Enfield
Safeguarding
Children Board
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is everybody's business

SERIOUS CASE REVIEW:
'YT'

Summary & Response from

Enfield Safeguarding Children Board

1. Introduction from Geraldine Gavin – ESCB Independent Chair

1.1. This Serious Case Review concerns the very sad case of a young man who took his own life just hours after arriving in this country. It is unlikely that anyone will ever know what led him to make that decision and indeed the review concludes that his death could not have been predicted.

1.2. It is important that those involved in the care of young people in similar circumstances learn as much as possible from such a tragic event. I am confident that the Serious Case Review that was undertaken was methodical and thorough in trying to understand what happened during the final hours of this young man's life and I welcome the recommendation regarding communication of potential risk that has arisen from it. I also welcome the enquiry from the subsequent coroner's inquest which relates to foster carers' ability to communicate with young people in circumstances such as this. I am pleased to note that there has been positive activity in addressing both these areas. Sadly, it does not seem likely that even if these recent actions had already been taken at the time, it would have been possible to prevent this young man from taking his own life. However, I am confident that processes and systems are now in place to ensure that information and risk is effectively communicated and I am confident that action has been taken to ensure all parties understand their roles and responsibilities in relation to ensuring effective translation services are available to young people and their carers

2. Background

2.1. YT, an Unaccompanied Asylum-Seeking Child (UASC) presenting as a 17-year-old male from Eritrea, first came to notice in Enfield following his arrest on 08/07/2106. After initial assessment and investigation of his situation he was placed under 'Police Protection' and looked after in emergency foster care commissioned by Enfield Children's Social Care Emergency Duty Team (EDT). The following evening (09/07/2016) at approximately 9pm, YT was found by his foster carers hanging in his bedroom. The circumstances indicated that the death was a suicide.

2.2. In August 2016 Enfield Safeguarding Children Board (ESCB) commissioned a Serious Case Review to explore the circumstances and identify any learning. An author, Richard Henson, was identified and it was agreed that a systems methodology would be used.

2.3. The report was finalised in May 2017. The conclusions and recommendation are copied below:

3. Conclusions of the Serious Case Review

3.1. *A fully comprehensive and holistic assessment would not be possible or even appropriate but there was opportunity to initiate and record a dynamic initial assessment that would assist others in managing risk and meeting the individual needs of that child. This type of activity too, can be considered as a vital and a 'task centred approach'. The absence of such a record to pass on and build*

upon means that the future carers and the professionals who deal with the case are deficient of some important information. Consequently, they must either 'start again' with assessment and / or they may need to operate in a generic way that is not centred on the known needs of the child. Both situations are inefficient and can add to the stresses for the child and safeguarders alike.

3.2. *There is an understandable reluctance to add to the bureaucracy of the EDT workers but the absence of records containing; rationale for decisions, risk management strategies and how the wishes / needs of the child are being supported creates uncertainty in the short term and additional work in handovers and case progression for all stakeholders.*

3.3. *There is almost nothing to suggest to any professional or carer that YT was a suicide risk. He was undoubtedly in a situation where he was isolated from his family and friends and in a place where verbal communication with professionals and the carers was difficult. A full assessment of his mental health situation was not possible or appropriate to the initial meeting with the EDT social worker. However, the social worker was an approved mental health practitioner and he made no assessment of pressing mental health concern.*

3.4. *There was no formal risk assessment for the handover to the carers. This meant that the foster carers were not in possession of all known relevant information. The fact that YT had become agitated and punched a wall inside the police station and had been handcuffed was relevant and should have been recorded and passed to others who had responsibility for his welfare. This may have prompted increased levels of vigilance including observation of his demeanour for new signs of agitation and allowed the foster carers to respond to needs more effectively or seek assistance from other professionals.*

3.5. *Although a weakness in the professional approach to this UASC the absence of such a risk assessment does not provide any direct causational factors that contributed to YT's own actions and death.*

3.6. *In considering the policy, processes and actions of professionals and the foster agency carers there is no evidence of any changes that could be made that would have specifically acted to deter YT from taking his own life. His death was not reasonably predictable to those who dealt with him. It would not have been appropriate to intrusively monitor him in his bedroom based upon what was known at the time.*

4. Recommendations of the Serious Case Review

4.1. *The analysis of agency submissions to this SCR permits evaluation on the quality of practice and analysis of the circumstances and allows recommendations for improvements to be made. This recommendation has arisen out of a case where the presenting vulnerability of the child was as an unaccompanied asylum seeker who needed to be accommodated out of hours. The recommendation will also apply to other situations where children at risk of significant harm require emergency care provision.*

4.2. *The single recommendation is intended to support safer and more efficient operational practice by introducing changes to support communication in respect of risk management and ensuring the focus of emergency activity is centred on the child's needs.*

4.3. *Timescales for delivering the changes needed for this recommendation are short / as soon as possible.*

Enfield Safeguarding Children Board (ESCB) should review and improve the ways in which professionals who are responsible for out-of-hours emergency child protection complete and record assessments and decisions;

- ***to record all aspects of vulnerability,***
- ***to ensure the voice of the child is heard,***
- ***to detail necessary actions to reduce the risk of harm and promote welfare,***
- ***to facilitate effective communication,***
- ***to assist other / subsequent service providers.***

5. Inquest

5.1. As a consequence of the circumstances surrounding YT's death the East London coroner decided that an inquest before a jury should be held. This took place on 28th, 29th and 30th June 2017. Publication of the Serious Case Review was delayed as a consequence of the inquest.

5.2. At the conclusion of the inquest the jury came to a narrative verdict. *YT died by his own actions but it was not possible to reach a conclusion beyond reasonable doubt that he intended to take his own life*

5.3. The coroner concluded by saying that a matter of concern for her is in relation to communication between YT and his foster carers. She was concerned that they had no method of communicating with him. She expressed her intention to write to the London Borough of Enfield regarding this matter

6. Response and Actions

6.1. Enfield Safeguarding Children Board took the view that rather than revisiting the Serious Case Review report it made sense to consider the recommendations and outcome of the report and the inquest together.

6.2. The recommendation from the Serious Case Review was acted upon immediately. It was already standard practice for placements made during office hours for a **Risk Assessment** document to be completed by the social worker requesting a placement. This document details any known behavioural or emotional issues which may present a challenge for the carers. Following the recommendation from this Serious Case Review two key changes were made. Firstly, the risk assessment form was amended to include a specific section on language and communication. This ensures that any information relating to this area will be passed on to the carers. Secondly it was

agreed that this form will be used for **out of hours** placements as well as for placements made during office hours. This means that the out of hours social work team will ensure that any risks that are either identified by them or communicated to them by another agency, such as the Police, will always be recorded on a Risk Assessment document which will be given to the carers. It is acknowledged that it will not be uncommon for out of hours workers to have limited information but agreed that it is imperative that whatever information they have about a young person, including all information passed to them from the Police, should be communicated to placement providers.

6.3. In response to the coroner's letter and the specific concern raised about carers' ability to communicate with young people, Enfield Children's Social Care are clear that it is the responsibility of the placement provider to ensure that carers have the means to communicate with children and young people. Where 'in-house' foster carers are used they all have access to the translation service called Language Line, and many make frequent and effective use of it. London Borough of Enfield has a contract with Language Line which is accessible to Social Workers and Foster Carers.

6.4. Where an 'in-house' provider is not available an independent provider will be sought. In all circumstances London Borough of Enfield has an expectation that all independent providers of placements have suitable facilities to communicate with young people, this includes access to translation systems. Once a potential provider has been identified they will be provided with information about the young person using agreed forms including the risk assessment. The forms will provide as much information about the young person as is available. This will include details of the child's first language and will clearly identify where there may be any identified communication challenges. As described above in 5.2, from June this year the same Risk Assessment document is routinely completed and provided to carers for both office hours and out of hours placements.

6.5. The ESCB has sought assurance that all providers are aware of their responsibilities in relation to communication with young people. The independent Chair has written to all independent providers reminding them of the importance of ensuring that carers are able to communicate with the children / young people placed with them and of their obligation to ensure that this is facilitated. The letter is appended by a short table asking providers to indicate which method/system they use to facilitate translation when it is required and whether or not they require any further support. Providers have been asked to return this information to the ESCB and the LAC service where it will be scrutinised. Any provider who indicates that they are unable to provide translation support will be signposted to companies who provide this service. Should any provider remain unable or unwilling to facilitate the service then the London Borough of Enfield will have no choice but to cease commissioning them to provide placements for vulnerable children and young people.