Learning Review of services provided to a girl who was at risk of Female Genital Mutilation (December 2019)

Background

Bromley Safeguarding Children Board (now Partnership) has conducted a learning review in relation to the services provided for a primary school aged girl. The focus of the review is on the possible risk of female genital mutilation (FGM). There had also been domestic abuse (mainly emotional and financial abuse) and there were continuing disagreements between the child's parents, who had divorced.

The review concerns services provided between the child's birth (though some of the domestic abuse began before that) and the age of 8. Unusually the child concerned had not suffered significant harm but the review was conducted to see whether lessons could be learned and also as an opportunity to understand whether the current response of services in Bromley to FGM was effective, given that the borough currently only has a relatively small number of children whose families come from countries in which FGM has traditionally been practised.

Domestic Abuse

The family court found that there had been a number of instances of domestic abuse. Given their nature these were classified by agencies as 'low risk' and the mother was directed to organisations that might advocate for her or give her support. There were never grounds for the local authority to undertake an assessment.

The review found that the response to these incidents, by the police, the local authority, Cafcass and the courts was proportionate to the type of allegations that had been made and in line with the policies, procedures and guidelines that staff are expected to follow. The review does not underestimate the anxiety caused by the incidents and recognises that they created a difficult climate for further parental negotiations over the child. They may have had a negative impact on a very young child.

Female Genital Mutilation

During the divorce proceedings the mother became concerned that the father might take their daughter to his country of origin in Africa where she would be at risk because of the very high prevalence of FGM. Although there has never been evidence that the father supported the practice of FGM, or that it was

ever his intention to put his daughter at risk, the mother believed that her daughter would be harmed if she was taken there because she would be likely to spend a considerable amount of time away from her father. The father asserted that other members of his family were also opposed to FGM but this was contested and impossible to prove.

The daughter was kept safe throughout the period under review by court orders preventing her from leaving the UK and restricting access to travel documents. There is no evidence that the father did not comply in full with these requirements or ever intended to breach them. In 2017 the High Court made a Female Genital Mutilation Protection Order (FGMPO) which consolidated and strengthened the existing orders. It would last until the daughter was 17, unless she sought to amend it herself.

In 2015 – 16 the local authority undertook a Section 47 investigation. It was carried out promptly and involved all of the relevant agencies as well as the family, including the child. It focused properly on the child's health and emotional wellbeing, as well as the risk of FGM. Initially the potential risk of FGM was considered to be low and it was advised that the father should be allowed to take his daughter on holiday to Europe. This recommendation was subsequently reversed.

The weakness of the Section 47 assessment was that it did not investigate in sufficient detail either the risk of FGM or the risk of abduction. The assessment listed factors relevant to the risk of FGM in the father's country of origin but no further detailed assessment of the attitude of the father's family was undertaken.

The local authority relied on its own knowledge in arriving at its conclusions when it would have been better served by consulting someone with more expertise.

More broadly professionals working with the family acted in good faith in seeking to understand the risks. There was much good practice in the work that was undertaken with the child by her school and CAMHS.

Learning

The responses of both the police and the local authority reflect the fact that in 2015 – 2016 front line staff working in Bromley in both agencies had limited expertise in dealing with FGM, including the potential value of an application for a FGMPO, which was new legislation at the time. Few staff had received specialist training and there was no specific local protocol on FGM. For the police this meant that reliance had to be placed on senior officers to make decisions, something that may have been appropriate, but took longer than if local officers had had the expertise.

Both agencies have told the review that their current level of preparedness for dealing with such a case is very different. Evidence for this is offered through the specific local protocol which is now part of the safeguarding partnership's

procedures and standard training on FGM and other 'harmful practices' that are considered abusive which is available to the police.

The review has highlighted that this remains extremely complex work in which detailed risk assessments, tailored to the specific circumstances in each case, are required.

Audit and review of recent practice on FGM in Bromley

At the outset the review established that as well as looking at a specific past case it should study current and more recent practice.

The review has identified Bromley as being a borough with a very low likely prevalence of FGM in comparison to other parts of London. This is confirmed by the very small number of potential cases identified in the borough. However it is also important to be aware that migrants from regions of the world where FGM is practised have and will continue to move into the borough. It is also important to recognise that the national origins and beliefs of the father may be significant, but these may not be apparent in services (such as maternity care) where it is the mother who presents seeking a service.

In order to ensure that agencies with safeguarding responsibilities develop and maintain a safe and proportionate response the review has sought to identify the basic elements of the framework that needs to be in place and has initiated self-assessment and audit on them.

These would include:

- The process for the identification of girls born to mothers who have suffered FGM and the creation of a marker on the child's medical record, as with other safeguarding risks
- Agreeing the best way for schools (both primary and secondary) to provide information to girls who may be at risk while not unnecessarily identifying and stigmatising small numbers of children from affected countries
- Auditing the response to the very small number of referrals made to the MASH to ensure that it properly safeguards the girls concerned

Interventions would now be guided by a local multi-agency FGM protocol which was extensively revised in 2018 and is accessible on the safeguarding partnership website. The partnership should ensure that any further learning arising from this review is added to the protocol, including links to relevant recent research on FGM and the numerous documents and assessment tools on the National FGM Centre, including social work assessment tools.[1]

The partnership has noted that the current London Child Protection Procedures include references to the legal and administrative changes (such as FGMPOs and mandatory reporting) that were introduced in 2015. They refer to risk

[1] https://assessment.nationalfgmcentre.org.uk/

assessment checklists drawn from the 2015 multi-agency and health service guidance. They were last revised in 2016 and may need to be updated.

Staff should also refer to the National FGM Centre risk assessment tool.

In a locality where cases of FGM will present very rarely, there is an argument for staff to have access to a small, well-informed multi-professional group who can offer advice on cases and in turn access outside advice.

Recommendations

The review has made recommendations in the following areas. These have been accepted by the safeguarding partnership:

- Health services audit of the framework to identify girls born to mothers who have suffered FGM, adding warning flags to the records of children as with other safeguarding risks. There should be periodic audits of the visibility of such flags in relevant health settings
- Steps to raise awareness of the importance of the father's views about FGM, and those of his family, as well as assessment of the history and views of the mother
- Agreement between head teachers, the local authority and the safeguarding partnership about how the issue of FGM is to be addressed in secondary schools in Bromley, taking into account the specific needs of the local school population
- A local authority audit of recent referrals to the MASH on FGM
- An update by all agencies on current arrangements for training on FGM and the level of awareness of their staff
- Revision of the current FGM protocol to take account of the findings of this review
- The partnership will identify a peer local authority area with a high estimated prevalence of FGM and invite it to review the Bromley approach
- The partnership will identify a small group of professional advisers and senior managers who will acquire a relevant degree of expertise in FGM
- The safeguarding partnership will draw relevant areas to the attention of the editorial board of the London Child Protection Procedures