Hounslow Safeguarding Children Board

Hounslow Local Safeguarding Children Board

Serious Case Review

Executive Summary

Anita B.

Edi Carmi

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1 INTRODUCTION

1.1 Initiation of Serious Case Review

1.1.1 This serious case review concerns the disappearance of a fifteen year old girl in April 2014. She is called Anita B in this report; not her real name but one selected by her mother. She had been subject to episodic episodes of severe mental illness from November 2011, when she was aged thirteen years old. She was reported as missing by her mother in April 2014, when she went to Egypt with one of her elder brothers, without her mother's permission.

1.1.2 Donald McPhail, Chair of Hounslow Safeguarding Children Board (HSCB) decided to initiate a serious case review following the receipt by the Police of information that she was believed to have died accidentally. Anita B has never been found and her body has never been located. The actual cause of Anita B's death is not known.

1.1.3 One of her brothers was convicted of her abduction in November 2015 and received a sentence for 3 years and 4 months.

1.1.4 This report provides an executive summary for the serious case review report which is being published in full at the same time.

1.2 Case summary

1.2.1 Anita B had suffered from episodic mental ill health since the age of thirteen, and during the acute episodes she was severely ill and was admitted to hospital on three occasions, including on one occasion through the use of compulsory admission.

1.2.2 Anita B was the youngest of four children, brought up by her mother following her parents' divorce. She was very much loved and cared for by her family and they co-operated with professionals involved in her care, primarily psychiatrists from the local Child & Adolescent Mental Health service (CAMHS). They did though struggle with understanding the cause of Anita B's sudden onset of mental illness and the severity of her disturbed thoughts, during the acute phases of her illness.

1.2.3 The family are Christian, but in 2011/ 2012 one of the elder siblings (sibling 2) converted to Islam whilst at university. This caused some friction within the family, especially as he was interested in converting his siblings and in particular his younger sister. The mother, whilst respecting her son's religious beliefs, felt that Anita B was too young to make such decisions.

1.2.4 The family went on a trip to West Africa in the summer of 2013, and when they returned home sibling 2 stayed in Africa with relatives, before moving to Egypt. He returned to London in April 2014 for a visit to the family, and without the knowledge or permission of his mother, disappeared with Anita B.

1.2.5 Mother immediately reported Anita B as missing and made every effort she could to locate her. She was extremely concerned for Anita's welfare as she had travelled without medication for her asthma or for the control of her mental health condition.

1.2.6 Mother managed to speak with her son and daughter briefly, in the presence of a police officer, when it was confirmed they were in Egypt. Subsequently she was unable to make contact with them. The police investigation could not locate Anita B.

1.2.7 Her brother was understood to leave Egypt in summer 2014 and eventually agreed to extradition from the United Arab Emirates in June 2015. He was convicted in November 2015 of her abduction in 2014 and is currently serving a prison sentence for this crime.

1.2.8 It is not clear what happened to Anita B. in Egypt, but she is understood to have died. The police had previously suspected she may have been taken to Egypt because of a belief that her mental ill health was associated with a form of spirit possession. Her brother's account is of an accidental death following a fall.

1.3 Findings & Recommendations

1.3.1 The findings of this serious case review relate to what we have learnt about the strengths and weaknesses in multi-agency safeguarding systems through examining what happened to Anita B.

1.3.2 It was not possible to predict that sibling 2 would abduct Anita B. in what was probably a misguided attempt to cure her mental illness.

1.3.3 No agencies were aware of any plans for sibling 2 to remove Anita B from the family home and therefore no action could be taken to prevent this. Prior to the summer of 2013 there was no indication that sibling 2 had any belief in spirit possession; in fact what evidence there was suggests this was not the case. He abducted Anita B. following a period living in Africa and the Middle East, and it is most likely that his views changed at that time about what was best for his sister; however, professionals would not have had access to such a change in beliefs.

1) Multi-agency working and lack of lead professional

There was a lack of co-ordinated multi-agency working. This would need a lead professional organising meetings across agencies, producing multi-agency plans, which would be reviewed and monitored. This did not occur because it was perceived that CAMHS were involved and would alert other agencies as and when required. However, this did not happen consistently and led to an element of silo working as described below.

Anita B.'s school reported that they struggled to get information about her mental health, and highlighted that this is usual in the absence of a social work lead professional and a child in need or child protection plan.

Priory records show that CAMHS was aware of Anita's admission and planned discharge from the Priory. The CAMHS consultant psychiatrist was identified in Priory records as being the 'care co-ordinator' who attended two Care Planning Approach meetings. However, there is little indication that CAMHS understood themselves to have a lead role vis a vis other local agencies, and for example did not communicate Anita B's discharge arrangements in 2012. This contributed to a lack of multi-agency collaboration to get Anita B. back into education and to consider the need for additional support to the family, despite the identified stress and conflict in the family.

When Anita B was discharged from Huntercombe Hospital in 2013 she was entitled to after care under section 117 of the Mental Health Act 1983 and should have been allocated a 'care co-ordinator' from the community. This is a duty for health and children's social care. The serious case review discovered that this duty was not known by practitioners or managers within children's social care and the hospital had not triggered this process.

The rarity of such severe mental ill health in such a young person should be identified as being likely to place such a stress on the family and the need to trigger a holistic assessment and service provision that considers the entire family.

Recommendation 1

The LSCB to review the criteria used in Hounslow to trigger the use of a lead professional to co-ordinate multi-agency assessment, intervention and support to families, so as to ensure this includes all children suffering from ongoing mental ill health and the need for the lead role of CAMHS in some circumstances.

Recommendation 2

The LSCB to review the effectiveness of communication processes between CAMHS and education services, in the absence of a child in need or child protection plan.

Recommendation 3

The LSCB to consider what actions are required so that practitioners and managers within children's social care and the CCG (clinical commissioning group) provide aftercare in accordance with section 117 of the Mental Health Act 1983.

2) Invisibility of school nursing service

The school nursing service did not undertake any assessments to establish if they needed to be involved. It is not known if this is due to assumptions made because Child & Adolescent Mental Health Services were involved with Anita B, or if this was symptomatic of a wider systemic problem due to resource shortages at the time. Moreover, it is not known if this resource shortfall has changed. Whilst their

involvement is unlikely to have made any difference to the outcome in this case, their absence is indicative of the lack of co-ordinated multi-agency support.

Recommendation 4

The LSCB to ask Public Health, as the current commissioners for school nurses, to report on the quality assurance of the school nursing service so as to establish if the mental health needs of children are adequately safeguarded when they are not subject to child protection or child in need plans.

3) Understanding of safeguarding responsibilities for university staff

Practice in this case demonstrated a lack of understanding of the safeguarding responsibilities of university staff in relation to potential child protection information on children, as opposed to their duty of care to their individual students.

Recommendation 5

The LSCB to ask the university concerned to review safeguarding procedures and staff training so that all university employees are clear about their safeguarding duties to children. This includes the duty to refer to relevant authorities any information received from a student in relation to the safeguarding of a child who is not a student at the university.

4) Mental ill health led to Anita B missing 13 months of education

The complexity of Anita B.'s mental health needs led to her missing 13 months of education, except for the periods she was a patient in a hospital. During this period she was not provided with any alternative education facilities, largely due to national systemic factors which mean that the local authority does not have any knowledge of children missing school long term due to episodes of ill health. Such information is held within schools unless the child's absence triggers report to the EWO. This did not happen for 7 months, due to Anita B being reported as sick by CAMHS or receiving alternative education within a hospital setting.

The subsequent delays arose due to mother's wishes, until November 2012, for her daughter to return to mainstream school, as opposed to an educational setting for children with ongoing health problems where they are prepared, if appropriate, for re-integration into the main stream setting. This setting required a referral from CAMHS, and in this case the delay was compounded due to a change of psychiatrist .

During the period under review there was also a lack of facility to provide interim arrangements, such as home tuition, when there are delays in obtaining suitable educational facilities for a child with mental ill health. The use of web based provision and sending work home was considered by the school to be sufficient.

Since September 2015, it has become possible for schools to commission services such as home tuition directly from the alternative education provider, with a referral from CAMHS. If used for children in these circumstances it may have enabled continuity of educational input whilst longer term provision was agreed with the mother.

Recommendation 6

The LSCB to consider how it is possible for the local authority to obtain an overview of :

- *arrangements for children who are not receiving education due to ongoing physical or mental health problems and*
- *the use or not of alternative provision , such as home tuition, in such circumstances*

If the current way education nationally is delivered makes such oversight impossible, this should be reported to the Department for Education as an obstacle in safeguarding ill children.

5) Belief in spirit possession as an explanation for mental illness in children

The family struggled to understand what had caused such a change to the mental functioning of their youngest child, which sometimes presented as Anita B speaking of having been taken over by 'demons'. In such circumstances, it is important in the provision of family support, as well as treatment of the child's psychosis, to understand the meaning of the presentation to family members.

Whilst the family had limited discussion with local professionals about their own beliefs, there is some information that at one point mother and at a later point sibling 2 considered that spirit possession was a factor in explaining Anita's health problems. This belief could have been behind sibling 2's abduction of his sister, with the intention of obtaining help for her that is not available in the UK, such as particular extreme forms of exorcism rites.

Recommendation 7

The LSCB consider how best to improve staff skills to be able to explore family members religious and cultural beliefs whenever there is any reference to a child being possessed.

6) The Prevent and Channel process at that time did not operate on a holistic multi-agency assessment

Whilst the outcome of the Channel Panels were probably appropriate, the process had shortcomings in terms of there being a narrow focus on police information only, and on sibling 2 in isolation, instead of as a family member with a vulnerable sister. Only police and the Channel chair participated in the process, which limited the information supplied and taken into account in the assessment. The referrer was not provided with

any information on the outcome of the process and the person undergoing the assessment and intervention had very little understanding of what was happening.

It is understood that since that time there have been changes made and there is now a more holistic assessment of the individual and her/his family, involving multi-agency representation and information about all family members. This enables a focus on safeguarding children in the family.

Practitioners also spoke about their lack of knowledge about their own responsibilities within this new agenda, such as when to make a referral, albeit this has also improved over time.

Recommendation 8

The LSCB to be assured that current practice of the Channel panel is consistent with the recently published London child protection procedures, and that practitioners in all agencies are aware of their roles and responsibilities in the Prevent and Channel process.

7) The lack of formally responding to mother's complaint in June 2013 is a shortcoming in the safeguarding of mentally ill children

The investigation of complaints, and where necessary the initiation of child protection enquiries under s.47 Children Act 1989, is an integral part of the safeguarding system.

There is no evidence that Mother's letter of complaint sent to CAMHS in June 2013 was ever passed to Huntercombe Hospital to investigate. This concerned general issues around her daughter's treatment as well as a specific allegation of her daughter being 'assaulted in an excessive manhandling by two male staff' who restrained her for an 'unnecessary injection'. She also expressed concerns that such treatment may not be unusual.

It may be that aspects of the complaint were discussed with the CAMHS psychiatrist and at the Care Planning Approach meeting the next week at the hospital. However the allegation of 'manhandling' was not investigated as either a complaint or a child protection enquiry.

Recommendation 9

The LSCB to be assured that complaints sent to CAMHS about other service providers receive a formal response including the action taken to direct the compliant to the appropriate service.

8) This case has highlighted some specific recording shortcomings

From the evidence on this case, CAMHS clinicians did not reliably record communications with other agencies and attendance at Care Planning Approach meetings in hospitals. It is not possible to comment whether or not patient contacts were all recorded, as these are not challenged through information supplied by other agencies to the review. Within the period covered by this review, CAMHS was transitioning to a new electronic record-keeping system that required paper records to be converted to an electronic format. This process had some difficulty as a result of capacity issues and this may explain some of the issues retrieving records relating to that period.

Another recording weakness evident on CAMHS and other health providers recordings is the repeated lack of identification of family members, other than mother and a sibling. Mother has told the LSCB chair and lead reviewer that all the three siblings provided support to her at appointments.

Recommendation 10

The LSCB to ask CAMHS to confirm current record keeping standards and practice to provide assurance that records consistently cover all multi-agency contacts and communications

Recommendation 11

The LSCB to ask all agencies to report on actions taken so as to have confidence that records of contact with family members consistently identify each person involved by name and relationship.

9) The delay in following child protection procedures highlights the need for London Child Protection procedures to address the processes to follow when a child is known to be abroad but her/his whereabouts are unknown and unauthorised

Anita B was reported to police as missing in late April 2014. Whilst a criminal investigation was initiated, there were no child protection processes started until August that year, when a strategy meeting was held. This delay highlights the confusion about the applicability of child protection procedures when a child is missing abroad.

Recommendation 12

The LSCB to raise with the London Safeguarding Children Board the need for the child protection procedures to specifically address the processes to follow when a child is missing abroad.

1.4 The next steps

1.4.1 The Local Safeguarding Children Board (LSCB) has prepared a separate document with their responses to the following findings, the plans to address these recommendations as well as the actions taken in response to the individual management reviews .

1.4.2 This is being published at the same time as the report of the serious case review.