Thurrock: A place of opportunity, enterprise and excellence, where individuals, communities and businesses flourish

Children's Services Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **20 December 2016**

Committee Room 1, Civic Offices, New Road, Grays, Essex, RM17 6SL

Membership:

Councillors Bukky Okunade (Chair), Angela Sheridan (Vice-Chair), John Allen, Joycelyn Redsell, Graham Snell, Aaron Watkins and Tom Kelly

Myra Potter, Parent Governor Representative
Anne Sentance, Church of England Representative
Kim James, Chief Operating Officer, HealthWatch Thurrock

Substitutes:

Councillors John Kent, Terry Piccolo and Sue Sammons

Agenda

Open to Public and Press

Page

1 Apologies for Absence

2 Minutes **5 - 14**

To approve as a correct record the minutes of Children's Services Overview and Scrutiny Committee meeting held on 13 October 2016.

3 Items of Urgent Business

To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.

4 Declaration of Interests

5	**Items Raised by Thurrock Local Safeguarding Children Board** This item is reserved to discuss any issues raised by the Thurrock Local Safeguarding Children Board.	
6	**Items Raised by the Youth Cabinet Members**	
7	**Ofsted Inspection Action Plan**	**15 - 74**
8	**Update Report On Child Sexual Exploitation**	**75 - 124**
9	**School Improvement Peer Review**	**125 - 136**
10	**Educational Attainments of Children Looked After**	**137 - 152**
11	**Thurrock Local Children's Safeguarding Board (LSCB), Serious Case Review (SCR) Report - James**	**153 - 248**
12	**Performance Dashboard**	**249 - 256**
13	**Work Programme**	**257 - 258**

Queries regarding this Agenda or notification of apologies:

Please contact Jenny Shade, Senior Democratic Services Officer by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **13 December 2016**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

Breaching those parts identified as a pecuniary interest is potentially a criminal offence

Helpful Reminders for Members

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

When should you declare an interest *at a meeting?*

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

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Does the business to be transacted at the meeting

- **relate to; or**
- **likely to affect**

any of your registered interests and in particular any of your Disclosable Pecuniary Interests?

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

A detailed description of a disclosable pecuniary interest is included in the Members Code of Conduct at Chapter 7 of the Constitution. **Please seek advice from the Monitoring Officer about disclosable pecuniary interests.**

What is a Non-Pecuniary interest? – this is an interest which is not pecuniary (as defined) but is nonetheless so significant that a member of the public with knowledge of the relevant facts, would reasonably regard to be so significant that it would materially impact upon your judgement of the public interest.

Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:

- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps

Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

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You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.

Vision: Thurrock: A place of **opportunity**, **enterprise** and **excellence**, where **individuals**, **communities** and **businesses** flourish.

To achieve our vision, we have identified five strategic priorities:

1. Create a great place for learning and opportunity

- Ensure that every place of learning is rated “Good” or better
- Raise levels of aspiration and attainment so that residents can take advantage of local job opportunities
- Support families to give children the best possible start in life

2. Encourage and promote job creation and economic prosperity

- Promote Thurrock and encourage inward investment to enable and sustain growth
- Support business and develop the local skilled workforce they require
- Work with partners to secure improved infrastructure and built environment

3. Build pride, responsibility and respect

- Create welcoming, safe, and resilient communities which value fairness
- Work in partnership with communities to help them take responsibility for shaping their quality of life
- Empower residents through choice and independence to improve their health and well-being

4. Improve health and well-being

- Ensure people stay healthy longer, adding years to life and life to years
- Reduce inequalities in health and well-being and safeguard the most vulnerable people with timely intervention and care accessed closer to home
- Enhance quality of life through improved housing, employment and opportunity

5. Promote and protect our clean and green environment

- Enhance access to Thurrock's river frontage, cultural assets and leisure opportunities
- Promote Thurrock's natural environment and biodiversity
- Inspire high quality design and standards in our buildings and public space

Minutes of the Meeting of the Children's Services Overview and Scrutiny Committee held on 13 October 2016 at 7.00 pm

Present:	Councillors Bukky Okunade (Chair), Angela Sheridan (Vice-Chair), John Allen, Joycelyn Redsell and Aaron Watkins Myra Potter, Parent Governor Representative Anne Sentance, Church of England Representative
Apologies:	Councillor Martin Kerin Kim James, Heathwatch
In attendance:	Rory Patterson, Corporate Director of Children's Services Roger Edwardson, Interim Strategic Leader School Improvement, Learning and Skills Kay Goodacre, Corporate Finance Anas Matin, Statutory Complaints & Engagement Manager Sonny Tipping, Youth Cabinet Representative Sarah Williams, School Capital and Planning Project Manager Jenny Shade, Senior Democratic Services Officer

Before the start of the Meeting, all present were advised that the meeting may be filmed and was being recorded, with the audio recording to be made available on the Council's website.

9. Minutes

The Minutes of Children's Services Overview and Scrutiny Committee, held on the 6 July 2016, were approved as a correct record.

10. Items of Urgent Business

There were no urgent items of business.

11. Declaration of Interests

Councillor Sheridan declared a non-pecuniary interest as she was a member on the William Palmer Committee and had a child at St Cleres School.

Anne Sentance declared a non-pecuniary interest as she was a Governing Body on the Horndon on the Hill Primary School.

The Parent Governor Representative, Myra Potter, declared a non-pecuniary interest as she was a member of staff at Palmer's College and had children attending Little Thurrock Primary School and St Thames of Canterbury Primary School.

Councillor Redsell declared a non-pecuniary interest as she had two grandchildren at Orsett Primary School.

12. Update from Youth Cabinet

Sonny Tipping from the Thurrock Youth Cabinet provided Members with an update on items that had taken place.

This week had been Democracy Week and that the Youth Cabinet had been pushing out to young people in Thurrock Schools with Councillors being invited to discuss and debate real time issues.

The "Curriculum for Life" Campaign was underway which concentrated on the young people's growth and development as they taught young people the vital life skills and to engage young people in political life.

The tackling of racism and discrimination was also being undertaken within the Youth Cabinet.

The Big Event had been organised and ran by young people for young people at secondary schools to participate in debates, find out what further education and activities such as Duke of Edinburgh were available.

A short film entitled "Make Your Mark" based around mental health had been shown at secondary schools to identify how this affects young people and what support would be available.

A short film on "Transport" was in the making following discussions with C2C and Ensign Buses. To look at how drivers could gain more confidence around young people.

Head Teacher meetings were being held to bring schools and Youth Cabinet members together.

The Chair thanked Sonny Tipping for the update and having attended a school debate on Wednesday with Councillor Halden and Redsell she stated how impressed she was.

Councillor Redsell stated that good discussions had taken place and how the Councillors were sometimes able to change the minds of some of the Youth Cabinet. Councillor Redsell encouraged the Youth Cabinet to invite Councillors to future meetings. With some of the Youth Cabinet being future budding politicians it was good practice to have lively debate.

Roger Edwardson also stated that he had attended a school debate and was very impressed with the quality of the debate and the interesting topics.

Myra Potter asked Sonny Tipping how young people can find about more about the activities and events held by the Youth Cabinet. Sonny Tipping stated that each college had a Youth Cabinet representative who should be

pushing the message through to students. He stated that more could be done on the advertising of these events.

Rory Patterson stated that the Make Your Mark event was important and that it was fantastic that the Youth Cabinet were being involved and that Inspire could help with the design and publicity of future events.

Councillor Redsell stated that hand-outs could be distributed at December Full Council.

13. School Capital Programme 2017/18

Sarah Williams presented the report and sought approval for up to £7 million funding to implement the next schools capital programme to include the secondary school expansions and possible expansion of a further two primary schools. One in Aveley/Ockendon area and other in the North East to meet the increased predicted demand for pupil places from September 2017.

The School Capital Expansion Programme had a current estimated provisional value of £7 million to be funded from the Department of Education capital basic needs grant, underspends would come from the current capital programme and S.106 education funding and would require Council approval.

The Chair stated that the report was for the committee to consider and not approve as recommendation 1 stated.

Councillor Watkins stated that he was confused by the forecast figures and asked how figures could be based on developments that had not yet gone through the planning application process. Sarah Williams stated that the forecast figures were predications based on the applications that had been received so far and that all applications would need to be addressed for demands to be met.

Roger Edwardson stated that the problem was trying to anticipate the demand and looking at projected increases in the population. He stated that part of the high demand and the success of Thurrock was the good reputation of the schools and that there was an identified gap in secondary and primary schools.

Councillor Redsell asked the Officers if the demand by parents to place their children in a certain school had increased and had this stopped children in that area getting into this school. Roger Edwardson stated that there were no longer catchment areas.

A discussion took place between Members and Officers on the clarification of catchment areas and how this was still being advertised on local housing developments and on the council web site. Roger Edwardson and Rory Patterson stated that the school admission process was being reviewed and would check the Council web site tomorrow to ensure that the correct information was being displayed.

Councillor Allen stated that with the increase of individuals, communities and businesses into the borough he had concerns that the number of school places would not match these increases.

Roger Edwardson stated that the Council were seeking additional 5-6 free schools under the free school programme at unknown locations at this present time. This would form part of the build programme over the next 5 years.

Councillor Redsell stated that a large number of children were being home tutored and asked Officers if these numbers were included in the forecasts. Roger Edwardson stated that home tutoring should be discouraged and that there were a large proportion of children home tutored not known to the council.

RESOLVED

1. **That a provisional School capital Programme budget of £7 million as set out in this report be recommended.**

2. **That authority subject to the Council's procurement rules delegate to the Director of Children's Services, in consultation with the relevant Portfolio Holder and Head of Legal, to commence, negotiate and award any contracts/agreements or documents incidental to the School Capital Programme within the budget as set out in this report.**

Sarah Williams left the committee room at 7.53pm.

14. Council Spending Review Update

Kay Goodacre, Corporate Finance Officer, presented the report that summarised the main changes to the Medium Term Financial Strategy for the period 2017/18 through to 2019/20 and the governance structure for the Council Spending Review and Transformation Programme, including the budget planning table enabling agreement of the budget in February 2017.

The report updated the committee on the proposals currently being considered and what would affect the Children's Services budget.

The Officer briefed members on the strategy to close the budget gap which had been set out in the Medium Term Financial Strategy and would focus on 3 key areas:

- Income generation – increases to the Council's commercial trading base.
- Achieving more/same for less – further transformational projects and contract reviews.

- Demand management/early intervention – example given included the Local Area Co-ordinators.

A discussion between Members and Officer took place on the children's social care system due to the high of demand and how the reduction in the proportion of agency staff could reduce costs.

Councillor Redsell thanked the Officer for the report and stated that money was being spent by placing Looked After Children out of the borough and that the Council had to work smarter and intervention should take place earlier to ensure such savings.

Councillor Sheridan stated that the criteria for the recruitment of foster carers should remain strict and ensure that the right people were recruited. Rory Patterson agreed with Councillor Sheridan's comments and stated it was a crucial part of ensuring foster carers and potential carers were interested and motivated to do undertake the role.

Councillor Watkins asked when the proposed programme of change would happen. Rory Patterson stated that they were in the implement phase now with staff and partner with iMPOWER commissioned until December 2016.

Anne Sentance stated that it was good that the word was getting out and that best practices should be shared with those areas that have good foster carers and asked Officers what interaction there had been with these areas. Rory Patterson stated that Thurrock was part of the Eastern Region Group who meet regularly and were working together with Councils and regularly peer reviews were held.

RESOLVED

1. **The Children's Services Overview and Scrutiny Committee note the revised Medium Term financial Strategy position and the Council Spending Review approach and timetable.**

2. **That Children's Services Overview and Scrutiny Committee comment on the proposals currently being considered within the remit of this committee.**

15. Educational Attainments

Roger Edwardson, presented the report and stated that raising achievements in all areas of education remained a key priority and that the Council had seen a considerable success in the last four years as attainment and progress had risen significantly. Roger Edwardson briefly took Members through each of the Good Level of Development figures and charts.

A new curriculum was introduced in 2014 and a new assessment procedure had been introduced in 2015 which had resulted in the national curriculum

levels being abandoned and a new system with more rigorous tests being introduced.

The Officer reminded the Members all data in the report was provisional and stated that result comparisons could not be made between the previous year's data and the last academic year.

The Officer stated that there were concerns with the Good Level of Development between girls and boys.

The Chair asked the Officer what the abbreviation STA stood for. The Officer stated that this stood for Standards Testing Agency.

Councillor Watkins thanked the Officer for the report and praise should be given to all the schools concerned but stated that there was always room for improvement.

Councillor Watkins asked the Officer that the internal projections were for Children Looked After. The Officer stated that each Looked after Child had a Pupil Education Plan which was updated on a six monthly basis, the number of Unaccompanied Asylum Seeker Children had increased in this age bracket.

The Chair asked the Officer what reassurances were in place for those Looked after Children in out of borough schools to ensure that they were not being disadvantaged. The Officer confirmed that there was a restructure of virtual schools, the tracking of data and outcomes would be used and that social workers and colleges should be working better together.

Councillor Watkins asked why Looked after Children were going to out of borough schools. The Officer stated this was due to the lack of foster carers in the borough.

Councillor Watkins asked Officers what was in place going forward for the pupils entering into the Year 7 new curriculum. Roger Edwardson stated that many Year 7 pupils will know their KS3 teacher who will offer the recognition deserved.

Councillor Redsell thanked Officers for a very comprehensive report but did not agree with Roger Edwardson's concern regarding the good level of development for boys and that feedback received was that 15-16 year olds were not being told enough about career opportunities. Roger Edwardson stated that the internet could be used more to seek more career opportunities with adult support.

Sonny Tipping stated that Colourful Success was a large database of job opportunities, work experiences and apprenticeships which could be used for those looking for job opportunities.

Anne Sentance stated that parents played a crucial part of a young person's start in life but there was only so much a parent could do.

Anne Sentence stated that the nursery in Horndon on the Hill had closed due to the increase in rent set by Thurrock Council and asked Officer why no information and help had been offered to the nursery by the Council. Roger Edwardson stated he would look into this matter and report back to Members.

Councillor Redsell stated that this was happening a lot in the borough and concern seemed to be around protecting the building rather than protecting what's in the building.

It was also recommended by Roger Edwardson that he would write out to all schools to commend and thank them for their achievements.

Councillor Allen asked if bullying had been addressed at main stream schools. The Chair reminded Councillor Allen that reports on the Anti-Bullying Policy and Anti-Bullying Prevention at Primary Schools were already on the work programme.

RESOLVED

1. **That the Children's Services Overview and Scrutiny Committee noted the provisional outcomes of the summer 2016 tests and examinations and commends schools, pupils and parents/carers on their achievements.**

2. **That the Committee recognised that data could not be compared to previous years due to a change in curriculum and assessments.**

3. **That the Committee recommended that Roger Edwardson write to all schools to thank them for their contributions.**

16. Children's Social Care Complaints and Representations Annual Report 2015/16

The Officer presented the annual report for Thurrock Council on the operation of the Children's Social Care Complaints Procedure covering the period 1 April 2015 to 31 March 2016. The Officer stated that it was a statutory requirement to produce an annual complaints report on children's social care complaints.

The report set out the 289 representations received in the year which included the number of complaints, compliments, the key concerns and issues arisen from complaints, MP and members enquiries and enquiries made by the ombudsman. The Officer stated that many of the complaints were being resolved quickly and responsible at Stage 1 and that Thurrock Council had a good escalation process.

Anas Matin, the Statutory Complaints and Engagement Manager, stated that case studies were now being used for learning purposes to try and understand themes and provide the appropriate training where necessary.

Myra Potter left the committee room at 9.00pm.

Councillor Redsell stated that it was good that a large number of complaints had been resolved.

The Chair stated that it was good to have compliments and thanked all officers involved.

Anas Matin left the committee room at 9.03pm.

RESOLVED

The Children's Services Overview and Scrutiny Committee considered and noted the report.

17. Ofsted Inspection Report and Action Plan

Rory Patterson apologised that Andrew Carter was unwell and that he would be presenting the report.

Rory Patterson presented the report that provided members with information on the outcomes of the recent Ofsted Inspection where Thurrock had been judged as "Require Improvement" by Ofsted and that Thurrock had fallen back from the previous judgement of "Good" in 2012. The report was encouraging that it identified that children and young people were found to be safe in Thurrock during the time of the inspection. There were 16 recommendations from the inspection which related to the practice improvements required in Thurrock. The following areas of concern were brought to member's attention:

- Thurrock was dependant on a high proportion of agency social workers.
- The service for children looked after was not consistent.
- Too many children had become looked after on an emergency basis.
- An increase in the number of in-house foster carers was needed.
- Management oversight needed to be improved with supervision regularly undertaken.
- Training for social workers to ensure permanence work with children started earlier.

Rory Patterson referred Members to the draft Action Plan and stated that a structure would be in place to oversee the quality of the process. Ofsted would undertake a one day inspection to look at the action plan and follow the progress made.

Proposed changes would include:

- Annual self-valuations
- Judge on what Thurrock say about ourselves
- What could trigger an inspection

- Modular inspections
  Councillor Watkins thanked the Officer for bringing the report back and highlighting the steps to be taken forward.

RESOLVED

1. **That the Children's Services Overview and Scrutiny Committee noted the outcomes of the recent Ofsted Inspection, recommendations and draft action plan to address the recommendations.**

2. **That the Board received assurance that the action plan will deliver the required improvements.**

18. Work Programme

Members agreed the Children's Services Overview and Scrutiny Work Programme for 2016/17.

The Chair announced that the next Children's Services Overview & Scrutiny Committee clashed with the Staff Award Ceremony on the 8 December 2016 and recommended that the date for this committee be changed. Members agreed for Democratic Service Officer to look at suitable dates and advise Members accordingly.

The meeting finished at 9.15 pm

Approved as a true and correct record

CHAIR

DATE

Any queries regarding these Minutes, please contact Democratic Services at Direct.Democracy@thurrock.gov.uk

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20 December 2016	ITEM: 7
Children's Services Overview and Scrutiny Committee	
Ofsted Inspection Action Plan	
Wards and communities affected: All	**Key Decision:** To note Action Plan
Report of: Andrew Carter, Head of Children's Social Care	
Accountable Head of Service: Andrew Carter, Children's Social Care (CATO)	
Accountable Director: Rory Patterson, Corporate Director of Children's Services	
This report is Public	

Executive Summary

This covering report provides an update on the Ofsted Inspection Action Plan. A copy of the updated action plan is attached to this report.

1. Recommendations

1.1 That Children's Overview and Scrutiny consider the current progress and direction of travel in completing the required actions.

1.2 That Children's Overview and Scrutiny receive assurance that action plan will deliver the required improvement.

2. Introduction and Background

2.1 All local authorities in England are inspected under the Single Inspection Framework (SIF) within a three-year period. The Children's Safeguarding Board is inspected at the same time. The Ofsted inspection of services for children in need of help and protection, children looked after and care leavers took place between 22.2.16 – 17.3.16.

2.2 In response to the recommendations of the Ofsted Report the department has completed a detailed action plan. The action plan is attached to this report as Appendix 2.

3. Issues, Options and Analysis of Options

3.1 Services to children, young people and families in Thurrock were judged to 'Require Improvement' by Ofsted. The inspectors stated in their report that 'children and young people were found to be safe in Thurrock during this

inspection, with none identified who were at immediate risk of significant harm without plans and services being in place to reduce these risks and to meet their needs'.

3.2 Ofsted has made 16 recommendations in relation to practice improvements that are required in Thurrock. Key areas of concern included:

- The instability of the social care workforce. The service was dependent on a high proportion of agency social workers, although it was acknowledged that a range of creative ideas had been implemented to improve recruitment;
- The service for children looked after was not consistent and too many children became looked after on an emergency basis:
- More needed to be done to increase the number of in-house foster carers as too many children and young people were placed out of the borough;
- Management oversight needed to be improved and frontline staff had to be supervised regularly to improve the quality of practice;
- The organisation's use of management information and quality assurance was poor and this impedes improvement; and
- Training for all social workers to ensure permanence work with children starts earlier and that delay is avoided.

3.3 The draft Action Plan to address the recommendations made by Ofsted has previously been presented to Children's Overview and Scrutiny Committee, the Corporate Parenting Committee and the Health and Wellbeing Board.

3.4 A final copy of the Action Plan has been shared with Ofsted.

3.5 An improvement Board was established and has been meeting regularly to ensure that all of the recommendations and other areas for improvement have been implemented. The Board is chaired by the Corporate Director of Children's Services. The Portfolio Holders for Children and Adults and Education and Health will provide an additional layer of oversight and challenge through by monitoring progress against the action plan on a monthly basis.

3.6 Ofsted is currently consulting on a new inspection framework where it is proposed that those authorities who were judged Requires Improvement will receive another inspection within three years. In addition, it is anticipated that new modular inspections will be undertaken in the next year. These inspections are carried out over 2-3 days to test whether authorities are making the requisite progress with their improvement plans. Furthermore, social care departments will be expected to submit an annual self- evaluation to Ofsted which must evidence improvement. While this is discretionary, failure to do so could trigger a full inspection of the service.

3.7 Effective progress is being made across all areas of the plan and additional input is being provided to address those areas that require this to remain on track.

4. Consultation

N/A

5. Impact on corporate policies, priorities, performance and community impact

The completed action plan will allow the council to meet and improve upon its core statutory functions in the delivery of services for children in need of help and protection, children looked after and care leavers.

6. Implications

6.1 Financial

Implications verified by: **Kay Goodacre**
Finance Manager

There are no immediate financial implications for the authority arising out of the action plan.

6.2 Legal

Implications verified by: **Lindsay Marks**
Principal Solicitor, Children's Safeguarding

The Local Authority has a statutory duty to provide services to children in need of help and protection, failure to effectively do so could lead to legal challenges and reputational damage. The Local Authority is required to provide clear evidence of how it is implementing the inspection recommendations.

6.3 Diversity and Equality

Implications verified by: **Rebecca Price**
Community Development Officer

The local authority and its partners must ensure that a range of services and provision is in place to protect children from all backgrounds. In implementing the action plan the authority must ensure that improvements are made for children and young people from all backgrounds and that none are directly or in-directly discriminated against.

6.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

N/A

7. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

Ofsted Single Framework Inspection Report dated 24.5.16

8. Appendices to the report

Appendix 1 - Ofsted Single Inspection Report
Appendix 2 - Local Authority Action Plan - Final

Report Author:

Andrew Carter
Head of Service
Children's Social Care

Thurrock Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 22 February 2016 to 17 March 2016

Report published: 24 May 2016

Children's services in Thurrock Council require improvement to be good		
1. Children who need help and protection		Require improvement
2. Children looked after and achieving permanence		Require improvement
	2.1 Adoption performance	Require improvement
	2.2 Experiences and progress of care leavers	Require improvement
3. Leadership, management and governance		Require improvement

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

Services to children, young people and families in Thurrock require improvement. Children and young people were found to be safe in Thurrock during this inspection, with none identified who were at immediate risk of significant harm without plans and services being in place to reduce these risks and to meet their needs.

While there are pockets of good practice across all areas of children's social care, the majority of practice is less than good, specifically much of the core business regarding assessment and planning for children, securing a stable workforce, supervision and management oversight. In the last inspection of safeguarding and looked after children services in 2012, the local authority was judged to be good. Following this inspection, senior officers and leaders did not continue to ensure that children and families received consistently good services.

The local authority has addressed effectively almost all areas for improvement that were identified at its last inspection, including its response to referrers, access to a range of leisure activities for children looked after and implementation of early help assessments. However, the quality of assessments and plans for children in need, including children with a disability, those in need of protection, children looked after and care leavers, requires improvement.

The local authority appointed a new permanent head of children's social care in October 2014, a new chief executive in September 2015 and an interim director of children's services (DCS) in late January 2016, pending the swift appointment of their new DCS who is due to start in May this year. These appointments have been of highly skilled professionals who have demonstrated their positive impact on services in a relatively short time.

Most children benefit from early help provided by a range of strong commissioned services. Children who have more complex needs and require a coordinated response do not always receive such effective early help and support. The local authority does not ensure that all children who have been missing from home or care benefit from a return home interview after they have been missing. Children in need of protection receive a swift and appropriate service, but children in need often experience delay in seeing their social worker for an assessment of their needs. Children are not effectively supported to attend and participate in their formal review meetings. When these meetings take place, reports and minutes from previous meetings are often shared too late to be fully considered.

Children looked after do not receive a consistently good service, and too many become looked after in an emergency. The recruitment of foster carers is not resulting in an appropriate range of local placement options, and too many children live outside the borough, away from their communities, families and friends. Children looked after achieve well relative to their peers in the early years. Outcomes for children looked after at the end of key stage 2 have improved significantly, but are still below outcomes for all children. However, educational outcomes for children looked after who are taking GCSE examinations are poor. Personal education plans are not sufficiently detailed. The virtual school does not effectively monitor the educational progress and outcomes for the majority of children looked after who live outside the borough.

Waiting times for children with a plan for adoption are reducing. However, workers within mainstream social work teams do not consistently consider adoption for all children who cannot return home. Post-adoption support is insufficient for children and families who are entitled to this service. Care leavers receive good day-to-day support, but not enough young people are benefiting from staying put arrangements after they turn 18 years, and they do not all receive effective support to transition into adulthood. Pathway reviews are not being undertaken within timescales.

The local authority's use of performance management and quality assurance information across all areas of the service is poor, and impedes any improvement needed. Use of feedback from children and families to inform service development is underutilised. Accurate data regarding performance is collated, but managers do not analyse this data in order to inform service developments. There are weaknesses in the analysis of social workers' activity in relation to timeliness (for example, of multi-agency safeguarding hub (MASH) processes and assessments), the consideration of trends from return home interviews and 'children missing education' information, the overview and analysis of findings from audit, and the full analysis of key factors affecting services for children in need of protection and children looked after.

The instability of the workforce leaves services vulnerable. The local authority is fully aware of the workforce challenges and has a range of creative initiatives in place to address this in the longer term. Management oversight of frontline practice is inconsistent, with too many areas of weakness, and results in a lack of effective challenge to progress children's plans and effect change for children. Currently, the local authority does not systematically ensure that the workforce receives supervision of sufficient quality and frequency.

Some elements of services to children and their families have improved. The local

authority's Multi-Agency Safeguarding Hub (MASH), for example, is securing strong information sharing between professionals and robust decision making regarding appropriate services for children and their families. Management oversight within the MASH is very strong. Other improvements include the response for children who are at risk of child sexual exploitation, which reduces their risks. The authority has also substantially improved its offer to teenagers, the vast majority of whom receive a good service from the adolescents team.

Despite changes of key personnel, the local authority has greatly improved its corporate and cross-party political support for children's services. The local authority had a recent peer review of its corporate arrangements by the Local Government Association, which endorsed the strong working relationships seen during this inspection. Effective support from the political leadership is evident through the challenging overview and scrutiny function, and in the proactive Health and Wellbeing Board.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority operates no children's homes.
- The last inspection of the local authority's safeguarding arrangements was in June 2012. The local authority was judged to be good.
- The previous inspection of the local authority's services for children looked after was in June 2012. The local authority was judged to be good.

Local leadership

- The interim director of children's services has been in post since January 2016.
- The chair of the Local Safeguarding Children Board has been in post since August 2012.

Children living in this area

- Approximately 40,093 children and young people under the age of 18 years live in Thurrock. This is 25% of the total population in the area.
- Approximately 21% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 14% (the national average is 16%)
  - in secondary schools is 14% (the national average is 14%).
- Children and young people from minority ethnic groups account for 22% of all children living in the area, compared with 22% in the country as a whole.
- The largest minority ethnic group of children and young people in the area is Black or Black British.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 17% (the national average is 19%)
  - in secondary schools is 10% (the national average is 15%).

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data, where this was available.

- Thurrock has the highest rate of unaccompanied asylum-seeking children (UASC) in the eastern region: 20.7 children per 10,000 population. The number of UASC has doubled in the last 12 months. In December 2015, one in four children looked after was a UASC.

Child protection in this area

- At 22 February 2016, 1,609 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,563 at 31 March 2015.
- At 22 February 2016, 263 children and young people were the subject of a child protection plan. This is an increase from 201 at 31 March 2015.
- At 22 February 2016, two children live in a privately arranged fostering placement. This is a reduction from seven at 31 March 2015.
- Since the last inspection, four serious incident notifications have been submitted to Ofsted and five serious case reviews have been completed or are ongoing at the time of the inspection.

Children looked after in this area

- At 22 February 2016, 336 children are being looked after by the local authority (a rate of 87.2 per 10,000 children). This is an increase from 280 (70 per 10,000 children) at 31 March 2015.
  - of this number, 245 (or 72.9%) live outside the local authority area
  - 31 live in residential children's homes, all of whom live outside the authority area
  - one lives in a residential special school[3] outside the authority area
  - 238 live with foster families, of whom 65.1% live outside the authority area
  - five live with parents, of whom two live outside the authority area
  - 77 children are UASC.
- In the last 12 months:
  - there have been 18 adoptions
  - 25 children became subjects of special guardianship orders

[3] These are residential special schools that look after children for 295 days or less per year.

- 114 children ceased to be looked after, of whom 5.3% subsequently returned to be looked after
- 21 children and young people ceased to be looked after and moved on to independent living
- no children or young people ceased to be looked after and are now living in houses of multiple occupation.

Recommendations

1. Ensure that accurate performance data is analysed and that this leads to specific actions for improvement.

2. Strengthen oversight, coordination and quality assurance of early help services to ensure that children and families are receiving the right support at the right time.

3. Ensure that assessments and plans for children are of a consistently high quality.

4. Improve the offer of return home interviews to children and young people who have been missing from home or care to increase take-up of these interviews.

5. Ensure that more children are supported to participate in, and contribute to, their meetings, conferences and reviews, that they and their parents have access to reports beforehand, and that meeting minutes are circulated promptly.

6. Ensure that robust arrangements are in place to reduce the need for children and young people to become looked after in an emergency.

7. Ensure that the recruitment of foster carers is appropriately targeted, better to meet the current and future demand for foster placements, and to reduce the number of children looked after who have to be placed out of the borough.

8. Ensure that personal education plans are of a consistently high standard and that the virtual school monitors and analyses effectively the progress of all children looked after, including those who attend schools outside of Thurrock.

9. Ensure that managers oversee and drive forward permanence plans for children effectively.

10. Develop post-adoption support arrangements to ensure that all children and families who are eligible have access to an appropriate service.

11. Ensure that an effective 'staying put' policy makes it possible for more young people to live with their former foster carers beyond the age of 18 years.

12. Ensure that pathway assessments and plans are developed to engage care leavers effectively, and that care leavers benefit from regular reviews.

13. Ensure that care leavers are supported to gain independence skills effectively, including through the setting of aspirational targets to help them to achieve educational and employment goals.

14. Secure a more stable workforce to ensure that children are able to build enduring relationships with social workers and to enable the local authority to drive through improvement to services, such as increasing early planning for permanence for children that starts at the front door.

15. Ensure and demonstrate that children's and families' views and feedback are used well to shape service developments.

16. Regularly audit supervision files to ensure that frequency and quality of supervision are resulting in improved practice.

Summary for children and young people

- Services to children and families in Thurrock require improvement. This means that the local authority has not maintained the quality of services since its last inspection in 2012, when services were judged to be good.
- Managers do not effectively use the information that they have about the performance of children's social care to understand what is going well or less well, or to help them to plan relevant improvements to services.
- Early help to children and their families is often helpful when only one service is involved. However, when children's needs are more complex and several services need to be involved to help them, these services do not always work well together to provide effective help to children.
- Most children who need a social worker are properly referred for this service. However, there are a small number of children who experience increasing levels of need and risk, and are not referred for a social work service quickly enough.
- The council set up a new team in 2014 to manage referrals for children: the multi-agency safeguarding hub (MASH). This team is doing some very good work. There is a range of professionals from different agencies within this team and they work closely together to share information and make good decisions about who should be working with children and families to meet their needs.
- Children who need immediate protection are seen quickly, and professionals work well together to make sure that any immediate risk is reduced. For those children who are in need, there is often a delay in seeing their social worker.
- The quality of assessments and plans for children, including those in need of protection, those who are looked after and care leavers, are not good enough. Managers do not monitor social workers and the progress of plans well enough, which means that there is sometimes a delay in things changing for the better for children and their families.
- The vast majority of teenagers receive a good service from the adolescents team. They have detailed assessments of need and effective plans.
- Younger children looked after are doing better at school, but most teenagers looked after are not supported to achieve good grades in their GCSEs.
- Although improving, there is still some delay for children who are being adopted.
- Managers have worked well to make sure that children who are at risk of child sexual exploitation receive a good service that reduces their risk.
- When children have been missing, return home interviews help them to talk through any issues. However, not all children receive an interview.
- There is a Children in Care Council, but managers and politicians need to do more to make sure they listen to the children and care leavers of this council.

The experiences and progress of children who need help and protection	Requires improvement

Summary

Early help commissioned services are effective and underpinned by a comprehensive early help commissioning strategy. However, oversight and monitoring of early help is not fully developed, so not all children and families receive early intervention and coordinated services at the time that they need it. Thresholds across early help and children's social care are not always applied appropriately, leading to delays in a small number of children and families receiving timely support.

Strong multi-agency partnership working ensures that urgent responses to protect children are established through the multi-agency safeguarding hub (MASH). Contacts are progressed quickly and receive effective management oversight, and appropriate consent is obtained from families.

The majority of social work intervention for children in need requires improvement. There are some examples of more positive practice, but this is inconsistent across the service. Weaker practice is particularly evident in assessments, planning and driving change for children. High caseloads and frequent changes in staff in some teams have had an impact upon relationships with children and families. For a minority of children, this means that change to meet their needs or reduce risk is not always timely or sustained.

A few children experience delays in being seen for an assessment of their needs. Feedback and advocacy for children and young people are not routinely used, and not enough children are supported to attend meetings. Plans are neither proactively driven forward to improve outcomes nor specific enough for families to know how to improve their circumstances.

Risks relating to child sexual exploitation are responded to well, and risk assessments tools are used effectively to reduce risks to children. Responses to children missing are inconsistent. Not all children receive a return home interview, and records from these are not always uploaded into children's records. When completed, return home interviews are of good quality.

While there is detailed oversight of individual children missing education and children electively home educated, the local authority does not routinely analyse and evaluate the data on them to respond to trends or to inform service development.

Inspection findings

17. A comprehensive early help commissioning strategy is in place, and appropriate early support is available for most children and families. This includes an effective range of commissioned services which are leading to improved outcomes for children and their families. Although all universal services are signed up to the offer of early help across the local authority area, children's centres and health visitors currently underuse early help assessments to inform their work with children and families. This means that they are not effectively coordinating early support for children and their families with other agencies.

18. When children and families with more complex needs require a coordinated early help response by more than one agency, there is some variability in practice. For most children, the local authority's early help team oversees these cases effectively, providing support to lead professionals, and makes good use of the multi-agency group (MAG) panels in the locality to clarify additional support needs for children and their families, and to signpost relevant services. For a small minority of children, there is insufficient monitoring and quality assurance of the early help offer, which results in a lack of assessment and a lack of a successful offer of help. The local authority recognises that coordination and oversight of early help are an area for improvement. It is currently exploring relevant options to achieve this (Recommendation).

19. Thresholds are understood, and are being appropriately applied in the large majority of cases, which means that children's and young people's needs are effectively risk assessed and their cases stepped up to children's social care when required. However, a small number of children do not receive the right help at the right time, or help that is proportionate to their needs and risks. During this inspection, a small number of cases were raised where children would have benefited from receiving a social work service rather than early help. The local authority responded swiftly and robustly to ensure that these children's needs and risks were being appropriately recognised and addressed. Parents spoken to by inspectors shared their frustration at not receiving support in a timely way. Conversely, some children who could have received appropriate support though provision of early help have received a statutory service.

20. Effective step-down arrangements between children's social care and early help are not consistently in place. A lack of continuing oversight of children's cases that have been stepped down means that the local authority cannot be assured that all children continue to receive services that promote their welfare via early help after closure to children's social care. During this inspection, no children

were identified to be at immediate risk of significant harm without services in place to reduce risk and meet their needs.

21. The MASH provides a strong response to referrals for early help, troubled families and children's social care. Contacts made using early help assessments are variable in quality, with a minority lacking basic information that is needed to inform decisions fully regarding the most appropriate response. For children in need of protection, strategy meetings are identified swiftly and prioritised for urgent action.

22. The troubled families programme in Thurrock is successful. All 360 families in phase one were helped to turn around much earlier than the target deadline. Managers have set a target to build upon existing success, with a further 1,160 families being helped by 2020. Recently, a frontline troubled families worker has been based in the MASH to identify eligible families actively and to make sure that they receive a timely response. The proactive way in which the local programme is prioritising children with child protection and child in need plans is providing additional practical support to these most complex families.

23. Strong multi-agency performance and information sharing has enabled the MASH to respond to 96% of contacts within 24 hours over the past six months. Good use is made of risk assessment tools and children's family history, alongside clear management oversight and direction in all cases. Professionals obtain appropriate consent from families and, where the need for consent is overruled for the protection of children, the reasons for this are clearly recorded. Appropriate feedback following contact is provided to referrers in order to share the actions taken to promote children's welfare. An experienced and stable emergency duty team ensures that immediate responses to safeguard children out of office hours are effective. The MASH has a good reputation with professionals, who praise the holistic approach taken in responding to children's needs, the advice available to professionals and the range of information collated to help inform decisions to safeguard children.

24. When children need protecting, strategy meetings are timely and include professionals from an appropriate range of agencies. Development of the MASH has helped to secure routine engagement from health and police professionals in strategy meetings. This means that intelligence about risks to children is shared effectively, and demonstrates a real shared ownership of decisions to keep children safe. In a small number of cases, not all key professionals participated in strategy discussion to inform decision making, although minimal impact on decision making for individual children was seen during this inspection. However, the large majority of children in need experience a delay

in being seen after allocation by children's social care, including after a step up from early help. Additionally, some teams have high caseloads and have had many changes of staff, which means that not all children and families were able to develop trusting relationships with workers.

25. The large majority of child protection investigations are thorough, timely and informed by information gathered from relevant professionals and children's histories. Children are seen, and parental involvement and views are appropriately obtained. Responses to safeguard children are proportionate to risks identified, and effective actions are taken to ensure their safety and welfare.

26. Developments to safeguard children at risk of female genital mutilation, as part of a Department for Education-funded innovation project, are beginning to improve awareness of this safeguarding issue across agencies. Referrals to the MASH have increased since December 2015, but further awareness raising is needed to ensure that all children who may be at risk of female genital mutilation in the local authority area are identified and appropriately supported.

27. Assessments of children's needs, risks, strengths and wishes vary in content and quality. Most assessments do not identify the impact of risks or family history for children well, and only a minority fully explore the child's experience. Consideration of identity, diversity and cultural needs, or how these can increase children's vulnerability, is inconsistent, and these needs are identified only in a small minority of assessments. These include assessments completed for children with disabilities, where evidence that social workers know the children well is not always clear and the impact of disability on children's identity is not fully addressed. Too few assessments contain the views of children. Their experiences do not routinely inform decisions made for them. Although there are systems in place to review the progress of assessments, these are not robust. A lack of management oversight contributes to drift in achieving change for a minority of children (Recommendation).

28. Child protection conferences are well attended by relevant agencies and include positive multi-agency engagement. Families do not always receive child protection reports in time to be able to prepare adequately for meetings, and advocacy is not routinely accessed for those families that would benefit from additional support. Children's assessments are used for initial and review conference reports, but do not always clearly record what changes and actions have been taken or progressed to safeguard children. The local authority is reviewing this, but a new process is not yet in place (Recommendation).

29. Child in need and child protection plans do not consistently address children's needs and are variable in detail. Half the plans seen require improvement to ensure that clear outcomes are identified and specific outcome targets set for individual children. In a small minority of cases, poor management oversight has led to drift in plans being progressed, and they are not updated following reviews. Few plans seen by inspectors showed evidence of strong management oversight and direction. However, core groups are held regularly, and are appropriately attended by parents and the relevant professionals in order to review and progress plans. When cases transfer between teams, risk assessment tools are appropriately used to identify actions, and appropriate challenge by managers is evident (Recommendation).

30. Positive and focused work with most teenagers and their families is completed by the adolescents team. This includes effective use of the child sexual exploitation risk assessment and adolescent neglect tool, when relevant, to support young people in need, including those in need of protection. Clear, directive and creative plans help professionals to prevent family breakdown and provide effective direct work with young people.

31. At the time of inspection, 263 children were subject to child protection plans, which is a substantial increase from the 201 who were subject to a plan at 31 March 2015. Managers have explored the reasons for this increase and appropriately identify that it is in response to stepping-up cases where no meaningful change or reduction of risk for children was being achieved at the child in need level. During this inspection, no children were found to be subject to child protection plans who did not require this level of statutory intervention.

32. At the time of this inspection, there were 125 children subject to child protection plans due to risk of emotional abuse, 120 due to neglect, six due to risk of physical abuse and 12 due to risk of sexual abuse. The local authority removed the category of multiple abuse by the end of January 2016 after a review revealed that the category was masking information regarding the risk of sexual abuse. This led to an increase in children who were subject to child protection plans for risk of sexual abuse, from 1% to 5%, since March 2015. There has also been an increase in the use of the category of emotional abuse, from 26% to 48% in the same period. The local authority is appropriately reviewing this in order to gain a fuller understanding of the issues leading to this increase. Effective child protection surgeries with senior managers are held in order to review progress and to reduce risk for children who have been subject to child protection plans for a nine-month period or longer. The additional oversight provided by these surgeries has helped the local authority

safely to manage down the number of children remaining on child protection plans for over two years.

33. Social workers recognise and respond well when children are at risk of sexual exploitation. Good use is made of the pan-Essex risk assessment tool to identify those who are most at risk. This leads to strategy meetings for those with complex needs to share information and to develop a strong, coordinated, multi-agency response for individual children. The child sexual exploitation coordinator provides social workers and managers with effective challenge, advice and guidance. Although the local authority currently keeps separate data in respect of children missing from home, school or care, and those at risk of child sexual exploitation, the operational risk assessment group rigorously cross-checks data against the most recent list of children reported as missing to the police to ensure that individual children are safeguarded and protected. However, the group is not using data collected from return home interviews to inform planning for these vulnerable children.

34. Appropriate referrals are made to a commissioned service to deliver return home interviews, but the large majority of children decline the offer of a return home interview after they have been missing. When they are completed, the return home interviews are rich in information about the child's life, home circumstances, who their friends are and places where they like to go. However, these records are not reliably uploaded to children's local authority records. This limits the potential use of this information to plan actively to reduce risk for children and young people (Recommendation).

35. The local authority has developed a range of good initiatives to help children and young people, including children looked after, to keep themselves and others safe from issues such as from bullying and online grooming. Successful projects such as 'Show racism the red card' are used in schools to deliver key messages about hate crime and 'Prevent'. An e-safety project has reached a number of troubled families, helping to make parents aware of potential dangers online.

36. A consultant practitioner provides expert advice to social workers in supporting children and families where parental substance misuse or mental health issues are a feature. This includes advice on hair strand tests and reports for court processes, to ensure that all risks to children are appropriately identified.

37. Children and young people aged five to 16 years who are experiencing domestic abuse within their families have access to domestic abuse support groups that are innovative, fun and creative. These groups support children to understand their rights, protect themselves and learn new skills. Appropriate

referrals are made to the multi-agency risk assessment conference (MARAC), where positive attendance, engagement from a range of agencies and clearly recorded safety plans ensure that effective actions are in place to protect children and adults.

38. Homeless 16 and 17 year olds who are identified as vulnerable or living in unsuitable accommodation are effectively assessed, and provided with accommodation if they are found to be in need. Those young people who do not wish to become looked after are appropriately supported through a joint protocol between housing and children's social care for homeless young people. They are provided with expert mediation from the homeless intervention project to assist them to return home, or they are provided with hostel accommodation with additional support from a commissioned provider. Bed and breakfast accommodation has not been used for the past two years.

39. There are 79 children missing education, including those who are in alternative education but not receiving their full 25 hours per week offer, with the number being reduced each month. A rigorous system is in place to monitor children missing education, and effective monthly strategic meetings on children missing education involve key professionals and their managers to focus on all children missing education. The local authority assures itself that children have a suitable school place and are confirmed as attending before it ceases its monitoring. Vulnerable children, including unaccompanied asylum-seeking children and those in Years 10 and 11, are discussed at detailed monthly inclusion panels. Here, the headteachers of secondary schools explore who can provide the best place for each individual child.

40. There are currently 173 Thurrock children who are electively home educated. The local authority actively reviews all children who are electively home educated at the monthly strategic meetings on children missing education. This includes checking the information that they hold to ensure that children are not at risk and that they have been seen, and to identify when a conflict with school can be resolved. A 'traffic light' system is used to flag families on this list that may need additional support. The local authority does not sufficiently analyse and evaluate the data about children missing from education and those who are electively home educated to find out if there are particular trends, for example if numbers are increasing or decreasing, or to consider fully why this may be (Recommendation).

41. Notifications about private fostering arrangements are responded to within statutory timescales and, in the large majority of cases, are subject to robust scrutiny to ensure that children are safe. Children are seen and visited

frequently, with their views and wishes recorded in private fostering assessments. Neither proactive engagement with community faith groups nor awareness raising with professionals and the public have increased notifications. These are very low, and only two children are currently being supported as privately fostered children.

42. The local authority's response to allegations against professionals working with children are effective and timely. Referrals and management planning meeting minutes clearly record risks to children and the actions to be taken. All planning meetings are well attended by appropriate agencies in order to share relevant intelligence and information, and to ensure that children are protected. Officers efficiently track the progress of investigations and plans.

43. The 'Prevent' duty has a high profile in Thurrock as a result of cooperative working relationships through the community safety partnership. Multi-agency working is supported by a clear 'Prevent' strategy and a thorough action plan that has recently been refreshed. A helpful practitioner guide for direct work with young people was used well with 14 young people in the past year. An excellent equality impact assessment underpins the 'Prevent' agenda. There is strong collaboration between agencies, including the Local Safeguarding Children Board (LSCB).

The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

Greater persistence is required to translate senior managers' goals into improved outcomes for all children looked after. Most become looked after in an emergency, including unaccompanied asylum-seeking children (UASC). The recruitment of foster carers needs to be better targeted. The fact that most children looked after live outside of the borough is having a significant impact on social work time, energy and resources. This is contributing to the generally poor quality of assessments and plans. Children's electronic case files are often incomplete. Family group conferences are not used fully, and the use of the public law outline is not consistently well recorded. The quality of pre-proceedings letters is variable. Assessments completed in support of care or adoption proceedings are generally of a good standard. The length of care proceedings has been reduced, and most are completed within 26 weeks. Good use of special guardianship is providing long-term stability for children and young people.

Most children live in settled and stable placements, but the staying put policy is not yet successful in achieving stability for young people post-18. Good attention is paid to children's health and emotional well-being. Reviews are regular, but children and families do not routinely see social workers' reports beforehand, and there are significant delays in distributing review meeting minutes. Not enough is done to support children to contribute to and participate in their reviews. Children looked after who are at risk of sexual exploitation receive effective help. The response for children who have been missing is inconsistent, and one in five are not offered an interview to explore their issues. The virtual school is not effectively evaluating the educational progress of children looked after. While the gap in attainment between younger children looked after and their peers is narrowing, very few young people looked after achieve five good GCSEs.

Adoption is not routinely considered at the earliest opportunity for all children who cannot safely return home. Once children have a plan for adoption, timely progress is made in recruiting and matching them with adoptive families. Further work is required to improve the volume and range of post-adoption support.
Assessments of care leavers' needs and subsequent plans are not sufficiently detailed and their style does not engage young people. Not all care leavers are supported to gain relevant independence skills. Care leavers do benefit from good day-to-day support, live in safe and suitable accommodation and the number of care leavers engaged in education, employment or training has increased.

Inspection findings

44. Children become looked after when risks increase and they need to be safeguarded and protected. The local authority responds positively to the needs of unaccompanied asylum-seeking children (UASC), who currently account for 23% of the children looked after population. However, too many children come into care in an emergency. These include UASC, for whom it is often not possible to forward plan. However, emergency placements are potentially traumatic for children and undermine the local authority's ability to match them with suitable placements (Recommendation).

45. The number of children looked after has increased from 280 at 31 March 2015 to 336 at the time of this inspection. In a small number of cases, inspectors saw evidence of the local authority having missed the opportunity to prevent family breakdown because it had been slow to intervene. However, when the vast majority of children return home, robust arrangements are put in place to ensure that they are appropriately safeguarded and protected.

46. The local authority is making extensive use of the public law outline, but this is not always well recorded, and the quality of pre-proceedings letters is variable. Some letters identify issues and concerns clearly and concisely, and explain in plain and simple language what needs to change. Others are over-complicated and include jargon and acronyms, which makes them less easy for parents to understand.

47. The creative potential of family group conferences (FGCs) to explore and develop family-based solutions is not being fully realised. FGCs are only used in cases where the public law outline has commenced, and there is a waiting list for this service. As a result, when cases come to court the local authority frequently finds itself under pressure to complete multiple viability assessments.

48. In the last nine months, the weekly threshold panel has become increasingly influential in overseeing potential placement decisions for children looked after. However, it does not retrospectively review all emergency placements, and this limits the local authority's ability to learn from these cases in order to reduce the number of children who become looked after in an unplanned way (Recommendation).

49. The majority of assessments require improvement. Inspectors observed delays in starting assessments, particularly in the case of UASC and older assessments that had not been updated. Assessments completed in support of care or adoption proceedings are generally of a much better standard. Almost all are

timely, take good account of historical issues and concerns, and are strong on analysis (Recommendation).

50. In the majority of cases, children are seen alone by their social worker, the views and experiences of the child are well recorded, and there is good observation and analysis of children's behaviour and interactions, and purposeful direct work. In a minority of cases, there is evidence of poor recording, lack of focus, historic gaps in the pattern of regular statutory visits and, in the case of UASC, delays between children becoming looked after and being seen by a social worker. In 2015, high staff turnover made it difficult for children and young people to build and maintain meaningful relationships with their social workers, and this contributed to drift and delay. According to foster carers, since then the appointment of a number of newly qualified social workers with protected caseloads has made a significant difference. Improved stability of social workers within the children looked after social care teams now means that frequent changes of social workers are now the exception rather than the norm.

51. Until very recently, social workers have not been sufficiently proactive in identifying children, particularly those who are estranged from their families, including UASC, who would benefit from having an independent visitor to befriend, advise and support them during their time in care. Between April and December last year there were 106 requests for advocacy support, all of which were met. Currently, however, nearly half of children looked after who are old enough to do so do not participate in or contribute to their reviews. The local authority has also recognised that further work is required to ensure that children and young people know how, and feel confident to, provide feedback on the services that they receive (Recommendation).

52. While good understanding and awareness of child sexual exploitation, and the need to safeguard and protect children who go missing from care, ensure that risks are identified and assessed, one in five children looked after who go missing are not offered a return interview. The local authority recognises that this is not good enough and is appropriately planning to address the problem (Recommendation).

53. Progress has been made in promoting the health and well-being of children looked after, as evidenced by improved performance figures. For example, dental checks are up from 84% in 2013–14 to 93% in 2014–15, and in 2014–15 86% of children looked after were to up to date with their immunisations compared to only 57.8% the year before. However, confusion about referral pathways and delays in completing the necessary paperwork mean that the

timeliness of initial health assessments (IHA) is still a cause for concern. While the issue is being actively addressed, as of 1 March 2016 approximately 20% of children looked after who were eligible for an IHA assessment were waiting for an appointment and a further 20% were waiting for the necessary paperwork to be completed. This is not acceptable, particularly given the high number of UASC who may not have had their health needs assessed for some time.

54. The local authority and its health partners are developing a more responsive approach to the emotional well-being and mental health of children and young people, including children looked after. Since 1 November 2015, children and families are able to self-refer to a single point of contact. Here, they are offered an effective weekday triage service resulting, for the most vulnerable, in an immediate response from the crisis team, or, in the case of those whose needs are less urgent, in timely clinic-based appointments. Six-weekly looked after children surgeries, chaired by the head of service, make sure that, after initial health assessments have been completed, the education and health needs of children looked after are met.

55. Although 87% of children looked after attend a good school, the virtual school does not consistently analyse and evaluate the information that it collects on the educational progress of children looked after, particularly the 73% of children looked after who attend schools outside of Thurrock (Recommendation).

56. In 2014/15, 80% of children looked after reached a good level of development at the end of the early years foundation stage (EYFS) and performed better than their peers overall. During the same period, the number of children looked after who attained a level 2B+ at key stage 1 in reading dropped to 70% and in writing to 50%. However, the most recent, unvalidated data suggests an improving picture at the end of key stage 2 with 89% of children looked after making the expected two levels of progress between key stage 1 and key stage 2. Although slightly below the average for all Thurrock children, the gap in attainment in reading, writing and mathematics at the end of key stage 2 is closing. The corporate parenting committee has identified the attainment of young people looked after at the end of key stage 4 as a cause for concern. Very few young people achieve five A* to C grades, including maths and English, at GCSE. The prediction that 15% of Thurrock young people looked after would achieve five A* to C grades in 2015/16 has been reduced to a prediction of 10%.

57. The quality of personal education plans (PEPs) is not good enough. The better ones include clear targets with measurable success criteria, and capture the

child's voice and foster carers' views well. The minority that are less good lack key information, include targets that are general rather than specific, and are not always sufficiently individualised for brothers and sisters. While 90% of compulsory school-aged children have a PEP, only 76% of those in Year 12, and 69% in Year 13, have one (Recommendation).

58. When children looked after are missing education, prompt action is taken to find a suitable school place for them. Currently, four school-aged children looked after are missing education. Two of these are not in receipt of full-time education and are accessing suitable alternative part-time provision or tutoring, as part of agreed plans to support them back into full-time education as soon as possible. For the remaining two children, the local authority is working proactively to identify an appropriate education place.

59. Most children looked after live with families. Only 31 (9%) live in residential care. A service level agreement with Essex County Council increases access to foster placements within a reasonable distance of Thurrock. The local authority is aware that it needs to improve long-term stability for children looked after, but inspectors found that most children are living in settled placements.

60. The large majority of placements are of a good standard and are meeting children's needs. Good communication and liaison between carers, placements, schools and social workers ensure that packages of support, sometimes involving a range of different agencies, are well coordinated. Children looked after are encouraged and supported to maintain contact with their birth families, where applicable. In most cases, contact arrangements are clear, appropriate and well recorded. Children looked after are encouraged and supported to participate in social and leisure activities. However, while the local authority has a formal scheme of delegation, it is not being used. In practice, foster carers contact social workers for permission for children to participate in everyday activities. This is wasteful of social workers' time, unhelpful for carers and potentially intrusive for children.

61. The quality of care plans varies considerably. Although most focus on outcomes, the majority are over-lengthy and are neither sufficiently specific nor measurable. This makes it difficult for children looked after to understand or own their plans and, in some cases, contributes to drift (Recommendation).

62. The majority of reviews are timely, purposeful, well attended and well recorded. Independent reviewing officers (IROs) are knowledgeable and experienced, and know the children well. They are concerned by and continue to challenge the fact that children and families do not routinely have the opportunity to read social workers' reports or view proposed changes to their

care plans before their looked after reviews. This is disempowering as well as disrespectful for children. Delays in circulating review meeting minutes are contributing to drift and delay. They also mean that children looked after, and those who are caring for them, do not have ready access to the decisions taken and actions agreed at their reviews. The backlog, which is substantial, is due to a combination of relatively high IRO caseloads and a lack of administrative support, exacerbated by the number of children who are living out of borough (Recommendation).

63. With refreshed marketing and publicity materials, the fostering team has recently renewed its efforts to attract potential foster carers. In the absence of any specific recruitment targets, the general focus is on increasing the number of in-house foster carers who are able to foster older children, and brothers and sisters together. It is too early to evaluate the full impact of the recruitment campaign, but there is evidence of some success in recruiting new carers. The number of expressions of interest in fostering have increased and, in October 2015, Thurrock had 96 fostering households, up from 85 in March 2015 (Recommendation).

64. Prospective foster carers are assessed thoroughly. In-house foster carers are well supported, have good access to training and are subject to rigorous annual household reviews. With training accredited by the University of Essex and support from a clinical psychologist, a skilled group of therapeutic foster carers provide high-quality placements for children who might otherwise need residential care.

65. The quality of evidence and legal applications is generally good. Positive working relationships with the Child and Family Court Advisory and Support Service (Cafcass) and the judiciary are helping to drive down the average length of care proceedings, which has fallen significantly. The large majority are now completed within 26 weeks. This means that children do not have to wait longer than necessary for key decisions to be made about their futures.

66. Achieving permanency is not always clear or straightforward for children, with evidence of delays in some cases and plans being changed significantly in others. In the absence of full engagement from the frontline teams to achieve earlier permanence, the drive and ambition evidenced by middle and senior managers is not yet consistently evident. Inspectors observed a lack of urgency in some cases. The local authority continues to make good and effective use of special guardianship orders (SGOs) to make it possible for children to live with extended family members when it is not safe for them to return to live with

their birth parents. In the last 12 months, 25 children became the subject of an SGO.

67. Staying put arrangements, which enable care leavers aged 18 and over to continue to live with their former foster carers, are not yet fully developed. Only seven young people are living with their former foster carers as part of a staying put arrangement. Lack of certainty about their future is a potential source of anxiety for young people and their carers (Recommendation).

68. The generally poor quality of chronologies makes it difficult for children and young people to understand their life stories. The quality of case records is variable. Key documents including, for example, threshold panel minutes, return home interviews and pre-proceedings letters are not consistently being uploaded to the electronic case record system. This has significant implications for children, if and when they choose to access their records.

69. A small but active Children in Care Council is having an impact. For example, members of the council have been involved in the recruitment of social workers, and in reviewing and refreshing the pledge. They are particularly proud of having managed to secure a commitment from senior managers to include passports, savings accounts and life story work within the new pledge. However, disillusion has led to some young people leaving the Children in Care Council. Currently, the council has very little contact with the many children looked after who are living more than 20 miles outside the borough.

70. In the majority of cases, the service that children and young people receive is sensitive to their individual needs and unique identities. However, social workers are not always sufficiently creative or imaginative in overcoming barriers to communicating with children with disabilities.

The graded judgement for adoption performance is that it requires improvement

71. Adoption is not always considered for all children looked after who are unable to return home. There are initial delays in progressing plans, and early opportunities to secure the child's permanency arrangements have been missed. Consequently, some children have lived with uncertainty for too long. However, it is evident that permanency arrangements for children, either through adoption or SGO, are progressed with a greater degree of urgency once the case is transferred to the permanency team (Recommendation).

72. There has been an increase in the number of children being adopted in Thurrock, from 13 in 2014–15 to 18 in the year to date. Managers are actively working to raise the profile and consideration of adoption and permanence in frontline teams through training, inter-team seminars and case tracking. However, it is too early to see the impact. An adoption and permanency case-tracking tool is also used to improve timely progression through children's social care to adoption. Its effectiveness is limited, as dates and details are not included or updated for all children on the tracker to enable them to benefit from this extra scrutiny.

73. The local authority is committed to pursuing adoption as an option for children with complex needs, and has successfully secured adoptive placements for children with disabilities or who have special needs, brother and sister placements, and a young person in their teens. In the last year, the local authority appropriately rescinded the decision of placement for adoption for one child.

74. There has been an improvement in the length of time that children wait from the date at which they enter care to when they are placed for adoption. For the 2012–15 three-year average this was 625 days, which is 85 days shorter than the 2011–14 period (710 days). However, this figure, while showing a speedier process, is greater than both the national average of 593 days and the government target of 487 days. Similarly, after the court makes an order for a child to be placed for adoption, the local authority now takes less time to place the child in an adoptive family. For 2012–15, this was 186 days, which was 58 days shorter than the 2011–14 period. This is shorter than the national average of 223 days, but longer than the government target of 121 days.

75. The positioning of the adoption family-finding social worker in the permanency team has strengthened parallel planning. A greater sense of urgency is now

being applied to reduce the time that children have to wait before being matched with a suitable family. The local authority has been proactive, and currently 10 children are subject to placement orders and waiting for adoption. One is still in the family-finding stage, six have already moved in with families and three children are linked to prospective adopters, awaiting panel decisions regarding the match.

76. Children are prepared well for adoption. A complete picture of the child, their views and needs are captured well in child placement reports in order to facilitate a positive match with prospective adopters. Detailed introduction plans, although intense for carers, maintain a clear focus on the child. Well-managed arrangements achieve a seamless transition for children into their adoptive families. However, the lack of timeliness in completion of children's life story work in 2015 limited the effectiveness of this work.

77. The recruitment and assessment of potential adopters is thorough and rigorous, and adheres to national regulations. All assessments, including prospective adopter reports, are of a good standard, sufficiently detailed and informative. Adopters spoken to described their experiences as 'stressful', 'rewarding' and 'challenging'. However, prospective adopters waited between seven and 10 months for approval. There has been a lack of clear feedback to adopters across all stages of the recruitment and assessment process, and adopters said that this caused them unnecessary anxiety and stress.

78. The adoption panel is made up of representatives with relevant personal and professional experience of adoption. The panel has appropriately identified areas for improvement in relation to the quality of the medical contribution, quality assurance and support. Improvements in these areas would help to ensure that cases were better prepared for panel and avoid unnecessary delay. The head of service, in his role as agency decision maker, provides oversight and examination of panel information, and his decision-making is clear, concise and timely.

79. The local authority completed a comprehensive appraisal of its adoption services for children and has established a detailed action plan to address the challenges for the service. For example, weaknesses include a lack of 'foster to adopt' and concurrent placements, and the requirement of placements for brothers and sisters and older children who do not match many of the prospective adopters' profiles. As a result, the recruitment, assessment and approval of prospective adopters moved to a commissioned service in October 2015. Thurrock's new and prospective adopters (eight approved, four at stage two, three at stage one and 27 enquiries) have moved to the commissioned

provider, and this transition has been well managed. There is emerging evidence of these new arrangements making a difference, with two children and their prospective carers soon to be presented to panel for matching.

80. Potential adoptive families are provided with effective support when children are first placed. However, once an adoption order has been secured, support is less developed and the range of services are limited. Adoptive parents are not clear about their future entitlements or what support could be available. Over the past year, only 11 families have received post-adoption support, with eight to 10 adults (total 20) attending bi-monthly group support sessions. Support offered includes bereavement support, direct work with children, life story and therapeutic play/work. The quality of this work is valued by the children and adults, but the number receiving support is too low. Thurrock is not meeting its responsibility to ensure that adoption support is available to all adoptive children and their parents living in their area. Inspectors were informed of seven adoption breakdowns for children who were previously adopted through other local authorities but who now live in the borough and are the responsibility of Thurrock. Workers with these young people failed to recognise the need to refer them to the adoption support service or to offer specialist adoption support, which they are entitled to (Recommendation).

81. The local authority provides an impressive support group for adoptive children. This gives them the opportunity to meet regularly, share experiences, gain confidence and learn from each other. Letterbox arrangements for 152 children are in place and effective; birth parents and adoptive parents are supported to maintain agreed levels of contact. Specialist support is also beginning to be secured through good use of the adoption support fund. Since November 2015, 17 applications have been made, nine of which have been successful, primarily for therapeutic counselling support. Five further requests are awaiting an outcome. Adoption support for new carers will be provided by the new commissioned provider. It is too early to evidence the impact of this new offer.

82. The local authority supports families with SGOs well and provides financial support to 133 children's special guardians at the same level as its foster carers. Following the commissioned provider taking over the support of adoptive carers, the adoption support service now has some capacity and has extended its support offer to special guardianship carers and their families. While it is still an emerging offer, the local authority successfully engaged 28 special guardians in a three-day workshop in March 2015, and it has a plan in place to provide regular support groups for adult carers, children and young people.

The graded judgement about the experience and progress of care leavers is that it requires improvement

83. At the time of the inspection, the local authority was responsible for supporting 157 care leavers. Of these, 61 were aged 16 to 18, 92 were aged 19 to 21 and four were over 21. Of these, 68 (43%) are unaccompanied young asylum-seekers (UASC), which is a greater proportion than in previous years.

84. There has been a creative decision to place two after-care workers within the targeted youth service, where their line manager and colleagues have great experience of engaging young people in purposeful activities. This has led to a significant improvement in the number of care leavers staying in education, or entering employment or training. Currently, 62% of care leavers aged 19 to 21 are in employment, education or training, compared to 41% in March 2015 (which was lower than statistical neighbours at 51% and the England average of 48%). Effective links have also been established with the local careers centre. Care leavers state that the drop-in sessions at the local careers office give them an insight into writing CVs and getting a job, which is very helpful. However, the take-up and impact of this service is not monitored to evaluate benefit and outcomes.

85. The local authority has appropriate plans in place to increase further the number of care leavers engaged in education, employment and training, through work with the Duke of Edinburgh's Award scheme and Prince's Trust. To date, 10 care leavers have participated in a Duke of Edinburgh's Award scheme programme and just one in the Prince's Trust, so this is still at an early stage of development.

86. After-care workers have a tangible and clear commitment to the care leavers whom they support. They frequently go beyond what they need to do in order to support them. As a result, the local authority is regularly in touch with 89 (97%) of its current care leavers aged 19 to 21, a significant improvement from 2014–15 when the reported figure was 79%. Five care leavers were in custody at the time of inspection. The local authority maintains regular contact with these young people to ensure that appropriate plans can be made for their release.

87. Regular contact with workers who know them well means that young people know where and how to get help if they need it. They feel safe, and any concerns or issues about their safety or well-being are taken seriously. All care leavers who were spoken with as part of this inspection were aware of the risks

associated with sexual exploitation. Their workers know about their situations and act promptly when required, such as in helping their care leaver when faced with a situation of domestic violence or abuse.

88. Assessment records are too formulaic and are not presented in a user-friendly format. The majority of pathway plans do not use the views of care leavers in planning targeted next steps or to suggest how improvements can be made. Young people told inspectors that they lose interest when developing and reviewing their plans, saying that they stay involved in meetings because they like, and do not want to offend, their workers (Recommendation).

89. Plans are not reviewed with sufficient regularity, due to capacity issues within the after-care team. Crucially, plans and reviews neither record longer-term aspirations nor adequately capture educational achievements and next steps that might encourage or motivate young people to attain qualifications or to broaden their horizons. For example, reviews are not suggesting possibilities for apprenticeships at different levels and where these can lead. Information about staying-on rates in school sixth forms and the numbers of those who enter further education or training are not systematically collected. This limits further planning and improvement to help young people make effective transitions through adulthood (Recommendation).

90. Care leavers receive prompt and helpful support for their health and well-being needs, and they know how to access medical help. They receive effective help from a range of services such as counselling, and mental health and sexual health services. They receive good personal support at times of need, and their workers encourage and coax them to persevere. The local authority has invested in a health app to give care leavers access to their health histories. Although this is a promising development, it is not known how many care leavers are using this new technology.

91. Support is limited for care leavers to develop skills for their transition to greater levels of independence. There are currently no groups for care leavers to support them in developing their independent living skills, although work is undertaken on an individual basis. Care leavers are provided with appropriate information, for example when applying for driving licences or passports. The progress in implementing the 'staying put' policy to maintain stability of accommodation and care has been too slow (Recommendation).

92. The large majority of care leavers (92%), including all those who have special educational needs or a disability, live in suitable accommodation. Full checks are made to ensure that accommodation is safe and that young people feel secure. Additionally, managers carry out spot checks effectively to be assured

that agreed measures are being followed by accommodation providers. Close attention is paid to making sure that UASC are housed where they are safe and can access services to help them, such as proximity to colleges to learn English.

93. The local authority gives priority and appropriate help to care leavers when they seek their own accommodation. However, further work is required to ensure that the process for securing local authority tenancies becomes more young person friendly. If issues arise over tenancies, such as rent arrears or unsocial behaviour, workers promptly intervene to minimise disruption, and to make sure that the care leaver learns from the error or misbehaviour and can be rehoused promptly.

94. Care and support for the 18 care leavers with disabilities are effective. They have clear pathway assessments and plans, and benefit from much stability. All are in suitable accommodation, with nine in residential accommodation and nine in foster care. The majority have high needs and attend two local special schools graded as outstanding by Ofsted.

95. Care leavers understand their rights and entitlements, and know what support they can expect from their workers. They told inspectors that this is achieved more successfully through personal contact with their workers than through the written information available about their entitlements, which they described as uninteresting and not engaging. Care leavers, including those with special educational needs or who have a disability, receive a care-leaving grant which helps them to settle into living more independently. The local authority celebrates the achievements of care leavers positively at an annual awards ceremony.

Leadership, management and governance	Requires improvement

Summary

Leadership, management and governance require improvement in Thurrock, because many elements of core business do not deliver consistently good services to children, young people and families. Performance management is unsophisticated. Key data is not sufficiently analysed to provide leaders and managers with a narrative to understand the underlying issues or trends over time, and thereby develop relevant action plans. Of note is the absence of regular case audit analysis. This gap means that an accurate understanding of the quality of practice and any differences between teams or particular aspects of work is missed, and improvements over time cannot be monitored.

The effectiveness of management oversight varies between teams, and this is an area for improvement recognised by the local authority. Steps are being taken to address this, with a number of panels and surgeries set up to ensure that cases are kept on track, alongside the development of management training and initiatives. However, the quality of supervision is not routinely scrutinised.

Strong partnership working is evident, alongside effective corporate and cross-party support for the maintenance and development of services. Swift action has taken place when improvements were identified. This is evident in the response to issues raised during this inspection and the recent appointment of a new DCS.

Commissioning arrangements are robust, and based on a comprehensive analysis and understanding of local needs. This has led to joint commissioning of new services, and detailed scrutiny and evaluation of the effectiveness of services already commissioned. Further work is needed by the local authority to ensure that there is a sufficient range and choice of placements for children and young people, and that specific targets are in place for the recruitment and retention of foster carers.

The local authority uses learning from a range of sources to develop practice, but it does not gather feedback from children and families sufficiently or demonstrate how it has been used to improve services.

The high number of agency staff and vacancy rates within the workforce have prompted the local authority to set up a retention and recruitment board to give this issue continued attention. The local authority is appropriately working with neighbouring authorities to develop joint strategies to reduce instability in the workforce, and has achieved some success in the longer-term teams.

Inspection findings

96. Performance management and quality assurance in Thurrock are underdeveloped. As a result, the local authority lacks a full understanding of the effectiveness of its services to children and families. A range of performance data is available, including a daily snapshot providing basic information such as numbers of children subject to plans and a corporate scorecard, which provides more detailed recording of monthly activity. However, while some documents offer a narrative and analysis, there are too many key areas, such as return home interviews for children who have been missing, in which data is not analysed to consider the key themes behind the figures. The newly appointed interim DCS quickly identified performance reporting and analysis as an area of weakness, and is working with colleagues to develop a strategic model to strengthen this critical area. Despite a regular programme of case auditing within the local authority, the information from these audits has not been evaluated and does not form the backdrop for an action plan. This means that there is an overall lack of clarity about the quality of practice, or improvement and trends over time (Recommendation).

97. Management oversight is not effective across all teams, contributing to inconsistent service delivery. The local authority found that management oversight was less than good in 85% of its own case audits for this inspection. The majority of case supervision records are poor, where actions agreed are not specific enough and workers are not challenged. This contributes to poor quality assessments and delays in progressing plans for children. In the minority of cases that were better, clear decision making is seen, which leads to decisive actions to protect and promote the welfare of children and young people, and to progress plans. When cases were referred by inspectors to the local authority for a review of decision making and actions, these were dealt with thoroughly and swiftly, and detailed action plans were immediately put in place to meet children's needs.

98. The local authority is aware of the variability of management oversight and is taking steps to address this. Senior managers are chairing a number of panels and surgeries to regain management grip, and to ensure that casework is progressed. The local authority also provides specific management training courses for new managers, and during 2015 three new managers received mentoring. A managers' forum is in place, and a new aspiring managers' scheme is being developed to provide training and support for those moving into management roles. This scheme is under development and its impact cannot yet be seen. Staff spoken with during the inspection stated that their

managers are supportive, know about the work they do, and are available to offer advice and guidance when needed.

99. Senior local authority managers, leaders and elected members work effectively together to promote services for children and families in Thurrock. Very clear governance arrangements are established between the key committees and groups, and there is active communication between board chairs, leaders and officers of the council. There is full corporate support for the work of children's services, and this critical function is receiving appropriate focus and prioritisation across the council. For example, through budget setting, leaders have maintained funding for children's services, and the local authority's planning department plays an active part in the Health and Wellbeing Board, helping to promote healthy lifestyles for children.

100. Children's social care receives strong cross-party support from elected members. This engagement is enhanced through monthly meetings between the chief executive and the lead for each political group to ensure that they are informed of current issues. Senior leaders and officers engage in regular discussions and meetings to ensure that key issues are communicated in a timely manner. For example, the head of care and targeted outcomes meets fortnightly with the lead member for children's services to provide an overview of key issues and progress of work undertaken. These meetings are supplemented by more informal discussions when critical incidents occur regarding the welfare of children or staff.

101. The chief executive and lead member have not held formal meetings over the past six months to hold the chair of the Local Safeguarding Children Board (LSCB) directly to account. However, this gap in meetings has had limited impact during what has been a busy time for the LSCB, as there have been numerous discussions between the LSCB chair, council leaders and officers regarding the publication of the recent serious case review, and the DCS and lead member regularly attends the LSCB. These activities have ensured effective scrutiny and oversight of the work of the LSCB and the chair.

102. The successful Health and Wellbeing Board is at the centre of the local authority's work with children, with its strategy providing the overarching framework for the children and young people plan (CYPP). This plan sets out four clear aims, priorities and actions, and gives direction to the Children Partnership Board in promoting and securing children's welfare. Although the Children Partnership Board could evidence its activity in a number of areas, it was not able to show readily the impact of its work or how this linked to the CYPP.

103. The vast majority of commissioning arrangements are robust and based on a joint strategic needs assessment (JSNA), which provides a detailed analysis of local needs. This has led to a clear commissioning strategy with seven priorities linked to the CYPP. Joint commissioning between Thurrock, Southend and Essex, alongside the seven Essex Clinical Commissioning Groups (CCGs), has been effective, for example with the recent commissioning of a children's and young people's emotional well-being and mental health service. In addition, examples of commissioned services within the early offer of help show these services to be making a real difference to the lives of children and families. Services such as those for alcohol and substance misuse, a domestic violence perpetrator programme and a sexual violence service are well evaluated, and contracts are regularly and robustly monitored. Monitoring arrangements consider how far services are meeting performance indicators and improving outcomes, whether they are achieving value for money and whether their work is preventing statutory involvement for children. Service user feedback about these services gives clear indications that individuals feel safer as a result of the help that they have received, and that they better understand the impact that their behaviours have on their children and young people.

104. While there is a good understanding of local needs, there is mismatch between the needs of the children looked after population and the availability of suitable placements to meet these needs. The sufficiency statement does not adequately address this gap and does not contain an updated action plan. This means that there are no set targets for the recruitment and retention of a specific number and type of foster carers to meet the needs of children looked after in Thurrock. Too many children are looked after in placements outside the borough (Recommendation).

105. With strong leadership, the corporate parenting committee is successfully driving improvements on a number of fronts, as evidenced by improved performance figures on immunisations, health assessments, dental checks and return home interviews, and better marketing and recruitment of foster carers. Not afraid to challenge senior managers and leaders, the committee has also listened to the Children in Care Council and is taking action on passports and savings accounts for children looked after. The committee has further work to do to ensure that members of the Children in Care Council feel valued for their contributions, and also to continue to improve timeliness of initial health assessments.

106. Councillors have a good understanding of children's social care and their corporate parenting role. However, this is limited due to the poor quality of strategic analysis of performance information. All 49 councillors in Thurrock

have successfully completed induction training to aid their understanding of children's social care, and 17 have attended corporate training courses. In addition, the lead member meets with the Children in Care Council, and elected members sit on the fostering and adoption panels. However, councillors do not ensure that they regularly engage with children and families to seek their views to inform service development. A recent report to the corporate parenting committee noted that opportunities for senior officers and councillors to attend meetings have not been used, which means that chances to hear children's views have been missed (Recommendation).

107. The overview and scrutiny committee is an effective group, which has increased its workload in order to consider a wide range of issues affecting children and families. The chair ensures that meetings consider a broad spectrum of reports and activities, while maintaining an open slot for the LSCB, Youth Cabinet or health services to bring any matters requiring immediate attention. The group is mindful of local authority spending and has sought evaluations of services and reasons for the development of particular packages of care. It has demonstrated its tenacity by repeatedly raising issues of concern arising from a serious case review.

108. Leaders, managers and elected members have a broad understanding of the service's strengths and weaknesses. Their self-assessment demonstrates a good understanding of the quality of their services to children and families. The local authority shows a willingness to assess its own performance and to bring in external agencies to advise or take on improvement work to augment its work. It has used independent scrutiny, such as a review of the MASH in 2015, and has recently commissioned an external provider to help it to strengthen its edge of care and early help services to seek to reduce the number of children becoming looked after. The local authority demonstrates that it can be swift in responding when change is identified. This was seen during the inspection in the effective response to cases requiring review and the response to a question from an inspector which led to the development of a leaflet for young people to explain the troubled families programme.

109. The local authority actively disseminates learning from serious case reviews, information about practice developments and national research through easy-to-read monthly blogs by the principal social worker. The local authority evidences learning from complaints, with clearly recorded learning logs which set out lessons learned and recommended actions. These have been effective and led to changes in practice, such as better arrangements for transporting children with disabilities, and identification of managers' actions to ensure that work is completed when staff are off sick. Children's and families' views and

feedback are not routinely sought, limiting opportunities for them to inform service development (Recommendation).

110. Despite a workforce development strategy, and a regular retention and recruitment board, the high number of agency staff in Thurrock leaves the local authority vulnerable to staff churn. Currently, half of the social workers employed in Thurrock are agency staff (49 of 98 registered social workers). Some children have experienced delay in progressing their assessments and plans as a result of changes in their social worker. The vacancy rate at the time of the inspection was 21%, which is a slight improvement from 25% at December 2015. Some teams such as the MASH and Children Family and Assessment Teams are predominantly staffed by agency workers, and the past nine appointments have been agency staff. Staff changes mean that teams lack cohesion, identity and resilience when challenges occur. Although this leaves the local authority potentially vulnerable, 22% of agency staff have been in post for over two years, and 51% between six months and one year, which does provide some stability. Conversely, staffing stability has improved within the longer-term teams, with the successful recruitment of a number of newly qualified social workers. Thurrock is taking action and working collaboratively with the 10 other local authorities in the eastern region in an attempt to limit the number of agency staff by managing pay rates, and terms and conditions. The impact of this measure is yet to be seen.

111. Caseloads for workers are increasing and are currently above comparators. They have risen from an average of 16 cases for a full-time worker in 2014 to 18 in 2015, and some social workers currently have caseloads of up to 28, which is too high. This will need further monitoring by the local authority, as it will not assist the recruitment of permanent staff.

112. The continued professional development of staff is actively encouraged, with clear pathways established from the assessed and supported year in employment (ASYE) social workers through to management level. This focus on staff development is a strength of the local authority. The ASYE academy is reported by staff as attractive to newly qualified social workers and, to date, is showing signs of success. An increasing number of newly qualified social workers are joining the local authority (19 this year and 12 last year). They receive relevant training through an increasingly effective academy, and they receive valued individual and group support. Successful use is being made of additional agency social work staff to ensure that caseloads for ASYEs remain low during their first year. Succession planning is being well considered, with the development of mentoring, senior practitioners as practice educators and the current development of an aspiring managers' scheme.

113. A comprehensive training programme is available to staff, and over the past 12 months 390 days' training have been presented across a range of relevant subjects. Figures are collated for the number of staff attending, but the impact of the training is not fully evaluated over time. Specific management training courses are available, such as a management essentials course with a focus on leadership style and priority setting. However, this area of training provision requires additional focus, as management oversight and supervision of staff remains too variable. Of 14 supervision files audited by inspectors, none were judged good, only four demonstrated reflective supervision and only one demonstrated follow up on previous actions. Despite the local authority's awareness of the variability of management oversight and the poor quality of supervision, it is not completing a regular audit of the frequency and quality of supervision. This leaves the local authority unclear about the performance of individual managers and the impact of management training (Recommendation).

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

The Local Safeguarding Children Board (LSCB) in Thurrock is effective and innovative, and has a clear understanding of the key safeguarding priorities across partner agencies. A renewal of governance and terms of reference in 2015 has brought helpful clarity and demonstrates continued progress, following a review of the board in 2013. There is a clear collective ownership of safeguarding across all partners, who are positively engaged in action and reflection to support children, young people and their families. The board is chaired well by an influential chair who both supports and challenges partners, and accountability is high. Strong and efficient support is offered by a committed business team. Partners report clear and collective responsibility, and a high degree of challenge, scrutiny and accountability. This was described by one board member as 'good transparency and honesty'.

Child sexual exploitation, female genital mutilation and 'Prevent' duty have a high profile, with key leads from relevant agencies working effectively with the LSCB. Elements of the work of the LSCB, such as the 'Walk on line' roadshows, are outstanding, ensuring that over 10,000 schoolchildren will have received interactive safeguarding workshops of a high quality. The children most at risk of going missing, sexual exploitation, gang involvement and online exploitation are given comprehensive multi-agency consideration. The effective risk assessment group (RAG) demonstrates added safeguarding value. Capitalising on the high degree of multi-agency commitment, it leads case discussion using live access to a range of databases and expertise.

The board considers the range of experiences for children, young people and their families. It has influenced the development of the MASH, the use of appropriate categories for child protection plans and deep-dive audits. These have evaluated the experiences of the most vulnerable, including those who have been on a child protection plan for more than 12 months and children looked after. The chair has challenged MARAC about the lack of a MARAC report to the LSCB for the past two years. This limits the board's ability to monitor the work of this critical multi-agency safeguarding group effectively. The quality of the audits undertaken individually is high, but they lack overarching analysis. The take-up of multi-agency training offered is good, and participants and partners speak positively about the benefits. More analysis is required to enable full understanding of the impact of the training offer.

Recommendations

114. To improve further the strategic learning available from the multi-agency audits through overarching evaluation and analysis of outcomes and impact.

115. To undertake a comprehensive evaluation of the training provided in order to demonstrate the impact on frontline practice.

Inspection findings – the Local Safeguarding Children Board

116. The LSCB in Thurrock meets its statutory requirements well. Governance arrangements were refreshed in 2015, leading to new terms of reference which provide a strong framework for the work of the board. This is also supported by a helpful protocol between the Health and Wellbeing Board, and both the children and adult safeguarding boards.

117. The LSCB works closely with other relevant boards and panels, and has ensured that it has access, either as a member or through an open offer of attendance, at the appropriate groups in order to influence planning. This includes either the LSCB chair or business manager sitting on the Health and Wellbeing Board and the separate health and well-being strategic group, and the community safety partnership group where the 'Prevent' duty is considered, the Children Partnership Board and the early offer of help, MASH and troubled families groups. The LSCB business team apprentice sits on the Youth Cabinet. This enables fully integrated planning and detailed links back to the LSCB executive group and the LSCB full board. A positive action that came from the Children Partnership Board ensured that each school was provided with a height and weight profile to address childhood obesity.

118. The board is able to prioritise and challenge effectively, according to local need, and in the last 12 months has shown impact through increasing the police attendance at child protection conferences. Between April and November 2015, police attended 18 out of 87 initial case conferences. At the time of this inspection, this had increased to attendance at 96% from April 2015 for all conferences. Other recent challenging conversations have focused on the need for equity of funding and an overall increase in funding to manage the increase in serious case reviews (SCRs), oversight of the development of the child sexual exploitation local strategy and action plan, and ensuring the board's proactive involvement in the development and analysis of the MASH. There is a clear business plan for the work of the board, and an action plan appropriately

reflects key local priorities, including missing children, protection from abuse and exploitation, and the early offer of help.

119. Challenge within the board is strong, with agencies held to account through the main board, and the chair demonstrating a strong and assertive style. Partners are challenged collectively through themed discussions at the full board, for example each agency's performance relating to listening to the voice of the child, and the impact of funding constraints and restructuring in individual organisations. This was particularly helpful in enabling probation to explain the transformation of their agency. The police identified a gap in following up with comprehensive victim support in the discussion about the voice of the child.

120. There is a clear challenge to make improvements, if needed, in individual agencies, and the chair demonstrates a strong challenge to the performance of partners. One partner agency described this as 'open, honest. We can fight, disagree and still be okay with each other'. There have been recent challenges to the police, for example, on the speed of their response to actions required by agency-specific inspections. The chair has also challenged when there has been poor attendance at subgroups and the lack of a report from MARAC for the past two years. This has still not been produced. The board challenged children's social care on the low use of sexual abuse as a category in child protection plans and on whether this fitted the anecdotal knowledge of risks to adolescents. This has resulted in an increase in the age profile of child protection plans to safeguard those at risk of child sexual exploitation. The number of 10 to 15 year olds on a child protection plan has risen from 24% to 31%. At the time of the inspection, 12 children (5%) had an open plan for sexual abuse. Numbers were previously suppressed, due to the low figure.

121. The work of the board is supported by the work of the management executive group, where the detail of operational issues and concerns is appropriately considered. As an example, the November 2015 meeting considered the decrease in private fostering figures, the multi-agency review of child sexual exploitation, a report from the youth offending service, risks of legal highs and the planning for feedback from the new child protection level 3 pilot training programme.

122. The performance board subgroup started in March 2015, enabling each partner agency to attend and present data on the safeguarding work of their agency. This is scrutinised by other board members, including the LSCB chair. This has provided in-depth information on the broad range of functions of each agency. This has led to peer challenge and an opportunity for detailed questioning, including, for example the caseloads of midwives, and training on child sexual

exploitation and female genital mutilation for fire, rescue and ambulance services. Board members spoke highly of the learning afforded by the performance board, the impact on understanding partner functions and the rigour of challenge.

123. Section 11 assessments are undertaken annually, and the board flexibly accepts the different formats used by agencies in acknowledgement that many agencies report to three LSCBs within the pan-Essex arrangements. Compliance is high, with very good progress made at the time of this inspection for the end-of-year submission. The board maximises the potential from the returns, and recently (spring term 2016) added a 'Prevent' audit to the school returns. This has enabled specific data to be extracted and used to inform the 'Prevent' duty action plan. A gap in training for school governors was identified and is now being met, with some training having already taken place and more planned.

124. The board has developed a helpful learning and improvement framework with statutory partners. The LSCB carefully considers whether a SCR is required, and demonstrates a strong commitment to learn and improve practice. Over the past three years, this has resulted in the board completing two SCRs, and it is currently in the process of completing a further three. Correct decisions have been made to explore learning through the rigorous SCR journey, resulting in added value to the understanding of safeguarding practice.

125. The SCR subgroup is an effective group and has appropriately checked with the national panel to reach decisions to proceed when there has been a split decision among the subgroup members. The SCRs are undertaken thoroughly and published on the website, and learning is disseminated widely. All of the SCRs and the one individual management review showed appropriate learning and led to a reconsideration of risk. For example, the adolescent neglect tool came from this learning, as did the reconsideration of child sexual exploitation as an increased area for a child protection plan for adolescents. It is clear from this inspection that support to adolescents from the local authority has improved. The majority of social workers are aware of the key issues from the most recent published SCRs. The board also produces excellent summary booklets to maximise learning, with a well-presented high-quality product.

126. If a decision is made that a SCR is not required, but that there are lessons for a single agency, then the board undertakes a management review. One such review has appropriately been undertaken and published in relation to fabricated illness, showing openness in the learning for health partners. All action plans are thoroughly followed up through an action matrix, and the chair presented one SCR to the local authority's overview and scrutiny committee.

127. The financial position of the board has been stretched, with challenges to ensure an equitable contribution from one pan-Essex partner and, additionally, to meet the need for SCRs. The number of SCRs has put added pressure on time and resources. The majority of partner agencies make a proportionate financial contribution overall, and the chair requested a review with one agency when this was not the case, and a constructive solution was found. All agencies have agreed to add finance to the board to meet the demands of the SCRs.

128. All partner agencies are committed to the board, and contribute time and resources to ensure that it functions effectively. The chair is very clear with partners that board business is part of everyone's work. Suitably senior and influential partner representatives attend the board, and are able to take back lessons and challenges to their individual agencies. This has been challenged by the chair previously to ensure that appropriate membership is now in place. Subgroups are chaired across a range of partner agencies, reflecting the collective ownership of the work of the board.

129. The LSCB in Thurrock benefits from being part of the Southend, Essex and Thurrock (SET) shared arrangements, including shared policies and procedures updated and available on the Thurrock LSCB website. Policies and procedures are clear, accessible and easy to understand. Shared resources offer an economy of scale between the three LSCBs as shown through the recent 'I didn't know' child sexual exploitation awareness campaign and sharing of local expertise, including the strategic SET child sexual exploitation group and a strategic SET child death review overview panel (CDOP) group. Child death overview arrangements are effective, and there are strong rapid response protocols in place. The number of notifications in Thurrock have remained consistent over the last three years (10 in 2013–2014, nine in 2014–2015 and nine in the year to date).

130. The Southend, Essex and Thurrock group enables collective pan-Essex learning to be analysed for appropriately focused awareness-raising campaigns. These have included safer sleeping, furniture safety and water safety. The current pan-Essex focus is on suicide prevention, with relevant planning underway using specialist mental health practitioners. There is a very strong commitment and attention to detail in the work undertaken by CDOP. For example, the safer sleeping campaign is launched every holiday with helpful information sent to holiday parks, where usual sleeping arrangements will be different. This is a highly efficient pan-Essex service with a strong commitment to prevention, understanding and to support for families.

131. Local understanding of child sexual exploitation in Thurrock is considered through the developing multi-agency sexual exploitation group (MASE). This subgroup has equipped itself for its task through exploration of the Ofsted child sexual exploitation thematic study and is ambitious to understand the local landscape more fully. This has included, for example, challenging each agency to identify its 10 most vulnerable children or young people, an exercise which revealed a gap in health data. It has also identified the five boys most at risk of child sexual exploitation.

132. The comprehensive child sexual exploitation strategy and action plan have been developed, and these are rigorously overseen through the work of the LSCB. The strategy has been tested during 2015 through both internal and peer review, which showed good steady progress, and the board has further developed the child sexual exploitation action plan in response. Further work will be undertaken, including the prosecution of perpetrators and increased awareness raising. The 'I didn't know' child sexual exploitation awareness-raising campaign was launched during this inspection, and the board works closely with the police. The MASE group has a good understanding of what more needs to be done and this is informed by the detail of the experiences of children through the risk assessment group (RAG). The plan for data analysis will address the need for a more sophisticated 'heat map' of local risks.

133. The RAG established in March 2015 has brought together a number of separate panels that looked at risk (child sexual exploitation, online exploitation and missing children). This effective group has offered a real-time live multi-agency discussion for the most vulnerable children, with immediate access to the range of different agency databases. This approach has enabled a more sophisticated understanding to emerge of the complex overlap between different types of risk. This has resulted, for example, in coordinated intervention when children are referred as being at risk, and also then found to be a risk to others. It has started to reveal more detail on the prevalence of underlying risk, such as children going missing and then found to be affected by gang involvement. A clear action matrix ensures that all actions for each child are followed up effectively. The RAG is chaired by the local authority and is an operational service, sitting under the auspices of the LSCB. This unusual positioning allows the broadest opportunity for referrals from all partners, and harnesses all knowledge and investment from partner agencies in Thurrock to consider and safeguard children. It is working well, with evidence of reduced risk for children who are particularly vulnerable. However, it does not currently consider information from return home interviews.

134. The quality of the multi-agency audit work undertaken is highly detailed, resulting in clear action plans that are effectively followed up. These audits consider a broad range of relevant safeguarding issues across the partnership. These include audits regarding children and young people who have been on a child protection plan for more than 12 months and attendance at child protection conferences. Issues considered demonstrate that the board is aware of key issues across the local authority, and the findings from the audits regarding areas for development are reflective of some of the findings from this inspection, for example management oversight and life story work. Despite good-quality detailed work, the audit subgroup is without a consistent chair and attendance has not been strong. In its role of overseeing the multi-agency audit programme in Thurrock, it has analysed and disseminated learning from the audit programme through a recent learning and improvement booklet, but requires regular multi-agency attendance to ensure a sustained higher degree of overarching analysis and evaluation (Recommendation).

135. The LSCB values the views and contributions of children, and ensures that their views and experiences influence the work of the board. The board is creative and innovative in how it does this, including holding a 'voice of the child' conference in 2013–14 and ensuring that children actively participated in the board's conference in 2014–15. The board, working jointly with the Community Safety Partnership, has recruited 12 safeguarding ambassadors aged 13 to 16, including a hate crime and a youth crime ambassador through the Youth Cabinet.

136. To gauge understanding and risk to children online, the LSCB started a series of roadshows called 'Walk on line' in 2014. These covered the broadest range of risks to children and young people, including child sexual exploitation, grooming, sexting, going missing, cyber-bullying, female genital mutilation and 'Prevent' from a child's perspective. Initially offered to Years 5 and 6 pupils, they were extended to Years 10 and 11 pupils at the request of the Youth Cabinet. 10,000 children and young people have attended, and impact has been shown through changed behaviours such as amending privacy settings, as measured through anonymous child-friendly questionnaires. 'Walk on line' demonstrates a creative and comprehensive understanding of risks to children and young people. This outstanding piece of practice demonstrates a strong partnership approach between the LSCB, education, parents and the specialist police knowledge by the child exploitation online service.

137. A good range of training is offered, and this is valued by partner agencies, with 117 agencies currently participating in the training programme. The LSCB has engaged well with non-statutory partners, including faith groups, and meets

regularly as a member of Thurrock Faith Forum. It has good relationships with local voluntary organisations that access training through the board and are represented on subgroups of the board. Each course is evaluated by the individual participant, and the learning and development subgroup evaluates the effectiveness of specific training through feedback forms. Training is also observed to evaluate its effectiveness directly. Partners are held to account for both their attendance at multi-agency training and the training that each agency offers on safeguarding, but there is no overall evaluation of the impact of the full training offer. This means that the board cannot assure itself that the training offer is having sufficient impact on frontline practice (Recommendation).

138. The LSCB produces a clear annual report that demonstrates a comprehensive understanding of the strengths and achievements of the board, together with work still to be done. Strengths include improved engagement of all types of educational establishments, close partnership work with the Youth Cabinet and the overall steady progress made since the review of the board in 2013. Evidence of impact includes the monitoring of child protection plans and the challenge to increase consideration of sexual abuse, which had been an area for improvement. All agencies contribute their own end-of-year evaluation, including data, to the annual report so that their voices are heard, and they are held to account for the difference that they have made.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference that adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people whom it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of eight of Her Majesty's Inspectors (HMI) from Ofsted.

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Thurrock Council Children's Services Single Inspection Framework Improvement Action Plan v3 - 25.8.16

Rory Patterson	**Name of Reviewer**
01-Nov-16	**Date of Review**

Introduction

The Ofsted inspection of services for children in need of help and protection and for looked after children in February 2016 agave and overall judgement that children's services require improvement to be good. Although services to children, young people and families in Thurrock require improvement, children and young people were found to be safe in Thurrock during this inspection, with none identified who were at immediate risk of significant harm without plans and services being in place to reduce these risks and to meet their needs.

We welcome the recommendations and areas of improvement highlighted by Ofsted. As a result we have incorporated these into our regular performance monitoring but also want to be explicit about how we are responding to these recommendations. This plan sets out how we will do this.
The improvement plan will be overseen by the corporate parenting committee. In addition a further level of scrutiny has been created by the children's portfolio holders who will be meeting

No.	Recommendation	Assigned Lead - Job Title/Name	**Score** - please select	**Update November 16**	Direction of Travel compared to last review - please select	Description of Action(s) - How	Owner(s) - Who	By When (date)
1	Ensure that accurate performance data is analysed and that this leads to specific actions for improvement	Iqbal Vaza, Strategic Lead I Performance, Quality & Business Support I HR,OD & Transformation	3	1	Improving	A) Increase capacity to develop and implement new performance digest, with clear metrics & analytics. B) Implement new 'Improvements Board' to be chaired by the DCS and underpinned by metrics & analytics within new digest . C)Review structure of Data and Performance Team to maximise effectiveness.	Director of Children's Services	Actions a,b & C completed.

No.	Recommendation	Assigned Lead - Job Title/Name	**Score** - please select	**Update November 16**	Direction of Travel compared to last review - please select	Description of Action(s) - How	Owner(s) - Who	By When (date)
2	Strengthen oversight, coordination and quality assurance of early help services to ensure that children and families are receiving the right support at the right time	Clare Moore, Acting Strategic Lead- Disabled Children, Family Group Conferencing, Emergency Duty Team and Early Offer of Help.	2	2	Improving	A) Complete demand management service review B) Implement improvement plan and service restructure to maximise effectiveness of the Early Offer of Help. C) Re-engage partners in the provision of help to the right families at the right time. D) Ensure quality assurance framework is reviewed and extended to include EOH services. E) To increase the amount of Early Help assessments for 0-5 by targeting Childrens Centres, Health Visitors and Early Years settings to promote the need for early intervention.	Head of Children's Social Care	June - Dec 16
3	Ensure that assessments and plans for children are of a consistently high quality	Teresa Gallager, Service Manager, FST & Joe Tynan, Service Manager, MASH & CFAT	3	3	Maintained	A) Complete implementation of Signs of Safety and monitor through audit programme. B) Introduce regular quality workshops with social workers to review quality of practice. C)Scope the introduction of volunteers within the assessment service to strengthen direct intervention with families during assessments. D) Implement demand managment plan to reduce the number of assessments undertaken (specifically those that lead to NFA), to reduce quantity and increase quality.	Head of Children's Social Care	June - Dec 16

No.	Recommendation	Assigned Lead - Job Title/Name	**Score** - please select	**Update November 16**	Direction of Travel compared to last review - please select	Description of Action(s) - How	Owner(s) - Who	By When (date)
4	Improve the offer of return home interviews to children and young people who have been missing from home or care to increase take-up of these interviews	Paul Coke, Service Manager, Children Looked After & Neale Laurie, Service Manager, Safeguarding and Child Protection	1	1	Improving	A) Weekly monitoring of children who go missing from home and care, and the referral and take up rate of return home interviews. B) Monthly monitoring of referral rates for looked after children to ensure that this increases from 80% - 100%. C) Improved contract monitoring to require pro-active engagement of young people by provider.	Head of Children's Social Care	Actions completed but needs to be monitored and maintained.
5	Ensure that more children are supported to participate in, and contribute to, their meetings, conferences and reviews, that they and their parents have access to reports beforehand, and that meeting minutes are circulated promptly	Neale Laurie, Service Manager, Safeguarding and Child Protection	3	2	Improving	A) Monitoring systems in place for all Child Protection Conference and Review minutes. B) Scoping exercise to be undertaken re: how best to increase participation drawing on good practice models. C) Advocacy and support services to be reviewed to ensure that these are promoting activity engagement and participation / challenging poor practice.	Head of Children's Social Care	Nov' 2016
6	Ensure that robust arrangements are in place to reduce the need for children and young people to become looked after in an emergency	Joe Tynan, Service Manager, MASH & CFAT and Teresa Gallagher, Service Manager, Family Support.	3	2	Improving	A) Review the patterns and numbers of children coming into care B) Strengthen preventative and support services to avoid accommodation or delay accommodation, so that this is planned. C) Strengthen role of Threshold Panel in managing accommodations.	Head of Children's Social Care	Sept 16 / ongoing. Actions A & C completed. Action B linked to iMPOWER timescales.
7	Ensure targeted recruitment of foster carers to better meet the current and future demand for foster placements and reduce the number of children looked after who have to be placed out of the borough	Andrews Osei, Service Manager, Fostering, Adoption and Placements	3	1	Improving	A) Targets are now in place for the recruitment of foster carers in line with current and predicted demand. Performance against these targets will be monitored at monthly performance surgeries. B) Monitor impact of refreshed recruitment campaign.	Head of Children's Social Care	Actions completed and now ongoing re: iMPOWER work and evaluations.

No.	Recommendation	Assigned Lead - Job Title/Name	**Score** - please select	**Update November 16**	Direction of Travel compared to last review - please select	Description of Action(s) - How	Owner(s) - Who	By When (date)
8	Ensure that personal education plans are of a consistently high standard & that the virtual school effectively monitors and analyses the progress of all children looked after, including those who attend schools outside of Thurrock	Keeley Pullen, Head of the Virtual School	3	1	Improving	A) Establish a governing body to monitor, drive and improve all aspects of the work of the virtual school. B) Corporate Parenting Committee and Children's Overview and Scrutiny to continue to monitor and challenge the academic progress and outcomes for looked after children. C) Regularly undertake quality audits to monitor improvements in plans	Roger Edwardson, Interim Strategic Lead,School Improvement, Learning and Skills	01/09/2016- actions a,b and c now complete. Ongoing monitoring of outcomes / impact
9	Ensure that managers oversee and effectively drive forward permanence plans for children	Paul Coke, Service Manager, Children Looked After & Andrews Osei, Service Manager, Fostering, Adoption and Placements	2	2	Improving	A) Embed partnership working with Coram and strengthen early permanency with a pro-active offer of concurrency and foster to adopt. B) Maintain and increase reduction in number of days between court authorisation to place for adoption and placement for adoption. C) Continue to target with Coram, through effective permanency planning, a significant reduction in the number of days between a child becoming looked after and placement for adoption - to bring this below the England average.	Head of Children's Social Care	May 16 - March 17
10	Develop post-adoption support arrangements to ensure that all children and families who are eligible have access to an appropriate service	Andrews Osei, Service Manager, Fostering, Adoption and Placements	3	1	Improving	Develop a new delivery model for post adoption support with Coram. Seek feedback from adopters on the quality of provision.	Head of Children's Social Care	Completed and being further developed with Coram

No.	Recommendation	Assigned Lead - Job Title/Name	**Score** - please select	**Update November 16**	Direction of Travel compared to last review - please select	Description of Action(s) - How	Owner(s) - Who	By When (date)
11	Ensure that an effective Staying Put policy makes it possible for more young people to live with their former foster carers beyond the age of 18 years	Paul Coke, Service Manager, Children Looked After & Andrews Osei, Service Manager, Fostering, Adoption and Placements	3	2	Improving	A) Update and improve current Staying Put policy in consultation with Thurrock Foster Carers and IFA providers. B) Promote Staying Put as an option for all fostered young people. C) Monitor and review the number of young people who are Staying Put to identify blocks and address these. D) Work in partnership with Eastern Region partners to better improve the local and regional offer.	Head of Children's Social Care	June - Sept 16 - Actions A;B C completed. Furtehr work needed re: Eastern Region. Impact to be monitored re: increase in young people staying put.
12	Ensure that pathway assessments and plans are developed to engage care leavers effectively and that care leavers benefit from regular reviews	Paul Coke, Service Manager, Children Looked After	3	2	Improving	A) Redesign the current Pathway Plan with care leavers and the CICC (update on previous re-design), to make it as simple and user friendly as possible. B) Establish Senior Practitioner post currently within the Aftercare Team to continue to lead on the review of pathway plans and track timeliness within revised performance digest. C)Undertake regular quality audits of plans.	Head of Children's Social Care	Sept 16 & June 17
13	Ensure that care leavers are effectively supported to gain independence skills, including through the setting of aspirational targets to help them to achieve educational and employment goals.	Paul Coke, Service Manager, Children Looked After	2	2	Improving	A) Develop a group work model of independence training / support for carer leavers and complement current 1:1 work. B) Continue to increase the number of care leavers who are EET (62%) and exceed aspirational target of 70% EET. Strengthen integrated working with Employability and Skills service to drive improvements.	Head of Children's Social Care	August 16 & March 2017

No.	Recommendation	Assigned Lead - Job Title/Name	**Score** - please select	**Update November 16**	Direction of Travel compared to last review - please select	Description of Action(s) - How	Owner(s) - Who	By When (date)
14	Secure a more stable workforce to ensure that children are able to build enduring relationships with social workers and to enable the local authority to drive through improvement to services, such as increasing early planning for permanence for children that starts at the front door	Andrew Carter, Head of Children's Social Care	3	2	Improving	A) Continue to drive effective retention and recruitment through the Retention and Recruitment Board, chaired by the DCS. B) Expand on programme to 'grow our own' staff through the ASYE Academy and the Aspiring Managers programme. C) Reduce the use of agency staff within the Eastern Region, MoC & work with iMPOWER on demand management.	Director of Children's Services	Ongoing
15	Ensure and demonstrate that children's and families' views and feedback are used to demonstrably shape service developments	Cherrylyn Senior, Principal Social Worker	3	3	Maintained	A) Strengthen participation work stream to ensure that this is producing clear outcomes that are monitored and evaluated at the 'Improvements Board'. B) Corporate Parenting Board and Children's Overview and Scrutiny to be encouraged to set clear targets for evidence of improvements / service developments that have been based on user feedback, consultation and or co-production.	Head of Children's Social Care	Nov' 2016
16	Regularly audit supervision files to ensure that frequency and quality are resulting in improved practice	Neale Laurie, Service Manager, Safeguarding and Child Protection	3	1	Improving	Establish a new quality assurance framework and put in place a regular cycle of auditing. Review and disseminate supervision policy and monitor compliance. Progress to be monitored at Improvements Board and proposed annual report to Children's Overview and Scrutiny on the quality of practice.	Head of Children's Social Care	Actions completed and ongoing monitoring required.

Once you have completed this sheet, please review scoresheet - next

Sheet Complete

20 December 2016	ITEM: 8
Children's Services Overview and Scrutiny Committee	
Update Report On Child Sexual Exploitation	
Wards and communities affected: All	**Key Decision:** To note Action Plan
Report of: Claire Pascoe, Child Sexual Exploitation Manager (CATO)	
Accountable Head of Service: Andrew Carter, Children's Social Care (CATO)	
Accountable Director: Rory Patterson, Corporate Director of Children's Services	
This report is Public	

Executive Summary

This report highlights the key strategic, operational, technological, partnership and practice developments relating to Child Sexual Exploitation (CSE) as progressed by Thurrock Council. As this is a public document details of current operations and measures to disrupt CSE have not been provided.

Thurrock Council have made significant steps to identify and tackle Child Sexual Exploitation but cannot afford to be complacent. Vigilance across the council and its partners is required to disrupt and prevent the exploitation of children.

The Local Government Association's *'Tackling Child Sexual Exploitation, A resource pack for councils*', 2014, is attached to this report. Members of this committee are asked to ensure that they and their fellow Thurrock Councillors are fully cognisant with the pack and their roles within it.

1. Recommendations

1.1 For Police and Community Safety to consider securing a data analyst for Thurrock, specifically to work on CSE, missing children and child trafficking data. An analyst would work in collaboration with the Essex Police and would enable professionals to target resources efficiently and effectively.

1.2 Whilst progress has been made awareness raising is still a key issue to truly embed recognition and respond appropriately. There is a need to provide ongoing training and awareness session with Thurrock Councillors. Councillors are encouraged to fully engage in CSE Training.

1.3 In order to strengthen Thurrock's response to victims, it is proposed that along with SERICC and the LSCB, we consult further with victims of CSE to inform our strategic and operational planning.

2. Introduction and Background

2.1 Regular reports have been present to the Overview and Scrutiny Committee on the progress and impact of steps taken by Children's Social Care and partner agencies to tackle, disrupt and address child sexual exploitation.

2.2 Children's Overview and Scrutiny Committee have requested a further update on progress within Thurrock.

3. Issues, Options and Analysis of Options

This update report on Child Sexual Exploitation (CSE) has been prepared at the request of Andrew Carter, Head of Children's Social Care for the Thurrock Children's Services Overview and Scrutiny Committee. It will highlight the key strategic, operational, technological, partnership and practice developments relating to CSE as led and progressed by Thurrock Council, during the period May 2015 to November 2016. Recommendations are made to collaboratively strengthen our individual, and partnership response to safeguarding children from CSE and contributing to the identification and targeting of possible perpetrators.

Key Developments:

Thurrock are committed to improving awareness, assessment, collaborative practice, development of processes and outcomes for the children of Thurrock who may be at risk of CSE or who have been sexually exploited, in a variety of ways: In responding to the findings of numerous reviews into CSE across the country and notably, those of Professor Alexis Jay in her '*Independent Inquiry into Child Sexual Exploitation in Rotherham 1997-2013'* the CSE Manager (referred to by Ofsted, as CSE co-ordinator), was appointed in May 2015. In collaboration with a range of statutory and voluntary partners, progress within this contested and closely scrutinised field has been externally acknowledged;

i. Ofsted:

Ofsted visited and undertook a single inspection of Thurrock Children's' Social Care in February 2016 for four weeks. Whilst the overall judgement was that Thurrock 'Requires Improvement' Ofsted concluded that children in Thurrock were safe. The work around CSE was acknowledged. Below, are some of a number of direct quotations from the Ofsted report:

- Managers have worked well to make sure that children who are at risk of child sexual exploitation receive a good service that reduces their risk.

- The Child Sexual Exploitation co-ordinator provides social workers and managers with effective challenge, advice and guidance.
- Social workers recognise and respond well when children are at risk of sexual exploitation.
- Positive and focused work with most teenagers and their families is completed by the Adolescent Team. This includes effective use of the child sexual exploitation risk assessment and adolescent neglect tool, when relevant; to support young people in need, including those in need of protection. Clear, directive and creative plans help professionals to prevent family breakdown and provide effective direct work with young people.
- Although the local authority currently keeps separate data in respect of children missing from home, school or care, and those at risk of child sexual exploitation, the operational risk assessment group rigorously cross-checks data against the most recent list of children reported as missing to the police to ensure that individual children are safeguarded and protected.
- Children looked after who are at risk of sexual exploitation receive effective help. Child sexual exploitation, female genital mutilation and 'Prevent' duty have a high profile, with key leads from relevant agencies working effectively with the LSCB.
- The children most at risk of going missing, sexual exploitation, gang involvement and online exploitation are given comprehensive multi-agency consideration. The effective risk assessment group (RAG) demonstrates added safeguarding value'.

ii. Risk Assessment Group (RAG):

The Risk Assessment Group, (RAG), is a bi-monthly operational multi-agency sub-group of the Local Safeguarding Children Board's, Multi Agency Sexual Exploitation (MASE), strategic group. The RAG was created in March 2015. The RAG's remit among others, is to review the cases of all children missing from home or care in Thurrock, and the complex cases of children who are vulnerable to CSE among a wider range of harm. With the benefit of voluntary and statutory partner's participation, and frequently their live access to their organisation's information systems, proposed actions to support and safeguard children and their families are made, recorded and monitored. The effectiveness of the RAG as an added safeguard, was highlighted by Ofsted.

iii. Multi Agency Sexual Exploitation Group (MASE):

Strategically overseeing the RAG is the LSCB's MASE Group, which came into operation in June 2015 and is attended by 13 statutory and voluntary agencies. To promote county-wide coherence and transcend boundaries (by which CSE perpetrators are not confined), the Southend Essex and Thurrock (SET), CSE Strategy has been used as the foundation on which the Thurrock,

CSE ‘Plan on a Page’ has been devised, and which partners are using to guide the development of their individual and collaborative plans to tackle CSE from a victim, as well as perpetrator perspective.

A key role of the MASE Group is to provide challenge around practice and performance among partners: the sharing by Thurrock Social Care of the names of the 10 children assessed to be particularly vulnerable to CSE, ensured all partners were and could as needed, contribute to the plans of these children. Also, and in line with wide ranging research indicating the ‘invisibility’ of boys as victims of CSE (Office of Children’s Commissioner, 2013: Barnardos, 2016), to promote their being kept ‘in professional view,’ Social Care shared the names of the 5 boys assessed most vulnerable to CSE.

iv. Missing /Found Children’s Return Home Interviews:

Research widely confirms the significant association between children who go missing from home and care, and their increased vulnerability to CSE, (DfE, 2014). In working to illuminate the ‘push’ and ‘pull’ factors associated with children going missing from home or care, Thurrock Children’s Social Care have commissioned the Open Door service to undertake independent return home interviews, (RHI). Improvement in timeliness of referrals of children who have been missing, over the past year can be demonstrated in the time between a child returning from being missing and being referred for their RHI reducing from 14 days in 2015, to an average of 3.5 days over the preceding 7 months to November 2016. Collaboration with Essex Police is currently seeking to reduce this time further, to expedite a child who has been missing, being spoken with within 72 hours, and identified remedies and actions, including potentially Section 47 enquiry being implemented more quickly. An ongoing challenge is to increase the numbers of children who agree to meet with Open Door for RHIs. For those children who decline, allocated Social Workers or whoever the child is most likely to engage with from the team, arrange to speak with the children to find out how they are and how they can be supported in not going missing from home or care again.

The MASE Annual Report was submitted in September 2016, and proposed recommendations have been allocated to partners to develop our response to CSE in safeguarding children further over the coming 12 months.

v. Training and Development:

Partnership working is enshrined in ‘*Working Together to Safeguard Children, Statutory guidance on inter-agency working to safeguard and promote the welfare of children*’, (DfE, 2015) and in the CSE-specific *National Action Plan*, (DfE, 2011). The centrality of partnership working is essential in the child protection arena of CSE, where victims frequently do not perceive themselves as victims, or for a wide range of reasons often associated with the impact of grooming, and / or fear, will feel unable to disclose what is happening to them to their families, friends or professionals. Equally,

perpetrators have myriad motivations for keeping their behaviour 'hidden'. In recognition of the apparently 'hidden' nature of CSE indicators and / or evidence, Thurrock Social Care in collaboration with partners, have thoughtfully and intensively invested in training and awareness raising, not only of Social Care Staff, but more widely. Essex Police and Thurrock Social Care have intentionally co-written and co-delivered the training, joined by Open Door and South Essex Rape and Incest Crisis Centre, (SERICC) for the Thurrock Foster Carer and Supported Lodging Provider training:

All training aims to maximise our chances of identifying vulnerabilities and risks associated with CSE, focusing equally, upon perpetrators, and using the multi-agency group to galvanise links / services to children: All training is bespoke, and includes advice on gathering evidence, local and national help and support and the pathways by which professionals and possible victims can share their concerns, make referrals and report abuse. Training completed and planned to date, is as follows:

- Thurrock Children's Social Care Staff: Co-written and delivered by Thurrock CSE Manager and Essex Police: 195 have been trained. Dates into new year have been set.

- Thurrock Foster Carers: Co-written and delivered by CSE Manager and partners, this training covers CSE indicators: Missing Children and processes of reporting / information capture regarding victims and perpetrators, (Essex Police): Return from Missing Interviews and Mentoring (Open Door) and support for children who have been sexually abused / exploited, (SERICC). Fifty eight carers have been trained to date: Dates into the new year have been set.

- Thurrock Licenced Taxi Drivers and Passenger Assistants: CSE and Child Trafficking training: Co-written and Delivered by CSE Manager and Essex Police: 253 have now trained; 220 remain to be trained. Bespoke 'indicators' and 'reporting Pathway cards and air fresheners have been produced for drivers and passenger assistants, and ongoing meetings with the Taxi Operators have been requested into new year set.

- Thurrock Housing Staff: 200 staff have received an introduction to CSE at the 'Eyes and Ears' conference in 2016: further, in depth training is scheduled to be delivered early 2017 for 300 accommodation staff in CSE, Missing and Child Trafficking.

- GPs: 27 Thurrock GPs have received an introduction to CSE.

- Multi-Agency Group: 280 professionals received a 'Gang-related CSE' presentation at the 'Gangs' conference, 2016.

vi. Developing our IT systems to provide a clearer 'problem profile' of CSE in Thurrock:

Understanding more closely our CSE 'problem profile' in Thurrock is something Social Care is committed to and are working in collaboration with partners to develop our understanding of. To this end, our Children's information system, LCS, now has an additional, bespoke 'work space' for CSE: combined process and practice guidance has been rolled out to Thurrock Social Care staff. Whilst in the nascent stages, it is anticipated that by December 2016, Thurrock Social Care will be able to report on numbers of CSE Risk Assessments having been completed by us, how many children are assessed to be a medium or higher risk of CSE, and to be able to report on a range of other key indicators. These themes and trends will be analysed and shared with MASE partners including the Police. They will be used to inform the emphasis of training, practice and commissioning in order to meet evolving need.

vii. Using national expertise to improve our multi-agency CSE Risk Assessment and Multi-Agency response across the wider Essex partnership:

In collaboration with Essex University, the National Working Group (NWG) a Charitable organisation formed as a UK network for professionals working on the issue of CSE and child trafficking within the UK, and with the Essex and Southend CSE leads, the Thurrock CSE Manager has developed a new, research-informed CSE Risk Assessment for professionals to complete and share with Social Care the Essex Police for children about whom they have CSE concerns. The Risk Assessment is supported by a comprehensive 'toolbox' for professionals including a range of interventions, resources, legislation and powers to support victims and their families; equally, to inform the multi-agency targeting and disruption of possible perpetrators. This is due to be launched county wide, on the 21st November, 2016.

viii. Re-launch of the Southend, Essex and Thurrock 'I Didn't Know' CSE campaign:

The, 'I Didn't Know' campaign was a collaboration between Essex Police and Southend, Essex and Thurrock Local Safeguarding Children Boards and was successfully launched in March 2016.

The concept for the campaign was inspired by a project designed and created by the Essex Children in Care Council. To maintain focus and further raise awareness about this important area not least our children, their parents and the wider Thurrock community, the Campaign is to be reviewed and re-launched in March 2017.

4. Reasons for Recommendation

To ensure that Thurrock Council and its partners are strategically and operationally able to maintain effective actions to prevent and disrupt CSE; providing support to victims and prosecuting perpetrators.

5. Consultation (including Overview and Scrutiny, if applicable)

Thurrock Local Children's Safeguarding Board (LSCB), Multi-Agency Agency Sexual Exploitation Group.

6. Impact on corporate policies, priorities, performance and community impact

Ensuring that children and young people are safe and free from exploitation is a central part of the statutory duties of the Council.

7. Implications

7.1 Financial

Implications verified by: **Kay Goodacre**

Finance Manager

A full costing breakdown will be required regarding how additional data analysis capacity will be obtain without increasing the staffing budget within Children's Social Care. Funding options across the Council need to be explored and utilised alongside potential funding streams from partners or Innovation bids.

7.2 Legal

Implications verified by: **Lindsay Marks**

Principal Solicitor, Children's Safeguarding

The Local Authority has a statutory duty to provide services to children in need of help and protection, failure to effectively do so could lead to legal challenges and reputational damage. Failure to address CSE could result in significant reputational damage for the council and possible litigation.

7.3 Diversity and Equality

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

The local authority and its partners must ensure that a range of services and provision is in place to protect children from all backgrounds. The impact of CSE on both genders needs to continue to be analysed and addressed.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

N/A

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

N/A

9. Appendices to the report

Appendix 1 - The LGA's *'Tackling Child Sexual Exploitation, A resource pack for Councils*', 2014

Appendix 2 - Thurrock LSCB, Multi-Agency Child Sexual Exploitation and Missing Children, Strategic Group, Plan on A Page

Report Author:

Claire Pascoe
Child Exploitation Manager

Andrew Carter
Head of Service
Children's Social Care

Local Government Association

Tackling child sexual exploitation

A resource pack for councils

Report and case studies

Foreword

Child sexual exploitation (CSE) is a terrible crime with destructive and far reaching consequences for victims, their families, and society. It is not limited to any particular geography, ethnic or social background, and all councils should assume that CSE is happening in their area and take proactive action to prevent it.

This is not just a job for the lead member for children's services or the local director of children's services. This pack is aimed at elected members at all levels. We all have a role to play in keeping children safe, and councils cannot stamp out CSE without the help of the wider community. Councillors have a key role to play in this, and should not be afraid to raise these issues within the communities they represent.

Recent inquires have again highlighted the scale of the problem, and local agencies risk seeming unaware of the true extent of CSE in their area. It is vital that all partners work closely together to develop and implement robust, coordinated activity at all stages of a child's journey, from identification to protection to treatment. Councils and their partners must use evidence and information to understand what is happening locally, develop a strategic response, support victims and facilitate police disruption activity and prosecutions.

Recent events have shown that all areas need to be prepared to respond to this challenge effectively, and there are many good examples of effective work to be found around the country for local government to share and learn from. It is vital that we learn from both mistakes and successes, and the case studies in this resource pack showcase some of the work that is already underway to improve local practice. These cover initiatives such as community engagement, regional work across local authority boundaries, building effective multi-agency partnerships and commissioning independent audits of local practice.

We have also included a summary of the key learning to emerge from recent inquiries and reviews, and advice on key lines of enquiry for councillors to pursue when assessing the quality of local practice. The resources in this pack will be updated regularly, so please do check www.local.gov.uk/cse for the latest information – including some online resources that have not been included in this pack.

Child sexual exploitation is a sensitive and complex issue and I understand that it is not an easy subject to talk about, but it is essential that we do. No council can assume that this is not happening in their area, and no councillor should assume that someone else will make sure that the necessary responses are in place. Tackling child sexual exploitation must be a priority for all of us, and the resources in this pack highlight the very real difference that councils can make in preventing this awful crime – and the crucial role of councillors within this.

Councillor David Simmonds
Chairman, LGA Children and Young People Board

Contents

Child sexual exploitation: an introduction

What is child sexual exploitation?

Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (eg food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition, for example being persuaded to post sexual images on the internet or mobile phones without immediate payment or gain. In all cases, those exploiting the child or young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social, economic and/or emotional vulnerability.

What is the scale of CSE?

Recent high profile court cases, local inquiries and reports have raised awareness of the extent of child sexual exploitation. The Independent Inquiry into CSE in Rotherham estimated that 1400 children had been sexually exploited over the 16 year period covered by the Inquiry. Ann Coffey's report into CSE across Greater Manchester identified 260 'live' investigations into CSE in June 2014, with 14,712 recorded episodes of children missing from home and care between January and September 2014.

The Office of the Children's Commissioner's two year Inquiry into CSE found that a total of 2,409 children were known to be victims of CSE by gangs and groups between August 2010 and October 2011; the equivalent of every pupil in three medium sized secondary schools[1]. It is generally agreed that these figures are an under-estimate. With each new inquiry that is published, we are becoming more aware about the extent of CSE and the scale of this horrific form of abuse in our communities.

Why do I need to be aware?

CSE has a devastating impact on children, young people and their families. It should be a concern for everyone. CSE is largely a hidden crime, and raising awareness of this type of abuse is essential to preventing it and stopping it early when it does happen.

Councils play a crucial, statutory role in safeguarding children, including tackling child sexual exploitation. However, they cannot do this alone. It needs the cooperation of the wider community and our partner agencies. Councils can use their links with police, schools, health professionals, and community and faith groups to highlight the signs and ensure people know where to turn if they have concerns. We know child sexual

1 Berelowitz, S. et al (2013). "If only someone had listened" The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Final Report. London: Office of the Children's Commissioner. Rochdale Oxford www.childrenscommissioner.gov.uk/content/publications/content_743

exploitation is a difficult and unpleasant subject to discuss, but having these conversations is crucial to stamping it out.

Statutory responsibilities

The statutory responsibilities of local agencies, including councils, are set out in the 2009 supplementary guidance on CSE. The 2011 National Action Plan further clarifies these, and also brings together a range of commitments from national and local partners[2]. Statutory requirements from these documents include:

- mechanisms should be in place to collect prevalence and monitor cases of CSE
- CSE is assumed to be present, and is prioritised if believed to be a significant issue
- preventative activity should be put in place, helping those being exploited and targeting perpetrators
- Local Safeguarding Children Boards (LSCBs) should have specific local procedures to cover CSE (eg a strategy).
- children and young people should be involved in the drafting of CSE strategies
- assess and identify patterns of exploitation (problem profiling) and amend interventions to reflect the local picture
- training should include warning signs of CSE, how to report concerns, how to safeguard and how to prevent
- training should also include advice on evidence gathering
- awareness-raising activities should be aimed at young people and the general public, including where to obtain help and how to report
- LSCB sub-groups should be established to lead on CSE, with close links to other groups (eg trafficking, missing children)
- LSCBs should ensure there is a lead person in each organisation to implement guidance
- arrangements should be in place for either a dedicated coordinator or co-located team
- arrangements should be in place for cross border working across neighbouring local authority areas
- there should be periodic audits of multi-agency safeguarding arrangements.

2 2011 DfE National Action Plan www.gov.uk/government/publications/tackling-child-sexual-exploitation-action-plan

Key lines of enquiry for all councillors

Evidence indicates that CSE is prevalent across the country, occurring in both rural and urban areas with perpetrators and victims coming from a range of social and ethnic backgrounds. All Local Safeguarding Children Boards (LSCBs) and councils should assume it is happening in their area, unless there is clear evidence to the contrary[3].

The experiences of Rotherham go to demonstrate the key role that the leader of the council, the lead member for children's services, scrutiny committees and all councillors have in questioning and challenging responses to CSE in their local area.

The 2014 Communities and Local Government (CLG) Select Committee report, "CSE in Rotherham: Some Issues for Local Government[4]", also highlights the vital role of scrutiny in challenging officers and the executive when there is evidence of a problem which the council has failed to address. All councillors should ask questions and ensure that plans are in place to raise awareness of CSE, understand what is happening, develop a strategic response, and support victims of exploitation and help to facilitate policing and prosecutions.

The following section suggests 'key questions to ask' of officers, the LSCB or other agencies, along with suggested points to look out for. It is not intended to be exhaustive, and local approaches will of course vary, but instead aims to provide prompts to enable discussions about how the issue is being addressed locally.

1. What is the extent and profile of CSE in our local area? How do we know?

It is impossible to develop an effective response to CSE without a detailed understanding of the scale and nature of the problem locally. Learning from national studies can be a useful aid, but cannot substitute for an in-depth understanding of local trends. The LSCB should have a clear process in place for mapping the extent and profile of CSE in its area. The mapping process should include a profile of children identified as at risk, a profile of offenders and an understanding of 'hotspots' or vulnerable locations.

2. Do we have a local CSE strategy and action plan? Are these multi-agency and how is progress monitored? How does this link to other plans and strategies?

The need for local areas to have appropriate policies and procedures to tackle CSE is a common theme of national research and guidance. These must be specifically tailored to the needs of the local area, and should

3 Safeguarding Children and Young People from Sexual Exploitation 2009, Statutory Guidance www.gov.uk/government/publications/safeguarding-children-and-young-people-from-sexual-exploitation-supplementary-guidance

4 The Communities and Local Government Committee, (2014). Child Sexual Exploitation in Rotherham: Some Issues for Local Government. www.publications.parliament.uk/pa/cm201415/cmselect/cmcomloc/648/648.pdf

provide a framework that allows all agencies (including the voluntary sector) to identify their role and understand how others will contribute to tackling CSE locally.

It is not enough to simply have a suite of plans in place – it is vital that they are working effectively, have full buy in from all agencies and are regularly reviewed and updated. Elected members should consider what mechanisms are in place to ensure that strategies are actually implemented in practice, and how their impact is evaluated. This is where council scrutiny panels or committees can play an important role in questioning strategies, plans and progress. It is also important to consider the extent to which CSE features in other council plans and strategies, and those of partner agencies. Is there sufficient join up with the overall CSE action plan and strategy?

3. How effective is the Local Safeguarding Children Board? Are all agencies engaged at a senior level, and is CSE an area for priority focus?

CSE cannot be tackled by one agency operating alone. They will hold only partial knowledge of the issues, and will be unable to deliver anything more than a partial response. Effective responses must be built on a holistic understanding of the problem, which will only come through a shared commitment to partnership working. A multi-agency response does not develop naturally, it must be systematically embedded at all levels and fully integrated through multi-agency forums and work plans.

The LSCB is the key body for fostering and co-ordinating this multi-agency work, and an ineffective LSCB will have a major impact on the extent to which a local area is able to tackle CSE in a coordinated way. This relies on full engagement from all partners at a senior level, and elected members should question the extent to which this is the case in their local area. Do key partners such as the police and health provide consistent, high level representation at LSCB meetings, or do they regularly send junior substitutes? Statutory guidance, for example, is clear that the chief officer of police must be included on the LSCB. Is this case locally, and how often do they attend? How strong is voluntary sector engagement? To what extent are partners involved in the Board's wider work, chairing subgroups or taking actions. Is this a true partnership, or does one agency dominate proceedings?

Most LSCBs will also have a CSE subgroup of the main Board, or a subgroup that considers CSE as part of a wider remit – perhaps linked to missing children, or trafficking. Neither approach is preferable to the other, but it is important that the LSCB is able to demonstrate that the subgroup's work is both focussed and effective. The CSE sub-group should provide the LSCB with regular updates on actions taken and impact.

4. Does the relevant scrutiny panel receive the LSCB's annual report, and use this to challenge local priorities and outcomes?

Council scrutiny processes are a vital tool in holding the local partnership to account, and the annual report of the LSCB is a key document to consider when assessing the effectiveness of local work to tackle CSE. Reports should be outcomes focused, with a clear assessment of progress over the past year and identification of key priorities for the year ahead. These should be considered carefully by scrutiny members, and the panel should hold the Independent LSCB Chair to account for delivery.

5. What other multi-agency forums exist to facilitate joint working?

At an operational level, it is important to consider what other multi-agency forums are in place to encourage a holistic, coordinated response. Some areas have implemented regular multi-agency practitioner meetings with a specific focus on CSE, which can be a good way to keep a focus on local trends and profiles of both victims and offenders. Many areas have also introduced multi-agency safeguarding hubs (MASH) or similar, which co-locate partner agencies to encourage quicker and more effective information sharing from the point that a referral is received.

No individual system or structure should be seen as a silver bullet in improving responses on CSE, but it is important that members understand how these processes are contributing to wider strategic objectives and consider the impact that they have on local practice.

6. How is CSE incorporated into local training programmes, and who is able to access this training? Does this include training for a wider cohort than just those professionals working directly with children and young people, such as licensing officers, environmental health officers or elected members? Are outcomes measured, and are changes made as a result?

Tackling CSE requires all partners to understand how to identify children at risk, respond appropriately when concerns arise, and ultimately ensure that children are protected. A sustained programme of single and multi-agency training is central to this, and it is vital that knowledge is comprehensively disseminated across all channels of identification and response.

Local areas should think creatively about who should access this training, rather than simply focusing on social workers, teachers, health staff or police officers who work directly with children. Licensing officers, for example, will benefit from a working understanding of CSE risks when considering licensing applications; environmental health officers may identify potential victims of CSE when inspecting takeaway outlets; and some councils have begun to offer CSE training to all elected members. This is not to imply that this is the right approach for all areas, but there should be a clear understanding of the rationale behind offering (or not offering) training to specific groups.

The LSCB should have oversight of the local training offer, and members should question how this is operating in practice. Do all partners attend multi-agency training sessions, or is one agency conspicuously absent? Importantly, is there a robust mechanism in place for monitoring the outcomes of local CSE training beyond simply counting who attends each session? What has changed as a result?

7. Is an awareness raising programme in place for children, families and the wider community? Is this reaching the right people?

As with any form of child abuse, statutory services cannot tackle CSE without the support of the wider community. Social workers and police officers can only respond to issues that they are aware of and while

professionals such as teachers and health workers have a key role to play in identifying children at risk; it is within families and the wider community that many of the key risk indicators will first come to light. It is vital that everyone is aware of the signs of CSE and knows how to refer concerns through to the relevant agency. A coordinated awareness raising campaign is an essential means to achieving this.

Any awareness raising programme must be informed by a full understanding of the local context around CSE, and should be effectively targeted to take account of local profiles of victims and offenders. In some areas, this may involve a concerted effort to engage with particular ethnic groups; in others it may involve a targeted approach in particular wards. Members should question which groups, if any, are the particular focus for awareness raising around CSE and the rationale behind this and whether members can facilitate in engaging with particular communities.

Parents and carers should be central to an awareness raising programme, and should be equipped to understand the key risk factors that their children may exhibit. Awareness raising must also be targeted at children and young people themselves, most often through schools, to ensure they have a full understanding of the risk factors and the support available to them.

8. What support is available to current, potential and historic victims of CSE?

An effective awareness raising campaign will naturally increase the number of children and young people identified as potential or actual victims of CSE, and may also encourage adults who were abused as children to come forward for support. It is vital that sufficient services are in place to provide for the needs of these groups, and members should question what is currently available – and whether there is sufficient capacity to meet expected demand.

CSE can have a devastating impact on a child's life, and victims may present with extremely complex needs. Services must be in place to meet these needs, and may include:

- individual therapeutic work
- group based therapeutic work
- family counselling
- youth work support
- education, training and employment support
- sexual health and relationship education
- drug and alcohol support
- supported placements.

This list is not exhaustive.

Learning and recommendations from recent inquiries

In 2014 the spotlight was again shone on local level accountability in tackling CSE, with the Independent Inquiry into CSE in Rotherham highlighting widespread failure to address sexual abuse across multiple agencies. In October 2014 the Coffey Report was published, reviewing the approach to CSE in Greater Manchester. It highlighted local gaps in services and made recommendations to agencies and government about the progress still needed to address sexual exploitation across Manchester.

November 2014 also saw the publication of the Ofsted thematic inspections of eight local councils. The thematic inspections came about as a direct consequence of the Rotherham Inquiry, and made recommendations to improve local practice. The Communities and Local Government Select Committee Inquiry into CSE in Rotherham also underlined lessons for local councils, making a number of recommendations, particularly about the role of council scrutiny.

Here we identify key issues raised in these reports that all councils should be aware of, alongside some of the themes outlined in the final report of the Children's Commissioner's inquiry into CSE in gangs and groups. We have also included learning identified by the National Working Group (NWG), a third sector organisation formed as a network of over 2500 practitioners working to tackle CSE, gleaned from a review of recommendations from a large number of CSE research reports and inquiries.

The recommendations below are not an exhaustive list, but draw together common findings:

- focus on victims
- engaging with all communities
- better awareness raising and education for professionals and the wider community
- training for all professionals
- professional attitudes and use of language
- leadership, challenge and scrutiny
- coordinated, strategic responses and performance management
- disruption and prosecution.

Focus on victims

Ongoing support services

Ongoing support and therapeutic interventions that children affected by CSE may need is a recurring theme. Interventions should not be offered on a short-term basis but for extended periods of time. Interventions may include formal counselling or informal outreach based project work. Ofsted found that referral pathways to access therapeutic support were not always well developed and that CSE cases working with victims should not be closed too soon. The Coffey report suggested that further research is needed on the availability of counselling services for victims and those at risk of CSE. Councils should make every effort to reach out to victims of CSE who are not yet in touch with services and LSCBs should work with agencies to secure the delivery of post-abuse support services.

Ensuring all possible victims are considered

The Coffey report suggested that local strategies and action plans should include references to boys and young men, ethnic minority groups and groups with learning difficulties, to ensure that they are represented and not ignored in any local response, strategy or action plan. All victims of CSE must be considered in local responses.

Missing children

Ofsted raised concerns about children who go missing, concluding that not enough children were having a return interview following a missing episode. It was also found that information was not being cross-referenced, particularly if there were short missing episodes, from school for example, where children were only missing for a part of the school day, which is a CSE risk indicator.

Engaging with all communities

The Rotherham Inquiry made it clear that the council had failed to work with and engage local minority ethnic communities and in particular the women of those communities on the issue of CSE and other forms of abuse.

Both the Manchester and Rotherham reports made a series of recommendations about engaging with all communities. For example, LSCBs and all partner agencies should improve their methods of communicating with, engaging and working in partnership with all communities, including socially advantaged, disadvantaged, white and minority ethnic communities to raise awareness of CSE and address the issue of underreporting of CSE and abuse. Councils and their partners need to engage with local community organisations such as women's groups, youth groups and religious groups. Learning should be disseminated to parents to help build the resilience of children and young people and prevent them from becoming victims or offenders in online and street grooming circles.

It is important to treat parents as equal partners in most instances, to improve the understanding of CSE and minimise the risk to children and young people.

Better awareness raising and education: for professionals and the wider community

More information needs to be provided to the public and professionals about CSE. Those people in frontline community roles, such as pharmacists, school nurses, bus drivers, housing officers, shopkeepers, hoteliers and taxi drivers, should be made aware of the signs and what to do if they suspect CSE. Awareness raising campaigns also need to be clear that CSE affects both boys and young men as well as girls and young women. Councils and their partners should engage the media in a more proactive way to raise awareness about CSE and the effect on victims. Ofsted's report commended the level and type of awareness raising campaigns to safeguard children in the areas it inspected.

The Office of the Children's Commissioner recommended that relationships and sex education must be provided by trained practitioners in every educational setting for all children and young people. This must be part of a holistic/whole-school approach to child protection that includes internet safety and all forms of bullying and harassment and the getting and giving of consent.

Leadership, challenge and scrutiny

The Rotherham Inquiry found that "the Rotherham Safeguarding Children Board and its predecessor oversaw the development of good inter-agency policies and procedures applicable to CSE. The weakness in their approach was that members of the Safeguarding Board rarely checked whether these were being implemented or whether they were working." The report drew attention

to the vital importance of the challenge and scrutiny function of the LSCB and of the council itself to ensure robust responses to tackling CSE.

The Ofsted thematic inspection report highlighted that, in areas where CSE had been made a priority, local strategies were better developed and linked in to other key local strategies, such as gangs and licensing. Senior leaders and politicians generally had a better understanding of the issues in those areas, and elected members were recognised as challenging and scrutinising the work of professionals effectively. Ofsted suggested that in areas where the LSCB CSE strategy was underdeveloped and the financial and resource implications of tackling CSE were unknown: "elected members must urgently improve the quality and level of scrutiny and challenge to ensure that local authority senior leaders and partners are coordinating an effective response."

The CLG Select Committee Inquiry recommended that any council where there are credible allegations or suspicions of child abuse must investigate them and conduct a review of the response and local approach. The report also raised a number of concerns about the role of scrutiny in Rotherham, citing that nobody had checked the quality or actual implementation of strategic plans. The Committee noted that, particularly where councils have a single party predominance or where there may be strong and dominating personalities, the role of scrutiny is essential. The scrutiny function should be separated from the executive of the council to ensure there is robust challenge when there is evidence of an acute problem which the executive and lead officers have failed to address. There were also concerns about the skills and level of training for executive councillors, who were not challenging low quality reports by officers.

In our 'Key lines of enquiry' section of this report, we suggest questions that lead members, scrutiny chairs and all councillors should be asking of their officers and partner agencies to ensure that CSE is being addressed effectively at the local level.

Professional attitudes and use of language

The Office of the Children's Commissioner's Inquiry and report recommended that the use of the term 'child prostitution' should be removed from all government documents and strategies. The recent Coffey report also recommended that there should be no references to child prostitution in any documentation. This dated language has been found in a number of areas and councils should review all of their documentation related to CSE and ensure that references to child prostitution are removed.

Coordinated, strategic approaches and performance management

Councils and LSCBs require a strategic approach, with coordinated, joined up local responses to address CSE. Recommendations include joint commissioning arrangements for CSE, sexual assault, rape and domestic abuse support services; common thresholds for interventions across agencies; clear referral pathways; pooling of budgets across the police, council children's services and health services.

Ofsted's thematic inspection raised concerns that not all local areas were collecting and sharing the information needed to have an accurate picture of CSE in their area. There was a lack of evaluation about how effectively CSE cases were being managed, and therefore this could not be used to improve current practice. Ofsted highlighted a number of concerns, including: not using formal child protection procedure in cases where children and young people were identified at risk of CSE; screening and assessment tools not being used consistently; management oversight of cases not being consistent and children in need plans not being robust enough. They also suggested that dedicated CSE teams did not necessarily mean that children received improved services, as specialist CSE support was also needed in addition to a social worker.

There are a series of recommendations from the recent reports for LSCBs, including:

- The LSCB should develop locally agreed clear information sharing protocols to ensure that children at risk can be identified at an early stage.
- LSCBs must undertake scoping activity in the local area to identify the level of need in their area and ensure that service provision effectively supports young people who experience both running away and CSE.
- Every Local Safeguarding Children Board should review their strategic and operational plans and procedures against the seven principles, nine foundations and the See Me, Hear Me Framework of the Office of the Children's Commissioner's final report, ensuring they are meeting their obligations to children and young people and the professionals who work with them. Gaps should be identified and plans developed for delivering effective practice in accordance with the evidence. The effectiveness of plans, procedures and practice should be subject to an on-going evaluation and review cycle.
- CSE should be included in local performance frameworks to ensure it is a priority for all agencies.
- Governance arrangements should be clear between the Health and Wellbeing Board, the Community Safety Board and the Local Safeguarding Children Board, to ensure a coordinated approach and ownership of the local response.

Training for all professionals

The National Working Group Network report, citing Barnardo's recommendations, suggested that training should be developed for frontline staff in services for children and young people to recognise the warning signs and risk factors of child sexual exploitation and how to respond using child protection procedures. This should include understanding the elements of grooming and coercion so that a child or young person's behaviour is not dismissed as rebellious or somehow consenting to the abuse. It should also include an understanding of the sexual exploitation of Black, Asian and minority ethnic victims and different types of victim-offender models. Information about the behaviour of people who sexually offend should also be incorporated into training and awareness-raising activities.

Ofsted suggested that existing training for professionals was of a high standard, but wasn't always reaching or targeting the right people. Councils were not found to be evaluating the impact of the training to find out whether it was making children and young people safer. Some staff, such as those working in education were not always attending or being given training. The report praised councils where the training was compulsory for elected members and professionals who work with children and young people, and saw a more coordinated approach to tackling CSE in those areas where this was the case.

Disruption and prosecution

Reports have raised concerns regarding the number of allegations made about CSE and perpetrators and the number of associated prosecutions. There are a number of recommendations for the police, the Crown Prosecution Service and others, but for councils it was made clear that not all areas are making best use of the full range of powers available to them to disrupt offenders.

For example some areas were not issuing abduction notices where they may have been appropriate to safeguard children from sexual exploitation. Multi-agency working and information sharing across partners, including with the police, was seen as a vital approach to improve disruption activity.

Child sexual exploitation: myth vs reality

Recent media attention on specific cases of CSE has led to sector wide concerns that stereotypes and myths about this crime could lead to a narrow focus on one particular form of CSE. The danger of this is that attention can be diverted from crimes which do not appear to match that model, with the risk of victims not receiving the help they need.

There are many myths surrounding CSE and the examples used here are taken from the interim report of the Office of the Children's Commissioner's (OCC) Inquiry into CSE in Gangs and Groups. They are all real, though the names have been changed[5].

10 myths and the reality

Myth #1:
There are very few 'models' of CSE

Reality: The grooming and sexual exploitation of young people can take many different forms. CSE can be carried out by individuals (lone perpetrators), by street gangs or by groups. It can be motivated by money ie commercial sexual exploitation, which involves the exchange of a child (for sexual purposes) for the financial gain of the perpetrator or for non-commercial reasons such as sexual gratification or a belief in entitlement to sex. It can occur in a wide range of settings, but the common theme in all cases is the imbalance of power and the control exerted on young people. The stories below highlight just some of the different models that exist.

Sophie's story

'Sophie's' mum, Linda, has been known to a local violence against women service for a number of years because of the violence she has experienced from multiple partners. Sophie is a white British young woman and she was 13 years old when Linda met Ray. Ray, who was also white British, moved in with Linda and was violent towards both her and her children. Ray began to invite his friends around to the house. They, in turn, were abusive to Linda and her children. Following this, Ray offered Sophie as a sexual commodity to his friends on a regular basis, and threatened Linda and Sophie with violence if Sophie did not comply.

Site visit 4 evidence

5 The myths in this report were put together for a 2013 briefing in conjunction with the NWG Network: Tackling CSE and the Office of the Children's Commissioner. Berelowitz, S. et al (2012) "I Thought I was the Only One. The Only One in the World" The Office of the Children's Commissioner Inquiry into Child Sexual Exploitation In Gangs and Groups Interim Report. http://www.childrenscommissioner.gov.uk/content/publications/content_636

Teegan's story

'Teegan', a white British young woman, was sexually exploited from the age of 12 years old. From the age of 13 Teegan was taken by a Turkish man to a variety of 'parties' across England that she reports were in nice houses and in some cases described as 'mansions'. In these houses Teegan would be raped by several men, from a range of ethnicities, who were paying to use her. Teegan described a book being available with photographs and ages of all of the girls being sexually exploited by this particular group. Men could choose which girls they wanted. Teegan reported men paying those who were exploiting her up to £500 for an hour with her. Groups of men could also request one girl to share between them over a night, where the rape of the girl would be filmed. The operation involved men working the streets to pick up vulnerable girls, forming 'relationships' with them by grooming them and then passing them on to the men who controlled the business. If Teegan ever refused to comply, she would be beaten and her family threatened. Following the abuse, Teegan took several overdoses, was placed in secure accommodation, and self-harmed by cutting and ligaturing sometimes on a daily basis. Teegan described the abuse that she experienced as serious and organised, and is unwilling to make a formal complaint for fear of repercussions from those involved in the operation.

CSEGG interview with a young person

Sahida's story

'Sahida', a 17-year-old British Pakistani young woman, made an allegation of sexual abuse against a family member. As a result she was threatened with a forced marriage. Sahida's family claim they want to remove her from the country to curb her 'wild behaviour'. Following these threats Sahida began spending time with older males, described by professionals as 'Asian', and was moved to multiple locations by them. Sahida is now pregnant as a result of the sexual exploitation she has experienced. Family members have physically assaulted Sahida as a punishment for the pregnancy.

Call for evidence submission

Myth #2:
It only happens in certain ethnic/cultural communities

Reality: Both perpetrators and victims are known to come from a variety of ethnic and cultural backgrounds. CSE is not a crime restricted to British Pakistani Muslim males or white British girls, despite media coverage of high profile cases. Site visits carried out by the OCC inquiry identified perpetrators and victims of CSE from a wide range of ethnic backgrounds. A thematic assessment by the Child Exploitation and Online Protection Centre identified that "Research tells us that the majority of known perpetrators in the UK of this crime are lone white males".

However, it is important that councils and partners do not shy away from confronting the reality of CSE in their area. Through the LSCB, a clear profile of local need should be developed that clearly identifies the prevalence and profile of sexual exploitation taking place. If a particular group or community is disproportionately involved in the abuse of children and young people, this must be acknowledged and tackled.

Myth #3:
It only happens to children in care

Reality: The majority of victims of CSE are living at home. However, looked after children account for a disproportionate number of victims and can be particularly vulnerable. An estimated 20-25 per cent per cent of victims are looked after, compared with 1 per cent per cent of the child population being in care. This does, however, leave around 80 per cent per cent of victims who are not in the care system.

Myth #4:
It only happens to girls and young women

Reality: Boys and young men are also targeted as victims of CSE by perpetrators. However, they may be less likely to disclose offences or seek support, often due to stigma, prejudice or embarrassment or the fear that they will not be believed. They may feel that they are able to protect themselves, but in cases of CSE physical stature is irrelevant due to the coercion and manipulation used.

Randall's story

'Randall' is a 15 year old boy, of mixed ethnic heritage, and described by professionals as 'exploring his sexuality'. He is said to be unaware of safe routes to meeting other gay young people. Professionals report Randall has been seen hanging around at bus stops. He has disclosed to professionals that he has been targeted by groups of men who are grooming him to exchange sex for alcohol, cigarettes and acceptance. Professionals are working with Randall to try to keep him away from areas of risk, but they are aware he continues to go missing and are unable to account for his whereabouts on all occasions.

Site visit 8 evidence

Myth #5:
It is only perpetrated by men

Reality: There is evidence that women can be perpetrators of this crime too. They may use different grooming methods but are known to target both boys and girls. In relation to group and gang related CSE, the OCC inquiry found that the vast majority involved only men and, where women are involved, they are a small minority. Where women or girls were identified as perpetrators, their role was primarily, though not exclusively, to procure victims. Women and girls who were perpetrating were identified during the inquiry's site visits tended to be young, had histories of being sexually exploited themselves and of abusing others in tandem with the group or gang that had previously sexually exploited them. Women and girls directly involved in sexually exploiting children were either in relationships with men who were perpetrators or related to, or friends with, men and boys who were abusers.

Myth #6:
It is adults abusing children

Reality: Peer-on-peer child sexual exploitation happens too and this can take various different forms. For example, young people are sometimes used to 'recruit' others, by inviting them to locations for parties where they will then be introduced to adults or forced to perform sexual acts on adults. Technology can also play a significant role, with young people known to use mobile technology as a way of distributing images of abuse.

Rebecca's story

Rebecca is a 15-year-old black British girl, and has reported she was forced by a group of girls to have sex with a boy in the girls' toilets at their school; otherwise they would beat her up. The group of perpetrators were made up of three 14-year-old girls and one 14-year-old boy, all of whom were black British. One of the girls is described as the 'instigator' of the assault .Another girl filmed the assault on her mobile phone. The assault took place as part of a pattern of ongoing bullying of Rebecca. She was anally raped by the 14-year-old boy. She had never had sex before this assault.

Police Case File Submission

Myth #7:
It only happens in large towns and cities

Reality: Evidence shows that CSE can and does happen in all parts of the country. CSE is not restricted to urban areas such as large towns and cities but does in fact happen in rural areas such as villages and coastal areas. High profile police operations in areas as diverse as Rochdale, Cornwall and Oxfordshire are clear examples of this. Young people can also be transported between towns, cities, villages etc., for the purpose of being sexually exploited and this is known as trafficking within the UK (an offence punishable by up to 14 years imprisonment).

Myth #8:
Children are either victims or perpetrators

Reality: The OCC inquiry found that around 6 per cent per cent of victims reported in their call for evidence were also identified as perpetrators. It is important to keep in mind that, although children may appear to be willing accomplices in the abuse of other children, this should be seen in the context of the controls exerted by the perpetrator.

Mitchell's story

'Mitchell' is a white British 17 year old boy, and has been known to the youth offending service for several years. From the age of 12 Mitchell was seen spending time with white British men, some of whom were believed to be sexually exploiting young women in the local area. Some of these older males bought Mitchell trainers, taught him how to comb his hair in particular ways and how to speak to girls. The older men also introduced Mitchell to some of the girls that they were sexually exploiting. At one point, he was found locked in a garage where one of the older males had brought young female victims of abuse. Mitchell gradually became involved in the sexual exploitation of young women in the local area, and would pass them onto his older peers.

Site visit 2 evidence

Myth #9:
Parents should know what is happening and should be able to stop it

Reality: Parents may be unlikely to be able to identify what is happening: they may suspect that something is not right but may not be in a position to stop it due to the control, threats or fear of the perpetrators. There can be risks to parents when seeking to protect their children and they can need support as well as their children. In some cases, there can be an overlap with abuse within the family and this could be a reason why parents do not intervene.

Myth #10:
Children and young people can consent to their own exploitation

Reality: A child cannot consent to their own abuse. Firstly, the law sets down 16 as the age of consent to any form of sexual activity. Secondly, any child under-18 cannot consent to being trafficked for the purposes of exploitation. Thirdly, regardless of age a person's ability to give may be affected by a range of other issues including influence of drugs, threats of violence, grooming, a power imbalance between victim and perpetrators. This is why a 16- or 17-year-old can be sexually exploited even though they are old enough to consent to sexual activity.

Local case studies

Blackburn with Darwen Council: Engage Team

Background
Operation Engage was a police led operation set up in 2005, focusing on an area of Lancashire where there were a large number of missing children. Operation Engage worked with a total of 30 children, all girls, over a period of three years. The team built up ongoing, trusting and supportive relationships with the young people, who over time disclosed a range of sexual and violent abuse. All of the children (bar one) were looked after, and mostly cared for in children's homes.

The project
In 2008 the Engage Team, a co-located multi-agency response to tackle CSE, was established by Blackburn with Darwen Safeguarding Children Board to continue the work initiated under Project Engage. The team are co-located in one building and key partners are social care, police and health. Voluntary sector service providers are also a key delivery partner. The team consists of: one team manager; six young people's workers (from the council, Barnardo's and Brook); one social worker; one administrator; two nurses; one PACE worker (Parents Against Child Sexual Exploitation, parent support worker); one Princes Trust worker; one detective sergeant; four detective constables and one missing from home coordinator (police). Many external partners are also involved in the work of the team, with virtual support for the wider group of partners who have weekly team meetings eg youth offending, schools, the women's centre, drug and alcohol service and licensing services.

The team has developed over time, becoming more specialised in CSE services from 2009 onwards. Understanding of patterns of abuse, risk factors and warning signs of CSE has developed over time and the team approach reflects this. Since April 2014 the team has additionally been responsible for all interviews when a child returns from a missing episode. The team are independent of the care planning pathway process for 11 -18 year olds, and only involve social workers when there is a clear need, for example where there are cases of neglect at home. CSE demands a non-stigmatising response, so young people's workers are the preferred main point of contact.

The team has access to information on databases from all agencies; the information is shared openly (and legally) in order to protect children. The team reports are always reported up to the LSCB. A work culture where everyone has a genuine voice, where all agencies are equal partners, works well in Blackburn with Darwen; there is no single dominating partner and everyone has ownership of the issues.

Impact
Current key challenges for the team are to ensure that they remain child focussed and non-stigmatising, whilst also aligning processes, such as the recording and evidencing required by social work procedures. Incorporating processes, without letting services be dictated by that process has been a key challenge, avoiding delays in supporting the child or loss of the sensitive approach.

The team has achieved a number of successful prosecutions, resulting in a total of 700 years in custody for perpetrators. This accounts for sexual offences specifically, and does not include other disruption activity such as prosecution for offences such as drugs related charges or abduction order notices. Prosecutions are led by police staff in the Engage Team. The Engage Team worked with the Crown Prosecution Service (CPS) to assess how they could gain convictions using robust evidence, and consequently the team now looks for evidence which supports the young person's story, rather than identifying the gaps and weaknesses. A young person's key worker will prepare the child for the court process, throughout the case, including post-trial; and a PACE worker provides support for parents. The team have a 98 per cent success rate. Over time the team are now predominantly dealing with grooming offences; concentrating on prevention and disruption activity.

The Engage Team Manager, Nick McPartlan, advises that "senior leaders and politicians need to be open, honest and transparent and demonstrate flexibility when addressing the abuse. Political sign-up, resources and capacity are vital."

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Calderdale Council: Co-located specialist CSE team and daily intelligence sharing meetings

Background
In Calderdale, prior to June 2014, children who were identified as being at risk of sexual exploitation were experiencing different levels of service provision across the first response and locality teams. Communication between the key agencies involved in service delivery was sometimes a barrier in ensuring young people received a swift joint approach to address their needs. The agencies delivering relevant services were based in different locations and not always available to respond immediately.

The project
Since June 2014, police officers and social workers have been co-located in a specialist CSE team at the police station. Other key agencies such as The Children's Society's 'Safe Hands', health, youth services and the youth offending team are also part of the virtual team. Daily briefings are held and any intelligence is shared immediately so robust action can take place to ensure children identified at risk of CSE are safeguarded. The roles and responsibilities of the police officers and social workers within the team are clearly set out, as are the responsibilities of the key partner agencies working with the team. The wider operational group of partner agencies now attend a weekly meeting so that all information can be shared in a more timely and effective way.

Impact
The new approach has led to a number of improvements in local work to protect children and young people from CSE:

- all new cases are discussed at the next daily briefing and multi-agency decisions are made regarding the appropriate action to be taken

- fewer transfer points are promoting greater consistency in services for children and young people
- there is improved communication and joint working between social care, the police and the voluntary sector service provider and an increased number of joint visits between the three key agencies
- the continuity of shared intelligence and response delivered by social care staff within the team has improved
- the team provides CSE expertise, support and where required, joint visits to children on the local CSE Matrix who have remained with other social care teams
- there is CSE social care support and guidance in respect of thresholds regarding young people who are on the CSE Matrix
- the team ensures that all operational group recordings and intelligence is shared with other social care staff and recorded on the child's electronic file
- social care staff are now a part of the preventative programme delivered to other agencies.

Many of the actions being taken in Calderdale are recent processes, and results and improvements in processes are already being seen. The council and partners acknowledge that there are still areas for further action including the continual review of team, the processes in place and resources available and needed.

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Essex Safeguarding Children Board: CSE champions

Background
Essex Safeguarding Children Board (ESCB) formed a strategic group with neighbouring local authorities, Southend and Thurrock, to ensure a joint approach to child sexual exploitation (CSE) across the County.

One of the key outcomes from the strategic group was to develop a CSE champion role, and each organisation was subsequently asked to nominate a lead within their agency.

The project
The key features of the CSE champion's role are to:

- keep up to date with developments, policy and procedures in relation to CSE
- act as a point of contact for disseminating information from the ESCB
- provide advice and signposting in relation to individual cases.

The CSE champions are expected to be familiar with the Essex CSE risk assessment toolkit, know how to submit intelligence to Essex Police, cascade the learning from the CSE champions training and provide ongoing updates to their teams.

Impact
There have been about 300 CSE champions trained from various organisations across Essex; some organisations have more than one champion because of their size.

Currently the format of the champions training comprises a full day, with the first half delivered by local practitioners from the Essex Police child sexual exploitation triage team and the Essex County Council CSE lead. The afternoon session is delivered by a psychotherapist who focuses on brain science, understanding perpetrators and making sense of responses of victims.

Going forward, Essex intends to make this a half day training session facilitated by the police and council with input from a voluntary sector organisation. The training will be more focussed on how to apply the tools available in Essex and will be a practical session using case studies.

One of the biggest outstanding challenges is being able to meet the demand for training, particularly as it is being delivered by operational staff and therefore has to fit in with the demands of their day job.

The champion role is an important mechanism for the ESCB, helping to raise awareness about CSE, the Essex risk assessment toolkit, and the importance of submitting the right intelligence to the police. Champions also act as a key communication route through the agencies to staff teams and the community.

As a way of providing ongoing support, the ESCB has recently completed four CSE Champions networking forums in each quadrant area, which have been well attended. This is part of the ongoing commitment to supporting CSE champions in their workplace.

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Greater Manchester: Project Phoenix, It's not okay campaign

Background
Project Phoenix emerged from the Greater Manchester Safeguarding Partnership in April 2012, following a scoping exercise into existing practice in relation to child sexual exploitation. The project was partly a response to high profile cases in Rochdale, Stockport and other parts of the country and recognition from all partners that a more effective joined-up approach was needed to tackle CSE. Project Phoenix was Greater Manchester's single, collaborative approach which aimed to improve the response to CSE strategically, operationally and tactically.

The project
Phoenix is a key priority for the Association of Greater Manchester Authorities' (AGMA) Wider Leadership Team. The Phoenix Executive Board is chaired by the City Director for Salford City Council and the Board feeds directly into the AGMA Wider Leadership Team and the Greater Manchester Leaders' Forum. Tackling CSE is also a priority for the Police and Crime Commissioner and Greater Manchester Police.

The main objectives of Phoenix are to:

- raise standards across all partners in dealing with CSE
- improve cross-border working between local authorities in Greater Manchester

- improve consistency across Greater Manchester
- achieve buy in from all key partners
- raise awareness of CSE with the public, professionals, businesses, young people, etc
- encourage people to report concerns in relation to CSE.

Under Phoenix there are now specialist CSE teams in place in each of the ten districts of Greater Manchester. Each team works with young people being sexually exploited and offers a joined-up, multi-agency response. Prior to Phoenix, there were only two such CSE teams in the region. Phoenix provides advice, support and guidance to these teams to ensure that all professionals are working to a consistent set of standards and procedures to improve services offered to victims and those at risk of CSE.

Impact
One of the main achievements of Phoenix has been to develop and roll out a consistent approach to measuring a young person's risk of CSE. Regardless of where a young person lives in Greater Manchester they will receive the same CSE assessment, meaning that all local authorities and key partners are talking about the same thing when it comes to CSE risk.

The scoring system of the tool allows for professional judgements to be made and is child focussed. The information can be collated and sent to LSCBs in a consistent way and is used to develop a better picture of the scale of CSE across Greater Manchester. The project has also developed local information sharing protocols, education guidance and guidelines around disruption activity.

According to Damian Dallimore, Project Phoenix Manager, "Since its inception in 2012 Phoenix has made great strides in the services we offer to young people affected by CSE and their families. To do this we need the support of the public, professionals, businesses and young people, to contact us with any concerns they may have in relation to young people being targeted and exploited in this way and I would encourage everyone to have a look at our website www.itsnotokay.co.uk where you can find out more about CSE as well as help and advice about where to report it and steps you can take to ensure young people are kept safe."

Further information
The Project Phoenix website, including campaign materials and a range of resources for young people, parents and professionals can be found at: www.itsnotokay.co.uk

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Pan-London Operating Protocol for CSE

Background
The Metropolitan Police Service (MPS) first set up a London wide CSE team in 2012, and the Pan-London Operating Protocol to tackle CSE emerged from the work of this regional team. Detective Superintendent Terry Sharpe chaired a multi-agency group and researched best practice in tackling and disrupting CSE from other areas, and those who had managed successful disruption and prosecution of offenders.

The project

The Pan London Operating Protocol brought together a set of procedures on how to tackle CSE for all 32 London Boroughs, to ensure a consistent approach was being taken across the capital. The Protocol was originally trialled in the summer of 2013 to ensure it was fit for purpose and the final version was launched in February 2014 in London's City Hall. The primary aim of the Protocol is to safeguard children and young people across London from sexual exploitation, and all London boroughs and LSCBs are signed up to the Protocol.

The Protocol is designed to raise awareness, safeguard children and young people and enable identification of perpetrators of CSE and to bring them to prosecution. To do this local interventions and disruptions are being put in place. It can often take a long time to gain the trust of a victim to get them to disclose what has happened to them, so in the meantime creative disruptions are put in place to stop or prevent the abuse from happening. For example a CSE investigation into one perpetrator led to their vehicle registration number being added to the police database. As a result the perpetrator was pulled over and firearms were found in the back of their vehicle. The perpetrator is now in prison, but is not aware that he was stopped as a result of a child sexual exploitation investigation.

The Protocol has established three categories of CSE. The first category, Level 1, is used when there is suspicion of CSE, but no evidence as to what is happening. This is recorded on the police system, so that if there are further suspicions at a later point in time, then there is more evidence to support the case. The information also helps to identify perpetrators and potential 'hotspots.' Level 1 cases are dealt with by local borough police officers or the appropriate statutory agency who is best placed to provide clarity regarding these suspicions. Details of children and young people and with suspected perpetrators are entered onto the Police National Database (PND). Therefore, if a frontline officer finds a young person in a known 'hotspot' area for CSE, or if they stop a car and have concerns, they will be able to take the appropriate action to safeguard the child even when no offences have been disclosed. The level 1 category was not previously recorded by the police in London on a crime recording database, as no crime has been known to be committed at this stage. Level 2 and 3 cases are more serious and dealt with by the centralised MPS CSE Team.

Impact

The Protocol is helping to raise awareness of CSE, particularly amongst frontline police officers. Two videos have been shown to all frontline officers, including telephone staff handling 101 calls. This includes a video outlining the warning signs of CSE. The mnemonic 'SAFEGUARD' has also been created to help officers remember the warning signs along with an app that can be downloaded to assist in remembering the signs. The second film highlights the approach taken by Thames Valley Police in the 'Operation Bullfinch' investigation and shares a victim's perspective of how she was dealt with by the police during her ordeal. This is followed up with a one hour training session, which all frontline Met police officers have attended.

The Protocol has led to improved awareness of CSE amongst the community, particularly with hoteliers and other local businesses such as taxi firms. For example, the London Borough of Waltham Forest has recently launched 'Operation Makesafe,' a partnership initiative with the local business community to identify potential CSE victims and, where necessary, to deploy police officers to intervene before any harm occurs to a child or young person. Operation Makesafe has involved an awareness raising marketing campaign and training for local hoteliers, off licences and taxi firms, to recognise the CSE warning signs and what action should be taken if CSE is suspected. As a result of the training a local firm agreed to donate marketing materials, such as hotel door adverts, posters and car mirror hangers for taxis, for free.

According to Detective Superintendent Terry Sharpe "senior level engagement across partner agencies in delivering the protocol makes a big impact in tackling CSE."

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The Pan-London Operating Protocol can be found at: http://content.met.police.uk/Article/Launch-of-The-London-Child-Sexual-Exploitation-Operating-Protocol/1400022286691/1400022286691

Portsmouth: CSE strategy and awareness raising campaign

Background
The Portsmouth Safeguarding Children Board set up a CSE subcommittee in 2012 and tasked the council in early 2014 with developing the local CSE strategy. The strategy has been implemented across partners alongside a local CSE action plan and risk assessment tool.

The project/strategy
In conjunction between the Portsmouth LSCB and the Safer Portsmouth Partnership, a marketing campaign was launched in 2013, using a web based approach and traditional billboard and bus adverts to promote 'Is this Love?' The campaign looked at the aspects of a healthy relationship, highlighting the concerns about both domestic abuse and sexual exploitation of young people. The campaign also tied into the Safer Portsmouth Partnership priority of addressing high rates of domestic abuse in the area, particularly amongst young people. It is important to distinguish CSE from other forms of abuse such as domestic violence, however, there may sometimes be links and similar indicators, so all teams in Portsmouth are joined up to ensure appropriate information sharing and plans are in place to safeguard children and young people identified as at risk of abuse.

In addition to the publicity work, a theatre based production for young people, Chelsea's Choice, was run in Portsmouth secondary schools to help young people explore the risks and warning signs of CSE. In early 2014 an awareness campaign was also delivered across local services including GPs and the police, this included a CSE conference for local agencies.

A risk assessment tool was developed as part of the local action plan, based on the Derby Model, and adapted to the local circumstances. This was recently implemented for local agencies to help identify children at risk of CSE. Spot the signs training was also delivered to professionals across the partner agencies. In early 2014 a local CSE strategy was developed; the strategy is a short document, used as a practical tool for front line workers, particularly to give local context to the CSE action plan. The CSE sub-committee of the Portsmouth Safeguarding Children Board has also established a multi-agency operational panel to ensure the coordination of the identification, assessment, and planning for children and young people at risk of or experiencing CSE.

Impact

As a result of the specific local focus and joined up approach to tackling CSE; there have been huge improvements in identification and support for children and young people at risk of CSE.

In Portsmouth a Joint Action Team, with co-located services including social workers, police, health, a domestic abuse worker, targeted youth support worker and Barnardo's, lead on

working with young people identified as being at risk of CSE or trafficking, as well as children and young people who have returned from a missing episode. The work of the team feeds directly into the multi-agency CSE operational group comprising health, police and children's services. The group regularly shares information on the age profiles of victims, gender and ethnicity information, as well as whether children are looked after by the local authority and any professional from any team can raise concerns they have about a specific young person. Details of suspected perpetrators, locations of concern and disruption work are also shared within the group. The meetings give the police the opportunity to share 'soft information' of interest, for example where shops may have been selling legal highs.

The Portsmouth CSE strategy provides direction and filters down to the front line to give focus on CSE, and has influenced changes in practice, for example the risk assessment toolkit is being updated to reflect recent national level developments in CSE. The CSE action plan and strategy is in the process of being refreshed to ensure that it incorporates the wider approach to missing, exploited and trafficked children and young people. Portsmouth Council, the LSCB and the police have also been working on an improved data gathering process for children who go missing. Incidences of children who go missing are currently under-reported, and the council and key partners are working to understand the levels of need of children who have been trafficked.

The refresh of the CSE strategy and action plan is examining in closer detail the impact and outcomes of the local approach, for example, many local indicators are moving in the right direction but the committee is now evaluating impact to establish whether the improvements are a direct result of the local action plan, awareness raising and disruption activities.

Nicola Waterman, Strategy Manager, says that "commitment of all partners is essential in developing a CSE strategy and action plan. Involving all partners from the outset, particularly where there are a number of health agencies, is vital."

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Slough Council: Licensing 'splinter' group

Background
In late 2013, Slough LSCB and Thames Valley Police agreed to work together on a CSE awareness raising campaign for licensed premises. A 'licensing splinter' group was established, linked to the CSE sub- group and consisting of representation from Slough Borough Council licensing team, an Engage worker (CSE specialist team) and a Thames Valley Police Inspector. The group continues to meet on a bi-monthly basis; their work is strongly supported by councillors and forms a key part of the overall communications package on CSE awareness raising.

The project
In late 2013, the licensing group wrote a short article about CSE, which was published in the Slough Taxi & Private Hire Newsletter. CSE has consistently featured in subsequent newsletters to re-enforce awareness, and taxi firms and ranks are a key focus for the 'Licensed Premises' working group. CSE is now mainstreamed into the work of the council licensing team, which has been significant in helping to maintain momentum on issues such as delivery of a CSE

presentation to the Pub Watch Scheme members in December 2013. The three teams involved in the working group set about coordinating premises visits in specific areas, and team members unfamiliar with CSE were trained and briefed on the key messages and action to take. A script with consistent messaging was developed to relay to local businesses. Thames Valley Police and the licensing team have now visited all local hotels and B&B's. The Engage team and police community support officers visited other local businesses and the council's food and safety and trading standards officers are also raising awareness at fast food outlets and other retail outlets during routine inspections.

During visits to local businesses, awareness raising packs were distributed. Hotels and B&Bs received a Say Something If You See Something (SSIYSS) poster, Children's Commissioner CSE indicators, a letter from the Slough LSCB Chair and a Barnardo's leaflet.

Impact
Following each 'wave' of visits, the team completed an evaluation detailing exactly which premises were visited and noting the time it took, who they spoke to and comments about the discussions with businesses and any concerns or questions that were mentioned.

- During 2013 there were 24 joint visits to hotels and B&B's, 44 packs were distributed.
- 261 joint visits were made to local businesses.
- Hotels contacted 101 to share concerns about CSE on three occasions.
- The number of visits in the two years up to December 2014 has now risen to 441.

The SIYSS posters and full awareness raising packs that the team put together, including the letter from the Chair of the LSCB, enabled a professional and credible range of information to be presented to the hotel trade. Over the summer of 2014 the team revisited premises in particular 'hotspot' areas, including hotels. The team took out posters and enquired to find out if they hotels had been displaying them and how staff members were being involved in being alert to CSE.

A multi-agency approach, embedded via the 'splinter group', has delivered enormous benefits, enabling a sharing of resources without placing a large capacity strain on a single agency. By visiting premises and hotels, publishing articles and having a better, wider presence across the town, the licensing working group has increased the degree of conversation within the communities about the issue of CSE in Slough.

In May 2014 the Engage team at Slough Council received an award from the National Working Group: Tackling Sexual Exploitation Network, for their work to address CSE. The council's licensing team was also recognised in early 2014 with a Berkshire Environmental Health Officers Award for Achievement for their work on raising awareness of CSE.

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www.slough.gov.uk/council/strategies-plans-and-policies/awareness-raising-initiatives.aspx

The NWG Network and The Children's Society have developed a campaign pack supporting local safeguarding children boards to work with retail, transport, and leisure and hospitality businesses to protect children in their communities from child sexual exploitation. The resources are available at: www.nwgnetwork.org/resources/resourcespublic?cat=74

Stoke-on-Trent City Council: Commissioning an independent review of CSE and missing children services

Background

Stoke-on-Trent City Council has always taken a proactive approach to analysing the work being done to protect and support vulnerable children and young people and was keen to learn how they could improve their practices and processes in this area.

A third sector organisation, Brighter Futures, is commissioned to deliver services for young people at risk and victims of sexual exploitation in Stoke-on-Trent. The service, known as Base 58, was due to be re-commissioned by March 2015. In February 2014, the decision was made to examine the existing service provision, looking at the strengths and weaknesses of the wider CSE multi-agency system, and assess where there were improvements needed. Brighter Futures was additionally contracted, alongside Base 58, to follow up children who had been reported missing, with workers making contact with young people who had been reported as missing within 48 hours of their return.

The authority commissioned a review of its CSE and missing children service which took place between May and July 2014. In August 2014, 'The Child Sexual Exploitation Service and Missing Children Service for Young People in Stoke-on-Trent; A Review' was published.

The project

The CSE and missing children service review was commissioned by children and young people's commissioners; with the public health team and the Stoke-on-Trent Safeguarding Children Board supporting the review.

The proposal for the review went to the LSCB for their approval and commitment. The process took a total of 8 months from the initial proposal to the final report. The design of the review included an assessment of best practice and benchmarking of the CSE and missing children services. Chanon Consulting in conjunction with the University of Bedfordshire was deemed to be the most appropriate bid, due to the academic rigour and credibility of the proposed approach.

The approach entailed a paper review of policies and procedures, as well as numerous qualitative and quantitative methods. Focus groups were conducted with practitioners, commissioners from the children and young people's service, police, managers, and third sector providers. Children in care were involved, as was the Chair of the LSCB. In addition, case studies of children and young people who had been using the services were also provided.

Outcomes

The report highlighted significant good work and practice, particularly concerning the council's joined-up work with safeguarding partners. In addition, there was praise for the recognition by agencies that CSE continues after 18, with support for young people transitioning to adult services; and mention of the efforts made with schools to raise awareness of the issues.

Recommendations for further work were also noted, with the need to address some minor issues, as well as longer term goals for the CSE and missing children service and suggestions for improved multi-agency working. Quick wins included the creation of a CSE coordinator post. The review has resulted in an action plan which has been put together and is being taken forward. The action plan is owned jointly by all agencies on the LSCB executive. The current CSE and missing children service has been extended for 12 months to enable the council to

ensure that it gets the recommendations of the report right, and to implement any necessary CSE service and wider system re-design.

Amanda Owen, strategic manager for safeguarding and quality assurance at Stoke-on-Trent City Council, says: "We take the issue of child sexual exploitation extremely seriously. That is why, as part of our overall strategy to prevent CSE in the city and to protect our vulnerable young people, we commissioned this independent review. The report has left the city in a very good position to improve services."

To fully benefit from a review of CSE services and strategies, councils and LSCBs should:

- be prepared to take an honest look at the services delivered
- be absolutely honest and transparent about arrangements, for example with the public, the media and all key stakeholders
- consider whether a review is being conducting for the right reasons. Are you willing to redesign and improve your services as an outcome of the review?
- ensure that the review is undertaken by professionals with an understanding of the effect of CSE on children and is undertaken with academic rigour.

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The final report is available at: www.beds.ac.uk/__data/assets/pdf_file/0011/449948/CSE-Missing-Service-Review-Stoke-on-Trent.pdf Christine Christie, July 2014, The Child Sexual Exploitation Service and Missing Children Service for Young People in Stoke on Trent: A Review. Chanon Consulting and The University of Bedfordshire.

West Midlands Region: Regional standards, pathways and self-assessment

Background
The West Midlands region recognised the cross boundary nature of CSE and the need for a robust response, so in 2011 set up a CSE strategic group. The group was established on a metropolitan area regional level involving the seven local councils and the respective police force in the region, as well as voluntary sector and health representatives. The group focussed on the common challenges of tackling CSE and what could be done together. The councils involved included: Birmingham City Council; Coventry City Council; Dudley Metropolitan Borough Council; Sandwell Metropolitan Borough Council; Walsall Council; Wolverhampton City Council and Solihull Metropolitan Borough Council as well as the West Midlands Police. There was recognition of the cross boundary nature of the threat and the need for a robust and consistent regional approach to CSE, to avoid a postcode lottery of service provision across the West Midlands.

The project
In 2013 a task and finish group, chaired by a local authority chief executive, was set up to create a consistent and child centred approach to responding to CSE across the region."
The group developed 15 regional standards and pathways for tackling CSE. Guidance was also developed for front line practitioners and managers to support the implementation of the

regional standards and pathways. It is anticipated that the regional standards will be added to each member LSCB's safeguarding procedures manual. (The pathways, standards and self-assessment tool can be found online at www.local.gov.uk/cse)

The aim of the approach was to create a consistent and child centred approach to responding to CSE across West Midlands Police Force area, underpinned by the See Me Hear Me framework developed by the Office of the Children's Commissioner. There are still locally tailored pathways in each council area, dependent on local level circumstances, but a more unified regional level approach is in place, for example through a regional induction pack for the workforce on missing children, trafficking and CSE.

Impact
Implementation of the standards and pathways was managed at the local level, with LSCB Chairs playing a key role in monitoring the progress and impact of the regional standards. A self-assessment framework assisted LSCBs with local implementation, and also enabled the identification of common areas for improvement across the seven LSCB areas; a regional workshop for practitioners and managers was held to support with implementation.

As a result of the common pathways and standards, and self-assessment screening tool, Solihull MBC has found that they are now much better at identifying victims of CSE. There has been a significant increase in the number of young people identified as at risk of harm from CSE since the screening tool was embedded, with an increase of 104 per cent of children identified at risk between May 2013 and October 2014.

Key learning from the regional approach suggests that:

- effective data collection is critical to the delivery of a robust response and to regional problem profiling
- a regional response does not replace the need for robust, coordinated action at a local level
- establishing a regional approach needs a commitment to extra resources and capacity to ensure timeliness and understanding and embedding of the approach
- senior buy in is needed for influence and impact
- sound governance arrangements were crucial to embed the standards and pathways when partners were at different stages of implementation.

Liz Murphy, former Safeguarding Children Business Manager at the Solihull LSCB highlights that "our aim has been to create a consistent response to CSE across the region and, most importantly, to use feedback from children and young people to develop and embed a multi-agency response that recognises and responds to children and young people as victims, and actively involves them in the safeguarding process. In addition we wanted to ensure sufficient emphasis on the disruption and prosecution of offenders."

Further information
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The See Me Hear Me West Midlands campaign website, developed by Dudley MBC as part of the communications plan for the regional framework can be accessed at:
www.seeme-hearme.org.uk/

Key resources and further reading

The online CSE resource for councillors available at: www.local.gov.uk/cse includes many further resources, key links, recommended reports and reading, and more details on our case studies included in this report. Below are a number of key resources:

- Berelowitz, S. et al (2013). "If only someone had listened" The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Final Report. London: Office of the Children's Commissioner. Rochdale Oxford www.childrenscommissioner.gov.uk/content/publications/content_743
- Alexis Jay (2014).Independent Inquiry into Child Sexual Exploitation in Rotherham 1997-2013. www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham
- Ann Coffey, (2014). Real Voices: Child Sexual Exploitation in Greater Manchester. An Independent Report by Ann Coffey MP. www.gmpcc.org.uk/wp-content/uploads/2014/02/81461-Coffey-Report_v5_WEB-single-pages.pdf
- Ofsted, (2014). The Sexual Exploitation of Children: It Couldn't Happen Here, Could It? www.ofsted.gov.uk/sites/default/files/documents/surveys-and-good-practice/t/The%20sexual%20exploitation%20of%20children%20it%20couldn%E2%80%99t%20happen%20here,%20could%20it.pdf
- The Communities and Local Government Committee, (2014). Child Sexual Exploitation in Rotherham: Some Issues for Local Government. www.publications.parliament.uk/pa/cm201415/cmselect/cmcomloc/648/648.pdf
- It's not okay: www.itsnotokay.co.uk/ Part of Project Phoenix, Greater Manchester
- See me hear me: www.seeme-hearme.org.uk/ Part of the West Midlands campaign, adapted from the Office of the Children's Commissioner's final report and recommendations.
- Pan London Operating Protocol to Tackle CSE and related resources http://content.met.police.uk/Article/Launch-of-The-London-Child-Sexual-Exploitation-Operating-Protocol/1400022286691/1400022286691
- Office of the Children's Commissioner, CSE Warning Signs and Vulnerabilities Checklist. www.local.gov.uk/c/document_library/get_file?uuid=72f54483-f97b-4f0e-a815-c969509cb27f&groupId=10180
- Barnardo's www.barnardos.org.uk/what_we_do/our_work/sexual_exploitation.htm
- Tackling CSE Helping Local Authorities to Develop Effective Local Responses http://www.barnardos.org.uk/tackling_child_sexual_exploitation.pdf
- The Children's Society http://www.childrenssociety.org.uk/what-we-do/policy-and-lobbying/children-risk/child-sexual-exploitation

- The APPG for Runaway and Missing Children and Adults and the APPG for Looked After Children and Care Leavers (2012). Report from the Joint Inquiry into Children Who Go Missing from Care. www.childrenssociety.org.uk/sites/default/files/tcs/u32/joint_appg_inquiry_-_report...pdf
- National Working Group, Tackling Sexual Exploitation www.nwgnetwork.org/
- NWG Network (2014) Summary of Recommendations: A summary of all recommendations from a series of reports, inquiries, serious case reviews and research. http://www.nwgnetwork.org/resourcefilepublic.php?id=1206&file=1
- Blast – project to support boys and young men http://mesmac.co.uk/blast
- PACE (Parents Against Child Sexual Exploitation) www.paceuk.info/
- University of Bedfordshire: International Centre researching CSE, violence and trafficking www.beds.ac.uk/intcent
- MsUnderstood www.msunderstood.org.uk/

Appendices

Key risk factors and warning signs of child sexual exploitation

CSE is not limited to any particular geography, ethnic or social background, and all councils should assume that CSE is happening in their area and take proactive action to prevent it.

The Office of the Children's Commissioner included in its interim report, a 'key warning signs and vulnerability checklist' to identify those at risk of CSE and for those who may already be victims of abuse.[6] There is no set formula for identifying CSE and therefore the lists should not be seen as exhaustive.

The following are typical **vulnerabilities in children prior to abuse**:

- Living in a chaotic or dysfunctional household (including parental substance use, domestic
- violence, parental mental health issues, parental criminality)
- History of abuse (including familial child sexual abuse, risk of forced marriage, risk of honour-based violence, physical and emotional abuse and neglect)
- Recent bereavement or loss
- Gang-association either through relatives, peers or intimate relationships (in cases of gang-associated CSE only)
- Attending school with children and young people who are already sexually exploited
- Learning disabilities
- Unsure about their sexual orientation or unable to disclose sexual orientation to their families
- Friends with young people who are sexually exploited
- Homeless
- Lacking friends from the same age group
- Living in a gang neighbourhood
- Living in residential care
- Living in hostel, bed and breakfast accommodation or a foyer
- Low self-esteem or self-confidence
- Young carer.

6 Berelowitz, S. et al (2013). "If only someone had listened" The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Final Report. London: Office of the Children's Commissioner. Rochdale Oxford www.childrenscommissioner.gov.uk/content/publications/content_743

The following signs and behaviour are generally seen in children who are **already being sexually exploited**:

- Missing from home or care
- Physical injuries
- Drug or alcohol misuse
- Involvement in offending
- Repeat sexually-transmitted infections, pregnancy and terminations
- Absent from school
- Change in physical appearance
- Evidence of sexual bullying and/or vulnerability through the internet and/or social networking sites
- Estranged from their family
- Receipt of gifts from unknown sources
- Recruiting others into exploitative situations
- Poor mental health.
- Self-harm
- Thoughts of or attempts at suicide.

The Barnardo's 2007 Sexual Exploitation Risk Assessment Framework[7] identifies a range of risk factors for CSE. These should not be seen as an exhaustive list, but include:

- Disrupted family life;
- A history of abuse and disadvantage;
- Problematic parenting;
- Disengagement from education;
- Going missing;
- Exploitative relationships;
- Drug and alcohol misuse;
- Poor health and well-being

7 Barnardo's Pilot Study 'Sexual Exploitation Risk Assessment Framework' (SERAF) (2007). The framework is used as a risk assessment framework by many local agencies. http://www.barnardos.org.uk/barnardo_s_cymru_sexual_exploitation_risk_assessment_framework_report_-_english_version-2.pdf

Overview of key prosecutions

The following list of prosecutions is not exhaustive, but helps to give an overview of the range of towns and locations that have seen high profile CSE cases. The list does not contain all prosecutions, for example cases where perpetrators have been prosecuted for other offences as part of disruption activity e.g. drugs or firearms offences.

Year	Area	Number of convictions
1997	Leeds	2
2003	Keighley	2
2006	Blackpool	2
2007	Oldham	2
2007	Blackburn	2
2008	Sheffield	2
2008	Oldham	2
2008	Manchester	2
2008	Blackburn	2
2009	Sheffield	1
2009	Blackburn	2
2009	Skipton	2
2010	Rochdale	4
2010	Nelson	2
2010	Rochdale	9
2010	Preston	2
2010	Rotherham	5
2010	Derby	9
2010	Cornwall	6
2011	Burnley	4
2011	Blackburn	4
2012	Rochdale	9
2012	Telford	2
2012	Derby	8
2012	Oxford	7
2012	Reading	4

Notes

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Local Government House
Smith Square
London SW1P 3HZ

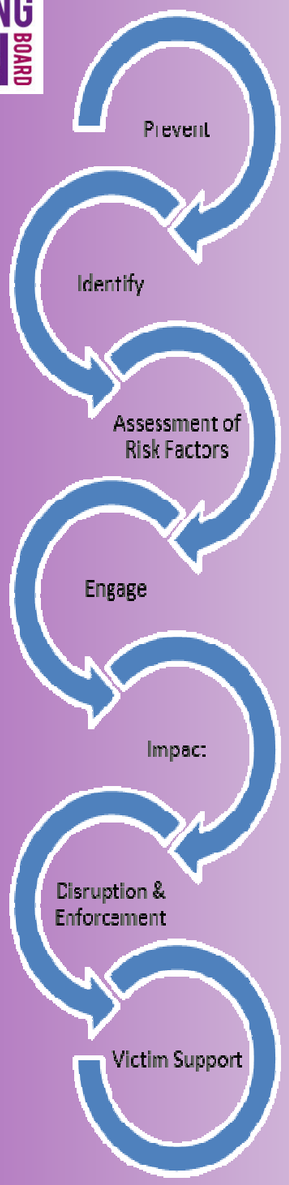
Telephone 020 7664 3000
Fax 020 7664 3030
Email info@local.gov.uk
www.local.gov.uk

For a copy in Braille, larger print or audio,
please contact us on 020 7664 3000.
We consider requests on an individual basis.

L14-738

THURROCK LOCAL SAFEGUARDING CHILDREN BOARD

CSE PLAN ON A PAGE 2016 - 2017



SET CSE STRATEGY

1.Prevent the occurrence of child sexual exploitation by raising awareness and undertaking work with children and young people, their parents and carers, to address risk factors. This will include awareness campaigns, both with professionals and local communities.

2. Effectively identify young people at risk of exploitation, likely perpetrators or locations of exploitation, through professional awareness, coordinated partnership working and appropriate information sharing processes

3. Agreed partnership referral pathways and processes; completion of CSE risk assessment tool. Put in place plans to engage with young person and to address the identified risks.

4. Provide services that young people and their families are able to engage with in order to address the risk of sexual exploitation and wider factors. Role of voluntary organisations/involvement and engagement team/ statutory services.

5. Ensure that services deliver interventions that have an impact on the young person's life and effectively reduce the risk of sexual exploitation.

6. The disruption of the activities of perpetrators, using preventative orders, arrests and seeking prosecutions wherever possible, to reduce the occurrence of child sexual exploitation. Consider support to perpetrators to prevent further offending.

7. Ongoing support for the victims of child sexual exploitation, including support/advocacy where prosecutions are brought; ongoing support/ therapy for victims.

OUR RESPONSE

1.Develop an effective communication and engagement strategy that engages professionals and the community in supporting the awareness and risks of sexual exploitation

2. Develop our information and intelligence processes to improve and understand the profile of those at risk of offending, going missing ,gang affiliation and sexual exploitation so we are better able to respond.

3. Ensure that partner agencies are effectively completing the Risk Assessment toolkit resulting in better outcomes for those at risk.

4. Review existing service provision to professionals and community and identify any additional needs with a focus on hard to reach communities.

5. Monitor the Risk assessment group (RAG) and MASH contacts with a focus on Looked after children to ensure that services deliver interventions are providing positive outcomes and reduce the risk of sexual exploitation.

6. Target known perpetrators, make effective use of disruption activities , increase the number of offenders brought to justice, and raise awareness of positive action.

7. Ensure clear pathways of support for those affected or at risk of CSE including therapeutic interventions .

STRAND 1

- Evaluate current intervention approaches
- Increase community, Faith and voluntary support in raising awareness
- Provide relevant training

STRAND 2

- Review and develop our existing profiling process and agree a CSE data set
- Review information sharing processes
- Review existing response in reducing offending

STRAND 3

- Review current risk assessment toolkit
- Develop and review risk assessment tool
- Review the outcomes of assessments

STRAND 4

- Annual report from partners on service activity
- Develop programme that targets hard to reach communities

STRAND 5

- Quarterly data from RAG and MASH
- Annual Review of partners response to Missing children
- Develop an effective performance framework

STRAND 6

- Quarterly Police data on reported offences and actions taken
- Review intelligence processes across partner agencies
- Review harmful sexual behaviour response

STRAND 7

- Review existing support programmes available.
- Conduct service review with victims
- Annual partner report on contribution to victim support

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20 December 2016	ITEM: 9
Children's Services Overview and Scrutiny Committee	
School Improvement Peer Review	
Wards and communities affected: All	**Key Decision:** All
Report of: Rory Patterson - Director of Children's Services Roger Edwardson – Strategic Leader School Improvement, Learning and Skills	
Accountable Head of Service: Roger Edwardson, Strategic Leader School Improvement, Learning and Skills	
Accountable Director: Rory Patterson, Director of Children's Services	
This report is public	

Executive Summary

The Eastern Region Peer Review sought to understand how Thurrock Council can continue and further develop its partnership with schools and academies to support improved outcomes and close performance gaps for all children and young people in Thurrock.

To support this focus, the council agreed a set of three further questions to be used in all discussions and interviews in the course of the review, which are listed below:-

- What do schools and academies value most in the current support and challenge provided by the School Improvement Team?
- What is the role of schools and academies in the light of the White paper?
- What is the role of the council in supporting school improvement in the light of the White Paper?

The report explores the current performance context for the council as at June 2016 and the strengths and areas for development linked to the overarching question. It sets out the council's ambition to break the inter-generational cycle of underperformance by supporting the development of free schools and the expansion of strong Multi-Academy Trusts. Through the newly created lobby unit, the cabinet member for educations lobby unit is showing strategic leadership in the development of a top class provision for Thurrock's children.

1. Recommendation(s)

1.1 Ensure that a clear council-level analysis of performance data for all phases, including vulnerable groups is provided by the data support team and evaluate this analysis to drive strategic priorities and stakeholder understanding.

1.2 Communicate clearly the council-wide school improvement priorities ensuring the golden thread between the data analysis, the Self Evaluation Form (SEF), the priorities for improvement, the 'Plan on a Page', the School Improvement Strategy and the Service Plan.

1.3 Co-define with schools the descriptors of both the future role of the council, schools and the Thurrock Education Alliance in a school-led system.

1.4 Develop and implement the council's monitoring role with all schools / MATs and governing boards, including the categorisation process, to ensure the council has a thorough overview of all schools.

1.5 Ensure commissioned and brokered support meets the priorities for improvement for schools/academies and is regularly quality assured for impact.

1.6 Develop a cross-service strategy to improve outcomes for vulnerable groups.

2. Introduction and Background

2.1 The council commissioned a peer review of support for school improvement by the Eastern Region consortium. Senior officers from Norfolk, Cambridgeshire and Bedford Borough formed the team. The review was undertaken on 28th and 29th June 2016 and the findings are included in this report.

The council identified an overarching question for the review of school improvement.

How can the council continue and further develop its partnership with schools and academies to support improved outcomes and close performance gaps for groups of pupils.

During the review the following underpinning questions were discussed:-

- *What do schools value most in the current support to schools?*
- *What is the role of schools in the light of the White paper?*

- *What is the role of the council in supporting school improvement in the light of the White Paper?*

The report includes the following sections:-

A. Introduction
B. Current performance context for the council
C. The strengths and areas for development linked to the overarching review question
D. Key recommendations
E. The follow up offers of support from peer Local Authorities

A. Introduction

The overarching question for the review was:-

How can the council continue and further develop its partnership with schools to support improved outcomes and close gaps in the light of the White Paper?

To support this focus the council agreed a set of three further questions to be used in all discussions and interviews in the course of the review, which are listed below:-

- *What do schools value most in the current support to schools?*
- *What is the role of schools in the light of the White paper?*
- *What is the role of the council in supporting school improvement in the light of the White Paper?*

The focus of the review:-

- the analysis of a range of performance data and the council documentation;
- discussions with focus groups of stakeholders encompassing members, council officers, Teaching Schools, System Leaders, Thurrock Improvement Consultants, Headteachers, and school governors
- visits to schools

The report outlined:-

- The current performance context for the council
- The strengths and areas for development linked to the overarching question
- A summary of key recommendations
- The follow up offers of support from peer Local Authorities

B. The current performance context for the Council

Following the outcomes of the Peer Review a new lobby unit has been established to advocate for more free schools and a grammar school to expand our strong MAT's; the council is shaping the conversation to further develop our skills and employment support offer.

The council is setting clear expectations for public services, giving a new focus on early years development to break generational issues by forming an integrated children's centre offer and putting a new healthy life style service in place for schools.

This means giving a clear vision and delivering on the ground, for example, new health living hubs and school capital plans. We will continue to foster school improvement links between strong and weaker schools by putting yearly funding into the Education Alliance. The policy of the council is to expand our strong schools that are in strong MAT's as much as possible to support parental choice and thus the competition that drives up standards.

Since 2009 there has been a significant improvement in the Ofsted profile of schools in Thurrock. The percentage of pupils attending a good or better primary school has increased from 30% in 2009 to 82% in June 2016. 88% of our primary schools and academies are now good or better. In secondary schools 88% of pupils are attending a good or better school.

Early Years Foundation Stage (EYFS) Profile results have risen significantly in recent years to well above national averages and there is a three-year upward trend for all groups of disadvantaged pupils, which is as a result of the successfully targeted Thurrock Council support.

Outcomes on the year 1 phonics screening check are close to national. At Key Stage 1 and 2, outcomes are broadly in line with national averages at the expected standard. However, outcomes in 2015 at the higher levels in KS2 were slightly below national in all subjects. The percentage of children making expected progress in English and mathematics is in line with national averages and the percentage of children making more than expected progress exceeds national averages.

At Key Stage 4 there was a significant overall drop in performance in Thurrock in 2015 to below national. On closer analysis of trend data there is an emerging concern of significant drops in performance in a number of secondary schools, and the overall trend over the last four years is a decline in performance. Progress between KS2 and KS4 is a developing concern. This profile at GCSE supports the need for the council to re-instate the process of engaging with all secondary schools in an annual performance conversation.

The council faces a significant challenge in terms of closing gaps for children who have special educational needs at the end of KS4 given the 50%+ gap at GCSE %5+ A* to C including English and Maths, which is larger than the national gap. FSM gaps at the end of KS4 are close to national. The council has serious concerns about the ongoing pattern of low attainment of Children Looked After (CLA) pupils at the end of KS4. This profile supports the need for the development of a cross phase strategy to improve outcomes for vulnerable pupils in Thurrock.

C. The strengths and areas for development linked to the overarching question

How can the council continue and further develop its partnership with schools to support improved outcomes and close gaps in the light of the White Paper?

Current Strengths:

1. Most of the schools involved in the review expressed a strong commitment to meeting the needs of all Thurrock children and young people reflecting a collective responsibility for improvement.

2. Elected members expressed a strong commitment to improving educational outcomes and expect a continuing role for the council in leading improvement.

3. Relationships between the council and schools are good.

4. The council is seen by schools/academies as a continuing partner in school improvement, post White Paper, in the following roles:

    - providing a high level strategic overview;
    - facilitating relationships;
    - brokering support;
    - monitoring all schools/ Multi Academy Trusts (MATs);
    - and sharing effective practice.

5. As a result of the strength of working relationships, the council is well placed to co-construct the definition of their future role in school improvement with schools.

6. Schools value the council provision of school performance data.

7. Primary schools recognize the significant impact of the council support to Early Years settings to improve outcomes at EYFS.

8. Primary schools value the support of their Thurrock Improvement Consultants (TICs).

9. Governors value the system of 'Progress Boards' to model for them a rigorous focus on school improvement and governor challenge.

10. The Teaching Schools work collaboratively with one another and the council to offer a package of support to schools.

11. Schools value highly the support from Inspire for Information, Advice and Guidance (IAG) to students, particularly in the context of supporting the high numbers of students in Thurrock who are' looked after' in Year 10/11.

D. Areas for development:

1. The council to continue with their focus of brokering relationships with all Thurrock schools and academies.

2. Agree, define and communicate the leadership role of the council in supporting school improvement.

3. Develop a succinct council-wide evaluation of performance data to include national comparisons and the performance of all vulnerable groups. This evaluation should drive strategic priorities and inform all stakeholders.

4. Clarify schools' understanding of the criteria and process for RAG ratings.

5. Improve the golden thread between the SEF/data analysis, strategic priorities, the 'plan on a page', the school improvement strategy and the service plan.

6. Facilitate schools' understanding of a school-led system to improve pupil outcomes, including the challenge role of Teaching Schools.

7. Quality assure the impact of support that is commissioned and/or provided by the council.

8. Ensure challenge and support is provided appropriately to all phases to fulfil the expectations of the council as champion for children and families as defined in the White Paper.

9. Develop a cross-service cohesive strategy to improve outcomes for all vulnerable groups.

E. The follow up offers of support from peer Local Authorities

Cambridgeshire: Support for developing the monitoring role of the council with all secondary schools.

Developing a school improvement board to lead school-led school improvement.

Norfolk: Support for developing a succinct council-wide evaluation of performance data driving strategic priorities.

Support for improving schools' understanding of a school-led system.

Bedford Borough: Support with developing a cross-service strategy to improve outcomes for vulnerable groups.

Support with developing the challenge role in school-to-school support strategies.

3. Issues, Options and Analysis of Options

Key Issues: Using the offers of support above

3.1 There is a need to further focus on the performance of vulnerable groups using data provided by the Schools Business Intelligence Team and evaluate this analysis to drive strategic priorities.

3.2 Working in partnership with schools and academies there is a need to co-define the descriptors of both the future role of the council, schools and the Thurrock Education Alliance in a school-led system.

3.3 Develop and implement the council's monitoring role with all schools / MATs and governing boards, including the categorisation process, to ensure the council has a thorough overview of all schools.

4. Reasons for Recommendation

4.1 None.

5. Impact on Corporate Policies, Priorities, Performance and Community Impact

5.1 None.

6. Implications

6.1 Financial

Implications verified by: **Kay Goodacre**

Finance Manager, Corporate Finance – Children and Adult's

There are no direct implications in this report.

We need to consider, as part of the partnership with our schools and academies, the need to develop an income generation model as part of the Thurrock Education Alliance arrangements.

6.2 Legal

Implications verified by: **Lucinda Bell**

Education Lawyer

This is a report for noting only; no decision is required. The Authority has statutory duties regarding education in respect of all children within its area. These apply whether or not the Council maintains the school. Many are contained within the Education Act 1996 (the Act) and include s13A, which requires local authorities to promote high standards, ensure fair access to opportunity for education and training and promote the fulfilment of learning potential by resident pupils up to the age of 20 including those with special educational needs. The function of school improvement comes from this general duty and is the subject of an Ofsted inspection regime.

6.3 Diversity and Equality

Implications verified by: **Rebecca Price**

Community Development

This report sets out the findings from the School Improvement Peer Review with accompanying recommendations to support improved outcomes for all children and young people in Thurrock including Children Looked After and other vulnerable groups.

7. Other implications (where significant) – i.e. Section 17, Risk Assessment, Health Impact Assessment, Sustainability, IT, Environmental

None

8. Rlisks

None

9. Conclusion

As part of the Eastern Region Peer Review the council identified how they should continue and further develop its partnership working with schools and academies to support improved outcomes and close performance gaps for groups of pupils.

During the review the following issues arose:-

- schools explained what they valued most in the current support to schools and academies and
- how the council might further support school improvement in the light the majority of schools being academies or in the process of academisation.

The Peer Review also informed the refreshed “Plan on a Page” (attached)

10. Background papers used in preparing the report (including their location on the Council’s website or identification whether any are exempt or protected by copyright):

- SI Peer Review
- SI Peer Review feedback report

11. Appendices to the report

- Appendix 1 - Plan on a Page

Report Author:

Roger Edwardson

Strategic Lead, School Improvement, Learning and Skills

Children’s Services

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Thurrock Education Strategic Priorities 2016-17
Plan on a Page

I want all of our pupils to be confident, self-assured learners who are proud of their achievements and are exceptionally well prepared for the next stage of their life.

Rory Patterson – Corporate Director of Children's Services

WHY ARE WE HERE?

1. TO ENSURE EVERY SCHOOL AND SETTING IN THURROCK IS GOOD OR OUTSTANDING AND PROVIDING EXCELLENT LEARNING EXPERIENCES FOR ALL OUR CHILDREN AND YOUNG PEOPLE (CYP)

2. THE PRIORITIES FOR 2016/17

Improve pupil achievement and attainment so that all Thurrock educational provision is at least good and any differences between disadvantaged pupils all other pupils nationally in progress and attainment is diminished and ensure that every child including the most able pupils receive the support they need to reach their full potential.	Deliver the recommendations of the Recruitment & Retention Strategy, thereby ensuring high quality teaching and learning in all schools, colleges and settings.	Ensure Safeguarding, Personal Development, Health & Wellbeing, including mental health, are central to the way schools, colleges and settings support and challenge their pupils in quality learning environments.	Ensure access to the best quality Local Offer to meet the needs of all CYP including those with Special Educational Needs and Disabilities (SEND) and Children who are Looked After (CLA).	Working with families, continue to develop the cultural entitlement within a high quality curriculum to include culture, music, sport and experience of work. (work experience Ofsted 2016)

2.1 To do this together we will:

- **Increase the pace of improvement and accelerate progress especially in English, mathematics and science whilst maximising the unique benefits of working in partnership with Royal Opera House and other outstanding external cultural partners to ensure our pupils have a rich and varied curriculum that meets the need of all pupils**
- **Improve attendance; reduce exclusions; reduce differences in progress and attainment in pupils with the same starting points**
- **Develop more effective use of best practice within the Borough, promoting school to school support and building on the good practice.**
- **Develop a range of high quality employment, apprenticeships and training opportunities supported by schools, academies, Higher Educational Establishments and business to ensure no one is NEET.**
- **Recruit high quality teaching staff through the 'Teaching in Thurrock' website, attend university recruitment fairs, develop a key worker scheme**

3. Outcomes

3.1

Performance

- 100% of schools, settings & colleges are good or better
- From different starting points, the progress in English and in mathematics is high compared with national figures.
- The progress of disadvantaged pupils from different starting points matches or is improving towards that of other pupils nationally.
- The attainment of almost all groups of pupils is broadly in line with national averages
- Pupils are exceptionally well prepared for the next stage of their education.

Recruitment & Retention

- All schools are signed up to the new Teaching in Thurrock Website
- There is a key worker scheme in place that benefits teacher recruitment and retention
- All schools are fully staffed with high quality teachers, leaders and support staff

Safeguarding & Wellbeing, Early Offer

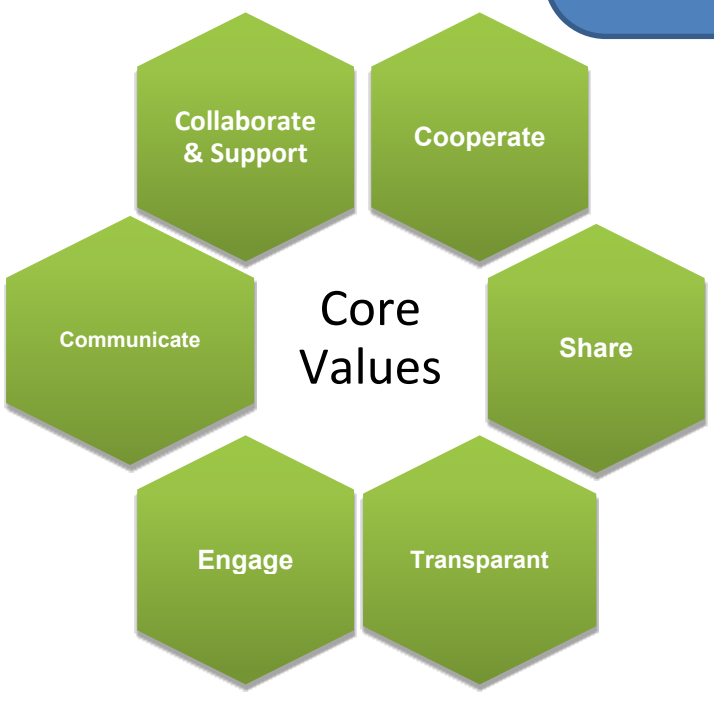
- There are fewer 'no further action' referrals to MASH due to the Early Offer of Help & Troubled Families programmes
- The Thurrock Health & Wellbeing Strategy has an impact on the lives of the children in Thurrock
- CSPA* referrals result in improved access to EHW** services for all children and young people

SEND/ Local Offer/ CLA

- High quality Local Offer is displayed on every school website
- Thurrock's Local Offer provides relevant services which meets the needs of children in Thurrock

Cultural Entitlement

- Through access to a wide range of cultural, sporting and musical experiences talent is nurtured and CYP are introduced to a range of new experiences
- CYP in Thurrock understand and have positive experiences of the world of work.



In Thurrock we share performance data and use the analysis of it to improve outcomes for all children and young people. We will work together as on community for the benefit and ongoing improvement of all education establishments in the borough.

**Children's Single Point of Access*
***Emotional Health and Wellbeing*

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20 December 2016	ITEM: 10
Children's Services Overview and Scrutiny Committee	
Educational Attainments of Children Looked After	
Wards and communities affected: All	**Key Decision:** All
Report of: Keeley Pullen – Headteacher of the Virtual School for Children Looked After	
Accountable Head of Service: Roger Edwardson, Interim Strategic Leader School Improvement, Learning and Skills	
Accountable Director: Rory Patterson, Director of Children's Services	
This report is public	

Executive Summary

Raising achievement in all areas of education for our Children Looked After [CLA] remains a key priority for Thurrock Council. The Virtual School monitors and supports the educational progress and outcomes for CLA irrespective of where they are placed, in or out of borough. The Virtual School is responsible for pupils aged between 3 years and 18 years and this includes those who have left care during an academic year.

This report will include the provisional outcomes for all pupils in the Virtual School cohort for the academic year 2015-2016 irrespective of their length of time in care. The Department for Education provides data in the Spring of 2017 which details the attainment of those who were in care continuously for 12 months or more.

A new curriculum was introduced in 2014 and new assessment procedures were introduced in 2015 which have resulted in national curriculum levels being removed and varying methods of assessment are now used by schools. The testing regime has changed for Key Stage 1 and 2 and this is now more rigorous and challenging. This has led to a significant fall nationally in results this year and has made comparisons for previous years' irrelevant.

Our Children Looked After face varying challenges on a daily basis and their resilience, attendance and progress made whilst in care should be recognised and praised. The Portfolio Holders for Education and Children's Social Care recognise that significant improvements in outcomes need to be achieved for this group and have asked for a review to be undertaken which will better articulate the high ambition that the council has for Children Looked After and the need to raise the current low level of expectations.

1. Recommendation(s)

1.1 That the Overview & Scrutiny Committee notes the provisional outcomes of the summer 2016 tests and examinations and commends the pupils, their schools and parents/carers on their achievements.

1.2 That the Committee recognises that data can't be compared to previous years due to a change in curriculum and assessments [particularly at Key Stage 1 and 2].

1.3 That the Committee recognises that the cohorts of pupils are small and that this should be considered when comparing year on year data.

1.4 That the Committee recognises that the length of time in care can affect the progress and outcomes of the pupils.

2. Introduction and Background

2.1 The target for Thurrock Children Looked After is for them to be improving year on year and to meet the expected standards. The target is to close the attainment gap between CLA and non-CLA and to be above national outcomes for all CLA.

2.1.1 The year groups to be reported are outlined as follows:

Early Years – Foundation Stage
Year 1 (6 year old)
KS1 (7 year old)
KS2 (11 year old)
KS4 (16 year old)

2.1.2 In 2016, KS1 assessments are no longer reported as levels and cannot be compared to previous years. National Curriculum levels have been replaced by National Standards in the interim Teacher Assessment Frameworks, which are only to be used in 2016 and 2017. The results are still based on teacher assessments and for the first time this year include a combined reading, writing and maths measure. Grammar, punctuation and spelling assessments were not included this year due to an error at Standards and Testing Agency.

2.1.3 In 2016, the new more challenging national curriculum, which was introduced in 2014, was assessed by new tests and interim frameworks for teacher assessment. KS2 results are no longer reported as levels: each pupil receives their test results as a scaled score and teacher assessments based on the standards in the interim framework. Progress data will be released by the DfE in December.

2.1.4 2016 GCSE results show a significant improvement on last year. However, attainment is still below the national average. This reports attempts to detail progress and attainment which is beyond the raw data results. The document titled 'The Educational Progress of Looked After Children in England: Linking Care and Educational Data' recommends that the outcomes for CLA particularly in Key Stage 4 are not merely confined to obtaining and comparing them against the standard national measures due to the nature of this cohort and the factors which affect their performance.

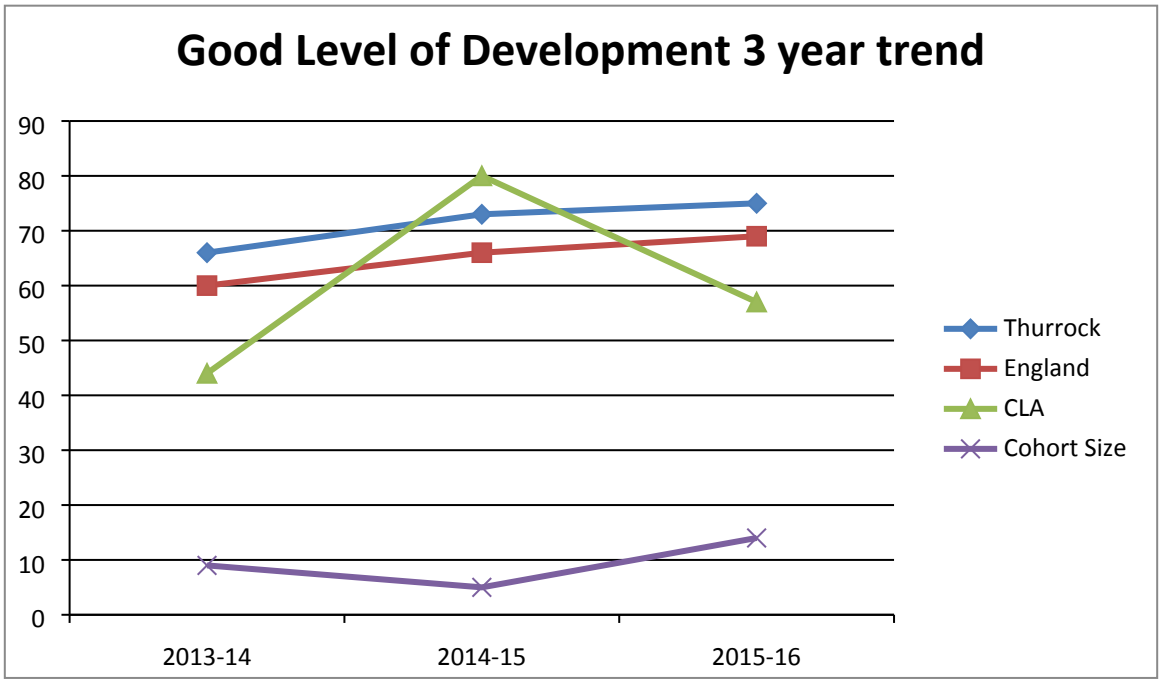
3. Attainment for Children Looked After:

3.1 Early Years Foundation Stage (EYFS age 5)

3.1.1 The Good Level of Development (GLD) measure is awarded at the end of EYFS when a pupil has achieved at least the expected level in the entire prime areas of learning and in literacy and mathematics.

3.1.2 The GLD has fluctuated significantly over a 3 year period and this demonstrates the uniqueness and small size of each cohort. The size of each cohort shows that each child's result is worth a significant percentage amount.

3.1.3 The diagram below illustrates the performance of Thurrock CLA against national and Thurrock non-CLA pupils. The Department for Education does not provide national data comparisons for Children Looked After in the area of a Good Level of Development.



3.1.4 To reach the percentage of children making a good level of development, each child is assessed against 17 Early Learning Goals; whether she/he

meets the level, has not yet reached the level or exceeded it and points are awarded accordingly in a range between 17 to 51. If a child meets every Early Learning Goal, she/he will receive at least 34 points.

3.1.5 The provisional GLD result for Thurrock CLA demonstrates a fluctuating but maintenance of an upward trend of attainment. The previous year saw that 4 out of 5 pupils achieved GLD whereas this year, 8 pupils out of 14 achieved this.

3.1.6 Although 15/16 data indicates that there is a dramatic decrease in attainment from the academic year 14/15, more pupils achieved GLD than in the previous year. The cohort size has increased significantly compared to the previous year from 5 pupils to 14. Of this year's cohort, 8 pupils [57%] attended a Thurrock school.

3.1.7 Contextually the profile of this year's cohort differs from that of the previous year. Of the 2015/16 cohort, 8 pupils [57%] had been in care for less than a year prior to the end of the Reception year. The remaining 6 pupils [43%] had been in care for more than a year, although 4 [67%] out of the 6 pupils stopped being looked after in the autumn term 2015 of their reception year due to SGO or adoption arrangements. A total of 7 pupils [50%] left care during the academic year 15/16. This demonstrates the effective work of the social care teams in finding permanent placements or for positive reunifications with birth families. Of the 6 pupils who had been in care for more than 1 year, 3 [50%] reached the expected standard of a GLD.

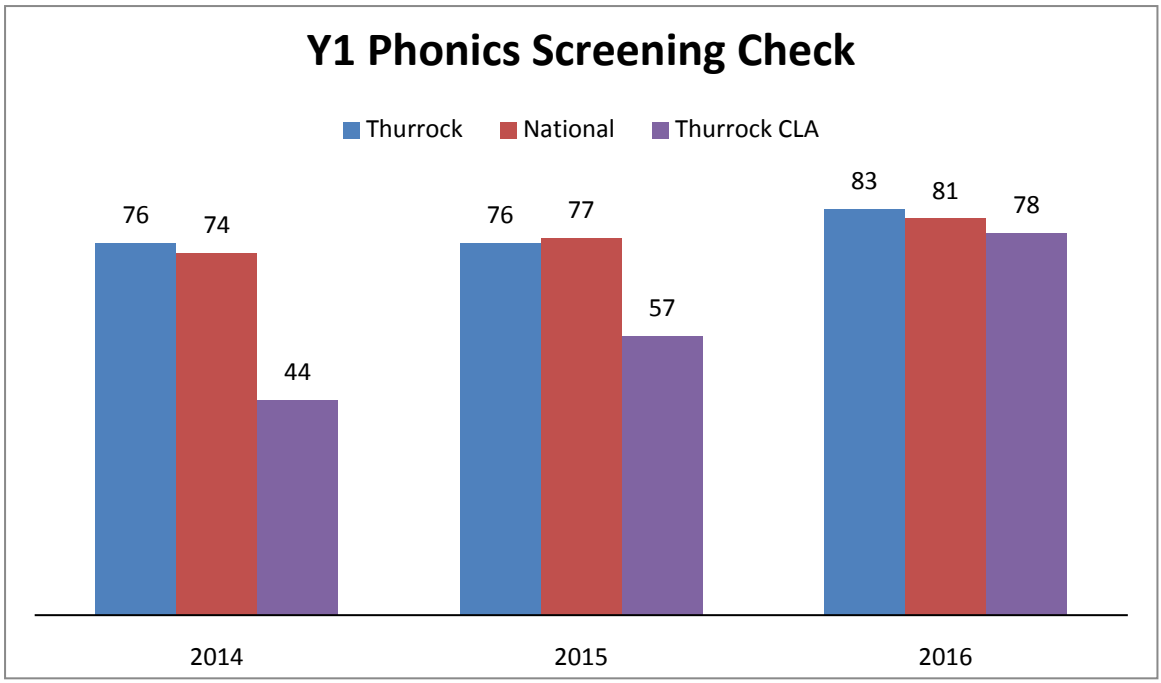
3.1.8 The academic profile of the 2015/16 cohort saw that 40% of the cohort was applicable for Special Educational Needs and Disabilities [SEND] classification with one of these pupils already having an Education Health Care Plan [EHCP] on entry to school. Pupils with SEND have specific learning needs and require extra support. Therefore, 40% of the cohort were working significantly below the national average according to development matters which assessed their learning at below their chronological age. In addition, these pupils had a larger gap to close in order to meet a Good Level of Development. They were provided with additional support in their schools through group and individual support interventions. It aided them in their progress and enabled them to catch up with their peers to make expected progress across the year, even if they did not meet the expected standards.

3.1.9 In terms of monitoring and progress this was through the Personal Education Plans [PEPs] for each pupil. These took place every term that the child was looked after and detailed the learning and development for every pupil and specific targets were set to enable them to make progress. Pupils made progress across the year by achieving their targets and by the Virtual School holding schools to account for the quality of teaching and support they provided and by the use and impact of Pupil Premium Plus funding. All pupils

in this cohort made at least expected progress across the academic year from their on entry starting points.

3.2 **Year 1 Phonics** (age 6)

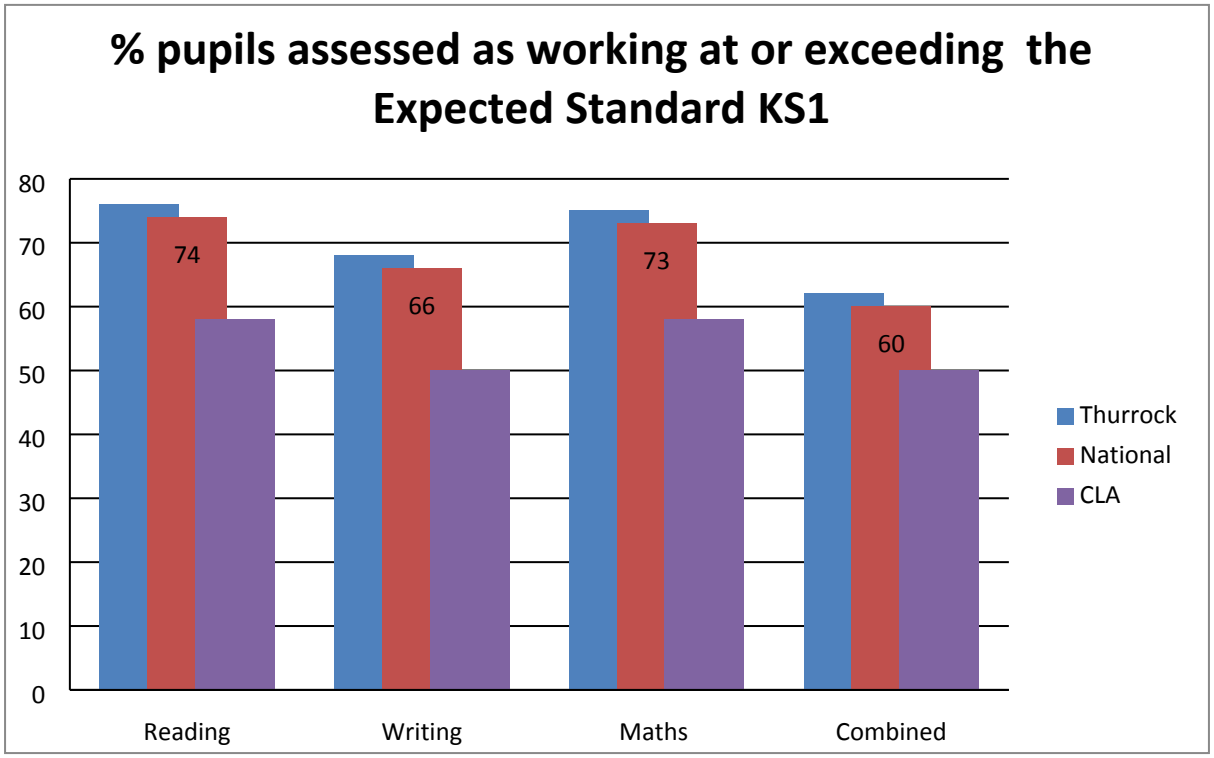
3.2.1 The year 1 phonics screening check is undertaken in June by all year 1 pupils and those pupils in year 2 who did not achieve age related expectations whilst in year 1. The percentage of children who reached the expected standard has risen by 21 percentage points; the national average has risen by 4 percentage points. The data for 2015 was based upon a cohort of 7 pupils, 4 [57%] of whom passed. In 2016 there were 9 year 1 pupils in the cohort and 7 pupils [78%] passed the screen. The gap between CLA and non-CLA is closing rapidly.



3.3 **Key Stage 1 (age 7, year 2)**

3.3.1 In 2016 KS1 assessments are no longer reported as levels and cannot be compared to previous years. National Curriculum levels have been replaced by National Standards in the interim Teacher Assessment Frameworks, which are only to be used in 2016 and 2017. The results are still based on teacher assessments and for the first time this year include a combined reading, writing and maths measure. Grammar, punctuation and spelling assessments were not included this year due to an error at Standards and Testing Agency.

3.3.2 In the graph below, it is possible to see how Children Looked After performed against National and Thurrock non-CLA. The table does not include National CLA performance data as this is not available at the time of this report.



3.3.3 The above data is based upon a cohort size of 12 pupils. This is a very small data set for comparison. Analysis of this data indicates that CLA have performed less well than their non-CLA peers nationally and Thurrock non-CLA pupils. What is difficult to gauge is a comparison with those who are looked after nationally due to lack of data.

3.3.4 Contextual data for the cohort shows that 7 [58%] of the 12 pupils were in an out of borough school. 4 [80%] pupils out of the 5 who achieved the combined score in reading, writing and maths attended a Thurrock school. This would indicate that those who did well attended a Thurrock school. This may well reflect the effective school improvement structures employed by Thurrock Council School's Improvement team as well as the strong relationships that the Virtual School Head has with Thurrock Head teachers who share the commitment for raising standards for all children in the borough.

3.3.5 The Virtual School maintains the same tracking and monitoring systems for all pupils irrespective of placement. The Personal Education Plan procedures are the same and the expectations and accountability measures are the same. Pupils across the year made expected progress based upon their individual targets and prior attainment.

3.3.6 In terms of prior attainment, only 50% of the cohort obtained a good level of development at the end of their reception year two years prior to the Key Stage 1 assessments. This would suggest that the rate of attainment and progress for these pupils has remained consistent across key stage 1. These

pupils would have needed to make accelerated progress in that time to be able to reach the expected standard. 1 pupil [20%] out of the 5 who did not reach GLD at the end of the Foundation Stage reached the expected standard at KS1.

3.3.7 The length of time in care varied for this cohort. Length of time in care is shown in the table below:

Period when entered care	Number of pupils [% = of total cohort size of 12]	Met expected standard [% of those in this period]
2015	4 pupils [33%]	3 pupils [75%]
2014	2 pupils [17%]	1 pupil [50%]
2013	3 pupils [25%]	2 pupils [67%]
2012	3 pupils [25%]	0

3.3.8 The data in the table above would suggest that the length of time in care has not impacted on this group in terms of attainment. It is worth noting that, of the 3 pupils who have been in care the longest, they have significant SEND and emotional needs. These 3 pupils have also had the most placement instability due to these needs, including changes of carers and schools. However, during this current academic year 16/17, there has been greater stability for these children in terms of placement and schooling. It is hoped that this will continue.

3.3.9 Of the 12 pupils in the cohort, 5 pupils [42%] had SEND with 1 attending a specialist residential placement who has an EHCP. A further 2 pupils are currently undergoing the EHCP process due to learning and social emotional needs.

3.4 Key Stage 2 (age 11, year 6)

3.4.1 In 2016, the new more challenging national curriculum, which was introduced in 2014, was assessed by new tests and interim frameworks for teacher assessment. KS2 results are no longer reported as levels: each pupil receives their test results as a scaled score and teacher assessments based on the standards in the interim framework.

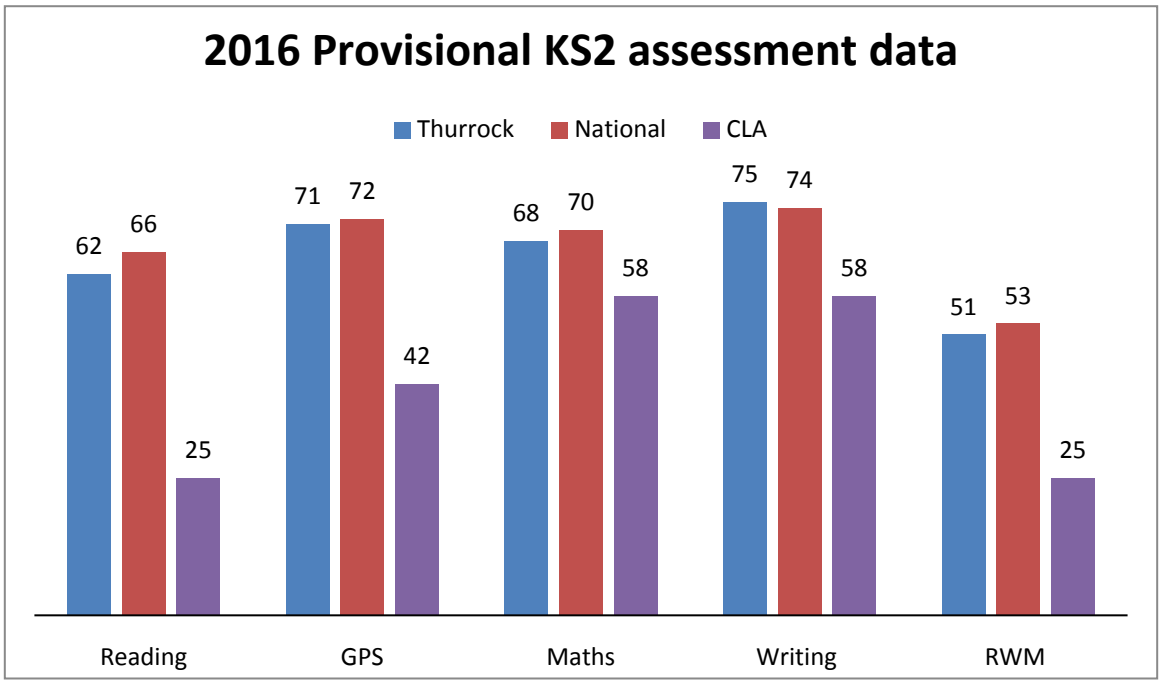
3.4.2 The expected standard in the tests is a scaled score of 100 or above. Attainment nationally in the tests is highest in grammar, punctuation and

spelling (GPS) at 72% and lowest in reading at 66%. At 74%, attainment in the writing teacher assessment is higher than in any of the test subjects.

3.4.3 Last year, to achieve a level 4 (the previous expected standard) pupils would have needed to get 46 per cent in their maths tests and 36 per cent in reading. This year, under the new, tougher standards, those percentages have increased to 54.5 per cent for maths, and 42 per cent for reading. GPS has remained the same at 61 per cent.

3.4.4 The cohort size for the Key Stage 2 SATS was 12 pupils. There were a further 2 pupils who attend special independent schools who do not take part in SATS testing, Therefore the decision has been made to dis-apply them from the reporting requirements. The data provided is based upon attainment for those pupils who took the tests.

3.4.5 For Thurrock CLA, reading was 25% [3 pupils], GPS was 42% [5 pupils], in maths 58% [7 pupils] and in writing was 58% [7pupils]. The graph below illustrates the comparisons with non-CLA nationally and all pupils in Thurrock. Nationally CLA statistical comparisons are not available at the time of this report due to the time of publication of the Statistical First Release.



3.4.6 Children Looked After were 10% below all Thurrock children in maths and 17% below in writing. The biggest area for development based upon this data would be reading. The reading test was particularly difficult at a national level this year and this is reflected by the decline in data nationally. Historically Thurrock CLA perform well in reading at the end of KS2 tests. However, the 2016 test proved to be too difficult for them. The subject matter of the reading

test involved family experiences as well as the type of life experiences which our CLA have not yet had. The depth of reading skills required were also extensive and required a level of maturity, knowledge and higher level reading skills which was not yet possible for some of the pupils in this cohort.

3.4.7 The Virtual School uses part of their budget to fund Letterbox Clubs. This scheme provides each Thurrock CLA from Year 2 to Year 6 with sets of books and educational games delivered to their house 6 months every year between May and October and a special Christmas package in December. The intention of this scheme is to raise the profile of reading as a pleasurable pass time and to foster a love of books within their placements. The implementation of this scheme is currently under review in terms of impact and how it could be used more effectively.

3.4.8 Monitoring and tracking was extensive for this cohort of pupils. All pupils had a termly PEP attended by a member of the Virtual School. Schools were required to provide termly tracking data and evidence how pupil premium plus was supporting learning and progress. Some pupils who did not meet the standard in one or more subjects had still made excellent progress and were working within the curriculum bands for their year group; however, they did not perform in the harder tests.

3.4.9 A particular success story for this year group should be noted for one pupil who made 3 years' worth of progress in 1 academic year. In year 5 the EHCP process had started due to this pupil being at least 2 years behind his peers in all subjects. There were many concerns regarding learning, development and social and emotional difficulties. However, this pupil met the expected standard in all subjects except reading where he narrowly missed the 100 score by scoring 98. An EHCP is not necessary due to his amazing efforts and the support received from his school, his carers and the Virtual School. He has successfully transitioned into year 7.

3.4.10 Prior attainment at Key Stage 1 for this cohort was extremely low with only 3 pupils [25%] reaching level 2B in reading, 2 pupils [17%] reaching 2B in writing and 4 pupils [33%] achieving 2B in maths. Progress measures from the Department for Education will be published later this academic year so a better analysis of progress can be provided. However, this prior data would suggest that pupils were not expected to reach the required standard at Key Stage 4 as 75% of the cohort were below national average previously. This progress measure would suggest that although pupils did not meet the expected standards, their rate of progress was good.

3.4.11 The Year 6 cohort contained 5 pupils [42%] out of the 12 entered for SATS with SEND. As mentioned above, pupils with SEND have additional learning and/or emotional needs which affect their learning and this affected their attainment within the harder tests.

3.4.12 The length of time in care varied for this cohort between 2007 and 2015. The table below illustrates this:

Period when entered care	Number of pupils [% = of total cohort size of 12]	Met expected standard RWM [% of those in this period]
2015	3 pupils [25%]	0
2014	2 pupils [17%]	0
2013	2 pupils [17%]	0
2012	4 pupils [33%]	2 pupils [50%]
2007	1 pupil [8%]	1 pupil [100%]

3.4.13 The length of time in care has had a positive influence on those obtaining the required standard. It is worth noting that of these, 2 of the 3 pupils achieved the expected levels at the end of KS1 too.

4 GCSE KS4 (age 16) - Indicative results

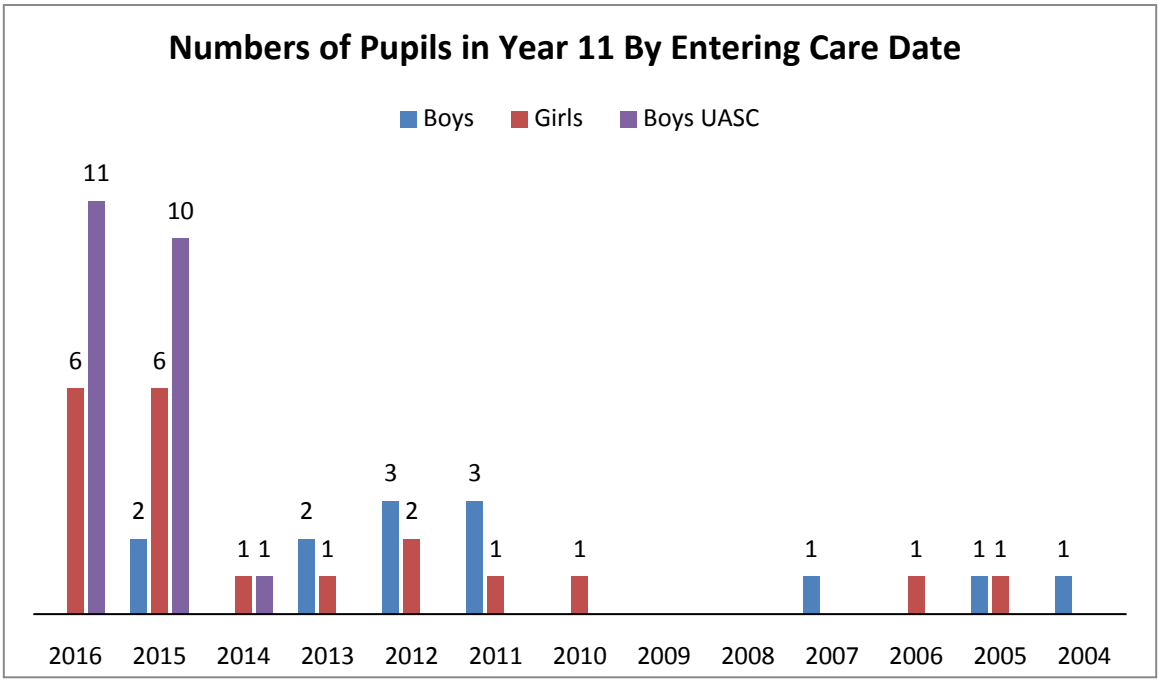
4.1 Provisional results for Thurrock CLA show an improvement from last year and the gap against national CLA is starting to close. The data provided for this report will contain information for the whole of the Year 11 cohort that the Virtual School was responsible for in the academic year 2015-2016 irrespective of when the young person came into care. This report will first detail a range of information for this cohort to provide a context for reporting and analysis.

4.2 At the beginning of the academic year there were 39 pupils in Year 11, by the end there were 55. The table below shows the period when various pupils in Year 11 became looked after. Potentially the length of time in care will affect educational outcomes.

4.3 When adolescents come into care during this time it is usually unplanned and in an emergency situation. This makes it extremely difficult for placements and education to be found in parallel. In the vast majority of cases when a young person is without education, it is extremely difficult to provide them with a school place. Schools are reluctant take a Year 11 pupil into their school citing the reason that they are not able to match their GCSE modules. This is even more difficult for those who have no English language.

4.4 This graph does not illustrate the fact that 30 pupils [55%] became looked after in the academic year 2015/16. This made it extremely difficult for the Virtual School and Social Care to have an impact on attainment for GCSEs in

that short space of time, particularly when a large majority of these young people were Unaccompanied Asylum Seeking Children [UASC] with no English.



4.5 When a young person is taken into care it is often an extremely traumatic time for them. This would potentially affect their ability to perform in the GCSE exams as their focus may be elsewhere. The lateness of them coming into care also means that services have not been able to support education as extensively prior to them entering care. They may not be in full time mainstream education before becoming looked after, their attendance could be poor. The may have missed significant parts of schooling and are therefore trying to catch up. If they do attend a school prior to becoming looked after, they may not have been entered for qualifications due to their ability or previous educational performance. All of these factors should be considered when looking at the achievements of these young people.

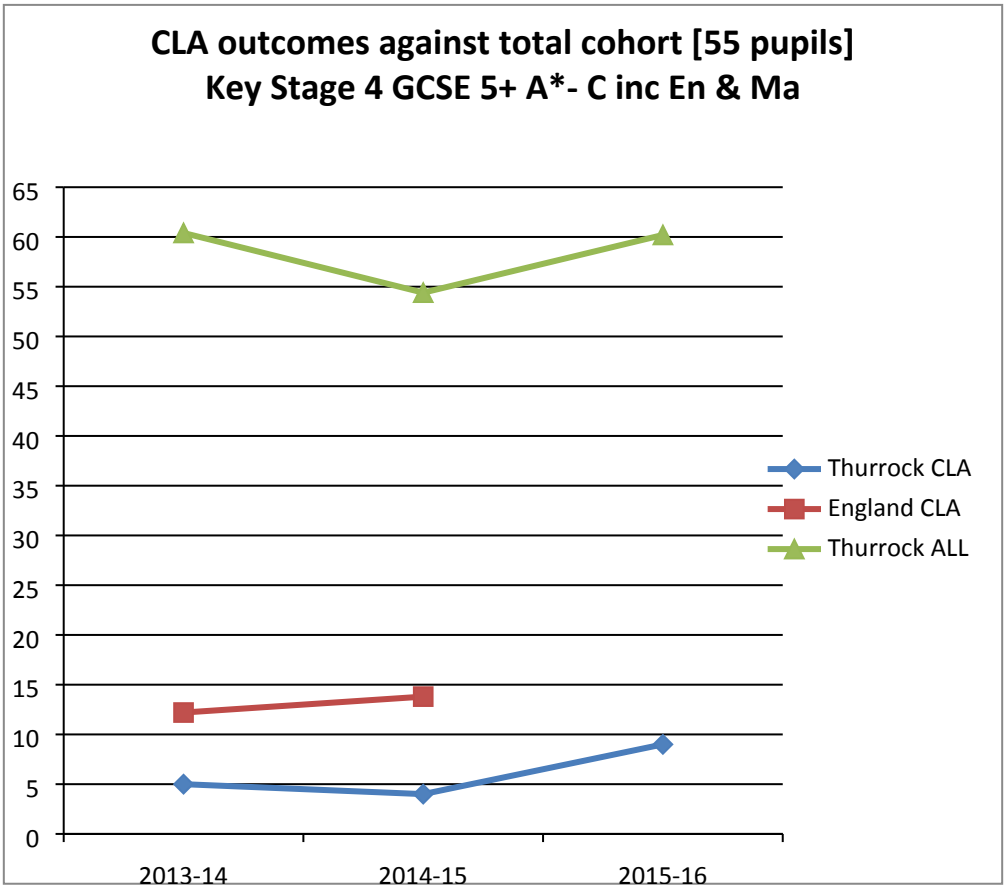
4.6 There were a total of 55 pupils in the year 11 cohort and 19 pupils [34.5%] were eligible to take 5 GCSEs. There was a further 1 pupil who took under 5 GCSEs.

4.7 Indicative data shows that 5 pupils [9%] of the total cohort achieved 5 A*-C grades at GCSE including English and Maths. 2 of the pupils who achieved 5 GCSEs grade C and above attended a Thurrock school. An additional 2 pupils [4%] achieved 5 or more GCSEs graded above C, however, they narrowly missed achieving both English and/or Maths. These pupils attended out of borough schools.

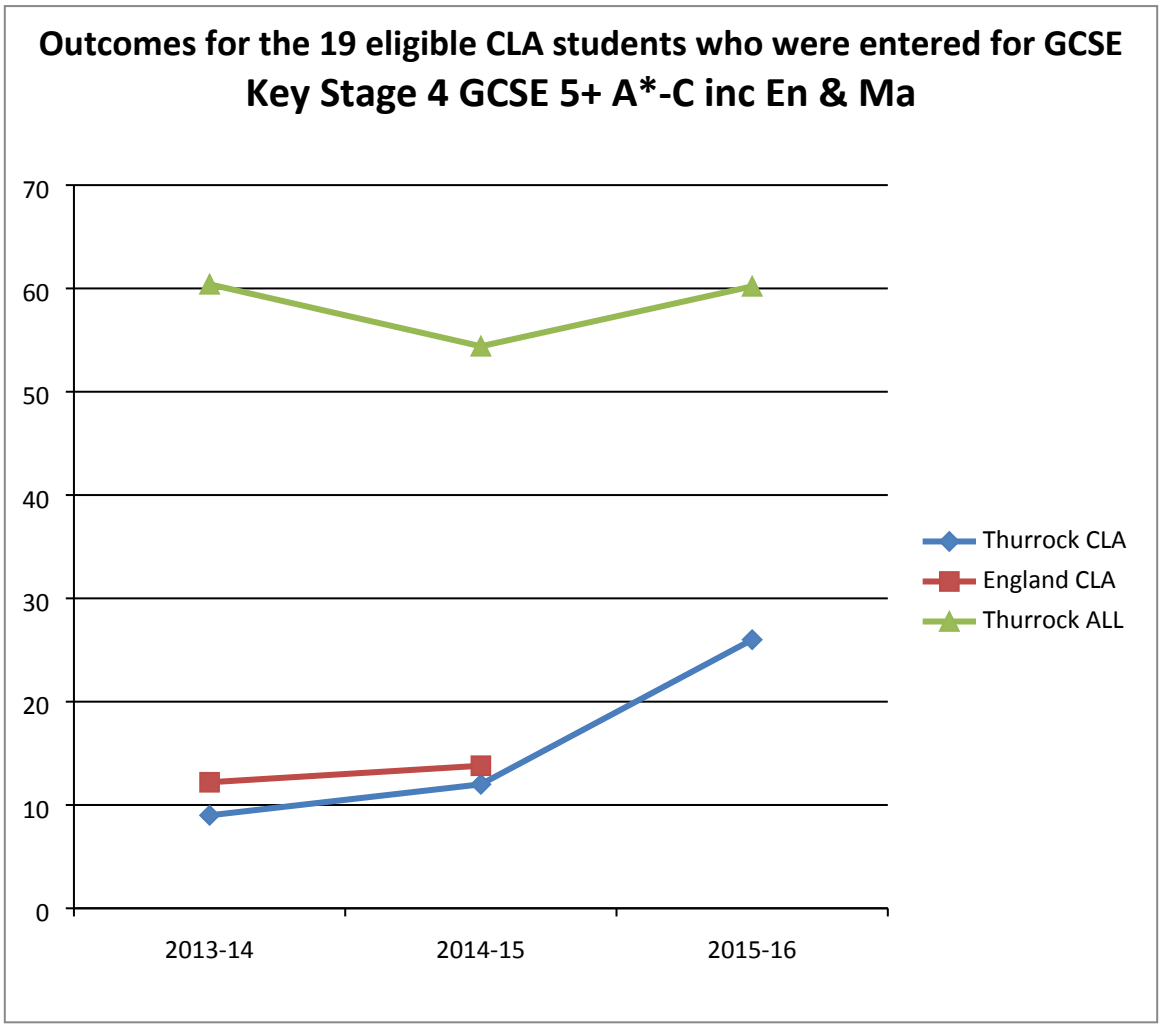
4.8 For maths, in total 8 pupils [14.5%] achieved a grade C or above. The figure for those achieving grade D or above in maths was 15 pupils [27%]. This data was for the whole cohort. When we narrow this figure down to those only eligible for taking GCSEs, it reduces to 19 pupils. This data shows a significant increase on last year. When considering those only eligible for GCSE, 79% achieved grade D or above in maths and 42% achieved grade C or above.

4.9 English language results for the whole cohort were a similar picture. In total 7 pupils [13%] achieved a grade C or above. For those achieving grade D or above, it was 15 pupils [27%]. When narrowed down to those eligible for GCSEs 37% [7 pupils] achieved grade C and 79% achieved grade D or above.

4.10 The graphs below highlight the improvement in outcomes against national CLA data and Thurrock all pupils' data.



This line graph depicts data for the whole of the cohort [55 pupils]



This line graph depicts data for the 19 pupils who were sitting 5 or more GCSEs

4.11 The two graphs illustrate an improving picture for Thurrock CLA and outcomes are improving. The attainment gaps are gradually decreasing and in terms of attainment at GCSE level this year, the indicative data shows that it has doubled from last year. The aim now is for this trend to continue to improve.

5. Additional Contextual Information for Key Stage 4 Cohort

5.1 There are specific reasons as to why not all of the 55 pupils were able to sit GCSE qualifications. It is important that this report includes these young people and accounts for their educational outcomes

5.2 48 [83%] of our year 11 pupils looked after by the local authority attended a provision that was out of borough, of which 17 [49%] students were in specialist provision. Specialist provision includes Pupil Referral Units, residential specialist schools, SEND schools. These placements matched the needs of the pupils at that time, based upon their social care and educational needs. Where possible these students sat formal qualifications which included

GCSE, BTEC, functional skills or Entry Level. However, this did mean that they were not at the level to study 5 GCSEs. It is important to note that these students obtained positive outcomes for them based upon their needs and their academic level or educational ability at the time.

5.3 A total of 7 students [17%] did not sit formal qualifications. 3 of these have significant SEND and 4 pupils are resitting Year 11 and so were not eligible for exams this academic year. Additionally 18 pupils [33%] of the cohort had SEND needs with 13 pupils [24%] with EHCPs or Statements. The 2 pupils with EHCPs who were eligible for GCSE exams achieved incredibly well based upon their level of needs with 1 obtaining 5 GCSEs C and above and 1 making accelerated progress to achieve D grades.

5.4 The length of time in care for this cohort has supported the educational progress of these pupils. Of those students who have been in care the longest, the majority have SEND needs. Although they may not have achieved GCSE qualifications, their placement and education needs were met in the appropriate provision. Those students who had been in care for a length of time who were able to sit GCSE qualifications did achieve pass grades and made appropriate progress against prior attainment. For example: 2 out of the 3 pupils who entered care in 2013 achieved 5 A*-C grades. The other pupil who came into care in 2013 attended a specialist residential provision due to significant SEND and achieved Entry Level 3 qualifications.

5.5 The number of Unaccompanied Asylum Seeking Children UASC entering care in year 11 is increasing. 23 pupils [42%] of the 15/16 cohort contained UASC pupils. Only 2 pupils were attending a school in Year 10 and as such had 4 terms of formal education in England in order for them to take their GCSEs. These 2 young men achieved pass grades. 3 UASC pupils were long term missing from care but they are still eligible for counting in our indicative results. A further 2 pupils had been placed back into year 10 and were not eligible to take their exams in 2016. The graph above illustrates when our UASC came into care. It is a challenge to find suitable educational places that can support the needs of these vulnerable pupils. The Virtual School assists with obtaining school places wherever possible or sourcing appropriate English Studied as an Other Language [ESOL] provision.

5.6 Monitoring and tracking was extensive for our year 11 cohort of pupils. All pupils had a termly PEP attended by a member of the Virtual School. Schools were required to provide termly tracking data and evidence how pupil premium plus was supporting learning and progress. In addition, 1-1 tuition was funded by the Virtual School through Fleet tuition services to key groups of pupils to support outcomes. This was in English and Maths.

6. Reasons for Recommendation

6.1 None.

7. Impact on Corporate Policies, Priorities, Performance and Community Impact

7.1 This report relates to the council priority to improve to create a great place for learning and opportunity.

8. Implications

8.1 Financial

Implications verified by: **Kay Goodacre**

Finance Manager, Corporate Finance – Children and Adult's

This report asks that the Committee notes the increasing demand of services for Children Looked After. The responsibilities of the Virtual School have increased to support those in pre-school and in post 16 as a result of the changes to the Statutory Guidance in July 2014. The growing demand for services, particularly for those who are post 16 and/or Unaccompanied Asylum Seeking Children has had an implication on spending due to the cost of interventions such as English Studied as an Other Language provision

8.2 Legal

Implications verified by: **Lucinda Bell**

Education Lawyer

This report asks that the Committee notes the provisional outcomes, and offer its commendations, taking into account in so doing the various contextual influences described by the report author. No decision is required. The Council is required by s22(3A) of the Children Act 1989, as amended, to promote the educational achievement of looked after children. The Children and Families Act 2014 amended s22 to require the Council to appoint an officer to ensure that the duty is properly discharged. There is statutory guidance "Promoting the education of looked after children" that must be followed in meeting this duty.

8.3 Diversity and Equality

Implications verified by: **Rebecca Price**

Community Development Officer

This report sets out the educational attainments of Children Looked After for the academic year 2015/16. Diversity and equality implications, including those related to young people with Special Educational Needs, are contained within the body of the paper and the supporting conclusion.

8.4 **<u>Other implications</u> (where significant) – there are no implications as a result of this report**

None.

9. Conclusion

9.1 In summary the above report details attainment outcomes. The results do not reflect the unique pathway of every individual in each cohort. Every pupil has an individual story which details the varying strengths and difficulties that she/he experiences as a child or young person in care. Some pupils overcame their challenges and exceeded expectations and made exceptional progress. All of our Children Looked After achievements should be recognised and celebrated and we as a Council will continue to support them in the next stages of their academic journey.

10. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- 'The Educational Progress of Looked After Children in England: Linking Care and Educational Data' ADCS

11. Appendices to the report

- None

Report Author:

Keeley Pullen

Head Teacher of the Virtual School for Children Looked After

Children's Services

20 December 2016	ITEM: 11
Children's Services Overview and Scrutiny Committee	
Thurrock Local Children's Safeguarding Board (LSCB), Serious Case Review (SCR) Report - James	
Wards and communities affected: All	**Key Decision:** No
Report of: Andrew Carter, Head of Children's Social Care	
Accountable Head of Service: Andrew Carter, Children's Social Care (CATO)	
Accountable Director: Rory Patterson, Corporate Director of Children's Services	
This report is Public	

Executive Summary

This covering report provides a summary to the Local Children's Safeguarding Board, Serious Case Review James. The full review has been attached to this paper. The review was undertaken following James's death by suspension, for which the coroner has recorded an 'Open Verdict'.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the requirement for Local Safeguarding Children's Boards to undertake reviews of serious cases where:

a) abuse or neglect of a child is known or suspected; and
b) either — (i) the child has died; or (ii) the child has 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.

Based on the review, professionals on all available knowledge and information could not have foreseen or were able to prevent the outcome of James' death. There were no previous concerns or behaviour known to family or practitioners to contemplate that James might take his own life or commit self-harm; even within the last few hours before he was found collapsed in his bedroom at his placement.

The James Serious Case Review identified six findings the Safeguarding Board need to consider with 11 associated recommendations. Those agencies that worked or supported James have been involved in this SCR and some changes have already taken place to improve our systems and processes.

1. Recommendation(s)

1.1 Children's Overview and Scrutiny Committee scrutinise the report of the LSCB, its findings and its recommendations.

1.2 Children's Overview and Scrutiny Committee track progress by Children's Services in responding to the recommendations of the review.

2. Introduction and Background

2.1 Methodology

2.1.1 The focus of this case review was to use a systems approach looking at multi-agency professional practice through a series of questions:

- Did all agencies work together effectively to safeguard this young person?
- Was the outcome preventable?
- Were safeguarding procedures followed appropriately?
- Was the young person's voice heard throughout agencies involvement?

2.1.2 The parents of James took part in the review and have been very supportive providing helpful information to assist in understanding James life.

2.2 Background

2.2.1 James was born in Hackney to parents of Ghanaian heritage. His parents divorced in 2001. After spending some time abroad with relatives James was brought up in his early years by his mother and both parents moved on to new relationships and having further children.

2.2.2 In 2012 aged 14 James moved to live with his father in Thurrock as his mother and step father could no longer cope with his violent mood swings and behaviour. Police became involved and records indicate approximately 33 contacts with the police for various incidents. James parents believed his behaviour was compounded by becoming a regular user of cannabis and possible affiliation with local gangs which James always denied.

2.2.3 James school years were often troublesome with poor attendance and he began to go missing. The records show James was reported missing on 27 occasions but his parents would not always report him missing as he would usually return home. Despite James' behaviour, through support from his father and the Education Welfare Service, James' attendance at school improved and he was able to achieve good GCSE grades.

2.2.4 In July 2014 aged 16 James was arrested in Norfolk for drugs offences and released on bail, issued with a travel warrant by Norfolk Police, and subsequently went missing for 20 days.

2.2.5 In December 2014 James presented himself to Thurrock Children's Social Care following continued unruly behaviour at his father's address, with regular police attendance for domestic and violent incidents. James became a Looked after Child (LAC) under Section 20 of the Children's Act 1989. He was allocated the relevant Social Worker and support team and a Care Plan implemented.

2.2.6 On leaving school James became Not in Employment, Education or Training (NEET) and the support workers made every attempt to help him gain employment or further education, but James was resistant to that support other than showing an interest in writing music.

2.2.7 James was placed in a five bedroom semi-independent accommodation in Haringey for 16—18 year olds. This was a spot purchase due to the unavailability of existing accommodation.

2.2.8 In May 2015 James went missing for several days and was stopped by Police in a known drug dealing area of Cambridge. In his possession were items from a recent burglary and also James admitted to having 21 wraps of heroin in his possession. James was bailed to appear at Court in Cambridge at a later date for the associated offences and taken back to London by Police. Enquiries identified that the home had failed to report this missing episode for three days.

2.2.9 James' Social Worker met with him on his return, but James would not discuss his arrest and continued to deny any involvement with Gangs. James continued to go missing and only ever accepted one return from missing interview. Those that worked with him had no firm evidence, but his recent possession of an iPhone and his lifestyle were not in keeping with the financial support he was being provided, which left underlying concerns of crime and gang involvement.

2.2.10 On 7th June 2015, James was stopped by Police in Portsmouth acting suspiciously. His placement was not aware he was missing. And at that time James appeared stressed when he returned. A few days later there was a violent incident between James and another resident at the placement. James left the scene prior to police attendance. The home and the victim declined to assist the Police and no further action was taken.

2.2.11 On 15th June 2015, there was a further incident at the home with James making threats to a resident with a knife. James was arrested for Affray and bailed to appear at Court on 14 July 2015, with conditions that he could no longer reside at that placement.

2.2.12 James was moved to another semi supported placement run by the same provider. James felt at this time that "his past was catching up with him" and shared some acknowledgement of his drug dealing with his Social Worker.

2.2.13 On 25 June 2015, James returned to Cambridge and was charged with possession with intent to supply class A drugs with a Court date set for 15 July 2015.Arrangements were made for James to be supported at his impending Court cases. It is not clear, due to the provider of the accommodation going into administration at the time of this review, but James failed to appear at Court on 14th July 2015 for the Affray charge and a warrant issued for his arrest.

2.2.14 On the evening of 14th July 2015 James was at the placement and seen by the in house support worker.

2.2.15 On the morning of the 15th July 2015 a different support worker from the provider attended to collect James for Court in Cambridge.

2.2.16 After initially failing to make contact with the in house resident support worker, entry to the home was gained. Both workers went to James room where he was found collapsed in his bedroom and subsequently pronounced dead by the paramedics who attended.

2.2.17 The Serious Case Review identified six findings the Safeguarding Board need to consider with 11 associated recommendations. Those agencies that worked or supported James have been involved in this SCR and some changes have already taken place to improve our systems and processes.

3. Issues, Optons and Anaylsis of Options

3.1 Please see copy of full review at:

http://www.thurrocklscb.org.uk/app/download/27433970/Thurrock+LSCB+SCR+James.pdf

Or

Hard copy attached as Appendix 1.

3.2 **Findings:**

3.2.1 **FINDING 1** – INSPECTION OF LAC PLACEMENTS. Does the Thurrock Board agree there is a need for Ofsted to carry out inspections of LAC semi-independent LAC placements?

3.2.2 **That is the issue?** Children's homes are subject to an Ofsted inspection. There is however, a natural gap in the inspection process, as semi-independent LAC placements are not currently inspected by Ofsted. The Thurrock Ofsted 2016 inspection stated commissioning was robust contrary to the findings found in this review. **(See also Finding 2)**

3.2.3 **What should be considered?** This serious case review highlights the need for a national inspection of all LAC including semi-independent placements.

Local Authorities overall aim is to supply a stable and safe environment, in order to support and develop a pathway for children and young people to succeed and thrive independently. Children and young people aged 16 to 18 years, accommodated in a semi-independent placement are as vulnerable as any other LAC. The issues within this review show the complexity and the requirement to ensure that the commissioning of the right placement, for the right LAC is essential and requires consistent monitoring of standards. It is suggested Thurrock Local Safeguarding Children Board consider the following recommendation, as there is a strong case to warrant such action and is further evidenced in **Finding 2**

3.2.4 **Thurrock LSCB Overview Report National Recommendation (1) for Inspection of LAC Placements**
It is recommended that the Department for Education consider the wider remit for Looked after Children inspections to include:

- The implementation of Ofsted inspections for all LAC provisions, regardless of the type of placement provided.
- An inspection to monitor the commissioning and compliance, checks by the Local Authority as to the suitability of the placement, experience of placement staff and financial checks made as to the stability of the Company and Board of Directors, providing the service provision.
- An opportunity for DfE and Ofsted enhancing support for Local Authorities, with the consideration of developing a national directory of suitable LAC service provider companies and directors in the industry.

3.3 **FINDING 2** – COMMISSIONING. Are the Thurrock Local Safeguarding Children Board satisfied?

1) With the system improvement this review has provisionally implemented in consultation, for financial stability checks for spot purchases with Thurrock's Children Commissioning and Service Transformation (CCST) for LAC placements?

2) Whether the current Thurrock commissioning strategy of LAC arrangements are safe?

3) Whether the regional Local Authorities commissioning services who work with Thurrock to identify suitable LAC Placements, should be shared up to date, relevant information of LAC placements?

4) Should the Thurrock Gang and Youth Violence, Local Assessment Process (2016), capture within the commissioning process for LAC placements, additional Gang and Youth Violence information to ensure Thurrock LAC involved or vulnerable to exploitation are not accommodated within significant Gang areas of concern?

3.3.1 **What happened?** James resided in two Thurrock LAC placements provided by the same company. However, Thurrock CCST in communication with the Independent Overview Author (IOA) stated that the company were spot purchases. The company was recommended by other Local Authorities in the

regional group that Thurrock CCST interact with to agree, share and recommend suitable placements. Information obtained during the course of this review raised concerns namely, Police being regularly called to the placements, a complaint made to the placement provider by Thurrock Children Social Care (CSC) regarding failure to comply with the reporting of missing persons, a former employee who confirmed that he was not being paid and had since left the company and finally in February 2016, while participating in this SCR, the company and its placement properties were put into administration. Routine financial checks in July and August 2014 would have shown that the company may have been in some financial difficulties. Regular checks as to the financial stability of companies were not carried out which could have stimulated further scrutiny. The Company may have perfectly valid reasons for going into administration and there is no criticism. It is not developed further within this Serious Case Review and is alluded to merely show that there was a system failure within commissioning. Thurrock CCST financial scrutiny of spot purchases will now be completed. They do not always have the time due to the urgency of finding a placement but insist checks will be carried out as soon as possible and then reviewed annually. In this case there was no contract or Individual Placement Agreement completed, the placements remained spot purchases and was a system failure.

3.3.2 **What should be considered?** (1 to 3 above) the new proposal will capture all spot purchases but are the Thurrock Local Safeguarding Children Board satisfied with the arrangement, support and supervision of the placement of LAC to provide a supportive and stable environment for Thurrock's LAC**. (**4 above) The Thurrock Local Assessment Process 2016 for Gangs and Youth Violence should ensure that sufficient checks are carried out as to the suitability of the location of a proposed placement. Particularly where vulnerable LAC liable to exploitation or association with gangs, are to be placed, to include contact with other area LAP's and Local Authority MASH's and Integrated Gang Teams. **(See also Thurrock CCG Recommendation 4),** regarding commissioning cases where a service is declined by an out of area provider, cases should be discussed at the Joint Funding panel so that the case can be escalated to specialist commissioners and funded as per the Responsible Commissioners guidance if indicated. The following suggested recommendations are completed for the decision of the Thurrock Board: -

3.3.3 **Thurrock LSCB Overview Report Recommendation (2) for Thurrock Children Social Care**

It is recommended that Thurrock CSC require, Thurrock Children's Commissioning and Service Transformation, to carry out a review of the supervision of commissioned contracts and spot purchases of LAC placements to ensure the continued stability of the accommodation for Looked After Children.

3.3.4 **Thurrock LSCB Overview Report Recommendation (3) for Thurrock Children Social Care**

It is recommended that Thurrock CSC require, Thurrock Children's Commissioning and Service Transformation, to share relevant information of concerns obtained from financial checks and scrutiny of their LAC placement service providers, with other regional Local Authority commissioning services, to ensure that only appropriate and viable contracts are awarded.

3.3.5 **Thurrock LSCB Overview Report Recommendation (4) for Thurrock Children Social Care**

It is recommended that Thurrock CSC review the Thurrock Gang and Youth Violence Local Authority Process 2016, to include commissioning checks to the suitability of the location of LAC Placements, to ensure that vulnerable children and young people are not placed in an area of significant gang and youth violence.

3.4 **FINDING 3** – MENTAL HEALTH AND OTHER ASSESSMENTS. Are the Thurrock Local Safeguarding Children Board satisfied that outcomes for LAC who are referred for a mental health and other assessments, are followed through to a recorded and acceptable conclusion?

3.4.1 **What happened?** 1) James' concerning behaviour was evident in February 2015 when it was known he was regularly using cannabis and referred for a Mental Health Assessment. His GP referred him to Child and Adolescent Mental Health Service (CAMHS) who declined their service and who referred his case onto a drug and alcohol service. Needless to say, his mental health concerns were never effectively assessed. There was no notable delusional concerns apparent to the same extent in the latter months, but his criminal offending and anger issues in the placement started to escalate. Ironically when James' room was searched on his death, there were no drugs found and toxicology results confirmed he had no drugs or alcohol in his body.
2) His Social Worker carried out a Strength and Difficulties Questionnaire (SDQ). James was deemed to have severe difficulties with a score of 27/40. The outcome of the SDQ was discussed by the Social Worker with the IRO. They were considering the option to move him to another area to reduce the risk and break the chain of him associating with others involved in crime and likely exploitation. He was however subsequently moved, not because of the SDQ outcome, but due to the assault incident concerning another resident in Placement 1 when he was transferred to his second placement.

3.4.2 **What should be considered?**

The GP referral to CAMHS St Anne's Hospital, records that his behaviour noted was possibly connected to his regular use of cannabis, CAMHS possibly believed that a referral to a drug and alcohol service was more acceptable. No consideration was made to look at the wider picture and is part of the service they advertise. Therefore no Mental Health Assessment was carried out. The rationale for CAMHS decision was never received for this serious case review or resolved within his Care Plan or LAC Reviews, so remained an unresolved Mental Health Assessment. It was not however seen as an issue at his inquest and in his GP appointment in May 2015, where he did not show such concerns.

3.4.3 Where a concern is identified within a Strength and Difficulties Questionnaire (SDQ) that a LAC has severe difficulties, there needs to be a robust system in place, with a clear support pathway identified, to address the concerns. **Comment:** To compliment these findings, **NELFT Agency Recommendation 3** addresses the need to follow up the outcome of LAC's immunisations, ensuring they are up to date. NELFT further identified **NELFT Agency Recommendation 4,** the requirement to embed a more robust record keeping and follow up process, in terms of health assessments and delays noted within this SCR, particularly for LAC placed out of the Borough, due to the added vulnerabilities they may encounter. The following suggested recommendations are submitted for the decision of the Thurrock Board:

3.4.4 **Thurrock LSCB Overview Report Recommendation (5) for Thurrock Children Social Care and NELFT**
It is recommended that Thurrock LSCB require Thurrock Children Social Care and NELFT, review LAC Care Plans and LAC Reviews, to ensure outstanding Mental Health assessments are notified and if required, escalated to the Thurrock Clinical Commissioning Group or appropriate partner agencies, in order that outstanding assessments are followed up and completed to a satisfactory standard, with the rationale recorded.

3.4.5 **Thurrock LSCB Overview Report Recommendation (6) for Thurrock Clinical Commissioning Group**
It is recommended that Thurrock LSCB request NHS Thurrock Clinical Commissioning Group under the Responsible Commissioners Arrangement, to escalate and provide support when notified by partner agencies, where a health practitioner makes a mental health referral for children and young people, which remains outstanding. This is in order to obtain a satisfactory outcome for the patient, with the rationale of the decisions recorded on the patients' health file by the provider organisation.

3.4.6 **Thurrock LSCB Overview Report Recommendation (7) for Thurrock Children Social Care, NHS Thurrock Clinical Commissioning Group and NELFT**
It is recommended that Thurrock LSCB require Thurrock Children Social Care, NHS Thurrock Clinical Commissioning Group and NELFT, to ensure that when a Strength and Difficulties Questionnaire (SDQ) identifies that a LAC has been assessed with severe difficulties, there is a robust system in place to track these high risk cases with appropriate intervention levels and effective pathways established and applied, to address the concerns in support of the LAC.

3.5 **FINDING 4** – EARLY RECOGNITION OF CONCERNS. Does the Thurrock Local Safeguarding Children Board believe there should be a process of an early recognition of concerns by supervisors and Independent Reviewing Officers, in addressing escalating issues for LAC and of action to be identified and taken to address these safeguarding concerns?

3.5.1 **What happened?** Within James LAC Care Plans and within his three LAC Reviews it was clear that issues were escalating with recorded actions allocated, however there was not a joined up approach. There was a goal for James to return home, although there was interaction with his father, there was no relevant contact with his mother by practitioners. Professional concerns of his many missing person episodes, his cannabis use, travelling to other parts of the country and possibly concerned in the supply of drugs, his anger and possible mental health issues, non-engagement with practitioners, being NEET and his father requesting James be placed within a placement in Essex prior to his third LAC review, were all evident.

3.5.2 **What should be considered?** Section 20 of the Children Act 1989 (Accommodation) stresses that the views not only of the subject but those of the parents should and have been taken into consideration and a Family Group Conference (FGC) would have been a sensible forum for this. There is a need for the consideration of holding an early FGC if there are relationship problems and a strategy meeting to discuss increasing criminal offending with the relevant agencies and to listen to the voice of both the subject and family.

3.5.3 In conversation with the Independent Reviewing Officer (IRO) and her manager, these suggestions in James' case regarding a FGC, would have been considered for future meetings and agreed with the IOA that there is a need to be able to recognise the evolving issues for the LAC earlier with multi-agency involvement. There is also a need to establish a robust system to effectively monitor the distribution of LAC minutes, to ensure that the information, actions and the outcomes are satisfactory completed by appropriate agency professionals. A consideration of the DfE 2014 Statutory Guidance on children who run away or go missing from home or care should have been followed to assist functioning. The following suggested recommendation is completed for the decision of the Thurrock Board: -

3.5.4 **Thurrock LSCB Overview Report Recommendation (8) for Thurrock Children Social Care**
It is recommended that Thurrock CSC ensure that supervisors and LAC Independent Reviewing Officers (IRO), develop a matrix for the early identification of escalating concerns with LAC and of action taken to address those concerns. This should include an effective system to monitor and distribute LAC minutes to appropriate key practitioners to guarantee that any actions identified are satisfactorily completed. Any interventions can be reflected within the IRO Annual Report for monitoring purposes.

3.6 **FINDING 5** – SHARING OF INFORMATION. Does the Thurrock Board believe that relevant medical disclosures made to a Forensic Medical Examiner by children and young people arrested in Police custody are sufficiently captured and relevant safeguarding information shared with children social care?

3.6.1 **What happened?** When James was in custody at a Haringey Borough Police Station, he was examined by a Forensic Medical Examiner (FME) and James

stated he was bi-polar. This was recorded in the detention and FME log. There is no record of this information being shared with CSC either from the medical professional carrying out the examination or whether it was recommended to the custody officer to complete a Merlin (Met Information) report for onward sharing. It has been confirmed by the Chair of the SCR who carried out further enquiries, that there is no record of James being on any medication for bi-polar or anything health related. The only history given to the GP was a part history of allergic asthma, allergy to nuts and smoking cannabis. The Metropolitan Police Service (MPS) Safety Compliance Investigation team state that there is no responsibility of FME's to inform partners, they complete the National Strategy for Police Information Systems (NSPIS) medical form, it is then for the custody officer to take whatever action is necessary.

3.6.2 **What should be considered?** The FME has a responsibility to bring to the attention of Police the medical history disclosed and how it can be determined, if the person does or does not have a particular illness and recorded in the custody detention and FME log. The Police need to remind custody officers to be aware of these situations, to ensure relevant information is shared after a consultation with the FME making the entry. This aspect is further discussed within Chapter 7 Conclusions, Paragraph 14, as there may be learning on the fringes of this review that can be developed. The following suggested recommendation is completed for the decision of the Thurrock Board: -

3.6.3 **Thurrock LSCB Overview Report Recommendation (9) for the MPS**
It is recommended that the Metropolitan Police Service remind custody officers, that any apparent condition or vulnerabilities disclosed to a Forensic Medical Examiner (FME) by a child or young person in custody, must be risk assessed. If this highlights any risks or concerns, this should be referred to appropriate agency partners by the investigating officer upon the completion of a Merlin.

3.6.4 **FINDING 6 – SAFEGUARDING CONCERNS FOR CHILDREN AND YOUNG PERSONS PRESENTING HOMELESS IN ANOTHER AREA. Are the Thurrock Local Safeguarding Children Board satisfied?**
1) The arrangements and the quality of the recording within Norfolk Constabulary custody records of children and young people are sufficient for safeguarding and accountability?
2) The welfare arrangements by Norfolk Children's Social Care, for a homeless child and young people were satisfactory in providing support and safeguarding the welfare?

3.6.5 **What happened?** Norfolk Constabulary. James was arrested in their area for an offence of possession of a controlled drug. The standard of the information supplied from Norfolk Constabulary regarding arrested children and young people appears to be unsatisfactory. In James arrest and release on bail, it does not detail sufficient information to exactly know or record the outcome for James. He was apparently watched by a Police Community

Support Officer (PCSO) while Norfolk CSC arranged accommodation for him and then supplied with a travel warrant. It was reliant on the memory of officers, not ideal for accountability. It did not give the rationale as to why the case was subsequently recorded as no further action. The presumption is there was insufficient evidence against him.

3.6.6 **What should be considered?** There is a need to record all safeguarding arrangements. It should detail how a travel warrant was issued and on whose advice. It should record details of the officers involved and their pocket books details. Records need to capture any agreement with Norfolk CSC as to the onward safeguarding arrangement for a vulnerable young person, as James was allowed to travel home alone.

3.6.7 **What happened?** Norfolk CSC. James presented as homeless to the CSC after his arrest and released on bail from Police custody. His father initially would not allow him home and he became the responsibility of Norfolk CSC. Subsequently the Norfolk Social Worker in contact with his father agreed he could return to him and was provided with a travel warrant. He was allowed to travel home, unaccompanied late at night and he missed his train. The Social Worker reported him missing as he could not be found. He remained missing for a significant period.

3.6.8 **What should be considered?** The CSC should have followed good practice under the Children Act 1989 and accommodated him for an assessment and not allow him to travel home alone late at night. This is a safeguarding issue and the welfare of the young person was not thoroughly considered and resulted in a vulnerable person going missing. The following suggested recommendations are submitted for the decision of the Thurrock Board:

3.6.9 **Thurrock LSCB Overview Report Recommendation (10) for Norfolk Constabulary**
It is recommended that Norfolk Constabulary review their custody safeguarding arrangements for the detention and supervision of children and young people within their care. This is to ensure that Police records accurately record all safeguarding arrangements and action agreed with Children Social Care for the outcome and welfare of children and young people within their custody.

3.6.10 **Thurrock LSCB Overview Report Recommendation (11) for Norfolk Children Social Care**
It is recommended that Norfolk Children Social Care, review their compliance to the Children Act 1989 for children and young people presenting as homeless in their area, as to their safeguarding and welfare arrangements for vulnerable children and young people.

4. Conclusions

4.1 **Predictability**
James death was not predictable. There had been extensive professional

interaction with him and contact with his family in the latter period of his life. The findings and learning identified for agencies, were on the fringes of the review and did not affect or contribute to the final tragic outcome of events.

4.2 **Preventability**
Professionals on all available knowledge and information could not have foreseen or were able to prevent the outcome of James' death. There were no previous concerns or behaviour known to family or practitioners to contemplate that James would take his own life or commit self-harm, even within the last few hours before he was found collapsed in his bedroom at his placement.

4.3 The fact that there is some learning identified and addressed within the agency and suggested overview report recommendations, should not detract from the enormous amount of professional involvement, resources and hard work provided to support this young person. Overall, services and support was constantly provided for James.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Thurrock Local Children's Safeguarding Board (LSCB).

6. Impact on corporate policies, priorities, performance and community impact

6.1 Thurrock Council has reviewed its commissioning policies and procedures in-line with the recommendations of this review.

7. Implications

7.1 **Financial**

Implications verified by: **Kay Goodacre**
Finance Manager

There are no financial implications arising from this review and its recommendations.

7.2 **Legal**

Implications verified by: **Lindsay Marks**
Principal Solicitor, Children's Safeguarding

The Local Authority as a statutory partner must engage fully in the completion of serious case reviews and the dissemination of learning from the review across the authority.

7.3 **Diversity and Equality**

Implications verified by**:** **Natalie Warren**

Community Development and Equalities Manager

In implementing the recommendations of the Serious Case Review the local authority must commission and ensure an effective range of services to meet the needs of children from all backgrounds.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

N/A

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

Thurrock LSCB, SCR Report James

9. Appendices to the report

Appendix 1 - Thurrock LSCB, SCR Report James

Report Author:

Andrew Carter

Head of Service

Children's Care and Targeted Outcomes

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JAMES

SERIOUS CASE REVIEW

OVERVIEW REPORT

Publication Date:- 1st December 2016

Independent LSCB Chair - David Peplow **Independent Overview Author - David Byford**

A THURROCK LOCAL SAFEGUARDING CHILDREN BOARD COMMISSION

Contents

OVERVIEW REPORT

CHAPTER 1 – INTRODUCTION

1. This Serious Case Review (SCR) was commissioned by Thurrock Local Safeguarding Children Board (TLSCB) following a notification of the death of James, a seventeen year old British male of Ghanaian heritage. He was a Thurrock Looked After Child (LAC). On 15th July 2015, James was found in his bedroom at his placement, a semi-independent accommodation in North London. He was discovered by two support workers attempting to wake him for a Youth Court appearance in Cambridge that morning. He was collapsed on the floor between his bed and his bedroom door, preventing access that was later gained by a London Ambulance Service (LAS) paramedic. He was found to have a bed sheet tied around his neck which was cut off by the paramedic. He was unresponsive and all emergency attempts to resuscitate him were made without success. James was pronounced dead at the scene by an Advance LAS paramedic at 9.46am.

2. James' unexpected death took his family and professionals by surprise. There had been no previous information, concerns or threats made by him to suggest he had any suicidal ideation or to self-harm that could have stimulated an intervention. At the subsequent post mortem, the Home Office Pathologist gave the cause of death as by way of "Suspension." The Coroner at James' inquest recorded an "Open Verdict" with no other third party involvement in his death.

3. The SCR is an opportunity to understand James life and to address the questions posed by TLSCB within the Terms of Reference set for this review. Additionally it avails the chance to analyse his personal circumstances, relationship breakdown with both of his estranged parents, mental health considerations, escalating criminal offending, his involvement and interaction with services, key professionals and agencies that provided those services, to enable change. To learn from his story, may help prevent a similar occurrence happening to others. It is hoped that lessons can be learnt, by translating the findings at Chapter 6 of this Overview Report (OR), into recommended programmes of action that lead to sustainable improvements for the welfare and support of LAC.

4. Thurrock Local Authority, Thurrock Local Safeguarding Children Board, the Independent Chair of the Serious Case Review Panel, the Independent Overview Author (IOA) and multi-agency partners within the SCR process, express their sincere condolences to James' family after his tragic death.

Abstract of findings

5. TLSCB, Thurrock Children Social Care (CSC) and agency partners should feel reassured that the tragic outcome for James, whilst a Thurrock LAC was neither predictable nor preventable. This assertion is further discussed and explained within the conclusions at Chapter 7. The review has sought to identify any short comings in existing and recent practice and aims to suggest recommendations at Appendix 4, for improvement that are learning on the fringes of the review and not a contributable factor.

Background

6. The family dynamics of James' early life, particularly with his parents and his and their relationship breakdown, were not well documented by agencies prior to this serious case review. This information has been enhanced from the family meetings between James' parents and the

Independent Overview Author (IOA) which were open and constructive. There were no criticisms expressed of professionals concerned in the support of their son while he was a LAC. Further details of the family is contained within the family involvement to this report and an anonymised genogram has been prepared at Appendix 5.

7. James was born in Hackney, to parents both of Ghanaian heritage. They lived together until they divorced in 2001. He went to live with his paternal grandfather, a successful business person and Civil Servant in Ghana for approximately two years, returning to live with his mother, in time to start his first day at school in Hackney. He was later brought up with his mother, step-father (who met in 2002) and a younger half-brother (who is now thirteen years of age). His father had two further relationships and has another son also aged thirteen years old. In his current relationship and second marriage, he has three daughters aged six years, three years and a six month old baby.

8. At the end of 2012, James went to live with his father in Thurrock, as his mother and step-father could not cope with his behaviour. They were concerned for him and the effect it was having on his half-brother. He had been given a stable and comfortable life, staying with his father at weekends in Essex. According to his mother, he suffered violent mood swings which led to a domestic incident where he picked up a knife and made threats. Metropolitan Police Officers (MPS) attended the home and diffused the situation. His mother and step-father believed his behaviour, was compounded by his regular cannabis use and possible affiliation with local gangs.

9. James was an intelligent young man who achieved good GCSE grades in Year 11 at School 4, which did not seem possible at first. He enrolled in the school after he initially went to reside with his father in the Thurrock area. On his first expected day of attendance in Year 10, he argued with his father and was reluctant to go to school. James then went missing but returned home later that day. Becoming a missing person became a persistent and concerning factor in his life which the father had to contend with. The father on most occasions reported his son missing as James continued to flout his father's home rules, usually returning to his unknown friends in Hackney. He at no time divulged details of his friends to Police, his family or practitioners. He either returned of his own accord, was found by MPS Police officers or turned up at Hackney Children Social Care (CSC) offices, which he did on two occasions. There were times when he was not reported missing by either parent due to their frustration, as they knew he would always return, but his missing episodes persisted. School 4 had concerns with CSC when seeking assistance to help challenge James' missing person episodes. Referrals and contacts did not receive adequate responses. School 4 have now introduced a system to challenge non responses and to escalate concerns with CSC or other agencies, if the situation persists in the future. **(See School 4 Agency IMR Recommendation at Appendix 4.)**

10. In Year 10, his attendance at one point was as low as 30%. Eventually after several months of failing to attend school, he was removed from the school register with his education monitored by the Education Welfare Service (EWS). His father managed to speak with James and convinced him of the importance of gaining an education. With the help of the EWS, James enrolled back at School 4. His Year 10 attendance rose to 86% and in Year 11 he attained 98.8%. A Common Assessment Framework (CAF) was carried out and this period educationally, was successful. He achieved six GCSEs A* to C grade, sufficient to continue into further education but he declined to take up the option.

11. During this period, James also attended Shoreditch Police Station and Hackney CSC, presenting himself as homeless. These contacts are further critiqued in Chapter 5. As well as attempting to

address his regular, if not daily use of cannabis, practitioners continually made further attempts to advise him to keep away from gang culture, which he always denied any association with.

12. After he left school, James became (NEET), not in education, employment or training. In October 2014, he was allocated a support worker from the Thurrock Adolescent Team who remained James' Personal Adviser when he transferred to the Careers Team, this maintained consistency for him. His Personal Adviser was the constant factor throughout James' period as a LAC who endeavoured to stop him being NEET. He managed to enrol James on a Prince's Trust twelve week course at Hackney College. James persistently failed to engage with the course, he was either always late or did not bother to turn up.

13. His father attempted to provide a home for James but he was constantly concerned with his son's use of cannabis which he felt affected him mentally. Professionals suspected that he was dealing in drugs and this suspicion was not unfounded as he was previously arrested in 2014 at Great Yarmouth, Norfolk in unusual circumstances. James was discovered at the home of a middle aged woman whose address the local Police were searching and found him hiding in a wardrobe. Both were arrested for a small amount of drugs found on the premises. Subsequently Norfolk Constabulary took no further action. There was however possible safeguarding concerns between Norfolk CSC and Police, as James when bailed for further enquiries by Police, was given a travel warrant and allowed to travel home late at night, after an apparent agreement between the Social Worker and his father. He missed his train and the Norfolk Social Worker had to report him as a missing person. He was not found until the following month, staying at his maternal aunt's home in South London.

14. There were a number of domestic incidents. James threatened his mother, as alluded to on one occasion and on several occasions he threatened his father and paternal uncle. Police attended on these occurrences, culminating in the last episode in December 2014 at his father's home. James was temporarily taken to stay with his maternal aunt as a stop gap, as his father declined to take further care of him. On the 29th December 2014 James presented himself to Thurrock CSC as homeless due to the breakdown in his relationship with his family. Up until that time he had not actually been homeless. Nevertheless, due to the emerging situation, Thurrock CSC took immediate and appropriate steps. James became a LAC, accommodated under Section 20 of the Children Act 1989[1]. Thurrock CSC carried out an assessment, instituted a statutory Care Plan and appointed an Independent Reviewing Officer (IRO) for his LAC Review meetings. He had an allocated key Social Worker, SW1, prior to this event and there is evidence between the three Social Workers James had whilst a LAC, that there was a smooth transition between them.

15. He was accommodated in a Semi-Independent Placement 1 in Haringey, a five bedroom house with four rooms allocated for residents aged 16 to 18 years of age. He was described by practitioners as a shy and withdrawn person who could lose his temper if provoked. Whilst in the placement he continued to go missing, predominately to the Hackney area, where his unknown friends were. He was suspected of smoking cannabis in his room and this and other concerns identified by his second Thurrock Social Worker (SW2) were escalated and challenged with support from Thurrock senior management. It was believed the placement did not know how to deal with him and were not compliant with reporting James missing, necessitating Thurrock CSC making a formal complaint to the Head Office of the company providing the placement.

[1] Section 20, Children Act 1989

16. Whilst in Placement 1, after a meeting with The Prince's Trust practitioners, they were concerned how James presented. (He was subsequently removed from the course for failing to engage.) They referred their concerns to Thurrock CSC who through SW2 and his key support worker at Placement 1, he was taken to his new GP surgery. The GP was concerned about his response to questions posed and also with his cannabis use and referred him to CAMHS. They did not accept the referral but suggested BUBIC, a local drug service, who in turn recommended Insight (Haringey) a drug and alcohol advocacy. Despite numerous attempts by Insight, he failed to engage with them and refused to attend meetings and they closed his case file. He continued to be withdrawn and kept to himself, spending hours alone in his room with the lights off and even taking light bulbs out, which the GP was alerted to. James did not associate with the three other residents in the placement.

17. He had an active Care Plan and the resources, support and advice offered to him is well documented for him to achieve and to take a better direction in life. Within Placement 1, his missing episodes continued with the time periods extending. It is now known that he was travelling to other parts of the country, believed to be for the purposes of criminality and suspected drug dealing. To keep James from being NEET his Personal Adviser helped him in preparing a Curriculum Vitae (CV), continued to look at employment and community projects such as garden maintenance, but James would not integrate with groups of people. He had a lack of interpersonal skills and would not consider any of these options. A music production course was identified at a college, as this was his only real interest, writing music and lyrics. Unfortunately it did not start until September 2015 and other alternatives where explored to bridge the long period until the course began, including the failed enrolment on The Prince's Trust Course.

18. In May 2015, James went missing for several days and was seen by a witness, a member of the public in Cambridge, acting suspiciously in a known drug dealing area of the city. There were two burglaries that occurred between the 6th and 9th May 2015. He was stopped on the 9th May and was found in possession of the second burglary victims' iPhone. The victim had used her "find my phone" iPhone app and called the Police to the location. James initially attempted to run off but was caught and had to be restrained. The witness who had seen him in the area over the preceding days believed he witnessed James going into bushes with "property." When he came out he did not have the "property" on him. Police subsequently recovered stolen laptops from the bush from another burglary. He admitted to the arresting officers at the scene that he had drugs on him, twenty one individual packets containing heroin. He was arrested for possession with intent to supply drugs and the two burglaries which were linked.

19. It transpired that he had been a missing person since the 1st May 2015 but Placement 1 had not reported him missing to Police until the 4th May 2015. After his arrest, MPS officers attended Cambridge, when he was bailed for the further investigation of his case and for the analysis of the drugs, to escort him back to his placement. SW2 made a point to see him to discuss the arrest but James was not forthcoming.

20. The placement arranged and carried out assessments for 1) Child Sexual Exploitation (CSE) and 2) knife and gang crime. There was no concern regarding CSE and it was confirmed that he was not visiting inappropriate websites. He continued to deny any knowledge or association with gangs. There were still underlying concerns that he was becoming involved in crime but with no firm evidence that he was in association with gangs. He accepted to be interviewed on one occasion by Open Door, an independent service that interview children and young people when they return from periods of being reported missing. They were not convinced by his denial of gang affiliation. He was

living above his limited means, bringing home expensive takeaways and still able to pay for his regular cannabis habit which he said he had for three years. His parents confirmed that they did not give him extra money and they did not know how he paid for an iPhone that was seized by Cambridgeshire Police.

21. On 7th June 2015, he was stopped by Police in Portsmouth as he was acting suspiciously. His placement were unaware he was missing. When he returned, the staff said that he seemed stressed. Several days later on the 10th June, there was a violent argument between James and another resident who it was alleged he assaulted. James left the placement prior to the arrival of Police. The victim and the placement staff declined to assist Police, so there was no further action taken.

22. On the 15th June 2015, James threatened another resident at his placement with a knife. MPS Police Officers attended and arrested him. He was later charged with an offence of affray to attend a London Court on the 14th July 2015. His bail conditions were not to return to the placement or to have any contact with named persons at the premises. The Placement Director carried out an urgent Risk Assessment in consultation with a SW Manager of Thurrock CSC. There was an agreement to transfer him to the company's Placement 2. James in communication with the Placement Director, stated that "my past is catching up with me." James also admitted to her and shared with SW2, an acknowledgement of his drug dealing in Cambridgeshire and his concern with going to prison.

23. On 25th June 2015, he returned to Cambridge to answer his bail. On the authority of the Crown Prosecution Service (CPS), he was charged with the possession with intent to supply Class A controlled drugs and the handling of the stolen iPhone only. He was bailed to appear at a Cambridgeshire Youth Court on the 15th July 2015. There was insufficient evidence against James to charge him for the two initial allegations of burglary.

24. Arrangements were made for Placement 2 to support him at his impending Court appearances. He subsequently failed to appear at a London Magistrates Court on the 14th July and a warrant for failing to appear was later issued but too early to activate before the event that followed. It is recorded that his Placement 2 key worker was aware of the date and had informed SW2 of it previously. The reason why he failed to appear, has not been obtained from his placement, as the company are now in administration. The following morning of the 15th July at 8.30am, an escort from the company placement provider arrived at Placement 2 to take him to his Cambridge Court appearance, when James was found collapsed in his bedroom. He was subsequently pronounced dead by the LAS called to the scene. **(See Chapter 3, Details of the Investigation into James Death.)**

CHAPTER 2 – INITIATION OF THE SERIOUS CASE REVIEW

1. Following a recommendation from Thurrock Local Safeguarding Children Board SCR Sub-Group, the Independent LSCB Chair David Peplow, took the decision to commission a Serious Case Review on the 18th August 2015, as the circumstances met the criteria in accordance with Section 5 (2) (a) and (b) (I) LSCB Regulations 2006[2] and Working Together to Safeguard Children 2015[3]

- *"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".*

2. Ofsted were notified of the decision to commission a SCR on the 13th October 2015 and the National Independent Serious Case Review Panel were informed by TLSCB of the review on the 18th November 2015. Additional time during the course of completing the review was requested and agreed. This was due to the complexity and number of agencies participating in the SCR, the parallel coronial process and the limited access to family and professionals required to be interviewed.

Period under Review and Terms of Reference

3. The Terms of Reference (TOR) requested information from James tenth birthday, until the date of his death. This period assisted in understanding the background history and for learning from the review. Each agency were asked to complete a brief summary of their involvement with the family prior to the agreed timescales.

Purpose of the Serious Case Review

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

- Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children and young people.
- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and,
- As a consequence, to improve inter-agency working and better safeguard and promote the welfare of children and young people.

Terms of Reference and Specific questions

5. Terms of Reference and specific questions identified to be addressed by Agencies are:

1) The arrangements in relation to James plan as a LAC. How that was or was not connected with what was happening in his life?
2) How was he being supported in his Court appearances?
3) What link was being made in relation to his possible connection with drugs?
4) Was the possibility of James being involved in drug dealing being considered?
5) The knowledge of staff within the home. Were they aware of his past and current needs?
6) Was there YOS involvement and if not why?
7) The referral made to CAMHS, what was the rationale for the referral?

[2] Local Safeguarding Children Board Regulations, 2006 Section 5 (2) (a) and (b) (i)
[3] Working Together to Safeguard Children, 2015

8) What plans were in place in relation to supporting James from becoming NEET?
9) The referral to Insight, what was this for and was it appropriate?
10) The reporting of absence or missing persons – was the appropriate policies and procedures complied with?

Key Issues

6. Key issues to consider

1) Did all agencies work together effectively to safeguard this young person?
2) Was the outcome preventable?
3) Were the safeguarding procedures followed appropriately?
4) Was the young person's voice heard throughout agencies involvement?

Scoping

7. The following Agencies were asked to provide a chronology and an Individual Management Report (IMR) or Summary Report where identified of their agencies involvement with James as follows:

Agency Participation
Metropolitan Police Service - IMR and chronology
Insight (Haringey) - Not required
CAMHS - No participation
NELFT - IMR and chronology (Received August 2016)
Youth Offender Service - Not required
Placement Service Provider - IMR and chronology
Courts - Not required
Cambridgeshire Police - IMR and chronology
Norfolk Police- Summary Report
Thurrock CSC - IMR and chronology
Haringey CSC - Not required
Hackney CSC - Chronology
GP - Report
Hampshire Police re Portsmouth - chronology
Education/School 4 - IMR and chronology
Essex Police - IMR and chronology
Thurrock CCG - IMR and chronology (Revised IMR received August 2016)
British Transport Police – Summary Report
National Probation Service – Not required

8. The Serious Case Review Panel (SCRP) met on eight occasions prior to the Final Overview Report being presented to the Thurrock Board for approval. The Independent Overview Author was invited to and attended all SCRP meetings from December 2015.

The SCRP meeting dates were:

21st September 2015, 11th December 2015, 11th February 2016, 7th March 2016, 25th April 2016, 22nd June 2016, 15th July 2016 and 5th September 2016.

Membership and Conduct of the SCR Panel

9. The Independent Chair for the SCR is Helen Gregory NELFT. Adviser to the SCR is Alan Cotgrove, Thurrock LSCB Manager and the Independent Overview Author, David Byford was appointed to carry out the SCR on the 17 November 2015. He has met all deadlines set by TLSCB.

10. Both Ms Gregory and Mr Byford have no operational involvement, connection or conflict of interest with the case of James. (See Appendix 1 for biographical summary for the Independent Chair and Overview Author.)

11. All Agency IMR and Report Authors have demonstrated their independence within their agency responses to the SCR.

12. The Serious Case Review Panel (SCRP) consisted of the Independent Chair, Independent Overview Author and the following Senior Representatives from agencies:

- Thurrock LSCB Manager
- Thurrock LSCB Project Officer
- Thurrock Children's Social Care
- Thurrock LSCB Legal Adviser
- Essex Police
- Thurrock Clinical Commissioning Group
- NELFT
- Metropolitan Police
- Deputy Principal Education Psychologist

Family (An anonymised genogram is produced at Appendix 5).

13. Subject:

James

Other relevant family members

Mother

Father

Step Brother

Step Father

Significant Others:

Maternal Aunt

Paternal Uncle

Methodology

14. In carrying out this review the following methodology and approaches were made:

- Liaison with Police, Thurrock CSC personal including CSC key Social Workers, Independent Reviewing Officer (IRO), Children's Commissioning and Service Transformation and the CSC IMR Author.
- Liaison with James' parents and step father, coroner's office, placement support workers and viewed coroner Police report and statements.

- Attended the Pre-Inquest and Inquest for James.
- A desk top review of all Thurrock LAC procedures, Care Plans and LAC Review meetings and consideration of previous Thurrock SCR's, Ofsted Inspections of Thurrock, 2012 and 2016 (see Chapter 5, paragraph 86) together with additional research of guidance material.
- Analysis of agency submissions to the SCR and compliance with the Terms of Reference and statutory requirements.
- A review of the Thurrock CSC complaint and escalation of Placement 1.
- Interviews with family members and key practitioners.

15. Statutory guidance provided by the Department for Education[4] 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.*

16. Thurrock Local Safeguarding Children Board (TLSCB) 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 James and his family. This was to utilise and analyse submissions to the review from Individual Agency Management Reports (IMR), agency chronologies, summary reports, key practitioners and family interviews.

17. The Independent Overview Author (IOA) identified at an early stage from the agency submissions, additional areas requiring further information to be provided and were requested from agencies. This additional information was predominately provided within the agencies final submissions. Significant case notes, documentation, policy and procedures, care plans, minutes of meetings, Police investigation reports particularly the report to the Coroner and the statements of witnesses directed to attend the formal inquest, were additionally obtained for direct analysis and comparison. Interviews of their agency key practitioners were carried out by IMR authors. Additional practitioners relevant to the review and the family were identified and interviewed by the IOA. Every effort has been made to ensure accuracy, openness, transparency, comprehensiveness and challenge of the information provided to the SCR process in completing this overview report.

Inhibitors to the process

18. The following inhibitors to timeliness have impacted this review:-

- Some agencies failed to meet the deadline for their submissions to the process. This necessitated an extension of the TLSCB timeline on several occasions with the commissioners actively chasing up individual agencies.
- Feedback and comments of the IMR's and reports by the IOA, required additional analysis and information with the specified questions in the TOR not always being addressed.

[4] Working Together to Safeguard Children, 2015 Chapter 4

Responses were slow and tightened the timescale for this author and TLSCB, requiring comment.

- Further lines of enquiry were therein identified, necessitating other agencies to be invited to participate and key professionals to be interviewed for the purposes of completing the SCR.
- The Coroner inquest processes delayed the interview with family and professionals, imperative to the SCR, as they were formal witnesses at the inquest into James' death.
- The TLSCB had three concurrent SCR's and other necessary commitments which effected administration of the review. During the review, they effectively recognised and recruited a new LSCB Administrative Assistant to alleviate and provide additional support. This was effective action by TLSCB and assisted the IOA by actively chasing outstanding responses.
- The company that provided both semi-independent placements have gone into administration during the SCR process and follow up enquiries were not readily available.
- A key placement support worker did not appear at the inquest and questions that the family and this serious case review wanted to know were not able to be asked. Attempts were made to make to contact but without success.

CHAPTER 3 – DETAILS OF THE INVESTIGATION INTO JAMES DEATH

Details of Investigation

Warning - The next section of this review contains details of the circumstances in which this young man was found, which some people may find upsetting. Thurrock LSCB considered this section and the contents very carefully. It was decided that it is an important part of the learning from this case to highlight just how quickly a person can be affected by the course of action which is described.

1. In the evening of Tuesday 14th July 2015, James was at his Semi-Independent Placement 2. It was a five bedroom house with a bedroom each for the four residents and another for staff who stayed overnight. He was seen by the support worker 1 who was on duty until the following day. He appeared in good humour and had eaten some food and went to bed at about 10.30pm. He was due to travel to Cambridge the following morning to attend a Youth Court to appear for the offence of Possession with intent to supply Class A controlled drugs and handling stolen property.

2. On the 15th July 2015, support worker 2 who did not know James and worked for the same company service provider at another location, attended Placement 2. He had been instructed to drive James to Cambridgeshire for his Court appearance. He should have arrived at 8am but due to heavy traffic arrived at 8.30 am. He had some difficulty getting into the premises. Eventually with the assistance of a telephone call to the resident support worker 1 from his Head Office, he was let in just before 9am. In her statement to Police the resident support worker said she made attempts to rouse James at 5.11 am, 6 and 7 am by knocking on his first floor bedroom. The only response received was on the first occasion, James did not say anything but she heard a thud sound on the bedroom door from inside. This was apparently a normal occurrence when staff knocked on the door and he did not want to get up.

3. Both support workers went to James bedroom, Support Worker 1's statement said it was 8am but support worker 2, who later gave evidence at the inquest, said it was nearer 9am which was more likely. They did not get a response and managed to partially open the door (whether a key was used or it was open is not known as Support Worker 2 could not recall and this review has not been able to obtain a response from Support Worker 1.) They could not open the door fully, as James was collapsed behind it wedging the door closed.

4. An emergency call for an ambulance was logged by the LAS at 8.51 am. Paramedic 1, attended the scene at 8.56am. On his arrival, he was taken to James' bedroom and was informed by the support workers that they could not get a response from James and could not open the door. The paramedic described the door as not locked and on pushing it, managed to get a glimpse of James wedged between the door and the bed. The door would not open beyond three inches. Fearing the worst, the paramedic called his control for Police and colleague backup. In the meantime, with the help of the support workers who assisted him, he pushed the door and eased through a tiny gap into the room.

5. Once inside he saw James, who lay in a lateral position, unresponsive and unconscious, tightly wedged between the door and the bed, with a white bed sheet tied around his neck. The paramedic pulled the bed away and dragged James to the centre of the room and cut loose the sheet wrapped around his neck. His airway was obstructed, he was not breathing and there was no palpable carotid pulse. He established a diagnosis of cardio respiratory arrest and instituted a full resuscitation attempt assisted by other LAS paramedics who subsequently attended. On the arrival of the "Advanced" paramedic, a surgical airway was established. Resuscitation attempts to revive James

were unsuccessful and at 9.46am James was pronounced dead at the scene by the "Advanced" paramedic.

6. Police Constable 1 from Wembley Police Station attended with other Police officers. He was present whist the paramedics were trying to resuscitate James. He described that James had a white sheet tied into a knot around his neck, with another knot in the sheet suggesting it had been tied around something else like the door handle. After James was declared dead at the scene, Police informed the staff of his death, Thurrock Children Social Care, the Coroners Officer, Scenes of Crimes Officer (SOCO) and the Criminal Investigation Department (CID), who having attended, agreed the death was non-suspicious, as there was no evidence of any third party intervention and no apparent injuries on his body. It was not known at the time if James had been in recent contact with Police for his outstanding Court case and his failing to appear the day before. As required, they notified the Directorate of Professional Services (DPS) who deemed the incident was not a death after Police contact.

7. The scene was photographed and searched. There were no mobiles phones discovered (Cambridgeshire Police had seized two previously.) The knotted sheet was taken possession of, as well as a blue exercise book which contained written rap song lyrics. The book was open at a page referring to dying and the end of life. The bedroom was untidy and a suitcase containing clothes and kitchen utensils was next to the unmade bed. There were no suspicious circumstances evident.

8. Copies of the LAS paramedic's notes and details of his missed and upcoming Court date were obtained. Statements were taken from the two support workers, Director of the placement and from two of the other residents. Nothing untoward was noted by anybody to suggest James might want to harm himself.

9. PC 1 provided the serious case review, with a copy of the Police report and statements he prepared for and on behalf of the Coroner. In conversation with the IOA at the subsequent Pre-Inquest and Inquest (see below), he stated that Police were often called to the placement for residents going missing and various other matters. The officer prior to the inquest, travelled to Cambridge and took possession of James' property that had been seized for possible evidence when he was arrested. The property seized included a Samsung mobile phone, a scroll tablet, oyster card, a sim card and Nike bag. At that time, they further retained his iPhone which because of the lack of a password could not be accessed. As Cambridgeshire Police had possession of his two mobile phones since his arrest, it is reasonable to suggest there was nothing relevant to James death on the devices.

Post Mortem

10. On the 21st July 2015, a post mortem was carried out by Home Office Pathologist David Rouse, at a public mortuary. He confirmed that on examining James, there were no obvious signs of third party involvement other than the attempts to resuscitate by the LAS paramedics.

He gave the cause of death as - 1a **Suspension.**

The pathologist records in his statement to the Coroner when describing suspension, that death could be immediate or within seconds. The subsequent toxicology report confirmed there was no alcohol or drugs detected within James' body at the time of his death.

Coroner's Inquest

11. The Coroner (details and location restricted) held a Pre-Inquest in March 2016 to determine the evidence and witnesses required to attend to give evidence at James inquest. Both parents attended

with the step-father. A decision was made that there would be no requirement to have a jury sworn and the date was fixed for the full Inquest.

12. In April 2016, the full inquest was held before the Coroner. Witnesses were called to give evidence in person and other witnesses had their Police statements read out in open Court. The parents and step-father were in attendance and were encouraged by the Coroner to ask questions of the witnesses. The support workers who found James collapsed in his room were called but only Support Worker 2 attended and gave evidence. The other support worker 1 did not attend. Questions therefore remained unanswered for the coroner and parents as to why she would try to wake him as early as recorded in her statement. Therefore the discrepancy in the times and whether a key was needed when Support Worker 1 and 2 together tried to open James' bedroom door, was not known. The likelihood is that it was just before 9am, more consistent with the account of Support Worker 2 and the recorded time of the subsequent emergency call and LAS paramedic attendance.

13. The mother confirmed to the IOA, the notebook found in his room was in James' own handwriting. The inquest discussed the notebook with the song lyrics that he had altered. The words could give the impression by the tone of the lyrics that he may have been in a low mood, but the Coroner's view was the notebook could not be determined a suicide note and that was accepted by the parents present. At the hearing Support Worker 2 disclosed to the IOA that he had left the placement company prior to them going into administration, as they were not paying him his wages.

Coroners Verdict

14. The Coroner after the evidence at the inquest was heard, recorded James's death as an **Open Verdict**. An open verdict means that the cause of death cannot be established and doubt remains as to how the deceased came to their death. In this case, the Coroner could not be sure that James intended to kill himself from the evidence available. Therefore he declared:-

James died as a consequence of suspension. Finding of fact – On 15th July 2015 in his room at (address) James was found in between the bed in the room and the door with a bed sheet tied around his neck and having died.

15. The Department of Health (DoH), statistical update on suicide, January 2014 (revised)[5] explains that open verdicts include cases where the evidence available to coroners is not sufficient to include that the death was suicide (beyond reasonable doubt) or an accident (on the balance of probability). They include those cases where there may be doubt about the deceased's intentions as in James' case.

Family Involvement

16. What was known by professionals at the time of the serious case review?

17. The information known about the family dynamics was not extensive and is incorporated within Chapter 2, Background, as above. However a fuller understanding was obtained in the family interviews with the IOA, encompassed in the following paragraphs.

18. What other information was obtained within the family interview for the SCR?

19. The IOA met with James's father, his mother and step-father to discuss James early years and his life in general, with the intent to obtain and understand the family dynamics and their views for the

[5] Statistical update on suicide, January 2014 (revised), DoH, Health Improvement Analytical Team

serious case review. Significant was the fact they had not been previously asked to any extent, about either James or their own background history by professionals, as a review of agency submissions would seem to confirm.

20. The parents of James are both of Ghanaian heritage and met in 1995. They lived together in the Hackney area and James was born two years later. They married in 1999 and divorced in 2001 when his father moved out, initially in Hackney and latterly to the Thurrock area. When James was aged two or three years of age he was sent to live in Ghana with his paternal grandfather, a very successful civil servant. He lived there for approximately two years until he returned to live with his mother in Hackney, in order to start schooling at School 1.

21. His grandfather, father and mother believed in the importance of education, a priority instilled from both sides of his respective families. Their aim was to support James in order for him to academically achieve. James' mother met her current husband, James' step-father in 2002. Their son James's half-brother, was born in 2003 and all four lived together as a family, with his mother and step-father marrying in 2006. James normally stayed with his father at weekends and this arrangement seemed to work.

22. In the meantime, his father had another relationship and in 2003 he had a son another half-brother to James. Both half-brothers are the same age (now 13 years of age). This relationship ended, but as he did with James, he actively remains to this day, part of his son's life. In 2005 his father met another lady who he married in 2006. In 2008, she moved out to Barking as she found it difficult coping with James. Although estranged from his wife, he still has a relationship with her and they have three daughters now aged six years, three years and six months of age. James only really knew his elder half-sister, his younger half-sister was not born until after James had died.

23. Within the narrative of this review, the chronology of key events from School 4, suggested that when James went to live with his father, he was not always present but living in Barking, leaving James with his paternal uncle who also lived with them. In fact he was dividing his time between two families, as he was visiting and staying with his wife and other children.

24. His mother's sister, James maternal aunt, resides in South London. James stayed with her for short durations as tension arose with his parents and during the missing person episodes in the latter period, shortly before he became a LAC. It was at her address that he went to in July 2014 after he went missing following his arrest in Great Yarmouth, Norfolk. The parents were aware of the arrest but were not fully aware of the circumstances.

25. There were four domestic incidents, one with his mother and three with his father where James would threaten everybody in the home. It culminated in the third and final incident at his father's home in December 2014, when James threatened his father and paternal uncle. He was taken to his maternal aunt, whilst Thurrock CSC made arrangements to accommodate him. However she could not supply him with a permanent home as she had children herself to raise. His step-father later collected him and took him to Thurrock and left him with his paternal uncle prior to him becoming a Thurrock LAC. James told his step-father, he was happy that he was going to be a LAC, believing he could do what he wanted and not having to comply with family rules.

26. There was some consternation that Placement 1 was only a short bus ride away from his friends who, the family believed, were coercing and corrupting him. It is recorded that the father had raised the issue of a placement out of London away from temptation, in an effort to avoid him becoming evolved in drugs and criminality. It is not recorded however that both his mother and step-father also felt the same way. The voice of the family was not realistically listened to or taken into account

in relation to this concern. In communication with the IOA, the family believed that an attempt to hold a Family Group Conference (FGC) would have been a good idea where James could hear from his own parents, how his behaviour affected them.

27. When he was younger, both parents and his step-father said that James was a pleasant and intelligent young man. His mother and step-father took him on holiday to Canada and on another occasion to Dubai. He was described as a good boy. His behaviour began to change when he started secondary school education at School 3. They did not realise it the time, but he got involved with the wrong people, as he was described as gullible and impressionable. His mother who is a safeguarding nurse, now knows that the school had a problem with gangs. They always enquired of James, wanting to know where he was going and who he was seeing. James never divulged his movements or contacts to either parents or subsequently in any dealings with professionals. According to his father, he was secretive and this statement is evident.

28. His parents and step father believed he began to smoke cannabis when he was thirteen years old. His step-father, on one occasion had to drive around the streets, as James had not returned home from school after many hours. He was found with a group of youths and was the only one still in his school uniform. He knew that if he had gone home to change clothing after school he would have been questioned as to his movements by his parents. His unauthorised absences started to increase. His mother initially reported him to Police but as later happened with his father, became frustrated and did not always report him missing, knowing he would always return home.

29. As his behaviour at home with his mother became erratic (believed through his use of smoking cannabis and his associating with youths or gangs), all efforts and advice given by his parents to change his behaviour, were ignored.

30. When his step-father went away for work, his mother was at times "scared" of James as he could explode into a rage. He never harmed her but he could be a bit rough with his younger brother. On one occasion his mother saw that he had his "Twitter" account open. She observed an individual was attempting to communicate with James speaking "street language," believing he was encouraging her son to use drugs. She challenged him on "Twitter" and the youth laughed off the approach. They wanted their son to get away from the area in order to break his connection with local youths, his smoking cannabis and the effect his behaviour was having on his sibling. They did not know how he was getting the money to feed his habit but strongly believed he was being used by others and probably concerned in drug dealing. His father agreed for him to move to his home and to start school in School 4. The concerns that followed at School 4 are analysed within Chapter 4 and 5 in more detail.

31. Culture was discussed and there were nothing significant to suggest culture and diversity was an issue. He did not like Thurrock because it was too far from his friends, but there was no cultural or diversity concerns. It was however culturally taboo in Ghanaian society to smoke even more so to smoke a drug like cannabis. It was also felt mental health may be a slight embarrassment but this did not stop them wanting him to get the help if needed. Both parents were of the view, he may have had a mental health problem that needed to be explored. James had a future and was given options as both parents had supported him and were prepared in the future to do so if circumstances changed. In a conversation with James, his father gave him options to return to Ghana, go to a paternal uncle in Miami or to consider property development with him in the future, if he changed his behaviour. The parents were aware that he had an interest in writing and producing music which his Personal Adviser had identified a suitable course for him to later attend. They disclosed he had managed to sell some of his work online.

32. His father spoke to him regularly but whilst at Placement 2 he had not managed to visit him. His mother did not visit him in either placement but had regular contact with him. She saw him twice before he died, since his arrest in Cambridge. The first occasion was one month before he died when he visited her at home. He kept receiving calls on a cheap throw away phone that he had and said "they won't leave me alone". He had to take his phone battery out to stop the calls. This statement would support the conclusions at Chapter 7 that he was being pressurised by others. On the second and last occasion, two weeks before his death, James visited his mother and step-father and he was wearing a suit which they had never seen him in before. They assumed he was going to Court but the timing it is suggested, may have been him returning to Cambridge at the end of June 2015 when he was charged for the offences alleged against him.

33. His step-father received a phone call previously from James but he cannot exactly recall when. It was before his arrest. He stated James was in Cambridge and apparently "stuck," asking for him to pay for a night in a hotel. He would not say why he was there and was told to return home. This would confirm that he had been to the area before.

34. The parents had no concern regarding the support provided to James by agencies and understood that he could be difficult and would not always engage with people. The mother was particularly complementary of his female support worker at Placement 1 (DM), SW2 keeping her up to date and the MPS when she had contact with them and when they went to Cambridge and returned James back to Placement 1. His father in a conversation with SW3 and the IRO the day before James died, discussed his case. He believed a custodial sentence for his outstanding Court cases may have been beneficial for him and an opportunity to learn the error of his ways.

35. In conclusion, both his half-brothers were not spoken to for this review, as they were being supported by their respective parents who did not want to unsettle them. The two meetings with the parents were open and rewarding. Even though there was no CAMHS mental health assessment or a FGC held, they believed he may not have wanted to engage in either case.

36. All three members of his family agreed with the consensus of opinion, he was being exploited to commit crime by others who were probably supplying him with cannabis to keep him involved. The parents in discussing the death, said it came as a total shock to them. They had no idea he had any inclination to take his own life. It was apparent to the IOA there was strong affection for James, with two homes available to him if he had only changed his behaviour. He was loved and is sorely missed. His mother summed up her feelings succinctly, "*I loved him but I did not like what he became."*

CHAPTER 4 - CHRONOLOGY OF KEY EVENTS WITHIN THE TERMS OF REFERENCE

Introduction

This section highlights the chronological events in James life as it evolved, together with a brief commentary. It outlines the significant key events of James and of professional practice during the period under review. Information from Police state that James came into Police contact on approximately 33 occasions and the CSC IMR identified 27 missing person episodes including unauthorised absences, during the period under review. They are not fully replicated here. A fuller version has been provided to TLSCB for corporate memory. The analysis of these events are expanded in some circumstances within Chapter 5, Analysis of Practice and within Chapter 6, Findings.

Key Events

Date	Event
2003 to 2009	
	Started School 1. Displayed disruptive behaviour in Year 6.
2009	
	James first became known to Hackney CSC. He commenced School 2.
2010	
	James attended School 2 until November 2010
2011	
	School 3, Year 8. He was disruptive in class. Mother states this was the period when he started to become involved with the wrong people at his school which had a gang problem.
2012	
	School 3, Year 9. James displayed disruptive behaviour and absences from school. He was twice placed in a seclusion room.
November	James was offered a place at School 4, Year 10 as James moved from his mother to his father's home in Essex.
November **James was reported missing on his first day at school, a constant theme throughout the period under review.**	James was reported missing to Essex Police by his father. James refused to commence his first day at School 4. He returned home later. This was the start of his father struggling to get him into school and to stop him going missing.
December	School 4 contact Thurrock Initial Response Team (IRT) as James who was missing, was in

School 4 concerns regarding Thurrock IRT and Hackney IRT dispute about who should accept responsibility for James.	Hackney and were concerned about his missing episodes. Both Thurrock and Hackney IRT's declined to pick up his case. A Thurrock duty Social Worker told them Hackney should come back to them if they do not assist. The school spoke with Hackney IRT who stated that as James main residence was in Thurrock they should pick up the case**. (School 4 Agency Recommendation.)**
December **Thurrock CSC's first contact with James**	James first became known to Thurrock CSC Adolescent Team whilst residing with his father. Limited background records showed he had been known to Hackney since 2009 with suspected gang affiliation. Thurrock and agency partners at the time confirmed there was no evidence of any gang association.
2013	
January **Domestic Incident with his mother.**	James had an argument with his mother within the family home. He picked up a knife. Police attended and upon investigation, no offences were alleged, highlighting anger issues. NFA.
January	James attendance at School 4 was poor recorded at 30.6% and his case referred to the Education Welfare Service (EWS).
January	James was removed from School 4 for poor attendance. James was then supported by the EWS who subsequently assisted James to return to education at School 4. (See entry for February below.)
10.02.13 **Police Protection**	James attended Shoreditch Police Station seeking accommodation as his mother and stepfather would not let him stay in the family home. He was taken into Police Protection, accommodated by Hackney CSC and returned to his father after consultation with James the following day. As James was not a resident, Hackney CSC closed their case file.
February	Request by James father for him to be reinstated at School 4 which was agreed. **Comment:** This second opportunity was taken and his attendance improved significantly.
16.04.13	James attended Shoreditch Police station stating he had an earlier argument with his father but now had no way to get home to Essex. His mother and step-father were contacted but wanted nothing to do with him. He returned home and Essex Police attended his father's home but he was not initially in. Recorded as NFA.

26.04.13	He first became known to NELFT and a record on their "SystmOne" computer database showed a request for his records was made to Child Health Records, South West Essex on this date. The records were not obtained until the 13.09.13. **(NELFT Agency Recommendation 4.)**
24.07.13	James registered as a new patient in the Thurrock area whilst residing with his father. James did not on any occasion attend his Thurrock GP surgery. **(Thurrock CCG Agency Recommendation 1.)**
24.08.13	MPS Police found James sleeping rough in Hackney and they returned him home to his paternal uncle. He was not reported missing.
September	James continued his education at School 4. According to the CSC IMR, James had plans to return to Hackney after his exams and stated that he sometimes sleeps on the street when he was living with his mother (this was not known by his mother). His Child Health records were received and reviewed by the School Nurse (SN) who recorded that there were no health or safeguarding concerns noted.
2014	
17.01.14	James was spoken to at school by the SN regarding his immunisation status which he believed he had already received. He was requested to find his "red book" (hand held child health record) and the SN would contact the GP. There is no record to show this was followed up. **(NELFT Agency Recommendation 3.)**
March **Domestic Incident - James was arrested at his father's home for affray to prevent a breach of the peace.** **SW1 from the Adolescent Team engaged.**	Essex Police attended the home address of the father regarding a Domestic Incident after he made an emergency call to say that James was threatening to stab him. James was arrested for Affray and to prevent a breach of the peace. The father later declined to press charges and no further action was taken. Thurrock CSC notified Police that they will be intervening due to James' age. SW1 dealing. The SN was made aware but there is not a record of any follow up with either James or his parents noted. **(NELFT Agency Recommendation 2.)**
March	A tutor at School 4 was informed by a third party that James' best friend in Hackney had been shot? He did not want his father to know and records he was supported by the

	tutor. There was no other details recorded as to whether it was true and what support was offered.
April **James presented to Hackney CSC as homeless.**	Hackney CSC record James presented himself to them as homeless advising that his father had kicked him out of the house. The duty Social Worker contacted Thurrock. He was advised to attend the Civic Offices in Grays, Essex.
11.06.14	There were no further incidents noted by the School Health Team and he was discharged as he had left the school.
04.07.14	Thurrock Adolescent Team wrote to his GP requiring information about him as they were carrying out a Child and Family Assessment. (See entry below for outcome.)
23.07.14 **James arrested in Norfolk. He was allowed to travel home alone with a travel warrant but missed his late night train. He was reported missing by the Norfolk CSC Social Worker dealing with the case at the time as he could not be found. He was located on the 13.08.14 at his maternal aunt's house.**	James aged 16 years of age was arrested for suspected possession of drugs with a middle aged woman whose house was being searched in Great Yarmouth, Norfolk. Police identified he was a vulnerable young person and informed Norfolk CSC. There were safeguarding issues identified, **(See Chapter 5 and the suggested TLSCB Overview Report Recommendation (10) for Norfolk Constabulary)** regarding the quality of information recorded on the custody record for the safeguarding of children and young persons in their custody **(TLSCB Overview Report Recommendation (11) for Norfolk CSC)** as to their compliance to the Children's Act 1989 and welfare of James. James' Thurrock GP sent a letter to Thurrock Adolescent Team confirming they had not seen James in the surgery since his registration, from his records his immunisations were up to date and the GP was not aware of any concerns as to his welfare or the parent's capacity to meet his needs.
30.07.14	Strategy Discussion (SD) held by Thurrock and Sec 47 Investigation commenced whilst James was still missing from home. A follow up SD was held a week later on the 05.08.14. It updated agency enquiries and actions, as he was still reported missing. He was active on twitter but he had blocked his father who did not have other contact details.
13.08.14	James had been missing from Cambridge and found at his maternal aunt's home in South London.

<u>26.08.14</u> **Domestic incident at his father's home.**	James' father made an emergency call to Police over a Domestic Incident where James was threatening everyone in the house over an argument regarding food and concerns about his continual use of cannabis. Police attended and found the situation was calm and no evidence of drugs. Father agreed to take him to his maternal aunt.
<u>23.09.14</u> **James stopped in London by Police admitted to criminality to fund his drug habit (cannabis).** **He presented to Hackney CSC as homeless.**	James was stopped in North London by Police. He admitted to criminality to fund his drug habit. The search was negative and NFA was taken. The MPS IMR records that a Merlin PAC (come to notice form) should have been created for this encounter to share the information. This was an isolated incident and individual learning for the officer. He presented himself at a Hackney service centre as homeless, similar to a previous entry in April. A Hackney SW informed him they would need to speak to his parents and told him to charge his dead mobile phone and then return and supply the contact details for his parents. He was informed Hackney would not be housing him and advised him to contact Thurrock CSC. He did not return, his whereabouts were unknown and therefore no proactive work was undertaken by Hackney. The information was later shared with Thurrock CSC when they contacted Hackney CSC about James.
<u>October</u> **Adolescent Team key worker MF who later became his Personal Adviser allocated.**	Adolescent Team Key Worker MF, who later became his Personal Advisor began working with James. A relationship that was maintained throughout his time with Thurrock and covered his total period as a LAC.
<u>November</u>	A Child and Family Assessment was completed. Child/Young Person's Plan (part 2) completed. His father agreed to support him financially in order to enable him to enrol in college and to adhere to family boundaries.
<u>11.12. 14</u> **Domestic Incident at his father's home.**	Domestic Incident. James threatened everyone in the house following an argument over food and his use of drugs. Police attended and found no evidence that he had taken drugs. His father took him to his maternal aunt's as he declined to further care for him.
<u>29.12.14</u>	**James was accommodated by Thurrock Local Authority as a LAC under the terms of Section 20 of the Children Act 1989**. A

James was accommodated by Thurrock Local Authority in Placement 1, a spot purchase. It was confirmed that no additional commissioning checks were carried as to the suitability of the placement. Case allocated to SW1.	Thurrock Child LAC Care Plan was completed and his first Looked After Health Assessment took place and accommodated in Placement 1 with SW1 allocated his key worker. His assessment recorded that he was using cannabis on a regular basis and was registered with The Princes Trust, a course to be overseen by his Personal Adviser, who was working with him to enrol on a music producer college course for the following September 2015 and to support him from being NEET. **Comment:** James presented himself to Thurrock CSC as homeless. In fact it was known that since the incident on the 11.12.14 at his father's home, his father had made the decision that he could no longer care for him. After the incident he was taken temporarily to stay with his maternal aunt to diffuse the situation. James was later picked up from his maternal aunts by his step-father and returned to Thurrock. Until the time of his self-presentation he had not been homeless. As his family were declining any further care for him, Thurrock CSC treated him as homeless and accommodated him.
2015	
13.01.15	Thurrock CSC completed a Child and Family Assessment, the review assessment stated that he was already subject to a CIN plan as he had been accommodated since December 2014 by Thurrock. NELFT LAC Team received notification Part A of the British Adoption and Fostering form (BAAF). NELFT emailed Placement 1 advising that his Initial Health Assessment (IHA) was due and that he was still registered with his Thurrock GP. **Comment:** James' IHA was subject to continual concern and was chased up by professionals throughout his Care Plan and LAC Reviews until the GP confirmed in April 2015 that it had been carried out. This lack of record keeping and delay in notification has been addressed. **(NELFT Agency Recommendation 4.)**
16.01.15	James was registered at a Haringey GP Surgery.
26.01.15 **First LAC Review (1 of 3)**	James First LAC Review. Health unmet target was to access mental health resources if needed. A DUST form to be provided by Personal Advisor to address how cannabis

	affects him and to carry out a revised Personal Education Plan (PEP) every six months. He continued to explore an attendance for James at the music college in Hackney for him and to continue with The Princes Trust Course he had recently started.
28.01.15	A CSE Assessment was completed. There was no concern that he was a victim of CSE and his placement were satisfied that he was not accessing inappropriate websites. The Designated Nurse attended a Thurrock placement panel where it was reported there does not appear any reconciliation with his parents, he had settled into Placement 1, he was still smoking cannabis, a DUST test was completed and he had been referred to a local drug and alcohol service. The Provider LAC Nurse was advised. **(Thurrock CCG Agency Recommendation 2.)**
19.02.15	CSC IMR records that his Personal Adviser contacted Placement 1 as he was concerned about James smoking cannabis which seems to be effecting his daily functioning and concerns reported by The Prince's Trust. He asked the key support workers to take him to his GP.
20.02.15	He was taken to his new GP, by staff from Placement 1 in confirmation, after The Princes Trust contacted Thurrock CSC regarding his strange behaviour displayed at a meeting to discuss his lack of engagement on the course. The GP referred him to CAMHS for a mental health assessment as a result of a high level of concern.
02.03.15 **Case allocated to SW2.**	James allocated to senior practitioner, Social Worker 2 (SW2) who remained his allocated Key Social Worker until 11.06.15.
March	An MPS intelligence report names James within a gang member's bail conditions (the gang member was affiliated to the 'Hoxton' gang.) This was an indirect link only. It was confirmed by the MPS that James was not known on any Gang Matrix.
11.03.15	A joint home visit conducted by SW2 at Placement 1 with his Personal Adviser. Police were at the premises as James was reportedly using threatening and abusive behaviour. He was apparently smoking cannabis in his room and a member of staff threw a bottle towards him to get his attention! The Police diffused the situation. SW2 and his Personal Adviser

	spoke with him about his behaviour. NFA taken by Police.
13.04.15 **LAC Review (2 of 3) held at Placement 1.**	LAC Review meeting held in Placement 1. SW2 invited both parents but neither parent attended. James was not happy with the meeting and walked out. Some practitioners had concern with the IRO management of the review and this was addressed. SW2 was chasing up the outcome of his initial health assessment (completed earlier in the year), CAMHS and contact with his GP. The IRO was concerned the two Placement 1 representatives had no report for the meeting and were not prepared.
17.04.15	SW2 spoke with James' GP who confirmed CAMHS had refused their service to him.
22.04.15	An internal Placement Panel was held and reports that James' father would consider taking care of him in the future when there was evidence he was not smoking cannabis. The Designated Nurse attended. It was recorded that James was having difficulties with his independence skills and stayed in his room for long periods and CAMHS had declined their services to him. He was also having an assessment by Insight and was receiving support from a local drugs service for his cannabis use. It was uncertain where he would live, post him attaining 18 years of age. The Provider LAC Nurse was advised.
26.04.15	Placement 1 reported him missing to Police and he returned later and was debriefed. **Comment:** - He was referred to Open Door to hold a return interview but James told SW2 he did not require one.
30.04.15 **SW2 escalated concerns of Placement 1 not being compliant when reporting James missing.**	James was reported missing from Placement 1. He returned the following morning. SW2 escalated his concerns to Head of Children Social Care (CSC), his Team Manager and the Placements Quality Assurance Team Manager and the IRO, regarding the non-compliance by Placement 1 reporting James as a missing person to both EDT and Police. A formal complaint was made by Thurrock CSC to the Placement Providers.
01.05.15 **SW2 carried out a LAC visit with a placement key worker and James who was argumentative and left. His bedroom was dirty and untidy. Several small empty plastics**	SW2 carried out a LAC visit with James and his key placement support worker. It was disclosed that he had a positive relationship with his paternal grandfather in Ghana. When he visited the UK and asked to see James he told his father that he "*had things to do"* and

bags were found that could have been used to hold cannabis. **James was stopped at Cambridge Railway Station and given a fixed penalty notice for not having a ticket.**	had to go out. His grandfather returned to Ghana a few days later having not seen James. Later the same day, he had been seen at Cambridge railway station, travelling several times in the evening on short journeys. Railway staff stopped and gave James a fixed penalty ticket as he did not have a valid ticket. They stated that he has possession of two phones and "acts suspiciously in his mannerisms." He had clearly left his placement and travelled to Cambridge. He was not reported missing until several days later by Placement 1.
04.05.15 **James was belatedly reported missing by his Placement. He was in Cambridge.**	Placement 1 reported James missing to the MPS, he was last seen on the 01.05.15 at 1.30pm. He was later found having been arrested in Cambridge (see entry for 09.05.15).
05.05.15 **Supervision and escalating by SW 2 to Head of CS.**	A complaint was made by Thurrock CSC about not being informed that he was missing on the 01.05.15. SW2 escalated to the Head of CSC, who gave advice, requesting to be kept informed.
09.05.15 **Arrested in Cambridgeshire** **James had possession of the following property:** • **£1000 cash.** • **Two mobile phones and sim cards containing evidence of apparent sale and distribution of Class A drugs** • **Quantity of heroin (21 individual wraps.** • **Possession of a stolen mobile iPhone.** **He admitted he used cannabis that day.**	An iPhone was stolen from a burglary in Cambridge and later reported to Police. The victim located her mobile by using the "'Find my phone" app. The location was given to Police. James was eventually stopped, having tried to run off and had to be restrained. He had possession of the iPhone and admitted to the officers that he had a quantity of heroin in his possession. He was arrested for two linked burglaries and for the possession of Class A drugs with intent to supply. James had been seen by a member of the public who suspected James was attempting to sell drugs in a student area of the city. Cambridgeshire Police carried out welfare and safeguarding checks and found he was reported missing from Placement 1. He declined to answer any questions and was bailed to attend the Police station following further enquiries. He had £1000 cash and two mobiles of his own taken from him, an iPhone which he declined to disclose the password for and another phone and sim card that Police obtained intelligence from subsequently. MPS officers were notified and they attended Cambridgeshire and escorted him back to his placement.

	Comment: - The drugs were later analysed and confirmed he had 21 wraps of Diamorphine (Heroin) with a street value of £250 to £350 as assessed by the Cambridge Expert Drug Witness. Open Door conducted their only return interview with him on 19.05.15 for these events.
13.05.15	SW2 visited the placement. James wanted to leave but was persuaded to stay and engage in discussion. He seemed friendly but did not want to be specific about his arrest other than he was caught for Class A drugs. He said he did not want contact with either of his parents and was willing to explore his education and college options. He said he had since cleaned his room and was aware that any more offending would be an aggravating factor in his current case in Cambridge.
15.05.15	James attended a GP appointment. There was no further concerns of delusional thoughts.
19.05.15	James attended a dental appointment and had his only Open Door return interview (See Chapter 5.)
27.05.15	James was reported missing from Placement 1. He was missing from 26.05.15 at 4pm and returned on 27.05.15 at 3.51am
28.05.15 **Placement 1 again reported James missing late.**	Placement 1 reported James missing since 8.53am however the placement did not report him missing until he went missing again on the 02.06.15. SW2 notified his senior management team.
June 15 **Gang and knife assessment/Drug Risk Assessment completed.**	Placement 1 and Thurrock CSC had concerns that James was involved in organised gangs and possibly exploited by others involved in criminal activity. He had an assessment regarding his relationship with gangs and knife crime and a drug Risk Assessment due to his offending behaviour in his recent arrest concerning Class A drugs. He denied involvement with gangs and the effect drugs had on him.
02.06.15	Placement 1 reported James missing person since 01.06.15 at 2.44pm. He returned on his own accord on the 08.06.15, having been stopped in Portsmouth on the 07.06.15 (see following entry.) MPS IMR states that the placement were not aware he was missing. MPS officers attempted to debrief him on the 11.06.15 but he would not converse.
07.06.15	Hampshire Police notified the MPS that James was stopped by Police in Portsmouth, called

James was stopped in Portsmouth.	to an incident between two youths one armed with a knife. James was stopped and searched and had no knife. His placement appeared unaware that he was missing. He was sent home by train to Placement 1 who says he returned stressed. This was noted by SW2 and reported within James' third LAC Review.
<u>08.06.15</u> **James assaulted another young person at Placement 1.**	At Placement 1, James assaulted another resident by punching him repeatedly in the face. Police were called but he left before their arrival. The allegation was recorded that James may have approached another resident with a knife but this was not the case according to officers at the scene. The victim declined to proceed with the allegation and staff would not provide a statement as they were concerned that it would lead to increased tension in the home. The case was closed.
<u>09.06.15</u>	SW2 carried out a Strength and Difficulties Questionnaire (SDQ). James was deemed to have severe difficulties with a score of 27/40. The concerns were due to his criminal involvement, periods of absconding and not complying with current strategies to keep him safe and to his cannabis use. His case was transferred to the Through Care Team. **Comment:** - The SW in discussion with the IRO looked at the option of moving him to another unit to reduce the risk and break the chain of him associating with others involved in crime and exploitation. However events outlined below at Placement 1 required that he be immediately moved to Placement 2 following a risk assessment. **(See TLSCB Overview Report Recommendations 7.)**
<u>10.06.15</u> **James returned to Cambridge in answer to his bail. SW2 attended placement.**	James returned to Cambridge with a key worker from Placement 1. He was further bailed to a later date. SW2 attended and spoke with the Placement 1 staff as James had not returned with his support worker from Cambridge. He informed the placement that James' case was being transferred to SW3 on the long term team.
<u>11.06.15</u>	Placement 1 reported James missing. He returned of his own accord the following day. James refused to speak to Police. SW2 was informed by a placement key worker by email confirming his bail conditions. He was in a positive mood and talked about a return to

	Ghana.
15.06.15 **James was arrested at Placement 1 for affray. He was charged to appear at Court on the 14.07.15** **A Risk Assessment was carried out by the placement. He was transferred to Placement 2.** **James disclosed he was bi-polar to an FME, a condition not known to health professionals within his medical history.**	Police were called to Placement 1 by staff when James had an altercation with another resident. He was brandishing a 7 inch knife. James was arrested for affray. He was later charged with the offence of affray with conditions not to attend Placement 1 or to have any direct contact with two named persons at the placement. He was bailed to appear at a London Magistrates Court on the 14.07.15. This was the Court date he later failed to appear at the day before his death. Whilst James was in custody he was examined and disclosed to the FME that he was Bi-Polar. The comment was recorded in the detention and FME log. It does not appear that this information was shared. **(TLSCB Overview Report Recommendation (9) for the MPS.)** The Placement Director provided a full Risk Assessment the same day, as a mechanism to manage his criminal and behavioural activity. A decision was made to remove him to the same company's LAC accommodation at Placement 2 after consultation with a SW manager. His move was not discussed at a placement panel meeting but was known and raised at James third LAC Review by the IRO. This issue and further placement commissioning failures were identified. **(See TLSCB Overview Report Recommendations and Finding 2.)** SW2 notified his father of the move, who was still of the opinion that James should be moved away from London.
20.06.15	His new Placement 2 reported him missing, he returned later the same day.
22.06.15 **Care Planning meeting**	Care Planning meeting held and plan effective until 29.06.15 when his third LAC Review at Placement 2 was arranged for. **Comment:** - The CSC IMR chronology made comment that the placement at the LAC Review was deemed unsatisfactory. It in fact refers to Placement 1. The concerns were addressed by CSC senior management at the time and he was subsequently moved to Placement 2 due to the incident against another resident in Placement 1 on the 15.06.15.
25.06.15 **James attended Cambridge with a placement support worker and charged to attend Court**	It appears from the CSC IMR that James was supported by placement support workers and returned to Cambridge Police station. He was charged with possession with intent to supply

on 15.07.15.	a Class A drug and handling stolen goods (iPhone) on the advice of the CPS. He was bailed to appear at a Cambridgeshire Court on the 15.07.15.
29.06.15 **LAC Review (3 of 3).**	James' third and final LAC Review was carried out at Placement 2. He appeared happier and fully engaged at this meeting. SW2 who was no longer his key worker as James was transferred to SW3 on the Thurrock Long Term LAC team, attended to ensure continuity. The IRO noted his engagement with proceedings. James agreed to remain after the review to speak with SW3. The Placement Director confirmed talking to and supporting James with his current concerns.
11.07.15	Placement 2 reported James missing, he had informed staff he was going to see his mother. He returned of his own accord early that morning. (His mother states she last saw him two weeks before his death.)
14.07.15 **James failed to appear at a London Magistrates Court for the offence of Affray.** **Father had a meeting with the IRO and SW3.**	James failed to appear (FTA) at Court and a warrant was issued. Thurrock CSC IMR states his Placement 2 support worker (RR) informed CSC of his bail conditions and records that he attended the Police station with him and Court. It has not been confirmed how he FTA, as the company are now in administration. On this day there was a meeting between the IRO, SW3 and James father to discuss the outcome of his LAC Review and the current situation facing James. The FTA was not known at this stage.
15.07.15 **James was found collapsed in his bedroom, unresponsive to emergency resuscitation and was pronounced dead at 9.46am.**	See Chapter 3 Details of the Investigation into James Death.

CHAPTER 5 – ANALYSIS OF KEY EVENTS AND PROFESSIONAL PRACTICE

1. The key events in Chapter 4 above, together with the input from the agencies and practitioners participating in this review, are further analysed within this section. The Findings and Lessons to be learnt are outlined within Chapter 6 below, for the Thurrock Board to consider.

Thurrock Children's Social Care

2. Thurrock CSC involvement began when James came to live with his father in late 2013. A period with James going missing, repeatedly returning to the Hackney area and failing to attend school. His father struggled to cope with his son's behaviour and cannabis habit and was allocated a key Social Worker from the Adolescent Team, SW1.

3. Prior to becoming a LAC, on the 23rd July 2014, Thurrock CSC were contacted by Norfolk CSC after James aged 16 years of age, was arrested in Great Yarmouth, Norfolk. He was bailed by Police for the offence of possession of a controlled drug for further investigation to Norfolk CSC. Norfolk and Thurrock CSC had a discussion as to who should have responsibility for James and whether to treat him as a homeless person. Both of James parents refused to accommodate him even though he was living with his father preceding this event and Norfolk CSC assumed responsibility.

4. This serious case review identified safeguarding issues for Norfolk Constabulary and CSC as James was allowed to travel home alone to his father's home after he was persuaded by a Norfolk Social Worker to accept him. James missed his train and the Social Worker could not locate him and had to report him as a missing person. (This is discussed further within the analysis for Norfolk Constabulary and Norfolk CSC below.) Thurrock subsequently held a strategy and follow up meeting, carrying out a Section 47 Investigation, as James was a missing person until the 13th August 2014, when he was found at his maternal aunt's and returned to his father.

5. There were three domestic incidents where his father had to call Police to the home address. The final incident in December 2014 was the reason why James became a Thurrock LAC after his father declined to care for him any longer. He was accommodated under Section 20 of the Children Act 1989 and provided with semi-independent accommodation at Placement 1.

6. The initial CSC IMR did not have sufficient detail regarding the LAC Reviews and the Independent Reviewing Officer (IRO) or the commissioning of the placements that were provided for James. In relation to the IRO it was known that she had a meeting with James' father the day before he died. However the IRO was not available to the CSC IMR author due to being certificated sick until early March 2016.

7. The IMR author assisted the process and met with the IOA to analysis practice and helpfully discussed James' case. What was evident, Thurrock CSC provided continuous support, resources and advice for James while he was a LAC that he often did not appreciate or accept. There were concerns when at Placement 1, with staff at the placement not always informing either the Emergency Duty Team (EDT) or the Police when he went missing. This was escalated with ample documentation showing that SW2 was in constant contact with senior management and the Head of Children Social Care (CSC) on numerous occasions. The Head of CSC personally supported and addressed the issues and outlined action that Placement 1 had to take to be compliant and to meet standards of care. The company through their Head Office, acknowledged the complaint, were supportive and increased their compliance.

8. The IOA also met with the Independent Reviewing Officer (IRO), the IRO's supervisor, his Personal Adviser (PA) and SW2 to obtain the additional knowledge of practitioners who knew and worked closely with James. This proved beneficial, confirming views on James family interaction, the extent of the professional input provided to support him, his drug offending and criminality and pressures of his impending Court cases. It further confirmed the attempts made to develop an educational and independent pathway for him and the incomplete assessment of his possible mental health issues. The IRO confirmed that she and SW3 met with James' father the day before his son's death to discuss the recent June 2015 LAC Review meeting that he could not attend.

LAC Care Plans

9. James' LAC Care Plan was completed efficiently, with timely updates and covered the full period James was a LAC. (See Chapter 6 Findings.) His continuing Care Plan was to explore rehabilitation in the home. It states a Family Group Conference (FGC) to be explored. However there was never a FGC carried out. The plan was to support James towards living independently and applying for housing as soon as he was eligible.

Comment: - There is evidence to support the open offer by his father to have James return home if he stopped smoking cannabis and followed house rules. It was also reiterated by his mother and step-father in the family interviews. (See also the comments within the entry for LAC Reviews below, regarding strategies to minimise future risk of repeated missing person episodes.)

LAC Reviews and the IRO

10. Context: The context of Thurrock LAC Reviews and IRO's during the period in James' case, were obtained from the IRO Annual Report 2014 to 2015 as submitted to the Corporate Parenting Committee in September 2015[6]. It confirms there were 283 children and young people in care at the end of 2014/2015 (71.6 per 10,000 of the population). Of the 671 reviews carried out, 640 were completed on time. This was a performance of 95.3% which compares favourably with the English and Statistical Neighbour data of 90.5% and 90.6% respectively.

11. LAC Reviews: There were three LAC Review meetings chaired by an IRO and are outlined within Chapter 4, the chronology of key events. His father was the main family contact with James' three allocated key Social Workers and his Personal Adviser during his LAC period. His father did not attend any LAC Review but did attend one Placement Panel Meeting. SW2 made attempts to engage with his mother to attend the reviews and although she also did not attend, she was regularly updated by SW2 and James' father. The ultimate goal was to prepare him for independent living with a prepared pathway plan, in the hope to reunite him with his family. Both parents as discussed above offered to have him back if he gave up his cannabis habit, changed his concerning behaviour and followed basic home rules. It was believed James' case would have benefited from a FGC. Both parents in conversation with the IOA agreed it may have helped but were not convinced he would have necessarily engaged. Whether it would or would not have succeeded, we cannot answer, as there was no attempt to arrange a FGC.

Comment: - Considering the objective was to build relationships with his parents in order for him to lead an independent life and to end being LAC, there should have been a concerted and documented attempt for professionals to understand more about the family dynamics, particularly with his mother and step-father. The reason for the breakdown in their relationship

[6] Thurrock IRO Annual Report 2014 to 2015 submitted to the Corporate Parenting Committee (Sept 2016)

and the anxiousness the mother had regarding her son, needed to be understood in order to try to forge a relationship. There was no Family Group Conference called but in the interview with the IRO and her line manager it was said this would still have been an option and would have been acceptable to the parents. (TLSCB Overview Report Recommendation 8.)

12. In his second review in April 2015, James became noticeably upset and did not understand the process and the terminology used by professionals. He then left the meeting. It was reported that some professionals including SW2 were not impressed how the IRO managed the meeting however, there were no such concerns in his first and last LAC Reviews. His missing person episodes remained a concern and there were still issues about him smoking cannabis and associating with gangs. It was also discussed that he was possibly dealing drugs to fund his regular cannabis habit and the practitioners were challenging this. He was not fully engaging with The Princes Trust and drugs advocacies initially from BUBIC, a local Tottenham Drug Service working with young people identifying their drug use and effects of substances, recommended by CAMHS who in turn referred to Insight (Haringey). They were still awaiting the outcome of the GP referral to CAMHS and whether James' Initial Health Assessment (IHA) was completed. The Designated Nurse for LAC reported that James had difficulty with independence skills and stayed in his room for long periods and Placement 1 confirmed he sat in his room with the bulbs taken out. SW2 raised his concerns about the chairing of the meeting to his Line Managers the following day and this was acknowledged by the IRO. There were no similar concerns in his third and final LAC Review.

Comment: - **It was confirmed that the IHA was completed. The GP was eventually spoken to after several attempts made by SW2 and confirmed the referral by the GP to CAMHS (St Anne's Hospital) was declined. The reason why has not been ascertained by professionals during the course of this Serious Case Review, after requests by the IOA to obtain their rationale.**

13. On the 29th June 2015, at James' final LAC Review, both the IRO and SW2, agreed that James was readily engaging. At this meeting, James was actively involved in discussions and asked questions. Information discussed included his impending Court appearances and he stated he did not want to live with either parent. His father could not attend on this occasion and there was no meaningful engagement or participation by his mother of note whilst James was a LAC.

14. On 14th July 2015, there was a meeting between the IRO, SW3 and James' father to discuss his LAC Review and the current position of his impending Court appearances. His father felt that in his opinion, it would be in the best interest of his son, that he received a custodial sentence as it would help him to stop using drugs and offending. He was of the view that people in Hackney were controlling him. He said that by December 2014 he was aware that he was dealing drugs but not witnessed it. He also believed James should have been given a placement in Essex away from temptation and this was the view of his mother and step-father. This does not seem to have been considered or explored by practitioners.

Comment: - The view of the location of James' placement by both parents (See Chapter 3 Family Contact), the issue of CAMHS declining their service, the referral to Drug and Alcohol Services which failed, his missing person episodes, escalating criminality, could other alternatives within his LAC Care Plan and Reviews, have been considered? (TLSCB Overview Report Recommendations 5 and 6.)

15. It was acknowledged by the IRO in the interview with the IOA that both a FGC and a Strategy Meeting could have been considered at an earlier period to address James' criminality, his behaviour and pending Court cases. It is noted that this it would have been considered but events took a

drastic turn with James' death shortly after the final LAC Review. **(See Findings at Chapter 6 and suggested TLSCB Recommendations at Appendix 4.)**

16. Thurrock CSC clearly provided noticeable support and numerous attempts were made to help and advise him. It was his own decision whether to engage or not. As alluded to, a Strategy Meeting could have been considered after his two arrests, to bring together the necessary agency professionals to consider options and initiatives to challenge and support James, looking at the wider issue of his criminal offending and whether he was being exploited to commit crime by others.

17. The DfE in 2014 issued the "Statutory guidance on children who run away or go missing from home or care."[7] This is a helpful flowchart showing the roles and responsibilities when a child goes missing from care and what should be considered. Thurrock CSC were compliant and readily challenged his placement when they failed to comply. These issues are subject to further comment within the Findings at Chapter 6 with suggested recommendations to cover both LAC Care Plans and LAC Reviews, to ensure that all aspects are captured and initiatives put in place to address increasing concerns and incomplete mental health issues for a LAC. **(TLSCB Overview Report Recommendation 4 and 6.)**

Thurrock Children's Commissioning and Service Transformation (CCST)

18. Context: Under the Guidance on the Provisions of Accommodation for Looked After Children 2010[8], the sufficiency duty requires Local Authorities to do more than just provide accommodation, they must also meet the needs of children. It should also take into consideration as in James' case, the type of accommodation, the particular skills, expertise or characteristics of carers, provisions for care leavers and the availability of additional services to ensure the needs of vulnerable children are met.

19. It transpired that there were concerns with Placement 1, which necessitated a formal complaint. The same company provided both Placement 1 and 2 and it is now known these were "spot purchases". It does not involve as much scrutiny and therefore when a spot purchase is made due to an urgency, a full Individual Placement Agreement (IPA) should be completed soon after agreeing to the placement. Unfortunately following extensive checks, no record could be found of an IPA being carried out and is a system failure.

20. The IOA carried out enquiries and revealed that financial checks would have showed that the company in July 2014 was subject to a "Winding Up" Petition by the Commissioners of HMRC. In August 2014 the company at Court, successfully challenged the petition and it was dismissed. This shows that there may have been some concerns that ultimately, we now know, ended in February 2016, with the company going into administration. There could be a perfectly valued reason why this situation occurred and if commissioning scrutiny had identified these facts, it could have been suitably considered and addressed.

21. In an interview with the IOA, the Strategic Lead and colleague of Thurrock CCST agreed to address the issue with the enhancement and requirement of more regular financial checks on service providers of LAC placements to increase scrutiny. In James' case, the necessary checks were not carried out. They will now systemically complete the necessary financial checks as soon as practicable on spot purchases which are provided only in urgent placement cases and then reviewed

[7] Statutory guidance on children who run away or go missing from home or care, DfE (2014)
[8] Guidance on the Provisions of Accommodation for Looked After Children, 2010

annually. Whilst this will not be the whole picture it does give an indication of the financial stability of the provider.

22. The problem that CCST have is that currently when they spot purchase with new providers, there is not always enough time to undertake these checks prior to placing the LAC. However, they say they can follow up and complete the requirement as soon as possible. **(See TLSCB Overview Report Recommendation 2.)**

Key Social Workers

23. There were three Senior Practitioners, Thurrock Social Workers (SW1, SW2 and SW3) allocated to James throughout his period as a LAC. SW2 and SW3 both attended the Coroner's Inquest for James and SW2 was interviewed by the IOA. He displayed a knowledge and understanding of James. He described James as both shy and withdrawn but if persons pushed him he could have an aggressive side. He had a physical presence that some may have found intimidating but this was never an issue with either SW2 or his Personal Adviser. SW2 made seven visits to see him and was also in regular communication. He maintained detailed notes which were viewed and helpful for the review. He correctly challenged Placement 1 on how they were dealing with his care and support and the non-compliance of reporting James as a missing person. The escalation resulted in a formal complaint to the company placement provider supported by Thurrock CSC senior management and supervised by the Head of CSC.

24. In particular, on the 1st May 2015, SW2 visited James at his placement. He refused to supply details of friends who he was meeting or a girlfriend that was mentioned, if in fact one existed. Staff were aware that he always had money when he arrived back at the unit, together with "takeaway" food that he would not normally be able to afford as he only had a £53.70 weekly allowance. He appeared defensive and paranoid when asked questions about this, stating that he does not understand why people always ask him a lot of questions. After a short period he took his bag, a sign that he would not return until later that evening and left the placement. In fact he went direct to Cambridge where he was until he was arrested on the 9thMay 2015.

25. His room was observed and it was noticed there was a number of small plastic bags that could be used for containing cannabis. A subsequent appointment was made to have a blood test but he failed to attend and this does not appear to have been followed up. His room was disorganised with dirty dishes, paper and clothing strewn on the floor. The shower cubicle was unclean and blocked and it was pointed out that the new toilet seat was his fourth, the others were still in the room. Staff did not know why they kept being broken and concluded James would not allow staff into his room to clean. His Personal Adviser arrived and agreed to follow up and discuss the concerns within his contacts with him.

Personal Adviser

26. James' Personal Adviser was interviewed by the IOA who started work with James when he was on the Adolescent Team in October 2014. He continued contact with James when he was transferred to Thurrock Careers in early 2015. He confirmed James as initially shy and withdrawn with no eye contact, an opinion that SW2 also shared of him. James had an interest in music production but the course at a college suitable for him was not available until the following September 2015. To stop him becoming NEET, he helped James with his CV and there was an attempt to encourage James to find employment and attend other educational courses or consider community project ideas to work on. He was not interested and refused to consider these options. James was secured a twelve week

course with The Princes Trust at Hackney College in North London. James' regular use of smoking cannabis was discussed with him as it was believed it was impacting on him coping with the course. It was evident from the interview with the Personal Adviser that he was conscientious and was trying to obtain the best for James' future, a similar impression given by SW2, as both professionals coordinated well with each other over James' case.

The Prince's Trust

27. This is a youth charity that helps young people aged thirteen to thirty years of age to get into employment, education and training. James was provided with a twelve week course during the start of 2015. He was supported by his Personal Adviser but James did not engage. On the 16th February 2015, due to his behaviour, he was spoken to by a Social Worker from The Prince's Trust about his lack of engagement in the team, attendance, punctuality and participation towards the programme. James displayed strange behaviour, drawing reference to his eyes being bigger than normal and being able to see into the future. This worried the practitioner, so a private meeting with James and other practitioners was held on the 19th February to address these concerns and the issues they had with his involvement on the course. During the course of the meeting he consistently displayed, what can only be described as worrying behaviour. Additionally when he was informed he could go home, he made the comment that he needs to wait until the big hand on the clock gets to one; he then spent time looking at the clock on the wall, moving his eyes around in various directions, holding his chest and breathing in a controlled way. As the Practitioners left the room, he insisted on staying until he had completed his gestures. Due to this behaviour, The Prince's Trust carried out a Risk Assessment and promptly shared their concerns with his Placement 1 Key Worker and his Personal Adviser. As James continued to fail to engage with The Prince's Trust, he was removed from the course.

General Practitioner

28. The following day the 20th February 2015, after the preceding disclosure from The Prince's Trust, Thurrock CSC took immediate steps and requested that James be taken to his GP. This was his first visit to the surgery and he was spoken in depth by Doctor RE who was concerned with James presentation. He admitted regular use of cannabis and his behaviour to comments made in the consultation were concerning, therefore the GP referred James to CAMHS (St Anne's Hospital). SW2 later telephoned the surgery and after several attempts he spoke to the GP who confirmed that CAMHS had declined to offer their service. James was being initially assessed by BUBIC a local drug advocacy which James felt he did not need. He was referred on, to receive support from Insight (Haringey), from a drug and alcohol dependency support service who would look at his drug habit. CAMHS reason for declining their service was not known to professionals and their rationale was requested for the purposes of this review but not obtained.

29. The GP referral to CAMHS records his symptoms and "odd delusions" are most likely due to his cannabis use, and may be affecting him, requesting a further assessment. It is believed that CAHMS may have taken this literally to refer him to a drug advocacy and did not take account of his presenting behaviour. This does not however answer the whole concern and therefore his mental health was not ever assessed effectively and should have been followed up within his LAC Care Plan and LAC Reviews, as it remained unresolved. James informed the GP he had been smoking cannabis for three years. The GP notes that it was his choice not to engage with people and does not find activities stimulating enough. He said he does not engage with SW1 or others around him as he does not believe there is anything wrong with him. He denied any visual or auditory hallucinations such as staying up at night. He was in denial that smoking cannabis for such a time had any effect on his physical or mental health. The GP tried to discourage him and an examination of James showed him

as of normal appearance with no suicidal ideation, intentions or plans. **(TLSCB Overview Report Recommendation 5 and 6, also Thurrock CCG Recommendation 4 in Appendix 4.)**

30. In March and April 2015 there was communication with both the allocated Key Worker from Insight (Haringey) and SW2. Insight confirmed that they tried working with James but after repeated attempts to make a visit or arrange a meeting with him, the Key Worker had to close the file as he would not engage and on the 15th May 2015 he attended and saw GP, Doctor NA. It records in his consultation that James went sightseeing to Cambridge where he was arrested for drugs and he felt unfortunate that he got caught. He discussed his Court case with the possibility of going to prison. His mood was positive, he admitted in the past to feeling paranoid but he stated he was no longer hearing voices and he was still using cannabis but denied using any other drugs.

Thurrock CCG (Health)

31. The first contact with James was on 24th July 2013 when he registered as a new patient in West Thurrock. In 2014 it records information known by a Senior Practitioner at Thurrock Social Care Adolescent Team that they completed a Family Assessment. On 29th January 2015 his electronic records were transferred out to his new GP with his address now at LAC Placement 1. The Designated Nurse (DN) for LAC attended two Thurrock Placement Panel meetings and reported no conciliation with James and his family. It was reported he was settled in his placement, following rules but still smoking cannabis. His Personal Adviser completed a DUST Tool (Drug and Alcohol Assessment Form and referred him to the local Drug and Alcohol Services). The DUST tool is designed for two main purposes 1) To help professionals make decisions about how to respond to drug/alcohol use by a young person, and 2) To allow a professional team to create a profile and audit the prevalence of drug/alcohol use within their caseload. The initial IMR Author (see below) states this was an appropriate use of the tool in James' case. The DN attended his second Placement Panel and reported that James had difficulty with independence skills and stayed in his room for long periods, a fact also confirmed by Placement 1.

32. Due to a change in personnel at the latter stages of the SCR, another CCG representative joined the SCRP and made suggested changes to the previous CCG IMR and recommendations. The revised Thurrock CCG IMR was received in August 2016. The IMR was further considered by the IOA and incorporated within this Overview Report. It includes two recommendations shown within the Thurrock CCG Agency Recommendations at Appendix 4. Their findings take into account a recent "Care Quality Commission" inspection for implementation in November 2015. The recommendations were made to comply with practices with "The GP Patient Registration Standard Operating Principles for Primary Medical Care" in relation to a child being seen on registration with the practice. It is a contractual requirement that once registered, all patients must be invited to participate in a new patient check and neither registration nor clinical appointments should be delayed because of the unavailability of a new patient check appointment. This advice has been sent electronically to all GP practices in Thurrock and raised within the local GP Safeguarding Leads Forum. **(Thurrock Agency Recommendation 1.)**

33. Furthermore after James became accommodated, his records were transferred out of his Thurrock GP practice. Statutory Guidance promoting the Health of Looked after Children 2015 (DFE DOH) state that: GP records for LAC are maintained, updated and health records are quickly transferred, with no timescale given. A local Primary Care Resource Pack was developed in April 2015. The pack outlines Primary Care Teams statutory responsibilities. The guidance states that all patients including children should have a named GP at the practice where they are registered with additional guidance for LAC. It stipulates that practices should ensure timely access to a GP or other

health professionals and provide information on the health of the child, to inform other assessments. They should maintain a record of the Health Assessment and contribute to actions within the Health Care Plan to ensure best practice is achieved. The IMR further identified a need for the CCG to review governance and information sharing following attendance at Thurrock Placement Panel meetings. **(Thurrock Agency Recommendation 2.)**

NELFT

34. James became known to NELFT in April 2013. The IMR identified delays in the statutory time-frames of his Initial Health Assessment (IHA). James was never seen by his GP whilst he resided in Thurrock. However when he became a LAC in December 2014 and placed out of borough, he was taken to a local GP for his IHA. It is noted that the outcome and record keeping in regards to the IHA was unsatisfactory. Regulation 7 of the Care Planning, Placement and Case Review (England) Regulations 2010[9] requires the LA that looks after the LAC, arranges for a registered Medical Practitioner to carry out an IHA. The request was timely within 20 days. There was no record to say the assessment took place and also no copy of the Health Assessment, but there were electronic records chasing up both the GP and Placement 1. Their IMR acknowledges the insufficient recording keeping and lack of information regarding his IHA. They have addressed the issue. **(NELFT Agency Recommendation 4.)** They also acknowledge that James' immunisation (January 2014) as well as a domestic incident (April 2014) were not apparently followed up by the School Nurse at School 4. **(NELFT Agency Recommendation 2 and 3.)**

Comment: - Their IMR suggested that Thurrock CSC should consider informing health professionals of the details of vulnerable young people in need of CIN Plans, to determine the level of service Universal Health Services can provide. It was also further suggested Thurrock CCG could possibly commission a programme for keeping young people from becoming NEET. NELFT Agency Recommendation 1 and 2.) These comments are learning on the fringes of this review and do not impact on the conclusions of this Overview Report as they will require further consideration outside the SCR process as to their feasibility. (See NELFT Agency Recommendations at Appendix 4.) Any learning, implementation or outcomes of these NELFT suggestions, should be reported for the information of the TLSCB Action Plan that follows and supports this Overview Report.

LAC Placements 1 – 2 and Compliance

35. James was placed with the same company service provider for both placements that he resided in whilst a Thurrock LAC. The company provides semi-independent accommodation and is a supported housing project, housing young people in the community from the ages of 16 to 24 years of age. In James' case, both placements were for young people aged 16 to 18 years of age only. The placements were "Spot Purchases" due to the initial urgency to find LAC commissioning services, and were recommended by other Local Authority LAC Commissioners, in a regional group that share information on placements. In this case, financial checks on these spot purchases were not carried out which are required when commissioning a full contract and an Individual Placement Agreement (IAP) was not completed and was a system failure. In February 2016 the company went into administration. (**See Chapter 6, Finding 3 regarding associated issues and suggested TLSCB Overview Recommendations**) for the Thurrock Board to consider.

36. Placement 1: James was housed in his first placement and allocated two Key Workers with 10 hours a week key work support, within a 24 hour staffed house. There were three other young people in residence at the time. The key work was commissioned by Thurrock CSC for the duration

[9] Regulation 7 of the Care Planning. Placement and Case Review (England) Regulations 2010

of his placement, to look at independent living skills and to support James with his appointments with professionals.

37. Throughout his placement, he was continually going missing and there was concern with him smoking cannabis. His behaviour at his father's home started to be displayed in his placement, with a number of incidents with other residents. He at times displayed challenging behaviour with knives and aggression towards other young people in the placement, as recorded in the key events above. In particular the incidents on the 8th June 2015 when James assaulted another resident who declined to press charges and on the 15th June, when he was arrested and subsequently charged with affray. This last incident culminated in the Placement Director carrying out a Risk Assessment and discussed with James his criminal offending and drug use. With the shared agreement of Thurrock CSC Social Work management, as his bail conditions to attend the London Court on the 14th July, stipulated that he should not attend Placement 1 or contact two named persons at the residence, he was moved to Placement 2, as a safeguarding necessity for others.

38. There had been concerns reported by SW2 who found the placement cleanliness unacceptable and queried whether the experience of some staff at the placement was suitable. Thurrock CSC also had cause to make a formal complaint whilst James was in Placement 1 as they were not appropriately informing both EDT and Police when he went missing. These failures were effectively challenged by Thurrock involving SW2, Senior Management and the Head of CSC. The placement responded to ensure compliance.

39. Placement 2: After James arrest for affray and after the Risk Assessment, James was transferred to the same company service providers Placement 2. It was a similar set up as Placement 1 with three other young people in residence. From an interview with SW2, it appears that this placement was in a better area but with less in the locality for him to do. James during this placement was transferred to SW3 as his case was transferred to the Long Term team. At the placement there were no significant concerns however, he went missing on a couple of occasions but only for short durations and returned of his own accord.

40. The Placement Director after he was moved to Placement 2 reported that since James returned from Portsmouth, he had been behaving strangely, agitated, annoyed and not his normal self. He agreed that he would not intimidate staff and other residents in future, as occurred with his arrest in his previous placement. Staff had overheard a conversation that when in Portsmouth, he was chased by an unknown male with a knife and possibly robbed. The Director informed her staff to keep an eye on James if there are any more changes in his behaviour. The Placement Director confirmed to Thurrock CSC that she had spoken to James and stated the following:-

- Speaking about going to Cambridge he said that he had been visiting friends and that he had been dealing (drugs) as he wanted to earn money. He said he did not plan on doing this forever but wanted to earn some cash. He said he had a plan for the future but that he might go to jail due to the recent incident.
- The people at the unit understood him and sometimes he feels that he has to wear a mask to hide who he really is but there are times that he feels he can talk to people.
- He was also asked why he liked to sit in the dark and hence why he had taken out his light bulb? He said sometimes sitting in the dark is what he likes, he can think in the dark and when he feels good he likes the light. He made a comment that he thought he might be "mad". He was told that when he is not happy with himself he becomes introverted and wants to be in the dark and be by himself.
- He said he writes music and wanted a computer to further his interest and he was offered studio time but he said he was more interested in the writing than the singing.

- James agreed to keep his room tidy and clean but he will not allow staff into clean his room because he did not like people in his bedroom.

41. On the 14th July 2015 James failed to appear at Court to answer his charge of affray and the reason why and what support that was offered by the placement is not known. Attempted contact by the TLSCB with the placement provider company, to provide the answer since the company went into administration, has not been successful. That evening at the placement he appeared normal and communicated with the on duty Support Worker before he went to bed. There was never any concern or intimation from James that he would attempt to commit suicide or self-harm. On the 15th July 2015 at about 9am, James was found collapsed behind his bedroom door by two support workers who called the LAS and Police. He was later certified dead at the scene. **(See Chapter 2 Details of the Investigation.)**

42. Placement Compliance for LAC: There was some good work provided by his Key Workers at Placement 1, to address James' missing person episodes and his regular use of cannabis which persisted. They took him to his GP appointments who, after concerns as to his presenting behaviour identified by professionals, referred him to CAMHS. His Key Support Worker DM consistently attempted to get James to engage but this was evidently difficult to achieve. Whilst at the placement he was supported in an effort to stop his offending, such as when he was arrested in Cambridge, outlined in Chapter 4 and discussed below. They supported him by taking him to Cambridgeshire to answer to his Police bail and when he was charged in June 2015. The placement updated his Social Worker by email on these occasions. The placement also attended all of James three LAC Review meetings. Significant comments made to questions posed by the Placement Director of the company in conversation with James in early June 2015 were captured. His voice and his concerns were heard and shared to Thurrock CSC, his SW and at the LAC Review meeting on 29th June 2015.

43. A Gangs and Knife Crime Risk Assessment was completed in June 2015. He did not talk about gangs, but the opinion was his behaviour was in keeping with gang culture in London and carrying knives. A drug Risk Assessment was also completed in the same month due to his offending behaviour in his recent arrests. Staff and other professionals were aware of the outstanding cases and offences concerning Class A drugs. As there was no CAMHS involvement they were not aware of his mental health without this input. The referral to CAMHS it is claimed, was made because of his change in behaviour, with more aggression shown and being withdrawn in the placement. They were also not aware of all his past issues but his father did disclose about James going missing previously while living at home.

Comment: - The placement company provided an IMR for this SCR but the IOA required further information. This was not forthcoming as during the process of completing this review in February 2016 the company went into administration. In a discussion with the IOA at James' Inquest, the support worker 2 (who came to take James to Court in Cambridge) stated he had left the company prior to it going into administration, because he was not getting paid. This statement together with the financial and company checks within the commissioning for LAC placements, identified a system failure as indicated previously and further addressed in the Findings at Chapter 6.

Their suggested IMR recommendations were on examination, not recommendations but questions posed. TLSCB have a copy of the recommendations which due to the company no longer being viable, are no long relevant, as training issues for LAC placement staff are captured within the Thurrock CSC IMR and his incomplete mental health assessment is also addressed under the IRO and LAC Reviews above within this chapter. It is clear from the analysis that Placement 1 was not compliant with reporting James missing as indicated within Chapter 4, Key Events. This was

appropriately escalated and Thurrock CSC were right to challenge and complain to the placement company.

Open Door Return Interview

44. Open Door administer a Missing Young People's Service and offer return interviews. James only agreed to one return interview following his periods of being reported missing. On the 19th May 2015 (after his arrest in Cambridgeshire) he was interviewed. He stated he had been brought up most of his life in Hackney with his mother but lived with his father in Thurrock for the last one and a half years before he was accommodated. He did not see his father much and did not like to travel to Thurrock. He sees his mother occasionally when he goes to Hackney, where he tries to spend as much time as possible with friends, usually once a week. When asked about his family he said he had four half brothers and sisters but does not ever see them "because they are with his parents". He did not mind being at his placement but did not agree with all the rules. He had a weekly allowance but was not allowed all the money at once, he received it in intervals during the week. He confirmed he did not attend college and spent most days in bed watching TV and sleeping. (He woke up at 3pm for the interview.)

45. James stated he had ambitions to do an apprenticeship, possibly in music as he can play the piano. He did not want to talk about going missing. Eventually he confirmed that he went to Cambridge to "stay with friends" and he was sightseeing but laughed to himself at this comment. He was asked if he stayed at one friend's house for the duration of the time he was missing? He said "No" and said "They are just friends". He said that it was not the first time he had been to Cambridge, he said he had been on lots of occasions before. (His step-father stated in telephone call from James that he was in Cambridge on one occasion.) He admitted that he was stopped by Police and arrested but denied he had any involvement in gangs.

46. Open Door Service made two recommendations, 1) Career advice and The Princes Trust, as he was keen to complete an apprenticeship, and 2) St Giles Trust SOS Gangs Project, a project that works specifically with young people at risk of gang involvement in London boroughs. Although James would not confirm this, the interviewer's suspicion was raised that he may have some involvement in a Hackney Gang. As previously stated he failed to engage with The Prince's Trust course.

CAMHS (St Anne's Hospital)

47. CAMHS declined the referral from the GP. BUBIC were suggested and appointed a SW to meet James and start an assessment and then referred on to Insight (Haringey). CAMHS at St Anne's Hospital sent a letter to the wrong address for Placement 1 who never received it. The placement requested in future all letters be addressed to the company to ensure that all correspondence was received and accounted for. This matter was addressed at the time. The concerns the GP outlined of James' behaviour in the referral, citing as a possible consequence of his regular cannabis use, may suggest CAMHS took this as a reason, that he only had a drug problem and was depressed. This does not however answer the whole concern from the referral submitted by his GP. Therefore the possibility of his mental health was not ever effectively assessed and should have been followed up within his Care Plan and LAC Review with health professionals. **(See the Findings at Chapter 6.)**

48. Since November 2015, CAMHS, is now run by Southend, Essex and Thurrock (SET) NELFT and called the Emotional and Wellbeing Mental Health (EWMH Service), an early help service and a single point of entry, enabling direct intervention to receive and screen referrals. The service will have a long term aim of responding earlier to children's needs to help prevent, reduce or delay the

need for more specialist interventions and is currently being rolled out. This may be beneficial for the future of SET but as many LAC are placed out of area will still require communication with other CAMHS in whose area the LAC is accommodated, therefore the recommendations suggested at Appendix 4, are still relevant.

School 4

49. On 23 November 2012 James was offered a place at School 4. Straight away his father had challenges for him to attend as highlighted in Chapter 4 key events, who reported him missing after an argument to attend on his first day. The school appropriately informed the Child Protection Officer, Assistant Head and Student Achievement Leader (SAL) of his absences and were aware that he was moved from Hackney as he was getting involved with gangs. James continued to miss school, wanting to return to the Hackney area. On one occasion in December 2012 during his persistent missing person episodes, James had convinced his mother that his father mistreats him and said he tried to strangle him. Both his father and mother in conversation with the IOA stated that James was playing both parents off against one another in order that he could stay in the Hackney area, using it as an excuse to keep off school. The school made a referral to Thurrock CSC and it was recorded as NFA. James continued to live with his father, as his mother refused to allow him to stay with her.

50. His attendance remained poor, recorded in January 2013 at 30.6% and School 4 referred James to the Education Welfare Service (EWS). On the 8 February the school sent a letter to his parents for failure to attend school since December 2012 and informed them James was removed from the school roll.

51. On the 27th February 2013, his father contacted the EWS and asked if James could return to School 4. He was allowed in March 2013 to restart at the school. There were other concerns and on the 17th April the School Child Protection Officer met James at school as he was very late and it was mentioned about apparent arguments he had with his father and uncle. The SAL was informed by email and records a CAF Referral was carried out having listened to him.

52. On 11th September 2013, School 4, received a referral to the Child Protection Officer about concerns of parenting. It noted that his father lives with his girlfriend in Barking and visits the house once a week to bring food. His paternal uncle lived at home but leaves for work at 9-10pm and returns after James goes to school in the morning. It was recorded as NFA and not clarified further.

Comment: - From the family interview the reason why his father continually went to Barking was to stay with his estranged second wife and at that time, his two young daughters.

53. In March 2014, a tutor was informed by a third party that James best friend in Hackney had been shot? He did not want his father to know. James was spoken to and offered bereavement support which he declined. It is not known whether this information was correct and was not elaborated on.

54. After James was accepted back into education in Year 10, he obtained 86% attendance. In Year 11 it rose to 98.8%. He left at School 4 with six GCSE's A* to C + grades including English and Maths. James had a careers interview and secured a place at South East Essex College but he did not take up the option. When he left Year 11 he was not NEET.

55. The IMR author made four recommendations. Only one recommendation is effective for the purposes of this review as the others have already been implemented. Their recommendation is regarding responses to referrals to an outside agency, as their IMR criticises social work allocation and involvement to tackle the issues surrounding James' missing from home episodes. Their

Safeguarding Officer will now address the situation and if necessary, escalate the matter if no satisfactory response is received from referrals to other agencies. **(School 4 Agency Recommendation at Appendix 4.)** However in James' case, no major referral was missed by School 4. Safeguarding procedures were followed and his voice was consistently heard even though, since April 2015 a more robust system to record student voice has been in place. The EWS and school intervention in Year 10 allowed James to settle well into Year 11, enabling him to go into further education if he so desired.

Hackney CSC

56. The CSC provided a chronology of contacts with James. They did not supply a report or an IMR of the analysis of events regarding him presenting himself to Hackney CSC as homeless, on two occasions. The chronology duplicated entries which were identified.

Comment: - A request was made by TLSCB to Hackney CSC to supply a report analysing their action taken and up to June 2016 this has not be supplied. The IOA has reviewed the chronology and cross referenced it with other submissions to the serious case review. There appears no significant concerns, but their view on the action taken, particularly when James presented for a second time on the 23rd September 2014, poses the question whether they should have offered more assistance to help him charge his phone battery to obtain his parents contact numbers? Consequently he left the Hackney Service Centre, his whereabouts were unknown and he did not later contact Hackney with the details. This information was later shared by Hackney CSC when Thurrock CSC contacted them for information on contacts with James.

Norfolk CSC

57. Norfolk CSC have been asked as to their agencies safeguarding arrangements for James as he was presenting as homeless in their area. The circumstances of the events in July 2014 are detailed in the Norfolk Constabulary entry below, when James was arrested in Great Yarmouth, Norfolk and are not replicated here. Norfolk and Thurrock CSC had a discussion as to who should have responsibility for James and whether to treat him as a homeless person. At that time, James' parents refused to accommodate him and he was living with his father preceding his arrest. It was agreed that Norfolk CSC assumed responsibility for him. There were safeguarding issues for Norfolk CSC, as James was allowed to travel home to his father's home and he missed his late night train, causing the Norfolk SW who could not find him, to report him as a missing person. He was later located at his maternal aunt's home in South London on the 13th August 2014 and the reason for their decision and action taken is not known. **(TLSCB Overview Report Recommendation 11.)**

POLICE

Essex Police

58. Contact first commenced in October 2012 when James was aged 14 and concluded in December 2014 after his 17th birthday. They dealt with him on numerous occasions when he resided with his father, mainly when he was reported missing, emergency calls by his father for domestic incidents in the home and in communication with the MPS when he was found missing in London.

59. The final contact was on 11th December 2014, when his father made another emergency call to Police, as James was threatening everyone in the house following an argument over food and regarding his use of drugs. Police found no weapons or evidence that drugs had been taken. There was no further action taken and it was agreed that he would be taken to his maternal aunt's home in

South London. This was the final straw for his father that ultimately led to James becoming a Thurrock LAC. There was good communication and sharing of information between Essex Police and the MPS in their contacts with James. No recommendations were identified by the IMR Author which is acceptable.

Metropolitan Police Service

60. James came to the notice of Police on thirty three occasions of which the MPS were concerned on twenty occasions. Of these, eleven related to him being reported missing between the period of January 2013 and July 2015. The common themes were disagreements with his parents, and failing to return to his placements. In all contacts between the MPS and James, referrals were appropriately made in relation to his missing person episodes. There were two incidents requiring further comment. On the first incident he was stopped in the street and admitted he committed crime to fund his cannabis habit which should have stimulated a referral by completing a Merlin (come to notice) for CSC. This was individual learning for the officer and secondly, when he was arrested in June 15 for affray at Placement 1, he mentioned to the Forensic Medical Examiner (FME) when examined in custody, that he was bi-polar. In all other aspects policies and procedures were complied with and information shared. It was confirmed that there were no identified links to James affiliation with gangs and he was not on the MPS Gang Matrix at that time.

61. In relation to the bi-polar comment, there is no record of this possible concern being shared with CSC either from the medical professional carrying out the examination nor whether it was recommended to the Police Custody Officer, to complete a Merlin report for onward sharing. It has been confirmed by the Chair of the SCR Panel, who carried out further enquiries, that there is no record of James being on any medication for bi-polar or anything health related. His history as given to his GP referred only to an allergic asthma, allergy to nuts and smoking cannabis. The MPS Safety Compliance Investigations Team state it would not be the responsibility of the FME, who will advise and complete the National Strategy for Police Information Systems (NSPIS) medical form, to raise concerns and it would be the responsibility of the Custody Officer to take any action. (**TLSCB Overview Report Recommendation (9) for the MPS.)**

Norfolk Constabulary

62. Norfolk Constabulary submitted a report, requested by the IOA, due to a possible safeguarding issue between Police and Norfolk CSC Initial Response Team (IRT.) In July 2014 James was arrested in Great Yarmouth, Norfolk. Police were carrying out a search of a fifty year old women's home where a small quantity of drugs (one wrap) was recovered at the scene. He was found hiding in a wardrobe. He declined to comment in interview but the women arrested with him alleged they met up a couple days previously and as he was homeless, she gave him somewhere to stay and had a "fling with him." She said that the drugs were left by another person who visited her home. He was provided with an Appropriate Adult from the Norfolk Appropriate Adult Scheme, but declined to answer questions. He was bailed by Police for the offence of possession of a controlled drug. Norfolk and Thurrock CSC discussed who had the responsibility for James and whether to treat him as a homeless person, as both of James parents refused to accommodate him at that time. His father confirmed that his son had no family contacts in the area. James was bailed by Police but kept in the company of a PCSO and supervised while Norfolk CSC arranged accommodation. After further negotiation by the Social Worker dealing with James, his father agreed he could return home to him. James was furnished with a travel warrant and allowed to travel home alone. He missed his late night train, causing the Norfolk Social Worker, who could not find him, having to report him as a missing person to Police.

Comment: The custody record lacks information and shows that his bail was subsequently cancelled but no details are recorded why? It was presumably due to the lack of evidence of who possessed the drugs. The report further states that ongoing safeguarding concerns were satisfied but cannot comment on the ongoing arrangements by Norfolk CSC. It does not explain how he was handed over to Norfolk CSC who were initially looking to accommodate him overnight and how he missed his late train home. (TLSCB Overview Report Recommendation 10.)

Cambridgeshire Constabulary

63. Between the 6th and 7th May 2015, a caretaker's office in a residential block of apartments was burgled overnight with two laptops and a pair of Nike training shoes stolen. The following morning James was apparently seen in the street, by a witness, who saw him carrying property. He went into a bush and when he came out he did not have the property on him. The witness informed Police who recovered a laptop bag with two computers inside from the bushes from the burglary. He believed he saw James several times over the preceding days and suspected he was dealing drugs to individuals. Later that day there was a walk in burglary at Lucy Cavendish College, part of the Cambridge University campus between 7.30 and 9.30pm. Cash and an iPhone were stolen from an unattended locker room. There were no suspects seen or witnesses to the actual burglaries but the two crimes were later linked.

64. On the 9th May 2015, the loser of the lost iPhone used the "Find my iPhone" app, she tracked and reported the location to Police. James was approached by Police and ran off but was arrested after a short chase. He had to be subdued as he was resisting arrest. He was described as having the physical size of a much older person. Once detained, he immediately conceded that he had Heroin drugs on him. This was the only significant admission he made. At the scene, Police requested paramedics to attend, as James complained of being unwell. They examined him and found him fit, with no concerns for further medical care.

Comment: - The area James was found in was frequented by drug users, this was not a familiar area with visitors to the city.

65. At the Police station, checks with the Police National Computer (PNC) showed he was a missing person from Placement 1 and in need of protection. James was interviewed by detectives in connection with his possession of drugs and a large quantity of cash found in his possession (£1000) and the burglaries. He was represented by an Appropriate Adult but declined to answer questions other than mentioning he had personally taken cannabis that day.

66. Cambridge Police notified Placement 1 and the MPS. James was bailed until the 10th June 2015 (later extended) to return to the Police station whilst forensic examination of the twenty one separate packets of drugs recovered in his Nike bag, and the investigation into the two burglaries continued. Property retained by Police was the cash, two mobile phones (an iPhone and a Samsung) together with a sim card for analysis of the contents. He was released into the care of MPS officers who attended Cambridge and escorted him back to Placement 1.

67. His bail was again varied for finalising enquiries until 25th June 2015 when he answered to his Police bail. He was further interviewed but declined to answer any questions. There was insufficient evidence in relation to the two burglaries however, the CPS gave authority to charge James with the offences of possession with intent to supply Class A controlled drugs and handling stolen property, the iPhone. He was released into the care of his placement support worker who had taken him to the Police station, to appear on 15th July 2015 at a Cambridgeshire Court.

Comment: - The drugs analysed confirmed he had Diamorphine (Heroin), with a street value of £250 to £350 as assessed by the Cambridge Expert Drug Witness.

68. Appropriate Risk Assessments were carried out by Cambridgeshire Police and they enquired into James' welfare. The Police officer dealing with him failed to complete Form 101, a child and young person coming to notice form, a referral through their Multi Agency Safeguarding Hub (MASH). The officer did however, contact James' father who declined to become involved. The officer through Police checks was aware he had come to notice of the MPS for potential 'gang related matters' and was regularly reported missing. James was given every opportunity to provide information. He did not give any indication of his relationship with any criminal gangs, individuals and there was no implied risk. He was reluctant to answer questions and it was not known who the drugs or cash belonged to or whether he was acting alone or on behalf of others, as the witness had seen him in the preceding days acting alone. Due to his age and following assessment whilst in custody, he was observed and placed in a CCTV cell to monitor his wellbeing which, was good practice by Cambridge Police.

69. Furthermore a Police Electronic Notification to YOS (PENY) on the point of charge is required within 24 hours and was not completed. This aspect was addressed by the IMR Reviewing Officer and it had no detrimental effect on the case. This omission slightly delayed any necessary notification, checks and input with the YOS team, PNC, crime files and other databases. These omissions are subject to their agency recommendations at Appendix 4 and did not impact on the outcome for this review.

Comment: - The IMR reports that a credited Expert Drug Witness stated that Cambridge is on occasions, being used by street level dealers from the larger Metropolitan areas. Working outside their own area may indicate that they are less likely to be identified and risks reduced. It is believed that a number of street level dealers are coerced into this by organised crime groups. This was not known if this was the case for James but his actions mirror the findings in the Home Office, Ending Gang and Youth Violence programme from 2011 to 2015[10] and which is now subject to Home Office Guidance 2016 for Local Authorities. All the London areas frequented by James in this serious case review of Hackney, Haringey and Brent had joined the initiative in April 2012 and may have been a source for the IRO to consider when addressing James behaviour and concerns in his LAC Reviews. Thurrock implemented their own Ending Gang and Youth Violence, Local Assessment Process in February 2016 after James death.

British Transport Police

70. On the 1st May 2015, James was noticed at Cambridge railway station. He was not seen by Police but BTP records confirm that ticket inspectors gave him a fixed penalty notice for not having a ticket. He had been seen to frequent the station for several journeys of short duration and had been in possession of two mobile phones, which we now know were subsequently seized by Police.

Hampshire Police

71. James was seen on the 7th June 2015 by Police officers in Portsmouth. He was stopped and questioned as to his demeanour and a record was made. Police were originally called to a male making threats to another male with a knife. James matched the description of one of the males involved but no knife was found on him. They record that he was "acting strange" and were more concerned for his welfare. He was sent home by train to Placement 1.

[10] Ending Gangs and Youth Violence programme, Home Office (2011 to 2015)

Comment: The Police officer having concern for welfare should have considered a safeguarding referral and it has been confirmed that their Child or Young Person at Risk form (CYPR) was not completed. This has been noted by the Hampshire Constabulary, Serious Case Reviewer and is learning for the officer which, is acceptable in the circumstances as the stop was recorded correctly for later accountability and the information was available to this review.

London Ambulance Service

72. The witnesses statements were obtained from four paramedics, compiled for James inquest who attended James on the 15th July 2015. There was no learning identified from the LAS report for this serious case review. Their account and actions taken by them is detailed within Chapter 3 above under Details of the investigation into James death.

Missing Person Episodes

73 James was reported missing or had unauthorised absences on approximately 27 occasions. There were several episodes as detailed in Chapter 4 that showed he was found by Police in London and not reported missing by his parents. In another case he was found sleeping rough by MPS Police officers who returned him to his father's home in Essex. On each occasion the agreement of both James and his father to return home was obtained. There was acceptable compliance to policy and procedures between Police notably the MPS and Essex with the respective Local Authorities Thurrock, Hackney and Haringey CSC's. It was also ascertained that Placement 1 had failed to report him missing and had no idea he was missing when he was discovered and sent home from Portsmouth or when he went missing to Cambridge on 1st May 2015 and was not reported missing by Placement 1 until the 4th May. This failure was challenged by SW2 and necessitated a formal complaint from Thurrock CSC.

74. Overall, his missing person episodes were actively pursued and attempts to hold return interviews as required were frustrated by James. He only agreed to have one interview with the Open Door service, commissioned to carry out return reviews. Police debriefs of James when available, were recorded as soon as practicable but met with unwillingness from James, who did not divulge anything of note as to his actions and whereabouts, whilst he was missing. James missing persons episodes are further discussed as above, within Care Plans and LAC Reviews, as there is a need for both processes to address and include strategies to minimise LAC persistently going missing and is discussed in the Findings at Chapter 6 and Conclusions in Chapter 7.

Gang Culture, Drugs and Criminal Offending

75. As part of the Home Office Gang and Youth Violence programme, Thurrock Local Authority developed a "Gang and Youth Violence" Local Assessment Process (LAP)[11], Thurrock (Feb 2016), and is expanded below. (See Ending Gang and Youth Violence in the proceeding category.) This is post the death of James but addresses the associating issues that impact on the Thurrock area, identifying amongst other matters, gang members coming into the area from London. However in James' case, there is no evidence that he was an affiliate of any gang and certainly not in Thurrock. His actions and the subsequent recorded events, makes it reasonable to assume that he had gang knowledge and connections, but any association for James would have been in the Hackney area of London.

76. James was travelling to other areas that drugs were known to be sold or easily able to be obtained. Information from the Cambridge Expert Drug Witness statement, confirm that drug

[11] Gang and Youth Violence Local Assessment Process (LAP) Thurrock (February 2016)

dealers from metropolitan areas like London, attend the area that James was frequenting, for the purpose of supplying drugs. Similarly also it could be said, when in July 2014, he was arrested in Norfolk. In that incident there was a local gang association but James was not known and in June 2015 when he was located in Portsmouth. James always denied he was in a gang, insisting his friends, who he never identified or spoke about, were not gang members. Both the IOA, his parents and professionals spoken to for the purposes of this review, are not convinced with his denial.

77. SW2 on one occasion saw two alleged friends waiting outside his placement and he seemed to be in a hurry and anxious to get away. Consequently SW2 received an email from the Placement 1 Head Office wanting it on record that James was seen at the placement with another former resident (possibly one of the two observed by SW2) who they had concerns with previously with a lifestyle of drugs. This could have been a form of an insurance policy for the placement as they were aware of the attendance of SW2. It was noted but not explored further but adds circumstantially to the conclusions below and within Chapter 7.

78. It is a reasonable assumption to suggest he was funded by other persons and sent to these targeted areas outside London, to deal in drugs. Furthermore, when he got back from Portsmouth, he was reported as stressed and not his usual self. He was overheard in his placement to say that he ran away from an unknown male with a knife when he was there. It is possible that this other person may have tried to or even managed to steal property from him, attacked for working on another dealers "patch" or seen as a vulnerable or an easy target. We will never be able to ascertain what really happened and this cannot be answered within this serious case review. However, such an incident did take place, as the response from Hampshire Police confirms they were called to an incident between two males, one with a knife. On stopping James, he did not have a knife or any illegal substances on his person. He may have been the victim on this occasion and not the aggressor.

79. Furthermore when arrested by Cambridge Police, they confiscated his drugs (street value between £250 and £350) and £1000 cash and had retained his two mobiles and sim card. Was he being exploited and did he owe a debt to pay these drugs and cash back to others? We can only surmise, but this is highly likely. Another scenario to consider is that at the time of his death, a search of his bedroom found no cannabis or other drugs. Furthermore his toxicology report showed that there was no alcohol or drugs found in his body. As a consequence he may not have been obtaining his cannabis, a persistent habit for his last three years. Was he keeping away from others because he owed the seized drugs and money? In support of this observation, in the family interview, it was disclosed that after his arrest in Cambridge, he visited his mother. He had a cheap throw away mobile phone and persons kept texting and phoning him (it is not known where this phone is!) He said to his mother "they will not leave me alone," he then took his battery out to prevent further interference.

80. James' father stated on several occasions that he wanted Thurrock CSC to move him to a placement well away from London and this is recorded. What was not apparent, was that his mother and step-father also shared the same view. They were concerned when he was first placed in Placement 1, as he was only a short bus ride away from the people they believed were coercing and controlling him into dealing drugs. It is a consensus of opinion, that gang members were probably paying him and supplying his cannabis for personal use to keep him involved and therefore exploited him to commit crime. The parents view to move him away from London, appears not to have been reasonably considered and is addressed under Finding 2 in Chapter 6 and within the family interviews with the IOA in Chapter 3. (**TLSCB Overview Report Recommendation 4.)**

Home Office Initiative - Ending Gang and Youth Violence

81. The Home Office (HO) funded Ending Gang Violence and Youth Violence (EGYV) programme January 2016[12] and is guidance and an approach to tackling gang related violence and exploitation.

Priorities for 2015/2016 and onwards are:-

1) Tackle county lines – the exploitation of vulnerable people by a hard core of gang members to sell drugs.
2) Protect vulnerable locations – places where vulnerable young people can be targeted, including pupil referral units and residential children's care homes.
3) Reduce violence and knife crime – including improving the way national and local partners use tools and power (extending gang injunctions, HO, with the Ministry of Justice (MOJ) to develop a national approach to information sharing and provide consistent reliable access to data etc.)
4) Safeguarding gang-associated women and girls, including strengthening local practices.
5) Promote early intervention – using evidence from the Early Intervention Foundation (EIF) to identify and support vulnerable children and young people (including identifying mental health problems). The EIF is a home office funded initiatives to identify risk and protective factors. The HO is working with the Department of Health and other agencies to work closely with other initiatives.
6) Promote meaningful alternatives to such as education, training and employment.

Comment: - This guidance stimulated Thurrock's Local Assessment Process in February 2016 as alluded to previously. It has been put in place since James death but is learning for the future. James case meets five of the six points in the above criterion, except point 4. LAC Care Plans and Reviews therefore should identify at an early stage and apply the EGYV and Thurrock's Local Assessment Programme guidance, to help identify trends and take appropriate action. (See TLSCB Overview Report Recommendation 4.)

Culture and Diversity

82. Culture and diversity was not an issue identified within this serious case review. It was discussed within the family interviews with the IOA and is included under family involvement within this report.

Voice of James

83. There is substantial information that James voice was consistently heard and listened to by professionals. He was able to determine himself what he wanted to do and what he wanted to say. This aspect is also addressed within the key questions set within the terms of reference in Chapter 2 and below.

OFSTED 2016

84. During the SCR James process, Ofsted carried out an inspection of Thurrock Council and published their findings in April 2016[13]. It was an inspection of services for children in need of help and protection, children looked after and care leavers, looking also at the leadership, management and governance. Ofsted's overall assessment was they were all "Requiring improvement". They also

[12] Ending Gang Violence and Youth Violence programme, Home Office (January 2016)
[13] Ofsted Inspection of Thurrock Local Authority (April 2016)

reviewed the effectiveness of the Local Safeguarding Board and gave it an overall grade of "Good." The previous Ofsted inspection in 2012 gave the local authority a grade of "Good."

85. Reference is made to the Ofsted 2016 Executive Summary and the issues identified requiring improvement, in comparison to the findings within this serious case review, as follows:-

- Assessment and planning for children. The assessment and planning for James was evident and efficiently put in place when he became a LAC.
- Securing a secure and stable workforce. TLSCB recognised the need to employ an additional administrative serious case review assistant to support SCR's and this greatly assisted the IOA in this review.
- Supervision and oversight. Supervision was displayed by Thurrock CSC who addressed the serious concern of the non-compliance of Placement 1 not correctly reporting James as a missing person. This was challenged with appropriate escalation through senior managers to the Head of CSC who took positive action to ensure compliance. An issue that does however require more supervision oversight is the LAC Review and IRO process which this overview report has identified and addressed within the findings in Chapter 6 and within suggested TLSCB Overview Report Recommendation 7.
- Children looked after do not receive a consistently good service/too many become looked after in an emergency. James received more than adequate support and this is documented within this narrative. He was accommodated in an emergency due to a domestic incident when his family declined to accept further responsibility to care for him and the local authority took appropriate action in his case.
- Children living outside the borough away from communities, family and friends. This has also been identified and addressed within the findings in Chapter 6. In James' case, keeping him away from his friends who were suspected to be coercing him to commit crime would have been a better option for him.
- Personal education plans. James Education Plan was consistently being monitored by his Personal Advisor. He would not readily engage, accept any of the advice or support offered to him.
- Performance management and quality assurance. Suggested TLSCB Overview Report Recommendation 7, identified in the findings in Chapter 6 would assist IRO's in the early intervention of escalating concerns for LAC that can be monitored and reflected in their annual report. Furthermore TLSCB Overview Report Recommendations 5 and 6, for Thurrock CSC, NELFT and NHS Thurrock CCG would allow quality assurance to be monitored in relation to the outcomes of mental health assessments and other assessments of children and young people.
- Consideration of trends from return interviews. James would only agree to one return interview with Open Door and all other attempts including approaches from Police to debrief him received a negative or non-committal response.

86. In conclusion, the sixteen Ofsted Local Authority recommendations for Thurrock should be read in conjunction with the findings in this SCR, particularly their Recommendation 15 - to ensure that children and families' views and feedback are used well to shape service developments. This review identified that the views of James parents did not receive adequate consideration which a FGC may have assisted in achieving.

87. Regarding FGC's, Ofsted identified that they were not being fully realised and is also a finding in this review. The emotional, wellbeing and mental health refers to the new SET procedures but as identified in this SCR, this would not be the whole picture, as so many LAC are accommodated

outside the area. This would require the constant vigilance of other service providers to ensure that they are meeting the needs of the Thurrock LAC.

88. In relation to leadership management and guidance, Ofsted states that commissioning arrangements are robust. This review has identified however systemic failings for commissioning of 16 plus Semi-Independent placements at a local and national level (see Findings 1 and 2.) The findings would suggest the proposed national TLSCB Overview Report Recommendation 1 for the inspection of Semi- Independent accommodation for LAC, needs serious consideration for implementation, as there is a noticeable gap in the inspection for vulnerable children and young people, in this type of accommodation.

Specified Questions and Key Issues from the Terms of Reference

89. The following specified questions and key issues to consider, were identified within the Terms of Reference to be addressed by Agency IMR's or Summary Reports in their submissions. Not all agencies adhered to the request but the responses were able to be elicited from agencies submissions.

Specified Questions:

90. The arrangements in relation to James plan as a LAC. How that was or was not connected with what was happening in his life?

There was reasonable assurance and corporate warnings within James' Care Plan identifying that he had a cannabis habit, a propensity to go missing from his placements, a suspicion of drug dealing, a possible gang affiliation, escalating criminal offending and concerning behaviour which stimulated a GP referral to CAMHS at St Anne's Hospital who cover the area Placement 1 was located in. Initiatives and numerous attempts were made to address these mounting issues which James either refused or failed to engage with. His arrests in Placement 1 for affray and in Cambridge for possession with intent to supply controlled drugs, should have triggered an emergency Strategy Meeting of key professionals to discuss all available options. He was facing a possible custodial sentence and the level of concern in the June LAC Review should have stimulated some positive action plan to be considered. The fact that this was not completed, did not impact or contribute to a lack intervention on the events that followed, as there was no inclination given by James that he contemplated self-harming, known to either family or professionals. The outcome, whether such action would have been successful, cannot be determined or whether James would have complied, but in other LAC cases, this may have a positive effect for the safeguarding and welfare of children and young people.

91. How was he being supported in his Court appearances?

Information regarding his attendance at the London Court on the 14th July 2015 for affray has not been confirmed due to the company now being in administration. His support worker in Placement 2 stated to SW2 that he knew of James Court date and was being supported. TLSCB enquiries with the company have not determined the answer who was attending with James to Court on this day, if he was escorted and how he failed to appear?

James was being supported for his Court appearance at a Cambridgeshire Court on the 15th July 2015. A key worker from the service provider's other placement attended Placement 2 on the morning of the hearing. He was to collect James and drive him to his Court appearance in Cambridgeshire, when he and the resident support worker found James collapsed behind his bedroom door.

92. What link was being made in relation to his possible connection with drugs?

It was identified and commented in his Care Plans and within his LAC Reviews regarding his connection with drugs. He had a regular habit of smoking cannabis. He was continually going missing from his placements and was found in other parts of the country and suspected of dealing in drugs. His three Social Workers and his Personal Adviser addressed these concerns with concerted efforts to stop his misuse throughout his term of being a LAC. There were additional attempts by his GP and an Insight (Haringey) drug worker, who he failed to engage with, to address his habit. He freely admitted smoking cannabis which in itself, brings him into the contact of the street dealing of drugs. Even though he was suspected of dealing in Class A drugs (see below), there is no evidence to say that he ever used these harder drugs. The fact that James regularly used cannabis was believed from the period when he was living with his mother in Hackney, when he was at School 3.

93. Was the possibility of James being involved in drug dealing being considered?

This must be read in conjunction with the aforesaid question. There is clear evidence that James was regularly dealing in drugs. Professionals and his father suspected that he was dealing in drugs and the events that subsequently occurred would seem to confirm this. He himself alluded to the fact about supplying drugs to others, in comments made to professionals, particularly to his key practitioner SW2 and the Placement Director, after he was charged in Cambridge with the serious allegation of the possession of a controlled drug with intent to supply.

When moving around the counties of Norfolk, Cambridgeshire and Hampshire and in situations that suggested possession of drugs and drug dealing, he was in areas where he had no connections. These are highlighted concerns that are a national issue along “County Lines”. The Home Office, Ending Gang and Youth Violence programme, identified criminality of people moving between areas to deal in drugs and other crime related matters, exploiting vulnerable persons, manipulated by gang members to deal on their behalf.

Confirmation to some degree was when he was arrested and charged for possession with intent to supply heroin in Cambridgeshire where he had a quantity of heroin and £1000 in cash in his possession. Would he have been indebted to pay the loss back and was this a worry playing on his mind? What must be remembered, he was never convicted of dealing in drugs but it is a reasonable assumption to make? Furthermore his allowance was such that he would not have the finances to purchase his own cannabis and other drugs to be able to deal and travel to other areas outside London for several days at a time. This practice would need funding, with other third party involvement.

94. The knowledge of staff within the home. Were they aware of his past and current needs?

His Care Plan and the LAC Reviews make it clear what was expected of staff within his placements. It would appear from information supplied by SW2 that they did not always know how to cope with him. One Placement 1 key worker repeatedly attempted to challenge his drug use and supported him in going to see his GP. James’ mother and father acknowledged that she was trying to support their son but he would not listen, had his own agenda and persistently ignored advice not to go missing. James would not comply and his room was noted to be unclean as he would not allow staff in his room to clean. SW2 had concerns that Placement 1 were not reporting him missing appropriately, this was challenged and escalated. Thurrock CSC made a formal complaint which the company provider accepted and ensured improvements. When James allegedly assaulted another resident in Placement 1, who did not wish to pursue charges against him, placement staff also

declined to assist Police so as not to aggravate the situation. However, a short while later he was arrested in the placement for affray aftMPDirector carried out a Risk Assessment and had James moved to their other semi-independent accommodation in Placement 2 and as previously stated, this decision was made in consultation with a Thurrock SW Manager. While at Placement 2, SW2 felt this was a better environment for him.

95. Was there YOS involvement and if not why?

There was no involvement with YOS other than after his arrests when SW2 was in contact with the local YOS to discuss his Cambridgeshire and Placement 1 arrests. In the two separate charges of crime that James was facing and due to attend Court for, the YOS were not at that early stage of Court proceedings, involved with James.

96. The referral made to CAMHS, what was the rationale for the referral?

The IOA has not received a rationale from CAMHS at St Anne's Hospital for declining their service to James. This aspect is also discussed above.

97. What plans were in place in relation to supporting James from becoming NEET?

In February 2013 he was referred to the Young People Hackney Service due to being NEET (not in education, employment or training.)

Thurrock allocated him a Personal Adviser who maintained contact and a relationship throughout James' period as a LAC. This overview report outlines within this chapter, the attempts made with James to prevent him becoming NEET. There was constant support and advice offered to James, but he persistently failed to engage or accept any suggestions, support or take reasonable advice.

98. The referral to Insight, what was this for and was it appropriate?

The referral to Insight (Haringey) a local drug and alcohol advocacy was appropriate, particularly as CAMHS were not accepting his referral. Despite attempts by his Placement 1 key worker, SW2 and the allocated Insight drugs worker, James failed to attend meetings or engage and Insight closed James' case.

99. The reporting of absence or missing persons – was the appropriate policies and procedures complied with?

From within the responses to the review from the Police (Essex, MPS, Norfolk, Cambridgeshire and Hampshire Police Services) and from information provided by Thurrock and Hackney CSC, displays evidence there was significant sharing of information between the agencies, with missing person policies and procedures followed. However Placement 1 consistently failed to comply with the reporting of James missing person episodes. They either failed to notify the Emergency Duty Team (EDT) or Police or both. There are recorded details that they were unaware when he was stopped in Portsmouth that he was missing. When he was missing and subsequently found in Cambridgeshire, the Placement had last seen him on the 1st May 2015 but did not report him missing to Police until the 4th May 2015. The SW2 and Thurrock CSC appropriately challenged the placement and made a formal complaint which the placement company acknowledged.

Essex Police use the COMPACT computer system to manage missing persons with automatic notification to local authorities. This allows effective information sharing between agencies. There

was good communication with the MPS when dealing with James's persistent missing person episodes.

Key Issues to consider

1) **Did all agencies work together effectively to safeguard this young person?**

There is clear evidence that agencies consistently worked effectively to safeguard James. He had numerous missing person episodes that were effectively shared, with a few exceptions that are detailed within Chapter 4 and 5, none of which impacted on James welfare and his safeguarding. However Placement 1 failed to consistently and in a timely manner, report James missing. As previously stated, this was effectively challenged by Thurrock CSC and was escalated to the Head of CSC and the Placement Director implemented compliance.

The Princes Trust identified worrying behaviour that James was displaying which was promptly reported to Placement 1 and Thurrock CSC, who acted quickly and ensured placement staff took James to his GP. The GP made an onward referral to CAMHS who declined their service to James. There has been no rationale why they made this decision and this has been requested for the purposes of this serious case review, with no response seen by the IOA and this is addressed within the narrative above.

In 2014 when he was arrested in Norfolk, there were safeguarding concerns. A discussion was held between Norfolk and Thurrock IRT over who had responsibility for James reported as homeless, as he resided with his father in Thurrock prior to his arrest. Thurrock declined and asked Norfolk to accommodate him. Later his father agreed with the Norfolk CSC Social Worker dealing with James that he could return home. He was given a travel warrant by Police at the request of Norfolk CSC but missed his train. He was then reported missing by the Social Worker. He was missing for about two weeks before being found safe.

James presented himself homeless at Hackney CSC on two occasions. This serious case review has not received any analysis of their agencies contacts with James as to the appropriateness of their actions.

Cambridgeshire Constabulary IMR identified omissions when James was arrested. Their Form 101 referral was not completed to share information but they carried out all necessary child protection safeguarding checks and identified that he was missing from London. Also their local YOS should have been notified via their PENY system at the point of charge. This was not completed but would have been addressed when James attended Court on the first occasion. There was however good liaison with the MPS who travelled to Cambridgeshire and escorted him back to Placement 1.

The MPS IMR reported in September 2014 that James was stopped in London and stated he committed crime for his drug habit, information that should have been referred by submitting a MERLIN come to notice form to Hackney CSC. This was individual learning for the Police officer. Furthermore when he was arrested in June 2015 for affray he was examined by an FME and stated he was bi-polar. This is addressed within Findings at Chapter 6 and subject to **(TLSCB Overview Report Recommendation 9.)**

School 4 IMR found that in their contacts with CSC's they did not return calls and have made a recommendation to follow up and address this issue. A CAF was completed. However the School Nurse should have followed up in January 2014, James' immunisation history and in

April 2014 with him and his parents following a domestic incident at his father's home. There is no record confirming that either was carried out. **(See NELFT Agency Recommendations 2 and 3.)**

It was also apparent that there was a lack of information and records of when and if his Initial Health Assessment was carried out. Repeated requests were made to his GP and professionals discussed the outstanding information and outcome within in his second LAC Review. This issue of record keeping and timeliness has been addressed. **(See NELFT Agency Recommendation 4.)** The Thurrock CCG IMR identified the need to incorporate guidance within training at GP Forums and Level 3 Safeguarding Training in relation to new contractual requirements for all new registered patients. **(See Chapter 5, Para 32/33 for full details, Thurrock CCG Agency Recommendation 1.)**

His LAC Care Plan and LAC Review were fully aware of James evolving concerns and reported actions to address them. DfE 2014 Statutory guidance on children who run away or go missing from home or care,[14] identifies the responsibilities of the Local Authority that care plans should include a strategy to minimise future risk of repeated missing episode and IRO's informed to address these in statutory reviews. His missing person episodes were allowing him the opportunity to become involved in criminality and early action even before he was eventually arrested for offences should have been considered by both processes and within supervision. Whether this would have been successful with James non-engagement should not deflect from complying with guidelines, particularly after his arrest, to call an urgent strategy meeting with all the agencies involved, to discuss his case and for the future, incorporating Thurrock's LAP 2016 for Ending Gang and Youth Violence guidance.

No issues outlined above within this question, impacted on the final outcome for James, as his fatal action was not suspected or anticipated by any person.

2) Was the outcome preventable?

The outcome for James death was, on the information provided, not preventable and came as a total surprise to family and professionals. He did not display any previous behaviour or intimated that he would either commit suicide or self-harm. This aspect is further discussed at the conclusions at Chapter 7 of this report. As the Thurrock CSC IMR states, James was showing elements of change to his behaviour the month before his death but there would have been no connection with him harming himself. On his second GP visit there was no concern of suicidal ideation or self-harming evident.

In his third and final LAC Review in June 2015, it records the harm probability remains high, as he continues to use drugs, is reported missing regularly and is involved in gangs. As suggested in the Thurrock CSC IMR, the harm probability was linked to his lifestyle and not to self-harming which is a reasonable assumption and the IRO's account would agree with this.

3) Were the safeguarding procedures followed appropriately?

Safeguarding procedures were generally followed as alluded to but this should be read in conjunction within Chapter 5, the analysis of practitioners practice and 1) above which also discusses safeguarding for James and concerns by Thurrock CSC making a formal complaint

[14] Statutory guidance on children who run away or go missing from home or care, DfE 2014

to Placement 1 for non-compliance of missing persons procedures. Their IMR considered that the strategy meeting after James went missing from Norfolk should have been held earlier and was not held immediately however, it was held whilst he was still reported missing and a follow up meeting was carried out prior to him being found safe at his maternal aunts home. It was felt that James should not have been allowed to travel home late at night and a suggested recommendation for Norfolk CSC has been made. **(TLSCB Overview Report Recommendation (11) and under Chapter 5 Analysis.)**

4) Was the young person's voice heard throughout agencies involvement?

There is significant information that shows James' voice was consistently heard and listened to. He often wanted to be left alone and did not like to be asked too many questions. In his Personal Education Plan he was able to identify the career he wanted to do in close association with his Personal Adviser and Social Workers. The chronology of key events at Chapter 4 outlines the contacts that he had with professionals, particularly whilst a LAC. His voice was heard in all contacts with agencies and practitioners. Although described as shy and withdrawn, he displayed an aptitude to communicate when he wanted to. The fact that he would decide when to engage and when to communicate is not through the fault of his family or professionals.

It is not known whether his regular use of cannabis impacted on his decision making and communication ability, as his mental health, as this review identifies, was not properly assessed. Other attempts to address his drug misuse were unsuccessful as he declined to engage with professionals attempting to provide a service to him. **(See TLSCB Overview Report Recommendations 5 and 6.)**

The advice, support supplied and offered by agencies is well documented and it is a reasonable assumption to say he was listened to by professionals from the information supplied to this SCR. This view is evidentially displayed in meetings with SW2, his Personal Adviser, the IRO within his LAC Reviews, within education, his only Open Door interview, two GP appointments and the Placement Director, this list is not however exhaustive.

CHAPTER 6 FINDINGS – LESSONS LEARNT AND SUGGESTED RECOMMENDATIONS FOR THE CONSIDERATION OF THE THURROCK BOARD

This chapter outlines the findings identified from the analysis of professionals practice. They are produced for the consideration of the Thurrock Board to identify and implement any learning from this serious case review. There is an expectation from the National Panel of Independent Experts for Serious Case Reviews that overview reports should have recommendations that are concise and smart. Therefore the Findings contain suggested TLSCB Overview Report Recommendations and are forwarded for the assistance to the Thurrock Board to consider for implementation:

FINDING 1 – INSPECTION OF LAC PLACEMENTS. Does the Thurrock Board agree there is a need for Ofsted to carry out inspections of LAC semi-independent LAC placements?

What is the issue? Childrens homes are subject to an Ofsted inspection. There is however, a natural gap in the inspection process, as semi-independent LAC placements are not currently inspected by Ofsted. The Thurrock Ofsted 2016 inspection stated commissioning was robust contrary to the findings found in this review. **(See also Finding 2 below.)**

What should be considered? This serious case review highlights the need for a national inspection of all LAC including semi-independent placements. Local Authorities overall aim is to supply a stable and safe environment, in order to support and develop a pathway for children and young people to succeed and thrive independently. Children and young people aged 16 to 18 years, accommodated in a semi-independent placement are as vulnerable as any other LAC. The issues within this review shows the complexity and the requirement to ensure that the commissioning of the right placement, for the right LAC is essential and requires consistent monitoring of standards. It is suggested Thurrock Local Safeguarding Children Board consider the following recommendation, as there is a strong case to warrant such action and is further evidenced in **Finding 2.**

Thurrock LSCB Overview Report National Recommendation (1) for Inspection of LAC Placements.

It is recommended that the Department for Education consider the wider remit for Looked after Children inspections to include:-

- **The implementation of Ofsted inspections for all LAC provisions, regardless of the type of placement provided.**
- **An inspection to monitor the commissioning and compliance, checks by the Local Authority as to the suitability of the placement, experience of placement staff and financial checks made as to the stability of the Company and Board of Directors, providing the service provision.**
- **An opportunity for DfE and Ofsted enhancing support for Local Authorities, with the consideration of developing a national directory of suitable LAC service provider companies and directors in the industry.**

FINDING 2 – COMMISSIONING. Are the Thurrock Local Safeguarding Children Board satisfied?

1) With the system improvement this review has provisionally implemented in consultation, for financial stability checks for spot purchases with Thurrock's Children Commissioning and Service Transformation (CCST) for LAC placements?
2) Whether the current Thurrock commissioning strategy of LAC arrangements are safe?
3) Whether the regional Local Authorities commissioning services who work with Thurrock to identify suitable LAC Placements, should be shared up to date, relevant information of LAC placements?
4) Should the Thurrock Gang and Youth Violence, Local Assessment Process (2016), capture within the commissioning process for LAC placements, additional Gang and Youth Violence information to ensure Thurrock LAC involved or vulnerable to exploitation are not accommodated within significant Gang areas of concern?

What happened? James resided in two Thurrock LAC placements provided by the same company. However, Thurrock CCST in communication with the IOA, stated that the company were spot purchases. The company was recommended by other Local Authorities in the regional group that Thurrock CCST interact with to agree, share and recommend suitable placements. Information obtained during the course of this review raised concerns namely, Police being regularly called to the placements, a complaint made to the placement provider by Thurrock CSC regarding failure to comply with the reporting of missing persons, a former employee who confirmed that he was not being paid and had since left the company and finally in February 2016, while participating in this SCR, the company and its placement properties were put into administration. Routine financial checks in July and August 2014 would have shown that the company may have been in some financial difficulties. Regular checks as to the financial stability of companies were not carried out which could have stimulated further scrutiny. The Company may have perfectly valid reasons for going into administration and there is no criticism. It is not developed further within this Serious Case Review and is eluded to merely show that there was a system failure within commissioning. Thurrock CCST financial scrutiny of spot purchases will now be completed. They do not always have the time due to the urgency of finding a placement but insist checks will be carried out as soon as possible and then reviewed annually. In this case there was no contract or Individual Placement Agreement completed, the placements remained spot purchases and were a system failure.

What should be considered? (1 to 3 above) the new proposal will capture all spot purchases but are the Thurrock Local Safeguarding Children Board satisfied with the arrangement, support and supervision of the placement of LAC to provide a supportive and stable environment for Thurrock's LAC**. (**4 above) the Thurrock Local Assessment Process 2016 for Gangs and Youth Violence should ensure that sufficient checks are carried out as to the suitability of the location of a proposed placement. Particularly where vulnerable LAC liable to exploitation or association with gangs, are to be placed, to include contact with other area LAP's and Local Authority MASH's and Integrated Gang Teams. **(See also Thurrock CCG Recommendation 4 and comments at Appendix 4),** regarding commissioning cases where a service is declined by an out of area provider, cases should be discussed at the Joint Funding panel so that the case can be escalated to specialist commissioners and funded as per the Responsible Commissioners guidance if indicated. The following suggested recommendations are completed for the decision of the Thurrock Board: -

Thurrock LSCB Overview Report Recommendation (2) for Thurrock Children Social Care.

It is recommended that Thurrock CSC require, Thurrock Children's Commissioning and Service Transformation, to carry out a review of the supervision of commissioned contracts and spot purchases of LAC placements to ensure the continued stability of the accommodation for Looked After Children.

Thurrock LSCB Overview Report Recommendation (3) for Thurrock Children Social Care.

It is recommended that Thurrock CSC require, Thurrock Children's Commissioning and Service Transformation, to share relevant information of concerns obtained from financial checks and scrutiny of their LAC placement service providers, with other regional Local Authority commissioning services, to ensure that only appropriate and viable contracts are awarded.

Thurrock LSCB Overview Report Recommendation (4) for Thurrock Children Social Care.

It is recommended that Thurrock CSC review the Thurrock Gang and Youth Violence Local Authority Process 2016, to include commissioning checks to the suitability of the location of LAC Placements, to ensure that vulnerable children and young people are not placed in an area of significant gang and youth violence.

FINDING 3 – MENTAL HEALTH AND OTHER ASSESSMENTS. Are the Thurrock Local Safeguarding Children Board satisfied that outcomes for LAC who are referred for a mental health and other assessments, are followed through to a recorded and acceptable conclusion?

What happened?

1) James' concerning behaviour was evident in February 2015 when it was known he was regularly using cannabis and referred for a Mental Health Assessment. His GP referred him to CAMHS who declined their service and who referred his case onto a drug and alcohol service. Needless to say, his mental health concerns were never effectively assessed. There was no notable delusional concerns apparent to the same extent in the latter months, but his criminal offending and anger issues in the placement started to escalate. Ironically when James' room was searched on his death, there were no drugs found and toxicology results confirmed he had no drugs or alcohol in his body.

2) His Social Worker carried out a Strength and Difficulties Questionnaire (SDQ). James was deemed to have severe difficulties with a score of 27/40 as outlined in the chronology at page 30. The outcome of the SDQ was discussed by the Social Worker with the IRO. They were considering the option to move him to another area to reduce the risk and break the chain of him associating with others involved in crime and likely exploitation. He was however subsequently moved, not because of the SDQ outcome, but due to the assault incident concerning another resident in Placement 1 when he was transferred to his second placement.

What should be considered?

1) The GP referral to CAMHS St Anne's Hospital, records that his behaviour noted was possibly connected to his regular use of cannabis, CAMHS possibly believed that a referral to a drug and alcohol service, was more acceptable. No consideration was made to look at the wider picture and is part of the service they advertise. Therefore no Mental Health Assessment was carried out. The rationale for CAMHS decision was never received for this serious case review or resolved within his Care Plan or LAC Reviews, so remained an unresolved Mental Health Assessment. It was not

however seen as an issue at his inquest and in his GP appointment in May 2015, where he did not show such concerns.

2) Where a concern is identified within a SDQ that a LAC has severe difficulties, there needs to be a robust system in place, with a clear support pathway identified, to address the concerns.

Comment: To compliment these findings, **NELFT Agency Recommendation 3** addresses the need to follow up the outcome of LAC's immunisations, ensuring they are up to date. NELFT further identified **NELFT Agency Recommendation 4,** the requirement to embed a more robust record keeping and follow up process, in terms of health assessments and delays noted within this SCR, particularly for LAC placed out of the Borough, due to the added vulnerabilities they may encounter. The following suggested recommendations are submitted for the decision of the Thurrock Board: -

Thurrock LSCB Overview Report Recommendation (5) for Thurrock Children Social Care and NELFT.

It is recommended that Thurrock LSCB require Thurrock Children Social Care and NELFT, review LAC Care Plans and LAC Reviews, to ensure outstanding Mental Health assessments are notified and if required, escalated to the Thurrock Clinical Commissioning Group or appropriate partner agencies, in order that outstanding assessments are followed up and completed to a satisfactory standard, with the rationale recorded.

Thurrock LSCB Overview Report Recommendation (6) for Thurrock Clinical Commissioning Group.

It is recommended that Thurrock LSCB request NHS Thurrock Clinical Commissioning Group under the Responsible Commissioners Arrangement, to escalate and provide support when notified by partner agencies, where a health practitioner makes a mental health referral for children and young people, which remains outstanding. This is in order to obtain a satisfactory outcome for the patient, with the rationale of the decisions recorded on the patients' health file by the provider organisation.

Thurrock LSCB Overview Report Recommendation (7) for Thurrock Children Social Care, NHS Thurrock Clinical Commissioning Group and NELFT.

It is recommended that Thurrock LSCB require Thurrock Children Social Care, NHS Thurrock Clinical Commissioning Group and NELFT, to ensure that when a Strength and Difficulties Questionnaire (SDQ) identifies that a LAC has been assessed with severe difficulties, there is a robust system in place to track these high risk cases with appropriate intervention levels and effective pathways established and applied, to address the concerns in support of the LAC.

FINDING 4 – EARLY RECOGNITION OF CONCERNS. Does the Thurrock Local Safeguarding Children Board believe there should be a process of an early recognition of concerns by supervisors and Independent Reviewing Officers, in addressing escalating issues for LAC and of action to be identified and taken to address these safeguarding concerns?

What happened? Within James LAC Care Plans and within his three LAC Reviews it was clear that issues were escalating with recorded actions allocated, however there was not a joined up approach. There was a goal for James to return home, although there was interaction with his father, there was no relevant contact with his mother by practitioners. Professional concerns of his many missing person episodes, his cannabis use, travelling to other parts of the country and possibly concerned in

the supply of drugs, his anger and possible mental health issues, non-engagement with practitioners, being NEET and his father requesting James be placed within a placement in Essex prior to his third LAC review, were all evident.

What should be considered? Section 20 of the Children Act 1989 (Accommodation[15]) stresses that the views not only of the subject but those of the parents should and have been taken into consideration and a Family Group Conference would have been a sensible forum for this. There is a need for the consideration of holding an early FGC if there are relationship problems and a strategy meeting to discuss increasing criminal offending with the relevant agencies and to listen to the voice of both the subject and family. In conversation with the IRO and her manager, these suggestions in James' case regarding a FGC, would have been considered for future meetings and agreed with the IOA that there is a need to be able to recognise the evolving issues for the LAC earlier with multi-agency involvement. There is also a need to establish a robust system to effectively monitor the distribution of LAC minutes, to ensure that the information, actions and the outcomes are satisfactory completed by appropriate agency professionals. A consideration of the DfE 2014 Statutory Guidance on children who run away or go missing from home or care,[16] should have been followed to assist functioning. The following suggested recommendation is completed for the decision of the Thurrock Board: -

Thurrock LSCB Overview Report Recommendation (8) for Thurrock Children Social Care.

It is recommended that Thurrock CSC ensure that supervisors and LAC Independent Reviewing Officers (IRO), develop a matrix for the early identification of escalating concerns with LAC and of action taken to address those concerns. This should include an effective system to monitor and distribute LAC minutes to appropriate key practitioners to guarantee that any actions identified are satisfactorily completed. Any interventions can be reflected within the IRO Annual Report for monitoring purposes.

FINDING 5 – SHARING OF INFORMATION. Does the Thurrock Board believe that relevant medical disclosures made to a Forensic Medical Examiner by children and young people arrested in Police custody are sufficiently captured and relevant safeguarding information shared with children social care?

What happened? When James was in custody at a Haringey Borough Police Station, he was examined by a Forensic Medical Examiner and James stated he was bi-polar. This was recorded in the detention and FME log. There is no record of this information being shared with CSC either from the medical professional carrying out the examination or whether it was recommended to the custody officer to complete a Merlin report for onward sharing. It has been confirmed by the Chair of the SCR who carried out further enquiries, that there is no record of James being on any medication for bi-polar or anything health related. The only history given to the GP was a part history of allergic asthma, allergy to nuts and smoking cannabis. The MPS Safety Compliance Investigation team state that there is no responsibility of FME's to inform partners, they complete the National Strategy for Police Information Systems (NSPIS) medical form, it is then for the custody officer to take whatever action is necessary.

[15] Section 20 of the Children Act 1989 (Accommodation) DfE
[16] Statutory guidance on children who run away or going missing from home or care, DfE (2014)

What should be considered? The FME has a responsibility to bring to the attention of Police the medical history disclosed and how it can be determined, if the person does or does not have a particular illness and recorded in the custody detention and FME log. The Police need to remind custody officers to be aware of these situations, to ensure relevant information is shared after a consultation with the FME making the entry. This aspect is further discussed within Chapter 7 Conclusions, Paragraph 14, as there may be learning on the fringes of this review that can be developed. The following suggested recommendation is completed for the decision of the Thurrock Board: -

Thurrock LSCB Overview Report Recommendation (9) for the MPS

It is recommended that the Metropolitan Police Service remind custody officers, that any apparent condition or vulnerabilities disclosed to a Forensic Medical Examiner (FME) by a child or young person in custody, must be risk assessed. If this highlights any risks or concerns, this should be referred to appropriate agency partners by the investigating officer upon the completion of a MERLIN.

FINDING 6 – SAFEGUARDING CONCERNS FOR CHILDREN AND YOUNG PERSONS PRESENTING HOMELESS IN ANOTHER AREA. Are the Thurrock Local Safeguarding Children Board satisfied with?

1) The arrangements and the quality of the recording within Norfolk Constabulary custody records of children and young people are sufficient for safeguarding and accountability?

2) The welfare arrangements by Norfolk Children's Social Care, for a homeless child and young people were satisfactory in providing support and safeguarding the welfare?

What happened? Norfolk Constabulary. James was arrested in their area for an offence of possession of a controlled drug. The standard of the information supplied from Norfolk Constabulary regarding arrested children and young people appears to be unsatisfactory. In James arrest and release on bail, it does not detail sufficient information to exactly know or record the outcome for James. He was apparently watched by a PCSO while Norfolk CSC arranged accommodation for him and then supplied with a travel warrant. It was reliant on the memory of officers, not ideal for accountability. It did not give the rationale as to why the case was subsequently recorded as no further action. The presumption is there was insufficient evidence against him.

What should be considered? There is a need to record all safeguarding arrangements. It should detail how a travel warrant was issued and on whose advice. It should record details of the officers involved and their pocket books details. Records need to capture any agreement with Norfolk CSC as to the onward safeguarding arrangement for a vulnerable young person, as James was allowed to travel home alone.

What happened? Norfolk CSC. James presented as homeless to the CSC after his arrest and released on bail from Police custody. His father initially would not allow him home and he became the responsibility of Norfolk CSC. Subsequently the Norfolk Social Worker in contact with his father agreed he could return to him and was provided with a travel warrant. He was allowed to travel

home, unaccompanied late at night and he missed his train. The Social Worker reported him missing as he could not be found. He remained missing for a significant period.

What should be considered? The CSC should have followed good practice under the Children Act 1989 and accommodated him for an assessment and not allow him to travel home alone late at night. This is a safeguarding issue and the welfare of the young person was not thoroughly considered and resulted in a vulnerable person going missing. The following suggested recommendations are submitted for the decision of the Thurrock Board: -

Thurrock LSCB Overview Report Recommendation (10) for Norfolk Constabulary

It is recommended that Norfolk Constabulary review their custody safeguarding arrangements for the detention and supervision of children and young people within their care. This is to ensure that Police records accurately record all safeguarding arrangements and action agreed with Children Social Care for the outcome and welfare of children and young people within their custody.

Thurrock LSCB Overview Report Recommendation (11) for Norfolk Children Social Care.

It is recommended that Norfolk Children Social Care, review their compliance to the Children Act 1989 for children and young people presenting as homeless in their area, as to their safeguarding and welfare arrangements for vulnerable children and young people.

CHAPTER 7 – CONCLUSIONS

Predictability

1. James death was not predictable. There had been extensive professional interaction with him and contact with his family in the latter period of his life. The findings and learning identified for agencies, were on the fringes of the review and did not affect or contribute to the final tragic outcome of events.

Preventability

2. Professionals on all available knowledge and information, could not have foreseen or were able to prevent the outcome of James' death. There were no previous concerns or behaviour known to family or practitioners to contemplate that James would take his own life or commit self-harm, even within the last few hours before he was found collapsed in his bedroom at his placement.

Conclusions

3. Recognition of the efforts of key practitioners to support James. The fact that there is some learning identified and addressed within the agency and suggested overview report recommendations, should not detract from the enormous amount of professional involvement, resources and hard work provided to support this young person. Overall, services and support was constantly provided for James.

4. James' engagement with professionals and family. He was a troubled adolescent who consistently failed to engage with the services offered to support him and this has been acknowledged by his parents to the IOA. Whether his persistent use of cannabis had any effect on his decision making cannot be determined within this review, as there was no satisfactory Mental Health Assessment carried out and is subject to comment and recommendations within this Overview Report. It is the view of the IOA that James did on occasions engage with professionals and family members, in particular after his arrests and when he was spoken to at length by the Placement Director, which was positive. However, James did not consistently engage with professionals. There is clear evidence provided to this SCR that supports this assumption. He only engaged with one return interview with Open Door and declined other attempts. Important information and follow up conversations with him after he returned from his missing person episodes, requiring to know his movements and whether he was being exploited, were declined by James or he was non-committal. He attended his three LAC Reviews at his placement but left on one occasion as he was not happy. He attended the dentist on one occasion and his GP on two occasions but had to be escorted to his appointments to ensure he attended. This view is also supported by information provided to this SCR from BUBIC, Insight, Princes Trust, Social Workers, his Personal Adviser, placement support workers and police. Overwhelmingly, he did not fully engage and his reasoning is not known to this review.

5. James was always determined to return to Hackney which his father believed was detrimental to his son. His non-engagement with Insight (Haringey) after his referral to CAMHS was declined, attempted to assess whether his behaviour was due to his drug habit or for other reasons. As CAMHS did not carry out any mental health assessment, whether it would have had a different outcome is pure speculation. It was likely he would not readily have engaged and in the opinion of his mother, that is a realistic assumption. There is no evidence to suggest these factors effected or impacted anyway on the subsequent death of James.

6. Analysis was evidenced by examining the interaction and support James had with key professionals obtained from interviews with practitioners and through agency submissions to the review. His father states he could be secretive and would not listen to the good advice from professionals and family and this view was supported in the family interview with James' mother and step-father. The father was the main family member supporting the practitioners to help him while he was a LAC and would often become frustrated with his sons intolerance to reason. He made it clear that he would have allowed his son to live with him, if he gave up his cannabis habit which he personally believed, was affecting him mentally and to follow behavioural guidelines in the home. His father had also discussed options for him to go to Ghana or to a paternal uncle in the USA. There was even talk about jointly become involved with property development, utilising the equity from a small property the father had.

7. There were repeated attempts by Thurrock CSC in particular from SW2, his Personal Adviser and key workers in his placement to get him to refrain from the use of cannabis and are well recorded. James who could be shy and withdrawn, could also be determined and would not engage, a consistent factor. He was an intelligent young man, which his educational GCSE examination results show, but he had his own mind, as can be expected of a young adolescent seventeen year old.

8. There is nothing known that confirms he was affiliated to any gang, as he was not on any Police gang matrix. It can be assumed however, that his criminal offending showed the signs to suggest that he had some form of gang association. He was spending more money than his weekly allowance supplied to him at intervals through the week by his placement. There was also the need to feed his cannabis habit suggesting he was supplying drugs to get the finances which his parents and practitioners suspected but never witnessed.

9. Exploitation. It appears that there were external factors that may have influenced his decisions. It is likely that he was used or enticed by others who had a financial hold on him, to the extent that he could have been exploited to commit crime. On one occasion when SW2 attended Placement 1, he saw two males waiting outside the premises whose disposition and flagrant display of gold and jewellery had a noticeable effect on James who appeared anxious. James it is known, visited other parts of the country often for several days at a time. His method was that of a young person coerced to travel to other areas along "County Lines" by gangs or others in order to commit crime. He attended areas frequented by other young people and in Cambridge he was in an area known for drugs dealing where he had no contacts, in circumstances that implies he was supplying drugs. This suggests others were supplying him with the necessary funds, illegal drugs and directing him to targeted areas to supply drugs to others.

10. This is a national problem acknowledged by the Home Office in their Ending Gang and Youth Violence (EGYV) programme which began in 2011. They recently promoted "Ending Gang Violence and Exploitation a Practitioners Guidance for Local Assessment Process (LAP) 2016[17]. As a result, Thurrock have issued their own Gang and Youth Violence LAP (February 2016). Under Chapter 6 Findings, of the overview report, it is suggested that further identification of suitable LAC placements, for those particularly vulnerable to gang association, is made for the safeguarding and welfare of LAC.

11. Opportunities to intervene prior to James death. We do not know what was on James mind or whether he really meant to harm himself when he placed the bed sheet around his neck. What is

[1717] Ending Gang Exploitation and Violence a Practitioner Guidance for Local Assessment Process, Home Office 2016

clear, neither family nor professionals who knew or worked with him, had heard him speak about taking his own life or to self-harm. As previously mentioned, it came as a surprise to everybody. Even though he struggled in his relationships with his parents, they still miss him and cannot understand why it happened. There was therefore, no possibility or prior knowledge to be able to intervene, to stop the dangerous action that he carried out. As the HO Pathologist records, when describing suspension, death could be immediate or within seconds.

12. Alternatives to consider for the future All 32 London Boroughs have a MASH and have signed up to run regular multi-agency Integrated Gangs Team meetings (not all London Boroughs have a gang team.) If there are issues of Gang and Youth Violence, this is an additional forum if the concern relates to Thurrock. A Thurrock practitioner could attend, discuss, share and capture information to promote a wider understanding. (This is only a suggestion to support the Thurrock's Local Assessment Process.) If in future a LAC persistently goes missing in a London placement, consideration should be made to contact the appropriate local borough MPS Missing Person Coordinator for advice or support, as it is their role to look at ways to prevent children and young people from going missing and to respond effectively to minimise the harm associated with missing person episodes.

13. Conclusions. The Overview Report's analysis of events for the review, was obtained from the contributions from within individual Agency IMR's, summary and other ancillary reports submitted to the review, including the participation and views of the family. Within Thurrock Serious Case Review Panel meetings, the IOA presented to the SCR Panel the findings and themes for discussion and challenge, identified in compiling the review, in order for the panel to critically examine the circumstances that lead to the tragic death of James. Where improvements and changes to policy and procedures were needed, if not already implemented, agencies made recommendations for lessons to be learnt, to challenge any shortfall. **(See suggested Agency Recommendations at Appendix 4 below.)**

14. Learning on the fringes of this review. The issues below were identified and raised within Agency IMR's and within SCR Panel meetings. It is suggested they should be addressed outside the processes of this SCR, to establish whether there are further lessons to be learnt.

- Thurrock Health Services. The bipolar comment James made whilst in custody, has been addressed within the Metropolitan Police TLSCB Overview Report Recommendation (9). However, Thurrock Health Services providers, should consider with NHS England whether there is a wider learning of the requirement for FME's to also share this information and not as present, a required police responsibility, as this review has established.
- Police - National Police Chiefs Council (NPCC). The TLSCB Overview Report Recommendation for the MPS discussed above, will allow Multi Agency Safeguarding Hubs (MASH) established throughout the MPS area, to be notified by the completion of a MERLIN (Come to Notice form.) This allows the information of a reported or established medical condition of a young person in custody to be risk assessed, with an opportunity to stimulate effective communication, ensuring relevant information is appropriately shared. However not all Police Forces have the same facility and practice. It is the view of this SCR, outside of the process, that there should be a dialogue with the NPCC for them to consider the wider implications and requirement to review police practice nationally in this respect. The need to seriously consider this suggestion is further supported (but not expanded upon within this report) by Thurrock LSCB. They have another current serious case review (SCR Harry) with similar concerns in relation to the sharing of information by police of a young person in custody with a medical condition. This could be an opportunity for the NPCC to support all Police Forces by creating clear procedural guidelines to address any evident risk or concern.

- NELFT. Their IMR Recommendations highlighted that Thurrock CSC could inform health professionals of the details of vulnerable young people in need of CIN Plans, to determine the level of Universal Health Services to be provided and also further suggested Thurrock CCG, consider commissioning a programme for keeping young people from becoming NEET. **(See NELFT Agency Recommendations 1 and 2.)**
- Education. Two issues regarding EWS and within Education were recently highlighted and could be considered. They are suggestions only which do not impact upon the findings of this SCR. The first issue was when James was apparently taken off School 4's roll for extremely poor attendance. With the assistance of the EWS, James was successfully reinstated back on the school role and went on to achieve good GCSE results and noticeably improved attendance. There is a requirement that a pupil should not be taken off a school roll until the forwarding school is known.
- The second issue relates to when James finished Year 11. He was offered a place in further education, an option he decided not to take up. It is not known what arrangements were made for onward planning to keep him from being NEET. What is known however, is that James became a Child in Need in the October 2014, a very short period after he could have commenced his further education? At that juncture, Thurrock CSC appointed him a Personal Adviser who attempted to work with him, to stop him being NEET. A recent follow up with the Careers Team confirmed that tracking letters were sent and his case would have been picked up during the term, whether or not he was a CIN. The SCRP Education Representative with Thurrock EWS may wish to consider these comments further as to the continuity and tracking of such cases and decide whether there may be lessons to be learnt for the future.

Comment: The comments above, are learning on the fringes of this review and do not impact on the Overview Report conclusions. Further consideration as to their feasibility and application is required and are suggested to stimulate further discussion. Any learning, implementation or outcomes should be reported to the TLSCB for inclusion into the TLSCB Action Plan that follows and supports this Overview Report.

15. No family member or professional knew any of James' friends or associates. He did not mix with other residents in his placements, remaining withdrawn and kept to himself, normally in his room. He was secretive and would not divulge any information readily. As he reportedly stated himself, he did not like being asked questions. James was at an age where he could make his own decisions but even though he was in a semi-independent placement, reasonable boundaries were set, which he repeatedly tested either by going missing or with his unauthorised absences and his behaviour towards others. It appeared to SW2 that Placement 2 was a better environment and both he, his Personal Adviser and the IRO were hopeful for his future, that makes his unexpected death the more difficult to accept.

16. This review can only surmise the pressures on him after he had a large quantity of drugs and cash taken from him on his arrest in Cambridgeshire, as to what additional worries he may have had? We will never know and James was of the disposition that he would not disclose any information. In discussions post his arrest in Cambridge with professionals, he stated "my past is catching up with me." However James was aware of the support available to him, but he chose not take up any option of help and this SCR cannot answer the reason why.

17. With this serious matter outstanding, together with him failing to appear at Court for his affray charge, his fragmented relationship with his parents, the possibility of others putting pressures on him, how cannabis was affecting him, whether he had any mental health issues, the possibility of going to prison and any other unknown concern, is not insignificant. We cannot determine with any degree of certainty the reason why he carried out the action that ultimately lead to his death. In

reiteration, his death was unexpected and a total surprise to his family and professionals that knew and worked with him.

18. The Coroner recorded an Open Verdict because he could not, with any degree of certainty, be sure that James intended to take his own life. The Coroners judgement carries significant weight, supported by the details within the Home Office Pathologist Report on the effect of death by suspension, as to whether James' death was preventable or predictable which, this serious case review believes it was not. Learning for agencies, as previously stated, are on the fringes and did not impact on James' death.

19. This independent overview report is submitted to Thurrock Local Safeguarding Children Board for the Thurrock Board to consider the Findings at Chapter 6 and the recommendations at Appendix 4 of this report. The aim is to capture any lessons to be learnt and to ensure effective change is implemented to safeguard the welfare of children and young people.

CHAPTER 8 – THURROCK LSCB INITIAL RESPONSE

Response to Serious Case Review James from the Chair of Thurrock LSCB

James's death was both unexpected and shocking to his family and professionals who worked with him. When the circumstances were referred to me I felt it was really important that we understand more about his life and to see if there were lessons that could improve how the partnership of agencies work to keep our young people safe. Thurrock LSCB will make sure that all agencies have put in place effective responses that ensure that learning from this review does improve the way professionals keep children and young people safe in the future.

It is clear that the findings show a number of positive areas where effective multi-agency working took place alongside missed opportunities and a need to revisit some procedures.

This review identified that it was not possible to have predicted the tragic death of James. It has enabled professionals to look at their actions to see if there was anything that could be done in future to further improve working between agencies in particular for children who are Looked After where the risks of gang influences and criminal activity may be involved.

The findings and issues for consideration from the review have been endorsed by those agencies involved who have already begun to make changes based on the review's findings. James parents have also been involved during the process and contributed to the review outcomes which have been shared with them.

Detailed learning plans are being undertaken by individual agencies in response to the findings and the questions posed to the Board by the Review Author. The Board through its Serious Case Review (SCR) Sub Group will monitor the review and the progress of these plans on both a short and long term basis.

Thurrock LSCB undertakes:

- To oversee the implementation of single agency learning plans arising from this review and reflect on progress in the Annual Report.
- In overseeing the implementation, the LSCB will establish timescales for action to be taken, agree success criteria and assess the impact of the actions.
- The SCR Sub Group of the LSCB will actively monitor progress on actions from the agencies by requiring updates quarterly.
- That all the findings from the Serious Case Review are assessed by the LSCB Training Sub Group to ensure multi-agency programmes commissioned by the LSCB reflect the learning.
- All agencies that had involvement with this SCR have been asked to ensure their practitioners have been given feedback from the review prior to the publication of the final report.
- At the point of publication, to ensure that the wider workforce is aware of the learning, the LSCB will also publish a SCR booklet. This will set out the key findings from the review, and also offer links to further advice and guidance should practitioners need it.

- A quarterly summary on progress on actions will be provided to the Full Board.
- Learning from this SCR will be incorporated into LSCB 'Learning from Review Sessions' delivered as part of the Learning and Improvement Framework.
- Thurrock LSCB will require partner agencies, as part of single agency Quality Assurance (QA) procedures, to undertake case file audit which incorporates a review of the findings identified.
- Thurrock LSCB Audit Sub Group will receive from single agencies 'quality assurance audit reports' which will provide findings from audit activity and detail of remedial actions implemented in response to any findings.

This Serious Case Review will be published on the Thurrock LSCB and NSPCC website to enable other Safeguarding Boards and Agencies to take any learning from the review.

Dave Peplow
Independent Chair

Appendix 1 - Biography

The Independent Chair, Helen Gregory is a Named Nurse for Safeguarding Children with NELFT NHS Foundation Trust. She has been a registered nurse for 30 years, and has specialised in Safeguarding Children since 2010. Helen holds a BSc (Hons), Specialist Community Public Health Nursing degree and a PG certificate in Safeguarding Children.

The Independent Overview 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) now The National Police Chiefs Council (NPCC), 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 invited to participate in the DfE funded NSPCC and SCIE led " Learning into Practice Project (LiPP) for improving SCR's (2016) to look at quality markers for Lead Reviewers. David is on the Association of Independent LSCB Chairs, National Directory as an SCR Lead Reviewer/Author.

Acknowledgements

The Independent Overview Author would like to take the opportunity to thank the family for their personal contribution to the serious case review. The review also could not have been completed without the valued assistance of the Thurrock Local Safeguarding Children Board's administration support and the assistance of the TLSCB Manager, the SCR Chair and panel members.

Appendix 2 - Bibliography

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Appendix 3 – Glossary of terms

AST	Adolescent Services Team	**EIF**	Early Intervention Foundation (HO)
BUBIC	Tottenham Drug Service	**EDT**	Emergency Duty Team
BTP	British Transport Police	**EGYV**	Ending Gang and Youth Violence
CAF	Common Assessment Framework	**EWS**	Education Welfare Service
CAMHS	Child Adolescent Mental Health Service	**FGC**	Family Group Conference
CCG	Clinical Commissioning Group	**FME**	Forensic Medical Examiner
CCST	Children's Commissioning Service	**FTA**	Failure to Attend
CID	Criminal Investigation Department	**Form 101**	Police referral form
COMPACT	Essex Police computer system	**GP**	General Practitioner
CSC	Children Social Care	**HMRC**	Her Majesty Revenue & Customs
CSE	Child Sexual Exploitation	**HO**	Home Office
CYPR	Child or Young Person at Risk	**IHA**	Initial Health Assessment
DfE	Department of Education	**IMR**	Individual Management Report
DN	Designated Nurse	**IPA**	Individual Placement Agreement
DoH	Department of Health	**IOA**	Independent Overview Author
DPS	Directorate of Professional Services	**Insight (Haringey)**	Drugs Advocacy

IRO	Independent Reviewing Officer	**NSPIS**	National Strategy for Police Information Systems
IRT	Initial Response Team	**Ofsted**	Office for Standards in Education, Children's Services and Skills.
LAC	Looked After Children	**OR**	Overview Report
LAC PLACEMENT 1	Same company. Details known TLSCB	**PA**	Personal Adviser
LAC PLACEMENT 2	Same company. Details known TLSCB	**PEP**	Personal Education Plan
LAP	Local Assessment Process	**PENY**	Cambridgeshire Police electronic notification system
LAS	London Ambulance Service	**PNC**	Police National Computer
London Court	Known to TLSCB	**SAL**	Student Achievement Leader
MASH	Multi Agency Safeguarding Hub	**School 1**	Known to TLSCB
Merlin	MPS come to notice form	**School 2**	Known to TLSCB
MOJ	Ministry of Justice	**School 3**	Known to TLSCB
MPS	Metropolitan Police Service	**School 4**	Known to TLSCB
NEET	Not in education, employment or training	**SCR**	Serious Case Review
NELFT	North East London Foundation Trust	**SCRP**	Serious Case Review Panel
NFA	No further action	**SD**	Strategy Discussion
NHS	National Health Service	**SET**	Southend, Essex and Thurrock
NPCC	National Police Chiefs Council	**SN**	School Nurse
SDQ	Strengths and Difficulties Questionnaire	**TOR**	Terms of reference
SOCO	Scenes of Crime Officer	**TLSCB**	Thurrock Local Safeguarding Children Board
SW	Social Worker	**YOS**	Youth Offender Service

Appendix 4 - Recommendations

Listed below are the suggested TLSCB Overview Report Recommendations, together with individual agencies recommendations, from Individual Management Reports and Summary Reports that have been reviewed and quality assured within their respective agencies. All agency recommendations have been considered and accepted after consultation by the IOA and the SCR Panel. The measurability, action taken by the agencies and timeliness for the completion of all recommendations are contained within the TLSCB's Action plan that will accompany this overview report. The suggested overview report recommendations are for The Thurrock Board to consider together with the Individual Agencies Recommendations for their determination as follows:-

Suggested TLSCB Overview Report Recommendations:

Thurrock LSCB Overview Report National Recommendation (1) for Inspection of LAC Placements.

It is recommended that the Department for Education consider the wider remit for Looked after Children inspections to include:-

- The implementation of Ofsted inspections for all LAC provisions, regardless of the type of placement provided.
- An inspection to monitor the commissioning and compliance, checks by the local authority as to the suitability of the placement, experience of placement staff and financial checks made as to the stability of the company and board of directors, providing the service provision.
- An opportunity for DfE and Ofsted enhancing support for local authorities, with the consideration of developing a national directory of suitable LAC service provider companies and directors in the industry.

Thurrock LSCB Overview Report Recommendation (2) for Thurrock Children Social Care.

It is recommended that Thurrock LSCB require, Thurrock Children's Commissioning and Service Transformation, to carry out a review of the supervision of commissioned contracts and spot purchases of LAC placements to ensure the continued stability of the accommodation for Looked After Children.

Thurrock LSCB Overview Report Recommendation (3) for Thurrock Children Social Care.

It is recommended that Thurrock LSCB require, Thurrock Children's Commissioning and Service Transformation, to share relevant information of concerns obtained from financial checks and scrutiny of their LAC placement service providers, with other regional local authority commissioning services, to ensure that only appropriate and viable contracts are awarded.

Thurrock LSCB Overview Report Recommendation (4) for Thurrock Children Social Care.

It is recommended that Thurrock Children Social Care review the Thurrock Gang and Youth Violence, Local Authority Process, 2016 to include commissioning checks to the suitability of the location of LAC Placements to ensure that vulnerable children and young people are not placed in an area of significant gang and youth violence.

Thurrock LSCB Overview Report Recommendation (5) for Thurrock Children Social Care and NELFT.

It is recommended that Thurrock LSCB require Thurrock Children Social Care and NELFT, review LAC Care Plans and LAC Reviews, to ensure outstanding Mental Health assessments are notified and if required, escalated to the Thurrock Clinical Commissioning Group or appropriate partner agencies, in order that outstanding assessments are followed up and completed to a satisfactory standard, with the rationale recorded.

Thurrock LSCB Overview Report Recommendation (6) for Thurrock Clinical Commissioning Group.

It is recommended that Thurrock LSCB request NHS Thurrock Clinical Commissioning Group under the Responsible Commissioners Arrangement, to escalate and provide support when notified by partner agencies, where a health practitioner makes a mental health referral for children and young people, which remains outstanding. This is in order to obtain a satisfactory outcome for the patient, with the rationale of the decisions recorded on the patients' health file by the provider organisation.

Thurrock LSCB Overview Report Recommendation (7) for Thurrock Children Social Care, NHS Thurrock Clinical Commissioning Group and NELFT.

It is recommended that Thurrock LSCB require Thurrock Children Social Care, NHS Thurrock Clinical Commissioning Group and NELFT, to ensure that when a Strength and Difficulties Questionnaire (SDQ) identifies that a LAC has been assessed with severe difficulties, there is a robust system in place to track these high risk cases with appropriate intervention levels and effective pathways established and applied, to address the concerns in support of the LAC.

Thurrock LSCB Overview Report Recommendation (8) for Thurrock Children Social Care.

It is recommended that Thurrock CSC ensure that supervisors and LAC Independent Reviewing Officers (IRO), develop a matrix for the early identification of escalating concerns with LAC and of action taken to address those concerns. This should include an effective system to monitor and distribute LAC minutes to appropriate key practitioners to guarantee that any actions identified are satisfactorily completed. Any interventions can be reflected within the IRO annual report for monitoring purposes.

Thurrock LSCB Overview Report Recommendation (9) for the MPS

It is recommended that the Metropolitan Police Service remind custody officers, that any apparent condition or vulnerabilities disclosed to a Forensic Medical Examiner (FME) by a child or young person in custody, must be risk assessed. If this highlights any risks or concerns, this should be referred to appropriate agency partners by the investigating officer upon the completion of a MERLIN.

Thurrock LSCB Overview Report Recommendation (10) for Norfolk Constabulary

It is recommended that Norfolk Constabulary review their custody safeguarding arrangements for the detention and supervision of children and young people within their care. This is to ensure that Police records accurately record all safeguarding arrangements and action agreed with Children Social Care for the outcome and welfare of children and young people within their custody.

Thurrock LSCB Overview Report Recommendation (11) for Norfolk Children Social Care.

It is recommended that Norfolk Children Social Care, review their compliance to the Children Act 1989 for children and young people presenting as homeless in their area, as to their safeguarding and welfare arrangements for vulnerable children and young people.

Agency IMR Recommendations:

The following are individual agencies own recommendations as supplied in their agency IMR's and reports.

Cambridge Constabulary

At the time of his arrest the reporting/arresting officer should have completed Form101 (Child at Risk) referral. However safeguarding checks were carried out and it was noted that James was a missing person from London and liaised with the MPS who after he was released on bail attended and escorted him back to his placement.

Recommendation 1: Further guidance is proposed to be circulated to all operational staff for compliance of completing Form 101 Child at Risk referral Forms.

Recommendation 2: For all custody officers to be canvassed to identify the training needs and awareness of their safeguarding responsibilities and implement any training accordingly.

The IMR also suggested two local aspirational recommendations which do not impact on this SCR and are not included.

School 4

The school did not always receive a response to referrals made to other agencies.

Recommendation 1: If the Academy makes a referral to an outside agency and does not receive a response, the Safeguarding Officer will intervene with a letter of concern to the relevant agency and their immediate line manager, sent with a date of an expected response.

Thurrock Clinical Commissioning Group

Recommendations comply with practices with "The GP Patient Registration Standard Operating Principles for Primary Medical Care" in relation to a child being seen on registration with the practice. These recommendations were subject to a late change.

Recommendation 1: Thurrock Clinical Commissioning Group should ensure that GP practices comply with the Guidance on Patient Registration, Standard Operating Principles for Primary Medical Care (NHSE 2015) and to incorporate guidance within training at GP Forums and Level 3 Safeguarding Training.

Recommendation 2: Thurrock Clinical Commissioning Group should review governance and information sharing following attendance at Thurrock Placement Panel meetings.

Thurrock Children Social Care

Recommendation 1: Thurrock Children Social Care commissioning, to ensure that the LAC Placement needs of the child and young people are specified and placement staff have the requisite skills.

Recommendation 2: Thurrock LSCB Learning and Development Group to arrange training to support workers to identify:

- Risk of self-harm.
- Substance misuse.
- Gang activity.

- Identifying and managing risk.
- Adolescent neglect including using the adolescent tool.

NELFT

Recommendation 1: NELFT should ensure that Universal Health Services receive information from Children's Social Care in relation to children and young people subject to a Child In Need Plan to enable the appropriate level of service to be offered.

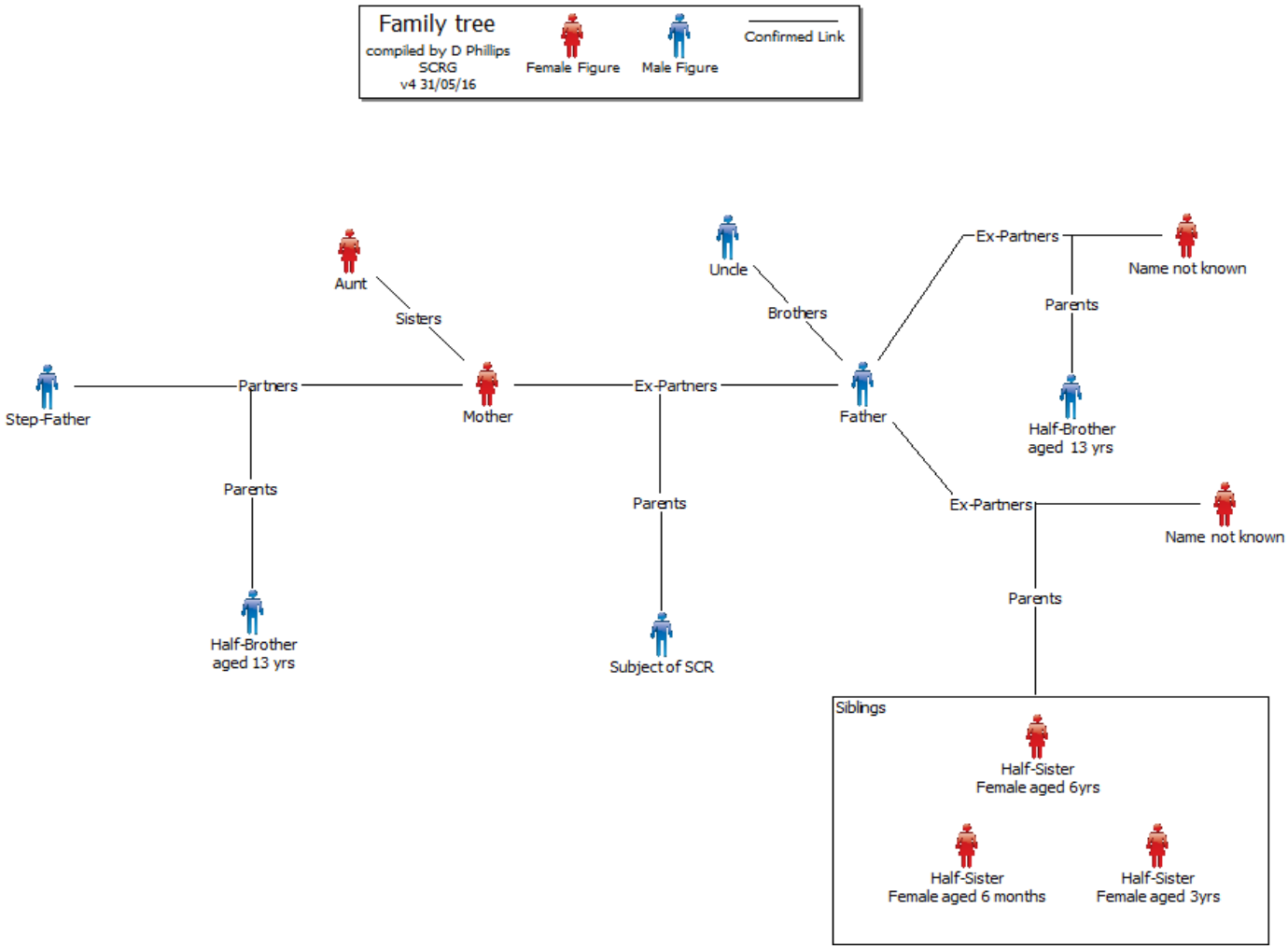
Comment: - This suggested recommendation is learning on the fringes of this review and is raised within the Conclusions in Chapter 7.

Recommendation 2: NELFT should ensure that School Nurses follow up incidents of domestic violence against children and young people, particularly where the young person is out of school and NEET. (Not in Education, Employment or Training.)

Comment: - The NELFT IMR further suggested that consideration be given by Thurrock CCG to commission a service for young people aged 16 to 18 years of age who are NEET. (Not in Education, Employment or Training.) It is the view of this SCR that this is learning on the fringes. It can be further considered outside the process, when considering the TLSCB Action Plan that will follow this Overview Report. (See Chapter 7 Conclusions for Learning on the fringes of the review.)

Recommendation 3: NELFT should ensure that where there is uncertainty around a child and young person's immunisation status, Health Practitioners should actively follow up and confirm whether the immunisation has been received and ensure that the child, young person and parent/carer are aware.

Recommendation 4: NELFT should ensure that the NELFT Looked After Children (LAC) Team embed a robust record keeping and follow-up process in terms of health assessments and any delays reported to the Designated Nurse for LAC and the Local Authority, with specific attention and monitoring applied to the vulnerability of LAC, placed out of the area.



Appendix 5 – Family Tree

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20 December 2016	ITEM: 12
Children's Services Overview and Scrutiny Committee	
Performance Dashboard	
Wards and communities affected: All	**Key Decision:** To note Action Plan
Report of: Andrew Carter, Head of Children's Social Care	
Accountable Head of Service: Andrew Carter, Children's Social Care (CATO)	
Accountable Director: Rory Patterson, Corporate Director of Children's Services	
This report is Public	

Executive Summary

This covering report introduces the Children's Social Care Dashboard. The Dashboard sets out to provide members of Children's Overview and Scrutiny with a range of performance data / measures for Children's Social Care. The Portfolio Holders for Education and Children's Social Care have established an Improvement Plan Overview Group to provide an additional layer of oversight and challenge. This is to ensure officers maintain high ambitions for the service and improvements are implemented with pace.

1. Recommendations

1.1 That Children's Overview and Scrutiny consider if the current Dashboard covers the areas that the committee wishes to focus on and identifies any other areas for scrutiny.

1.2 That Children's Overview and Scrutiny receive assurance as to the current functioning and performance of Children's Social Care.

1.3 That Children's Overview and Scrutiny identify any areas that they would require a 'deep-dive' analysis of.

2. Introduction and Background

2.1 The attached report has been prepared following discussion with Children's Overview and Scrutiny. The Director of Children's Services proposed and members agreed that it would be useful to have detailed performance information in relation to Children's Social Care.

2.2 The attached report is the first draft of the Dashboard and members are asked to consider if the information provided meets their requirements and what additional information or changes they would like.

3. Issues, Options and Analysis of Options

Please see attached Dashboard.

4. Reasons for Recommendation

Members have a duty to ensure that children's social care services are performing well and safeguarding and promoting the welfare in their area. The performance dashboard is a key element in judging how well the service is delivering against its statutory requirements.

5. Impact on corporate policies, priorities, performance and community impact

Ensuring the effective performance of Children's Social Care in protecting the vulnerable and promoting best outcomes, is a key priority for the Council.

Closely tracking performance will allow the Council to ensure best value and effective outcomes in meeting key statutory requirements.

6. Implications

6.1 Financial

Implications verified by: **Kay Goodacre**
Finance Manager

It is vital that the Council understands current and future demand pressures and what these mean for the budget. An increase in demand pressures in Children's Social Care is generating a considerable overspend.

6.2 Legal

Implications verified by: **Lindsay Marks**
Principal Solicitor, Children's Safeguarding

The Local Authority has a statutory duty to provide services to children in need of help and protection, failure to effectively do so could lead to legal challenges and reputational damage. Key performance indicators and accurate data allow the Council to monitor and ensure that it is appropriately discharging its statutory duties.

6.3 **Diversity and Equality**

Implications verified by: **Becky Price**

Community Development Officer

The local authority and its partners must ensure that a range of services and provision is in place to protect children from all backgrounds. A focus on diversity within future Dashboards would be helpful.

6.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

N/A

7. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

Performance Dashboard November 2016

8. Appendices to the report

Appendix 1 - Performance Dashboard November 2016

Report Author:

Andrew Carter
Head of Service
Children's Social Care

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Children's Services Overview and Scrutiny Report December-2016

Looked After Children

(Data taken on 31st October 2016)

Total number of Looked After Children (LAC)	356
– Number of Looked After Children per 10,000 child population	87
– Number of LAC that are Unaccompanied Asylum-Seeking Children	90

The current rate of looked after children is 87 per 10,000 population of children in Thurrock. This is significantly higher than the national average of 60 per 10,000 and statistical neighbours of 68 per 10,000 on 31st March 2016. The number of looked after children have also increased since 31st March 2016 from 333 to 356. This is entirely down to the increase of unaccompanied asylum seeking children (UASC) from 67 on 31st March to 92 at the end of October. Numbers of other looked after children have actually fallen by 9 children since 31st March. Without the UASC the rate per 10,000 would be 65 which is close to the national average for looked after children and below the statistical neighbour average.

Number of Children Looked After since before 01-Apr-2016	269
– Number of LAC in 3 or more placements since 01-Apr-2016	5

There are 269 of the 356 looked after children that have been looked after since April 2016. Of these children, 5 have moved placement at least twice (lived in at least 3 placements since April). Looked after placements are continually monitored to ensure they are the most suitable placement for the child. The national average for 3 or more placements during a year is 10% (2015-16).

Percentage of placements that are *In Borough*	32%
Percentage of placements that are *Out of Borough*	68%

113 of the 356 looked after children are currently placed in Thurrock. Nationally the percentage of looked after children placed within the council boundary is 62% (2015-16). This figure will vary for each council depending on the size of the borough and location. There is a current focus to increase the percentage of placements within Thurrock.

Child Protection

(Data taken on 31st October 2016)

Total number on a Child Protection Plan	299
– Number on a Child Protection Plan per 10,000 child population	73
– Number on a Child Protection Plan for the second or subsequent time	80

The current rate of children on a Child Protection Plan (CP Plan) is 73 per 10,000 population of children in Thurrock. This is significantly higher than the national average of 43 per 10,000 and statistical neighbours of 51 per 10,000 on 31st March 2016. The number of children on a CP Plan has also increased since 31st March 2016 from 288 to 299. 80 of the 299 children on a CP Plan have had a CP Plan previously. There has been an increase in the percentage of children becoming subject of a plan for a second or subsequent time nationally with the latest figure at 18% during 2015-16. There was a decrease for Thurrock in that period from 20% to 19%.

Percentage in the *Emotional* abuse category	47%
Percentage in the *Neglect* abuse category	46%
Percentage in the *Physical* abuse category	4%
Percentage in the *Sexual* abuse category	3%
Percentage in multiple abuse categories	0%

There has been an increase in the percentage of children becoming subject of a CP Plan due to emotional abuse which was 25% back in April 2015. This is partially explained due to multiple categories no longer being used in Thurrock which accounted for 15% back in April 2015.

Percentage on a CP Plan for less than 3 months	19%
Percentage on a CP Plan for 3 to 5 months	24%
Percentage on a CP Plan for 6 to 11 months	37%
Percentage on a CP Plan for 1 to 2 years	17%
Percentage on a CP Plan for 2 to 3 years	2%
Percentage on a CP Plan for more than 3 years	1%

The highest proportion of children on a CP Plan is within 6 months to less than 1 year. A low proportion of children are currently subject of a plan for more than 2 years.

Adoption

Number of adoptions between 1st April 2016 and 30th September 2016	5

Average number of days between child entering care and child moving in with adoptive family (taken over a rolling 3 year period up to 30th September 2016)	560

Average number of days between court agreeing adoption and local authority approving a match (taken over a rolling 3 year period up to 30th September 2016)	206

There have been 5 adoptions between 1st April 2016 and 30th September 2016 from 81 children that left care during that period (20 of which were unaccompanied asylum seeking children). There were 12 adoptions during this period in 2015 from 64 children that left care (10 of which were unaccompanied asylum seeking children).

The average number of days between child entering care and child moving in with adoptive family has continued to reduce from 602 days between April 2013 and March 16 to 560 days between October 2013 and September 2016. The national average for 2012-15 was 593 days. No data is available for 2013-16 at present. For the 5 children adopted since April, the average number of days to move in with their adoptive family from becoming looked after is 314 days – a significant improvement.

The Average number of days between court agreeing adoption and local authority approving a match has increased from 189 days between April 2013 and March 16 to 206 days between October 2013 and September 2016. However, this is mainly due to the challenging cohort of children during these periods where two children that were in the previous period were matched to an adoptive family prior to the court agreeing adoption. The national average for 2012-15 was 223 days. No data is available for 2013-16 at present. For the 5 children adopted since April, the average number of days to approve a match is 131.

Total number of approved foster carers	88
- Mainstream carers	73
- *Connected Person* carers	4
- Temporarily-approved carers	9
- *Shared Care* carers	2

Total number of in-house foster placements occupied	105
- Number of children placed in-house (including *Shared Care* and *Connected People*)	99
- Number of care leavers on *Staying Put Agreements*	6

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Children's Services Overview & Scrutiny Committee
Work Programme
2016/17

Dates of Meetings: 6 July 2016, 13 October 2016, 20 December 2016, 1 February 2017

Topic	Lead Officer	Requested by Officer/Member
	6 July 2016	
Ofsted Report and Action Plan	Andrew Carter	Members
0-19 Wellbeing Model	Bath Capp	Members
Review of Children Centre Services	Andrea Winstone	Members
Serious Case Review Update Actions from Megan	Andrew Carter	Members
13 October 2016		
Educational Attainments	Roger Edwardson	Members
Children's Social Care (CSC) Complaints and Representations Annual Report 2015/16	Anas Matin	Members
Final Report on the Ofsted Action Plan	Andrew Carter	Members
School Capital Programme 2017/18	Janet Clark / Sarah Williams	Members
20 December 2016		
Update on Ofsted Action Plan	Andrew Carter	Members
Update of Child Exploitation	Andrew Carter	Members

Updated: October 2016

School Improvement Peer Report	Roger Edwardson / Andrea Winstone	Members
Academic Report for Children Looked After	Keeley Pullen	Members
Serious Case Reviews for James	Andrew Carter	Members
Performance Dashboard	Andrew Carter / Rory Patterson	Members
1 February 2017		
The implementation of the increase from 15 to 30 hours free childcare from September 2017	Roger Edwardson	Members
Anti-Bullying Prevention at Primary Schools	Malcolm Taylor	Members
Anti-Bullying Policy	Malcolm Taylor	Members
Fees and Charges 2017/18	Laura Last	Officers
School Budgets 2017/18, moving to a National funding Formula	Kay Goodacre	Officers