BRISTOL SAFEGUARDING CHILDREN BOARD BRIEFING

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CHILD PROTECTION INCIDENT REVIEW BRIEFING – FAMILY P

What is a CPIR?

A CPIR (Child Protection Incident Review) is undertaken by BSCB when a case is referred that does not meet the criteria for a Serious Case Review, but can still provide learning at a local level in respect of:

- How agencies are working together
- Improvements that might be required in local services

In Bristol the decision to undertake a CPIR is made by the Serious Case Review Sub-group. A CPIR is completed by local reviewers appointed by the Serious Case Review Sub-group, using the same 'systems' based approach that is used for Serious Case Reviews.

CPIR's are not published, but their learning needs to be shared within the professional community, both what to do differently, and where best practice is identified.

To help embed this learning with all professionals involved in safeguarding children we have decided to issue briefing notes for Bristol CPIR's that can be used to inform practice, and for training purposes across the city.

WHAT WE KNOW ABOUT THE FAMILY AND WHAT HAPPENED

Family P is: Mother, Father and 4 children (aged 2, 4, 6 and 8 years). In 2009, when the eldest child was 2 years old the parents took her to Bristol Children's Hospital with concerns that a family visitor may have inappropriately touched her. The child seemed upset, not walking easily and had not passed urine for a couple of days. The child was examined, children's social care were informed but no concerns were raised and no further action was deemed necessary.

In March 2014 the parents took their third child, who was then 2 years old, to Bristol Children's Hospital with an episode of vaginal bleeding and pain. Children's social care were involved, Female Genital Mutilation (FGM) was identified and a Police Protection Order was utilised to remove all of the children and place them in foster care. The children were returned home 4 days later but subsequently made the subject of a child protection plan. The parents denied that any FGM had taken place throughout proceedings.

In October 2014 the youngest child was born and was made subject to a child protection plan, but the plans for the three siblings ended. At the end of June 2015 the Mother and all the children left the UK for a North African country with a high prevalence of FGM, stating that they would return at the beginning of August. The Mother and children have not returned to the UK to date.

OUR FOCUS IN THIS REVIEW: FGM – ARE ARRANGEMENTS FOR AGENCIES TO WORK TOGETHER EFFECTIVE?

Throughout the period examined by this review the parents were on police bail regarding their possible involvement in the FGM of their third child, and other processes were started or considered, including the care proceedings.

The reviewers found that a lack of knowledge and understanding regarding FGM was a theme across all agencies involved in this case. Professionals did not feel confident in making decisions, which led to some decisions, such as the decision to remove the children initially, being made without full consideration of the situation, the risk, or alternative options.

This lack of knowledge also led to professionals assuming that other agencies had powers that they would exercise (e.g. seizing of passports by the police) which was not the case, and an assumption that other agencies knew what they were doing contributed to a lack of challenge about decisions made.

The role of community advocates wasn't clearly defined before they began working with the family, and when a professionals meeting was called in May 2015, the parents found out and attended. This meeting was not rearranged so the issues it was called to resolve were not dealt with effectively.

THE GOOD PRACTICE THAT WE IDENTIFIED

- All the professionals involved in this review worked really hard to engage with the family and address the concerns.
- During the initial stages of this case there was strong, clear multi agency communication, and there was clearly an intention to work together across all agencies, including community advocacy groups.
- Some individuals went 'above and beyond' in attempts to engage the family, and in ensuring that agencies were aware of risks to the children.

WHAT WE HAVE LEARNT

- Professionals need to feel supported when working cases involving FGM, and have confidence in understanding the potential orders and powers and applying for them to best safeguard children.
- All agencies lacked confidence in understanding the practice of FGM and the response required. This led to confusion around the role of agency 'champions', of community advocates, and also a lack of challenge as professionals assumed that others knew what they were doing.
- Failure to communicate effectively included not always being aware of which professionals were involved in the case, so not everyone was updated with developments that needed to be. Not having all of the information combined with some professionals making assumptions about what had been put in place by social care and the police let to a belief that safeguards around the children were more robust than they actually were.

WHAT WE CAN DO DIFFERENTLY IN THE FUTURE

- Make sure that we have an understanding of FGM, and that we know who the 'champion' is in our organisation. That champion should be widely known and able to offer advice and guidance to practitioners and contribute to multi agency discussions and forums.
- Make sure that minutes from strategy discussion and child protection conferences reach everyone

involved in the case. If you receive them as the lead professional in your organisation make sure anyone else involved gets them too. Inform the social worker of any professionals involved who might not be able to attend the conference so that they can be sent copies directly.

- If there are multiple proceedings running concurrently (criminal/civil/family) then have a protocol in place to ensure join up and links between them.
- In cases with potential community impact, plan and engage with opportunities to meet and speak with the community. It's not just about the individuals involved.

GOOD PRACTICE GUIDANCE RELATED TO THIS REVIEW

- Bristol has a FGM delivery and safeguarding partnership – a forum to support professionals, it coordinates work across Bristol, organises conferences, and discusses safeguarding and child protection at every meeting. Make sure that your agency champion is involved.
- BSCB guidance regarding FGM: https://bristolsafeguarding.org/children-home/professionals/#FGM

FEEDBACK, SUGGESTIONS AND IDEAS

Tell the BSCB how you have used this briefing to improve practice at:

- Email: bscb@bristol.gov.uk
- Twitter: @BristolLSCB
- Website: www.bristolsafeguarding/children/contact/contact-the-bscb

Let us know if you identify work that the BSCB could complete to support professionals learning and development in relation the findings from this review.