Lincolnshire Safeguarding Children Board

LSCB briefing on Serious Case Review

Young Person A

1. YPA 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.

3. Significant Incidents

   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".* 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 support to deal with the abduction incident.

4. 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.

5. Throughout his lifetime, he attended nine different schools and changed home on ten occasions. At the schools he was disruptive, occasionally showed bullying tendencies and displayed inappropriate sexualised behaviour towards other pupils and staff in several placements. There is consistent evidence of the effort and time given to YPA by agencies, particularly education with continued and heightened support provided to him together with the interaction with him and his family. In the latter part of 2012, when sixteen years of age and living with mother, he withdrew from his eighth school.

6. YPA 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.

7. YPA's suicide occurred in December, whilst he was staying with his paternal family. It occurred after he visited his paternal grandmother with his father and half-brother and his family (his father had two elder sons from a previous relationship). 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. 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. 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 he had been reported missing, that details of him experiencing an incident of "cyberbullying" by YPD was revealed, information not previously disclosed to professionals.

8. It was only then that the family explained to police that YPA had conflict with YPD, only hours before his suicide. Police were informed that YPA had apparently been previously assaulted by YPD who head butted him in the face sometime before and had received on line threats from YPD shortly before he went missing. The assault and threats were 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 malicious communications YPA.

9. **Predictability**

The suicide of YPA was not predictable. 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.

10. **Preventability**

Professionals on all available knowledge and information, could not have foreseen or were able to prevent the outcome.

Lessons Learnt / Recommendations

11. **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. Partner should ensure such a presentation should stimulate an intensive follow up, to understand why, to address his needs, provide support and to promote awareness to the dangers of alcohol and drug misuse.

12. **Compliance with Missing Persons.**

Police had previously in 2011, dealt with YPA as a Missing Person. 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. Police should ensure appropriate resources are in place to monitor and review missing people.

13. *Specific* recommendations have been made by agencies from within Agency Narrative Reports. The agency recommendations are contained within the LSCB Action Plan which accompanies the full Overview Report whose three recommendations are as follows:-

1) 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) 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) 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.

The full report is published on http://www.lincolnshire.gov.uk/lscb

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