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.
<u>04.05.15</u> **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).
<u>05.05.15</u> **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.
<u>09.05.15</u> **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.
<u>29.06.15</u> **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.
<u>11.07.15</u>	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.)
<u>14.07.15</u> **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.
<u>15.07.15</u> **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

Care Quality Commission (2010) Guidance about compliance: Essential standards of quality and safety. What providers should do to comply with the section 20 regulations of the Health and Social Care Act 2008, London: CQC.

Children and Families Act, 2014.

Children's Act 1989, 2004 (DfE).

Ending Gang and Youth Violence, Local Assessment Programme, Thurrock (February 2016).

Ending Gang and Youth Violence programme Annual Reports, Home Office 2011 to 2015.

Ending Gang Exploitation and Violence, Practitioners Guidance for Local Assessment Process, Home Office, 2016.

Hale, D and Viner, R (2012).Policy responses to multiple risk behaviours in adolescents. Journal of Public Health 34 (i11-i19).

Information sharing to tackle violence: Audit of progress. The Department of Health initiative how A&E departments and community safety partnerships (CSPs) share non-confidential information to tackle violent crime.

Keeping Children Safe in Education 2014, Department of Education.

Ofsted inspection of Thurrock Safeguarding and looked after children inspection. (June 2012 and April 2016.)

Munro, E (2011) the Munro Review of Child Protection: Final Report. A child-centred system London: DFE.

National Panel of Independent Experts for Serious Case Reviews, 1st Report (July 2014) and the 2nd Report, (November 2015).

Statistical update on suicide, Department of Health (January 2014).

The Law Lords decision R(G) v Southwark LBS (May 2009) in relation to duty on councils to accommodate 16 and 17 year olds under Sec 20 of the Children Act 1989.

Thurrock Serious Case Reviews – Julia and Megan.

Thurrock Children and Young People Plan, 2015 – 2016, Thurrock Children and Young People Partnership.

Working Together to Safeguarding Children (DfE 2006, 2010, 2013 and 2015) Chapter 4.

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.

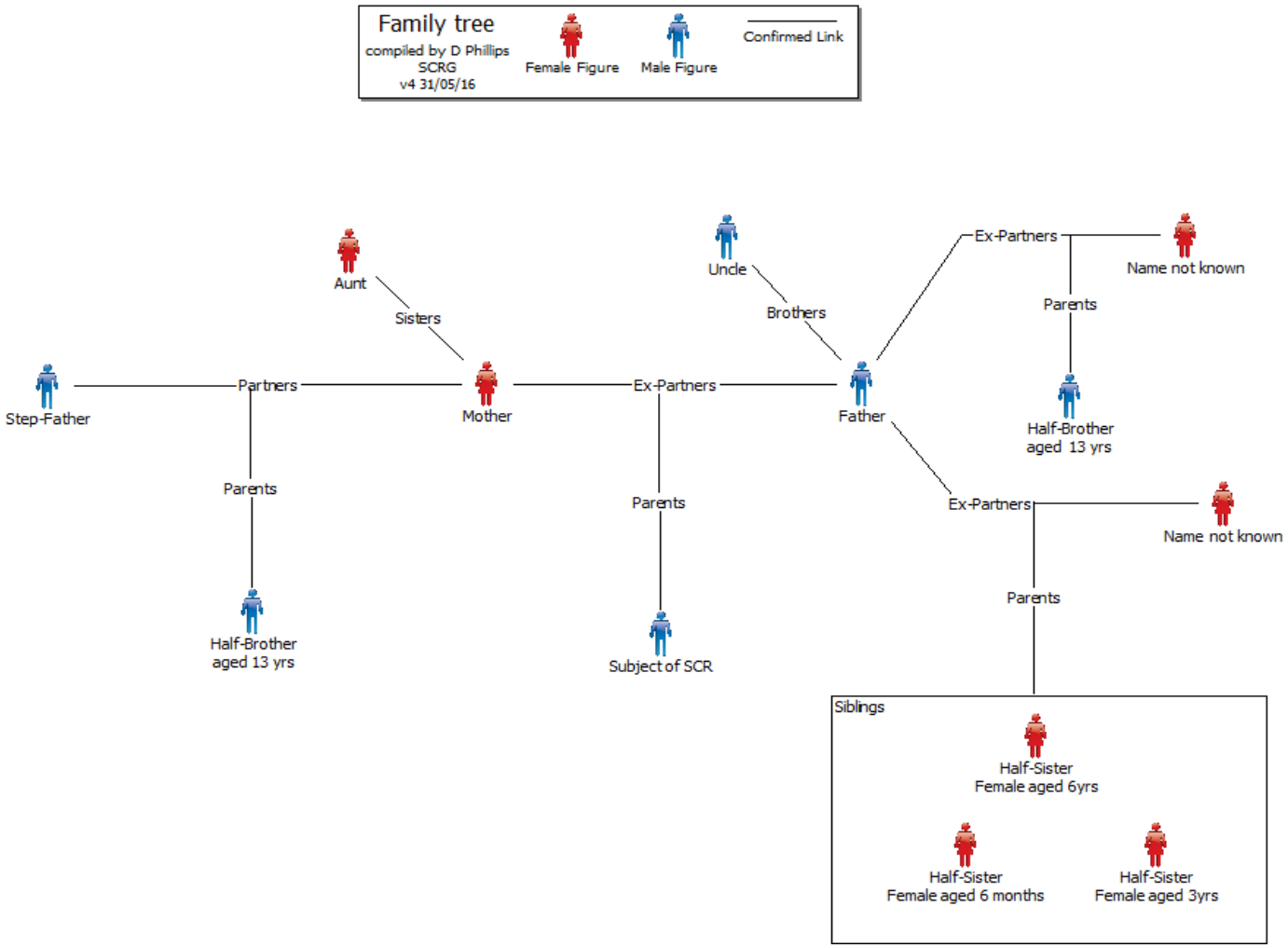
Comment: - This suggested recommendation is learning on the fringes of this review and is raised within the Conclusions in Chapter 7.

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