1 February 2017	ITEM: 8
Children's Services Overview and Scrutiny Committee	
Thurrock Local Children's Safeguarding Board (LSCB), Serious Case Review (SCR) Report - James	
Wards and communities affected: All	**Key Decision:** None
Report of: Andrew Carter, Head of Children's Social Care	
Accountable Head of Service: Andrew Carter, Children's Social Care (CATO)	
Accountable Director: Rory Patterson, Corporate Director of Children's Services	
This report is Public	

Executive Summary

The James Serious Case Review (SCR) was presented to Children's Overview and Scrutiny on 20 December 2016. This covering report summaries again the findings of the review. The full review has been attached to this paper as appendix 2.

The serious case review was undertaken following James's death by suspension, for which the coroner has recorded an 'Open Verdict'. A multi-agency Action Plan has been developed based on the recommendations of the review.

Agreement is pending from partner agencies to share in full their actions as part of the responses to the recommendations. Therefore as in previous reviews an interim update on the recommendations has been provided based on actions by Thurrock Children's Service. The responses to the recommendations have been included as appendix 1.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the requirement for Local Safeguarding Children's Boards to undertake reviews of serious cases where:

a) Abuse or neglect of a child is known or suspected; and

b) Either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the Authority, their Board Partners or other relevant persons have worked together to safeguard the child.

Based on the review, professionals on all available knowledge and information could not have foreseen or were able to prevent the outcome of James' death. There were no previous concerns or behaviour known to family or practitioners to contemplate

that James might take his own life or commit self-harm; even within the last few hours before he was found collapsed in his bedroom at his placement.

The James Serious Case Review identified six findings the Safeguarding Board need to consider with 11 associated recommendations. Those agencies that worked or supported James have been involved in this SCR and some changes have already taken place to improve our systems and processes.

1. Recommendations

1.1 Children's Overview and Scrutiny Committee consider the progress to date by Children's Services as set out in the responses to the SCR recommendations at appendix A.

1.2 Children's Overview and Scrutiny Committee track progress by Children's Services in responding to the recommendations of the review.

2. Introduction and Background

2.1 Methodology

2.2 The focus of this case review was to use a systems approach looking at multi-agency professional practice through a series of questions.

- Did all agencies work together effectively to safeguard this young person?
- Was the outcome preventable?
- We're safeguarding procedures followed appropriately?
- Was the young person's voice heard throughout agencies involvement?

2.3 The parents of James took part in the review and have been very supportive providing helpful information to assist in understanding James life.

2.4 <u>Background</u>

2.5 James was born in Hackney to parents of Ghanaian heritage. His parents divorced in 2001. After spending some time abroad with relatives James was brought up in his early years by his mother and both parents moved on to new relationships and having further children.

2.6 In 2012 aged 14 James moved to live with his father in Thurrock as his mother and step father could no longer cope with his violent mood swings and behaviour. Police became involved and records indicate approximately 33 contacts with the police for various incidents. James parents believed his behaviour was compounded by becoming a regular user of cannabis and

possible affiliation with local gangs which James always denied.

2.7 James school years were often troublesome with poor attendance and he began to go missing. The records show James was reported missing on 27 occasions but his parents would not always report him missing as he would usually return home. Despite James' behaviour, through support from his father and the Education Welfare Service, James' attendance at school improved and he was able to achieve good GCSE grades.

2.8 In July 2014 aged 16 James was arrested in Norfolk for drugs offences and released on bail, issued with a travel warrant by Norfolk Police, and subsequently went missing for 20 days.

2.9 In December 2014 James presented himself to Thurrock Children's Social Care following continued unruly behaviour at his father's address, with regular police attendance for domestic and violent incidents. James became a Looked After Child (LAC) under Section 20 of the Children's Act 1989. He was allocated the relevant Social Worker and support team and a Care Plan implemented.

2.10 On leaving school James became Not in Employment, Education or Training (NEET) and the support workers made every attempt to help him gain employment or further education, but James was resistant to that support other than showing an interest in writing music.

2.11 James was placed in a five bedroom semi-independent accommodation in Haringey for 16-18 year olds. This was a spot purchase due to the unavailability of existing accommodation.

2.12 In May 2015 James went missing for several days and was stopped by Police in a known drug dealing area of Cambridge. In his possession were items from a recent burglary and also James admitted to having 21 wraps of heroin in his possession. James was bailed to appear at Court in Cambridge at a later date for the associated offences and taken back to London by Police Enquiries identified that the home had failed to report this missing episode for three days.

2.13 James' Social Worker met with him on his return, but James would not discuss his arrest and continued to deny any involvement with Gangs. James continued to go missing and only ever accepted one return from missing interview. Those that worked with him had no firm evidence, but his recent possession of an iPhone and his lifestyle were not in keeping with the financial support he was being provided, which left underlying concerns of crime and gang involvement.

2.14 On 7th June 2015, James was stopped by Police in Portsmouth acting suspiciously. His placement was not aware he was missing. And at that time James appeared stressed when he returned. A few days later there was a violent incident between James and another resident at the placement. James

left the scene prior to police attendance. The home and the victim declined to assist the Police and no further action was taken.

2.15 On 15th June 2015, there was a further incident at the home with James making threats to a resident with a knife. James was arrested for Affray and bailed to appear at Court on 14 July 2015, with conditions that he could no longer reside at that placement.

2.16 James was moved to another semi supported placement run by the same provider. James felt at this time that “his past was catching up with him” and shared some acknowledgement of his drug dealing with his Social Worker.

2.17 On 25 June 2015, James returned to Cambridge and was charged with possession with intent to supply class A drugs with a Court date set for 15 July 2015. Arrangements were made for James to be supported at his impending Court cases. It is not clear, due to the provider of the accommodation going into administration at the time of this review, but James failed to appear at Court on 14th July 2015 for the Affray charge and a warrant issued for his arrest.

2.18 On the evening of 14th July 2015 James was at the placement and seen by the in house support worker.

2.19 On the morning of the 15th July 2015 a different support worker from the provider attended to collect James for Court in Cambridge.

2.20 After initially failing to make contact with the in house resident support worker, entry to the home was gained. Both workers went to James room where he was found collapsed in his bedroom and subsequently pronounced dead by the paramedics who attended.

2.21 The Serious Case Review identified six findings the Safeguarding Board need to consider with 11 associated recommendations. Those agencies that worked or supported James have been involved in this SCR and some changes have already taken place to improve our systems and processes.

3. Issues, Options and Analysis of Options

3.1 Please see copy of full review at:

http://www.thurrocklscb.org.uk/app/download/27433970/Thurrock+LSCB+SCR+James.pdf

Or

Hard copy attached as Appendix 1.

3.2 Findings:

3.3 **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? Children's homes are subject to an Ofsted inspection. There is however, a natural gap in the inspection process, as semi-independent LAC placements are not currently inspected by Ofsted. The Thurrock Ofsted 2016 inspection stated commissioning was robust contrary to the findings found in this review. **(See also Finding 2.)**

3.4 **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**

3.5 **Thurrock LSCB Overview Report National Recommendation (1) for Inspection of LAC Placements**
It is recommended that the Department for Education consider the wider remit for Looked after Children inspections to include:-
The implementation of Ofsted inspections for all LAC provisions, regardless of the type of placement provided. An inspection to monitor the commissioning and compliance, checks by the Local Authority as to the suitability of the placement, experience of placement staff and financial checks made as to the stability of the Company and Board of Directors, providing the service provision. An opportunity for DfE and Ofsted enhancing support for Local Authorities, with the consideration of developing a national directory of suitable LAC service provider companies and directors in the industry.

3.6 **FINDING 2 – COMMISSIONING. Are the Thurrock Local Safeguarding Children Board satisfied?**

1) With the system improvement this review has provisionally implemented in consultation, for financial stability checks for spot purchases with Thurrock's Children Commissioning and Service Transformation (CCST) for LAC placements?
2) Whether the current Thurrock commissioning strategy of LAC arrangements are safe?
3) Whether the regional Local Authorities commissioning services who work with Thurrock to identify suitable LAC Placements, should be

shared up to date, relevant information of LAC placements?

4) Should the Thurrock Gang and Youth Violence, Local Assessment Process (2016), capture within the commissioning process for LAC placements, additional Gang and Youth Violence information to ensure Thurrock LAC involved or vulnerable to exploitation are not accommodated within significant Gang areas of concern?

3.7 **What happened?** James resided in two Thurrock LAC placements provided by the same company. However, Thurrock CCST in communication with the Independent Overview Author (IOA), stated that the company were spot purchases. The company was recommended by other Local Authorities in the regional group that Thurrock CCST interact with to agree, share and recommend suitable placements. Information obtained during the course of this review raised concerns namely, Police being regularly called to the placements, a complaint made to the placement provider by Thurrock Children Social Care (CSC) regarding failure to comply with the reporting of missing persons, a former employee who confirmed that he was not being paid and had since left the company and finally in February 2016, while participating in this SCR, the company and its placement properties were put into administration. Routine financial checks in July and August 2014 would have shown that the company may have been in some financial difficulties. Regular checks as to the financial stability of companies were not carried out which could have stimulated further scrutiny. The Company may have perfectly valid reasons for going into administration and there is no criticism. It is not developed further within this Serious Case Review and is alluded to merely show that there was a system failure within commissioning. Thurrock CCST financial scrutiny of spot purchases will now be completed. They do not always have the time due to the urgency of finding a placement but insist checks will be carried out as soon as possible and then reviewed annually. In this case there was no contract or Individual Placement Agreement completed, the placements remained spot purchases and was a system failure.

3.8 **What should be considered?** (1 to 3 above) the new proposal will capture all spot purchases but are the Thurrock Local Safeguarding Children Board satisfied with the arrangement, support and supervision of the placement of LAC to provide a supportive and stable environment for Thurrock's LAC**. (**4 above) The Thurrock Local Assessment Process 2016 for Gangs and Youth Violence should ensure that sufficient checks are carried out as to the suitability of the location of a proposed placement. Particularly where vulnerable LAC liable to exploitation or association with gangs, are to be placed, to include contact with other area LAP's and Local Authority MASH's and Integrated Gang Teams. **(See also Thurrock CCG Recommendation 4),** regarding commissioning cases where a service is declined by an out of area provider, cases should be discussed at the Joint Funding panel so that the case can be escalated to specialist commissioners and funded as per the Responsible Commissioners guidance if indicated. The following suggested recommendations are completed for the decision of the Thurrock Board: -

3.9 **Thurrock LSCB Overview Report Recommendation (2) for Thurrock Children Social Care**

It is recommended that Thurrock CSC require, Thurrock Children's Commissioning and Service Transformation, to carry out a review of the supervision of commissioned contracts and spot purchases of LAC placements to ensure the continued stability of the accommodation for Looked After Children.

3.10 **Thurrock LSCB Overview Report Recommendation (3) for Thurrock Children Social Care**

It is recommended that Thurrock CSC require, Thurrock Children's Commissioning and Service Transformation, to share relevant information of concerns obtained from financial checks and scrutiny of their LAC placement service providers, with other regional Local Authority commissioning services, to ensure that only appropriate and viable contracts are awarded.

3.11 **Thurrock LSCB Overview Report Recommendation (4) for Thurrock Children Social Care**

It is recommended that Thurrock CSC review the Thurrock Gang and Youth Violence Local Authority Process 2016, to include commissioning checks to the suitability of the location of LAC Placements, to ensure that vulnerable children and young people are not placed in an area of significant gang and youth violence.

3.12 **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 Child and Adolescent Mental Health Service (CAMHS) who declined their service and who referred his case onto a drug and alcohol service. Needless to say, his mental health concerns were never effectively assessed. There was no notable delusional concerns apparent to the same extent in the latter months, but his criminal offending and anger issues in the placement started to escalate. Ironically when James' room was searched on his death, there were no drugs found and toxicology results confirmed he had no drugs or alcohol in his body.

2) His Social Worker carried out a Strength and Difficulties Questionnaire (SDQ). James was deemed to have severe difficulties with a score of 27/40. The outcome of the SDQ was discussed by the Social Worker with the IRO. They were considering the option to move him to another

area to reduce the risk and break the chain of him associating with others involved in crime and likely exploitation. He was however subsequently moved, not because of the SDQ outcome, but due to the assault incident concerning another resident in Placement 1 when he was transferred to his second placement.

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 Strength and Difficulties Questionnaire (SDQ) that a LAC has severe difficulties, there needs to be a robust system in place, with a clear support pathway identified, to address the concerns.
Comment: To compliment these findings, **NELFT Agency Recommendation 3** addresses the need to follow up the outcome of LAC's immunisations, ensuring they are up to date. NELFT further identified **NELFT Agency Recommendation 4,** the requirement to embed a more robust record keeping and follow up process, in terms of health assessments and delays noted within this SCR, particularly for LAC placed out of the Borough, due to the added vulnerabilities they may encounter. The following suggested recommendations are submitted for the decision of the Thurrock Board: -

3.13 **Thurrock LSCB Overview Report Recommendation (5) for Thurrock Children Social Care and NELFT**

It is recommended that Thurrock LSCB require Thurrock Children Social Care and NELFT, review LAC Care Plans and LAC Reviews, to ensure outstanding Mental Health assessments are notified and if required, escalated to the Thurrock Clinical Commissioning Group or appropriate partner agencies, in order that outstanding assessments are followed up and completed to a satisfactory standard, with the rationale recorded.

3.14 **Thurrock LSCB Overview Report Recommendation (6) for Thurrock Clinical Commissioning Group**

It is recommended that Thurrock LSCB request NHS Thurrock Clinical Commissioning Group under the Responsible Commissioners Arrangement, to escalate and provide support when notified by partner agencies, where a

health practitioner makes a mental health referral for children and young people, which remains outstanding. This is in order to obtain a satisfactory outcome for the patient, with the rationale of the decisions recorded on the patients' health file by the provider organisation.

3.15 **Thurrock LSCB Overview Report Recommendation (7) for Thurrock Children Social Care, NHS Thurrock Clinical Commissioning Group and NELFT**

It is recommended that Thurrock LSCB require Thurrock Children Social Care, NHS Thurrock Clinical Commissioning Group and NELFT, to ensure that when a Strength and Difficulties Questionnaire (SDQ) identifies that a LAC has been assessed with severe difficulties, there is a robust system in place to track these high risk cases with appropriate intervention levels and effective pathways established and applied, to address the concerns in support of the LAC.

3.16 **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) stresses that the views not only of the subject but those of the parents should and have been taken into consideration and a Family Group Conference (FGC) would have been a sensible forum for this. There is a need for the consideration of holding an early FGC if there are relationship problems and a strategy meeting to discuss increasing criminal offending with the relevant agencies and to listen to the voice of both the subject and family.

In conversation with the Independent Reviewing Officer (IRO) and her manager, these suggestions in James' case regarding a FGC, would have been considered for future meetings and agreed with the IOA that there is a need to be able to recognise the evolving issues for the LAC earlier with multi-agency involvement. There is also a need to establish a robust system to effectively monitor the distribution of LAC minutes, to ensure that the information, actions and the outcomes are satisfactory completed by

appropriate agency professionals. A consideration of the DfE 2014 Statutory Guidance on children who run away or go missing from home or care should have been followed to assist functioning. The following suggested recommendation is completed for the decision of the Thurrock Board: -

3.17 **Thurrock LSCB Overview Report Recommendation (8) for Thurrock Children Social Care**

It is recommended that Thurrock CSC ensure that supervisors and LAC Independent Reviewing Officers (IRO), develop a matrix for the early identification of escalating concerns with LAC and of action taken to address those concerns. This should include an effective system to monitor and distribute LAC minutes to appropriate key practitioners to guarantee that any actions identified are satisfactorily completed. Any interventions can be reflected within the IRO Annual Report for monitoring purposes.

3.18 **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 (FME) and James stated he was bi-polar. This was recorded in the detention and FME log. There is no record of this information being shared with CSC either from the medical professional carrying out the examination or whether it was recommended to the custody officer to complete a Merlin (Met Information) report for onward sharing. It has been confirmed by the Chair of the SCR who carried out further enquiries, that there is no record of James being on any medication for bi-polar or anything health related. The only history given to the GP was a part history of allergic asthma, allergy to nuts and smoking cannabis. The Metropolitan Police Service (MPS) Safety Compliance Investigation team state that there is no responsibility of FME's to inform partners, they complete the National Strategy for Police Information Systems (NSPIS) medical form, it is then for the custody officer to take whatever action is necessary.
What should be considered? The FME has a responsibility to bring to the attention of Police the medical history disclosed and how it can be determined, if the person does or does not have a particular illness and recorded in the custody detention and FME log. The Police need to remind custody officers to be aware of these situations, to ensure relevant information is shared after a consultation with the FME making the entry. This aspect is further discussed within Chapter 7 Conclusions, Paragraph 14, as there may be learning on the fringes of this review that can be developed. The following suggested recommendation is completed for the decision of the Thurrock Board: -

3.19 **Thurrock LSCB Overview Report Recommendation (9) for the MPS**
It is recommended that the Metropolitan Police Service remind custody officers, that any apparent condition or vulnerabilities disclosed to a Forensic Medical Examiner (FME) by a child or young person in custody, must be risk assessed. If this highlights any risks or concerns, this should be referred to appropriate agency partners by the investigating officer upon the completion of a Merlin.

3.20 **FINDING 6 – SAFEGUARDING CONCERNS FOR CHILDREN AND YOUNG PERSONS PRESENTING HOMELESS IN ANOTHER AREA. Are the Thurrock Local Safeguarding Children Board satisfied?**

1) The arrangements and the quality of the recording within Norfolk Constabulary custody records of children and young people are sufficient for safeguarding and accountability?

2) The welfare arrangements by Norfolk Children's Social Care, for a homeless child and young people were satisfactory in providing support and safeguarding the welfare?

What happened?

Norfolk Constabulary. James was arrested in their area for an offence of possession of a controlled drug. The standard of the information supplied from Norfolk Constabulary regarding arrested children and young people appears to be unsatisfactory. In James arrest and release on bail, it does not detail sufficient information to exactly know or record the outcome for James. He was apparently watched by a Police Community Support Officer (PCSO) while Norfolk CSC arranged accommodation for him and then supplied with a travel warrant. It was reliant on the memory of officers, not ideal for accountability. It did not give the rationale as to why the case was subsequently recorded as no further action. The presumption is there was insufficient evidence against him.

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: -

3.21 **Thurrock LSCB Overview Report Recommendation (10) for Norfolk Constabulary**

It is recommended that Norfolk Constabulary review their custody safeguarding arrangements for the detention and supervision of children and young people within their care. This is to ensure that Police records accurately record all safeguarding arrangements and action agreed with Children Social Care for the outcome and welfare of children and young people within their custody.

3.22 **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.

3.23 Conclusions

Predictability
James death was not predictable. There had been extensive professional interaction with him and contact with his family in the latter period of his life. The findings and learning identified for agencies, were on the fringes of the review and did not affect or contribute to the final tragic outcome of events.

Preventability
Professionals on all available knowledge and information could not have foreseen or were able to prevent the outcome of James' death. There were no previous concerns or behaviour known to family or practitioners to contemplate that James would take his own life or commit self-harm, even within the last few hours before he was found collapsed in his bedroom at his placement.

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. Consultation

Thurrock Local Children's Safeguarding Board (LSCB).

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

Thurrock Council has reviewed its commissioning policies and procedures in-line with the recommendations of this review.

6. Implications

6.1 Financial

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

There are no financial implications arising from this review and its recommendations.

6.2 Legal

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

The Local Authority as a statutory partner must engage fully in the completion of serious case reviews and the dissemination of learning from the review across the authority.

6.3 Diversity and Equality

Implications verified by: **Natalie Warren**
Community Development and Equalities Manager

In implementing the recommendations of the Serious Case Review the local authority must commission and ensure an effective range of services to meet the needs of children from all backgrounds.

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

N/A

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

Thurrock LSCB, SCR Report James

8. Appendices to the report

Appendix 1 - Thurrock LSCB, SCR James – Action Plan
Appendix 2 - Thurrock LSCB SCR James

Report Author:

Andrew Carter
Head of Service
Children's Social Care