Sandwell Policy and Procedures to Address Female Genital Mutilation

Contents

Version	Change	Author	Date
0.1	Initial draft	MK/IV	30.09.15
0.2	Policy revised to include adult safeguarding	IV	01.12.16

1.0 Introduction

1.1 Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act 2003. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies. It is primarily, though not exclusively, carried out on minors. Adult safeguarding issues may arise where there is re-infibulation (where a woman is reclosed) after childbirth or pressure for later FGM to take place in connection with marriage. FGM is a form of child abuse and is a violation of a child or adult's human rights and can result in both short term and long term medical complications. FGM is illegal, has no health benefits and harms girls and women in many ways.

1.2 The World Health Organisation (WHO) defines FGM as *"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, 1996)*.

1.3 **Types of FGM**

1.4 The most common types of FGM are excision of the clitoris (Type 1), and excision of the clitoris and labia minora (Type 2) — accounting for up to 80% of all cases. The most extreme type is infibulation (Type 3), which constitutes about 15% of all procedures, but is practised among as many as 90% of women from Somalia, Djibouti and Northern Sudan — with a consequently higher rate of complications FGM has been classified by the World Health Organisation into the following 4 categories:-

- **Type 1** - Clitoridectomy: partial or total removal of the clitoris (the small sensitive erectile part of the female genitalia) In rare cases the prepuce (hood of the clitoris) only is removed.
- **Type 2** - Excision: partial or total removal of the clitoris and the labia minora, with or without the excision of the labia majora. (The labia are the 'lips' surrounding the vagina)
- **Type 3** - Infibulation: narrowing of the vaginal opening by cutting and re-positioning 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.

1.5 FGM 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.

1.6 **Guidance**

1.7 Sandwell Domestic Abuse Strategic Partnership (DASP), Sandwell Safeguarding Children Board (SSCB) and Sandwell Safeguarding Adults Boards (SSAB) have worked in partnership to develop this policy to provide professionals, practitioners and anyone working with adults, children and young people with an understanding of FGM and what action they

should take to safeguard women and girls who they believe may be at risk, or have already been harmed through FGM.

1.8 Professionals, volunteers and individuals coming across FGM for the first time can feel shocked, upset, helpless and unsure of how to respond appropriately to ensure that children are protected from harm. They may be afraid of tackling the issue due to perceived cultural sensitivities. However, it is important for this issue to be addressed, and women and girls to be safeguarded.

1.9 This FGM policy and procedures document provides guidance for frontline professionals and their managers, individuals in Sandwell's local communities and community groups on:

- *Identifying when a child may be at risk of being subjected to FGM and responding appropriately to protect the child;*
- *Identifying when a child has been subjected to FGM and responding appropriately to support the child and;*
- *Measures which can be implemented to prevent and ultimately eliminate the practice of FGM.*

This procedure should be read in conjunction with Sandwell adult and child safeguarding procedures.

2.0 Legislation and Policy

2.1 **National legislation**

2.2 In England, Wales and Northern Ireland all forms of FGM are illegal under the Female Genital Mutilation Act 2003, and in Scotland it is illegal under the Prohibition of FGM (Scotland) Act 2005.

2.3 A person is guilty of an offence if s/he excises infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris except for operations performed on specific physical and mental health grounds by registered medical or nursing practitioners. It is also an offence to assist a girl to mutilate her own genitalia.

2.4 The Act also includes anyone who may aid and abet any of the above. Professionals need to be aware of this, with the incidences of parents arranging for their children to travel abroad to have FGM done. Necessary operations by a registered medical practitioner or midwife for medical reasons or related to child birth are specific exclusions under the Act.

2.5 The 2015 Serious Crime Act widened the laws relating to FGM. Sections 70–75 of the Act introduced the following new measures:

2.6 **Extension of extra-territorial liability to 'habitual' UK residents**

2.7 The Female Genital Mutilation Act 2003 was originally concerned with acts done by UK nationals or permanent UK residents to girls or women who are UK nationals or permanent UK residents. Perpetrators and victims who were habitually resident in the UK (but not UK nationals or permanent UK residents) were not covered by the legislation. The Serious Crime Act amended sections 1 to 3 of the 2003 Act so that it applies to UK nationals and habitual residents rather than only to UK nationals and permanent UK residents. A UK resident is someone who is habitually resident in the UK.

2.8 **Lifelong victim anonymity**

2.9 Section 4A and Schedule 1 have been inserted into the 2003 Act and provide for injunctions prohibiting the publication of any matter that could lead the public to identify the alleged victim of an offence under the Act. The prohibition lasts for the lifetime of the alleged victim. The power to waive the restrictions is limited to the circumstances necessary to allow a court to ensure that a defendant receives a fair trial (Article 6 ECHR) or to safeguard freedom of expression (Article 10 ECHR). The rationale is that anonymisation will encourage women and girls to report FGM offences committed against them and to increase the number of prosecutions.

2.10 **Parents' and guardians' liability for failing to protect a child from FGM**

2.11 Section 3A offence of failing to protect a girl under the age of 16 from the risk of FGM is introduced into the 2003 Act. A person is liable for the offence if they are responsible for a girl at the time when an offence is committed against her and when FGM has actually occurred.

2.12 **Female Genital Mutilation Protection Orders (FGMPOs)**

2.13 Female Genital Mutilation Protection Orders (FGMPOs) which are designed to safeguard girls who are at risk of FGM at home or abroad (or who are already victims) came into effect from the 17th July 2015. An order can be made to protect either a girl or woman at risk of FGM. FGM protection orders are modelled on forced marriage protection orders introduced by the Forced Marriage (Civil Protection) Act 2007. The terms of such an order can be broad and flexible and enable the court to include whatever terms it considers necessary and appropriate to protect the girl. These include, for example, provisions requiring a person to surrender his or her passport.

2.14 Under the Children Act 1989, local authorities can apply to the courts for various orders to prevent a child being taken abroad for mutilation. These include an Emergency Protection Order, Interim Care Order and Prohibited Steps Order.

2.15 **Mandatory reporting for relevant professionals**

2.16 Section (5B) of the 2003 Female Genital Mutilation Act places a duty on persons who work in a 'regulated profession' in England and Wales, namely healthcare professionals, teachers and social care workers, to notify the police when, in the course of their work, they discover that an act of FGM appears to have been carried out on a girl who is under 18. The section does not apply to girls or women who might be at risk of FGM or cases.

2.17 Regulated health and social care professionals include all professions regulated by a body overseen by the Professional Standards Authority. The PSA oversees the following regulatory bodies: where professionals discover a woman who is 18 or over has endured FGM.

2.18 See appendix 1 for further information and guidance on mandatory reporting.

2.19 The Government's mandatory reporting procedure can be accessed here: https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information

2.20 **International legislation**

2.21 There are two international conventions which contain articles that can be applied to FGM. Signatory states, including the UK, have an obligation under these standards to take legal action against FGM:

- The UN Convention on the Rights of the Child;
- The UN Convention on the Elimination of All Forms of Discrimination Against Women.

2.22 **National policy**

2.23 The Children Act 2004 requires all statutory agencies to take responsibility for safeguarding and promoting the welfare of every child and within this legislative framework supported by statutory guidance (Working Together 2015) professionals and volunteers from all agencies have a responsibility to safeguard children from being abused through FGM

2.24 In April 2016 HM Government released latest version of the 'Multi Agency Practice Guidelines for FGM': https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

2.25 **Legal interventions**

2.26 "If at any time it is considered that the child may be a child in need as defined in the Children Act 1989, or that the child has suffered significant harm or is likely to do so, a referral should be made immediately to local authority children's social care. This referral can be made by any professional" Working together to Safeguard Children (2015).

2.27 Working Together to Safeguard Children (2013) p.13 FGM is recognised as significant harm. Professionals should intervene to safeguard girls who may be at risk of FGM or have been affected by it, by using the relevant existing statutory procedures. There may be a joint investigation which would be managed in accordance to the Safeguarding Board procedures and Working Together to Safeguard Children (2015).The police may use their protection powers under section 46 of the Children Act 1989 where there is reasonable cause to believe that a child or young person under 18 years is at risk of significant harm. Children's social care would be informed by the police and initiate child protection enquiries.

2.28 A Female Genital Mutilation Protection Order (FGMPO) is a civil measure which offers the means of protecting victims or potential victims from FGM under civil law. An application can be made by;

- The girl or women to be protected (in person or with legal representation);
- A Relevant Third Party (a person or organisation appointed by the Lord Chancellor. Currently, only local authorities have been classified as relevant third parties);
- Any other person with permission of the court (for example, this could be the police, a voluntary sector support service, a healthcare professional, a teacher, a friend or a family member.

See Appendix 2 Making an Application for an FGM Protection Order (FGMPO) for additional information on making an application.

2.29 An FGMPO can also include terms which relate to conduct which occurs both within and outside England and Wales. For example, it is an offence for an individual to arrange, by

telephone from their home in England, for their UK national daughter to have an FGM operation carried out abroad by a foreign national.

2.30 Emergency Protection Order (EPO) is generally applied for by children's social care. An EPO authorises the applicant to remove the girl and keep her in safe accommodation. It lasts for 8 days but can be renewed for up to a further 7 days.

2.31 Care Orders and Supervision Orders - Children's social care may need to consider whether the circumstances constitute likely significant harm to justify initiating care proceedings. The court will decide whether the threshold has been reached and which order is most appropriate depending on the circumstances and the age of the child or young person (Children Act 1989 section 31).

2.32 Under the Children Act 1989, local authorities can apply to the courts for various orders to prevent a child being taken abroad for FGM, however with the introduction of FGMPO it is envisaged that these orders will be used more prevalently.

2.33 A Prohibitive Steps Order (Children Act 1989, Section 8) can be sought to prevent parents or carers from carrying out a particular act without the consent of the court.

2.34 Where an adult female is deemed to meet the criteria in the Care Act 2014 of having care and support needs and is experiencing or is at risk of FGM, and is unable to protect themselves from the abuse/risk of abuse, additional support mechanisms would be available through adult safeguarding processes.

3.0 Context in which FGM occurs

3.1 **Prevalence**

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

3.3 The World Health Organisation estimates that between 130-140 million girls and women in the world have experienced female genital mutilation and up to two million girls per year undergo some form of the procedure each year.

3.4 The great majority of affected women and girls live in sub-Saharan Africa, but the practice is also known in parts of the Middle East and Asia.

3.5 FGM is prevalent in 30 countries. These are concentrated in countries around the Atlantic coast to the Horn of Africa, in areas of the Middle East, and in some countries in Asia however, in each of those countries the extent of the practice varies. African countries with the highest likelihood of FGM being practiced are Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Mali, Sierra Leone, Somalia and Sudan.

3.6 **Map of African Countries with communities practicing FGM:**

Source: Hosken FP. Female Genital Mutilation; Estimate: total number of girls and women mutilated in Africa. *Lexington MA: Women's International Network News, 1997.*

3.7 In England and Wales, women from non-African communities which are most likely to be affected by FGM include Yemeni, Iraqi Kurd and Pakistani women.

3.8 **Sandwell data**

3.9 In Sandwell, the 2014 school census data revealed that there were 261 female pupils attending Sandwell schools with languages associated with countries affected by FGM (Appendix 3).

3.10 FGM data from Midwifery at Sandwell and West Birmingham Hospitals in July 2015 indicated that there were a total of 62 FGM cases identified in Sandwell & West Birmingham hospitals where the patient was a Sandwell resident during a six month period.

Prevalence of FGM in England and Wales

3.11 FGM's prevalence in England and Wales is difficult to estimate because of the hidden nature of the crime. However, a recent 2015[1] study estimated that:

It is estimated that approximately 103,000 women aged 15-49 and

- 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

[1] *Macfarlane A, Dorkenoo E. (2015) Prevalence of Female Genital Mutilation in England and Wales: National and local estimates.London: City University London and Equality Now http://openaccess.city.ac.uk/12382/*

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.

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

3.13 **Cultural underpinnings**

3.14 Female genital mutilation is a complex issue - despite the harm it causes, many women from FGM practicing communities consider FGM a normal part of their cultural identity.

3.15 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 woman or 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.

3.16 Although FGM is practised by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. However, neither the Bible nor the Koran supports the practice of FGM. In addition to giving religious reasons for subjecting their daughters to FGM, parents say they are acting in a child's best interests because it:

- Brings status and respect to the girl;
- Preserves a girl's virginity / chastity;
- Is part of being a woman;
- Is a rite of passage;
- Gives a girl social acceptance, especially for marriage;
- Upholds the family honour;
- Gives the girl and her family a sense of belonging to the community;
- Fulfils a religious requirement mistakenly believed to exist;
- Perpetuates a custom / tradition;
- Helps girls and women to be clean and hygienic;
- Is cosmetically desirable.

3.17 **Age and procedure**

3.18 The age at which FGM is subjected on women and girls varies enormously depending on the community or ethnic group that the woman or girl belongs to. The procedure may be carried out when a girl is new born, 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.

3.19 FGM is usually carried out by an older woman in a practicing community, for whom it is a way of gaining prestige and can be a lucrative source of income. It is believed that foreign nationals may be flown into the UK to perform a number of circumcisions to cut costs for families; it is also believed that children are flown out to their home countries to have the procedure carried out, usually at the beginning of the summer holidays to allow the

wounds to heal before the new school term. It is also believed that there are 'cutters' available within the communities here in the UK. Where information is received about cutters operating locally or nationally, information should be passed to the police.

3.20 The arrangements for the procedure usually include the child being held down on the floor by several women and the procedure carried out without medical expertise, attention to hygiene and anaesthesia. The instruments used include unsterilised household knives, razor blades, broken glass and stones. In addition the child is subjected to the procedure unexpectedly. In some cases the child might be told that they are to have a party or celebration, and a party will in fact take place. If professionals are told this by a child from a practicing community, careful questioning should take place and caution given.

3.21 **Names for FGM**

3.22 Terminology for referring to FGM varies between communities and individuals may only recognise the terminology used within their own community. FGM is known by a number of names, including 'female genital cutting', 'circumcision' or 'initiation'. 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.

3.23 See 16.0 for list of terms used for FGM in different languages.

4.0 Consequences of FGM

4.1 Many women in practicing communities appear to be unaware of the relationship between female genital mutilation and its harmful health and welfare consequences, in particular the implications affecting sexual intercourse and childbirth, which occur many years after the mutilation has taken place. FGM can cause both short term and long term complications. Some of these are as a result of the procedure being performed in unhygienic circumstances.

4.2 **Short-term implications:**

- Severe pain;
- Shock – emotional, psychological and medical trauma;
- Haemorrhage;
- Wound infection including tetanus and blood borne viruses such as HIV and hepatitis B and C;
- Damage to organs around the clitoris and labia;
- Urine retention;
- Fracture of bones or dislocation of joints as a result of restraint;
- Damage to other organs.

4.3 **Long-term implications:**

- Damage to the reproductive system including infertility;

- Chronic vaginal and pelvic infections;
- Cysts and abscesses;
- Complications in pregnancy and child birth, including death;
- Psychological damage;
- Painful sexual intercourse;
- Sexual dysfunction;
- Difficulties in menstruation;
- Difficulties in passing urine and chronic urine infections;
- Renal impairment and possible renal failure;
- Increased risk of HIV and other sexually transmitted infections;
- Fear of childbirth;
- Death.

4.4 There is increasing awareness of the severe psychological consequences of FGM which can be lifelong. There is evidence to suggest that girls having undergone FGM suffer from post-traumatic stress disorder with flash backs and many suffer from anxiety and mood disorder. The feeling of betrayal, incompleteness, anger and regret are also themes reported by young women who have undergone counselling.

4.5 **Mental Health Problems**

4.6 In FGM practicing communities, the procedure for FGM is usually performed without anaesthetics and with instruments such as razor blades. Case histories and personal accounts from women note that FGM is an extremely traumatic experience for girls and women that stay with them for the rest of their lives.

4.7 The results from research in practicing African communities are that women who have undergone FGM have the same levels of Post-Traumatic Stress Disorder as adults who have been subject to early childhood abuse, and the majority of the women (80%) suffer from affective (mood) or anxiety disorders.

4.8 For information on the long-term consequences of FGM, including mental health problems, PTSD, depression, psychosexual dysfunction, etc., see page 13 Multi-Agency Practice Guidelines: Female Genital Mutilation (HM Government) 2014.

5.0 Principles supporting this procedure

5.1 The following principles should be adopted by all agencies in relation to identifying and responding to adult women with care and support needs, children (and unborn children) at risk of, or who have experienced female genital mutilation and their parent(s):

- The safety and welfare of the child is paramount;
- To prevent harm and reduce the risk of abuse to children and adults with care and support needs;
- All agencies act in the interests of the rights of the child as stated in the U.N. Convention on the Right of the Child (1989);

- FGM is illegal and is prohibited by the Female Genital Mutilation Act 2003 and Prohibition of Female Genital Mutilation (Scotland) Act 2005;
- It is acknowledged that some families see FGM as an act of love rather than cruelty. However, FGM causes *Significant Harm* both in the short and long term and constitutes physical and *Emotional Abuse* to children;
- All decisions or plans for the children should be based on good quality assessments and be sensitive to the issues of race, culture, gender, religion and sexuality, and avoid stigmatising the child or the practicing community as far as possible. However, this is an issue by its very nature which involves questioning culture, and professionals should not be afraid to tackle the issues for fear of offending the family - FGM is against the law, and is child abuse;
- The Serious Crime Act 2015 amends the FGM Act 2003 to prohibit the publication of any information that would be likely to lead to the identification of a person against whom an FGM offence is alleged to have been committed. Anonymity will commence once an allegation has been made and will last for the duration of the victim's lifetime (except in some specific circumstances to do with court cases);
- Accessible, acceptable and sensitive Health, Education, Police, Children's Social Care and Voluntary Sector service provision must underpin this procedure;
- All agencies should work in partnership with members of local communities, to empower individuals and groups to develop support networks and education programmes.

5.2 **For this policy to be effective it is essential that each agency and person working in that agency recognises that safeguarding women and girls from FGM is everyone's responsibility and any assessment must also assess any potential risk of FGM to any other women or girls living in the same family**. Those working with adults should recognise the risk of FGM to any children and those working with children should be able to identify the risk of FGM to adults. Adult females (who meet the criteria of the Care Act 2014) will have similar needs for support and protection but different legislation and routes to safety will apply.

5.3 **This procedure should be read in conjunction with Sandwell Safeguarding Children Procedures and Adults Safeguarding Procedures.**

6.0 Identifying women and girls at risk of FGM

6.1 A woman or girl from a practicing community may be at risk of FGM but it cannot be assumed that all families from practicing communities will want their females to undergo FGM.

6.2 The risk of FGM to an individual is greater when the community is less well integrated into British society, when their own mother or sister has been the subject of FGM or when they have been withdrawn from Personal, Social and Health Education (PSHE) lessons at school. The withdrawal from such lessons may be the parent's way of keeping the girl uninformed of her rights and her own body.

6.3 A girl may be taken out of the country for a holiday for the procedure to be carried out abroad with time for recovery, but there is also evidence that FGM is carried out in the UK. Girls are particularly vulnerable during the summer holidays, both for female genital

mutilation and forced marriage. All professionals, particularly those in education settings, are encouraged to be particularly alert to the signs of potential abuse at this time of year.

6.4 **Risk factors that heighten a girl/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.

6.5 **Alerts to imminent FGM may include:**

- A visiting female elder being in the UK from the country of origin;
- A professional hearing reference to FGM e.g. having a "special procedure";
- A disclosure or request for help if the woman/girl is aware or suspects she is at risk;
- Parents taking the child out of the country for a prolonged period;
- The girl talking about a long holiday to one of the countries where FGM is practised.

6.6 FGM may already have taken place but it is important that this is recognised so that help can be offered to the girl, other family members at risk can be safeguarded and so that a criminal investigation can be carried out.

6.7 **Indications that FGM has already been carried out may be suspected if:**

- A girl seems to have difficulty walking, sitting or standing.
- A girl spends longer than normal in the bathroom/toilet due to difficulties urinating.
- A girl spends long periods away from the classroom with bladder or menstrual problems.
- A girl misses a lot of time off school or college.
- A girl has a change in behaviour.
- A girl being unduly reluctant to have a normal medical examination.
- A girl confides in someone or may ask for help but not be explicit due to fear or embarrassment.

6.8 **There are four circumstances relating to FGM which require identification, assessment and possible intervention:**

- Where a child is at risk of FGM;
- Where a child has been subjected to FGM;
- Where a (prospective) mother has undergone FGM;
- Where an adult with support and care needs is at risk of FGM or has been subjected to FGM

6.9 Professionals and volunteers in most agencies have little or no experience of dealing with female genital mutilation. Coming across FGM for the first time they can feel shocked, upset, helpless and unsure of how to respond appropriately to ensure that a child, and/or a mother, is protected from harm or further harm.

6.10 The appropriate response to FGM is to follow usual child protection procedures (or adult protection if adult with care and support needs) to ensure:

- Immediate protection and support for the child/ren and;
- That the practice is not perpetuated.

6.11 **An appropriate response to a child suspected of having undergone FGM as well as a child at risk of undergoing FGM could include:**

- Arranging for an interpreter if this is necessary and appropriate;
- Creating an opportunity for the child to disclose, seeing the child on their own;
- Using simple language and asking straightforward questions;
- Using terminology that the child will understand e.g. the child is unlikely to view the procedure as abusive;
- Being sensitive to the fact that the child will be loyal to their parents;
- Giving the child time to talk;
- Getting accurate information about the urgency of the situation, if the child is at risk of being subjected to the procedure;
- Giving the message that the child can come back to you again.

6.12 **An appropriate response by professionals who encounter a girl or woman who has undergone FGM includes:**

- Arranging for a professional interpreter and not agreeing to friends/family members interpreting on their behalf;
- Being sensitive to the intimate nature of the subject;
- Making no assumptions;
- Asking straightforward questions;
- Being willing to listen;
- Being non-judgemental (condemning the practice, but not blaming the girl/woman);
- Understanding how she may feel in terms of language barriers, culture shock, that she, her partner, her family are being judged;
- Giving a clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM if/when they have daughters.

The procedure includes a screening assessment framework tool (Appendix 4) which supports a professional to know the type of risk to look for, and the specific factors which are most likely to affect families with girls who are at risk of FGM.

7.0 Responding to FGM

7.1 **See Appendix 2 <u>Multi Agency Female Genital Mutilation decision-making and action flowchart for details of process to follow for FGM</u>**

7.2 All females, regardless of age, who are at risk of FGM need to be safeguarded. Anyone with information that a child is potentially or actually at risk of significant harm, is required to inform children's social care or the police (Children Act 1989; consolidated by s10 Children Act 2004, places a duty on all key agencies to co-operate to improve the well-being of children and young people.) Children's social care services will then assess the risk to the child under a section 47 investigation.

7.3 The appropriate response to FGM is to follow usual safeguarding procedures to ensure:

- Immediate protection and support for the girl;
- That the practice is not perpetuated.

7.4 Adults with care and support needs who have symptoms or signs of FGM, or there is good reason to suspect they are at risk of FGM having considered their family history or other relevant factors, must be referred using standard existing adult safeguarding procedures.

7.5 Staff in education settings, obstetrics and midwifery services must be aware of the potential risks to girls and women from communities known to practice FGM.

7.6 After a woman has given birth, the healthcare professional must include information about her FGM status in the discharge summary record sent to the GP and Health.

7.7 **Responding to FGM – the Role of Health Practitioners**

7.8 Healthcare professionals encountering a girl or woman who has undergone FGM should be alert to the risk of FGM in relation to her:

- Sisters;
- Daughters or daughters she may have in the future;
- Extended female family members, including cousins and grand-daughters.

7.9 All girls/women who have undergone FGM should be given information about the legal and health implications of practising FGM. Following consultation with the girl/woman on their individual circumstance, and with their agreement, consideration should be given to providing information to their boyfriend, partner or husband as appropriate. Any potential impact of this on the girl or woman should be taken into account before pursuing this further, because there is a risk of domestic violence, honour-based violence and FGM procedure being expedited if a disclosure is made to other family members. Each woman should be offered counselling to address how things will be different for her afterwards.

7.10 Information about a girl or woman who has undergone or is at risk of FGM should be clearly recorded in the notes (and, where possible, diagrammatically) recorded by maternity and health visiting professionals, GPs and practice nurses.

7.11 If a girl or woman who has been de-infibulated requests re-infibulation after childbirth, health professionals should ensure the mother receives appropriate information about the legal and health implications of practising FGM.

7.12 They should consult their designated child protection advisor and make a referral to Children's Social Care.

7.13 **Responding to FGM – the role of education / leisure / community / voluntary and faith groups**

7.14 Teachers, other school staff, volunteers and members of community groups may become aware that a girl is at risk of FGM through her disclosure or her disclosure to another child or young person, or a parent/other adult about the procedure being planned or that it has already happened to an older girl in the family.

7.15 Nursery nurses and school nurses are in a particularly good position to identify FGM or receive disclosure about it. A professional, volunteer or community group member who has information or suspicions that a girl is at risk of FGM should consult with their agency's designated safeguarding lead (if they have one) or should make a referral to Children's Social Care. If the girl appears to be in acute physical and/or emotional distress, or the plans for FGM appear to be imminent, they should make an immediate referral to Children's Social Care or the Police.

7.16 Professionals in all agencies must record information about FGM which may be relevant. This includes education or nursery staff who identify a girl may be at risk of FGM because an older sister or female cousin has had the procedure. *See 16.0 of this document for further details and guidance on Mandatory reporting*

7.17 Professionals should be aware that a disclosure may be the first time that a woman has discussed her FGM with anyone. Referral to the police must not be introduced as an automatic response when identifying adult women with FGM, and each case must continue to be individually assessed. The healthcare professional should seek to support women by offering referral to community groups for support, clinical intervention or other services as appropriate: for example, through an NHS FGM clinic. The wishes of the woman must be respected at all times.

7.18 The Department of Health 2014 statement to healthcare professionals sets out the current requirements of NHS staff in relation to FGM:

- It is mandatory to record FGM in a patient's healthcare record;

7.19 Following publication of the Data Standard on 2nd April 2014, it became mandatory for any NHS healthcare professional to record within a patient's clinical record if they identify through the delivery of healthcare services that a woman or girl has had FGM.

7.20 A woman may disclose that she has undergone FGM in the past and would like to access support and/or services. This should be treated in the same way as any disclosure of historical abuse. If the woman discloses information that suggests the practice is continuing and that girls in her family or community are at risk of FGM, a referral to MASH needs to be made. If the adult victim was born in the UK and FGM has been carried out recently, or where she has attended for a second or subsequent child and FGM has been carried out on her again, then professionals need to consider a referral to MASH as both these cases are criminal offences.

7.21 If a person woman over the age 18 is at risk of FGM and is deemed to meet the criteria in the Care Act 2014 of having care and support needs then a Safeguarding Concern (SA1) to the local authority should be completed. **Email:** sandwell_assist@sandwell.gov.uk **or call: 0845 352 2266. Textphone: 0121 569 2083 (for people who are Deaf or hard of hearing).**

7.22 **When talking about FGM, it is good practice for professionals to:**

- Ensure a female professional is available if the girl prefers;

- Make no assumptions;
- Be sensitive to the fact that the girl may still be loyal to her family;
- Be non-judgemental and stick to facts e.g. the legal position and health implications;
- Gain accurate information and keep accurate records;
- Use simple, non-loaded and value neutral terminology;
- Ask direct questions to avoid confusion.

7.23 If an interpreter is required, they should have received training in relation to FGM, must not be a family member nor have any influence in the girl's community.

7.24 Females may be frightened about contact with statutory agencies for a variety of reasons including being in breach of immigration rules. However, the female may need medical treatment or may be the victim of a crime. The situation should be handled sensitively and may need agreement between the police and UK Visas and Immigration officials.

7.25 Females may also find it difficult to disclose FGM because of fear of the consequences for the family, including being taken to court.

7.26 If a medical examination is required, this should be carried out by an appropriately trained person. For children this should be carried out under safeguarding procedures by a senior paediatrician, preferably one with experience of dealing with FGM. This will also be dependent upon local arrangements; therefore any local policies and guidelines need to be adhered to where available.

7.27 Professionals may feel uncomfortable about disclosing information about FGM, but law and policy allow for disclosure when it is in the public interest or where a crime may have been committed. Professionals should follow appropriate guidance regarding confidentiality and disclosure, e.g. Information Sharing Guidance for Practitioners (2008) Nursing and Midwifery Council's advice on confidentiality (2009), General Medical Council guidance (2009), Local Safeguarding Children Boards' policy and procedures.

7.28 Professionals need to be aware that an individual may be at risk of both FGM and forced marriage. The national and local guidance on forced marriage should be consulted.

7.29 **If you have any concerns at all about a child's safety or wellbeing, or think that a child may have needs that are not being met contact Sandwell MASH on 0121 569 3100 (this number is available outside office hours). Referral forms and guidance are available from Sandwell Safeguarding Children Board's website.**

7.30 **Community Education**

7.31 Cities such as London, Liverpool, Birmingham, Sheffield and Cardiff have substantial populations from the countries where FGM is widely practised. However, it is important to note that FGM is not necessarily confined to these areas.

7.32 Practising communities where FGM is deeply embedded in the culture may resent the imposition of 'liberal' western values on them. Professionals nonetheless must be aware that FGM can be very harmful and is not a matter that can be left to personal preference or culture.

7.33 It is important however, that any community education is sensitive to the cultural norms and pressures applied to parents and children. Professionals involved will have to be aware of language and terminology. Consideration should be given to the production of

leaflets in specific languages in order to help with this process. Any safeguarding policy adopted will need to be effective within the community to which it is targeted and therefore liaison with community members to work with agencies around education will need to be put in place.

7.34 **Support**

7.35 Families involved may need to be referred to appropriate counselling services, to deal with any psychological conflicts that may arise. It is imperative for agencies to recognise that many families, who are considering perpetrating this practice, have a considerable cultural dilemma. Families should be warned that this is an illegal practice in this country and that they are liable to prosecution if they proceed. This can take away the decision from the family and therefore reduce criticism from within their own community.

8.0 Reducing the prevalence of FGM

8.1 **The role of Local Safeguarding Children Boards**

8.2 Local Safeguarding Children Boards' (LSCBs) duties and responsibilities include promoting activity amongst local agencies and in the community to:

- Identify and prevent maltreatment or impairment of health or development, and ensure children are growing up in circumstances consistent with safe and effective care;
- Safeguard and promote the welfare of groups of children who are potentially more vulnerable than the general population;
- Increase understanding of safeguarding children issues in the professional and wider community, promoting the message that safeguarding is everybody's responsibility.

8.3 The LSCB should undertake initiatives in relation to FGM which fulfil these duties and responsibilities.

8.4 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.

8.5 **The role of Adult Safeguarding Boards**

- Write policies and procedures so that organisations work together to protect adults at risk and prevent abuse;
- Monitor abuse and how it is dealt with, and constantly improve how this can be done. We want to learn more about what works well;
- Provide opportunities for learning and development in how to keep people safe;
- Make people aware of how serious abuse is and help them to take action to prevent it;
- Take abusers and organisations, that are not keeping people safe, to court.

9.0 Information sharing

9.1 Professionals in all agencies need to be confident and competent in sharing information appropriately, both to safeguard children from being abused through FGM and to enable children and women who have been abused through FGM to receive physical and emotional and psychological help.

9.2 Professionals in all agencies should share information in line with Sandwell Safeguarding Information Sharing Procedures.

10.0 Links with forced marriage and honour-based violence

10.1 It must be recognised that in many cases dealt with by professionals in this county, there are significant links between FGM and Forced Marriage. Anecdotal evidence from local practitioners supports this relationship with many working on cases where FGM is a precursor to forcing the girl into marriage. Given that FGM has implications around chastity, purity and marriageability, then the motivation behind mutilation, prior to forced marriage, becomes all the more clear.

10.2 Forced marriage and honour-based violence are abuses of human rights and fall within the Government's definition of domestic violence.

10.3 Forced marriage is defined as a marriage conducted without the full consent of both parties and where duress is a factor. There is a clear distinction between forced marriage and an arranged marriage. In arranged marriages, the families may take a leading role in arranging the marriage, but the choice whether or not to accept, remains with the prospective spouses. In a forced marriage, one or both spouses do not consent to the marriage. This person could be facing physical, psychological, sexual, financial or emotional abuse to pressure them into accepting the marriage.

10.4 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/forcedmarriage#guidance-for-professionals. You can seek advice/guidance or refer to the police, MA, Children's Social Care/Adult Social Care and Sandwell Women's Aid.

10.5 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).**

10.6 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.

10.7 'Honour-based' violence can include the following:

- Forced marriage (FM);
- Female genital mutilation (FGM);
- Honour killings (murder);
- Domestic imprisonment;

- Dowry-related abuse.

10.8 **Definition of Honour-Based Violence (HBV)**

10.9 The terms 'honour crime', 'izzat' or 'honour-based violence' embrace a variety of crimes of violence (mainly but not exclusively against women), including assault, imprisonment and murder, where the person is being punished by their family or community. They are being punished for actually, or allegedly, undermining what the family or community believes to be the correct code of behaviour. In transgressing against this “correct” code of behaviour, the person shows that they have not been properly controlled to conform by their family and this is to the 'shame' or 'dishonour' of the family.

10.10 FGM and forced marriage are types of abuse that fall into the category of honour-based violence. For further information please refer to the following local safeguarding board procedures for further guidance in relation forced marriages:

Sandwell Safeguarding Children Board:

http://www.sandwelllscb.org.uk/

Sandwell Adults Safeguarding Board:

http://www.sandwell.gov.uk/info/200216/adults_and_older_people/2215/sandwell_safeguarding_adults_board_ssab

11.0 Raising awareness/training

11.1 Training with regard to the recognition of female genital mutilation may be needed. Sensitivity in managing the patients, referral facilities for reversal surgery, pre-birth examination and information gathering would have to contain awareness that women may not recognise female genital mutilation as surgery and indeed may not consider it abnormal. It is important that enquiries are made as early as possible in pregnancy in order to identify infibulated women and refer them for a medical opinion. Similarly it is important to stress that re- infibulation is illegal. (Infibulation is the practice of surgical closure of the labia majora (outer lips of the vulva) by sewing them together to partially seal the vagina, leaving only a small hole for the passage of urine and menstrual blood).

11.2 There will be issues for all staff involved regarding training and case management including cultural sensitivity issues.

11.3 There is a clear need to build up relationships with families to overcome the initial hostility which intervention may generate. There is also a need to emphasise the positive aspects of the family’s culture, since for many FGM is usually practised out of a positive regard for a woman’s future status within her community.

11.4 Workers who are dealing with these issues will need specific support because it may be that if they are members of a similar community to the families they are working with, they may be seen as outsiders and treated with particular hostility.

11.5 All frontline practitioners will need to have an a awareness of the problem, both from the point of view of offering or referring into support services and also for raising awareness in health education programmes.

11.6 To access a range of training on domestic violence and abuse in Sandwell offered by the Domestic Abuse Strategic Partnership (DASP), Safeguarding Children Board (SSCB) and Safeguarding Adults Board (SSAB) please visit:

http://www.sandwell.gov.uk/downloads/file/22478/domestic_abuse_training_plan

To access details of Sandwell Safeguarding Children's Board training visit:

http://sandwelllscb.org.uk/site/training.html

To access details of Sandwell Safeguarding Adult's Board training visit:

http://www.sandwell.gov.uk/downloads/file/23051/ssab_learning_catalogue

12.0 Conclusion

12.1 Female genital mutilation is not a race or a religious issue; it is a safeguarding issue which will need to be managed consistently. All staff involved in the safeguarding of children and adults must recognise this.

12.2 The practice of female genital mutilation tends to run in families and therefore if one family member is identified as being at risk of undergoing FGM or has undergone FGM, risks to other female family members must be recognised.

12.3 Any concerns regarding female genital mutilation must be acted upon in accordance with Sandwell Safeguarding Children and Adults Boards' policies and guidance.

13.0 Appendices

- **Appendix 1: Mandatory Reporting of FGM guidance**
- **Appendix 2: Making an application for Female Genital Mutilation Protection Order (FGMPO)**
- **Appendix 3: Map of Female Pupils attending Sandwell schools with languages associated with countries affected by FGM**
- **Appendix 4: Multi-agency Female Genital Mutilation decision-making and action flowchart**
- **Appendix 5: FGM Screening Tool**
- **Appendix 6: Professional pathway for reporting safeguarding concerns that meet the criteria for S42 Enquiry**

14.0 References and useful documents

- **HM Government, Multi-Agency Practice Guidelines: Female Genital Mutilation, 2014**
- **HM Government, Working Together to Safeguard Children, 2015**
- **World Health Organisation, Female Genital Mutilation, Fact Sheet No 241, 2014**

Useful documents

- **British Medical Association. Female Genital Mutilation: Caring for patients and safeguarding children, Guidance from the British Medical Association, 2011. www.bma.org.uk**
- **HM Government, Multi-Agency Practice Guidelines: Female Genital Mutilation, 2014**
- **https://www.gov.uk/government/publications/female-genital-mutilation-guidelines**
- **Home Affairs Committee – second report – Female genital mutilation: the case for a national action plan, July 2014.**
- **http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/201/20102.htm**
- **Royal College of Nursing. Female genital mutilation: An RCN educational resource for nursing and midwifery staff, 2006. www.rcn.org.uk**
- **World Health Organisation, Female Genital Mutilation, Fact Sheet No 241, 2014**
- **http://www.who.int/mediacentre/factsheets/fs241/en/**

Resources

- **Home Office – FGM Support materials**
- **https://www.gov.uk/government/publications/fgm-suppport-materials**
- **Home Office – FGM Resource Pack**
- **https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack**
- **World Health Organisation - FGM Factsheet http://www.who.int/mediacentre/factsheets/fs241/en/**
- **Home Office – FGM Unit**
- **https://www.gov.uk/government/collections/female-genital-mutilation**

- **Home Office – FGM Multi-Agency Guidelines**
- **https://www.gov.uk/government/publications/female-genital-mutilation-guidelines**
- **West Midlands Police - FGM**
- **http://www.west-midlands.police.uk/advice-centre/help-and-advice/honour-abuse/female-genital-mutilation/**
- **CPS – Female Genital Mutilation Legal Guidance**
- **http://www.cps.gov.uk/legal/d_to_g/female_genital_mutilation/index.html**

15.0 Glossary of terms

- Female genital mutilation is sometimes called female circumcision or female cutting.
- Type 1 FGM may be known to some communities as 'Sunna'. Sunna is an Islamic word used to describe an action by the Prophet Mohammed.
- Infibulation is derived from the name given to the Roman practice of fastening a 'fibular' or 'clasp' through the large lips of a female genitalia (usually within marriage) in order to prevent illicit sexual intercourse.
- De-infibulation is the name for having FGM reversed and opening the entry to the vagina again.
- Re-infibulation is the term used when women seek to be restored to their previous state usually following child birth.
- The term "closed" refers to type 3 FGM where there is a long scar covering the vaginal opening. This term is particularly understood by the Somali and Sudanese communities.

16.0 Terms used for FGM in different languages

Country	Term used for FGM	Language	Meaning
EGYPT	Thara	Arabic	Deriving from the Arabic word 'tahar' meaning to clean / purify
	Khitan	Arabic	Circumcision - used for both FGM and male circumcision
	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
ETHIOPIA	Megrez	Amharic	Circumcision / cutting

	Absum	Harrari	Name giving ritual
ERITREA	Mekhnishab	Tigregna	Circumcision / cutting
KENYA	Kutairi	Swahili	Circumcision - used for both FGM and male circumcision
	Kutairi was ichana	Swahili	Circumcision of girls
NIGERIA	Ibi / Ugwu	Igbo	The act of cutting - used for both FGM and male circumcision
	Sunna	Mandingo	Religious tradition / obligation - for Muslims
SIERRA LEONE	Sunna	Soussou	Religious tradition/ obligation - for Muslims
	Bondo	Temenee	Integral part of an initiation rite into adulthood - for non Muslims
	Bondo / Sonde	Mendee	Integral part of an initiation rite into adulthood - for non Muslims
	Bondo	Mandingo	Integral part of an initiation rite into adulthood - for non Muslims
	Bondo	Limba	Integral part of an initiation rite into adulthood - for non Muslims
SOMALIA	Gudniin	Somali	Circumcision used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word 'halal' ie. 'Sanctioned' - implies purity. Used by Northern & Arabic speaking Somalis.
	Qodiin	Somali	Stitching / tightening / sewing refers to infibulation
SUDAN	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
	Tahoor	Arabic	Deriving from the Arabic word 'tahar' meaning to purify
CHAD - the Ngama	Bagne		Used by the Sara Madjingaye
Sara subgroup	Gadja		Adapted from 'ganza' used in the Central African Republic
GUINEA-BISSAU	Fanadu di Mindjer	Kriolu	'Circumcision of girls'

	Fanadu di Omi	Kriolu	'Circumcision of boys'
GAMBIA	Niaka	Mandinka	Literally to 'cut /weed clean'
	Kuyango	Mandinka	Meaning 'the affair' but also the name for the shed built for initiates
	Musolula Karoola	Mandinka	

17.0 Support/help available

- Contact the police if you think that a girl or young woman is in danger of FGM and is still in the UK. Telephone: 999 in an emergency or call 101.

- Contact the Foreign and Commonwealth Office if the girl has already been taken abroad
  Telephone: 020 7008 1500
  From overseas: +44 (0)20 7008 1500

- Sandwell Women's Aid
  www.sandwellwomensaid.co.uk
  Telephone: 0121 553 0090

- Celestine celeste Community Organisation
  http://www.celestinecelest.org/
  Telephone: 0121 749 7627

- Muslim Women's Network UK
  http://www.mwnuk.co.uk
  Telephone: 0121 236 9000
  Mobile: 07415 206936
  E: contact@mwnuk.co.uk

- FORWARD (Foundation for Women's Health, Research and Development)
  www.forwarduk.org.uk
  Telephone: 020 8960 4000

- Birmingham Heartlands Hospital – Heart of England NHS Foundation Trust
  Telephone: 0121 424 3909

- Daughters of Eve
  www.dofeve.org/stopping-fgm.html
  Mobile: 07983030488

- The Dahlia Project
  Telephone: 020 7281 8970

- Birmingham and Solihull Women's Aid
  www.bswaid.org

Telephone: 0121 685 8550

- African Well Woman's Service (Birmingham Heartlands Hospital)
  Alison Hughes
  Mobile: 07817 534274
  Weekly clinic: Friday mornings

- African Well Woman's Service (Birmingham Women's Hospital)
  Alison Hughes
  Mobile: 07738 741614
  Weekly clinic: Thursday mornings

FGM specialists

- DC Gill Squires, West Midlands Police FGM Lead
  Telephone: 0121 609 6909

- Alison Byrne, Specialist Midwife, Heart of England NHS Trust
  Telephone: 0121 424 3909
  Email: alison.byrne@heartofengland.nhs.uk

- PETALS - web app to understand more about FGM

Resources for police

- College of Policing (2015) Authorised Professional Practice: Female Genital Mutilation www.app.college.police.uk/app-content/major-investigation-and-public-protection/female-genital-mutilation/?s=female+genital+mutilation#prevention

- Crown Prosecution Service, Provision of Therapy for Child Witnesses Prior to a Criminal Trial www.cps.gov.uk/publications/prosecution/therapychild.html

- Ministry of Justice (2011) Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures www.cps.gov.uk/publications/prosecution/victims.html

Asylum

Information on claiming asylum in the UK www.gov.uk/claim-asylum

- **Legal interventions**

- Children and Family Court Advisory and Support Service, information on legal interventions to safeguard children *www.cafcass.gov.uk/grown-ups/professionals/care.aspx*

- For clinical guidelines on the care of women who have undergone FGM, please see *Female Genital Mutilation and its Management (Green-top Guideline No. 53)*, published by Royal College of Obstetrics and Gynaecology.

- NHS Choices, FGM guidance for professionals *www.nhs.uk/guidelines*

- Department of Health (2015) Female Genital Mutilation: Risk and Safeguarding – Guidance for professionals *www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf*

- Health and Social Care Information Centre, Information on the Female Genital Mutilation Risk Indication System *www.hscic.gov.uk/fgmris*

- Health and Social Care Information Centre, Information on the Female Genital Mutilation (FGM) Enhanced Dataset Information Standard (SCCI2026) *www.hscic.gov.uk/fgm*

- Department of Health and Health and Social Care Information Centre (2015) Understanding the FGM enhanced dataset *www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm*

- Royal College of Nursing (2015) Female Genital Mutilation *www.rcn.org.uk/clinical-topics/female-genital-mutilation*

- General Medical Council, Guidance on child protection examinations *www.gmc-uk.org/guidance/ethical_guidance/13430.asp*

- General Medical Council (2008) Consent: Patients and Doctors Making Decisions Together *www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp%20*
- General Medical Council (2009) Confidentiality *www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp*

- General Medical Council (2013) Intimate Examinations and Chaperones *www.gmc-uk.org/guidance/ethical_guidance/21168.asp*

- British Medical Association. Doctor's responsibilities in child protection cases. London: BMA, 2004;

- Mwangi-Powell, F. (ed) Female genital mutilation: Holistic care for women. A practical guide for midwives. London: FORWARD, 2001;

- FGM Royal College of Midwives. Female genital mutilation (female circumcision). Position paper no. 21. London: Royal College of Midwives, 1998;

- Royal College of Obstetricians and Gynaecologists. Setting Standards to improve women's health, Female Genital Mutilation, Statement No 3, May 2003;

- Royal College of Obstetricians and Gynaecologists. Female Circumcision (Female Genital Mutilation), June 1997;

- Hedley, R., Dorkenoo, E. (1992) Child protection and female genital mutilation: Advice for health, education, and social work professionals. London: FORWARD;

- Toubia, N. (1999) Caring for women with circumcision: A technical manual for health care providers. New York: Rainbow;

- World Health Organisation (1997) Management of Pregnancy, Childbirth and the Postpartum Period. Report of a WHO Technical Consultation Geneva, 15-17 October 1997;

- American College of Obstetricians and Gynaecologists. Female circumcision/female genital mutilation: Clinical management of circumcised women. Washington, DC: ACOG, 1999;

- FORWARD: Another form of abuse. London: FORWARD, 1992. This video, produced by FORWARD with funding from the Department of Health, gives a general introduction to female genital mutilation and its health implications. It also includes an interview with a woman who has had female genital mutilation performed on her.

Appendix 1

Mandatory Reporting of FGM Guidance

Effective from 31st October 2015

The mandatory reporting duty requires certain professionals **to report to the police any known cases of FGM in girls aged under 18** which they identify in the course of their professional work.

Who does the duty apply to?
The duty to report cases applies to teachers and registered health and social care professionals. However, if you know that another professional has already made a report, there is no duty to make a second report.

What is a "known case"?
A case may be visually identified or verbally disclosed.

Visual identification will generally be made in the course of another examination or while carrying out another task. There is no requirement for an examination to discover whether FGM has been carried out, nor for a full clinical diagnosis of FGM before a report is made.

Verbal disclosure occurs when a girl discloses to you that FGM has been carried out on her. The duty does not apply when another person – for example a parent, guardian or sibling – discloses that FGM has been carried out on a girl. However normal child protection procedures will still apply.

The victim must be aged under 18 at the time of the disclosure – there is no duty to report cases in which an adult reports that FGM was carried out on her while she was still a child. However this may still be a crime that should be reported.

How quickly must I make the report?
The report should be made as soon as possible - it is generally best practice for reports to be made by the close of the next working day. However there may be exceptional circumstances that justify a longer timeframe. The legal requirement is that the report must be made within a maximum timeframe of one month, and the expectation is that all reports will be made much sooner than this.

How do I make a report to the police?
Reports may be made orally or in writing - It is recommended that they are made orally by telephoning 101.

Before you make the report you should inform the girl and/or her parents of what you intend to do and why, unless you believe that this would put the child or another person at risk of serious harm.

January 2016

When you contact the police –

- State clearly that you are making a report under the FGM mandatory reporting duty.
- Give the girl's details (name, age/date of birth and address).
- Give your name and professional contact details (work address, telephone number and email address), and the contact details for your organisation's designated safeguarding lead.
- State what safeguarding actions you, and your organisation, have taken or intend to take.

The police call handler will give you a call reference number. Write down this number and keep it.

In all cases, record your actions in accordance with the policy of your agency/service

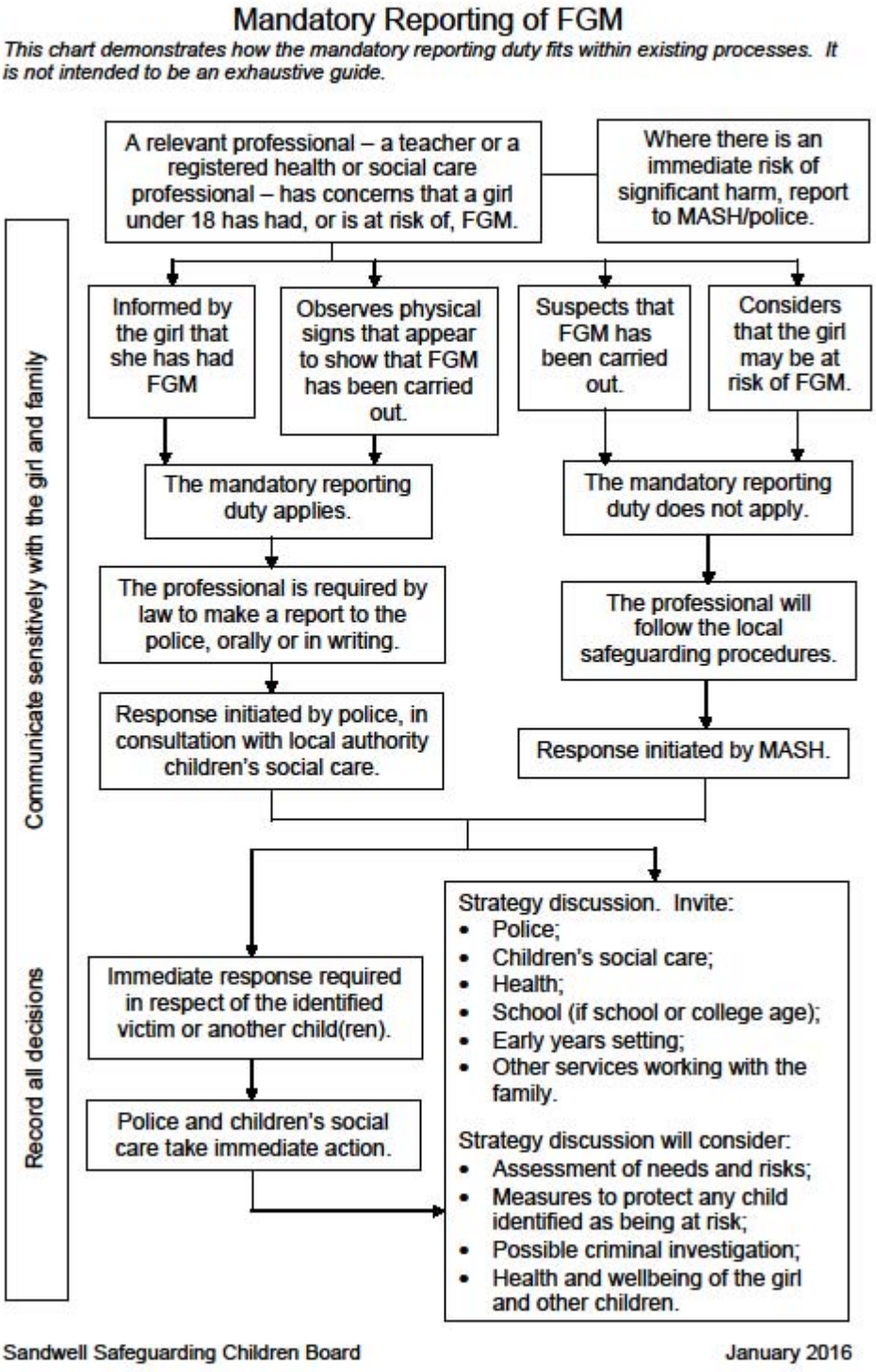
What will the police do?
The call handler will refer the report to the relevant team in the police force. They will contact you to ask for more information and to discuss the situation in more detail.

The police will initiate a multi-agency response in line with local procedures. Depending on your role and the specific circumstances of the case, you may be required to contribute to this response.

What do I do if I have concerns about a child but the duty does not apply?
If the duty does not apply (i.e. there is neither visual identification or verbal disclosure) there may still be a need to report concerns about a child under the Sandwell Safeguarding Children Board Policy and Procedures

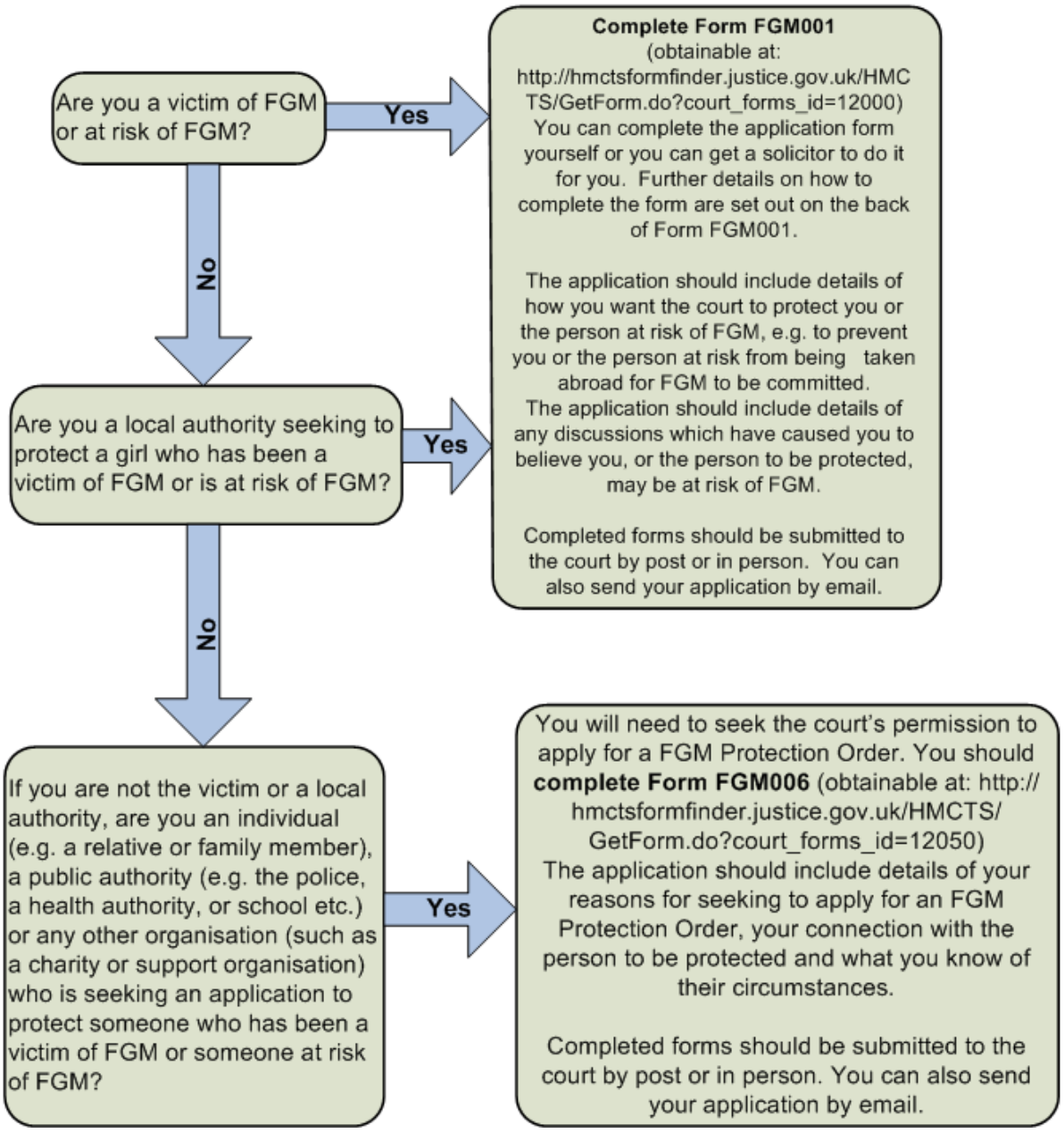
More information and guidance is available at
https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information

Sandwell Safeguarding Children Board January 2016


Mandatory Reporting of FGM
This chart demonstrates how the mandatory reporting duty fits within existing processes. It is not intended to be an exhaustive guide.
A relevant professional – a teacher or a registered health or social care professional – has concerns that a girl under 18 has had, or is at risk of, FGM.
Where there is an immediate risk of significant harm, report to MASH/police.
Informed by the girl that she has had FGM
Observes physical signs that appear to show that FGM has been carried out.
Suspects that FGM has been carried out.
Considers that the girl may be at risk of FGM.
The mandatory reporting duty applies.
The mandatory reporting duty does not apply.
The professional is required by law to make a report to the police, orally or in writing.
The professional will follow the local safeguarding procedures.
Response initiated by police, in consultation with local authority children's social care.
Response initiated by MASH.
Communicate sensitively with the girl and family
Record all decisions
Immediate response required in respect of the identified victim or another child(ren).
Police and children's social care take immediate action.
Strategy discussion. Invite:
Police;
Children's social care;
Health;
School (if school or college age);
Early years setting;
Other services working with the family.
Strategy discussion will consider:
Assessment of needs and risks;
Measures to protect any child identified as being at risk;
Possible criminal investigation;
Health and wellbeing of the girl and other children.
Sandwell Safeguarding Children Board
January 2016

Appendix 2

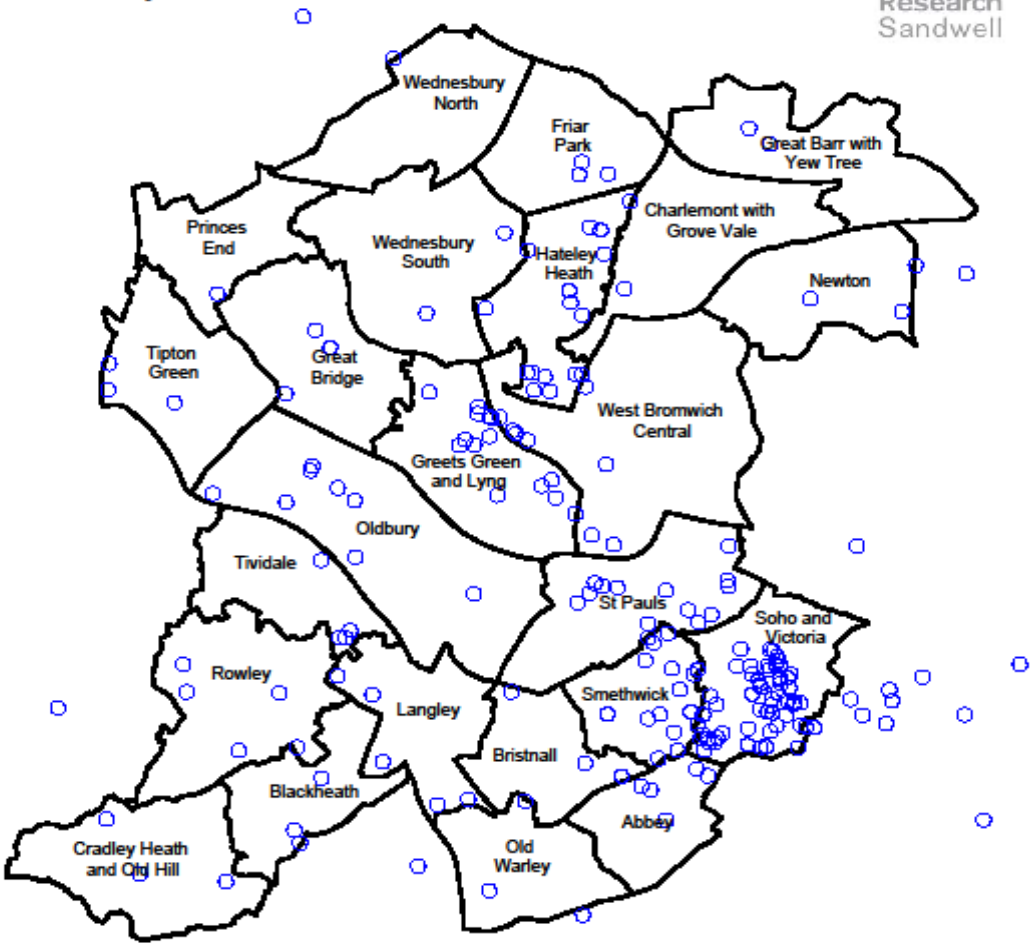
Making an Application for an FGM Protection Order (FGMPO)



Appendix 3

Female Pupils Attending Sandwell Schools with Languages Associated with Countries Affected by FGM

Research Sandwell



Female Pupils Attending Sandwell Schools and Resident in Sandwell with Languages Associated with Countries Affected by FGM

Ward	Count	Ward	Count
Soho and Victoria	112	Great Bridge	4
Smethwick	23	Newton	4
Hateley Heath	21	Tipton Green	3
St Pauls	19	Blackheath	3
Greets Green and Lyng	17	Cradley Heath and Old Hill	3
West Bromwich Central	10	Friar Park	3
Oldbury	8	Old Warley	2
Abbey	5	Wednesbury South	2
Langley	5	Great Barr with Yew Tree	2
Rowley	5	Princes End	1
Bristnall	4	Charlemont with Grove Vale	1
Tividale	4	Wednesbury South	0
Within the Borough	251		

Source: Sandwell School Census Jan 2014

Key

Pupil Residential Location

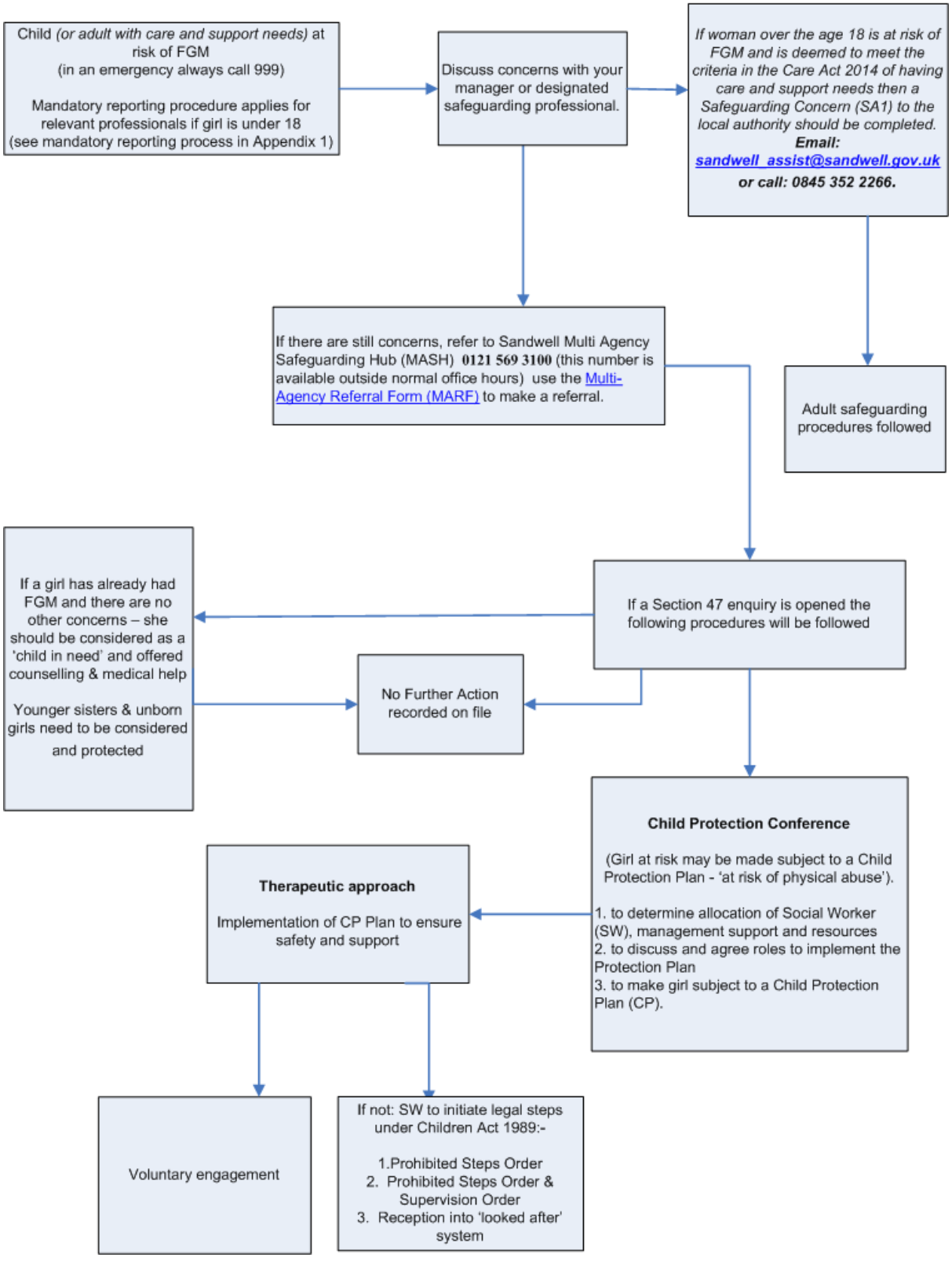
Sandwell Ward

Research Sandwell, Improvement and Efficiency, Sandwell MBC

Data Source: Sandwell School Census - Jan 2014, Children & Young Peoples Services, Data Intelligence Unit

Appendix 4

Multi-agency Female Genital Mutilation decision-making and action flowchart



Appendix 5

Sandwell Safeguarding Children Board

Female Genital Mutilation Screening Tool

How to use this tool

This tool is to help professionals working in health services, hospitals, schools, police and children's services to identify and assess the risks of FGM. It should be read in conjunction with the Sandwell safeguarding procedures on FGM.

The tool is divided into three parts:
Part One - children at risk of being abused through FGM
Part Two - children who may have been subjected to FGM and suffering physical and emotional harm
Part Three - women with FGM presenting to GP/maternity/gynaecology/urology/sexual health services.

Professionals need only complete the part that applies to the child/adult they are working with. Use the tool to identify the relevant indicators, being careful to record whether each indicator is known to be present, definitely not present, or suspected to be present; and make a brief note of your evidence.

What to do next

- Having completed the screening tool and identified any risk indicators, professionals should seek consultation and advice from their agency's FGM operational lead or their designated safeguarding lead. Where no such designation exists, they should seek advice from Safeguarding Children's Services via the Multi-Agency Safeguarding Hub (MASH) **Tel. 0121 569 3100**
- In instances where the risk of harm to a child is judged to be high i.e. that is it likely that FGM will happen in the near future or has happened and a child is suffering harm, there should be no delay in referring the child to Safeguarding Children's Services via Multi-Agency Safeguarding Hub (MASH) **Tel. 0121 569 3100**

Female Genital Mutilation Screening Tool

Professional completing this screening tool :……(Name)……(desig.)

Agency……Contact tel no/email address……
Date of completion……

Action to be taken following completion of the screening tool……
……
……

Please indicate whether the personal data in this screening tool is:

1. Being shared with other agencies with the consent of the subject/parent(s) of the subject? Yes No

2. Being shared with other agencies under the SSCB information-sharing protocol for reasons of child protection? Yes No

If yes to 1 or 2 above, name and address of subject……
……

3. Being discussed on an anonymised basis at the FGM consultation meeting? Yes No

If yes, no name and address to be included on this record. Enter consultation reference no provided at the meeting……
……

Part One: Children at risk of being abused through FGM

Indicator	***Yes***	***No***	***Suspected***	***Brief details***
A child seeks help to avoid FGM or the circumstances in which FGM is a risk (eg going abroad)				
A parent or family member expresses concern that FGM may be a current risk				
Mother comes from a community known to practice FGM (see Appendix One)				
Mother has undergone FGM herself (see Appendix Two)				
Father comes from a community known to practice FGM				
Grandmother is very influential within the family				
A female family elder is involved/will be involved in the care of the girl				
Mother has limited contact with people outside of her family				
Parents have poor access to information about FGM and nobody has advise them about the harmful effects of FGM or UK law				
Parents stating that they or a relative will be taking the girl abroad for a prolonged period				
Girl has spoken about a long holiday to her country of origin/another country where the practice is prevalent				
Girl has attended a travel clinic or equivalent for vaccinations/anti-malarial for her country of origin/another country where the practice is prevalent				
Girl has confided in another that she is to have a 'special procedure' or to attend a 'special occasion'				
Girl has talked about going away 'to become a woman' or 'to become like my mum and sister'				
FGM is referred to in conversation by the child, family or close friends of				

the child (see Appendix Three for traditional and local terms)				
Girl has a sister or other female relative who has already undergone FGM				

Part Two: Children who may have been subjected to FGM and may be suffering physical or emotional harm

Indicator	***Yes***	***No***	***Suspected***	***Brief details***
Girl asks for help with symptoms of FGM				
Girl confides in a professional that FGM has been done				
Girl spends long periods away from the classroom with bladder or menstrual problems				
Girl finds it hard to sit still for long periods of time, which was not a problem previously				
Prolonged absence from school				
Noticeable behavioural changes following long summer holiday or prolonged absence from school				
Girl has spoken about having been on a long holiday to her country of origin/another country where the practice is prevalent				
Increased emotional and psychological needs e.g. withdrawal, depression				
Girl avoiding physical exercise or requiring to be excused from PE lessons without a GP's letter				

Part Three: Pregnant/non-pregnant women/girls, with FGM, with existing female children, anticipated female child or with other female children in household

Indicator	***Yes***	***No***	***Suspected***	***Brief details***
Mother comes from a community known to practice FGM (Appendix 1)				
Mother has undergone FGM herself (Appendix 2)				
Father comes from a community known to practice FGM				
Grandmother (maternal or paternal) is influential in family				
A female family elder is involved/will be involved in care of daughter				
Mother has limited integration in UK community				
Woman believes FGM is integral to cultural or religious identity				
*Parents have limited/ no understanding of harm of FGM or UK law**				
Mother has been reinfibulated following previous delivery *				
*Mother requesting reinfibulation following childbirth**				
Woman's sisters'/brothers' daughters have undergone FGM				
Woman's sister/brother-in-law's daughters have undergone FGM				
*Woman already has daughters who have undergone FGM***				

*It is important to consider the opposite of this as indication of willingness to abandon FGM practice: a woman who herself has ongoing physical, psychological and/or sexual dysfunction that she recognises/acknowledges are a result of her FGM, and/or who is involved or is highly supportive of FGM advocacy work/eradication programmes, is less likely to mutilate her own children.

**Reinfibulation following childbirth in Sudan is highly prevalent- not to be closed after birth carries great stigma. Reinfibulation *per se* does not necessarily indicate ongoing support of FGM by the woman herself. One should enquire how the woman felt about reinfibulation after birth. This is in contrast to a woman giving birth in the UK requesting reinfibulation - this should be considered a significant indicator of risk of FGM for a female child. In addition, a reinfibulated woman requesting elective c/section without medical indication should be explored as it may indicate an awareness re. the law and a wish to avoid deinfibulation. Enquiry needs to be sensitively made- as potential alternative explanation for maternal request c/section may relate to trauma/PTSD.

Reinfibulation in this country is potentially illegal under the FGM Act 2003- if a woman has been reinfibulated, it is important to establish which country this took place in and when.

*** if woman discloses she has daughter(s) who have already undergone FGM, it is important to establish when and where this took place and which type of FGM. This is for two reasons: 1) if child was a UK national at time of FGM, a crime has taken place- this should be escalated to Social Care and Police as per protocol; 2) if child was not a UK national at time of FGM i.e., FGM took place prior to coming to this country, it is important to enquire regarding FGM status of any subsequent daughters born in the UK. If no FGM has been carried out on UK-born female child, one should establish why this is the case (e.g. ?change in attitude or ?fear of prosecution ?lack of opportunity, ?child too young). This is a complex area- many women have greater agency in decision-making re. FGM when outside their country of origin and may elect not to continue FGM practice. This is an important indicator of positive attitudinal change and should be taken into consideration in risk assessment of any siblings.

Appendix 6

Professional pathway for reporting safeguarding concerns that meet the criteria for S42 Enquiry