. In particular, YPA's ex-girlfriend referred to as YPC, who is a vulnerable young person and also the offender YPD who assaulted and threatened YPA online via social media. They were both invited to participate but the LSCB received no response. However, it has been possible to obtain some information to help understand their involvement from within the material supplied to the SCR.

Background to the SCR

26. At the time of his death, YPA had only been known to Lincolnshire Children Services (CS) whose area he resided in, for a relatively short time. YPA began to regularly move homes and schools with his mother and his elder sibling Young Person B (YPB), who was approximately eighteen months his senior, after his parents relationship broke up in 1998. Both parents however remained actively involved in the care and upbringing of their children. YPA was also known to other services across Lincolnshire, North East Lincolnshire, North Lincolnshire, Lancashire and Dudley Local Authorities throughout his life time. The family were not in receipt of any services from Children's Social Care (CSC) at the time of his suicide.

27. The professional contact with YPA was primarily through his interaction with health and education providers. The findings and themes identified and discussed within this SCR was learning on the fringes for the agencies and did not contribute to the outcome of YPA's death. There were two significant incidents known to agencies prior to YPA taking his own life, highlighted in this narrative.

28. Significant Incident 1 - When YPA was five years old, he became a victim of child abduction by a neighbour of his father. This was appropriately dealt with by agencies, the suspect was subsequently arrested and later convicted of the offence. His mother blamed this incident for the start of his behavioural problems both at home and later at school, stating that *"YPA started to have nightmares and his behaviour became worse".*

29. During YPA's consistent relocations with his mother, his behavioural problems persisted and when seven years old, he was made subject to a Statement of Special Educational Needs (SEN) for his behaviour and emotional problems which remained in place throughout his years in education.

30. From 2003 and over the following five years, he received intermittent therapy from the Child, Adolescent and Mental Health Trust (CAMHS) for psychological assessment of his behaviour, emotional problems and the abduction incident.

31. Significant Incident 2 - In 2011, YPA presented at a North Lincolnshire and Goole NHS Trust (NLAG) Accident and Emergency (A&E) Department, in an intoxicated and vulnerable condition. At the same time, he notified hospital staff that he had taken drugs. His condition was appropriately dealt with by the hospital but the incident of his presentation and the disclosure made, was not followed up by contact with the Hospital Safeguarding Team or Children's Social Care and there has been lessons learnt by the Trust.

32. Throughout his lifetime, he attended nine different schools and changed home on ten occasions with his mother and sibling, staying with his father at weekends. At the schools he was disruptive, occasionally showed bullying tendencies and displayed inappropriate sexualised behaviour towards other pupils and staff in several placements. Importantly, there is consistent evidence of the effort, time and support given to YPA by professionals and agencies, particularly within education and the interaction with him and his family, to address his Statement of Special Educational Needs, in order to understand his behaviour. It was clear that within the educational environment, he could rebel and struggled to engage. This resulted in him often being made subject to school exclusions and even permanent exclusions for his inappropriate behaviour. He was also however likeable and his inappropriate behaviour was at times, him wishing to push boundaries, to gain attention as suggested in the subsequent interview with the family for the SCR. This behaviour would have the effect that he would be excluded and sent home from school, which was his ultimate intention. It transpired the reasons for his exclusions were not robustly shared between professionals or the details of the exclusions included or acknowledged within his Educational Pupil File, when moving between schools or in or out of a Local Authority area. In the latter part of 2012, when sixteen years of age and living with mother, he withdrew from his eighth school.

33. He then went to live permanently with his father, as his mother was insisting that he should return to school which, he refused to do. He remained living with his father up to the time of his death.

34. YPA began an association with a group of young people in his village, in particular YPC who became his girlfriend and who later ended their relationship and with YPD another young male, who was around the same age as YPA. He also came to the notice of police for minor infringements such as, possession of a small amount of cannabis, minor crime and anti-social behaviour. YPA could be described as a young person under the radar, struggling with his adolescent behaviour, no worse than many young people in society today. It was believed by his father that he began experimenting with drugs prior to his son residing with him. He however, never personally witnessed any drugs being taken by YPA.

35. Attempts to provide his continued educational provision, caused some difficulty and delay whilst residing with his father. In early 2013, a placement with his ninth and final school was found but, he did not fully engage with the school and had continual unauthorised absences. According to his family, he was not stimulated at the placement and did not enjoy the classroom setting. He then made up his own mind and permanently left school to seek employment. At the time of his death,

he was employed with a "hot tub" hire company. Aspirations to join the Army articulated by him in his final Annual Review of his Statement of Special Educational Needs, never materialised.

36. YPA's suicide occurred in December, whilst he was staying with his paternal family. It occurred after he visited his paternal grandmother at the beginning of the month with his father and half-brother and his family (his father had two elder sons from a previous relationship). YPA asked his father when it was time to go home, if he could stay for a longer period, which was agreed. He moved in with his paternal aunt and her two teenage children, younger cousins of YPA, who lived nearby to the paternal grandmother. His father returned home and agreed to collect him nearer to Christmas.

37. YPA it was said, appeared happy and contented whilst staying with his paternal aunt, until events caused him to get upset in the evening and early morning of the 14 and the 15 December. In the early hours of the 15 December, he left the paternal aunt's home and made final emotional and confused mobile telephone calls from a local beach to his father, half-brother and YPC. His father listened, showed support and advised him to go home to his paternal aunt's home. He further told his son that he would speak to him again in the morning and if YPA required, he would personally go to visit him. Later that morning, several hours later, YPA was found to be missing from the paternal aunt's home, having failed to return as requested by his father. The local police were informed and they immediately instigated a missing person enquiry. His body was found a few days later on a local beach on the 17 December, by a member of the public. It was only after had been reported missing, that details of him actually being a victim of assault and receiving online "cyberbullying", involving personal threats by YPD against him and to his father's property, was disclosed to professionals.

38. The family divulged to police that YPA had conflict with YPD, just hours before his suicide. Police were informed that YPA had been previously assaulted by YPD, who head butted him in the face, prior to his family visit and had received persistent online threats from YPD shortly before he went missing. The assault and threats were apparently over YPC, who having ended her relationship with YPA, had started a relationship with YPD. YPD was later charged and convicted of the assault and the online abuse against YPA.

39. A Post Mortem for YPA was held on the 19 December. On 23 May 2014 at a Coroner's Inquest, the Assistant Coroner in whose area YPA's death occurred, made the following ruling:

- **Medical cause of death 1a) Immersion.**
- **On the 17 December 2013 off the coast the deceased drowned.**
- **Conclusion of the Coroner as to the death: YPA Killed Himself.**

40. The Assistant Coroner in summing up at the inquest, identified "*cyberbullying*" had contributed towards YPA's suicide. However this SCR can confirm, this factor was unknown to professionals, his parents and family and there had been no previous opportunity to intervene.

View of the Family

41. It was a privilege to meet with the family and it was a great benefit for this serious case review that the family fully engaged in the process, enabling the review to understand more fully, YPA's life and the dynamics within the family. It was a positive and constructive meeting that was open,

cordial and rewarding, held at the maternal grandparent's home, where his mother currently resides. The meeting involved both parents, YPB, the maternal grandparents and maternal aunt. The interview was conducted by the Independent Author, together with the LSCB Safeguarding Business Manager. It was held in a harmonious atmosphere, with all questions answered frankly and honestly.

42. The family held no animosity towards professionals and agencies and were easy to talk to. They displayed a caring and understanding nature towards each other. It gave the impression that YPA had support from both sides of his family, also evident from the analysis within the serious case review. It confirmed the view by professionals that both parents shared the responsibility for bringing up YPA and his sibling after their relationship ended in the 1998.

43. The parents acknowledged YPA could be troublesome with his emotional and behavioural problems but, he was still loved and is missed by his family. He was described as "cheeky", able to make friends easily and was well liked. He could be articulate and responsive as noted within the information supplied to the serious case review but the parents believed his behaviour within school was to get attention. He displayed an aptitude to work with his hands particularly with motor vehicles that was not sufficiently explored within his later period of education. When asked why she kept moving home with her children, the response was that she could not settle, often due to her own personal circumstances. She agreed that it was not an ideal situation and interrupted her children's education, which was not explored by professionals. This aspect of lifestyle and the implications on a family, will in future, be addressed by the recommendations and legislatives changes that have been introduced and referred to below (see lessons learnt and action already implemented).

44. The parents and his sibling YPB in discussing the suicide, said it came as a total shock to them. They had no idea he had any inclination to take his own life. His father and YPB believed that YPA dealt with the threats to his family, by unselfishly removing himself from the situation, believing the threats against his family would then disappear which, ironically they did. The conclusion is that this was a family extremely supportive to YPA and his loss is a tragedy for the whole family. If the information had been known earlier that YPA was receiving online threats, the family would have responded expeditiously to address the situation. This was effectively displayed by the paternal aunt who, on the day that YPA went missing and hearing from her children of the online threats made by YPD against her nephew the evening before, contacted YPD on a social media website. When challenged, YPD rescinded his threats, and requested the paternal aunt to inform YPA of the fact. Unfortunately this action came too late for YPA.

Lessons Learnt and Action already implemented

45. Agency learning, in the process of completing the SCR are detailed within the accompanying LSCB Action Plan. The key lessons learnt and implementations made are highlighted within this Overview Report, as follows:-

46. **The requirement to identify Key Risk Factors**. *Health* - YPA was known to have used drugs as he alluded to himself, when in 2011, he was admitted to a North Lincolnshire and Goole NHS Trust (NLAG), Accident and Emergency Department in an acute intoxicated state. It has been recognised that this should have stimulated a more intensive follow up, to understand why, to address his needs, provide support and to promote awareness to the dangers of alcohol and drug misuse. The

NHS Overview Report identified a missed opportunity to assess YPA further. Changes have since been implemented to ensure that such cases are reported appropriately to the Hospital Safeguarding Team and/or Children's Social Care for a possible referral. There should have also been a consideration of a referral for a Common Assessment Framework (CAF), a system that was in place at the time, within North Lincolnshire and Goole NHS Trust. This has now been superseded by a Single Assessment Framework which coordinates and brings together professionals to initiate the Team Around the Child, Child in Need and Child Protection.

47. *Education* - There was a need to recognise the wider safeguarding aspects within schools, to address inappropriate behaviour displayed towards other pupils and staff in order to identify the heightened risk. There are now clearer instructions to conduct more effective risk assessments, to ensure that all the available facts of a pupil's behaviour are known and shared with other professionals as a safeguard for other cases in the future, as this was not being done, with little or no communication between schools. The Designated Safeguarding Lead at his sixth school (subject to the first LSCB Overview Recommendations within this report), has advised that since 2012, current practice regarding the admission of pupils once a transfer is known, generally through a parent seeking a place, is for the school to contact the previous school, requesting all the information on the student. This is done either by email or phone. The school in 2013, also introduced an admission checklist, which shows further good practice.

48. The challenge of his education and meeting the needs of his Statement of Special Educational Needs. Some schools did not always adequately communicate between one another and this cannot be good practice. YPA attended nine schools from mainstream to specialist schools to meet his Statement of Special Educational Needs. As previously stated, there is extensive evidence from agencies of their input and support provided to help him to meet his emotional behaviour and needs. Special Educational Needs have been superseded and procedures have changed since September 2014 with the implementations of Education Health Care Plans (EHCP)[4]. The introduction of EHCP's, aims to provide a more holistic view of a child and young person's needs and involve the family in each key decision making step.

49. There were a number of situations, with reasons given, highlighting a delay in the adherence of timescales to provide YPA, with a placement provision between some schools. All education services are recorded through the new MOSAIC system since April 2015. This should greatly improve record keeping and information sharing. The statement of Special Educational Needs assessments, were educationally focused and did not include relevant non-educational information and targets, which EHCP's should now take into consideration.

50. Dudley Education Services, have put improvements in place for the Education Welfare Service for children and young people with a statement of Special Educational Needs (now under EHCP's), to ensure unauthorised absences are challenged, timescale are met, to place children and young people back into education.

51. The challenge of working with parents who are difficult to engage. It is reported that both parents have on occasions failed to work with professionals and have been difficult to engage. However in analysing the submissions to this SCR, both parents and in particular YPA's mother, have consistently been available to assist and support, showing concern and care for YPA, working with professionals within his schools to address his needs. The implementation of EHCP's should effectively address and challenge concerns in engagement, assessments, schools, the family lifestyle

[4] Education Health Care Plans, Children and Families Act 2014

and behaviour that needed to be discussed as in YPA's case, with both parents on how the family dynamics impacted on their sons lifestyle, particularly YPA with his behavioural needs.

52. Compliance with Missing Persons. Both Lincolnshire Police and Humberside Police had previously in 2011, dealt with YPA as a Missing Person, on one occasion each. They correctly ensured he had returned safely but, did not personally see him. Therefore, as he was a vulnerable young person, an opportunity to conduct a safe and well check, did not occur. Both agencies accepted the shortfall in service and have already implemented improvements to their procedures that are active and sufficient to ensure they are compliant. Lincolnshire Police have since employed a Missing Persons Review Co-ordinator and Humberside Police have updated their IT procedures.

Conclusions

53. Predictability. The suicide of YPA was not predictable. There had been extensive interaction with him, his parents and professionals for most of his life, initially with health and then within education, dealing with his Statement of Special Educational Needs. There was no contact made by YPA or the family with professionals for many months prior to his suicide and there was no indication given to any person that YPA would seek to take his own life. The findings and learning identified for agencies, were on the fringe of the review only and did not affect or contribute to the final tragic outcome of events.

54. Preventability. Professionals on all available knowledge and information, could not have foreseen or were able to prevent the outcome. His psychological mind, due to his relationship failing with YPC, threats to him and his family by YPD, would appear to have had a drastic effect on him but, this would not have been known to agencies at that time. Other than his involvement with CAMHS some years before, there was no detailed assessment of his mental health state of mind. Concerns only came to notice within the last few hours before he went missing, when he displayed emotion, witnessed by his two younger cousins after he had been either speaking or communicating with YPC on his mobile phone and after the threatening social media "cyber- bullying" from YPD, he was receiving at the time.

55. *Recognition of the efforts of key practitioners to support YPA.* The fact that there is some learning identified and addressed within the agency and overview report recommendations, should not detract from the enormous amount of professional involvement, resources and hard work provided to support this young person. Good work was let down on occasions by not keeping suitable records, lack of communication between some professionals, family and risk assessments, but overall, services were offered and taken up by YPA and his family. These factors did not affect or impact on the subsequent death of YPA.

56. *Opportunities to identify Cyber-Bullying.* The Assistant Coroner's judgement at YPA's inquest, recorded that "cyber-bullying" was an element which contributed towards YPA's suicide, as identified in the criminal investigation. However the serious case review, confirms there was no opportunity or concern previously identified, that was known to professionals regarding any online abuse. From information obtained for the purposes of the serious case review, this information only came to the notice of the immediate family, shortly before and after he took his life. All agencies within the review, displayed a thorough knowledge and understanding of bullying and "cyber-bullying" within their own organisations with procedures, information, training and initiatives in place for the awareness of professionals, children and young people and the wider community.

57. *The Voice of YPA***.** There is substantial information that the voice and YPA's views were consistently heard and within written form, evident through the intervention of schools addressing his Statement of Special Educational Needs, his Annual Reviews and with his presentation in 2011 at A & E for acute intoxication. From the subsequent family interview, as previously mentioned, it was their opinion YPA was not being stimulated at his last school placement and an opportunity to engage with him was missed. In YPA's final Annual Statement review in March 2013, he makes it clear that he did not engage, did not like school and had no intention of going to college. He was an adolescent struggling with education that he ultimately rejected. He acknowledged his lifestyle impacted on his education. There is no other detailed personal information from him in regards to his constant change of schools and homes, which undoubtedly caused a continual interruption to his educational pathway that EHCP's should now identify, challenge and address.

58. *Keeping track of YPA's changing lifestyle.* The constant movement between homes and schools with his mother was difficult at times for professionals to monitor, particularly when no prior notice was given by her before she removed him from school. This has been an aspect throughout this case, as the current system of transfer of pupil files and records highlighted that neither the previous schools nor the receiving placements, communicated with each other. Furthermore, his educational file at his final placement was lost. Recommendations in this Overview Report, address these issues.

59*.* *Intervention opportunities after the assault on YPA*. Information obtained in the police investigation, identified the previous head butting assault on YPA by YPD. It was known both to his father who saw YPA's bloody nose as a result of the assault and by his half-brother who was aware that it occurred. Both stated that, YPA did not want any police involvement, therefore police were not informed until after he went missing in December 2013.

60. Both YPC and YPD were asked by the LSCB to contribute to the serious case review, but no response was received. Therefore important questions and information that may have assisted the serious case review relating to their involvement with him, could not be answered or obtained for the processes of completing the review.

61. The Overview Report's analysis of events for the review, was obtained from the contributions from within individual Agency Narrative Reports, the NHS Overview Report and other ancillary reports submitted to the review, including the participation and views of the family. Within the Lincolnshire's Serious Case Review Panel meetings, the Independent Overview Author presented to the SCR Panel the findings and themes for discussion and challenge, identified in compiling the review, in order to critically examine the circumstances that lead to the tragic suicide of YPA. Each Agency Narrative Report author supported the process, by preparing, open and transparent reports. Where improvements and changes to policy and procedures were needed, if not already implemented, recommendations were made for lessons to be learnt, to challenge any shortfall (see recommendations below).

62. This serious case review identified minor learning for agencies on the fringe of the review that did not impact on YPA taking his own life. As previously alluded to, elements of "cyber bullying" which the Assistant Coroner at YPA's inquest declared, was a contributing factor to his suicide, were not previously known to agencies or the family until after he went missing on the 15 December.

63. This Overview Report is submitted to Lincolnshire Safeguarding Children Board, to consider the lessons to be learnt and to ensure that effective change is implemented, to safeguard the welfare of children and young people.

RECOMMENDATIONS

64. The LSCB Overview Recommendations, together with individual agencies recommendations, from the Agency Narrative Reports and the NHS Overview Report have been reviewed and quality assured within their respective agencies. All recommendations have been considered and accepted by the author of this report and the SCR Panel. The measurability, action taken by the agencies and timeliness for the completion of all recommendations are contained within the LSCB Action plan that accompanies this Overview Report. The recommendations for the serious case review for YPA are as follows:-

LSCB Overview Recommendations:

1) **LSCB Overview Recommendation for a Lancashire School**

It is recommended that a Lancashire School review their policies in relation to risk assurance for cases of inappropriate sexualised behaviour, and complying with Keeping Children Safe in Education (2014) to safeguard other pupils and staff as to their health and safety.

2) **LSCB Overview Recommendation for Education Services**

It is recommended that Lancashire Children Services, Lincolnshire CS, North East Lincolnshire CS, and Dudley Metropolitan Borough Council, Education Services, remind schools that schools must provide full details about any child or young person transferring in or out of the Local Authority. Where the child has an exclusion, the reasons for those exclusions must be included or acknowledged within their Pupil File.

3) **LSCB Overview Recommendation for Lincolnshire County Council Education Services**

It is recommended that Lincolnshire County Council,

- **Remind its schools and academies that the process for the retention and transfer of pupil's personal educational files must be followed and recommend that Governing Bodies have the policy audited.**
- **LSCB should ask Solutions 4 and School 9 to audit their processes with regard to retention and transfer of pupil's personal educational files and assure LSCB that they are compliant with policy.**

Agency Narrative Report Recommendations:

Dudley Clinical Commissioning Group

It is recommended that Practice staff within Dudley should take care to ensure that all information about any child should be forwarded to the receiving GP, that all significant events should be included in the summary. This should include any statement of Special Educational Needs and any safeguarding concerns, next of kin and details of those with parental responsibility to be included on all children's GP records outlined as follows:

1) **Dudley Clinical Commission Group Practice staff within Dudley should take care to ensure that ALL information about any child should be forwarded to the receiving GP. Other involved CCGs may wish to consider this recommendation.**
2) **All significant events should be included in the summary (page of the GP record). This should include any statement of SEN and any safeguarding concerns.**
3) **Next of Kin /details of those with parental responsibility to be included on all children's GP records.**

Humberside Police

The content of Humberside Police's Agency Narrative Report should be shared with the Missing Operational Board to ensure that the lessons learnt are incorporated into the review of the North East Lincolnshire Local Safeguarding Children Board – 'The runaway and missing from home and care protocol'.

Lancashire County Council for a Lancashire School

It is recommended that a Lancashire School update the Admissions Policy to incorporate the findings and learning from the Agency Narrative Report and the updated Admissions Policy and checklist will be distributed to all staff.

Lincolnshire Education

- **All service areas will be made aware of the local authorities timescales set for placing a child in provision and will be challenged to meet these.**
- **Ensure that all service areas relevant to this case have timescales within the procedure to be monitored through performance indicators.**
- **Ensure that all service areas relevant to this case have made improvements to their record keeping.**
- **That quality assurance of Education, Health and Care plans should ensure that they include the wider non-educational needs of the child and that parents/carers are fully involved in the process.**
- **To ensure that all case files follow a closure procedure and a visual checklist and that documentation is placed on the file to evidence this.**

- **To ensure that all service areas adhere to the new transfer of files guidance which is now in place.**

North Lincolnshire and Goole NHS Trust

1) **Develop a pathway for children and young people who attend accident and emergency departments when under the influence of alcohol or drugs including guidance in relation to listening to the child and seeking the child's views with regards to the reason for taking the substance and any wider social issues.**

Health Overview Recommendations:

1) **NHS England and Clinical Commissioning Groups to seek assurance from NHS organisations involved in this review that within their records management processes there are systems in place to ensure the updating of electronic systems to enable reading of data electronically stored on obsolete technology, e.g. floppy discs in a rapidly advancing IT / digital world.**
2) **For North East Lincolnshire Health Economy to provide clarification to the LSCB of the health offer for children and young people up to the age of 18 years including at points of transition and when not in education provision.**
3) **For NHS England and Clinical Commissioning Groups involved in this review to seek assurance from the local GPs and NHS providers that adults presenting children for treatment are identified and parental responsibility confirmed and entered within the records.**

Appendix 1

Biography

The Independent Chair, Leila Barron is a qualified social worker with more than 30 years' experience, 20 years of which in management roles. Most of her working life has been within local authorities but for the last 10 years she has worked for Action for Children.

The Independent Author, David Byford is a Safeguarding Expert and Managing Director of his own Safeguarding Consultancy. He retired in September 2014 after 40 years within the Metropolitan Police Service (MPS) including over 25 years' experience in Child Protection. He was a Senior Investigating Officer responsible for investigating serious crimes against children and young persons. In 2003 with a colleague, he developed the SCR process for the MPS. After retirement as a serving police officer (2006), he was again employed by the MPS as a Senior Review Officer, responsible for the MPS SCR responses for all 32 London Boroughs. He has acted as an adviser on SCR's to the MPS, Association of Chief Police Officers (ACPO), police nationally, local authorities, Independent Schools and LSCB's. He has carried out national sensitive and bespoke reviews including for the Attorney General and the Director of Public Prosecutions on expert witnesses. In 2010 he conducted an ACPO National Review for CEOP's on SCR's for the police service. He has completed the DfE sponsored training "Improving the Quality of SCR's" and is on the Association of Independent LSCB Chairs, National Directory as an SCR Lead Reviewer/Author.

Appendix 2

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