HM Government

Multi-Agency Practice Guidelines:
Female Genital Mutilation

Acknowledgements

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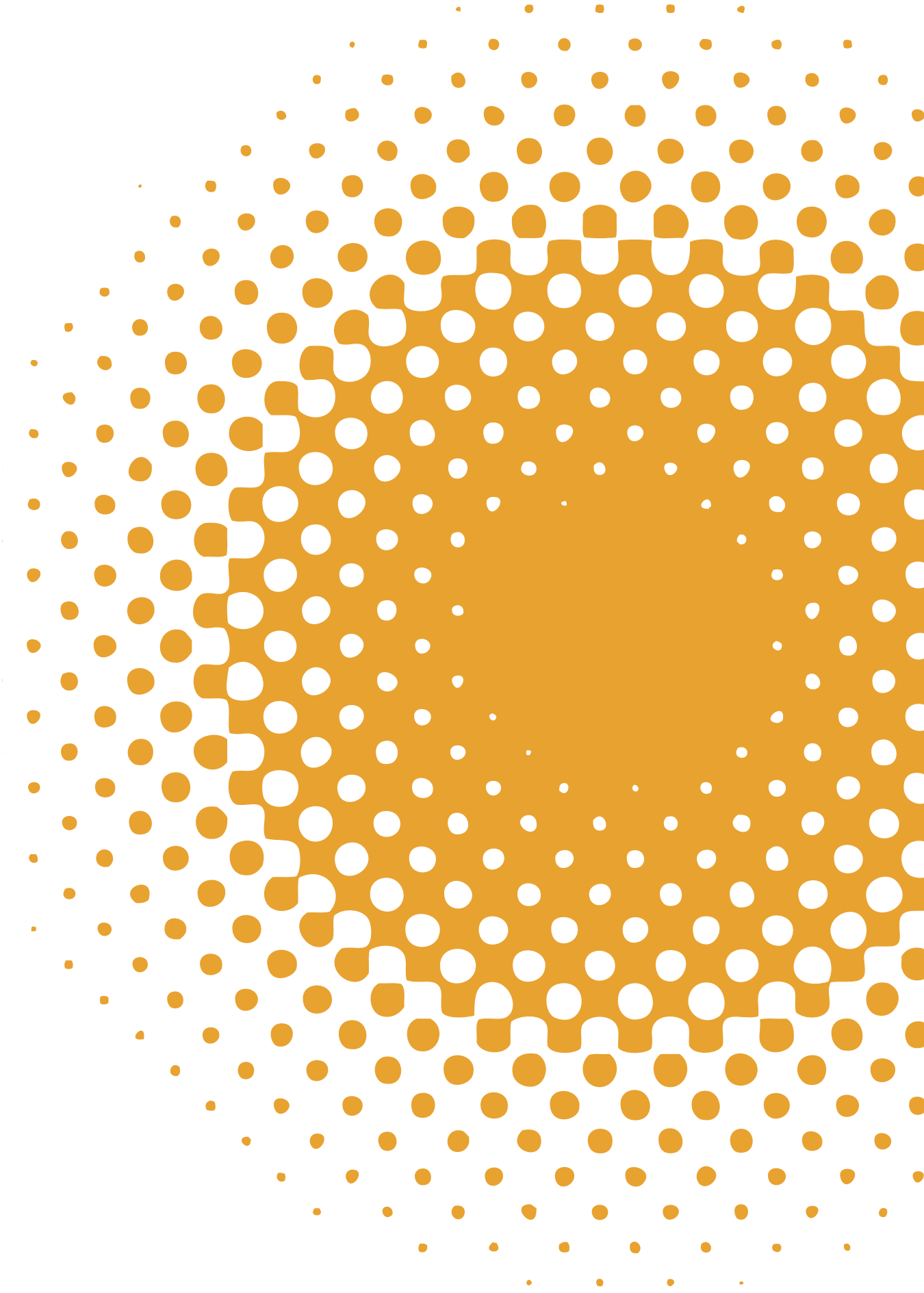
Comments or suggestions on the guidelines?

We would welcome any comments or suggestions about how to improve these guidelines. Please send your input to FGMEnquiries@homeoffice.gsi.gov.uk.



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CHAPTER ONE

THE PURPOSE OF THE GUIDELINES

1.1 AIMS

This document seeks to provide advice and support to frontline professionals who have responsibilities to safeguard children and protect and support adults from the abuses associated with female genital mutilation (FGM). As it is unlikely that any single agency will be able to meet the multiple needs of someone affected by FGM, this document sets out a multi-agency response and strategies to encourage agencies to cooperate and work together.

This guidance provides information on:

- identifying when a girl (including an unborn girl) or young woman may be at risk of FGM and responding appropriately to protect them;
- identifying when a girl or young woman has had FGM and responding appropriately to support them; and
- measures that can be implemented to prevent and ultimately eradicate the practice of FGM.

FGM is child abuse and a form of violence against women and girls, and therefore should be dealt with as part of existing child and adult safeguarding/protection structures, policies and procedures.

1.2 AUDIENCE

This guidance is designed for all frontline professionals and volunteers within agencies that work to:

- safeguard children and young people from abuse
- protect adults from abuse
- support those who have had FGM

This includes, but is not limited to, NHS staff and other health professionals, police officers, children's social care workers, and teachers and other educational professionals.

The information may also be relevant to non-governmental organisations and voluntary organisations working directly with girls and women at risk of FGM, or dealing with its consequences.

1.3 THE STATUS OF THE GUIDELINES

These are practice guidelines and are designed to be educative and provide advice; they are not a substitute for existing statutory guidance such as *Working Together to Safeguard Children* (March 2013) in England or *Safeguarding Children: Working Together Under the Children Act 2004* in Wales.

Existing strategic bodies should ensure that their member agencies work effectively using existing policies and procedures to tackle this issue. This includes, but is not limited to, local authorities, local councils, Community Safety Partnerships, Local Strategic Partnerships, Local Safeguarding Children Boards, Children's Trusts, Multi-Agency Risk Assessment Conferences, Health and Wellbeing Boards, Local Criminal Justice Boards, Local Family Justice Councils, NHS agencies and arms-length bodies and Multi-Agency Adult Protection Management Committees.

1.4 COVERAGE OF THE GUIDELINES

These guidelines are designed for application in England and Wales.

For more information about the Scottish Government's work to prevent and tackle FGM, visit www.scotland.gov.uk/Topics/People/Equality/violence-women/MinorityEthnicIssuesPages/FemaleGenitalMutilation

For more information about the Northern Ireland Executive's work on domestic violence, visit www.dhsspsni.gov.uk/domestic_violence

1.5 PRINCIPLES SUPPORTING THE GUIDELINES

The following principles should be adopted by all agencies in relation to identifying and responding to girls (and unborn girls) and women at risk of, or who have experienced FGM, and their parent(s):

- The safety and welfare of the child is paramount.
- All agencies act in the interests of the rights of the child as stated in the UN Convention (1989).
- FGM is illegal in the UK (for more information, see Section 2.3).
- FGM is not a matter that can be left to be decided by personal preference – it is an extremely harmful practice. Professionals should not let fears of being branded 'racist' or 'discriminatory' weaken the protection and support required by vulnerable girls and women.
- Accessible, acceptable and sensitive health, education, police, social care and voluntary sector services must underpin interventions.
- It is acknowledged that some FGM practising families do not see it as an act of abuse (for more information, see Section 2.8). However, FGM is child abuse and has severe significant physical and mental health consequences both in the short and long term (see Sections 2.10 and 2.11), and as such must never be excused, accepted or condoned.
- As an often embedded 'cultural practice', engagement with families and communities will be required to achieve a long-term abandonment and eradication of FGM.
- All decisions or plans should be based on good quality assessments (using, for example, the Common Assessment Framework in England and the Framework for the Assessment of Children in Need and their Families in Wales) and be sensitive to the issues of race, culture, gender, religion and sexuality; and should avoid stigmatising the girl or woman affected, and the practising community, as far as possible given the other principles above.

CHAPTER TWO

UNDERSTANDING THE ISSUES AROUND FGM

SUMMARY

- FGM is illegal in the UK. For the purpose of the criminal law in England, Wales and Northern Ireland, FGM is mutilation of the labia majora, labia minora or clitoris.
- FGM is prevalent in 28 African countries as well as in parts of the Middle East and Asia.
- It is estimated that approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM.
- FGM is practised by families for a variety of complex reasons but often in the belief that it is beneficial for the girl or woman.
- FGM constitutes a form of child abuse and violence against women and girls, and has severe short-term and long-term physical and psychological consequences.

2.1 DEFINITION

FGM comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It has no health benefits and harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and hence interferes with the natural function of girls' and women's bodies. The practice causes severe pain and has several immediate and long-term health consequences, including difficulties in childbirth also causing dangers to the child.

2.2 TYPES OF FGM

FGM has been classified by the World Health Organization into four types:

- Type 1 – Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- Type 2 – Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the 'lips' that surround the vagina).
- Type 3 – Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
- Type 4 – Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

The age at which girls undergo FGM varies enormously according to the community. **The procedure may be carried out when the girl is newborn, during childhood or adolescence, just before marriage or during the first pregnancy**. However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 and therefore girls within that age bracket are at a higher risk.

2.3 UK LEGISLATION

FGM is illegal in the UK.

In England, Wales and Northern Ireland, the practice is illegal under the Female Genital Mutilation Act 2003 (this offence captures mutilation of a female's labia majora, labia minora or clitoris), and in Scotland it is illegal under the Prohibition of Female Genital Mutilation (Scotland) Act 2005.

Under the 2003 Act, a person is guilty of an offence if they excise, infibulate or otherwise mutilate the whole or any part of a girl's or woman's labia majora, labia minora or clitoris, except for

necessary operations performed by a registered medical practitioner on physical and mental health grounds; or an operation performed by a registered medical practitioner or midwife – or a person undergoing training with a view to becoming a medical practitioner or midwife – on a girl who is in labour or has just given birth for purposes connected with the labour or birth (these exceptions are set out in section 1(2) and (3) of the Act).

Other than in the excepted circumstances, it is an offence for **any person (regardless of their nationality or residence status)** to:

- perform FGM in England, Wales or Northern Ireland (section 1 of the Act);
- assist a girl to carry out FGM on herself in England, Wales or Northern Ireland (section 2 of the Act); and
- assist (from England, Wales or Northern Ireland) a non-UK person to carry out FGM outside the UK on a **UK national or permanent UK resident** (section 3 of the Act).

Provided that the mutilation takes place in England, Wales or Northern Ireland, the nationality or residence status of the victim is irrelevant.

2.4 FGM TAKING PLACE OVERSEAS

Section 4 of the 2003 Act extends sections 1 to 3 to extra-territorial acts so that it is also an offence for **a UK national or permanent[1] UK resident to**:

- perform FGM abroad (sections 4 and 1 of the Act);
- assist a girl to perform FGM on herself outside the UK (sections 4 and 2 of the Act); and
- assist (from outside the UK) a non-UK person to carry out FGM outside the UK on a UK national or permanent UK resident (sections 4 and 3 of the Act).

The extra-territorial offences are intended to cover taking a girl abroad to be subjected to FGM. By virtue of section 1(4) of the 2003 Act, the exceptions set out in sections 1(2) and (3) also apply to the extra-territorial offences.

Any person found guilty of an offence under the Female Genital Mutilation Act 2003 is liable to a maximum penalty of 14 years imprisonment or a fine, or both.

2.5 INTERNATIONAL PREVALENCE OF FGM

FGM is a deeply rooted tradition, widely practised mainly among specific ethnic populations in Africa and parts of the Middle East and Asia, which serves as a complex form of social control of women's sexual and reproductive rights.

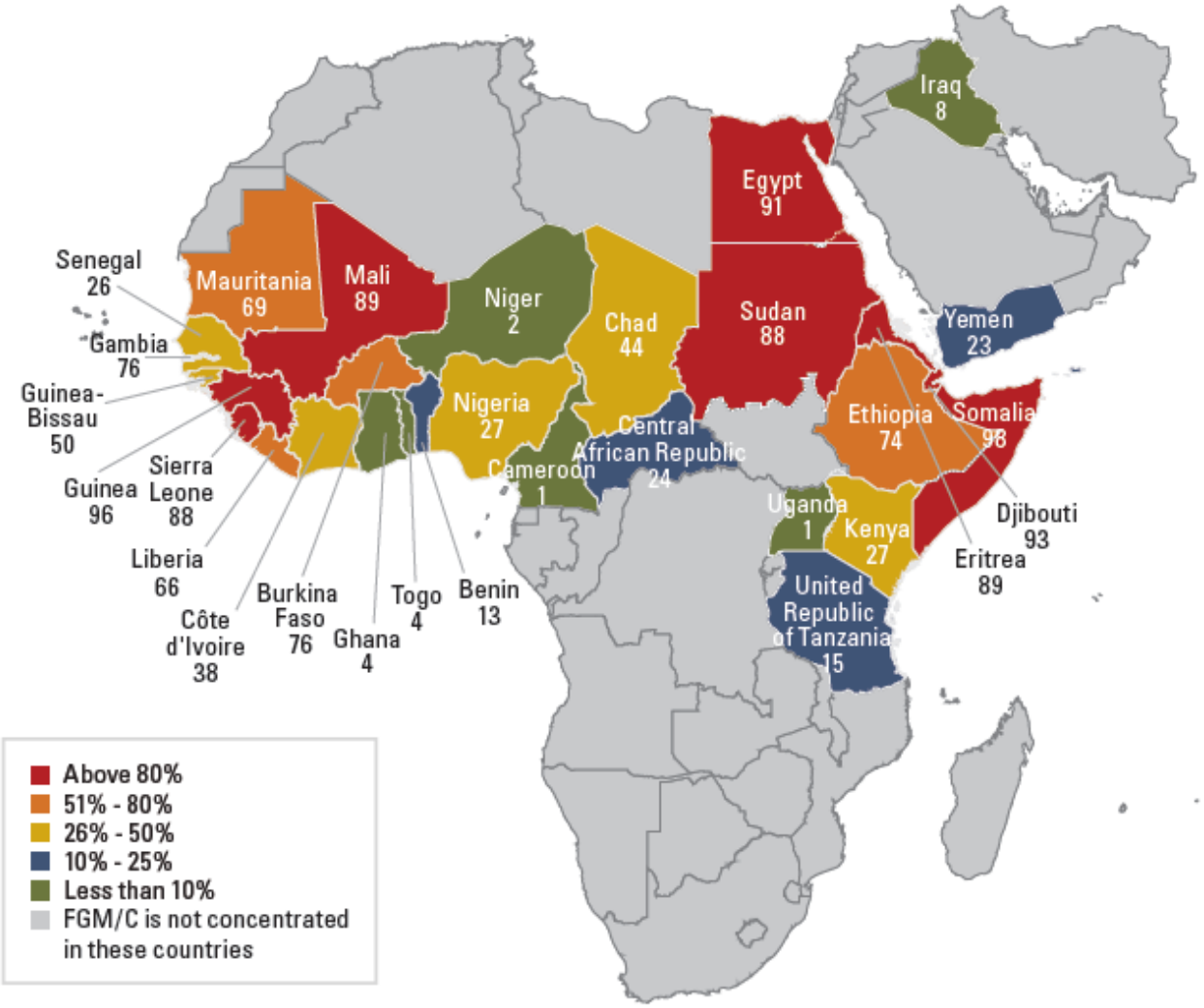
The World Health Organization estimates that between 100 and 140 million girls and women worldwide have experienced female genital mutilation and around 3 million girls undergo some form of the procedure each year in Africa alone. See Figure 1 on page 8 for African countries' prevalence.

FGM has also been documented in communities in **Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan**.

1 The Serious Crime Bill published on 6 June 2014 contains provisions that will extend the extra-territorial reach of the offences in the Female Genital Mutilation Act 2003 so that they apply to offences involving habitual (as well as permanent) UK residents.

FIGURE 1: PREVALENCE OF FGM AMONG WOMEN AGED 15-49 IN AFRICA AND THE MIDDLE EAST

Source: UNICEF (July 2013), global databases based on data from Multiple Indicator Cluster Survey, Demographic and Health Survey and other national surveys, 1997–2012.



2.6 PREVALENCE OF FGM IN THE UK

FGM's prevalence in the UK is difficult to estimate because of the hidden nature of the crime. However, a recent study[2] estimated that:

- approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM.
- approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM.

It is possible that, due to population growth and immigration from practising countries since 2001, FGM is significantly more prevalent than these figures suggest.

There is likely to be an uneven distribution of cases of FGM around the country, with more occurring in those areas of the UK with larger communities from the practising countries (listed in Section 2.5) – found by the same study to be London, Cardiff, Manchester, Sheffield, Northampton, Birmingham, Oxford, Crawley, Reading, Slough and Milton Keynes.

However, all areas, local authorities and professionals must be aware of and actively prevent and tackle FGM.

2.7 NAMES FOR FGM

FGM is known by a number of names, including 'female genital cutting', 'circumcision' or 'initiation'. The term 'female circumcision' is unfortunate because it is anatomically incorrect and gives a misleading analogy to male circumcision. The names 'FGM' or 'cut' are increasingly used at the community level, although they are still not always understood by individuals in practising communities, largely because they are English terms.

See Appendix B for terms used for FGM in different languages.

2.8 CULTURAL UNDERPINNINGS AND MOTIVES OF FGM

FGM is a complex issue, with a variety of explanations and motives given by individuals and families who support the practice.

Reasons given for practising FGM:

- It brings status and respect to the girl.
- It preserves a girl's virginity/chastity.
- It is part of being a woman.
- It is a rite of passage.
- It gives a girl social acceptance, especially for marriage.
- It upholds the family honour.
- It cleanses and purifies the girl.
- It gives the girl and her family a sense of belonging to the community.
- It fulfils a religious requirement believed to exist.
- It perpetuates a custom/tradition.
- It helps girls and women to be clean and hygienic.
- It is aesthetically desirable.
- It is mistakenly believed to make childbirth safer for the infant.
- It rids the family of bad luck or evil spirits.

FGM is often seen as a natural and beneficial practice carried out by a loving family who believe that it is in the girl's or woman's best interests. This also limits a girl's incentive to come forward to raise concerns or talk openly about FGM – reinforcing the need for all professionals to be aware of the issues and risks of FGM.

It is because of these beliefs that girls and women who have not undergone FGM can be considered by practising communities to be unsuitable for marriage.

2 Macfarlane A, Dorkenoo E. Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk.

Interim report on provisional estimates. London: City University London and Equality Now, 2014.

"People know of it as a tradition. They take it for granted as an operation that must be done to all girls.[3]"

Despite the harm it causes, many women from FGM practising communities consider FGM normal to protect their 'cultural identity'. As a result of the belief systems of the cultural groups who practise FGM, many women who have undergone FGM believe they appear more attractive than women who have not undergone FGM. Women who have attempted to resist exposing their daughters to FGM report that they and their families were ostracised by their community and told that nobody would want to marry their daughters. In some cases where women are deemed to have shamed the family honour, they have been subjected to 'honour' based abuse.

"In our community the mother usually tells you that you have to protect yourself and your honour and not to bring the family shame.[4]"

Infibulation (Type 3) is strongly linked to virginity and chastity, and used to safeguard girls from sex outside marriage and from having sexual feelings. In some cultures, it is considered necessary at marriage for the husband and his family to see her 'closed' and, in some instances, both mothers will take the girl to be cut open enough to be able to have sex.

Although FGM is practised by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. However, FGM predates Christianity, Islam and Judaism, and the Bible, Koran, Torah and other religious texts do not advocate or justify FGM.

Despite this, religion is sometimes given as a justification for FGM. For example, some people from Muslim communities argue that the Sunna (traditions or practices undertaken or approved by the prophet Mohammed) recommend that women undergo FGM, and some women have been told that having FGM will make them 'a better Muslim'. However, senior Muslim clerics at an international conference on FGM in Egypt in 2006 pronounced that FGM is not Islamic, and the London Central Mosque has spoken out against FGM on the grounds that it constitutes doing harm to oneself or to others, which is forbidden by Islam.

Some views of people from FGM practising communities[5]

"I cannot trust her if she is not circumcised"

"Female circumcision in our country has many beneficial aims like to keep the honour of the girl. But generally circumcision is not good because there is a difference between circumcised women and uncircumcised women"

"Yes I am happy to marry an uncircumcised woman"

"The right time to open my circumcision is at night-time of marriage"

2.9 FGM PROCEDURE

It is believed that FGM happens to British girls in the UK as well as overseas (often in the family's country of origin). Girls of school age who are subjected to FGM overseas are thought to be taken abroad at the start of the school holidays, particularly in summer, in order for there to be sufficient time for her to recover before returning to her studies.

"Usually it is a gruesome ordeal with a lot of crying from the girl, and even with the child's screams no one does anything about it and her screams are ignored.[6]"

3 Quote from interviews conducted as part of FORWARD (2009) FGM is Always with Us: Experiences, Perceptions and Beliefs of Women Affected by Female Genital Mutilation in London. Results from a PEER Study.
4 Ibid
5 Quotes taken from interviews conducted by midwife and FGM specialist Comfort Momoh MBE.
6 Quote from interviews conducted as part of FORWARD (2009) FGM is Always with Us: Experiences, Perceptions and Beliefs of Women Affected by Female Genital Mutilation in London: Results from a PEER Study.

FGM is usually carried out by an older women in a practising community, for whom it is a way of gaining prestige and can be a lucrative source of income. The arrangements for the procedure usually include the child being held down on the floor by several women with the procedure carried out without medical expertise, attention to hygiene or anaesthesia. The instruments used include unsterilised household knives, razor blades, broken glass and stones. The girl may often not be expecting the procedure, exacerbating the shock and trauma that is experienced. However, there is an increasing trend of medical staff carrying out the procedures in hospitals. Those who support the practice have sought to eliminate risks of infection in order to legitimise FGM. While infection and health risks immediately after the procedure are a real consideration, the longer term psychological and physical effects will persist regardless of how the procedure was done. FGM is a harmful practice regardless of who does it or where it is done.

2.10 CONSEQUENCES OF FGM

Many men and women in practising communities can be unaware of the relationship between FGM and its harmful health and welfare consequences as set out below, in particular the longer-term complications affecting sexual intercourse and childbirth.

2.10.1 SHORT-TERM IMPLICATIONS FOR A GIRL'S HEALTH AND WELFARE

The short-term consequences following a girl undergoing FGM can include:

- severe pain.
- emotional and psychological shock (exacerbated by having to reconcile being subjected to the trauma by loving parents, extended family and friends).
- haemorrhage.
- wound infections, including tetanus and blood-borne viruses (including HIV and Hepatitis B and C);
- urinary retention.
- injury to adjacent tissues.
- fracture or dislocation as a result of restraint.
- damage to other organs.
- death.

2.10.2 LONG-TERM IMPLICATIONS FOR A GIRL'S OR WOMAN'S HEALTH AND WELFARE

The longer-term implications for women who have had FGM Types 1 and 2 are likely to be related to the trauma of the actual procedure, while health problems caused by FGM Type 3 are more severe and long-lasting, However, all types of FGM are extremely harmful and cause severe damage to health and wellbeing. World Health Organization research has shown that women who have undergone FGM of all types, but particularly Type 3, are more likely to have complications during childbirth.

The long-term health implications of FGM can include:

- chronic vaginal and pelvic infections.
- difficulties with menstruation.
- difficulties in passing urine and chronic urine infections.
- renal impairment and possible renal failure.
- damage to the reproductive system,including infertility.
- infibulation cysts, neuromas and keloid scar formation.
- obstetric fistula.
- complications in pregnancy and delay in the second stage of childbirth.
- pain during sex and lack of pleasurable sensation.
- psychological damage, including a number of mental health and psychosexual problems such as low libido, depression, anxiety and sexual dysfunction; flashbacks during pregnancy and childbirth; substance misuse and/or self-harm.
- increased risk of HIV and other sexually transmitted infections.
- death of mother and child during childbirth.

2.11 PSYCHOLOGICAL AND MENTAL HEALTH PROBLEMS

Case histories and personal accounts taken from women indicate that FGM is an extremely traumatic experience for girls and women, which stays with them for the rest of their lives.

Young women receiving psychological counselling in the UK report feelings of betrayal by parents, incompleteness, regret and anger[7]. There is increasing awareness of the severe psychological consequences of FGM for girls and women, which can become evident in mental health problems, drug and alcohol dependency, etc.

The results from research[8] in practising African communities are that women who have had FGM have the same levels of Post Traumatic Stress Disorder (PTSD) as adults who have been subjected to early childhood abuse, and that the majority of the women (80 per cent) suffer from affective (mood) or anxiety disorders.

The fact that FGM is 'culturally embedded' in a girl's or woman's community does not protect her against the development of PTSD and other psychiatric disorders.

Professionals, particularly those in the health sector, should ensure that mental health support is made available to assist girls and women who have undergone FGM, as well as treatment for any physical symptoms or complications.

7 Haseena Lockhat (2004) Female Genital Mutilation: Treating the Tears, London: Middlesex University Press.
8 Behrendt, A. et al (2005) Posttraumatic Stress Disorder and Memory Problems after FemaleGenital Mutilation, American Journal of Psychiatry 162:1000–1002, Ma

CHAPTER THREE

IDENTIFYING GIRLS AND WOMEN AT RISK

Professionals in all agencies, and individuals and groups in relevant communities, need to be alert to the possibility of a girl or woman being at risk of FGM, or already having undergone FGM. **There are a range of potential indicators that a child or young person may be at risk of FGM, which individually may not indicate risk but if there are two or more indicators present this could signal a risk to the child or young person.**

Victims of FGM are likely to come from a community that is known to practise FGM – see Section 2.5 for the nationalities that traditionally practise FGM.

Provided that the mutilation takes place in the UK, the nationality or residence status of the victim is irrelevant.

Professionals should also note that the girls and women at risk of FGM may not yet be aware of the practice or that it may be conducted on them, so sensitivity should always be shown when approaching the subject.

3.1 SPECIFIC FACTORS THAT MAY HEIGHTEN A GIRL'S OR WOMAN'S RISK OF BEING AFFECTED BY FGM

There are a number of factors in addition to a girl's or woman's community or country of origin that could increase the risk that she will be subjected to FGM:

- The position of the family and the level of integration within UK society – it is believed that communities less integrated into British society are more likely to carry out FGM.
- Any girl born to a woman who has been subjected to FGM must be considered to be at risk of FGM, as must other female children in the extended family.
- Any girl who has a sister who has already undergone FGM must be considered to be at risk of FGM, as must other female children in the extended family.
- Any girl withdrawn from Personal, Social and Health Education or Personal and Social Education may be at risk as a result of her parents wishing to keep her uninformed about her body and rights.

3.2 INDICATIONS THAT FGM MAY BE ABOUT TO TAKE PLACE SOON

The age at which girls undergo FGM varies enormously according to the community. **The procedure may be carried out when the girl is newborn, during childhood or adolescence, at marriage or during the first pregnancy**. However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 and therefore girls within that age bracket are at a higher risk.

It is believed that **FGM happens to British girls in the UK as well as overseas** (often in the family's country of origin). Girls of school age who are subjected to FGM overseas are thought to be taken abroad at the start of the school holidays, particularly in the summer holidays, in order for there to be sufficient time for her to recover before returning to her studies.

There can also be clearer signs when FGM is imminent:

- It may be possible that families will practise FGM in the UK when a female family elder is around, particularly when she is visiting from a country of origin.

- A professional may hear reference to FGM in conversation, for example a girl may tell other children about it (See Appendix B for commonly used terms in different languages).
- A girl may confide that she is to have a 'special procedure' or to attend a special occasion to 'become a woman'.
- A girl may request help from a teacher or another adult if she is aware or suspects that she is at immediate risk.
- Parents state that they or a relative will take the child out of the country for a prolonged period.
- A girl may talk about a long holiday to her country of origin or another country where the practice is prevalent (see Section 2.5 for the nationalities that traditionally practise FGM).
- Parents seeking to withdraw their children from learning about FGM.

3.3 INDICATIONS THAT FGM MAY HAVE ALREADY TAKEN PLACE

It is important that professionals look out for signs that FGM has already taken place so that:

- the girl or woman affected can be supported to deal with the consequences of FGM (see Sections 2.10 and 2.11).
- enquiries can be made about other female family members who may need to be safeguarded from harm.
- criminal investigations into the perpetrators, including those who carry out the procedure, can be considered to prosecute those breaking the law and to protect others from harm.

There are a number of indications that a girl or woman has already been subjected to FGM:

- A girl or woman may have difficulty walking, sitting or standing and may even look uncomfortable.
- A girl or woman may spend longer than normal in the bathroom or toilet due to difficulties urinating. A girl may spend long periods of time away from a classroom during the day with bladder or menstrual problems.
- A girl or woman may have frequent urinary, menstrual or stomach problems.
- There may be prolonged or repeated absences from school or college.
- A prolonged absence from school or college with noticeable behaviour changes (e.g. withdrawal or depression) on the girl's return could be an indication that a girl has recently undergone FGM.
- A girl or woman may be particularly reluctant to undergo normal medical examinations.
- A girl or woman may confide in a professional.
- A girl or woman may ask for help, but may not be explicit about the problem due to embarrassment or fear.
- A girl may talk about pain or discomfort between her legs.

CHAPTER FOUR

GOOD PRACTICE TO FOLLOW IN ALL CASES

IN ALL CASES:
If you are worried about a child under 18 who is at risk of FGM or has had FGM, you have a legal obligation to share this information with social care or the police.

It is then their responsibility to investigate, safeguard and protect any girls involved. Other professionals should not attempt to investigate cases themselves.

4.1 DUTY TO SAFEGUARD CHILDREN

Safeguarding girls at risk of harm of FGM poses specific challenges because the families involved may give no other cause for concern, for example with regard to their parenting responsibilities or relationships with their children. However, there still remains a **duty for all professionals to act to safeguard girls at risk**[9] – with four key issues to consider:

1. An illegal act being performed on a female, regardless of age.
2. The need to safeguard girls and young women at risk of FGM.
3. The risk to girls and young women where a relative has undergone FGM.
4. Situations where a girl may be removed from the country to undergo FGM.

4.1.1 FGM IS AN ILLEGAL ACT PERFORMED ON A FEMALE, REGARDLESS OF HER AGE

In addition to the legislation specifically criminalising FGM (see Section 2.3), professionals must abide by other relevant laws such as the Children Act 2004 (England and Wales) and the Children (Northern Ireland) Order 1995, the Human Rights Act 1998, and the European Convention on Human Rights, particularly Article 3 that no one will be "subjected to torture or to inhuman or degrading treatment or punishment".

The UN Convention on the Rights of the Child, which the UK has ratified, also applies and makes clear that any person below the age of 18 has the right to protection from activities or events that may cause them harm and that they need special safeguards and care, including appropriate legal protection.

Professionals have a responsibility to ensure that families know that FGM is illegal, and should ensure that families are aware the authorities are actively tackling the issue. This knowledge alone may deter families from having FGM performed on their children, and save girls and women from harm.

4.1.2 THE NEED TO SAFEGUARD GIRLS AND YOUNG WOMEN AT RISK OF FGM

Anyone who has concerns about a child's welfare should make a referral to local authority children's social care; anybody can make a referral. Initially, the professional will refer the potential victim as a child in need and social care will assess the risk.

4.1.3 THE RISK TO GIRLS AND YOUNG WOMEN WHERE A RELATIVE HAS UNDERGONE FGM

Where professionals believe that an individual has undergone FGM, they must also consider the risks to other girls and women who may be related to or living with her and/or her family. As FGM is an inter-generational practice, their girls and young women may also be at significant risk of harm.

9 See section 11 of the Children Act 2004 for details of the bodies with a duty to safeguard girls; similar duties apply to other bodies, e.g. the UK Border Agency under section 55 of the Borders, Citizenship and Immigration Act 2009.

4.1.4 SITUATIONS WHERE A GIRL MAY BE REMOVED FROM THE COUNTRY TO UNDERGO FGM

As described in Sections 2.3 and 2.4, it is unlawful to perform FGM, or to assist a girl or woman to perform FGM on herself, in England and Wales. It is an offence for UK nationals or permanent UK residents to perform FGM, or to assist a girl to perform FGM on herself, abroad.

It is also an offence for a UK national or permanent resident to assist a non-UK person to perform a relevant act of FGM (as defined in section 3(2) of the Female Genital Mutilation Act 2003) abroad – this would cover taking a girl abroad to be subjected to FGM. However, there may be instances where the exact risk of this occurring is not known, but one parent – or a professional – may be concerned enough to alert professionals. In certain circumstances a Prohibitive Steps Order or Wardship Order can be used to prevent a girl being removed from the country – Chapter 5 describes legal interventions in more detail.

4.2 TALKING ABOUT FGM

FGM is a complex and sensitive issue that requires professionals to approach the subject carefully.

When talking about FGM, professionals should:

- √ ensure that a female professional is available to speak to if the girl or woman would prefer this.
- √ make no assumptions.
- √ give the individual time to talk and be willing to listen.
- √ create an opportunity for the individual to disclose, seeing the individual on their own in private.
- √ be sensitive to the intimate nature of the subject.
- √ be sensitive to the fact that the individual may be loyal to their parents.
- √ be non-judgemental (pointing out the illegality and health risks of the practice, but not blaming the girl or woman).
- √ get accurate information about the urgency of the situation if the individual is at risk of being subjected to the procedure.
- √ take detailed notes.
- √ record FGM in the patient's healthcare record, as well as details of any conversations.
- √ use simple language and ask straight forward questions such as:
  - □ "Have you been closed?"
  - □ "Were you circumcised?"
  - □ "Have you been cut down there?"
- √ be direct, as indirect questions can be confusing and may only serve to compound any underlying embarrassment or discomfort that you or the patient may have. If any confusion remains, ask leading questions such as:
  - □ "Do you experience any pains or difficulties during intercourse?"
  - □ "Do you have any problems passing urine?"
  - □ "How long does it take to pass urine?"
  - □ "Do you have any pelvic pain or menstrual difficulties?"
  - □ "Have you had any difficulties in childbirth?"
- √ give the message that the individual can come back to you at another time if they wish.
- √ give a very clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM if/when they have daughters.
- √ offer support for example counselling, NHS FGM specialist clinics, "Statement Opposing FGM leaflet" etc.

An accredited female interpreter may be required. **Any interpreter should ideally be appropriately trained in relation to FGM and in all cases should not be a family member, not be known to the individual, and not be someone with influence in the individual's community**. This is because girls or women may feel embarrassed to discuss sensitive issues in front of such people and are frightened that personal information may be passed on to others in their community and place them in danger.

Furthermore, there is a risk that interpreters who are from the family or who are from the individual's community may deliberately mislead professionals and/or encourage and even threaten the individual to drop the complaint and submit to the wishes of their wider community or family.

Women often recount feelings of great distress and humiliation due to the responses they receive from professionals when it is revealed that they have been subjected to FGM. They describe looks of horror, inappropriate and insulting questions, and feelings of shame from being made to feel 'abnormal'. Such negative reactions from professionals are caused by a lack of awareness or understanding of the issue, but can be devastating to a woman who has been subjected to FGM. These stories of negative experiences may reach the communities that practise FGM and could build barriers to the effective care and prevention of FGM, and deter women and girls from seeking treatment or support.

"Sometimes when circumcised women go to the hospital, the nurses call each other to see the circumcised woman. This is an unhappy experience for many women. The nurses ask a lot of questions and they stare.[10]"

Asking the right questions in a straightforward and sensitive way is key to establishing the understanding, information exchange and relationship needed to ensure that the girl or woman, and her family members, are given the care, protection and safeguarding they need.

Remember:

- Individuals may wish to be interviewed by a professional of the same gender.
- She may not want to be seen by a professional from her own community.
- Alerting the girl's or woman's family to the fact that she is disclosing information about FGM may place her at increased risk of harm.
- Develop a safety and support plan in case they are seen by someone 'hostile' at or near the department, venue or meeting place, e.g. agree another reason why they are there.
- If they insist on being accompanied during the interview, e.g. by a teacher or advocate, ensure that the accompanying person understands the full implications of confidentiality, especially with regard to the person's family (see Section 4.6 for more details about disclosure). For some, an interview may require an authorised accredited interpreter who speaks their dialect.
- Do not assume that families from practising communities will want their girls and women to undergo FGM.

"There is this lady who has been circumcised.... When she gave birth to her baby girl, they sent her a letter telling her not to circumcise her daughter and that if she circumcised her, it would be against the law and she could go to jail. The woman found the letter threatening and she was very angry because she did not intend to circumcise her daughter She was angry that the authorities assumed this just because she was circumcised. She wished the authorities had confronted her about her intentions instead of threatening her without knowing anything.[11]"

10 Quote from interviews conducted as part of FORWARD (2009) FGM is Always with Us: Experiences, Perceptions and Beliefs of Women Affected by Female Genital Mutilation in London: Results from a PEER Study.

11 Quote from FORWARD (2009) FGM is Always with Us: Experiences, Perceptions and Beliefs of Women Affected by Female Genital Mutilation in London: Results from a PEER Study.

4.3 THINGS TO BE AWARE OF IN DEALING WITH CASES OF FGM

It is important to make the distinction between adults and children when considering reporting FGM:

Children: FGM is child abuse and should be dealt with as such. Under section 47 of the Children Act 1989, anyone who has information that a child is potentially or actually at risk of significant harm is required to inform social care or the police. Professionals must always respond by informing social services or the police.

Adults: It is important to note that as with domestic violence and rape, if an adult woman has had FGM and this is identified through the delivery of NHS healthcare, the patient's right to patient confidentiality MUST be respected if they do not wish any action to be taken. No reports to social services or the police should be made in these cases.

For many people, prosecuting their family is something they simply will not consider.

If the girl or woman is from overseas, fleeing potential FGM and applying to remain in the UK as a refugee is a complicated process and may require professional immigration advice (see **https://www.gov.uk/browse/visas-immigration/asylum** for more information about the asylum application process).

Many individuals, especially women, may be extremely frightened by contact with any statutory agency, as they may have been told that the authorities will deport them and/or take their parents or children from them.

Professionals need to be extremely sensitive to these fears when dealing with a victim or potential victim from overseas, even if they have indefinite leave to remain (ILR) or a right of abode, as they may not be aware of their true immigration position. These circumstances make them particularly vulnerable.

If it is discovered that they are in breach of immigration rules (for example if they have overstayed their visa), remember that they may also require medical treatment, or be the victim of a crime and be traumatised as a result. Guidelines on NHS treatment for overseas visitors can be found at **https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations**

Do not allow any investigation of their immigration status to impede police enquiries into an offence that may have been committed against the victim or their children. UK Border Agency officials and police officers may choose to establish an agreement or protocol about how any two simultaneous investigations may work.

4.4 MEDICAL EXAMINATIONS

Intimate medical examinations to identify or determine FGM presence are not carried out in the NHS. In some cases however, it may be necessary to seek a medical examination for emotional or physical conditions. It may not be advisable to call or visit a medical practitioner from the local community as this may threaten the security of the victim.

The General Medical Council (GMC) have issued guidance on child protection examinations at **http://www.gmc-uk.org/guidance/ethical_guidance/13431.asp**. Consent or other legal authorisation is required to carry out any child protection examination, including a psychiatric or psychological assessment. The GMC guidance also outlines the steps to take when consent to examination is not given.

It is mandatory for health professionals to record in their healthcare record if a patient has FGM whenever it is identified in the course of NHS treatment. It is also advisable in all cases where injuries are apparent to encourage the person to have those injuries documented for future reference.

Remember:

- Any examination of a child or young person should be in strict accordance with safeguarding children procedures and should [normally]

be carried out by a consultant paediatrician, preferably with experience of dealing with cases of FGM.

The GMC has issued ethical guidance on child protection which outlines how to identify risk, considerations around confidentiality and procedures to follow. The guidance can be accessed at: **http://www.gmc-uk.org/guidance**.

4.5 MAKING ENQUIRIES

In general, enquiries should be undertaken by police officers with assistance from social workers.

However, there may be occasions when professionals may wish to make informal enquiries before involving police if, for example, a girl has been absent from school for a prolonged period. In these circumstances, it is important not to reveal that enquiries are related to FGM as this may increase the risk to the girl or woman. If the fact that the enquiries relate to FGM needs to be shared, this should only be shared with professionals aware of the need to handle such information appropriately.

4.6 DISCLOSURE AND CONFIDENTIALITY

To safeguard children and young people as required by UK law, it may be necessary to give information to people working in other agencies or departments.

For some professionals, this can pose dilemmas when it involves going beyond the normal boundaries of confidentiality. Nonetheless, **both law and policy allow for disclosure where it is in the public interest or where a criminal act may have been perpetrated**. There may also be the perception that passing on information can damage the relationship of trust built up with families and communities. However, it is crucial that the focus is kept on the best interests of the child as required by law.

Guidance about disclosure and when confidentiality can be breached is available in the following publications:

- What to Do if You are Worried a Child is Being Abused (HM Government, 2006).
- Nursing and Midwifery Council's advice on confidentiality (2009).
- General Medical Council's guidance (2009) Confidentiality.
- Guidance on the Management of Police Information. **http://www.app.college.police.uk/.**

Referrals to other professionals or agencies should be conducted using existing and agreed procedures and arrangements.

4.7 A VICTIM-CENTRED APPROACH

Whatever an individual's circumstances, they have rights that should always be respected, such as the right to personal safety and to be given accurate information about their rights and choices. Professionals should listen to the victim and respect their wishes whenever possible.

However, there may be times when a victim wants to take a course of action that may put them at risk – on these occasions, professionals should explain all the outcomes and risks to the victim and take the necessary child or adult protection precautions. Professionals should also be clear that FGM is a criminal offence in the UK and must not be permitted or condoned.

4.8 FORCED MARRIAGE AND FGM

There have been reports of cases where individuals have been subjected to both FGM and forced marriage.[12]

If you are concerned about an individual who may be at risk of both practices, you should consult the multi-agency practice guidelines on handling cases of forced marriage. These can be found at: **https://www.gov.uk/forced-marriage#guidance-for-professionals**

Alternatively, you can contact the government's Forced Marriage Unit for advice on 020 7008 0151 (Monday – Friday, 9am – 5pm; call 020 7008 1500 and ask for the Global Response Centre in emergencies outside these hours).

12 Civil protection for (potential) victims of forced marriage is covered by the Forced Marriage (Civil Protection) Act 2007.

CHAPTER FIVE

LEGAL INTERVENTIONS

FGM is illegal in the UK (see Sections 2.3 and 2.4 for more details), and is a clear and severe form of child abuse and violence against women. Professionals should intervene to safeguard girls and protect women who may be at risk of FGM or have been affected by it.

This chapter does not set out new policies, procedures or requirements for the police or other statutory authorities. Instead, it sets out the relevant existing statutory procedures that may be used in cases of FGM.

5.1 POLICE PROTECTION

Children's social care may approach the police and ask for their assistance in undertaking a joint investigation. The way in which this is to be handled should be covered in the procedures prepared by the Local Safeguarding Children Board and in accordance with *Working Together to Safeguard Children* in England or *Safeguarding Children: Working Together Under the Children Act 2004* in Wales. A joint approach may be particularly useful where it is thought that a girl or young woman is at immediate risk of FGM.

Where there is reasonable cause to believe that a child or young person, under the age of 18 years, is at risk of significant harm, a police officer may (with or without the cooperation of social care) remove them from the parent and use the powers for 'police protection' (section 46 of the Children Act 1989) for up to 72 hours. The police must inform children's social care and ask them to assist in finding safe and secure accommodation for the girl or young woman. Children's social care should commence child protection enquiries under section 47 of the Act. After 72 hours, the child or young person must be returned to a parent or carer with parental responsibility.

However, children's social care may apply for an Emergency Protection Order (EPO) (see Section 5.2) at any point within the 72 hours if the child or young person is still considered to be at risk of significant harm. The police have the power to make their own application for an EPO, but as a matter of practice this is done by children's social care. Children's social care should assist the police, if requested to do so, by arranging a placement for the child or young person in a place of safety, taking into account risk management and safety planning – whether this is in local authority accommodation provided by children's social care, on their behalf, or in a refuge.

Remember:

- Police officers have powers, under section 17(1)(e) of the Police and Criminal Evidence Act 1984, to enter and search any premises in order to protect life or prevent injury.
- Police officers can also prevent the removal of a child or young person from a hospital or other safe place in which the child or young person is accommodated.
- The parents may ask for contact with the child or young person under protection, but this does not have to be granted if it is not in the best interests of the child or young person, i.e. if it would place the child or young person in danger.
- The local police child protection officer must be informed of any child or young person under police protection.
- A girl or woman may wish to see a police officer of the same gender.
- The girl or young woman may, or may not, want to see a police officer from her own community – try to give the child or young person the choice.
- In all cases, ensure that the child protection register has been checked.
- The police do not have parental responsibility with respect to the child or young person while they are under police protection, but they can do what is reasonable in the circumstances for the purposes of safeguarding or promoting the welfare of the child or young person.

- The police cannot make any decisions for the child or young person beyond the 72 hours of the order.

5.2 EMERGENCY PROTECTION ORDERS (EPO) UNDER SECTION 44 OF THE CHILDREN ACT 1989

If it is not considered appropriate to take a girl or young woman into police protection, or if the situation cannot be resolved during the 72 hours of police protection, an EPO should be considered.

The application can be made by anyone – including social workers, police, youth workers, advocates or friends of the girl or young woman – but in practice it is usually made by children's social care.

An EPO authorises the applicant to remove the girl and keep her in safe accommodation. An EPO will only be granted to safeguard the girl's welfare. An EPO lasts for up to eight days but it may be renewed for up to a further seven days. If the person applying for an EPO is anyone other than the local authority, children's social care must be informed and must then undertake section 47 enquiries. The local authority has the power, having consulted the applicant and the child or young person, to take over the order and responsibility for the child or young person (Emergency Protection Orders (Transfer of Responsibilities) Regulations 1991, SI 1991/1414).

An application may be made to court for an EPO without giving notice to the parents if this is necessary to protect the child or young person. In exceptional cases, where the application is particularly urgent, it can be made by telephone.

Remember:

- An EPO is open to challenge by the child's or young person's parents or any person with parental responsibility.
- Once an EPO is made, the local authority shares parental responsibility with the parents but can only exercise parental responsibility so far as is required to safeguard or promote the welfare of the child or young person.
- The local authority does not need to release details of where the child or young person is living if this is necessary to protect them.
- If it is necessary to protect the child or young person, the court should be asked for an order that states there be no contact (or only restricted contact) during the period of the EPO. If this is not asked for, there is a presumption of reasonable contact.
- Children's social care have a duty to make child protection enquiries (under section 47) when a child or young person living in their area is the subject of an EPO or is in police protection or who they have reasonable cause to suspect is suffering, or is likely to suffer from, significant harm.

For further information on court orders, refer to The Children Act 1989: Guidance and Re gulations, Volume 1: Court Orders (2008).

5.3 CARE ORDERS AND SUPERVISION ORDERS

Sometimes, an EPO is followed by an application from the local authority for a Care Order (sections 31 and 38 of the Children Act 1989). Without such an application, the EPO will lapse and the local authority will no longer have parental responsibility. A court will only make an interim Care Order or an interim Supervision Order under section 38 of the Children Act 1989 if it is satisfied that there are reasonable grounds to believe that the following threshold criteria are met:

- The child or young person concerned is suffering, or is likely to suffer, significant harm; and
- The harm, or likelihood of harm, is attributable to (among other things) the care given to the child or young person, or likely to be given to them if the order were not made, not being what it would be reasonable to expect a parent to give to a child or young person.

Note: the term 'significant harm' should be taken to include all forms of abuse – physical, sexual and emotional, and all forms of ill treatment that are not physical.

It is the court's responsibility to decide whether an order is necessary to protect the child or young person and what sort of order is the most appropriate.

Section 31(3) of the Children Act 1989 provides that no Care Order or Supervision Order may be made with respect to a young person who has reached the age of 17 (or 16 in the case of a young person who is married).

The advantage of a Care Order over a Supervision Order is that it allows greater protection to be offered to the child or young person, as the local authority may obtain an order that there be no contact with the family and may conceal the whereabouts of the child or young person if that is necessary to ensure adequate protection.

When a Care Order or Supervision Order is not available due to the age of the young person, children's social care should be aware of the opportunities presented by a Ward of Court Order. This is available up to 18 years old and while social services themselves cannot have a young person 'warded' (without leave of the court under section 100 of the Children Act 1989), the young person or an adult friend or advocate can apply for wardship and various injunctions can be attached as required.

Very commonly, for a child or young person in fear of being taken abroad, the injunctions will relate to surrendering passports to the court so that the child or young person may not leave the jurisdiction without the court's permission (see Section 5.5 for further information on wardship).

Remember:

- A Care Order gives parental responsibility to the local authority. The local authority can decide the extent to which others with parental responsibility may meet that responsibility. A Care Order places a duty on the local authority to receive the child or young person into its care in order to safeguard and promote the child's or young person's welfare. The local authority also has a duty to accommodate and maintain the child or young person. Young people are not able to apply for a Care Order on their own behalf.
- A Care Order cannot be made once a young person has reached the age of 17 or, in the case of a married person, once they reach 16.
- If a Care Order is granted, it lasts until the young person reaches the age of 18 unless it is discharged before this date.
- It is a criminal offence to remove a child or young person who is subject to a Care Order from the UK, without the express consent of the local authority (and every other person who has parental responsibility), or the court.
- When a Care Order is not appropriate, wardship (see Section 5.5) may still be an option.

The parents may agree to the child or young person being accommodated by the local authority in an attempt to forestall the local authority's application for an interim Care Order. The accommodation provided must adequately protect the child or young person. When a child or young person is accommodated, the local authority does not share parental responsibility and may be forced to disclose to the parents where the child or young person is living. It may be the case that a Care Order or wardship can offer greater protection to the child or young person.

If there is a relative or adult whom the child or young person can trust, that person could apply for a Residence Order with respect to the child or young person. This can be done as a freestanding application or within the care proceedings. Again, the question is likely to arise as to whether such an action will provide adequate protection to the child or young person. Although the Residence Order holder would share parental responsibility, the parents would retain their parental responsibility and would know where the child or young person was living. However, the Residence Order holder could also apply for a Prohibited Steps Order or a Specific Issue Order to keep the whereabouts of the child or young person undisclosed.

It is possible for a local authority to acquire a Supervision Order (on the same criteria as a Care Order) to accompany a Residence Order. A Supervision Order places a duty to advise, assist and befriend the supervised child or young person while providing support and back- up to a Residence Order holder, but the order would not give the local authority parental responsibility. If the child or young person is not in care, it is also possible for a local authority to obtain a Prohibited Steps Order under section 8 of the Children Act 1989. Such an order could prohibit the parents from removing the child or young person from the country without the permission of the court. The local authority would need to seek the leave of the court before it obtained such an order. Such an order does not confer parental responsibility on the local authority. Following a Prohibited Steps Order, further steps should be made by children's social care, education professionals and the police tomonitor the continuing wellbeing and safety ofthe child or young person if they continue to live in the family home.

5.4 INHERENT JURISDICTION

There will be cases where a Care Order is not appropriate, possibly because of the age of the young person. A children's social care department may ask the court to exercise its inherent jurisdiction to protect the young person. Any interested party, including the young person themselves, a private individual or the Children and Family Court Advisory Support Service (CAFCASS/CAFCASS CYMRU) legal services department can apply to have a young person up to the age of 18 made a ward of court.

For the purposes of obtaining protection for a child or young person, there is little difference between wardship and the other orders made in the exercise of the inherent jurisdiction of the High Court. Both types of orders under the inherent jurisdiction are flexible and wide-ranging and an order may be sought where there is a real risk of a girl or young woman being subjected to FGM. Where there is a fear that a girl or young woman may be taken abroad for the purpose of FGM, an order for the surrender of their passport may be made as well as an order that the child or young person may not leave the jurisdiction without the court's permission.

Orders for the immediate return of the child or young person can be obtained. These orders can be enforced on family members or extended family members. The orders are in the form of injunctions with penal notices attached.

5.5 APPLICATIONS FOR WARDSHIP

Once a young person has left the country, there are fewer legal options open to police, social services, other agencies or another person to recover the young person and bring them back to the UK. One course of action is to seek the return of the young person to the jurisdiction of England and Wales by making them a ward of court.

An application for wardship is made to the High Court Family Division, and may be made by a relative, friend close to the child or young person, or CAFCASS/CAFCASS CYMRU legal services department or any interested party, including a local authority, if they have permission under section 100 of the Children Act 1989. An Emergency Family Division Applications Judge is available at 10.30am and 2pm on all working days at the Royal Courts of Justice in the Strand, London, to hear without notice applications. Once the order is obtained, the cooperation of the authorities in the country to which the child or young person has been taken can be sought. Without such cooperation, it may be difficult to locate and return the child or young person.

5.6 REPATRIATION

When a British national seeks assistance at a British Embassy or High Commission overseas and wishes to return to the UK, the Foreign and Commonwealth Office (FCO) will do what it can to assist or repatriate the individual. Sometimes the FCO may ask the police or social services for assistance when a British national is being repatriated to the UK from overseas.

In many cases a victim of FGM may be extremely vulnerable: because of their age, the country in which they are located or their personal circumstance. If the FCO is able to repatriate them, the FCO may not be able to give the police or social services much, if any, notice of the person's arrival due to the urgency of the situation. Sometimes a person may have risked their life to escape and their family may go to considerable lengths to find them. The victim may be extremely traumatised and frightened. These factors can make victims particularly vulnerable when they return to the UK and it is likely that urgent multi-agency consideration of the level of risk faced by a victim of FGM will be appropriate.

Many FGM cases involve children under the age of 16. In such cases, in order to assist the victim to return to the UK the support and assistance of UK agencies (such as police and social services) will be essential and assistance from overseas authorities seized with safeguarding duties is also likely to be necessary. In some countries this could be the police, but in others it may be the Ministry for Children or even Health. Supporting repatriation of FGM victims under 16 without the support of at least one person with parental responsibility or the safeguarding authorities in-country may be very difficult and drawn out.

Remember:

- The FCO cannot pay for repatriation. They will normally ask the person or trusted friends to fund the cost of repatriation. In some cases, repatriation has been funded by schools or social services. However, this should never delay the process of getting the individual to safety.
- The FCO can facilitate a British national's return to the UK by providing emergency travel documents, in some exceptional circumstances helping to arrange flights and, where possible, by helping to find temporary safe accommodation while the victim is overseas.
- The FCO or social services may ask the police to meet the person on arrival, in case family members try to abduct them, at the airport.

13 Quote from interviews conducted as part of FORWARD (2009) FGM is Always with Us: Experiences, Perceptions and Beliefs of Women Affected by Female Genital Mutilation in London: Results from a PEER Study.

CHAPTER SIX

GUIDELINES FOR HEALTH PROFESSIONALS

INTERIM HEALTH GUIDANCE ONLY – FULL GUIDANCE TO BE ISSUED IN NOVEMBER 2014

Professionals should be familiar with the full range of clinical guidance when dealing with any case of suspected FGM. Details of relevant publications can be found in Appendix E.

6.1 HOW HEALTH PROFESSIONALS CAN MAKE A DIFFERENCE

Health professionals are key to providing essential support to women with FGM and intervening to prevent girls and women at risk of FGM from being harmed.

"They fear that if they tell the midwife or another health professional, that they will not understand our culture and tradition and think that we are illiterate or have bad traditions.[13]"

Steps to be taken by all health professionals

It is mandatory for health professionals to record the presence of FGM in a patient's healthcare record whenever it is identified through the delivery of NHS healthcare. It is also mandatory for all Acute Trusts to report the number of patients who have FGM in their active patient caseload to the Department of Health every month.

The information collected will be anonymised and no personal confidential data will be shared as a result of the information collection, which will be used to improve FGM services as well as to assist the police and social services in their work towards prosecutions and safeguarding respectively.

Information Standard and Implementation Guidance and formal notification of this requirement were sent to named contacts at all NHS organisations in April 2014.

Health professionals in Acute Trusts may find it helpful to contact their Information Team if they have any questions about implementation. The guidance is available at: **http://www.isb.nhs.uk/documents/isb-1610/amd-01-2014/index_html/**

To summarise, the patient's health record should always be updated with whatever discussions or actions have been taken. If the patient has had FGM, referral to a specialist FGM clinic should always be considered. In addition to any referral to social services and/or police, and this being recorded in the medical record appropriately, if a patient is identified as being at risk of FGM, this information must be shared with the GP and health visitor, as part of child safeguarding actions.

While the overarching legal issue related to FGM is its illegality, the primary roles of the NHS are to prevent FGM, to protect girls at risk of FGM and to support women living with the damaging effects of FGM. Investigations and enquires about any criminal offence are the responsibility of the police and social care, and should not be conducted by health professionals.

Professionals must ensure that the care and support they provide is consistent with safeguarding law and policy. To aid this, professionals should be familiar with the range of relevant publications for health professionals listed at Annex E [as well as Royal College of Midwives, Royal College of Nursing, Royal College of Obstetricians and Gynaecologists, Equality Now, UNITE Intercollegiate Guidelines Tackling FGM in the UK, Intercollegiate recommendations for identifying, recording and reporting].

It is essential to refer to, and work with, others such as teachers, social care colleagues and the police where necessary (see Section 4.6 for details on referrals to appropriate agencies and breaching confidentiality). Both law and policy allow for disclosure where it is in the public interest or where a criminal act such as FGM has been perpetrated. However, health professionals must note the distinction between adults and children when reporting cases of FGM:

Children: FGM is child abuse and should be dealt with as such. Under section 47 of the Children Act 1989, anyone who has information that a child is potentially or actually at risk of significant harm is required to inform social care or the police. Professionals must always respond by informing social services or the police, who will then conduct their own enquiries.

Adults: It is important to note that as with domestic violence and rape, if an adult woman has had FGM and this is identified through the delivery of NHS healthcare, the patient's right to patient confidentiality MUST be respected if they do not wish any action to be taken. No reports to social services or the police should be made in these cases.

Good practice to follow: Awareness of FGM, the communities involved (see Section 2.5) and the indicators of risk (see Chapter 3) is a vital starting point to ensure provision of relevant care, support and interventions. In addition to the specific steps set out below, all professionals are encouraged to:

- inform/raise awareness among their colleagues about the issues surrounding FGM.
- include issues such as FGM within domestic violence, safeguarding, and other relevant training.
- circulate and display copies of FGM leaflets and posters (see Appendix E for details).
- deal with FGM in a sensitive and professional manner, and be sufficiently prepared so that they do not exhibit signs of shock, confusion, horror or revulsion when treating an individual affected by FGM (see Section 4.2 for advice on how to talk about FGM).
- always consider other girls and women in the family who may also be at risk of FGM when dealing with a particular case and take action accordingly.
- ensure that mental health issues are also considered when supporting girls and women affected by FGM.
- ensure that staff record the identification of FGM in patient records whenever it is identified through the delivery of NHS care.
- ensure that their NHS Trust submits a monthly return on the number of patients with FGM in their active patient caseload.
- consider the risk of FGM being performed on girls and women overseas when vaccinations are requested.

6.2 CLINICAL ISSUES AND PROCEDURES

Health professionals, particularly nurses and midwives, need to be aware of the specialist care required by women and girls who had FGM, particularly during labour and childbirth.

All professionals should also be familiar with the full relevant clinical guidance when dealing with any case of suspected FGM. Details of publications can be found in Appendix E.

Some women seek medical help because they wish to undergo deinfibulation before marrying, or may be experiencing problems conceiving because of difficulties with penetration. Often known as 'reversal', deinfibulation involves opening the scar tissue that covers the vaginal introitus and the urethral meatus surgically. Although best performed when not pregnant, women may need reversal to be done as an emergency, for example during labour or miscarriage. This is because products of conception, such as blood clots and fetal tissue, can be retained behind scar tissue and may lead to serious infection.

All women who have undergone Type 3 FGM (infibulation) should be informed that deinfibulation is an option available to them and should be informed about the benefits of this.

There are a number of specialist FGM clinics in the NHS which offer a range of healthcare services

for women and girls who have had FGM including counselling, deinfibulation and other services. A GP referral is usually required. Women affected should be referred to a specialist FGM service with the relevant skilled and experienced healthcare professionals to carry out the procedure. A list of specialist NHS FGM clinics is available at **www.nhs.uk/fgm**.

6.3 COUNSELLING AND SUPPORT

All girls or women who have undergone FGM should be offered counselling to address any psychological or emotional problems they may have as a result of having FGM, and how things will be different for them afterwards if the woman has had a deinfibulation procedure. Boyfriends, partners and husbands should also be offered counselling.

The woman should be offered counselling sessions, taking into account that she may not want to make the arrangements for these while her boyfriend, partner, husband or other family members are present. Professionals should be aware that there may be coercion and control involved, which may have repercussions for the girl or woman, and should have these discussions with the woman on her own whenever possible.

"The woman has a lot of emotional suffering due to circumcision as something of her was taken away from her. The memories and the pains follow her throughout her lifetime whenever she remembers her experience.[14]"

14 Quote from interviews conducted as part of FORWARD (2009) FGM is Always with Us: Experiences, Perceptions and Beliefs of Women Affected by Female Genital Mutilation in London: Results from a PEER Study.

CHAPTER SEVEN

GUIDELINES FOR POLICE OFFICERS

7.1 HOW POLICE OFFICERS CAN MAKE A DIFFERENCE

FGM is not a matter that can be left to be decided by personal preference or tradition; it is an extremely harmful practice. FGM is child abuse, a form of violence against women and girls, and is against the law with a maximum prison sentence of 14 years. Officers must not let fears of being branded 'racist' or insensitive to cultural traditions weaken their investigative strategy or decision(s) to arrest suspects. Investigation must be robust. In addition officers should be culturally aware and understand all the people they are dealing with as part of any investigation.

Criminal investigations should follow national and local police 'guidance, for safeguarding and child abuse investigations

Further reference may be made to a number of Association of Chief Police Officer and College of Policing guidance documents:

- Child Abuse Investigations **http://www.app.college.police.uk/**.
- Guidance on Investigating Domestic Abuse (2008).
- Risk Identification and Assessment Model for Police Staff – Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) (2009).

All these documents can be found on force Intranet sites.

Police officers can also contact the Metropolitan Police Service's specialist Project Azure team on 020 7161 2888 for information or their own Force's Honour Based Violence and Public Protection Leads.

7.2 EXAMPLE OF PROTOCOLS

This section has been adapted from the Metropolitan Police Service's protocols to safeguard children and make London safe for children and young people. The procedures apply in particular to officers and staff in the following roles:

- Child abuse investigation teams.
- Community safety units.
- Public Protection units.
- Missing persons teams.
- Specialist sexual offences investigation teams
- All police officers and police staff who in the course of their duty deal with or come into contact with children and young people.

7.2.1 INITIAL STEPS WHEN A GIRL MAY BE AT RISK OF FGM

If officers or members of police staff believe that a girl may be at risk of undergoing FGM, the duty inspector must be made aware and an immediate referral should be made to their local child abuse special team or similar. If this is outside their core hours, the duty inspector must ensure that effective protection measures are put in place to ensure the safety of the victim in addition to undertaking an effective primary investigation. The safety and welfare of the child or young people is of paramount importance. The specialist team will in turn make an immediate referral to the relevant local authority children's social care team if not already done by the first responders / primary investigators.

If any officer believes that the girl could be at immediate risk of significant harm, they should consider the use of police protection powers under section 46 of the Children Act 1989 (see Section 5.1).

Officers should carry out the following actions:

- Complete appropriate checks, e.g. PND, PNC, Children's Social Care.
- Submit an appropriate intelligence log.

- Complete relevant risk assessment and management plans (as per Force Policy).
- Complete a crime report, ensuring that the incident is flagged in accordance with force procedures.
- Complete a MERLIN entry or similar in accordance with Every child Matters principals.
- Inform their supervisor, who must be at least the rank of inspector (the on-call superintendent should also be made aware of the referral).
- All officers and staff must consider whether this could be a critical incident and deal with the matter accordingly.
- Consider 'Golden Hour' principles in relation to evidence gathering

7.2.2 NEXT STEPS WHEN A GIRL MAY BE AT RISK OF FGM

In accordance with section 47 of the Children Act 1989, every referral with regard to FGM must generate a strategy meeting with the police, local authority children's social care, health professionals (school nurse, health visitor, or community/hospital paediatrician as appropriate) and the referrer (e.g. school) as soon as practicable (and in any case within two working days). Ensure that minutes of the meeting and the decisions taken are recorded in line with relevant procedures.

The first consideration should be informing the parents of the law and the dangers of FGM. This can be done by representatives from schools, local authority children's social care, health professionals and/or the police. It is the duty of all professionals to look at every possible way that parental cooperation can be achieved, including the use of community organisations to facilitate the work with the parents and other family members. If there is any suggestion that the family still intends to subject that child to FGM, the first priority is the protection of the child and the least intrusive legal action should be taken to ensure the child's safety.

Officers should consider the use of police protection powers under section 46 of the Children Act 1989 and remove the girl to a place of safety (see Section 5.1). In addition, local authority children's social care should consider the use of a Prohibitive Steps Order or Emergency Protection Order (see Section 5.2). **The welfare of other children within the family, in particular (but not exclusively) female siblings, should be reviewed**. The investigation should be the subject of regular ongoing multi-agency reviews to discuss the outcome and any further protective steps that need to be taken with regard to that girl and any other siblings.

7.2.3 INITIAL STEPS WHEN A GIRL IS THOUGHT TO HAVE ALREADY UNDERGONE FGM

If any police officer or police staff is made aware that a girl has already undergone FGM, the duty inspector must be made aware and an immediate referral should be made to their local child abuse special team. If this is outside their core hours, the duty inspector (or on-call senior investigating officer) must manage the initial phase of the investigation and ensure that effective protection measures are put in place. The specialist team will in turn make an immediate referral to the relevant local authority children's social care team.

Officers should carry out the following actions:

- Complete appropriate checks, e.g. PND,PNC, Children's Social Care.
- Submit an appropriate intelligence log.
- Complete relevant risk assessment and management plans (as per Force Policy).
- Refer to local authority children's social care (unless they were the referrer).
- Complete a crime report, ensuring that the incident is flagged in accordance with force procedures.
- Inform their supervisor, who must be at least the rank of inspector.
- Ensure that the on-call superintendent is made aware of the referral.
- Complete a MERLIN entry or similar in accordance with Every child Matters principals.

- All officers and staff must treat this crime as a critical incident and deal with the matter effectively.
- The investigative strategy should consider obtaining evidence or intelligence identifying the excisors (people who carry out FGM for payment or otherwise) and investigating these individuals with a view to identifying further victims and closing down such networks.
- Investigating officers must refer to the Police / CPS Protocol for the investigation and prosecution of FGM cases. The 43 English and Welsh police forces have signed this protocol.

7.2.4 NEXT STEPS WHEN A GIRL IS THOUGHT TO HAVE ALREADY UNDERGONE FGM

If it is believed or known that a girl has undergone FGM, a strategy meeting must be held as soon as practicable (and in any case within two working days) to discuss the implications for the child and the coordination of the criminal investigation.

There is a risk that the fear of prosecution will prevent those concerned from seeking help, resulting in possible health complications for the girl; thus police action will need to be in partnership with other agencies, affected communities and specialist non-governmental organisations. This should also be used as an opportunity to assess the need for specialist support services such as counselling and medical help as appropriate.

Police officers should refer to the Crown Prosecution Service's guidance document entitled *Provision of Therapy for Child Witnesses Prior to a Criminal Trial*.

As highlighted above investigating officers must refer to the Police / CPS Protocol for the investigation and prosecution of FGM cases, which has been signed by the 43 police forces in England and Wales.

A second strategy meeting should take place within ten working days of the initial referral.

7.2.5 CONDUCTING INTERVIEWS ABOUT FGM

As with all criminal investigations, children and young people should be interviewed under the relevant procedure/guidelines (e.g. Achieving Best Evidence) to obtain the best possible evidence for use in any prosecution.

Consent should be obtained to record the interview and for allowing the use of the interview in family and/or criminal courts. In addition, information gained from the interview process will enable a risk assessment to be conducted as to the risk to any other children or siblings.

See Section 4.2 for more information on talking about FGM with those affected.

7.2.6 MEDICAL EXAMINATIONS

Corroborative evidence should be sought through a medical examination conducted by a qualified medical professional trained in identifying the different types of FGM. Consideration should be given as to the effective use of a specialist FGM nurse.

In all cases involving children, an experienced paediatrician should be involved in setting up the medical examination. This is to ensure that a holistic assessment which explores any other medical, support and safeguarding needs of the girl or young woman is offered and that appropriate referrals are made as necessary. Where a child refuses to be interviewed or undergo medical examination, assistance should be sought from an intermediary or community organisation.

7.2.7 STEPS WHEN AN ADULT FEMALE HAS UNDERGONE FGM

If any police officer or police staff is made aware that an adult female has undergone FGM, a multi-agency meeting must be convened to consider the risks to the woman. This meeting should discuss any potential risk to any girls within the family (and extended family) and consider initial and core assessments of those girls. It should also consider providing supportive services for the woman,

including counselling and medical assistance and signposting the FGM survivor to specialist non government organisation (NGO) support networks.

The investigative strategy should consider obtaining evidence or intelligence identifying the excisors (people who carry out FGM for payment or otherwise) and investigating these individuals with a view to identifying further victims and closing down such networks. Investigating officers must consult early with the CPS in all FGM cases - as per the Police / CPS protocol so the most effective investigation and prosecution opportunities are identified. Further advice on progressing an investigation can be found online on the Authorised Professional Practice (APP) website (**http://www.app.college.police.uk/**).

CHAPTER EIGHT

GUIDELINES FOR CHILDREN'S SOCIAL CARE

All children's social care professionals should work in accordance with the guidelines in Working Together to Safeguard Children (2013) in England and Safeguarding Children – Working Together Under the Children's Act 2004 (2004) in Wales.

8.1 HOW CHILDREN'S SOCIAL CARE CAN MAKE A DIFFERENCE

Any person found guilty of an offence under the Female Genital Mutilation Act 2003 is liable to a maximum penalty of 14 years imprisonment or a fine, or both. Children's social care (CSC) therefore has a clear duty to safeguard children and so should work to prevent FGM taking place, and protect and offer support to any girls affected by the practice.

FGM is not a matter that can be left to be decided by personal preference – it is an extremely harmful practice and a form of child abuse. Professionals should not let fears of being branded 'racist' or 'discriminatory' weaken the protection they are required to give to vulnerable girls and women.

Each Local Safeguarding Children Board will have local safeguarding protocols and procedures for helping children and young people who are facing abuse. Every children's services department should, as part of domestic violence and safeguarding children protocols, have multi-agency policies and procedures, consistent with those developed by their Local Safeguarding Children Board that include handling cases where FGM is alleged or known about. As FGM is considered a form of child abuse, professionals have a statutory obligation under national safeguarding protocols (e.g. Working Together to Safeguard Children 2013) to protect girls/women at risk of FGM.

Once concerns are raised about FGM, there should also be consideration of possible risk to other girls in the family and practising community. Professionals should be alert to the fact that any one of the girl children among these could be identified as being at risk of FGM and will then need to be responded to as a child in need or a child in need of protection.

8.2 STRATEGY MEETING

On receipt of a referral, a social worker should acknowledge receipt, discuss it with their manager and decide on the next course of action within one working day. Where there are concerns about a child's immediate safety, an immediate strategy discussion must be set up involving all other relevant agencies: the police, children's social care, education professionals, and health services. Details of the processes for referral and assessment are available in Working Together to Safeguard Children 2013.

Health providers or voluntary organisations with specific expertise – for example on FGM, domestic violence and/or sexual abuse – should be invited; and consideration may also be given to taking legal advice.

The strategy meeting must first establish whether the parents or girl has had access to information about the harmful aspects of FGM and the law in the UK. If not, they should be given appropriate information regarding the law and harmful consequences of FGM. The girl should be provided with information on specialist therapeutic counselling services to assist her in understanding the psychological impact of this harmful practice.

An interpreter, if required, appropriately trained in all aspects of FGM must be used in all interviews with the family. A female interpreter should be used, who is not a family relation. See Section 4.2 for more details.

CSC professionals undertaking interviews with the family, in particular the child, should be trained to work with survivors/those at risk of FGM.

Every attempt should be made to work with parents on a voluntary basis to prevent the abuse. It is the duty of the investigating team to look at every possible way that parental cooperation can be

achieved, including the use of community organisations and/or community leaders and for a written agreement to be undertaken with parents not to perform FGM on the girl (whose views on FGM are known and approved) to facilitate the work with the family.

However, the child's interests are always paramount, and any agreement reached must be carefully monitored and enforced by all agencies.

If no agreement is reached, the first priority is protection of the child and the least intrusive legal action should be taken to ensure the child's safety (see Chapter 5 for details of options). The primary focus is to prevent the child undergoing any form of FGM, rather than removal of the child from the family.

8.3 STEPS WHEN A GIRL IS AT IMMEDIATE RISK OF FGM

If the strategy meeting decides that the girl is in immediate danger of FGM and/or professionals consider that her parents will proceed with performing FGM, then an Emergency Protection Order should be sought (see Section 5.2).

8.4 STEPS WHEN A GIRL HAS ALREADY UNDERGONE FGM

As with a child at risk of FGM, following a referral the social worker should decide on the next course of action within one working day. If there are concerns about the immediate safety of the child, or any other female siblings or relatives, an immediate strategy discussion should be convened, to decide whether any immediate safeguarding action is needed, and who to give information to about what is happening (especially whether to give information to the parents). The strategy discussion will consider how, where and when the procedure was performed and the implication of this. The strategy discussion will need to consider carefully whether to continue enquiries and 0assess the need for support services. If there is evidence of any criminal act having taken place (for example, if the FGM took place in the UK or was performed or assisted by a British resident overseas), legal advice must be sought and a criminal investigation conducted.

If after the initial strategy discussion there are grounds to initiate an enquiry under section 47 of the Children Act 1989, a social worker should lead an assessment based on the needs of the child and other professionals contribute. If concerns are substantiated and the child is likely to suffer significant harm, the social work manager should convene a child protection conference within 15 days of the strategy discussion.

A girl who has already undergone FGM might not be subject to a child protection plan, unless additional child protection concerns are identified. It would depend on the individual circumstances of the case. However, due to the interconnected nature of Violence Against Women and Girls (VAWG), vigilance of other underlying issues should be applied when reviewing such cases. She should be offered counselling and medical help. Consideration should also be given, during the assessment process, to any other female siblings in the family and they should be given the necessary protection if they are at risk from FGM.

More details of the legal requirements for referral and assessment of children in need are available in Working Together to Safeguard Children 2013.

CHAPTER NINE

GUIDELINES FOR SCHOOL, COLLEGES AND UNIVERSITIES

Schools' and colleges' statutory safeguarding responsibilities are set out in Keeping Children Safe in Education, published on 3 April 2014. These apply to FGM as to any other risk.

9.1 HOW STAFF CAN MAKE A DIFFERENCE

Girls who are threatened with, or who have undergone FGM may withdraw from education, restricting their educational and personal development. They may feel unable to go against the wishes of their parents and consequently may suffer emotionally. Staff may become aware of a student because she appears anxious, depressed and emotionally withdrawn. They may be presented with a sudden decline in her performance, aspirations or motivation. There may be occasions when a student comes to school or college but then absents herself from lessons, possibly spending prolonged periods in the bathroom.

Students who fear they may be at risk of FGM can often come to the attention of, or turn to, a teacher, lecturer or other member of staff before seeking help from the police or social services. Sometimes the student's friends report it to staff. Teachers, lecturers and other members of staff are in an ideal position to identify and respond to a victim's needs at an early stage.

Educational establishments should aim to create an 'open environment' where students feel comfortable and safe to discuss the problems they are facing – an environment where FGM can be discussed openly, and support and counselling are provided routinely. Students need to know that they will be listened to and their concerns taken seriously.

This guidance is mainly addressed to schools and colleges. Universities are less likely to encounter girls at risk of FGM but they may become aware that a student is concerned about a younger female relative, for example, or who discloses that she has undergone FGM herself when younger. They should consider how best to respond in such circumstances, seeking the advice of appropriate agencies in drawing up their policies. Universities may find that some of the guidance in this document is helpful to them in their particular circumstances.

It is for schools and colleges to decide exactly how they address this issue, taking account of the numbers of pupils from relevant communities. They can, however, create an 'open' and supportive environment by some or all of the following:

- circulating and displaying materials about FGM (see Appendix E for details).
- displaying relevant information, e.g. details of the NSPCC's Helpline and ChildLine services, Careline, National Domestic Violence Helpline and appropriate black and minority ethnic women's groups (see Appendix D for more information).
- ensuring that a private telephone is made available should students need to seek advice from the above organisations or other relevant groups discreetly.
- raising awareness of FGM among staff – including appropriate training in continuing professional development, where relevant.
- ensuring that the designated member of staff with responsibility for safeguarding children is well versed in the issues around FGM.
- referring students to an education welfare officer, a child protection lead, pastoral tutor, learning mentor or school counsellor as appropriate.
- encouraging young people to access appropriate advice, information and support (see Appendix D).
- making materials such as books and DVDs available (see Appendix E).
- introducing FGM into the school curriculum within relevant classes, such as:

- Personal, Social Health and Economic Education (PSHE) in England, and Personal and Social Education (PSE) in Wales,
- Sex and relationship education (SRE), having regard to relevant statutory guidance;
- Science, particularly in ensuring accurate naming of body parts as required by the curriculum programme of study
- Citizenship

9.2 WHAT TO DO WHEN YOU ARE CONCERNED THAT A STUDENT MAY BE AT RISK OF, OR HAS UNDERGONE, FGM

Staff may be concerned about a student because she is exhibiting some of the signs described in Sections 3.1 and 3.2. Alternatively, a student may approach a member of staff because she is concerned that she is at risk, or to disclose that she has undergone FGM.

Girls may be most at risk during the long summer holiday, so staff may wish to pay particular attention in the summer term, and when girls return to school or college in the autumn.

Any member of staff may make a referral to children's social care, but in most cases staff will initially share their concerns with the school or college's designated safeguarding lead. The actions set out below may be taken by either the staff member who first identifies a concern, or by the safeguarding lead.

All efforts should be made to establish the full facts from the student at the earliest opportunity.

Once the full facts have been established, the member of staff should be able to decide on the level of response required. If there is an indication that the child or young person is at risk of FGM or has undergone FGM, or she has expressed fears of reprisals or violence, the information must be shared with both the police and children's social care.

Staff should:

√ talk about FGM in a professional and sensitive manner, in line with Section 4.2.

√ explain that FGM is illegal in the UK and that they will be protected by the law.

√ recognise and respect their wishes where possible, but child welfare must be paramount. FGM is child abuse and against the law. If a member of staff believes that the girl is at risk of FGM, or has already undergone FGM, the police and social services must be informed even if this is against the girl's wishes. If you do take action against the student's wishes, you must inform them of the reasons why.

√ activate local safeguarding procedures, using existing national and local protocols for multi-agency liaison with the police and children's or adults' social care.

√ ensure that the girl is informed of the long-term health consequences of FGM to encourage her to seek and accept medical assistance.

√ liaise with the designated teacher with responsibility for safeguarding children.

√ refer the student, with their consent, to appropriate medical help, counselling and local and national support groups (see Appendix D for details).

√ ensure that safeguarding and protection is considered for any female family members.

Staff should not:

x treat such allegations merely as a domestic issue.

x ignore what the student has told them or dismiss out of hand the need for immediate protection.

x decide that it is not their responsibility to follow up the allegation.

x approach the student's family or those with influence within the community, in advance of any enquiries by the police, adult or children's social care, either by telephone or letter.

It is not the role of teachers, lecturers and staff to investigate allegations of abuse of a student and therefore, if the student is under 18 years, all referrals should be made in accordance with the relevant safeguarding children guidance. These referrals will usually be to children's social care or the police.

Remember:

- The student may not wish to be referred to a social worker, police officer or a guidance/ pastoral/head teacher from her own community.
- Consult other professionals, particularly an experienced manager/colleague, the local police child protection or domestic violence unit.
- Speaking to the student's parents about the action you are taking may place the student at risk of emotional and/or physical harm. Therefore, do not approach the family as they may deny the allegations, expedite any travel arrangements and hasten their plans to carry out the procedure.

9.3 WHAT TO DO WHEN A STUDENT STOPS ATTENDING SCHOOL

Details of the steps that local authorities need to take to meet their duty to identify all children not receiving a suitable education are described in (England) Children missing education – statutory guidance for local authorities (Nov 2013) **https://www.gov.uk/government/publications/children-missing-education or Statutory Guidance to Help Prevent Children and Young People from Missing Education: Welsh Assembly Government Circular 006/2010**.

If a teacher, lecturer or other member of staff suspects that a student has been removed from, or prevented from, attending education **as a result of FGM**, a referral should be made to the local authority adult or children's social care and the police.

Staff may consider speaking to the student's friends to gather information – although they should not make clear that FGM is suspected as this may get back to the family who may hasten any plans to perform the procedure (as well as potentially breaching confidentiality).

Remember:

- There may be occasions when an education welfare officer or teacher visits the family in the UK to find out why the student is not attending school or college. The family may tell the teacher that the student is being educated overseas. This is in itself permissible – parents have a right to choose how and where there child is educated – but local authority social care may wish to investigate because of the FGM risk.
- Sometimes, the family may suggest that the teacher or social worker speaks to the student on the telephone. If this occurs, the teacher should refuse to speak on the telephone and (if the student is a British national) insist that the student is presented at the nearest British Embassy or High Commission. There have been occasions when students have not been able to talk freely over the telephone or a different individual has spoken to the teacher.

Staff should not:

- x Delete a pupil from the school's admission register, except in certain circumstances. These are prescribed in The Education (pupil registration) (England) Regulations 2006. In certain circumstances, schools are required to inform the relevant local authority of a pupil to be removed from the admission register.
- x Dismiss the student as taking unauthorised absence.

The above regulations require all schools to inform the relevant local authority, at intervals agreed between them, of the names and details of every pupil who has been absent from the school without authorisation.

CHAPTER TEN

REDUCING THE PREVALENCE OF FGM

Wherever possible, all professionals should actively seek and support ways to reduce the prevalence of FGM in practising communities in the UK. This is not a straightforward process as cultural practices, such as FGM, have been ingrained for many generations, and require extensive work to change attitudes in order to address the issues thoroughly and effectively.

10.1 THE ROLE OF LOCAL SAFEGUARDING CHILDREN BOARDS

The scope of the Local Safeguarding Children Board (LSCB) includes:

- activity that affects all children and aims to identify and prevent maltreatment or impairment of health or development and ensure that children are growing up in circumstances consistent with safe and effective care; and
- proactive work to safeguard and promote the welfare of groups of children who are potentially more vulnerable than the general population.

In particular, one of the LSCB's functions is communication to persons and bodies in the area of the need to safeguard and promote the welfare of children, raising awareness and encouraging them to do so.

Within this context, the **LSCB should undertake initiatives in relation to FGM**.

LSCBs may consider developing and supporting a centralised virtual team of experts (including community groups and specialist women's groups) to advise professionals on the prevention of FGM in the community and the appropriate professional response to individual cases. In order to prevent FGM it is important that LSCBs ensure that they have up to date information in respect of individual agency activity and referral data.

10.2 PROFESSIONAL LEARNING REQUIREMENTS

Raising awareness about the socio-cultural, ethico-legal, sexual health and clinical care implications involved in FGM is essential. Education and training need to be provided for all health and social care professionals who may work with affected women and girls and with their families. It is also important to consider the issues of ethnicity, custom, culture and religion in a sensitive manner.

LSCBs are responsible for ensuring that single agency and inter-agency training on safeguarding and promoting welfare is provided in order to meet local needs, i.e. that staff who have responsibility for child protection work are acquainted with child protection procedures in relation to FGM and are confident working with local preventative programmes relating to FGM.

It is recommended that FGM should be a part of all staff training on safeguarding. Any programme of training around FGM should include the following:

- Overview of FGM (what it is, when and where it is performed).
- Socio-cultural context, including the perception of FGM as a religious obligation.
- Facts and figures.
- UK FGM and child protection law.
- FGM complications.
- Safeguarding children – principles to follow when FGM is suspected or has been performed.
- Roles of different professionals.

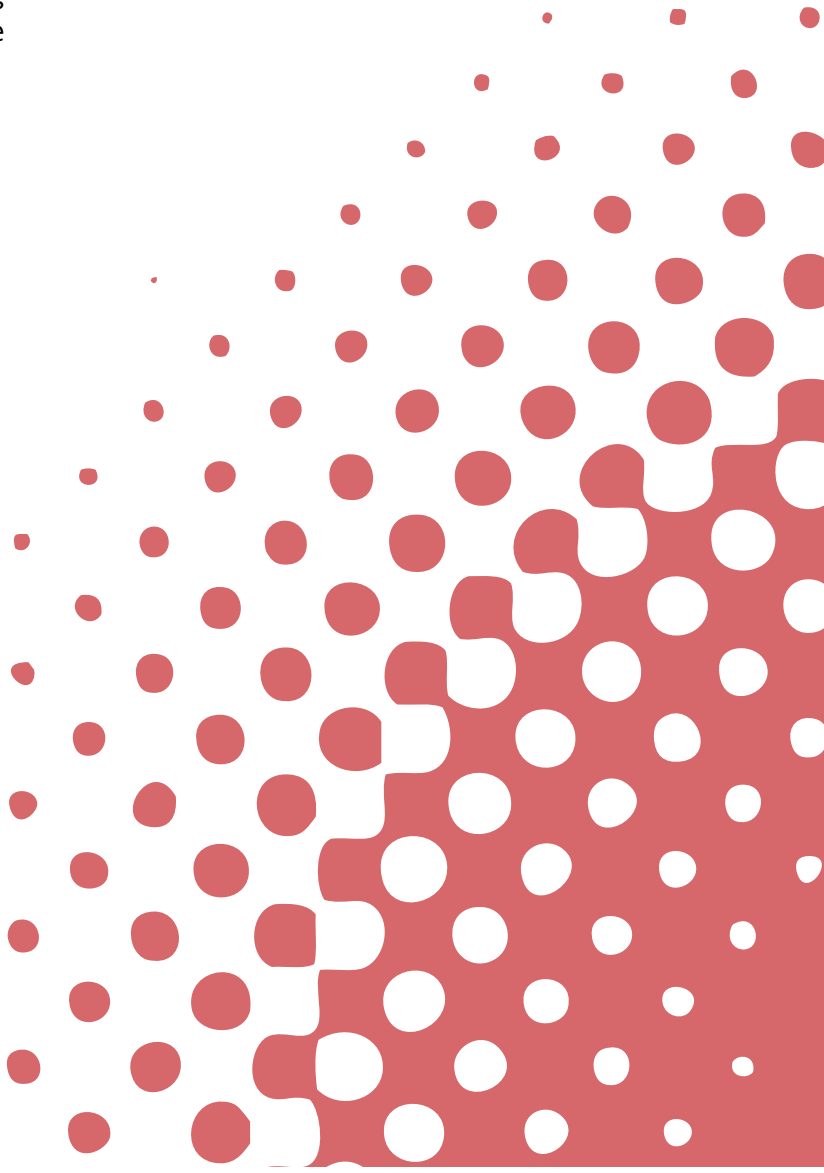
See Appendix E for details on materials available to professionals.

10.3 WORKING WITH COMMUNITIES TO ABANDON FGM

So-called cultural practices, such as FGM, can be deeply embedded in communities and so working towards their abandonment must be a 'bottom-up', community-led approach.

When dealing with individual cases, professionals should explore ways of resolving problems about the continuation of this practice in ways that involve individuals and families with their full participation. Education of male partners and community leaders is also key to reducing the number of girls and women who suffer in the future. All community members should be encouraged to report any suspected cases of FGM, and the various anonymous means for doing this (see Appendix D) should be highlighted for those unwilling to provide information to the authorities.

Local authorities, LSCBs and all professionals are encouraged to actively consider how best this could be done as part of existing work and engagement with practising communities, and how new initiatives could be established.



APPENDIX A

GLOSSARY OF TERMS USED

ADULT

'Adult' means a person aged 18 years or over.

CHILD, CHILDREN AND YOUNG PEOPLE

As defined in the Children Acts 1989 and 2004, 'child' means a person who has not reached their 18th birthday. This includes young people aged 16 and 17 who are living independently; their status and entitlement to services and protection under the Children Act 1989 is not altered by the fact that they are living independently.

CHILD ABUSE AND NEGLECT

Throughout this document, the recognised categories of maltreatment as set out in Working Together to Safeguard Children for England and Safeguarding Children – Working Together Under the Children's Act 2004 for Wales have been used. These are:

- physical abuse.
- emotional abuse.
- sexual abuse.
- neglect.

CHILD IN NEED

Children who are defined as being 'in need' under section 17 of the Children Act 1989 are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired, without the provision of services, plus those who are disabled. Local authorities and other bodies have a duty to safeguard and promote the welfare of children in need.

DOMESTIC VIOLENCE

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological.
- physical.
- sexual.
- financial.
- emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.[15]

FORCED MARRIAGE

A forced marriage is a marriage in which one or both spouses do not (or, in the case of some adults with learning or physical disabilities, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure.

INFIBULATION

Infibulation (Type 3 FGM) is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia.

DEINFIBULATION

(sometimes known as or referred to as deinfibulation or defibulation or FGM reversal): The surgical procedure to open up the closed vagina of FGM type 3.

15 Home Office (2013) Guidance: Domestic Violence and Abuse (https://www.gov.uk/domestic-violence-and-abuse)

REINFIBULATION OR RE-SUTURING

Reinfibulation is when the raw edges of the FGM wound are sutured again following childbirth, recreating a small vaginal opening similar to the original FGM Type 3 appearance.

SIGNIFICANT HARM

The Children Act 1989 introduced the concept of 'significant harm' as the threshold that justifies compulsory intervention in family life in the best interests of children and young people. It gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm. This was amended by the Adoption and Children Act 2002 to include, "for example, impairment suffered from seeing or hearing the ill-treatment of another.[16]

16 HM Government (2010) Working Together to Safeguard Children, Section 1.23; and Welsh Assembly Government (2006) Safeguarding Children: Working Together Under the Children Act 2004, Section 6.31.

APPENDIX B

TERMS USED FOR FGM IN OTHER LANGUAGES

Country	Term used for FGM	Language
CHAD – the Ngama Sara subgroup	Bagne	
	Gadja	
GAMBIA	Niaka	Mandinka
	Kuyungo	Mandinka
	Musolula Karoola	Mandinka
GUINEA-BISSAU	Fanadu di Mindjer	Kriolu
EGYPT	Thara	Arabic
	Khitan	Arabic
	Khifad	Arabic
ETHIOPIA	Megrez	Amharic
	Absum	Harrari
ERITREA	Mekhnishab	Tigregna
IRAN	Xatna	Farsi
KENYA	Kutairi	Swahili
	Kutairi was ichana	Swahili
NIGERIA	Ibi/Ugwu	Igbo
	Didabe fun omobirin/ ila kiko fun omobirin	Yoruba
SIERRA LEONE	Sunna	Soussou
	Bondo	Temenee
	Bondo/sonde	Mendee
	Bondo	Mandinka
	Bondo	Limba
SOMALIA	Gudniin	Somali
	Halalays	Somali
	Qodiin	Somali
SUDAN	Khifad	Arabic
	Tahoor	Arabic
TURKEY	Kadin Sunneti	Turkish

Thanks to FORWARD for details – contact details can be found in Appendix D.

APPENDIX C

FGM SPECIALIST HEALTH SERVICES IN ENGLAND AND WALES

For an up to date list of FGM Clinics, please click the link below and then go to 'Download a list of all available clinics'.

http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Pages/fgm-health-services-for-women.aspx

APPENDIX D

ORGANISATIONS WORKING ON ISSUES ON AROUND FGM

POLICE SERVICE

Metropolitan Police Service / Project Azure
020 7161 2888

UK GOVERNMENT

https://www.gov.uk/female-genital-mutilation

HELPLINES

National Society for the Prevention of Cruelty to Children (NSPCC) FGM Helpline
24 –hour Helpline. Free phone 0800 028 3550
www.nspcc.org.uk/fgm

Black Association of Women Step Out (BAWSO)
24-hour Helpline: 0800 731 8147
www.bawso.org.uk

ChildLine
24-hour Helpline for children: 0800 1111
www.childline.org.uk

National Domestic Violence Helpline
24-hour Helpline: 0808 2000 247
www.nationaldomesticviolencehelpline.org.uk

NSPCC British Sign Language Helpline for deaf or hard-of-hearing callers
ISDN videophone: 020 8463 1148
Webcam: nspcc.signvideo.tv (available Monday – Friday, 9am – 5pm, in English language only)
Text: 0800 056 0566

OTHER ORGANISATIONS

28 Too Many
http://28toomany.org/

Africans Unite Against Child Abuse (AFRUCA)
http://www.afruca.org/

Agency for Culture and Change Management UK (ACCM UK)
http://www.accmuk.com/

Birmingham & Solihull Women's Aid
http://bswaid.org/

Foundation for Women's Health Research & Development (FORWARD)
http://www.forwarduk.org.uk/

Halo Project
http://www.haloproject.org.uk/

Manor Gardens Health Advocacy Project
http://www.manorgardenscentre.org/

The Maya Centre
www.mayacentre.org.uk

For more organisations and local services, please visit
https://www.gov.uk/female-genital-mutilation

APPENDIX E

MATERIALS AVAILABLE ABOUT FGM

GUIDANCE AND GUIDELINES FOR PROFESSIONALS

The following list is not designed to be an exhaustive list of all applicable publications. Professionals should consult the relevant professional bodies and agencies for the up to date guidance.

- All Wales Child Protection Procedures Review Group (2005) All Wales ACPC Female Genital Mutilation Protocol 2005
- Association of Chief Police Officers (2005) Guidance on Investigating Child Abuse and Safeguarding Children
- Department for Children, Schools and Families (2010) Working Together to
- Safeguard Children: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children
- British Medical Association (2006) Female Genital Mutilation – Caring for Patients and Child Protection
- General Medical Council (2006) Raising Concerns about Patient Safety
- General Medical Council (2007) 0–18 Years: Guidance for All Doctors
- General Medical Council (2008) Consent: Patients and Doctors Making Decisions Together
- General Medical Council (2009) Confidentiality
- HM Government (2006) What To Do If You Are Worried A Child Is Being Abused
- HM Government (2009) Multi-Agency
- Practice Guidelines: Handling Cases of Forced Marriage
- HM Government (2010) Call to End Violence against Women and Girls
- Standardisation Committee for Care Information (2014) Female Genital Mutilation Prevalence Dataset;
- Nursing and Midwifery Council (2008) The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives
- Royal College of Midwives, Royal College of Nursing, Royal College of Obstetricians and Gynaecologists, Equality Now, UNITE (2013) - Intercollegiate Guidelines Tackling FGM in the UK - Intercollegiate recommendations for identifying, recording and reporting. (2013)
- Royal College of Midwives (2011) RCM Position Statement: Female Genital Mutilation
- Royal College of Midwives (2011) Guidance for Midwives
- Royal College of Nursing (2006) Female
- Genital Mutilation – An RCN Educational
- Resource for Nursing and Midwifery Staff
- Royal College of Obstetricians and Gynaecologists (2009) Green-top Guideline No. 53 – Female Genital Mutilation and its Management
- Welsh Assembly Government (2004) Safeguarding Children: Working Together to Safeguard Children Under the Children Act 2004

The FGM National Clinical Group has produced an educational DVD which clearly instructs and shows doctors, midwives and nurses how to undertake de-infibulation. This can be ordered from the group's website: **www.fgmnationalgroup.org**

An NHS Choices FGM page containing information and support for frontline professionals and members of the public who are concerned about the practice and are seeking advice. (**www.nhs.uk/fgm**)

A Department of Health DVD about FGM can be also ordered by emailing **fgm@dh.gsi.gov.uk**

Information about the government's strategy to eradicate violence against women and girls can be found at **https://www.gov.uk/government/policies/ending-violence-against-women-and-girls-in-the-uk**

Information from the Department for Education about safeguarding children can be found at **https://www.gov.uk/childrens-services/safeguarding-children**

GOVERNMENT-PRODUCED LEAFLETS AND POSTERS

Professionals, civil society partners and members of the public can request copies of the government's leaflets, posters and latest DVD about FGM from **FGMEnquiries@homeoffice.gsi.gov.uk**

OUTREACH AND PEER SUPPORT

The government's FGM unit can offer advice and support to local areas who would like to strengthen or develop their work on tackling FGM.

To contact the FGM unit, please email **FGMEnquiries@homeoffice.gsi.gov.uk**

More information on the role of the FGM unit can be found at: **https://www.gov.uk/government/collections/female-genital-mutilation**

RESOURCES

To view some examples of effective practice in tackling FGM, please visit: **https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack**

BOOKS ABOUT FGM

- Comfort Momoh, Female Genital Mutilation (ISBN 9781857756937)
- Waris Dirie, Desert Flower (ISBN 9780688158231)
- Layli Miller Bashir and Fauziya assindja, Do They Hear You When You Cry? (ISBN 9780553505634)
- Alice Walker, Possessing the Secret of Joy (ISBN 9780671789428)
- Tasmin Bradley Women, Violence and Tradition: Taking FGM and other practices to a secular state (ISBN 9781848139589)
- Susannah Carlton, Biting The Stick (ISBN 9781497363489)

RESEARCH ABOUT FGM

- FORWARD (2007) A Statistical Study to
- Estimate the Prevalence of Female Genital Mutilation in England and Wales **http://www.forwarduk.org.uk/key-issues/fgm/research**
- To view other FORWARD resources and publications, please visit **http://www.forwarduk.org.uk/resources**
- UNICEF (2013) Female Genital Mutilation/ Cutting: A statistical overview and exploration of the dynamics of change **http://www.unicef.org/media/files/FGCM_Lo_res.pdf**
- EIGE (2013) Female Genital Mutilation in the European Union and Croatia **http://eige.europa.eu/sites/default/files/EIGE-Report-FGM-in-the-EU-and-Croatia_0.pdf**

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e-mail – FGMEnquiries@homeoffice.gsi.gov.uk

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