Hounslow Safeguarding Children Board

Hounslow Local Safeguarding Children Board

Serious Case Review 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.

1.2 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 cooperated 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 Summary of Findings

1.3.1 The following provides a summary of the 9 findings and associated recommendations arising from this serious case review.

i. 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 Child and Adolescent Mental Health Services were involved and would alert other agencies as and when required.

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.

ii. 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.

iii. 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.

iv. 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, partly due to national systemic factors which mean that the local authority does not have 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 education welfare officers. 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.

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.

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.*

v. 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.

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.

vi. 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.

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.

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.

vii. 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 the child and adolescent mental health service in June 2013 was ever passed to the hospital concerned for investigation.

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 complaint to the appropriate service.

viii. This case has highlighted some specific recording shortcomings

There was evidence in this case of a widespread tendency in records across agencies to record family members present in terms of their relationship with Anita B, but not their name. Where there is more than one sibling in the family, this leads to inability to identify who was present in the many professional contacts.

Critical records were missing from the information available within Child & Adolescent Mental Health Services. This may be explained by the fact that, within the period covered by this review, the service 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.

Recommendation 10

The LSCB to ask CAMHS to confirm current record keeping standards and practice and 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.

ix. The delay in following child protection procedures highlights the need for London Child Protection procedures to specifically 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, no child protection processes were initiated 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 What will the LSCB do in response to this?

1.4.1 At the end of each finding in section 6 recommendations have been made for the LSCB. The LSCB has prepared a separate document which describes the actions that are planned to strengthen practice in response to the findings and recommendations of this serious case review.

1.5 Structure of the report

1.5.1 The report is structured as follows:

- **Section 2** explains the review process
- **Section 3** provides background context of the family
- **Section 4** explains what happened from the perspective of those involved at the time
- **Section 5** provides an analysis of the themes emerging from the practice in this case
- **Section 6** provides the overall findings and recommendations
- A glossary of terms is included at the end of the report

2 REVIEW PROCESS

2.1 Introduction

2.1.1 The serious case review process was chaired by Donald McPhail, the Local Safeguarding Children Board (LSCB) chair, and the report was written by the independent Lead Reviewer Edi Carmi. They worked with a panel of local senior managers from the agencies involved with the family.

2.1.2 The review process involved individual management reviews (IMRs) from local agencies; written information from hospital outside of Hounslow to which Anita B was admitted; meetings with staff at sibling 2's university; meetings with Anita B's mother and sibling 2 and a practitioner meeting.

2.1.3 Local agencies involved with the family and providing individual management reviews are as follows:

- Children's Social Care [CSC]
- Metropolitan Police Service [MPS]
- Anita B.'s school
- Continuing Access to Education Service
- Hounslow clinical commissioning group [CCG] commissioning NHS Health Services on behalf of the population of Hounslow borough
- Hounslow and Richmond Community Healthcare NHS Trust (HRCH) (providers of school nursing and paediatric liaison)
- West Middlesex University Hospital (WMUH) (providing A & E and paediatric services) commissioned by Hounslow CCG
- West London Mental Health NHS Trust (WLMHT) (providers of the Child & Adolescent Mental Health Service (CAMHS) - lead commissioner is Ealing CCG)
- Hounslow General Practitioners (GPs) (providing GP services) - commissioned by NHS England
- Local Authority Prevent
- Youth Centre
- Early Help Hounslow
- Education Welfare

2.1.4 Written responses to specific questions were submitted by the hospitals outside of Hounslow who had contact with Anita B.:

- Huntercombe Hospital : Independent provider which provided in-patient treatment to Anita B.
- South West London and St George's Mental Health Trust
- The Priory: Independent provider which provided in-patient treatment to Anita B.

Staff involvement

2.1.5 A few staff were involved by some of the IMR authors, albeit largely around understanding about explaining of systems and processes, as opposed to ascertaining what happened at the time (and why). Partly this was due to the fact that key members of staff had left Hounslow.

2.1.6 The independent lead reviewer and the MPS IMR author met with two members of staff at sibling 2's university.

2.1.7 The LSCB chair and the lead reviewer met with the practitioners involved in the family, in a group event. This aimed to obtain a fuller understanding of why actions were or were not taken at the time.

Family participation

2.1.8 The LSCB offered individual invitations to participate in the serious case review process to Anita B's mother, father and three siblings. This process took some time, but both her mother and sibling 2 agreed to participate as described below.

2.1.9 Anita B's mother saw the LSCB chair and the lead reviewer on 16.02.16, accompanied by her supporter from Southall Black Sisters. She subsequently provided the review with various documents to evidence her experiences with statutory agencies. She clearly articulated the family's love and care of their youngest child, as well as the difficulties they faced in keeping Anita B safe when she was suffering acute mental health episodes. She spoke about:

- Her grief and anguish at the loss of her daughter and youngest child, who until she became ill at the end of 2011, was a happy, healthy beautiful girl with ambitions to become a model and of whom mother was extremely proud
- The love and care provided by mother and all Anita B's three siblings in caring for Anita B and keeping her safe at all times, and especially during the acute stages of her illness, when there was a risk to her as she would run out into the road without due care
- The extent to which the family struggled to understand the very sudden onset of her daughter's psychiatric illness
- The level of stress the mother experienced at this time due partly to her worry about Anita B and the level of input required to keep her safe
- The additional stress mother was suffering due to disputes with her housing provider (around the unsuitability of one aspect of the accommodation), as well as her financial worries, due to the threatened loss of benefits arising from her ill health [mother explained that after a lengthy legal dispute with the authorities, she did eventually succeed, after Anita B's disappearance, in maintaining her benefits]

2.1.10 Overall Anita B's mother did not feel that professionals in local agencies understood how difficult it was for the family to care for Anita B and would have welcomed more support over and above that which was addressed specifically to her daughter's mental health needs.

2.1.11 Sibling 2 (One of Anita B's elder siblings, see 3.1) met with the LSCB chair and lead reviewer on 11.03.16 and also expressed his grief and sadness at what had occurred. He explained that he wanted to help his sister, cared for her deeply and wanted to give her a 'break' from what he perceived as the stresses of her life in the UK. He had maintained contact with her whilst in Egypt and arranged with her that he would come and fetch her so she could have a holiday in Egypt, where he thought she might gain some peace just as he had done.

2.1.12 Sibling 2 also spoke of the family wanting and needing help, both with regard to understanding what was happening to Anita B and to the mother having more support to care for her whilst managing the other problems she was facing. Sibling 2 spoke about the cyclical nature of Anita B's mental health problems, with her being well between acute episodes of ill health. This reflects mother's views as articulated to CAMHS at the time.

2.1.13 Sibling 2 was absolutely clear Anita B was suffering from mental ill health. However, he explained that through his religious beliefs he got an understanding of the causes of such ill health being associated with the work of 'jinn', which in orthodox Islam resembles the beliefs of 'spirit possession' in fundamental Christian Churches. This belief is discussed further in 5.11.

2.1.14 The views of Mother and sibling 2 are included where relevant in the appraisal of practice and the analysis sections.

2.2 Limitations of review

2.2.1 Because of the passage of time, it was not possible to locate and involve some of the critical practitioners involved with the family in this serious case review. This limited understanding of exactly what happened at points in time and the reasons for this, but it is not considered that it would have affected the findings of the review.

2.2.2 The particular gap in involvement of practitioners has been the inability of the review to obtain full information about the GP involvement with Anita B. This is not unusual in case reviews, but is part of the ongoing challenge to obtain GP involvement in multiagency child protection learning activities locally and in the lead reviewer's experience more widely in England, due to the pressures on the GPs time within the modern NHS.

3 CONTEXT

3.1 Family composition

3.1.1 The following shows the family composition as known to the agencies. The left hand column provides the term used in the report to describe each family member. Anita B is not the real name of the subject of this serious case review, but is the name selected by her mother to be used in the report.

Term used in report	Relationship to Anita B.	Age in September 2011	Age in April 2014	Residence during period under review
Anita B	subject	13	15	Family home
Sibling 1	Eldest sibling			Unknown but understood to be local
Sibling 2	Elder sibling	21	23	Variously living locally and visiting /living in other countries
Sibling 3	Elder sibling			Family home
'Mother '	Anita B's mother			Family home
'Father'	Anita B's father			Unknown

3.2 History of family prior to period under review

3.2.1 The parents originate from West Africa. Prior to the period under review, there was little known about the family in Hounslow, outside of the universal provision of health and education services.

3.2.2 Anita B.'s parents separated in 2006 and the police were involved in 2008 and 2009 when Anita B.'s mother alleged that Anita B.'s father was jealous and reported two incidents of him threatening violence. Children's social care were notified of the incidents, but neither warranted intervention by them, albeit mother was provided with information about support services .

3.2.3 The mother is Christian and brought her children up to attend Church regularly. Sibling 2 converted[1] , or from his perspective 'reverted' to Islam as an adult.

3.3 Anita B

3.3.1 Anita B was thirteen years old when she had her first mental health episode in November 2011. Before she suffered from mental ill health she was doing well at school, both

[1] This review uses the term 'convert' to Islam, as opposed to the term 'revert' . The former is the term used by Christians and the latter is used by many Muslims. Because the family in Hounslow are Christian, the serious case review uses the term 'convert' throughout the report.

socially and academically. Her school have provided descriptions of her for the review including the following:

- ' a very polite and personable student' with an 'excellent behaviour record'
- (in Year 7): 'a positive attitude to work in lessons. Her positive approach to work led to her making good progress in the majority of her subjects. In her selfassessment in Year 7 she felt herself to be a confident person who had good and positive relationships with her peers and the staff'.
- a 'respectful student who wanted to succeed and please others' ■ a 'well-liked member of the form who was elected as Vice Form Captain' and being 'well organised and supported her form tutor and peers in this role by assisting with administrative tasks for the form, maintaining an unwaveringly polite and willing manner'.
- recognising 'that her parents had high aspirations for her and she herself hoped to get good grades and go on to University to study Drama or English. She hoped eventually to become an actress or a writer. She perceived herself as a hard worker who was getting somewhere through persistence and high levels of effort'
- making '...good academic progress', being 'a creative student' and a member of a choir, maintaining her aspirations towards a career in Drama and getting good grades generally 'for a better life'.

3.4 Sibling 2

3.4.1 Sibling 2 had attended youth activities and then started to work at the youth centre. He is remembered as being a talented youth worker, mixing well with peers and young people, until his conversion to Islam led him to believe he could no longer continue to do this role.

3.4.2 At university sibling 2 was described as a bright young man, well dressed with impeccable manners and invariably respectful of others. He spoke to his peers, but was not part of any group or involved in close relationships with others. This is not unusual at that university and did not change following his conversion to Islam whilst at university. He spoke to his tutor of being very comfortable in his new religion.

4 WHAT HAPPENED?

4.1 Introduction

4.1.1 Section 4 describes what happened during the period under review, from 1st September 2011 to 25th April 2014. This is from the context of what was known by professionals about Anita B. and her family, at the time.

4.1.2 4.2 explains what happened, which for ease of reading is broken into time periods. The commentary within the shaded boxes is an appraisal of professional practice in that

period. Where such appraisal and explanation reflects a recurrent theme regarding the service provided there is a cross reference to subsequent findings.

4.2 Chronological appraisal of practice

September - October 2011: First local agency knowledge of sibling 2's interest in Islam

4.2.1 At this time Anita B. was at a local school. Sibling 2 was a University student studying psychology. He also worked at a Youth Centre, where he spoke of having developed an interest in Islam, being worried about what was happening in the world and that this was why he worked with young people.

November 2011: Anita B.'s first known mental health episode and request to change school

4.2.2 In November 2011 Anita B. (aged thirteen) was brought to A&E at West Middlesex University Hospital (WMUH) by her mother and two of her brothers. She was reported to have taken an overdose of her mother's prescription medication, along with some bleach. She had also left a suicide message on her mobile telephone.

4.2.3 Anita B. was admitted to hospital over the week-end, when she was assessed by a CAMHS psychiatrist and a social worker. She was difficult to engage in a meaningful conversation, was variously drowsy, anxious, agitated, confused and unable to give a coherent account of her mental state. She spoke of being bullied by peers, stress at school and through being in a modelling competition.

4.2.4 The next day, when seen by the social worker and CAMHS doctor with her mother, the family history was provided of parental separation and conflict. Mother described Anita B. as a happy and healthy child, who was asthmatic and appeared well until four days prior to her hospital presentation.

4.2.5 Over the week-end the records refer to Anita B. experiencing auditory hallucinations, believing she had 'evil demons' inside her.

4.2.6 A good relationship between mother and daughter was observed and Anita B. was discharged home to her mother's care on the Monday, with a CAMHS outpatient appointment two days later. Children's social care closed the case as CAMHS were providing support.

4.2.7 Mother and daughter attended CAMHS two days later. Anita B. was more settled, albeit still distressed and scared that what she had done had hurt or even 'killed' the people around her. Anita B. was prescribed medication for 5 days.

4.2.8 Anita B did not return to school and mother submitted an application form to the local authority for a change of school, requesting a place at either of two other schools. Mother's reasons for a transfer were that her daughter was being bullied.

Comment:
The response at the hospital to Anita B.'s presentation demonstrated good practice with admission to a ward over the week-end, provision of one to one nursing care and making referrals to CAMHS and children's social care. The hospital also notified Anita B.'s school and the school nursing service of the admission. Full records were maintained, but the lack of identification of the names of the two brothers is a weakness, which is a pattern throughout professional contact in this case.

Both CAMHS and children's social care provided a timely assessment and good multi-agency working. The decision for Anita B. to go home 'on trial' but if needing help before the CAMHS appointment 2 days later to call the psychiatrist was sensitive to the family's needs and anxieties.

The decision to close the case to social care was appropriate given that CAMHS were offering support and further assessment, and mother was in agreement with this. However, the assessment itself had shortcomings. There was no contact with the school, which was relevant given Anita B.'s stated unhappiness at school, albeit it is now known that the school had not been aware of her being unhappy or being bullied..

December 2011:
Sibling 2 converts to Islam and Anita B improves but does not wish to return to her school

4.2.9 Sibling 2 attended university in 2011, but his work deteriorated and he was missing lectures. He spoke to his tutor of having moved from the family home and having converted to Islam.

4.2.10 In December 2011 Sibling 2 told a colleague in his job as a youth worker that he had become a Muslim and would have to change the way he lived.

4.2.11 Mother, Anita B. and an (unidenitifed) brother attended CAMHS a few days after this conversation, when Anita B. was brighter in mood, but spoke of being scared much of the time and having harmed those around her. A week later she was seen again, when she was more relaxed.

4.2.12 Anita B. did not return to school in December, and she spoke at CAMHS of wanting a new school. Mother told CAMHS she had requested a transfer on the grounds of bullying, but the school had no knowledge of any reported incidents of bullying.

January - mid March 2012:
Anita B.'s 2nd & 3rd mental health episodes and continuing absence from school

4.2.13 In this period, Anita B.'s mental health fluctuated rapidly, with family reports on her health varying.

4.2.14 Mother and daughter told Dr A at CAMHS in early January 2012 that Anita B was 95% better, eating and sleeping well but fearing a return to school. She returned to school the next

day for three days. A meeting was held at the school on the third day (Friday), which was attended by Anita B, mother and an [unidentified] brother. It was agreed Anita B would meet with the Inclusion Mentor on the Monday, but this did not occur as she became ill when she got home from school on the day of the meeting and she never returned to the school.

4.2.15 Mother took Anita B. to CAMHS and reported that her daughter's behaviour was similar, albeit not as severely disturbed, as after the overdose. She was afraid and needing assistance to walk. This was noted as an 'acute dissociative stress reaction with background of insecure attachment / anxious temperament'.

4.2.16 During the second half of January Anita B.'s mental health improved with her mother reporting her to be brighter, and eating and sleeping well. She did not though return to school and mother informed Dr A that Anita B. did not want to return and mother had sent the form to the education authority to request a different school.

4.2.17 The Head of Access wrote to mother in January, explaining her application for a transfer had been sent to both schools selected, as they were voluntary aided schools and the local authority would contact her if they received a response that either was able to offer a place. The letter advised mother that Anita B should remain on roll at her current school in the meantime.

4.2.18 The police were called by mother in late February because Anita B. jumped from the living room window and had run away. Mother chased her and a neighbour subsequently found her and returned her home. Anita B. explained to police that she wished to see her father and was unable to sleep due to her distress at not doing so, despite using sleeping pills.

4.2.19 A planned meeting at school did not occur on 19th March as mother was unable to attend. Mother told CAMHS Dr A that Anita B. did not want to return to school because of bullying and the psychiatrist agreed to write a letter in support of a school transfer, with potential home tuition in the interim.

4.2.20 The knowledge available to the school at that point in time was that Anita B was unwell. This came from communication with CAMHS. Their understanding at that point was that mother was consenting to the plan for Anita B to return to the school.

Comment

By this point Anita B had attended school for 3 days since she had her mental health breakdown in November. The fact that a child remains without any educational input whatsoever for 1.5 terms is of concern. ***See 5.9 for further discussion of this and finding 4 in section 6****.*

End of March - end of May 2012: 4th mental health episode and 2nd hospital admission

4.2.21 On 30th March, Mother reported to CAMHS Dr A that Anita B. was again confused, and a discussion was held about the cyclical nature of the episodes and that CAMHS would follow up with the paediatric consultant the need to investigate possible organic causes.

4.2.22 Mother and [unidentified] brother took Anita B. to A&E at WMUH that day, and whilst she was there the GP telephoned and requested a scan as s/he felt there was 'something else' going on. An MRI and EEG took place [results were normal].

4.2.23 CAMHS Dr A saw Anita B. a few days later on the 4th April, accompanied by her mother and [unidentified] brother. Anita B. was passive, made no eye contact and sat very still, responding to questions with a nod or shake of the head. Mother reported that her daughter was demonstrating more aggressive behaviour than previously, grabbing her mother's hair and putting her hands around her mother's throat.

4.2.24 Sussex Police were called to Gatwick Airport four days later on the 8th April, when mother and daughter were due to catch a flight to Berlin (en route to West Africa), but Anita B. was 'ranting hysterically ' and her mother was holding her to stop her from throwing herself in front of vehicles. They were taken to East Surrey Hospital by ambulance.

4.2.25 Anita B. was discharged from East Surrey Hospital the next day and transferred to Springfield Hospital, where she spent a day before being admitted to the Priory Hospital. The discharge summaries sent to the GP refer to these admissions following episodes of bizarre and aggressive behaviour at Gatwick Airport.

4.2.26 Both WMUH and East Surrey Hospital informed children's social care [CSC] and the school nurse of the respective hospital presentation and admission. East Surrey Hospital referred to the disturbed behaviour occurring roughly every six weeks, in line with Anita B.'s menstrual cycle. CSC spoke to CAMHS Dr A and were re-assured that Anita B. still attended her appointments there and the social worker advised CAMHS to refer if any safeguarding concerns.

4.2.27 Anita B. remained at the Priory Hospital for 6 weeks until the 22nd May. The discharge summary refers to her appearing perplexed with gross psychomotor retardation, paranoid and disordered thought. She also reported experiencing auditory hallucinations. Blood tests, thyroid function tests and MRI were all reported as normal. Following medication, her mental state began to improve and by the beginning of May she started home leave.

4.2.28 The Priory electronic records show that the care co-ordinator was identified as a psychiatrist from CAMHS (Dr A) and he spoke with the Priory three days after admission and attended both the Care Planning Approach (CPA) meetings on the 4th and 22nd May. The latter planed the discharge that day, including an appointment with Dr A.

4.2.29 CAMHS records however do not include any notification or written communication to or from the Priory, although Dr A was told by the family of Anita B's admission, which he followed up by a telephone conversation shortly before discharge .

4.2.30 Dr A saw Anita B. a week after her discharge. She was feeling well but Mother was fearful of a recurrence. Dr A agreed to write to education suggesting home tuition as Anita B. was still out of school.

Comment
There is a discrepancy between the Priory electronic records and the West London Mental Health Trust records. The former show additional communication as well as attendance at two CPA meetings in May 2012.
This is discussed further in section 5 and finding 2 and 8.

June - August 2012: addressing Anita B.'s needs for education and socialisation

4.2.31 Anita B had received no educational input from her first mental health episode in November 2011. On June 19th 2012 mother and daughter emptied Anita B.'s belongings from her locker at school. Prior to this the school had been unaware of her discharge from hospital. The school immediately made a referral to the education welfare officer (EWO), who visited the next day when mother told her that CAMHS Dr A was recommending home tuition.

4.2.32 The EWO contacted both CAMHS and CSC to discuss Anita B.'s educational needs and agreed with the psychiatrist that whilst alternative provision would be suitable for Anita B, home tuition was not advisable due to lack of social contacts. The CAMHS psychiatrist agreed to write to the local authority's Head of Access to communicate Anita B.'s needs. The EWO informed the school and the Head of Access, along with an education plan to be followed until alternative provision provided.

4.2.33 The EWO and the school subsequently continued to follow up the question of Anita B.'s education provision in July, with the Head of Access, who explained that there had been no communication from CAMHS.

4.2.34 Meanwhile sibling 2 took Anita B. to the Youth Centre where he worked in July and August. Sibling 2 spoke to colleagues at this time of being a Muslim, requested a place to pray and ceased to be friends with female colleagues or able to do 'high fives' with girls attending the Centre. He did not though impose his beliefs on Anita B.: she engaged in all activities, mixing with both boys and girls and wearing sportswear. She did not follow her brother out of the sessions to pray.

Comment
Anita B.'s continued lack of educational provision is a significant concern, despite the attempts of practitioners and the involvement of the Head of Access. This is discussed further in 5. 8

September - October 2012: Anita B. still out of school and becoming interested in Islam

4.2.35 In early September, CAMHS Dr A wrote a letter to support child A receiving alternative education, but that mother was not happy for the suggested alternative education

provider[2]. The EWO asked Dr A to make a referral as this has to come from CAMHS; Dr A had by then left CAMHS, which caused some further delay in the making of the referral.

4.2.36 The EWO visited the family to discuss options. Mother wanted her daughter back in mainstream education, but agreed to visit the alternative education provider.

4.2.37 In mid September the first recorded mention of Anita B. wishing to convert to Islam was discussed at CAMHS. Mother explained that this was under the influence of sibling 2, who had himself converted in the last year. She spoke of the stress this was causing in the family, that she was a Christian herself and could not fully understand and hence support Anita B. in this religion. Also that Anita B. did not fully understand the consequences of a decision to convert and this could be too much pressure at the same time as getting back into education. Dr A was clear with mother and daughter that it was not his place to advise on this, that exploring beliefs was part of adolescence and that with so many changes taking place it was advisable to take time in such decisions.

4.2.38 In September, sibling 2 requested a letter from the GP to state he was in good health as he was due to apply to an overseas university in Saudi Arabia.

4.2.39 Anita B. continued to attend the Youth Centre. Her brother meanwhile explained to his manager that he could not work with girls who had gone through puberty so he could only work with the boys' group.

4.2.40 In mid October, Mother and daughter reported to the practice nurse at the GP surgery and to the new psychiatrist, Dr B, at CAMHS that Anita B. appeared to have recovered and was well mentally. Mother told the psychiatrist they were waiting to hear from education regarding school provision.

Late October 2012: Safeguarding allegation and 5th mental health episode

4.2.41 Sibling 2 called the police on 23.10.12, reporting that Anita B. had been assaulted by her mother. Police attended the home and found Anita B. running around hysterically and throwing herself in front of cars. Mother reported having moved Anita B. out of her way in a non aggressive manner. Anita B. said that life at home was generally good except for the tensions due to her converting to Islam.

4.2.42 Six days later mother reported to CAMHS Dr B that Anita B.'s behavioural and emotional disturbances coincided with the menstrual cycle, that she does not let Anita B. out in case she runs away, but Anita B. has not shown any aggression towards herself or others. Agreed for medication to be continued.

[2] the alternative education provider is for those young people unable to access mainstream education for medical reasons, with the aim of re-integrating the young person into mainstream education or other suitable full time education placement

November 2012 - January 2013: educational provision provided and Anita B.'s mental health appears to be stable

4.2.43 The EWO made arrangements for a visit to the alternative education provider by mother and daughter, following an enquiry on progress by Dr B. This was positive and following a referral from Dr B to the alternative education provider in mid November, an interview was offered early December, and Anita B. started at the alternative education provider on 10.12.12, over a year after her first mental health episode.

4.2.44 Mother and daughter attended CAMHS in November and described an episode when Anita B. was crying and complaining of a headache, struggling to eat, wash and dress herself. Unlike in previous episodes Anita B. denied any perceptual abnormalities, such as auditory or visual hallucinations. Anita B. also reported her plan, to the psychiatrist, to leave the decision about conversion to Islam until she is 18 years old.

4.2.45 When they returned to CAMHS in January, Dr B noted that Anita B. was pleased to be at the alternative education provider and mother and daughter reported a good atmosphere at home. Communication with the alternative education provider by the psychiatrist confirmed that Anita B. was attending regularly , doing well and will be moving to a bigger class.

February - March 2013: safeguarding allegation and concerns about the emotional stress within the family over religion

4.2.46 Sibling 2 resigned from the Youth Centre on 1st February 2013 following a discussion with his manager. This was due to his difficulties working with girls who were post puberty, in accordance with his religious beliefs.

4.2.47 On the 25th February, Anita B. (and sibling 2) were reported as missing by their distressed mother. She was very distressed and requested police attend the home.

4.2.48 The siblings attended the police station that evening (8pm) to complain that their mother was 'oppressive' to Anita B, because she had converted to Islam and that when she refused to convert back to Christianity mother had slapped her face. The police reporting officer noted that Anita B. stated she had mental health issues, but appeared mentally healthy and 'conversed like any other 14 year old'.

4.2.49 After consulting Mother, it was agreed that Anita B would return home if her brother accompanied her and stayed over. He wanted to ensure his sister's safety and agreed to do so. The police officer noted that mother and her children needed help as soon as possible from 'social services'.

4.2.50 In fact, sibling 2 took his sister to his own flat for a few days, without his mother's permission and Mother believes that this was allowed by the police (see comment box below).

4.2.51 The next day the alternative education provider contacted the EWO after Anita B. arrived at school with sibling 2. She was dressed in a jilbab[3] and her brother said she should not have a male tutor or male students in her group, and should not listen to music or draw any art 'with a soul' (such as people or animals). The alternative education provider also discussed concerns with the attached community police officer who agreed to pass to PREVENT[4] officer.

4.2.52 The EWO contacted the Youth Club and learnt that Anita B. had not attended in recent weeks, that sibling 2 no longer worked there and had cut all ties with his friends subsequent to his conversion to Islam.

4.2.53 The alternative education provider head teacher and the EWO contacted children's social care who shared the earlier police referral and planned to visit Anita B. at the alternative education provider that day (then delayed till the next day due to the sickness of social workers).

4.2.54 Two social workers did visit the next day (27th February) and an assessment was undertaken, seeing Anita B on her own and learning she was staying with sibling 2. Mother had two telephone conversations with a social worker, when records show she agreed that Anita B could stay with sibling 2 for two weeks.

4.2.55 Children's social care reported to CAMHS on 20th March that the assessment concluded that nothing in mother's parenting would warrant social work involvement, but there are concerns about the influence of sibling 2 on Anita B. and that mother was worried this could impact on Anita B.'s emotional state. The social worker recommended that CAMHS consider providing joint work for mother and daughter, and no further action for social work services.

4.2.56 Following reports to the police by the alternative education provider and the EWO, on 25th March the Channel Panel[5] requested information sharing requests in relation to sibling 2.

Comment
There was appropriate information sharing and response to the report by Anita B. that mother had slapped her. Also appropriate was the recognition by the alternative education provider and EWO of the need to inform the police and children's social care of possible concerns about sibling 2's views .However:

[3] jilbab refers to any long and loose-fit coat or garment worn by some Muslim women

[4] PREVENT is part of the government's counter-terrorism strategy; its aim is to stop people becoming terrorists or supporting terrorism;

[5] Channel Panel is part of the Prevent strategy. It is a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into terrorism. The Channel Panel should be the forum in which information is shared and risks about radicalisation considered. If a risk is identified, a plan will be agreed and intervention offered. Acceptance of such intervention is voluntary and cannot be imposed.

- *Both mother and sibling 2 recounted that police gave sibling 2 permission to take Anita B to his home: this is not consistent with police records and is likely to be what sibling 2 told his mother, but it has become part of the family belief that sibling 2 was allowed by police to have care of his sister, without the mother's permission*
- *the mother was not seen as part of the assessment by children's social care (see 5.2)*
- *the social workers recommendation of joint work with mother and daughter did not address the concerns about sibling 2's influence and was not followed up by either agency.*

April - July 2013: 6th mental health episode

4.2.57 Mother telephoned CAMHS on 3rd April requesting an appointment as Anita B. was having another 'episode'. When they attended CAMHS on 9th April no manic signs were noted, Anita B. was not wearing Islamic clothes and she spoke of implementing Islam gradually into her life. The prescribed medication was continued.

4.2.58 Mother telephoned CAMHS for advice on the 19th April as Anita B. was manic overnight, singing, dancing and laughing in her room. However, mother was not concerned about her daughter's safety and agreed to monitor closely.

4.2.59 The next evening mother called emergency services as Anita B. had locked herself in her room and was restrained by sibling 3. The police attended and Anita B. was taken to hospital by ambulance. She had been aggressive and thrown clothes out of the window. She told the ambulance crew that 'God is punishing me'. At A&E Anita B. assaulted staff and family, whilst shouting, crying and screaming. She tried to leave the hospital and police were called. She was restrained and sedated, became less aggressive but started to sing and dance. She was assessed by two psychiatrists in the presence of a social worker and sectioned under the Mental Health Act (Section 2)[6].

4.2.60 Staff experienced difficulties in managing Anita B. whilst waiting transfer to a psychiatric in-patient unit. Early the next morning she was transferred to Huntercombe Hospital.

4.2.61 The Channel Panel met the following day and agreed for police to see sibling 2. Anita B. was discussed but did not meet the threshold for inclusion in the process. It was noted sibling 2 hoped to travel to Saudi Arabia or Yemen. The panel was followed by police officers meeting with sibling 2 and a subsequent meeting between him and an intervention provider. This assessment concluded there was no need for further action.

4.2.62 There were regular family visits to Anita B. and communication between CAMHS Dr B, mother and Huntercombe Hospital. Mother was not happy with the hospital and wanted

[6] Section 2, Mental Health Act 1983 provides power for compulsory admission to hospital for assessment. An application for admission for assessment may be made in respect of a patient on the grounds that— (a)he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and (b)he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

her daughter transferred to the Priory, but was advised that there was a lack of beds in appropriate units nearer home.

4.2.63 In early June the CAMHS psychiatrist and family attended the Care Plan Assessment (CPA) at Huntercombe. Anita B. was diagnosed as bipolar. The meeting agreed to contact children's social care social worker, to stay in the same hospital ward under Section 3, Mental Health Act 1983[7] with increased leave, another CPA in three weeks, blood tests to monitor medication and request a brain MRI.

4.2.64 When the CAMHS psychiatrist attended the discharge CPA near the end of July. Anita B. was bright and calm and her mental state was stable. Whilst mother was not happy with a bipolar diagnosis, the hospital's psycho-educational input explained the possibility of environmental links such as a possible link with the HPV vaccine. Mother had long considered this vaccine as a trigger, and in the light of this possibility being acknowledged appeared to accept the diagnosis.

4.2.65 Anita B. was discharged that day and the family planned to leave for West Africa in August for a few weeks as maternal grandmother was ill. Mother had appropriately first sought advice about the suitability of this trip for Anita B.

Comment
There was good information sharing between Huntercombe Hospital and the local agencies.

Channel Panel: There was no evidence that Anita B. met the threshold for intervention. Further work was undertaken to explore the possibility of risk arising from potential radicalisation for sibling 2, and this concluded appropriately that he was not a risk. What was missing here was the consideration by Channel of the risks within the family of sibling 2's beliefs, in the context of a vulnerable and ill child as is discussed in 5.11 and finding 6.

September - October 2013: stable following hospital discharge

4.2.66 CAMHS Dr B left in August 2013 and Dr D met with Anita B. in September when her mood was stable and a good holiday in West Africa was reported. It was agreed to keep medication stable and to consider a cautious reduction at the next appointment.

4.2.67 When mother and two [unidentified] brothers attended CAMHS with Anita B. at the end of October it was noted that Anita B. was compliant with medication and remained well. It was agreed to reduce her dosage level due to some side effects.

[7] Section 3, Mental Health Act 1983 enables the treatment of a patient in a hospital.

November 2013 - January 2014: Mother concerned about possible relapse

4.2.68 Two weeks later mother spoke to the mental health nurse as Anita B was 'unwell' and mother agreed to monitor closely. At the review appointment early December Anita B. was reported to be well again following the increase of medication dosage. She remained well when seen in early January.

4.2.69 Anita B.'s attendance at the alternative education provider in this period was deteriorating. She reportedly got ready for school, but then felt unable to leave the house, would throw her clothes around and be tearful.

February - early April 2014

4.2.70 On the 27th February, mother contacted CAMHS because Anita B. had become aggressive, depressed and tearful. She was sleeping less and lying in bed with her eyes open and not speaking much, but when she did, it was difficult to understand. Anita B. was missing her [unidentified] brother who was in West Africa as well as saying she was upset her father had left her. Mother was advised to go to A&E should she deteriorate.

4.2.71 Dr D saw Anita B. five days later and noted she had been unsettled for the last few weeks with sleeping difficulties, low moods and fleeting thoughts of suicide. That day she and her mother spoke of missing one of the siblings who was noted to be in Africa. Mother had financial worries and daughter was worried about the family. There was no active suicidal ideas and no 'biological features of depression'. The psychiatrist wrote to the GP requesting a referral for family therapy and physical investigation of Anita B.'s 'secondary amenorrhoea'[8].

4.2.72 When Anita B. returned to CAMHS a month later, she appeared to be doing well. She was happier, sleeping well and was no longer worried about her [unidentified] brother, and spoke to him most days [it is now assumed this is sibling 2, the brother previously said to be in Africa].

4.2.73 At the alternative education provider, Anita B. had been entered for seven GCSEs and secured a place at college to study child care. In these last months she had attended in Western dress.

Late April 2014: Anita B. missing

4.2.74 Mother reported Anita B. missing to the police on the 24th April. She had left her with sibling 2. Her passport and a few clothes were missing. Whilst at the police station mother received a text from sibling 2 saying he and Anita B. were in Egypt, that she had come with him voluntarily. Mother called him and she put the phone on speaker. Sibling 2 re-iterated that he did not force his sister to go with him. Police spoke to him and to Anita

[8] Secondary amenorrhea is when a woman who has been having normal menstrual cycles stops getting her periods for 6 months or longer.

B, but they did not say when they would return to the UK. Sibling 2 spoke of mother stopping Anita B. from practising Islamic practices at home.

4.2.75 The police assessed Anita B. as high risk and completed a missing person report.

4.2.76 A few days later Mother reported to CAMHS and GP that Anita B. had been abducted.

Professional actions following Anita B.'s abduction

Police investigation

4.2.77 The following sequence of events shows the information found by police as part of their investigation.

4.2.78 The police established that brother and sister flew out of the country on 24th April, the same day mother reported Anita B. to be missing. Sibling 2 flew to Egypt on a single ticket, whilst Anita B. had a return ticket.

4.2.79 The same day at the police station mother spoke to both her children on the telephone in Egypt. This was her last contact with her daughter. Mother was concerned that Anita B. did not have her medication with her.

4.2.80 The police learnt that the previous summer the family had all gone to West Africa, but that when the rest of the family returned, sibling 2 remained on family business. However he was assaulted there and moved to Cairo, where he lived for five or six months. He returned to the UK on a trip lasting eight days before returning to Egypt with his sister.

4.2.81 Because of the sensitivities of Egyptian politics at the time of Anita B.'s disappearance, the police were limited in their investigations. She was reported as a missing person, but the address that mother was given did not exist.

4.2.82 In August 2014 the police had information that Anita B. had died during an exorcism, but this has never been verified. The police also learnt that sibling 2 told mother before they went that he wanted to take Anita B. to Egypt to be cured. Mother made reference to 'demons' and 'spirits' in her conversation with police.

4.2.83 Police learnt that sibling 2 travelled to Tanzania in early 2015 and then to Dubai. In March 2015 sibling 2 was arrested in the United Arab Emirates (UEA) as a result of the British police issuing a 'red notice' to arrest him in relation to child abduction.

4.2.84 Sibling 2 was granted bail in May 2015, and his mother went there to find him. She spoke of being told that Anita B. was alive and well in Cairo.

4.2.85 In June 2015 sibling 2 was re-arrested and agreed to extradition to the UK. The extradition arrangements with the UAE are complex and mean that an individual cannot be prosecuted for a more serious offence than that cited as the charge on the extradition. In consequence sibling 2 was interviewed as a suspect for Child C's abduction but could only be interviewed as a witness in relation to child C's suspected death. His account is

untested but detailed the deterioration of child C's emotional state. She suffered from sleep difficulties and was restrained due to her aggression. His account is that he found her unconscious on his return from Mosque and she later died. Sibling 2 will not say where child C is buried, other than she received a full Islamic burial.

4.2.86 In November 2015 sibling 2 received a sentence for 3 years 4 months for the abduction of his sister.

4.2.87 The police investigation has confirmed that whilst sibling 2 has fundamental Islam beliefs and wants to live in a Salafi [9] community, there is no known link between sibling 2 and any terrorist organisation.

Comment
When a child goes missing, and there is concern s/he is at risk of significant harm, a s.47 enquiry should be initiated and a strategy meeting held. In this case there was no s.47 enquiry, and instead CSC did not open a referral, and closed the communication of Anita B being missing five days later. A strategy meeting was only held nearly four months after she disappeared without her medication and to a place in the world which was at the time unsettled following political events.
This is discussed further in 5. 8 and finding 9.
Mother was wanting help to locate her daughter, making her a Ward of Court and going to the media for help. However, the view was taken by Hounslow agencies not to support media involvement, in case it placed Anita B at greater risk, due to advice from the Foreign Office.

5 THEMATIC ANALYSIS

5.1 Introduction

5.1.1 Section 5 considers professional practice thematically, explaining why actions and decisions were taken in this case. Section 6 provides the systemic findings and recommendations arising from this analysis.

5.1.2 This analysis is addressing itself to the following questions:

A. Were Anita B.'s health needs adequately understood and addressed?

B. Were Anita B. and her family's needs for support understood and addressed?

C. What was the role of religion in this family and was this understood and any associated risks assessed?

[9] The Salafist doctrine is an ultra-conservative approach within Sunni Islam. Followers reject religious innovation and support the implementation of sharia (Islamic law). The movement is often divided into three categories: the largest group are the purists who avoid politics; the second largest group are activists in politics; the smallest group are the jihadists, who form a tiny (yet infamous) minority.

D. To what extent was there a lead professional co-ordinating multi-agency practice? If not was this needed?

E. What was the role of religion in this family and was this understood and any associated risks assessed?

A. WERE CHILD C'S HEALTH NEEDS ADEQUATELY UNDERSTOOD AND ADDRESSED

5.2 Anita B.'s mental and physical health

5.2.1 Apart from mild asthma which was under control, Anita B. had no other major physical health needs. However, from the age of thirteen she suffered with a severe mental illness and during her severe episodes she displayed psychotic symptoms.

An extremely ill child

5.2.2 Anita B had frequent mood fluctuations and during the period of this review at least 6 instances of more severe mental health episodes. At the age of fourteen she was subject to both a section 2 and section 3 order under the Mental Health Act 1983. During these episodes, Anita B. was acutely distressed, aggressive with sleep and appetite disturbances. There were concerns for her safety as she tried to leave home and throw herself under vehicles, and at times displayed psychotic symptoms. She was diagnosed with bipolar disorder in 2013.

5.2.3 The Young Minds web-site states: 'Bipolar disorder is not a common mental health problem and it is quite rare in children. It affects 1 in 100 people and usually starts when a young person is between 15 and 19 years-old. '

5.2.4 Anita B was relatively younger than is common at the age of onset of her disorder and it is a marker of her level of illness that she had two hospital admissions (2012 and 2013) and was subject to both a section 2 and a Section 3 of the Mental Health Act as a result of her illness.

5.2.5 Anita B and her family's engagement with services was ongoing throughout her illness as they faced the task of adjusting to the impact and implications of her becoming unwell with a major mental health condition. Her functioning was affected across all domains of her development and this required a different level of engagement with services to that which parents would usually expect, particularly in respect of her access to conventional education and need for mental health service input.

5.2.6 What is not clear is if the multi-agency network appreciated how rare this level of ill health is in someone so young and the consequent need for extensive family support.

5.2.7 A CAMHS psychiatrist was the lead professional within the multi-agency network, seeing Anita B. regularly and maintaining contact with mother and other professionals in the multi-agency network. This was good practice.

5.2.8 Anita B. was provided with the appropriate professional mental health assessments and support, including inpatient treatment when that was necessary for her health. She was though in 2013 placed outside of Hounslow in Huntercombe Hospital. The IMR of the local Mental Health Trust (WLMHT) refers to:

> *'... a national bed crisis in relation to CAMHS and children who require acute Hospital treatment and in particular a secure setting. It is a matter that WLMHT can only influence through alerting NHS England and ensuring data is fed via recognised pathways to the government when these events occur. It is true that in this case the CAMHS team understood mother's distress and regularly enquire of the local bed availability and would have requested that Anita B. was moved nearer home if an opportunity arose.'*

Causation

5.2.9 The issue of causation of Anita B.'s mental health was an ongoing concern to the family during the period under review as they struggled to understand and accept how she had apparently suddenly changed from a healthy into a mentally ill young girl. Mother observed that it commenced after the HPV vaccination and was asking if there could be a link. Also the cyclical nature of Anita B.'s episodes was observed and Mother raised the possibility of her mental ill health being hormonal in causation. Although there were a variety of tests undertaken whilst Anita B. was in hospital, such as scans and blood tests, there does not appear to have been any tests to establish the links with Anita B.'s periods.

5.2.10 Anita B.'s GPs were asked by CAMHS psychiatrists on two occasions (June 2012 and March 2013) to make a referral due to the irregularities of Anita B.'s periods. These requests were received by two different GP practices as Anita B. changed GP in the intervening period and there is no information in records whether such a referral was made and if not why not. The GP IMR refers to the possibility that the GP did not make the referral in 2012 as Anita B.'s periods had returned once she ceased taking her medication for her depression.

5.2.11 The lack of involvement by the GPs in this serious case review means we have not been able to establish the reason for the lack of referral to explore possible links with any underlying hormonal cause. However, the psychiatrist on the review panel has advised the link between hormonal status and bipolar disorder is complex and would not have been likely to explain the aetiology of Anita B's disorder. However, the requests to the GP for a referral were made so as to provide re-assurance to the family and to support their engagement with services, as they were more concerned about such a link.

5.3 The role of school nursing in relation to Anita B.'s health and welfare

5.3.1 The school nursing service was appropriately informed of Anita B.'s mental health episodes, but there was a lack of pro-active follow-up by the service.

5.3.2 In November 2011, having been informed of Anita B.'s mental health admission, the school nurse response was limited to confirmation that Anita B. had been seen by CAMHS, but no discussion directly with the clinicians involved occurred, no further information was sought and consequently no possibility of making any informed judgement about any potential future risks or whether the school nursing service needed to be involved.

5.3.3 This pattern continued of the school nurse receiving information intermittently, usually from the hospital or the EWO, but without there being consideration of possible assessment by the nurse. Examples include Anita B.'s admission to the Priory in 2012; A&E presentation in 2013; lack of education from November 2012 and then subsequent transfer to the alternative education provider.

5.3.4 It may be that the school nursing service assumed there was no role for themselves because of CAMHS involvement and that the help and support required was beyond the early intervention strategies provided by school nursing. However, such a judgement should be based on an assessment of need involving discussion with CAMHS and the school / the alternative education provider.

5.3.5 The health overview report and HRCH management review indicate that resource issues may have been a contributory factor to the lack of school nurse assessment of Anita B.'s needs, with a vacancy rate of nearly 29% and high caseloads for children subject to child protection or child in need plans (which take priority). Moreover only two of the school nurses were appropriately qualified at the time.

5.3.6 What is not known is the extent to which this was a systemic issue and if so if there has been any change over time and with the different commissioning arrangements and change of provider.

5.3.7 Whilst a more active school nursing role is unlikely in itself to have made much difference in this case, it is part of the lack of any integrated forum to provide support

for the family, involving professionals from different agencies and co-ordinated by a lead professional {see section D below].

5.4 Communication between hospital and community services

5.4.1 Anita B. received regular input from the GP and CAMHS. She also had several hospital presentations, with admission for treatment at the Priory for six weeks in April and May 2012 and Huntercombe for three months from April 2013.

5.4.2 Generally communication was good between hospital and community health services, but the GP was not informed of Anita B.'s hospital attendance in November 2011 - the reason for this omission is not known, but it appears to be an isolated failure in information sharing and not indicative of any systemic weaknesses by the local hospital. The GP also appears not to have been informed of Anita B's admission to the Priory until the discharge summary was received.

5.4.3 It is difficult to be clear what information sharing there was between The Priory Hospital and West London Mental Health Trust due to discrepancies in their records. Although not in the West London Mental Health Trust records, the Priory records demonstrate that Dr A spoke with the Priory within days of her admission, that he attended two Care Planning Approach (CPA) meetings in May, including one on the day of her discharge and had interim feedback between these meetings. Dr A was identified as the care co-ordinator and agreed at the discharge meeting to see Anita B within days of her return home.

5.4.4 There was good communication between community services and Huntercombe Hospital, another independent provider of mental health services, possibly due to a well established working relationships. The Hounslow CAMHS psychiatrist was involved in the CPA meetings at the hospital and children's social care invited (albeit did not attend).

5.4.5 The missing communication was between hospitals and the education providers for Anita B. Practitioners told us that this is usual practice, although CAMHS would have expected the education providers to be directly involved by the hospital. Without such communication, education is provided in hospitals without liaison with the child's teachers and school staff are not involved in CPA meetings and are unaware of discharge arrangements. This led in this case to the school not being aware Anita was back home, but not attending school when she was discharged from the Priory in 2012.

B. WERE ANITA B.'S SAFEGUARDING NEEDS ADDRESSED?

5.5 Safeguarding concerns in February 2013

5.5.1 There was one occasion when there was a particular possible child protection concern, arising from the report to police on 25th February 2013 that mother had slapped Anita B.'s face. This was appropriately reported to children's social care and followed up in a timely manner, with a telephone strategy discussion, police consideration of the need or not for a child protection investigation (s.47 enquiry[10]) and agreement for social care to undertake an assessment to see if this was necessary. This assessment gave consideration

[10] S.47 enquiry refers to section 47 Children Act 1989:r where a local authority has reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

to key issues and the history and included seeing both Anita B. and sibling 2 individually, but not Anita B's mother, nor the other sibling living in the family home.

5.5.2 The assessment highlighted the potential emotional abuse to Anita B. by her mother arising from mother's concern about the influence of sibling 2's perceived brainwashing of his sister with regard to Islam. This emotional abuse allegedly included threats to use magic, take Anita B. to West Africa or place her in foster care. The risks of this acrimony were identified in terms of triggering a potential relapse of Anita B.'s mental health.

5.5.3 More positively, apart from the issue of religion, the family appeared to function well, with sibling 2 speaking positively of mother's parenting and Anita B. wanting to be in her care. The incident of physical chastisement was assessed as a one off incident. The police involvement when mother was said to have 'pushed' Anita B in October 2012, was not mentioned in the assessment, although was considered in the strategy discussion. Despite mother's view that Anita B. was too young to convert to Islam, she had demonstrated some acceptance, buying Halal food and sewing Islamic garments.

5.5.4 Overall the decision not to move into child protection processes was appropriate. However, there was no meeting with the mother herself, to assess what had driven a caring parent into such action. This was particularly a weakness of the assessment given that mother herself has reported subsequently contacting CSC and requesting help, but never obtaining a response, albeit this is not in social care records. Also, the other sibling living in the home was not included in the assessment. Th e lack of the involvement of the mother and other sibling also meant a limited understanding of their perspectives of the conflicts in the family arising from religion.

5.5.5 The decision to close the case and leave to CAMHS would have been reasonable if there had been any confirmation that CAMHS planned to undertake the requested family work to explore the difficulties that had occurred due to the differences of opinion of Anita B's conversion to Islam, and the likely impact this could have on her mental health. However, such a confirmation was not received.

5.6 Knowledge of safeguarding concerns about Anita B. by sibling 2's university tutor

5.6.1 Another possible child protection issue arose when sibling 2 spoke to his tutor at university. Sibling 2 expressed his concern that something needed to be done about Anita B., she had tried to commit suicide and that psychology did not seem to help. He did not like his sister being at home as his mother's religion encouraged her to think she had the devil in her. He made a reference to having been through it himself and possibly mentioned 'beatings'. At a later stage sibling 2 was pleased that Anita B. was in hospital and would be treated. He was re-assured that the hospital suspected a link to puberty and hormone levels.

5.6.2 Sibling 2's tutor did not communicate these concerns to local services because she perceived her role as being there for sibling 2 and that she could not break that confidentiality. She was though re-assured that sibling 2 had informed agencies of his concerns locally and that later Anita B. was receiving the care she needed as she was now in hospital.

5.6.3 The tutor's understanding of child protection procedures does not appear to include the limits of confidentiality in terms of concerns about children. It is not known if this is an isolated individual misunderstanding or one that applies more generally to the staff at that university.

5.7 Response to complaint about Anita B.'s treatment whilst in Hospital

5.7.1 In June 2013, mother wrote to CAMHS to 'express her disappointment' at her daughter's treatment at Huntercombe Hospital, describing the service as substandard. In particular she mentioned the lack of formal diagnosis, the hurried approach of a psychiatrist and the lack of communication from 'medical decision makers' and requesting more family involvement in developing care plans.

5.7.2 Also within the letter is an allegation that Anita B 'was assaulted in an excessive manhandling by two male staff', who restrained for an 'unnecessary injection'. Mother raises the concern that 'it may be that this practice is not uncommon in regards to her' given the amount of injections that were being administered.

5.7.3 It is clear that Mother's concerns were discussed with the CAMHS psychiatrist, and at a Care Plan Assessment meeting the following week, with family and with Anita B herself. However, the focus of the discussion, from information provided by CAMHS to the review team, was about the family's wish to move Anita B to a different hospital, as opposed to the specific allegation of 'manhandling' and any consideration of the advisability of two male staff.

5.7.4 In CAMHS records there is a reference to this 'complaint', but no specific reference to what happened as a result of this and whether or not the complaint was passed to Huntercombe Hospital to investigate. Huntercombe Hospital have not responded to the this particular question which was sent to them by the serious case review.

5.7.5 The was no formal response to mother's letter by CAMHS and evidence that it was passed to the hospital to investigate. There does not appear to have been any exploration of the allegations around 'manhandling', and both mother and sibling 2 mentioned the lack of any formal response to their concerns when being interviewed for the purposes of this review.

5.8 Response to Anita B being missing

5.8.1 Mother reported Anita as missing in April 2014, and it was immediately established that mother had not given permission for her daughter to accompany her son to Egypt. She also immediately expressed her concern that Anita B did not have the medications she needed to take for her asthma and her mental health condition.

5.8.2 The police informed CSC the next day. CSC made the decision not to open the case because Anita B was out of the UK and this would be a police investigation. This seems to ignore the fact that she was at risk of significant harm as she was without her medication as well as in a country which was in a state of political unrest, albeit the Foreign Office was not at that point advising against travel there.

5.8.3 It also ignored the London child protection procedures (of 2014) which stated:

' For any child who is missing from home, a strategy meeting / discussion should be held within 28 days, arranged by LA children's social care and the police invited ..... '

5.8.4 The term 'missing' was defined as:

' their whereabouts are unknown, whatever the circumstances of their disappearance. They will be considered missing until they are located and their well-being or otherwise is established.'[11]*,*

5.8.5 It should be noted that this has become even more significant in the 2016 procedures, which only allow 7 days for the holding of a strategy meeting.

5.8.6 Only when the police pointed out the lack of a strategy meeting (as per procedures), did this occur in August.

5.8.7 Whilst local agencies would have been limited in what actions they could have taken at this point, a meeting would have enabled earlier consideration of support requirements for the family.

5.8.8 This delay in convening a strategy meeting highlights potential misunderstandings of the need to use child protection processes when a child is missing abroad. Whilst it was known she was with her brother, Anita B was missing from home and police accepted she had been abducted.

C. WERE ANITA B.'S EDUCATIONAL NEEDS MET?

5.9 Educational provision

5.9.1 Following the first episode of Anita B.'s illness (November 2011) she was out of school for thirteen months. In December 2012 she was reintegrated into education at the alternative education provider to enable her to catch up and re-integrate into

[11] London Child Protection Procedures in force in 2014

mainstream education. Reports from the school and the alternative education provider were that she was made good progress in her education and her relationships with peers.

5.9.2 During these thirteen months, Anita B did not receive any alternative education provision such as home tuition, but mother was advised by the school of web based resources and Anita B was provided with some homework. It is not clear if she ever accessed such provisions.

5.9.3 To have been out of education for thirteen months is of great concern and is in itself a safeguarding issue. The serious case review panel were advised by the Director of Education (a panel member) that it is unusual for a child to be out of school for this length of time, but the complexity and the circumstances in this case, would make it harder to find a suitable school place.

November 2011- June 2012: three days education

5.9.4 Between November 2011 and mid June 2012 Anita B attended school for three days only, in early January. There are different understandings of her situation at this time:

- From the perspective of the local authority Anita B remained on the roll of the school - they had no further information until June and were unaware she was not receiving any education: there is no system for identifying children not receiving an education unless they are either missing from home, or reported as not attending by the school [this is understood to be a national issue]
- The school continued to consider Anita B as a pupil, who was ill during the Spring term and then educated off site when she was admitted to the Priory Hospital in April - without receiving notification from the hospital of her discharge, Anita B continued to be understood to be in hospital until her mother contacted them in mid June to collect Anita B's belongings from her locker
- Mother's view [from CAMHS records] was that she was that she had applied for school transfer, Anita B did not want to return to school and mother wanted home tuition whilst waiting for an alternative placement
- The psychiatrist's source of information was the mother and on two occasions agreed to write a letter of support for school transfer and home tuition in the interim [but this was not done during this period]

5.9.5 Illness was clearly a factor in Anita B's non school attendance, with a deterioration in early January, late February and the end of March, culminating in a hospital admission in April 2012 for six weeks in mid May. However, from CAMHS records it is evident that for much of this period Mother considered Anita well, but that she was waiting for another school place. Anita seemed to be well in December, parts of January, February, March, May and June.

5.9.6 Another factor at this point was the lack of an overall understanding of Anita's educational provision, associated with the lack of a lead professional in the network able to co-ordinate the agency input (see 5.10).

Mid June - December 2012

5.9.7 Following mother's removal of Anita B's belongings from her school locker in mid June, the school made a referral to the education welfare officer (EWO). The chronology cites a great deal of activity by the EWO from June /July and attempts by her, Anita B.'s school and CAMHS to obtain an alternative educational placement.

5.9.8 Delays continued and it took a further six months for Anita B to be able to start at alternative education provision, despite continued efforts by the EWO. During these six months, Anita B's mental health was largely stable, except for a deterioration for a short period at the end of October. However, getting educational provision took half a year due to mother initially wanting a mainstream school, as opposed to the suggested alternative education provider, and this wish being in the first letter written by the psychiatrist. Then with a change of CAMHS psychiatrist there was further delay in making a CAMHS referral to the alternative education provider.

5.9.9 Throughout this time, there were no interim arrangements made to support Anita B whilst awaiting a school placement, such as home tuition. She was provided with access to web based support though.

Systemic obstacles in such complex cases

5.9.10 Whilst the review panel understand that this was a complex case and it is very rare that children do not receive educational input for such periods, there are no systems in place locally or nationally for us to know the numbers of children who are on roll at schools, classified as long term ill, and are not receiving any educational input.

5.9.11 The local authority is only notified of those who are considered to be either 'missing' (whereabouts unknown) or not attending. Before mid June, Anita B did not fall into either category as she was classified as sick by the school.

5.9.12 After June, it took another six months to get Anita B into education, despite a great deal of time and effort by the EWO. No alternative temporary arrangements were put into place, such as home tuition.

5.9.13 Since September 2015 such home tuition facilities are available in Hounslow, as schools are able to choose to commission such a service directly and the alternative education provider now offers this as a service.

D. TO WHAT EXTENT WAS THERE A LEAD PROFESSIONAL CO-ORDINATING MULTI-AGENCY PRACTICE? IF NOT WAS THIS NEEDED?

5.10 Understanding of and support to family

5.10.1 One of the notable features of this case was the support and care provided to Anita B. by her mother and brothers. It is apparent from the records that the mother and Anita B's brothers were extremely concerned about Anita B.'s mental health and her welfare. Mother always attended health appointments with her and often present was a brother, and sometimes two of them.

5.10.2 What is less clear is the extent professionals understood the family dynamics or considered the necessity of doing so, despite knowledge of the family conflicts arising from the involvement of sibling 2 and Anita B. in Islam and recognition of the risks to Anita B. due to such ongoing stress.

5.10.3 A notable feature of the lack of attention paid to family dynamics was the repeated failings in agency records to identify which brother was present at any appointment or ward round. This was even in the context of knowledge of the conflict arising from the conversion of one brother to Islam.

5.10.4 Even when it was considered appropriate to address the family problems, it was usually considered in terms of the mother / daughter relationship, without acknowledgement that this was only part of the complex dynamics within this family.

5.10.5 A missed opportunity to consider the wider family dynamics was when Anita B alleged to police in February 2013 that she had been slapped by her mother and then the alternative education provider referred sibling 2 to Prevent. However, the recommendation by children's social care to CAMHS was for work on the mother/daughter relationship, as opposed to the entire family relationships.

5.10.6 It is likely that the lack of identification of the need for an understanding of family dynamics related to the fact that Anita B. clearly had a mental health problem and that this was not perceived as arising from family problems. However, it was identified as being exacerbated by these problems.

5.10.7 The lack of any co-ordinated multi-agency input will have contributed to the narrow approach taken to supporting the family. Had there been meetings involving the family and professionals involved in the family, including CSC, EWO, school / the alternative education provider, GP and CAMHS, a better understanding of the problems facing the family, including mother's own health and financial problems, should have emerged. Also the fact that Anita B remained without educational input would have also emerged earlier and may have been resolved more quickly. Had there been an identified lead professional, it would have facilitated such multi-agency assessment and co-ordination (see finding 1).

E. WAS THE ROLE OF RELIGION IN THIS FAMILY UNDERSTOOD AND ANY ASSOCIATED RISKS ASSESSED?

5.11 Was the threat of 'radicalisation' relevant to professional practice in this case?

Government response to terrorism

5.11.1 In December 2011 the Terrorism Prevention and Investigations Measures Act 2011 introduced the new system of terrorism prevention and investigation measures designed to protect the public. *Prevent* is part of the government's counter-terrorism strategy (CONTEST) to protect the public from the small number of people who pose a terrorist threat. Preventing terrorism involves challenging extremist (and non-violent) ideas that are part of a terrorist ideology and intervening to stop people moving from extremism into terrorist-related activity.

5.11.2 Prevention involves supporting people who are at risk of being drawn into terrorist activity through the 'Channel' process. This involves a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into terrorism.

5.11.3 During the period under review professionals were working to the July 2011 Prevent Strategy and the non-statutory guidance regarding the Channel strand issued to Police, Local Authorities and partners in 2012. The guidance sets out that, *'Channel is about safeguarding children and adults from being drawn into committing terrorist-related activity'* (Part 1 paragraph 1.2).

5.11.4 The guidance sets out that, 'On receipt of a referral Channel Police Practitioners must, using their professional judgement make an assessment of its suitability for Channel. A review of the information available must show a concern that the individual is vulnerable to radicalism' (paragraph 4.4).

Identification of possible risk

5.11.5 In this case following sibling 2's unexpected arrival at the alternative education provider, requesting that Anita B. not mix with male pupils or staff, not listen to music and not undertake art activities involving drawing people or animals, staff queried whether there was any cause for concern. Appropriate referrals were made immediately regarding both sibling 2 and Anita B. to Prevent. The decision, after initial screening, to only refer sibling 2 to the Channel panel for assessment was entirely appropriate. In the case of sibling 2 there was some information about his aspirations to travel to study in the Middle East, hence the decision to undertake further assessment was appropriate, as he himself agreed when he met with the author and LSCB independent chair.

Assessment and decision making process

5.11.6 The assessment process started with sibling 2 meeting two police officers and discussing his conversion to Islam and the family situation. He was open with the police officers and spoke of his conversion at the end of 2011, his concerns for his sister's mental health as

she was psychotic and in hospital, as well as his understanding that she was a practising Muslim. Whilst he wanted her to be taught by female teachers at school, he was aware that he could not enforce this and had to accommodate to the needs of society. He was aware that his religious conversion had created problems in the family but this had improved over time. He spoke about his hopes to get married and have children, but would not want them raised in a democracy, and would prefer Saudi Arabia to be his future home.

5.11.7 Sibling 2 agreed to meet an intervention provider to discuss his faith and general life views. He did so and was considered to have deeply conservative religious views, but respective of others and with a strong resilience to terrorism.

5.11.8 On the basis of the Prevent police assessment and the conversation with the intervention provider it was appropriately agreed at the next Channel panel meeting in June 2013 that sibling 2 would exit the Channel process subject to six and twelve months reviews. The review in January 2014 involved an exchange of information between the MPS and the Channel chair, and agreed that the status of sibling 2 remain unchanged.

Comment

5.11.9 At this time period, the use of Prevent and the Channel panel was comparatively new and practitioners commented as part of this serious case review that they were largely unaware of the process at that time. Within this context the alternative education provider and the education welfare officer are to be commended for the recognition of a need to make a referral to the police, despite there being no information about any involvement in any form of terrorist activity. Sibling 2 also told the LSCB chair and the lead reviewer that he thought this has been appropriate.

5.11.10 A practice weakness was the lack of multi-agency involvement in the Channel panel process at that time, with attendance limited to the Chair and the police at both the initial meeting and the six month review. This meant that the panel was unaware of sibling 2's previous involvement at the Youth Centre.

5.11.11 The Channel Panel's focus and assessment was predominantly around sibling 2 and not Anita B. This lack of wider family safeguarding perspective limits the information into the process as well as consideration of risks to other family members, such as in this case a very vulnerable sister.

5.11.12 However, even if attendance had been multi-agency at the Channel Panel, and included a family perspective, there was no evidence that any of sibling 2's beliefs or activities involved any risk in terms of radicalisation.

5.11.13 A further potential weakness relates to the understanding and expectations within the multi-agency around the role of Prevent and the Channel Panel and to what extent there should be an understanding of what happens when a referral is made and what feedback

there is to professionals and to the subjects of such assessment. In this case the referrer was never told about the outcome. Sibling 2 told the LSCB chair and lead reviewer that he had little understanding of being discussed at Channel Panel or the outcome of the assessment by the intervention provider.

5.11.14 It is recognised that the way that the Channel panel operates is still developing nationally, in changing circumstances, especially in the light of the statutory reporting duties that have been introduced in 2015. In the light of this it will be useful to review the way the Channel panel operates and the extent to which there is now multi-agency and subject involvement and understanding of the process and its outcomes (see finding 6).

5.12 Mental health and fundamental religious beliefs

5.12.1 The family experienced difficulty in understanding the causes of, and coming to terms with, Anita B.'s mental ill health, especially given the lack of any previous indications of this, prior to November 2011. They were very concerned for her, but had doubts about her diagnosis and the medication: both mother and sibling 2 wanting the medication stopped when they attended a ward round at Huntercombe Hospital in May 2013. Mother expressed confusion about the illness, highlighting that it started with headaches, it was cyclical in nature along with Anita B.'s menstruation and started following the HPV vaccination.

5.12.2 It is known that sibling 2 was very worried about his sister, but not clear what his views were about the cause of her poor mental health, but the following provide some insights about how his views may have changed over time:

- At a ward round in May 2013 at Huntercombe Hospital, sibling 2 stated he did not believe that Anita B. had a mental illness
- Sibling 2 spoke to his tutor at university (at an unidentified time) expressing his concern that his mother's religion encouraged her to think Anita B had the devil in her
- Sibling 2's tutor never had any indication that he believed in the concept of the devil inside Anita B.

5.12.3 In his interview for this serious case review, sibling 2 was clear that his sister was mentally ill, albeit he also acknowledged a belief through his religion in the possibility of this being associated with Jinn[12] (which can be good or mischievous). It is understood this belief was never part of the views sibling 2 expressed prior to living in Africa and Egypt

5.12.4 The family were provided with psycho-educational input at the hospital via a booklet to help them understand the nature of her ill health. By the time of Anita B.'s discharge from

[12] The spirit world of created beings in the Islamic cosmological world is composed of human spirits, angels and jinn. The jinn represent the only possible source of spirit possession of humans from an orthodox Islamic viewpoint. *The Exorcist Tradition in Islam, Dr. Abu Ameenah Bilal Philips, 2007 Al-Hidaayah Publishing & Distribution*

Huntercombe Hospital in July 2013, mother appeared to have a change of heart and had accepted the need for medication. Mother committed to supervise medication and seek early help in the face of a deterioration. The indications, in the family interactions with CAMHS, is that mother followed psychiatric advice and consistently let CAMHS know whenever there was any deterioration in Anita B.'s health.

5.12.5 What was not sufficiently explored with the family, and with Anita B. herself was the impact of the family's religious beliefs on the view of what caused Anita B.'s mental health problems. This was significant given the difficulty there was in being able to help the family understand the apparently sudden and extreme change in the behaviour and functioning of Anita B, and the cyclical presentation of her illness.

5.12.6 With hindsight, and the knowledge of Anita B.'s possible death during an exorcism, some potential areas of risk are identifiable, albeit at the time these would not have been recognised.

5.12.7 The belief in spirit possession leading to possible safeguarding risks is not new and was most notably raised in the case of Victoria Climbie[13]. This risk has continued with the incidence of referrals around spirit possession rising in recent years [14]. This has most commonly been associated with a belief in 'witchcraft' within certain Christian groups, but the basic belief that a child can be invaded by spirits (or in Islam 'Jinn') can lead to efforts to get rid of such a spirit possession. The methods used can vary, but can be harmful to a child, for example due to the exertion of physical force or through emotionally harmful practices.

5.12.8 The learning from this case is that if mental illness presents in terms of possible spirit possession, it is very important that mental health clinicians explore fundamental beliefs with family members, so as to have a full understanding of the impact on family members of their beliefs in how to cure a child. This is particularly significant when family struggle to understand and accept the causation of the illness. The potential risks of exorcisms in relation to mental illness needs to be better understood by professionals, along with the role of such rites in different religions and cultures. CAMHS did do this to some extent, but this was in relation to Anita B's own beliefs, as opposed to those of all the family members.

[13] The Victoria Climbie Inquiry (2003)

[14] http://www.communitycare.co.uk/2014/10/10/guidance-released-help-tackle-rising-tide-child-abuselinked-witchcraft-beliefs/

6 FINDINGS & RECOMMENDATIONS

6.1 Introduction

6.1.1 This section contains the overall findings of this serious case review, with the associated recommendations for the LSCB. The findings relate to what we have learnt about the strengths and weaknesses in multi-agency safeguarding systems through examining what happened to Anita B.

6.1.2 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.

6.1.3 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.

6.1.4 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 .

6.2 Findings

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 reintegration 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.

7 GLOSSARY OF TERMS & ABBREVIATIONS

A & E	Accident and Emergency Department at the hospital
CAMHS	Child & Adolescent Mental Health Service

CCG	Clinical commissioning group
Channel Panel	Channel Panel is part of the Prevent strategy. It is a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into terrorism. The Channel Panel should be the forum in which information is shared and risks about radicalisation considered. If a risk is identified, a plan will be agreed and intervention offered. Acceptance of such intervention is voluntary and cannot be imposed
CPA	Care Plan Assessment
CSC	Children's social care
EWO	Education welfare officer
GP	General Practitioner
IMR	Individual Management Reviews: these are reports provided by individual agencies to the serious case review and explains the involvement of professionals with the family
LSCB	Local Safeguarding Children Board
MPS	Metropolitan Police Service
PREVENT	PREVENT is part of the government's counter-terrorism strategy; its aim is to stop people becoming terrorists or supporting terrorism
WMUH	West Middlesex University Hospital

Hounslow Safeguarding Children Board

Serious Case Review Anita B

Action Plan

	Recommendation	Action	When	By Whom	Outcome
1	The LSCB to review the criteria used in Hounslow to trigger the use of a lead professional to coordinate multi-agency assessment, intervention and support to families, so as to ensure this includes all children suffering from ongoing mental ill health and the lead role of CAMHS in some circumstances.	To ensure that the revised threshold documents include guidance on the appointment of lead professionals when there is a mental health concern.	October 2016	Business Manager of the Board	Identification of a lead professional for children and their families when there is a mental health concern in the context of multi-agency working.
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.	To review current practice of CAMHS engaging with Education Services to achieve appropriate and timely education services.	November 2016	Chair of Missing and Vulnerable Sub Group and Chair of	Educational support is provided for all young people with mental health problems

				Education Network.	
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.	To ensure that there is an understanding of section 117 responsibilities and an agreed process for fulfilling them	December 2016	Chair of Missing and Vulnerable Sub Group and Chair of Health Network	Appropriate after care provided to young people who have been subject to section 3 of the Mental Health Act
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 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.	Report to the Board. Reporting to the LSCB to include level of resourcing, use of suitably qualified and experienced staff and evidence of audits of assessment activity	January 2017	Director of Public Health	Improved support to young people with mental health needs
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.	To write to the University to highlight this issue and request assurance that appropriate guidance is being provided. 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.	September 2016	Chair of the Board	The safeguarding needs of young people are appropriately referred to relevant local authority

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	To hold a workshop to explore these issues and establish how such children can be identified and how they can be notified to the local authority.	November 2016	Chair of Monitoring and Evaluation Sub committee	Improved identification of children who are not receiving education
7	The LSCB to 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.	The Training Sub Committee to establish how to strengthen practitioners' skills.	January 2017	Chair of Training Sub Committee	Improved recognition of risks to children
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.	The Chair of the Board to meet with the Channel Panel chair to confirm compliance with the London chid protection procedures.	September 2016	Chair of the Board	Improved recognition of risks to children
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.	The Board to ensure that the CAMHS complaints procedure addresses complaints about third parties.	November 2016	Chair of the Board	Complaints are addressed by the appropriate agency
10	The LSCB to ask CAMHS to report on what actions they have taken to have confidence that their records consistently cover multi-agency contacts and communication, as well as patient contact and communications.	CAMHS to be asked to confirm that their recording procedures are comprehensive.	November 2016	Chair of the Board	Recordings include professional contacts

11	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.	The Board to write to the London Board to ask that children missing abroad is addressed in revised procedures.	September 2016	the Board	Guidance is provided for children who are reported missing abroad