



North Tyneside Safeguarding Children Board



Female Genital Mutilation

Safeguarding Board Multi agency procedure

September 2015

Section A: Background Information

1. Introduction

This document provides a procedure for professionals who have responsibilities to safeguard children and protect and support adults from the abuse associated with female genital mutilation (FGM)

FGM is child abuse and a form of violence against women and girls, and therefore it should be dealt with as part of North Tyneside and Northumberland child protection and adult safeguarding policies and procedures.

2. What is FGM

The World Health Organisation (WHO) states that female genital mutilation (FGM):

“Comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons”

WHO Fact sheet No. 241 (February 2014)

FGM is also known as Female Circumcision (FC) and Female Genital Cutting (FGC). The reason for these alternative definitions is that it is better received in the communities that practice it, who do not see themselves as engaging in mutilation.

FGM is included within the revised (2013) Government definition of Domestic Violence and Abuse .

For more information see <https://www.gov.uk/female-genital-mutilation>

3. Female Genital Mutilation is classified into Four Major Types

1. 'Clitoridectomy which is the partial or total removal of the clitoris and, in rare cases, the prepuce (the fold of skin surrounding the clitoris);
2. Excision which is the 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 1 and II account for 75% of all worldwide procedures;
3. Infibulation which is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, and sometimes outer, labia, with or without removal of the clitoris; Type III accounts for 25% of all worldwide procedure and is the most severe form of FGM;
4. All other types of harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

4. Local Terms for the Procedure

These include tahara in Egypt; tahir in Sudan; and bolokoli in Mali, which are words synonymous with purification.

Several countries refer to Type 1 FGM as Sunna circumcision (which means usual practise/tradition in Islam). It is also known as kakia, and in Sierra Leone as Bundu, after the Bundu secret society.

Type III FGM (infibulation) is known as "pharaonic circumcision" in Sudan, and as "Sudanese circumcision" in Egypt.

5. Who Practices It

FGM is practised around the world in various forms across all major faiths. Today it has been estimated that currently, about three million girls, most of them under 15 years of age, undergo the procedure every year. The majority of FGM takes place in 29 African and Middle Eastern countries, and also includes other parts of the world; Middle East, Asia, and in industrialised nations through migration which includes; Europe, North America, Australia and New Zealand. Globally the WHO estimates that between 100 and 140 million girls and women worldwide have been subjected to one of the first three types of female genital mutilation.

It should be noted that FGM is not purely an African issue, although there is greater prevalence there. In the UK FGM has been found among Kurdish communities; Yeminis, Indonesians and among the Borah Muslims.

It is important to recognise that the migrant populations may not practice FGM to the same level as their country of origin; a migrant's reason for being in the UK may well be avoidance of FGM and second and third generation migrant populations may have very different attitudes towards FGM than their parents. However that same second or third generation may often be the children or adults at greatest risk of having the procedure carried out.

5.1 Estimated prevalence of FGM

Figure 1: The % prevalence rates of FGM in girls and women aged 15-49 years within the top 15 practicing countries.

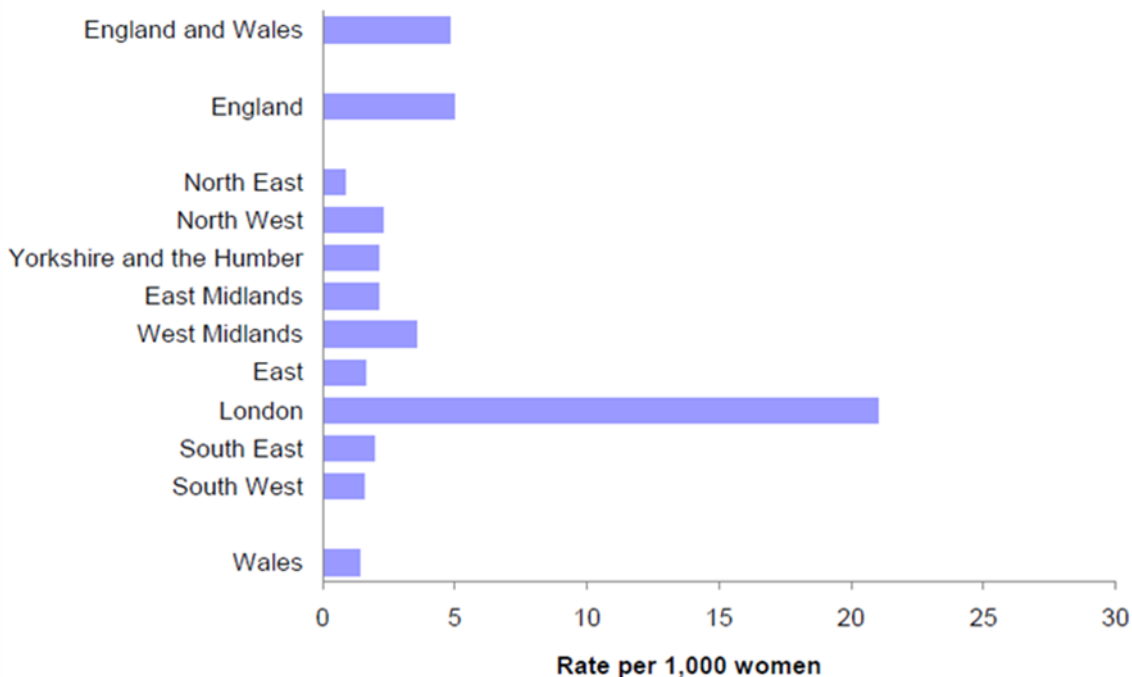
Rank	Country	Continent	Survey Type	Year	%
1	Somalia	Africa	MICS*	2006	97
2	Egypt	Africa	DHS	2005	95.8

3	Guinea	Africa	DHS	2005	95.6
4	Sierra Leone	Africa	MICS	2005	94
5	Djibouti	Africa	MICS	2006	93.1
6	Sudan	Africa	Local Survey	2006	89.3
7	Eritrea	Africa	DHS	2002	88.7
8	Mali	Africa	DHS	2006	85.2
9	Gambia	Africa	MICS	2005-6	78.3
10	Ethiopia	Africa	DHS	2005	74.3
11	Burkina Faso	Africa	MICS	2006	72.5
12	Mauritania	Africa	MICS	2007	72.2
13	Guinea-Bissau	Africa	MICS	2006	44.5
14	Ivory Coast	Africa	MICS	2006	36.4
15	Kenya	Africa	DHS	2003	32.2

It important to understand that countries with a lower prevalence rate could have high rates of FGM within the various ethnic groups such as Iraq, and Iran where overall prevalence rates are low but within the Kurdish communities the rate of FGM is high. Equally in India and Pakistan prevalence rates within the Muslim Bohra community is over 90%.

An estimated 137,000 women and girls with FGM, born in countries where FGM is practiced, were permanently resident in England and Wales in 2011. This represented a prevalence rate of 4.8 per 1,000 population (City University London 2015). There are substantial populations of people in the UK from countries where FGM is endemic; in London, Liverpool, Birmingham, Sheffield, Cardiff and Manchester. Although prevalence rates showed for the most part, people born in countries where FGM is practised tended to be concentrated in urban areas, there are likely to be affected women and girls living in every local authority area.

Estimated prevalence of FGM by region, all ages



Source: Prevalence of Female Genital Mutilation in England & Wales: National and local estimates, 2015, City University London

6. Religion and FGM

Muslim scholars have condemned the practice and are clear that FGM is an act of violence against women. Furthermore, scholars and clerics have stressed that Islam forbids people from inflicting harm on others and therefore most will teach that the practice of FGM is counter to the teachings of Islam. However, many communities continue to justify FGM on religious grounds. This is evident in the use of religious terms such as “Sunnah” that refer to some forms of FGM (usually Type I).

FGM is not practised amongst many Christian groups except for some Coptic Christians of Egypt, Sudan, Eritrea and Ethiopia. The Bible does not support this practice nor is there any suggestion that FGM is a requirement or condoned by Christian teaching and beliefs.

FGM has also been practiced amongst some Bedouin Jews and Falashas (Ethiopian Jews) and again is not supported by Judaic teaching or custom.

7. Communities at Risk of FGM in the UK

UK communities that are most at risk of FGM include Kenyans, Somalis, Sudanese, Sierra Leoneans, Egyptians, Nigerians, Eritreans and Ethiopians. However women from non-African communities that are at risk of FGM include Yemeni, Kurdish (Iraqi, Iranian and Turkish country of origin), Indonesian, Malaysian, Pakistani women and Indian women

(Muslim Bohra Community).

8. Health Impact

FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies.

Many women appear to be unaware of the relationship between FGM and its health consequences; in particular the complications affecting sexual intercourse and child birth which can occur many years after the mutilation has taken place.

8.1 Health Impact Complications Are Common and Can Lead to Death

The highest maternal and infant mortality rates are in FGM-practicing regions*. The actual number of girls who die as a result of FGM is not known. However, in areas of Sudan where antibiotics are not available, it is estimated that one-third of the girls undergoing FGM will die.

8.2 Immediate Physical Problems

- Intense pain and/or haemorrhage that can lead to shock during and after the procedure;
- Occasionally death;
- Haemorrhage that can also lead to anaemia;
- Wound infection, including tetanus.
- Urine retention from swelling and/or blockage of the urethra;
- Injury to adjacent tissues;
- Fracture or dislocation as a result of restraint;
- Damage to other organs.

9. Long-term Health Implications

In the UK, girls and women affected by FGM will manifest some of these long term health complications. They may range from mild to severe or chronic.

- Excessive damage to the reproductive system;
- Uterine, vaginal and pelvic infections;
- Infertility;
- Cysts;
- Complications with menstruation;
- Psychological damage; including a number of mental health and psychosexual problems, e.g. depression, anxiety, post traumatic stress, fear of sex **. Many children exhibit behavioural changes after FGM, but problems may not be evident

- until adulthood
- Abscesses;
- Sexual dysfunction;
- Difficulty in passing urine;
- Increased risk of HIV transmission/Hepatitis B/C – using same instruments on several girls;
- Increased risk of maternal and child morbidity and mortality due to obstructed labour.
- Women who have undergone FGM are twice as likely to die during childbirth and are more likely to give birth to a stillborn child than other women. *** Obstructed labour can also cause brain damage to the infant and complications for the mother (including fistula formation, an abnormal opening between the vagina and the bladder or the vagina and the rectum, which can lead to incontinence).

* British Medical Association - Female Genital Mutilation: caring for patients and safeguarding children (2011)

** Toubia, N. Female Genital Mutilation: A Call for Global Action, Women, Ink (New York, 1993)

*** Koso-Thomas, O: The Circumcision of Women: A Strategy for Eradication (Zed Books, London, 1987)

10. The Myths of why Circumcision is Necessary Vary Between Ethnic Groups

Among some of the more common myths are:

Myth	Fact
Circumcision protects the sexual morality of girls before marriage and women within marriages. Women that aren't circumcised are not in control of their sexual urges and are likely to be sexually promiscuous	FGM makes no difference to a woman's libido but usually prevents her from enjoying sex. Pre or extra marital sex also occurs in women who have been mutilated
If the clitoris is not cut it will harm the husband during intercourse	The clitoris gives a woman pleasure and does not cause harm to the husband but can enhance the sexual experience for both of them
Girls that are not circumcised do not reach puberty, nor do they develop female shapes and are not able to get pregnant	Girls reach puberty and conceive in communities not practising FGM. FGM can lead to infertility
Babies that are in contact with the clitoris during birth will die	The clitoris causes no harm to the newborn baby
If the clitoris is not removed, it will continue to grow until it develops into the size of a penis	The clitoris stops growing after puberty
If a woman does not undergo FGM her genitals will smell	Infection from any type of FGM can cause a smell

11. Common Justifications for FGM

- Maintain family honour and a girl's virginity;
- Improving a girl's marriage prospects;
- Protecting perceived cultural and religious beliefs and traditions

In some communities the bridal price for an uncircumcised girl is lower or non-existent, bringing an economic reason for keeping the custom. For these reasons alone, many mothers and grandmothers are the advocates of FGM for their young daughters or granddaughters.

Some men are brought up to believe that they have no way of knowing that their bride is a virgin unless she is circumcised. A bride who is not a virgin has little value in many African communities.

In some communities, the uncircumcised are considered unclean and are not permitted to enter a part of a house where worship takes place. They may be excluded from prayer and other religious rites. This can have an emotional impact on uncircumcised adults and children.

FGM is a form of child and adult physical abuse. However, the issue is complex and despite its very severe health consequences, some parents and others who want their daughters to undergo this procedure do not intend it, or regard it, as an act of abuse.

FGM is a social norm and communities are socialised into accepting FGM as essential and those who fail to conform may be ostracised or stigmatised. In general FGM aims to promote acceptance and sense of belonging.

12. Risk Factors that Heighten the Girl's/Woman's Risk of Being Subjected to FGM

- The family comes from a community that is known to practice FGM;
- Any female child born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family;
- Any female who has a relative who has already undergone FGM must be considered to be at risk;
- The socio-economic position of the family and the level of integration within UK society can increase risk.

13. Protective Legislation

FGM has been a criminal offence in the UK since The Prohibition of Female Circumcision Act 1985. This Act was repealed by The Female Genital Mutilation Act 2003 and closed a loophole which had enabled victims to be taken outside of the jurisdiction for the purposes

of FGM, without sanction. The Female Genital Mutilation Act 2003 makes it illegal to take a British national or permanent resident abroad for FGM or to help someone trying to do this. This legislation is designed to prevent families and carers from taking girls abroad to undergo the procedure. The Act increases the maximum penalty for being found guilty of FGM from 5 to 14 years imprisonment. The Female Genital Mutilation Act 2003 also makes it a criminal offence to re-infibulate following an FGM procedure.

The Serious Crime Act 2015 amends the 2003 Act to insert new provisions to:

- Provide anonymity for victims of FGM
- Create a new offence of failure to protect a girl from FGM
- Introduce FGM Protection Orders (FGMPO) for the purposes of protecting a girl against the commission of a genital mutilation offence or protecting a girl against whom such an offence has been committed. Breach of an FGMPO would be a criminal offence with a maximum penalty of five years' imprisonment, or as a civil breach punishable by up to two years' imprisonment.
- Section 5B(2)(a), (110 and (12) of the Act introduces a mandatory reporting duty which requires regulated professionals in England to report **'known' cases** of FGM in under 18s which they identify in the course of their professional work to the police.

For the purposes of the section of this act —

(a) A person works in a "regulated profession" if the person is—

- (i) A healthcare professional or
- (ii) A teacher

The duty applies from 31 October 2015 onwards.

Link to serious crime act 2015:

http://www.legislation.gov.uk/ukpga/2015/9/pdfs/ukpga_20150009_en.pdf

'Known' cases are those where either a girl informs the person that an act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was, or was part of, a surgical operation.

The Home Office have published guidance on this new duty to report to the police which can be found via:

<https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information>

The purpose of the above document is to give professionals subject to the duty and their employers an understanding of the legal requirements it places on them, a suggested process to follow, and an overview of the action which may be taken if they fail to comply with the duty. It also aims to give the police an understanding of the duty and the next

steps upon receiving a report.

When a report must be made

The FGM mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015). The legislation requires regulated health care professionals and teachers in England to make a report to the police where, in the course of their professional duties, they either:

- Are informed by a girl under 18 that an act of FGM has been carried out on her. The duty applies to cases directly disclosed by the victim; if a parent, guardian, sibling or other individual discloses that a girl under 18 has had FGM, the duty does not apply and a report to the police is not mandatory. Any such disclosure should, however, be handled in line with wider safeguarding responsibilities

Or

- Observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

For healthcare professionals, if, in the course of their work, they see physical signs which they think appear to show that a child has had FGM, this is the point at which the duty applies – the duty does not require there to be a full clinical diagnosis confirming FGM before a report is made to the police.

The healthcare professionals are not required to 'verify' that FGM has occurred in order for the duty to apply and a report to be made to the police. Whether the girl needs to be referred for a diagnosis will be considered as part of the subsequent multi-agency response.

For the purposes of the duty, the relevant age is the girl's age at the time of the disclosure/identification of FGM (i.e. it does not apply where a woman aged 18 or over discloses she had FGM when she was under 18).

Complying with the duty does not breach any confidentiality requirement or other restriction on disclosure which might otherwise apply.

The duty is a personal duty which requires the individual professional who becomes aware of the case to make a report to the police verbally or in writing; the responsibility cannot be transferred. The only exception to this is if you know that another individual from your profession has already made a report and there is evidence of this; there is no requirement to make a second.

Timeframe for reports

Reports to the police under the duty should be made as soon as possible after a case is discovered, and best practice is for reports to be made by the close of the next working

day, unless any of the factors described below are present. You should act with at least the same urgency as is required by your local safeguarding processes.

In order to allow for exceptional cases, a maximum timeframe of one month from when the discovery is made applies for making reports to the police. However, the expectation is that reports will be made much sooner than this.

It is recommended that you make a report orally by calling 101, the single non-emergency number.

Where there is a risk to life or likelihood of serious immediate harm, professionals should report the case immediately to police, including dialling 999 if appropriate.

In all cases you should ensure that you are given a reference number for the case and keep a record of this.

Failure to comply with the duty to the police

Cases of failure to comply with the duty to report will be dealt with in accordance with the existing performance procedures in place for each profession. FGM is child abuse, and employers and the professional regulators are expected to pay due regard to the seriousness of breaches of the duty.

Health professionals

For health professionals, failure to comply with the duty may be considered through fitness to practise proceedings by the regulator with whom the professional is registered.

Regulators will use their frameworks to consider a professional's ability currently to practise safely. This will therefore take all aspects of the circumstances of the case into consideration, including the safety of the individual child and her immediate needs. This may result in a wide variety of recommendations as to suitable action (e.g. re-training or supervision). Regulators may wish to issue guidance to their registrants as to how to act and when action may be taken.

Teachers

For teachers, schools will need to consider any failure to comply with the duty in accordance with their staff disciplinary procedures. Where the school determines it is appropriate to dismiss the teacher as a result of the failure to comply, or the teacher would have been dismissed had they not resigned, the school must consider whether to refer the matter to the National College of Teaching and Leadership (NCTL) in England or the Education Workforce Council (EWC) in Wales, as regulators of the teaching profession.

For teachers in England, the NCTL will consider referrals to determine whether the facts presented in respect of the individual's failure to comply with the duty are proven and whether they amount to unacceptable professional conduct or conduct likely to bring the profession into disrepute. If proven, the NCTL will consider whether it is appropriate to make a prohibition order which prevents the individual from carrying out teaching work in any school, children's home, sixth form college, and relevant youth accommodation in England.

Not all girls are protected under the FGM Laws, in which case statutory professionals may have to utilise their statutory powers to protect girls from being mutilated.

FGM is considered to be a form of child abuse (it is categorised under the headings of both Physical Abuse and Emotional Abuse). A local authority may exercise its powers under Section 47 of the Children Act 1989 if it has reason to believe that a child is likely to suffer or has suffered FGM. Under the Children Act 1989, local authorities can apply to the Courts for various Orders to prevent a child being taken abroad for mutilation.

FGM is also an abuse of female adults usually categorized under honour based violence and domestic abuse definitions. Where a female adult is also defined as a Vulnerable Adult, additional support mechanisms would be available through local social care teams and adult safeguarding processes.

Private law remedies can be used as a form of legal protection. For example a Prohibited Steps Order under Section 8 Children Act 1989 can be used to prevent a child being taken abroad or from having the procedure. A Non Molestation Order under Part IV of the Family Law Act 1996 may also be used as protection for the child or adult. The Domestic Violence Crime and Victims Act 2004 make the breach of a Non Molestation Order a criminal offence.

It may be possible for victims of FGM to claim compensation from the Criminal Injuries Compensation Authority. The injuries must be reported to the police.

The Police have Police Protection powers 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 the child from the parent and use the powers for 'police protection' (section 46 of the Children Act 1989) for up to 72 hours.

The Local Authority has further powers under Section 44 of the Children Act 1989. Under this section, the Local Authority may apply for an Emergency Protection Order (EPO). The Order authorizes the applicant to remove the girl and keep her in safe accommodation for up to 8 days. This Order is often sought to ensure the short term safety of the child.

An EPO can be followed by an application from the Local Authority for a Care Order, Supervision Order or an Interim 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 for the child.

There will be cases where a Care Order is not appropriate, possibly because of the age of the young person. A Local Authority may ask the Court to exercise its inherent jurisdiction to protect the young person.

Once a young person has left or been removed from the jurisdiction, the options available

to police, Local Authority and other services become more limited. In such situations an application may be made to the High Court to make the young person a Ward of Court and have them returned to the UK.

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.

International legislation

There are two international conventions containing articles which can be applied to FGM. Signatory states, including the UK, have an obligation under these standards to take legal action against FGM. These include The UN Convention on the Rights of the Child and The UN Convention on the Elimination of All Forms of Discrimination against Women. Female Genital Mutilation breaches several of these rights.

14. National Developments

- A pocket guide to the UK law on female genital mutilation is available to girls at risk to help them speak out against the practice. The leaflet a Declaration against Female Genital Mutilation (FGM) for Families and Girls is designed to slip in the back of a passport allowing girls to present it as a formal document to friends or family reminding them that FGM is against the law in the UK. It also sets out what the penalties are for offenders, including a maximum fourteen year custodial sentence, as well as advice on help and support;
- The NSPCC has launched a free 24hour helpline to protect children and young people affected by FGM. Anyone who is worried about a child being or has been a victim of FGM can contact **0800 028 3550** for information and support;
- Revised statutory guidance Keeping Children Safe in Education (2014) includes advice on FGM. The Education Secretary has written to all schools in England to ask them to help protect girls from female genital mutilation;
- The government has appointed a consortium of leading anti-FGM campaigners to deliver a global campaign to end the practice. The consortium will work across Africa to bring about a transformation in attitudes towards FGM.

Section B: Practice Guidance

15. Safeguarding: Actions to be taken by Single and Multi-Agency Partners

There are three circumstances relating to FGM which require identification and intervention:

- Where someone is at risk of FGM:
- Where someone has undergone FGM;
- Where a prospective mother has undergone FGM.

Professionals and volunteers in most agencies have little or no experience of dealing with female genital mutilation. Encountering FGM for the first time can cause people to feel shocked, upset, helpless and unsure of how to respond appropriately to ensure that a child, and/or a mother/any female adult, is protected from harm or further harm. The following agency specific guidance may help support the professional.

15.1 When someone is at risk of FGM

Indicators that FGM may soon take place:

- Parents state that they or a relative will take the child out of the country for a prolonged period;
- A child may talk about a long holiday (usually within the school summer holiday) to her country of origin or another country where the practice is prevalent;
- A child may confide to a professional that she is to have a 'special procedure' or to attend a special occasion;
- A professional hears reference to FGM in conversation, for example a child may tell other children about it;

15.2 Where someone has undergone FGM

Signs that FGM has taken place:

- Prolonged absence from school with noticeable behaviour changes on the girl's return;
- Longer/frequent visits to the toilet particularly after a holiday abroad, or at any time;
- Some girls may find it difficult to sit still and appear uncomfortable or may complain of pain between their legs;
- Some girls may speak about 'something somebody did to them, that they are not allowed to talk about';
- A professional overhears a conversation amongst children about a 'special

procedure' that took place when on holiday;

- Young girls refusing to participate in P.E regularly without a medical note;
- Recurrent Urinary Tract Infections (UTI) or complaints of abdominal pain.

Any information or concern that a female is at immediate risk of, or has undergone, FGM should result in a safeguarding referral to the appropriate Local Authority Social Care and the Protecting Vulnerable People (PVP) Unit.

16. Procedure within Social Care for Safeguarding Children, at Risk of or who have Undergone FGM

When information is received by Social Care, the Referral must be discussed with the Duty Manager who will subsequently inform the appropriate team in line with local policies and procedures. In all cases, professionals should not discuss the referral with the parents/carers/family until a multi-agency action plan has been agreed.

On receipt of referral, a Strategy Meeting must be called within two working days or sooner as directed by the duty/Team Manager. If a referral is received by Adult Social Care in relation to an adult at risk of FGM consideration will be given to the need for a Strategy Meeting.

In response to the initial referral, a strategy meeting will be convened to ensure a sensitive and coordinated multi agency response.

The Strategy Meeting should include:

- A Team Manager, to chair and co-ordinate the meeting;
- The allocated social worker responsible for the enquiry;
- Northumbria Police representative from the PVP Unit;
- A legal representative should be available for consultation;
- Appropriate health representation (for example the Sexual Assault Referral Centre/paediatrician);
- Any other professional deemed appropriate by the social care manager.

The Strategy Meeting must establish whether parents or the girl/woman has had access to information about the harmful aspects of FGM and the law in the UK. If not, this information should be made available to them.

The Strategy Meeting should consider the need for medical assessment and / or therapeutic services for the female. A girl who has undergone FGM should be seen as a Child in Need and offered services as appropriate.

An FGM Strategy Meeting should cover, at a minimum, the following issues:

- Family history and background information;
- Scope of the investigation, what needs to be addressed and who is best placed to do this;
- Roles and responsibilities of individuals and organisations within the investigation, with particular reference to the role of the police;
- As to whether a medical examination/treatment is required and if so who will carry out what actions, by when and for what purpose;
- What action may be required if attempts are made to remove the child / adult from the country;
- Identify key outcomes for the child/adult and their family and implications and impact on the wider community.

17. Assessment

See also Single Assessment Procedure.

Where a female has been identified as at risk or has been mutilated, it may not be appropriate to take steps to remove the child or a Vulnerable Adult from an otherwise loving family environment. Experience has shown that often the parents themselves can experience pressure to agree to FGM and see it as the best thing they can do for their daughter's marriageable status. It is also important to recognise that those seeking to arrange the mutilation are unlikely to perceive it to be harmful and, on the contrary, believe it to be legitimised by longstanding traditions. Therefore it is essential that when first approaching a family about the issue of FGM a thorough assessment should be undertaken, with particular focus on:

- Parental/carer attitudes and understanding about the practice and where appropriate;
- Child/young person/Vulnerable Adult's knowledge, understanding and views on the issue. For Vulnerable Adults a Capacity assessment will be required to see whether the legislation of the Mental Capacity Act 2005 applies.

Every attempt should be made to work with parents/carers on a voluntary basis to prevent abuse. It is the duty of social care to look at every possible way that parental/family co-operation can be achieved. However, the child's/adult's best interest is always paramount.

Some thought and consideration should be given to where the assessment is undertaken. For example it may be beneficial to talk to the family/affected female outside the home environment to encourage them to talk freely and acknowledge the impact FGM would have.

An interpreter must be used in all interviews with the family, and more importantly the affected female, if their first language is not English. The interpreter must not be a family relation and must not be known by the family. The interpreter should be female.

In cases where an interpreter is not used and English is not the female's first language, the reasons for not using an interpreter must be recorded, as part of the assessment.

Appropriate communication aids must be offered for females who have difficulties communicating due to disability/illness.

All interviews should be undertaken in a sensitive manner, and should only be carried out once.

With regards to children - parental consent and the child's agreement should be sought before interviews take place. All attempts must be made to work in partnership with parents, and to endeavour for parents to retain full parental rights in these circumstances; where consent is not given, legal advice should be sought.

Adults who are vulnerable need to be interviewed alone and a Capacity assessment completed. In order to establish capacity, the individual must be able to:

- (a) Understand the information relevant to the decision,
- (b) Retain that information,
- (c) Use or weigh that information as part of the process of making the decision, or,
- (d) Communicate his decision (whether by talking, using sign language or any other means).

Capacity is decision-specific – the decisions to be assessed may include whether they can consent to travel abroad when there is a risk of their family arranging for them to undergo FGM. If they are not able to make a decision or safeguard themselves, then a Best Interests decision should be made. When an adult lacks Capacity and needs to be safeguarded the Local Authority can apply to the Court of Protection to give them powers to protect an individual. If a Vulnerable Adult is assessed as having Capacity but cannot take a decision (freely) because of coercion, undue influence or constraint – or other circumstances – then an application can be made relying on the Court's inherent jurisdiction. Other adults may be protected for example through non molestation orders, or a FGM Protection Order (see page 7)

The Strategy Meeting should reconvene as agreed to discuss the outcomes and recommendations from the assessment and continue to plan the protection of the female. At all times the primary focus is to prevent the female undergoing any form of FGM by working in partnership with parents, carers and the wider community to address risk factors. However where the assessment identifies a continuing risk of FGM then, the first priority is protection and the local authority should consider the need for:

- Legal action;

- Criminal prosecution;
- An Initial Child Protection Conference.

Following all enquiries into FGM, regardless of the outcome, consideration must be given to the therapeutic/counselling needs of the female and the family.

Medical examination, if necessary must only be undertaken with the child's and the parents' consent or the consent of the adult female. If the adult lacks the Capacity to consent to the examination; then a Best Interests decision can be made for them. Where parents do not consent, legal advice should be sought.

In the majority of cases there should only be one medical examination of the child or woman. In cases where subsequent medicals are required, clear reasons for this decision should be recorded as part of the assessment.

If a medical/surgical procedure is required, and parents refuse consent, legal advice must be sought immediately.

Children in Immediate Danger

Where the child appears to be in immediate danger of FGM and parents cannot satisfactorily guarantee that they will not proceed with it, an Emergency Protection Order should be sought. The police should also be contacted.

When the immediate danger to the child/young person has been addressed, a Strategy Meeting should be convened.

Adults in Immediate Danger

When an adult is in immediate danger, contact the police. Protection can also be obtained by an emergency order by the Court of Protection where an adult lacks Capacity under the Mental Capacity Act 2005. Where an adult who lacks Capacity is being put under duress to comply with a situation, seek immediate legal advice; in some instances it will be necessary to approach the High Court for an emergency interim order.

If there is no evidence of risk

If the safeguarding enquiry concludes that there is no clear evidence of risk to the female then Social Care will:

- Consult the female's GP and a child's GP, Health Visitor or School Nurse about this conclusion and invite her/him to notify Social Care if any further information challenges it;
- Notify appropriate professionals involved with the family of the enquiry and the stage at which it was concluded;

- Inform the family and the referrer that the enquiry has been concluded;
- Consider whether any child may be a Child in Need or if the adult requires additional assessment and, if so, offer the family/carers any appropriate support services.

If it appears that no other females are at risk:

- Social Care will take no further action other than to liaise with health services to review any health concerns for the female who has undergone the procedure;
- If the FGM seems to have been performed in the UK, the police will seek information for the possible prosecution of the perpetrator;
- Social Care will notify the female's GP and a child's Health Visitors/School Nurse and invites her/him to notify them if any changes in the situation give rise to further concerns, e.g. the mother giving birth to further girls;
- If there are concerns about younger girls in the family, Children's Social Care must convene a Strategy Meeting as soon as possible to discuss whether any protective action can be taken.

18. Procedure for Safeguarding Children and Adults from FGM within Education / Leisure and Community and Faith Groups

Teachers, other school staff, volunteers and members of community groups may become aware that a female is at risk of FGM (see **Section 15.1, When someone is at risk of FGM**) through a parent / other adult, a child or other children disclosing that:

- The procedure is being planned;
- An older child or adult in the family has already undergone FGM.

See **Section 15.1, Indicators that FGM May Soon Take Place.**

A professional, volunteer or community group member who has information or suspicions that a female is at risk of FGM should consult with their agency or group's designated safeguarding adviser (if they have one) and should make an immediate referral to LA Social Care and PVP Unit (Police). The referral should not be delayed in order to consult with the designated safeguarding adviser, a manager or group leader, as multi-agency safeguarding intervention needs to happen quickly.

Once concerns are raised about FGM there should also be consideration of possible risk to other females in the practicing community.

From 31 October 2015 regulated health and social care professionals and teachers in England and Wales have a duty to report known cases of FGM in under 18-year-olds to the police.

The Home Office have published guidance on this new duty which can be found via <https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information>

19. Procedure for Safeguarding Children and Adults from FGM within the Health Sector

Health professionals in GP surgeries, sexual health clinics, Women's Health, A&E and maternity services are the most likely to encounter a girl or woman who has been subjected to FGM. All girls and women who have undergone FGM should be given information about the legal and health implications of practicing FGM. Health Professionals should remember that some females may be traumatised from their experience and have already resolved never to allow their daughters to undergo this procedure.

Health Professionals should deal with FGM in a sensitive and professional manner when treating patients affected by FGM. They should ensure that the mental health needs of a patient are taken into account.

From 31 October 2015 regulated health care professionals have a duty to report known cases of FGM in under 18-year-olds to the police.

The Home Office have published guidance on this new duty which can be found via <https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information>

GPs, and Practice Nurses should be vigilant to any health issues such as resistance to partake in cervical smear testing, recurrent urinary tract infections or vaginal infections that may indicate FGM has been carried out. Those that do attend for health checks or travel vaccinations from affected communities could be asked about FGM and advised about its health impacts. They should be offered/referred for additional support. They should document if a female patient has:

- Undergone FGM;
- What type of FGM;
- If there is a family history of FGM;
- If any FGM-related procedure has been carried out on a women (including de-infibulation).

Document any advice or leaflets provided. Any concerns about a parent's attitude towards FGM should be taken seriously and appropriate referrals made. Professionals should consult with their child protection lead and with the LA Children's Social Care duty team about making a referral to them.

A question about FGM should be asked when a routine new patient history is being taken from girls and women from communities that practise FGM. Information on FGM could be

included in a welcome pack which is given to new patients from practising communities.

Where a prospective mother has undergone FGM

Midwives and nurses should be aware of how to care for women and girls who have undergone FGM during the antenatal and postnatal periods. They should discuss FGM at the initial booking visit to all women who come from countries that practice FGM or if they are married to or in a relationship with men from FGM practising communities. They should document if the woman has:

- Undergone FGM;
- What type of FGM;
- If there is a family history of FGM;
- If any FGM-related procedure has been carried out on a women (including de-infibulation).

They must also document what plan is in place for delivery. Document that the woman has been told about the health risks and the law and given a leaflet in an appropriate language (if available) that explains the health risks of FGM, the law and local support services. All this information should be shared with appropriate health professionals (including the GP and the Health Visitor). Professionals should consult with their safeguarding leads for guidance and support.

If a girl or woman who has been de-infibulated requests re-infibulation/re-suturing after the birth of a child, and/or the child is female or there are daughters in the family, health professionals should consult with their safeguarding leads and with Children's Social Care about making a referral to them. Re-infibulation is illegal in the UK.

Whilst the request for re-infibulation is not in itself a safeguarding issue, the fact that the girl or woman is apparently not wanting/able to comply with UK law due to family pressure and / or does not consider that the procedure is harmful raises concerns in relation to female children she may already have or may have in the future.

Some women may be pressured to ask for re-infibulation by their partner. This would come under the category of Domestic Violence and local protocols must be followed.

Health visitors are in a good position to reinforce information about the health consequences and the law relating to FGM. Health visitors should discuss the risks of FGM and document the parent's response and the advice and any leaflets given to explain the law relating to FGM. Any concerns about a parent's attitude towards FGM should be taken seriously and appropriate referrals made. Professionals should consult with their safeguarding leads about making a referral to social care and inform the family's GP of the referral. Midwives and Health visitors should seek to record this information to ensure that all relevant health professionals are aware of the FGM incident and any concerns for

female children.

Public Health School Nurses are in a good position to reinforce information about the health consequences and the law relating to FGM. The school nurse should work closely with the child's school supporting them with any concerns. They should be vigilant to any health issues such as recurrent urinary tract infection that may indicate FGM has been undertaken. If the school nurse has contact with any family that originates from a country where FGM is practised, they should discuss the risks of FGM and document the parent's response along with any advice and leaflets provided to explain the law relating to FGM. Any concerns about a parent's attitude towards FGM should be taken seriously and appropriate referrals made.

Accident and Emergency Departments and Walk-in Centres need to be aware of the risks associated with FGM if girls/women from FGM practising countries attend, particularly with urinary tract infections (UTIs), menstrual pain, abdominal pain, or altered gait for example. Their assessment should include assessing the risks associated with FGM. This should be documented and professionals should consult with their child or adult safeguarding lead about making a referral to social care.

See **Section 12, Risk Factors that Heighten the Girl's/Woman's Risk of Being Subjected to FGM.**

Health services for Asylum Seekers & Refugees. Where initial health assessments for asylum seekers and refugees are undertaken, the health professional can introduce a discussion about FGM. They should document if the female has undergone FGM and what type. They must also document that the woman has been told about the law and given a leaflet in an appropriate language (if possible) that explains the risks of FGM, the law and local support services. All this information should be shared with appropriate health professionals (GP, Health Visitor etc). Professionals should consult with their safeguarding lead about making a referral to social care.

From April 2014, it is a mandatory requirement for NHS hospitals to record:

- If a patient has had FGM;
- If there is a family history of FGM;
- If an FGM-related procedure has been carried out on a women – (de-infibulation).

From September 2014, all acute hospitals must report this data centrally to the Department of Health on a monthly basis. This is the first stage of a wider ranging programme of work in development to improve the way in which the NHS will respond to the health needs of girls and women who have suffered FGM and actively support prevention.

Documents that guide health professionals include:

- FGM: Caring for patients and child protection (BMA, July 2011);
- Royal College of Nursing- FGM educational resource (2006);
- Royal college of Obstetrics and Gynaecology FGM guidelines;

20. Procedures for Police Officers/Police Staff

There is a risk that the fear of prosecution of family members may prevent those concerned from seeking help and support from relevant agencies and in particular medical help as a result of long term complications caused by FGM.

In many communities where the practice of FGM is prevalent, children who may have undergone/be due to undergo FGM may accept it as part of their religious/cultural upbringing due to a lack of understanding of the potential criminal offence being committed and future health complications that may prevail.

Police should work with other agencies to obtain relevant support and guidance for the victim. Where relevant they can work with other professionals to prevent FGM by educating parents/carers about the legislation relating to FGM and possible consequences.

Police staff working with Children - If a girl is at risk of undergoing or has already undergone FGM, the PVP Unit should be made aware and in their absence the CID. Relevant safeguards should be put in place immediately in order to prevent any risk of harm to the child.

- Risk to any other children should be considered and acted upon immediately;
- The investigation should be dealt with as a child safeguarding issue taking cognisance of any honour-based violence issues.

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.

The PVP Unit should attend Strategy Meetings with Children's Social Care and relevant agencies.

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.

A second Strategy Meeting should take place within ten working days of the initial referral. 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.

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.

21. When an Adult Female has Undergone/is about to Undergo FGM

These incidents should be dealt with by the protecting Vulnerable People Unit as a form of Domestic Violence and Abuse/Honour Based Violence incident. Relevant risk assessments (such as the domestic abuse risk indicator checklist) and safeguards should be put in place and referrals to partner agencies made as appropriate in order to ensure the victim receives all relevant support.

If the adult female is a Vulnerable Adult, the adult safeguarding process should be initiated and a Strategy Meeting arranged. Note however, if the adult has Capacity and does not give consent the safeguarding process would not be taken forward unless there was a wider 'public interest' element to the case. Immediate protection may be secured through the Court of Protection or the High Court.

22. Links to Forced Marriage and Domestic Violence and Abuse

There can be a link between FGM and Forced Marriage, particularly in adults/teenagers when the woman may be mutilated shortly before the marriage. Professionals should be alert to this and consider a joint response to the Forced Marriage through local protocols alongside protection from FGM.

Women and girls may be raped within their relationship and suffer pain and re-traumatisation every time a partner demands sex. Some men may be more understanding and the couple may seek support. It is important to consider the wider support needs a woman may have including immigration, housing, debt, childcare and counselling support through community groups and domestic abuse specialist support. She may need to be referred to her local Multi Agency Risk Assessment Conference (MARAC) if the risk of forced marriage or domestic violence is high.

23. Support for Girls and Women Affected by FGM

What can we offer?

Counselling

Girls and women suffering from anxiety, depression or who are traumatised as a result of FGM should be offered counselling and other forms of therapy. All girls and women who have been undergone FGM should be offered counselling to discuss how de-infibulation

will affect them. Parents, husbands boyfriends, partners can also be offered counselling.

The Angelou Centre in Newcastle has a dedicated FGM project which can offer individual support and advocacy for women and girls affected by FGM.

Tel: 0191 2260394

Rape Crisis Tyneside and Northumberland do not have a separate service but can offer counselling, helpline, email support and information to women affected by FGM.

enquiries@rctn.org.uk

E Learning Resource

The Government has developed an e- learning course [Recognising and preventing FGM training](#) for professionals with safeguarding responsibilities. It gives an introduction to FGM and the action you must take to protect girls who may be at risk.

Female Genital Mutilation (FGM) Multi-Agency Pathway
 Referral to Children's Social Care (CSC) **must** be made in the following circumstances:

- Woman has had FGM and / or has strong cultural belief in FGM **and**
- Has female children or is pregnant
- Physical observation during labour

FGM risk could be identified via the following:
 Routine enquiry/consultation, disclosure, country of origin, female children in family (including extended), girl talks about special celebration

Health Professionals and teachers
 If FGM is '**known**' have a duty to report to the police and ensure that detail and **crime number are documented** in records.

Inform woman of concerns (**unless** jeopardising safety or criminal investigation).
Make woman aware that FGM is an illegal process

Health staff
 Primary Care, acute & mental health NHS Trusts
 If FGM has already been performed, it is **mandatory** that it is recorded in clinical health records including type if known and safeguarding lead **must be informed**.

Female children involved? Including those in wider family

Yes
 Make referral to Children's Social Care If risk imminent, inform police

No but adult(s) with care and support needs or at risk of / discloses that she has plans to undergo FGM, **must** submit referral to Adult Social Care.

Not an adult with care and support needs despite historic FGM
 No action, sign post for information

Strategy meeting under NTSCB / NSAB procedures
 Adult's rep as required. Police must be involved

NTSCB / NSAB Safeguarding Adults procedures followed. Police must be consulted and children's services as required

SUPPORT SERVICES
 NSPCC 0800 028 3550 (national)
Rosie@angelou-centre.org.uk a dedicated resource based in Newcastle offering support and advocacy 0191 2260394

- Single assessment enquiry / CIN or signpost to services
- Alert / coding to records
- Document details including type.
- All female children in extended family to be assessed as at potential risk.

- Concerns recorded and risks assessed. Threshold guidance identifies FGM as critical risk of harm;
- Multi-agency meeting should be held;
- Safeguarding Adults Plan developed in response to identified risks to adult(s).