**IN THE MATTER OF THE INQUEST TOUCHING THE DEATH OF IMRAN DOUGLAS**

---

**Response from the London Borough of Tower Hamlets to the Coroner's Regulations 28 Report**

---

## Introduction

1. This is the response from the London Borough of Tower Hamlets ('the Council') to the Coroner's Regulation 28 Report dated 29 December 2015 following the inquest into the death of Imran Douglas ('ID').

2. ID was a 17 year old Looked After Child at the time of his arrest for murder, having asked to be taken into the care of the Council 2 weeks previously. He turned 18 shortly after pleading guilty to the offence, but continued to be entitled to Leaving Care services from the Council through its Children's Social Care team. The Youth Offending Service was also working with ID. He died in HM Prison Belmarsh on 13 November 2013 and the jury at the inquest concluded that his death was suicide.

3. The Council provided formal evidence at the inquest via statements and live evidence from [redacted] Operational Court Team Manager from the Youth Offending Service ('YOS'), [redacted] Team Manager of the Children with Disabilities Team and [redacted] Head of Children's Services.

4. This response addresses the concerns from the Coroner's report which relate to the adequacy of knowledge and interagency working between social care in London Borough of Tower Hamlets and the secure estate. The Council accepts the Coroner's concerns and has taken the following actions to remedy these issues.

a) *Improvements to Policy and Guidance*

5. On 30 November 2015 the Youth Justice Board circulated the Joint National Transitions Protocol, which they developed and agreed in partnership with the National Probation Service and National Offender Management Service. This is designed to support the planned and safe transition of appropriate young people and their sentence management from youth offending teams to probation service providers on or around their 18th birthday, to comply with Strategic Standard 11:

> *'Establish and implement clear local policies and protocols in relation to the transition of young people between youth justice services and from the youth to adult criminal justice system (drawing on the Youth to Adult Transitions Framework for community transfers and relevant NOMS custody transitions guidance'*

6. The National Protocol will be presented to the Youth Offending Team Management Board on 25 February 2016 for sign off. This is a statutory board, comprising senior managers from both Tower Hamlets and the City of London Youth Offending Services, and the Directors of both local authorities' Children's Social Care Services ('CSC'). In addition to the National Protocol, a presentation has been itemised to discuss the concerns raised in the Coroner's Report, together with a training session on the learning points arising from the inquest and the Thematic Review by Alex Chard (see below).

*b) Interagency and inter-departmental cooperation and communication*

7. The Council recognises that the YOT and the rest of the CSC social work teams have historically worked in parallel rather than in an integrated way. In response to the recommendations of a Thematic Review which included ID's case (detailed below), the council has refocused the Risk Management Panel that existed within the YOT to a High Risk Management Panel, chaired jointly by an operational YOT manager and a

senior manager in Children's Social Care. The purpose of this Panel is to share information and develop joint risk assessments and plans for older high risk children, including those engaged in the Youth Justice System. Other relevant agencies that can contribute to young people's safety and welfare attend the panel and it provides a multiagency forum to consider how to reduce the risk posed to and from young people who are most challenging for their families and the agencies that support them.

8. The High Risk Management Panel meets fortnightly and it contributes to the care planning and case management of a range of young people, with direct access to the service manager level for conflict resolution.

9. The Council has also initiated a multi-agency Task and Finish Group, in order to undertake the following review of procedures and policy relevant to the findings of the inquest.

10. The group has already reviewed the internal Risk Management Procedures, and has planned an agenda of work through to June 2016. This includes the consideration of the full range of procedures that impact on young people in secure placements, on remand and thus in the care of the Local Authority. It is also is tasked with reviewing the transition process from the youth estate to the adult estate, in line with the Joint National Transitions Protocol for managing the cases of young people moving from Youth Offending Teams to Probation Services. Training will then be provided to managers and front line staff to support implementation.

11. Finally, within Children's Social Care, a Looked After Child Track Panel has been introduced to track every young person on remand on a quarterly basis and ensure officers are fully compliant with all requirements in respect of care and transition planning and that proper services are in place to meet their welfare needs and support their return to the community. This is chaired by the Head of Children's Services, and attended by Service Head for the Youth Offending Service, Service Head for Looked After Children, Group Manager for the Independent Reviewing

Service and Designated LAC Medical Officer, as well as front line managers and social workers for the individual young people.

12. Additionally, Tower Hamlets is currently engaged in a project through the London Independent Reviewing Officer Managers Forum to improve communication and partnership working with the secure estate. [redacted] Group Manager for the Independent Reviewing Officer (IRO) Service has visited Feltham Young Offenders Institute three times, and met with the Governor to discuss proposals to promote the welfare needs of young people in custody. Due to the success of this programme, similar meetings have now been scheduled with Cookham Wood YOI.

13. Matters addressed during these meetings include discussions around educational needs, personal allowances, reducing bullying and managing gangs. Of particular relevance to ID's case, on 21 December 2015, the group discussed Looked After Child reviews/Pathway Planning meetings and the difficulties for social workers and IROs in arranging to meet with young people in their care. Feltham are trying to address this and have agreed to offer two slots for Looked After Reviews which will enable IROs to see the young person before the meeting. Feltham is undertaking work to see how they ensure young people are present for reviews and are in the process of securing another more private meeting space which should be operational from April 2016. Visits are reviews can also be booked on line.

*c) Training and Information for social workers and Youth Offending Team officers*

14. The concerns raised by the Coroner in respect of the understanding of the social workers giving evidence of the purpose of a Transition Plan is accepted. It is important to note that because [redacted] the officer giving evidence on behalf of CSC works in the Children with Disabilities Team, Transition Planning has a different meaning, which led to confusion in the witness box. Her understanding of Transition Planning relates to children

with profound physical or learning disabilities transitioning to Adult Social Care provision. As ID's care needs did not reach the threshold for Adult Social Care services because of the progress he had made since his car accident, he would not have been in receipt of a Transition Plan in this context. Further, because of the needs of the young people who ordinarily receive a service from the Children with Disabilities as such that they are extremely unlikely to be remanded or sentenced to custody, this team has never previously had a case where they have been involved with the secure estate. However, it is accepted that in these circumstances, greater care should have been taken by senior managers to ensure that the allocated team was supported to understand that additional requirements of meeting the needs of a young person on remand.

15. Following the update to the Care Planning Guidance in April 2014 in respect of Looked After Children in contact with youth justice services, practice guidance was circulated to all social workers with a work flow setting out 'what to do if a young person is remanded', including statutory timescales for visits and reviews. This provided a copy of a detention placement plan and an explanation of the additional matters to be addressed within the plan.

16. This is now being updated in light of the issues raised during the course of the inquest and will be recirculated by 31 March 2016 to all YOS and CSC teams, to specifically address the following issues:

- The interaction between LAC pathway planning and Transition Planning in terms of moving to the adult secure estate
- The requirement for social workers and YOS workers to attend Transition Planning meetings, and to invite relevant officers from the secure estate to Looked After Child reviews/Pathway Planning meetings
- The requirement to provide a copy of the young persons' detention placement plan/pathway plan and the minutes of the LAC review/

Pathway Planning meeting with the Governor of the Youth Detention Accommodation.

- The importance of effective communication between professionals, including direct communication between social workers and officers within the secure estate, as well as YOS officers, in respect of young people for whom they are mutually responsible
- The importance of confirming any verbal communication between professionals in writing, in particular where this relates to the immediate welfare needs or safety of the young person
- Updating the precedent detention placement plan to the format provided by the Youth Justice Board

17. A training session was provided on 8 February 2016 for line managers, social workers and YOS officers, which was well attended. In addition to giving an overview of the Legal Aid, Sentencing and Punishment of Offender Act 2012, the following topics were addressed:

When a young person is remanded to Youth Detention Accommodation the importance of an assessment being completed to consider present needs but also post sentencing needs and post release needs.

The need for all work to be jointly undertaken with YOS and CSC, t draw from the expertise of each service

- Transition between YOS and Probation Services post-18. Staff were advised of the support available from the YOS probation officer
- YOS will keep some young people post-18 if they have particular vulnerabilities, and this will be determined on case by case basis
- High Risk Management Panel highlighted
- Names of heads of each service for Feltham YOI were provided to enable social workers to make direct contact about a particular young person Held in custody; health, education, safeguarding and contact. Staff were advised that Feltham YOI staff have all signed up to be contacted directly by the IRO Group Manager or social workers.

- Discussion on the move from YOI to adult secure and requirements of the Joint National Protocol for Transitions were explained
- Emphasised the importance of close communication between YOS, CSC and the secure estate to meet the welfare needs of children

18. In respect of concerns raised that conversations which took place between professionals where important information, such as ID's risk of self-harm, were not properly recorded, the Council has implemented a new Recording Policy and Procedure which was launched to staff at the Social Work Conference on 21 November 2013. Further training was delivered during February and March 2014 including targeted workshops for key staff, and regular 'refresher' sessions take place at staff forums. All new staff receive an induction and in addition to being available on the Intranet, hard copies are available for staff. This policy will now be recirculated annually, to remind staff of the importance of clearly documenting communications.

*d) Thematic Review*

19. In addition to the Critical Learning Review which was undertaken on ID's case specifically and provided to the Inquest, a thematic review that was instigated by the Tower Hamlets Safeguarding Children Board to study the common themes and professional interventions in the lives of six children. This followed a range of incidents which took place in 2013 and 2014 when several older children committed grave offences, which included ID. It was agreed that the key purpose of the review was to help to understand how we can reduce the likelihood of older children either coming to serious harm or harming others. The findings of this report were presented to the Local Safeguarding Children Board on 12 February 2016, to ensure that all of the Council's safeguarding partners could share in the learning points identified. The executive summary from the report is available on the Tower Hamlets' Local Safeguarding Children Board website:

http://www.childrenandfamiliestrust.co.uk/wp-content/uploads/2015/12/Troubled-Lives-Summary-Report-Final1.pdf

20. The learning from the ID inquest and the Thematic Review will be the focus of a development session for the Youth Offending Management Board on 25 February 2016 to ensure that partners with responsibility for the management of the Tower Hamlets and the City of London Youth Offending Service are fully appraised of the lessons learned and their responsibility towards the children and young people who are involved with the YOT.

**Conclusion**

21. I hope that the above address the concerns raised in the Coroner's report. The Council remains committed to learning lessons from untoward incidents and continually improving the care provided to young people for whom we are responsible.

Signed. _____ Dated. 23.2.16

[redacted]

Head of Children's Social Care

ondon Borough of Tower Hamlets