

Multi-Agency Practice Guidelines:
Female Genital Mutilation

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COMMENTS OR SUGGESTIONS ON THE GUIDELINES?

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

CONTENTS

CHAPTER ONE	
THE PURPOSE OF THE GUIDELINES	1
1.1 AIMS	1
1.2 AUDIENCE	1
1.3 THE STATUS OF THE GUIDELINES	1
1.4 COVERAGE OF THE GUIDELINES	1
1.5 PRINCIPLES SUPPORTING THE GUIDELINES	2
CHAPTER TWO	
UNDERSTANDING THE ISSUES AROUND FGM	3
2.1 DEFINITION	3
2.2 TYPES OF FGM	3
2.3 UK LEGISLATION	3
2.4 FGM TAKING PLACE OVERSEAS	4
2.5 INTERNATIONAL PREVALENCE OF FGM	4
2.6 PREVALENCE OF FGM IN THE UK	6
2.7 NAMES FOR FGM	6
2.8 CULTURAL UNDERPINNINGS AND MOTIVES OF FGM	6
2.9 FGM PROCEDURE	7
2.10 CONSEQUENCES OF FGM	8
CHAPTER THREE	
IDENTIFYING GIRLS AND WOMEN AT RISK	11
3.1 SPECIFIC FACTORS THAT MAY HEIGHTEN A GIRL'S OR WOMAN'S RISK OF BEING AFFECTED BY FGM	11
3.2 INDICATIONS THAT FGM MAY BE ABOUT TO TAKE PLACE SOON	11
3.3 INDICATIONS THAT FGM MAY HAVE ALREADY TAKEN PLACE	12
CHAPTER FOUR	
GOOD PRACTICE TO FOLLOW IN ALL CASES	15
4.1 DUTY TO SAFEGUARD CHILDREN AND PROTECT WOMEN AT RISK	15
4.3 THINGS TO BE AWARE OF IN DEALING WITH CASES OF FGM	18
4.4 MEDICAL EXAMINATIONS	18
4.5 MAKING ENQUIRIES	19
4.6 DISCLOSURE AND CONFIDENTIALITY	19
4.7 A VICTIM-CENTRED APPROACH	19
4.8 FORCED MARRIAGE AND FGM	19
CHAPTER FIVE	
LEGAL INTERVENTIONS	21
5.1 POLICE PROTECTION	21
5.2 EMERGENCY PROTECTION ORDERS UNDER SECTION 44 OF THE CHILDREN ACT 1989	22
5.3 CARE ORDERS AND SUPERVISION ORDERS	23
5.4 INHERENT JURISDICTION	24
5.5 APPLICATIONS FOR WARDSHIP	25
5.6 REPATRIATION	25

CHAPTER SIX	
GUIDELINES FOR HEALTH PROFESSIONALS	27
6.1 HOW HEALTH PROFESSIONALS CAN MAKE A DIFFERENCE	27
6.2 GENERAL PRACTITIONERS AND PRACTICE NURSES	27
6.3 HEALTH VISITORS, SCHOOL AND COMMUNITY CHILDREN'S NURSES	28
6.4 MIDWIVES AND NEONATAL NURSES	28
6.5 OTHER HEALTHCARE PROFESSIONALS	29
6.6 CLINICAL ISSUES AND PROCEDURES	29
6.7 RE-SUTURING OR REINFIBULATION	29
6.8 COUNSELLING	30
CHAPTER SEVEN	
GUIDELINES FOR POLICE OFFICERS	31
7.1 HOW POLICE OFFICERS CAN MAKE A DIFFERENCE	31
7.2 EXAMPLE OF STANDARD OPERATING PROCEDURES	31
CHAPTER EIGHT	
GUIDELINES FOR CHILDREN'S SOCIAL CARE	35
8.1 HOW CHILDREN'S SOCIAL CARE CAN MAKE A DIFFERENCE	35
8.2 STRATEGY MEETING	35
8.3 STEPS WHEN A GIRL IS AT IMMEDIATE RISK OF FGM	36
8.4 STEPS WHEN A GIRL HAS ALREADY UNDERGONE FGM	36
CHAPTER NINE	
GUIDELINES FOR SCHOOLS, COLLEGES AND UNIVERSITIES	37
9.1 HOW STAFF CAN MAKE A DIFFERENCE	37
9.2 WHAT TO DO WHEN YOU ARE CONCERNED THAT A STUDENT MAY BE AT RISK OF, OR HAS UNDERGONE, FGM	38
CHAPTER TEN	41
REDUCING THE PREVALENCE OF FGM	41
10.1 THE ROLE OF LOCAL SAFEGUARDING CHILDREN BOARDS	41
10.2 PROFESSIONAL LEARNING REQUIREMENTS	41
APPENDIX A GLOSSARY OF TERMS USED	43
APPENDIX B TERMS USED FOR FGM IN OTHER LANGUAGES	44
APPENDIX C FGM SPECIALIST HEALTH SERVICES IN ENGLAND AND WALES	45
APPENDIX D ORGANISATIONS WORKING ON ISSUES AROUND FGM	48
APPENDIX E MATERIALS AVAILABLE ABOUT FGM	49

CHAPTER ONE

THE PURPOSE OF THE GUIDELINES

1.1 AIMS

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

This guidance provides information on:

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

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

1.2 AUDIENCE

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

- safeguard children and young people from abuse
- protect adults from abuse.

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

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

1.3 THE STATUS OF THE GUIDELINES

These are practice guidelines and are designed to be educative and provide advice; they are not a substitute for existing statutory guidance such as *Working Together to Safeguard Children* (2010) in England or *Safeguarding Children: Working Together Under the Children Act 2004* in Wales.

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

1.4 COVERAGE OF THE GUIDELINES

These guidelines are designed for application in England and Wales.

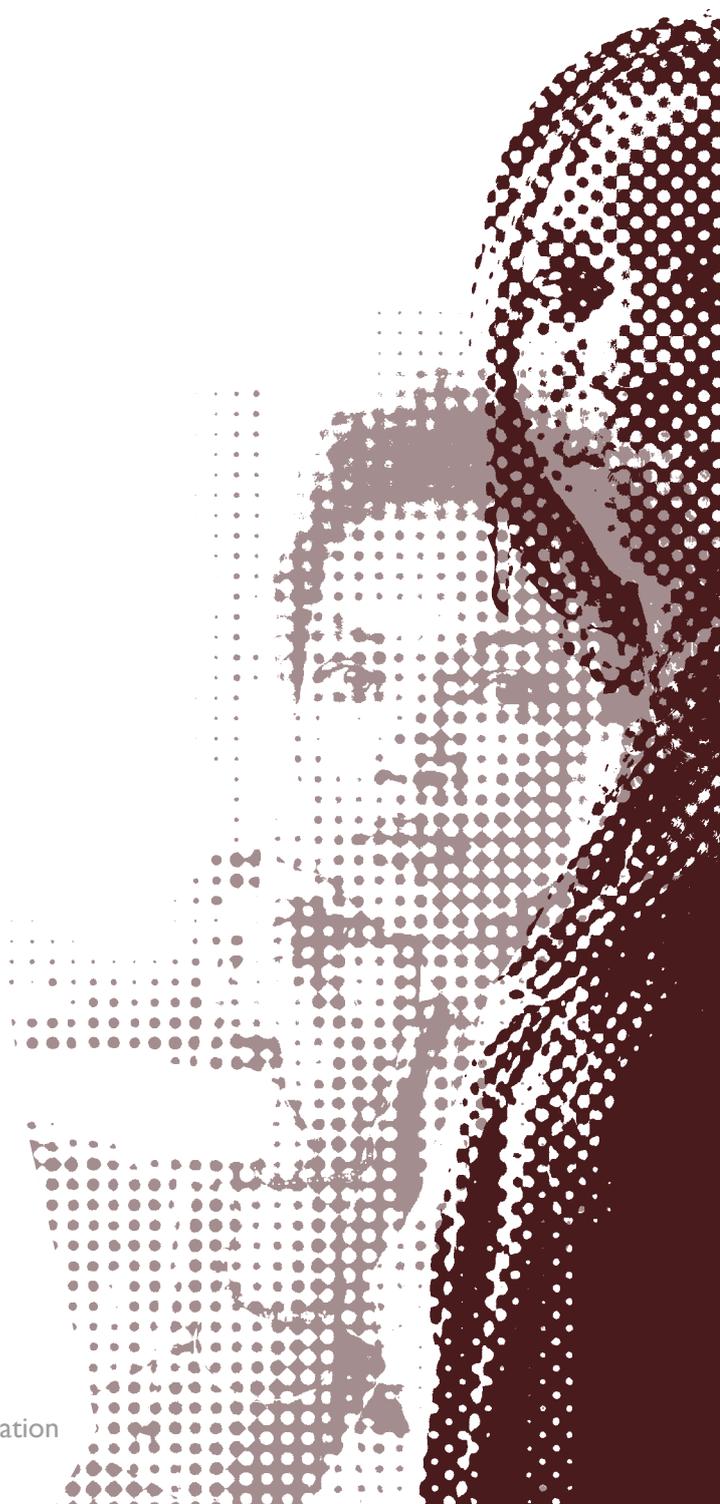
For more information about the Scottish Government's work to prevent and tackle FGM, visit www.scotland.gov.uk/Topics/People/Equality/violence-women/MinorityEthnicIssuesPages/FemaleGenitalMutilation

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

I.5 PRINCIPLES SUPPORTING THE GUIDELINES

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

- The safety and welfare of the child is paramount.
 - All agencies act in the interests of the rights of the child as stated in the UN Convention (1989).
 - FGM is illegal in the UK (for more information, see Section 2.3).
 - FGM is not a matter that can be left to be decided by personal preference – it is an extremely harmful practice. Professionals should not let fears of being branded ‘racist’ or ‘discriminatory’ weaken the protection required by vulnerable girls and women.
 - Accessible, acceptable and sensitive health, education, police, social care and voluntary sector services must underpin interventions.
 - It is acknowledged that some FGM-practising families do not see it as an act of abuse (for more information, see Section 2.8). However, FGM has severe significant physical and mental health consequences both in the short and long term (see Sections 2.10 and 2.11), and must not be excused, accepted or condoned.
 - As an often embedded ‘cultural practice’, engagement with families and communities will be required to achieve a long-term abandonment and eradication of FGM.
- All decisions or plans should be based on good quality assessments (using, for example, the Common Assessment Framework) and be sensitive to the issues of race, culture, gender, religion and sexuality; and should avoid stigmatising the girl or woman affected, and the practising community, as far as possible given the other principles above.



CHAPTER TWO

UNDERSTANDING THE ISSUES AROUND FGM

SUMMARY

- It is illegal in the UK to subject a girl or woman to FGM or to assist a non-UK person to carry out FGM overseas. For the purpose of the criminal law in England, Wales and Northern Ireland, FGM is mutilation of the labia majora, labia minora or clitoris.
- FGM is prevalent in 28 African countries as well as in parts of the Middle East and Asia.
- It has been estimated that over 20,000 girls under the age of 15 are at high risk of FGM in the UK each year and that 66,000 women in the UK are living with the consequences, although its true extent is unknown due to the hidden nature of the crime.
- FGM is practised by families for a variety of complex reasons but often in the belief that it is beneficial for the girl or woman.
- FGM constitutes a form of child abuse and violence against women and girls, and has severe short-term and long-term physical and psychological consequences.

2.1 DEFINITION

FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life.

2.2 TYPES OF FGM

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

- Type 1 – Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- Type 2 – Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the ‘lips’ that surround the vagina).
- Type 3 – Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

- Type 4 – Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

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

2.3 UK LEGISLATION

FGM is illegal in the UK.

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

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

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

It is also an offence to assist a girl or woman to mutilate her own genitalia.

It is an offence for anyone (regardless of their nationality and residence status) to perform FGM in the UK or to assist a girl to perform FGM on herself in the UK. Provided that the mutilation takes place in the UK, the nationality or residence status of the victim is irrelevant.

2.4 FGM TAKING PLACE OVERSEAS

It is an offence under the 2003 Act for a UK national or permanent UK resident to perform FGM, or to assist a girl to perform FGM on herself, outside the UK. It is also an offence to assist FGM carried out abroad by anyone (including foreign nationals), although in some cases the offence is limited to the situation where the **victim** is a UK national or permanent UK resident. This would cover taking a girl abroad to be subjected to FGM. The exceptions set out in sections 1(2) and (3) of the 2003 Act also apply to this offence.

Under the Children Act 1989, local authorities can apply to the courts for various orders to prevent a child being taken abroad for mutilation – see Chapter 5 of these guidelines for more information.

“ The girls knew from school that they shouldn't allow [FGM] to be done to them. They didn't want to be [mutilated] so they refused to go back [to their family's country of origin]...

They went to the authorities and told them they were afraid to go back because of this. The authorities made the family [guarantee] that if they went back to their country on holiday, they would not do anything to the girls [and monitored this].¹ ”

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

2.5 INTERNATIONAL PREVALENCE OF FGM

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

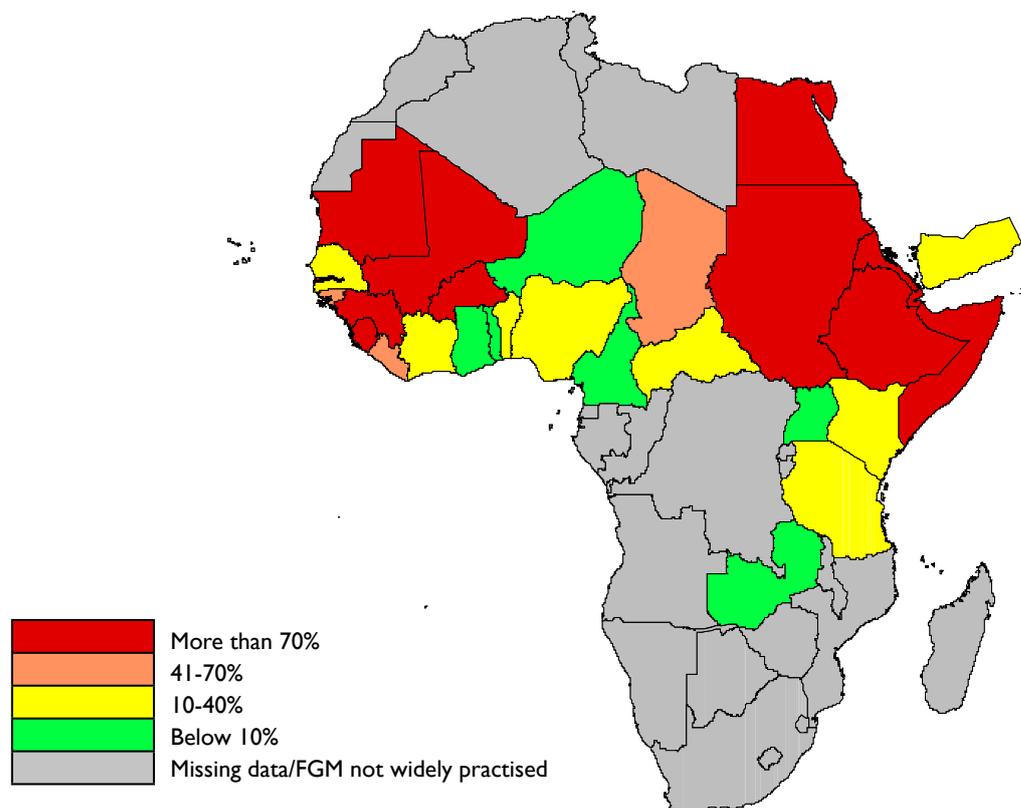
The World Health Organization estimates that between 100 and 140 million girls and women worldwide have experienced female genital mutilation and around 3 million girls undergo some form of the procedure each year in Africa alone. See Figure 1 on page 5 for African countries' prevalence.

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

¹ Quote from interviews conducted as part of FORWARD (2009) *FGM is Always with Us: Experiences, Perceptions and Beliefs of Women Affected by Female Genital Mutilation in London: Results from a PEER Study.*

FIGURE I: PREVALENCE OF FGM AMONG WOMEN AGED 15-49 IN AFRICA

Source: UNICEF (October 2010), global databases based on data from Multiple Indicator Cluster Survey, Demographic and Health Survey and other national surveys, 1997–2009.



DATA YEAR	COUNTRY	FGM PREVALENCE
2006	Somalia	97.9%
2005	Guinea	95.6%
2006	Djibouti	93.1%
2008	Sierra Leone	91.3%
2008	Egypt	91.1%
2006	Sudan	89.3%
2002	Eritrea	88.7%
2006	Mali	85.2%
2005/06	The Gambia	78.3%
2005	Ethiopia	74.3%
2006	Burkina Faso	72.5%
2007	Mauritania	72.2%
2007	Liberia	58.3%
2004	Chad	44.9%
2006	Guinea-Bissau	44.5%

DATA YEAR	COUNTRY	FGM PREVALENCE
2006	Côte d'Ivoire	36.4%
2008	Nigeria	29.6%
2005	Senegal	28.2%
2008/09	Kenya	27.1%
2006	Central African Republic	25.7%
1997	Yemen	22.6%
2004/05	Tanzania	14.6%
2006	Benin	12.9%
2006	Togo	5.8%
2006	Ghana	3.8%
2006	Niger	2.2%
2004	Cameroon	1.4%
2005	Zambia	0.9%
2006	Uganda	0.6%

2.6 PREVALENCE OF FGM IN THE UK

FGM's prevalence in the UK is difficult to estimate because of the hidden nature of the crime. However, a recent study² based on 2001 census data suggested that:

- over 20,000 girls under the age of 15 could be at high risk of FGM in England and Wales each year;
- nearly 66,000 women in England and Wales are living with the consequences of FGM.

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

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

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

2.7 NAMES FOR FGM

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

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

2.8 CULTURAL UNDERPINNINGS AND MOTIVES OF FGM

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

Reasons given for practising FGM:

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

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

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

² FORWARD (2007) *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales*.

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

Despite the harm it causes, many women from FGM-practising communities consider FGM normal to protect their ‘cultural identity’. As a result of the belief systems of the cultural groups who practise FGM, many women who have undergone FGM believe they appear more attractive than women who have not undergone FGM. Women who have attempted to resist exposing their daughters to FGM report that they and their families were ostracised by their community and told that nobody would want to marry their daughters.

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

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

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

Despite this, religion is sometimes given as a justification for FGM. For example, some people from Muslim communities argue that the Sunna (traditions or practices undertaken or approved by the prophet Mohammed) recommend that women undergo FGM, and some women have been told that having FGM will make them ‘a better Muslim’. However, senior Muslim clerics at an international conference on FGM in Egypt

in 2006 pronounced that FGM is not Islamic, and the London Central Mosque has spoken out against FGM on the grounds that it constitutes doing harm to oneself or to others, which is forbidden by Islam.

Some views of people from FGM-practising communities⁵

“I cannot trust her if she is not circumcised”

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

“Yes I am happy to marry an uncircumcised woman”

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

2.9 FGM PROCEDURE

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

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

³ Quote from interviews conducted as part of FORWARD (2009) *FGM is Always with Us: Experiences, Perceptions and Beliefs of Women Affected by Female Genital Mutilation in London: Results from a PEER Study*.

⁴ Ibid

⁵ Quotes taken from interviews conducted by midwife and FGM specialist Comfort Momoh MBE.

⁶ Quote from interviews conducted as part of FORWARD (2009) *FGM is Always with Us: Experiences, Perceptions and Beliefs of Women Affected by Female Genital Mutilation in London: Results from a PEER Study*.

FGM is usually carried out by the older women in a practising community, for whom it is a way of gaining prestige and can be a lucrative source of income. The arrangements for the procedure usually include the child being held down on the floor by several women and the procedure carried out without medical expertise, attention to hygiene or anaesthesia. The instruments used include unsterilised household knives, razor blades, broken glass and stones. The girl may often not be expecting the procedure, exacerbating the trauma that is experienced.

2.10 CONSEQUENCES OF FGM

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

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

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

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

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

The longer-term implications for women who have been subjected to FGM Types 1 and 2 are likely to be related to the trauma of the actual procedure, while health problems caused by FGM Type 3 are severe.

World Health Organization research has shown that women who have undergone FGM of all types, but particularly Type 3, are more likely to have complications during childbirth.

The long-term health implications of FGM can include:

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

2.11 PSYCHOLOGICAL AND MENTAL HEALTH PROBLEMS

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

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

The results from research⁸ in practising African communities are that women who have undergone FGM have the same levels of Post Traumatic Stress Disorder (PTSD) as adults who have been subjected to early childhood abuse, and that the majority of the women (80 per cent) suffer from affective (mood) or anxiety disorders.

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

Professionals, particularly those in the health sector, should ensure that mental health support is made available to assist girls and women who have undergone FGM.

⁷ Haseena Lockhat (2004) *Female Genital Mutilation: Treating the Tears*, London: Middlesex University Press.

⁸ Behrendt, A. et al (2005) Posttraumatic Stress Disorder and Memory Problems after Female Genital Mutilation, *American Journal of Psychiatry* 162: 1000–1002, May.



CHAPTER THREE

IDENTIFYING

GIRLS AND WOMEN AT RISK

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

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

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

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

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

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

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

3.2 INDICATIONS THAT FGM MAY BE ABOUT TO TAKE PLACE SOON

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

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

There can also be clearer signs when FGM is imminent:

- It may be possible that families will practise FGM in the UK when a female family elder is around, particularly when she is visiting from a country of origin.
- A professional may hear reference to FGM in conversation, for example a girl may tell other children about it. (See Appendix B for commonly used terms in different languages).

- A girl may confide that she is to have a 'special procedure' or to attend a special occasion to 'become a woman'.
- A girl may request help from a teacher or another adult if she is aware or suspects that she is at immediate risk.
- Parents state that they or a relative will take the child out of the country for a prolonged period.
- A girl may talk about a long holiday to her country of origin or another country where the practice is prevalent (see Section 2.5 for the nationalities that traditionally practise FGM).
- A girl or woman may have frequent urinary or menstrual problems.
- There may be prolonged or repeated absences from school or college.
- A prolonged absence from school or college with noticeable behaviour changes (e.g. withdrawal or depression) on the girl's return could be an indication that a girl has recently undergone FGM.
- A girl or woman may be particularly reluctant to undergo normal medical examinations.
- A girl or woman may confide in a professional.
- A girl or woman may ask for help, but may not be explicit about the problem due to embarrassment or fear.

3.3 INDICATIONS THAT FGM MAY HAVE ALREADY TAKEN PLACE

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

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

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

- A girl or woman may have difficulty walking, sitting or standing.
- A girl or woman may spend longer than normal in the bathroom or toilet due to difficulties urinating.
- A girl may spend long periods of time away from a classroom during the day with bladder or menstrual problems.





CHAPTER FOUR

GOOD PRACTICE TO FOLLOW IN ALL CASES

IN ALL CASES:

If you are worried about someone who is at risk of FGM or has had FGM, you must share this information with social care or the police. It is then their responsibility to investigate and safeguard and protect any girls or women involved. Other professionals should not attempt to investigate cases themselves.

4.1 DUTY TO SAFEGUARD CHILDREN AND PROTECT WOMEN AT RISK

Safeguarding girls at risk of harm through FGM poses specific challenges because the families involved may give no other cause for concern, for example with regard to their parenting responsibilities or relationships with their children. However, there remains a **duty for all professionals to act to safeguard girls at risk⁹** – with four key issues to consider:

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

4.1.1 AN ILLEGAL ACT BEING PERFORMED ON A FEMALE, REGARDLESS OF AGE

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

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

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

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

Under section 47 of the Children Act 1989, **anyone who has information that a child is potentially or actually at risk of significant harm is required to inform social care or the police.** Initially, the professional will refer the potential victim as a **child in need** and social services will assess the risk. This definition of harm has been extended in the Adoption and Children Act 2002, which includes where someone sees or hears of the ill treatment of another. Specifically, this relates to situations where there may not be direct disclosure of FGM being performed.

A local authority should exercise its powers to make enquiries to safeguard a girl’s welfare under section 47 of the Children Act 1989 if it has reason to believe that a girl is likely to be subjected to or has been subjected to FGM. However, despite the very severe health consequences, parents and others who have FGM performed on their daughters do not intend it as an act of abuse – they believe that it is in the girl’s best interests to conform with their prevailing custom (see Section 2.8). Therefore, where a girl has been identified as being at risk of significant harm, it may not always be appropriate to remove the child from an otherwise loving family environment. Where

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

a girl appears to be in **immediate** danger of FGM, consideration should be given to legal interventions (see Chapter 5).

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

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

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

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

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

4.2 TALKING ABOUT FGM

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

When talking about FGM, professionals should:

- ✓ ensure that a female professional is available to speak to if the girl or woman would prefer this;
- ✓ make no assumptions;
- ✓ give the individual time to talk and be willing to listen;
- ✓ create an opportunity for the individual to disclose, seeing the individual on their own in private;
- ✓ be sensitive to the intimate nature of the subject;
- ✓ be sensitive to the fact that the individual may be loyal to their parents;
- ✓ be non-judgemental (pointing out the illegality and health risks of the practice, but not blaming the girl or woman);
- ✓ get accurate information about the urgency of the situation if the individual is at risk of being subjected to the procedure;
- ✓ take detailed notes;
- ✓ use simple language and ask straightforward questions;
- ✓ use terminology that the individual will understand, e.g. the individual is unlikely to view the procedure as ‘abusive’;
- ✓ avoid loaded or offensive terminology such as ‘mutilation’ (see Appendix B for terms used in different languages that may be useful);
- ✓ use value-neutral terms understandable to the woman, such as:
 - “Have you been closed?”

- “Were you circumcised?”
- “Have you been cut down there?”
- ✓ be direct, as indirect questions can be confusing and may only serve to reveal any underlying embarrassment or discomfort that you or the patient may have. If any confusion remains, ask leading questions such as:
 - “Do you experience any pains or difficulties during intercourse?”
 - “Do you have any problems passing urine?”
 - “How long does it take to pass urine?”
 - “Do you have any pelvic pain or menstrual difficulties?”
 - “Have you had any difficulties in childbirth?”
- ✓ give the message that the individual can come back to you if they wish;
- ✓ give 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.

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

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

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

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

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

Remember:

- Individuals may wish to be interviewed by a professional of the same gender.
- They may not want to be seen by a professional from their own community.
- Alerting the girl’s or woman’s family to the fact that she is disclosing information about FGM may place her at risk of harm.
- Develop a safety and support plan in case they are seen by someone ‘hostile’ at or near the department, venue or meeting place, e.g. prepare another reason why they are there.

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

- If they insist on being accompanied during the interview, e.g. by a teacher or advocate, ensure that the accompanying person understands the full implications of confidentiality, especially with regard to the person's family (see Section 4.6 for more details about disclosure). For some, an interview may require an authorised accredited interpreter who speaks their dialect.
- Do not assume that families from practising communities will want their girls and women to undergo FGM.

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

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

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

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

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

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

If it is discovered that they are in breach of immigration rules (for example if they have overstayed their visa), remember that they may also require medical treatment, or be the victim of a crime and be traumatised as a result. Guidelines on NHS treatment for overseas visitors can be found at www.dh.gov.uk/en/Healthcare/Entitlementsandcharges/OverseasVisitors/index.htm

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

4.4 MEDICAL EXAMINATIONS

In some cases, it may be necessary to arrange a medical examination for emotional or physical conditions; in other cases, a person may require attention to injuries for evidential purposes. In either circumstance, it may not be advisable to call or visit a medical practitioner from the local community as this may threaten the security of the victim.

It is advisable in all cases where injuries are apparent to encourage the person to have those injuries documented for future reference.

Remember:

- The examination of a child or young person should be in accordance with safeguarding children procedures and should normally be carried out by a consultant paediatrician, preferably with experience of dealing with cases of FGM.

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

4.5 MAKING ENQUIRIES

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

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

4.6 DISCLOSURE AND CONFIDENTIALITY

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

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

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

- *What to Do if You are Worried a Child is Being Abused* (HM Government, 2006)
- Nursing and Midwifery Council's *advice on confidentiality* (2009)
- General Medical Council's guidance (2009) *Confidentiality*

- National Police Improvement Agency on behalf of the Association of Chief Police Officers (2010) *Guidance on the Management of Police Information.*

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

4.7 A VICTIM-CENTRED APPROACH

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

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

4.8 FORCED MARRIAGE AND FGM

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

If you are concerned about an individual who may be at risk of both practices, you should consult the multi-agency practice guidelines on handling cases of forced marriage. These can be found at: www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/forced-marriage

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

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



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

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

This chapter sets out summaries of:

- 5.1 – Police protection
- 5.2 – Emergency Protection Orders under section 44 of the Children Act 1989
- 5.3 – Care Orders and Supervision Orders
- 5.4 – Inherent jurisdiction
- 5.5 – Applications for wardship
- 5.6 – Repatriation

5.1 POLICE PROTECTION

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

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

However, children's social care may apply for an Emergency Protection Order (EPO) (see Section

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

Remember:

- Police officers have powers, under section 17(1)(e) of the Police and Criminal Evidence Act 1984, to enter and search any premises in order to protect life or prevent injury.
- Police officers can also prevent the removal of a child or young person from a hospital or other safe place in which the child or young person is accommodated.
- The parents may ask for contact with the child or young person under protection, but this does not have to be granted if it is not in the best interests of the child

or young person, i.e. if it would place the child or young person in danger.

- The local police child protection officer must be informed of any child or young person under police protection.
- A girl or woman may wish to see a police officer of the same gender.
- The girl or young woman may, or may not, want to see a police officer from their own community – try to give the child or young person the choice.
- In all cases, ensure that the child protection register has been checked.
- The police do not have parental responsibility with respect to the child or young person while they are under police protection, but they can do what is reasonable in the circumstances for the purposes of safeguarding or promoting the welfare of the child or young person.
- The police cannot make any decisions for the child or young person beyond the 72 hours of the order.

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

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

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

An EPO authorises the applicant to remove the girl and keep her in safe accommodation. An EPO will only be granted to safeguard the girl’s welfare. An EPO lasts for up to eight days but it may be renewed for up to a further seven

days. If the person applying for an EPO is anyone other than the local authority, children’s social care must be informed and must then undertake section 47 enquiries. The local authority has the power, having consulted the applicant and the child or young person, to take over the order and responsibility for the child or young person (Emergency Protection Orders (Transfer of Responsibilities) Regulations 1991, SI 1991/1414).

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

Remember:

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

For further information on court orders, refer to [The Children Act 1989: Guidance and Regulations, Volume I: Court Orders](#) (2008).

5.3 CARE ORDERS AND SUPERVISION ORDERS

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

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

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

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

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

The advantage of a Care Order over a Supervision Order is that it allows greater protection to be offered to the child or young person, as the local

authority may obtain an order that there be no contact with the family and may conceal the whereabouts of the child or young person if that is necessary to ensure adequate protection.

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

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

Remember:

- A Care Order gives parental responsibility to the local authority. The local authority can decide the extent to which others with parental responsibility may meet that responsibility. A Care Order places a duty on the local authority to receive the child or young person into its care in order to safeguard and promote the child's or young person's welfare. The local authority also has a duty to accommodate and maintain the child or young person. Young people are not able to apply for a Care Order on their own behalf.
- A Care Order cannot be made once a young person has reached the age of 17 or, in the case of a married person, once they reach 16.
- If a Care Order is granted, it lasts until the young person reaches the age of 18 unless it is discharged before this date.

- It is a criminal offence to remove a child or young person who is subject to a Care Order from the UK, without the express consent of the local authority (and every other person who has parental responsibility), or the court.
- When a Care Order is not appropriate, wardship (see Section 5.5) may still be an option.

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

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

It is possible for a local authority to acquire a **Supervision Order** (on the same criteria as a Care Order) to accompany a Residence Order. A Supervision Order places a duty to advise, assist and befriend the supervised child or young person while providing support and back-

up to a Residence Order holder, but the order would not give the local authority parental responsibility. If the child or young person is not in care, it is also possible for a local authority to obtain a Prohibited Steps Order under section 8 of the Children Act 1989. Such an order could prohibit the parents from removing the child or young person from the country without the permission of the court. The local authority would need to seek the leave of the court before it obtained such an order. Such an order does not confer parental responsibility on the local authority. Following a Prohibited Steps Order, further steps should be made by children's social care, education professionals and the police to monitor the continuing wellbeing and safety of the child or young person if they continue to live in the family home.

5.4 INHERENT JURISDICTION

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

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

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

5.5 APPLICATIONS FOR WARDSHIP

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

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

5.6 REPATRIATION

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

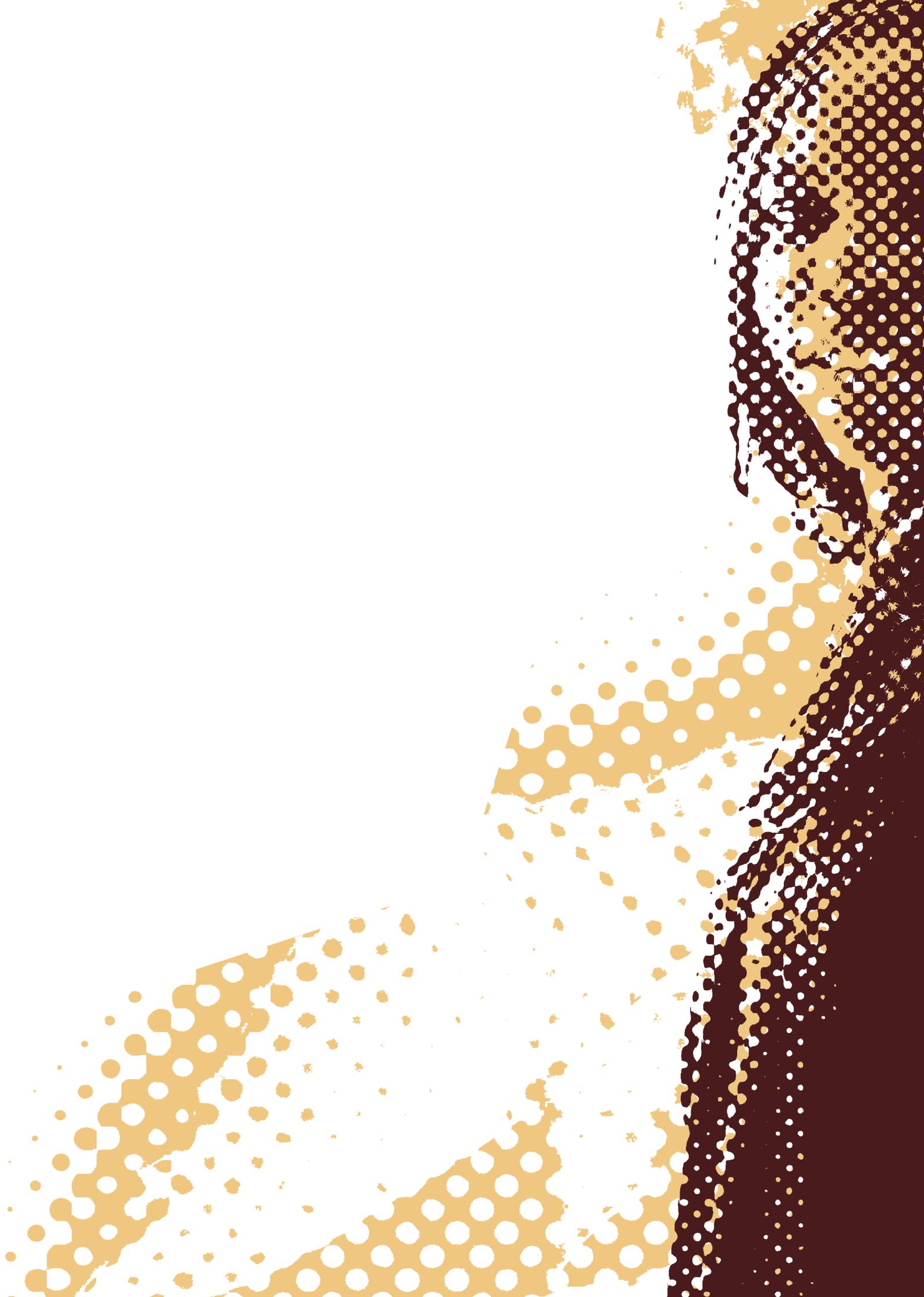
In cases concerning FGM, the victim may be extremely traumatised and frightened. They may have been held against their will for many months or years. They may have suffered emotional and physical abuse. Sometimes they will have risked

their life to escape and their family may go to considerable lengths to find them. This makes all victims extremely vulnerable when they return to the UK. Unfortunately, due to the urgency of the situation, the FCO may not be able to give the police or social services much, if any, notice of the person's arrival.

In some instances the FCO will only be able to assist a repatriation with the assistance and support of UK agencies – for example, in the case of the repatriation of a minor in very limited circumstances where certain criteria are met.

Remember:

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



CHAPTER SIX

GUIDELINES FOR HEALTH PROFESSIONALS

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

6.1 HOW HEALTH PROFESSIONALS CAN MAKE A DIFFERENCE

Health professionals are key to providing support to victims of FGM and intervening to prevent girls and women from being harmed. However, investigations and enquires about any criminal offence are the responsibility of the police and social care, and should not be conducted by health professionals.

While the overarching legal issue related to FGM is its illegality, professionals must also ensure that they provide care and support that is consistent with safeguarding law and policy. Professionals should be familiar with *What to Do if You are Worried a Child is Being Abused* (HM Government, 2006), *Working Together to Safeguard Children* (HM Government, 2010) in England and *Safeguarding Children – Working Together Under the Children’s Act 2004* in Wales, and the appropriate sections of the Children Acts of 1989 and 2004 in England and Wales.

It is essential to refer to, and work with, others such as teachers, social care colleagues and the police where necessary (see Section 4.6 for details on referrals to appropriate agencies and breaching confidentiality). **Both law and policy allow for disclosure where it is in the public interest or where a criminal act has been perpetrated.**

Awareness of FGM, the communities involved (see Section 2.5) and the indicators of risk (see Chapter 3) is an important starting point in ensuring provision of the support and interventions needed. In addition to the specific steps set out below, all professionals are encouraged to:

- inform/raise awareness among their colleagues about the issues surrounding FGM, including these guidelines;
- include black and ethnic minority women’s issues (such as FGM) within domestic violence training;
- circulate and display copies of FGM leaflets and posters (see Appendix E for details);
- deal with FGM in a sensitive and professional manner, and be sufficiently prepared so that they do not exhibit signs of shock, confusion, horror or revulsion when treating an individual affected by FGM (see Section 4.2 for advice on about how to talk about FGM);
- always consider other girls and women in the family who may be at risk of FGM when dealing with a particular case;
- ensure that mental health issues are considered when supporting girls and women affected by FGM.

6.2 GENERAL PRACTITIONERS AND PRACTICE NURSES

General practitioners (GPs) and practice nurses are well placed to identify girls and women in need of treatment to deal with the consequences of FGM (see Section 2.10), as well as to identify and protect those who may be at risk.

GPs and practice nurses are encouraged to consider a number of areas:

- A question about FGM should be asked when a routine patient history is being taken from girls and women from communities that traditionally practise FGM (see Section 2.5).
- Information about FGM could be made part of any ‘welcome pack’ given to a practice’s new patients (see Appendix E for details of materials available).

- Consider the risk of FGM being performed on girls and women overseas when vaccinations are requested for an extended break.

6.3 HEALTH VISITORS, SCHOOL AND COMMUNITY CHILDREN'S NURSES

The position of health visitors, school nurses and community children's nurses (CCNs) means that they are well placed to identify those at risk of FGM and those who have already been affected, and to act.

Health visitors, in particular, work closely with families in their homes, and have a key role in terms of health promotion and education from an early age in a girl's life. This may include helping and supporting families to explore ways of breaking the cycle of FGM. Health visitors, school nurses and CCNs are also well placed to collaborate in support and referral as part of multi-professional teams.

Health visitors, school nurses and CCNs can intervene to tackle FGM in a number of ways:

- Health visitors visiting a mother known to have undergone FGM should ensure that the family is aware of its illegality in the UK, and consider whether any girls in the family need safeguarding.
- School nurses and CCNs, like teachers, may be in a position of trust and receive disclosures from girls and young women (or their friends) that lead them to suspect that they are at risk. They should be prepared and able to talk about the subject professionally and sensitively (see Section 4.2).

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

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

6.4 MIDWIVES AND NEONATAL NURSES

Midwives may become concerned about a girl being at risk while attending a family for the birth of a female sibling.

A number of practical actions can be taken to support those at risk of FGM:

- At the antenatal booking, the process of history taking should identify women who have undergone FGM.
- The appropriate care pathway for the woman during pregnancy, delivery and postnatal care should be developed by the midwives and obstetricians with the woman.
- The presence of FGM should be considered even if a woman has had previous vaginal births. This should be addressed as early as possible during pregnancy or, if a woman is admitted who is already in labour, it is important to check for any re-suturing.
- When a woman who has undergone FGM gives birth to a daughter, she should be provided with clear information that FGM is illegal in the UK and should not be performed on her daughter. It is important that this is done in a sensitive manner as the woman may have been a victim of enforced FGM and may be distressed at the suggestion that she would do the same to her daughter (see Section 4.2 for more details on talking about FGM).
- The type of FGM (see Section 2.2) should be clearly recorded on the woman's medical records, including a detailed description of the genitals, identifying the presence/absence and condition of each structure.
- FGM should be documented in the antenatal notes but if for any reason this is not the case, it should be done postnatally before the transfer home after delivery.

- The woman's health visitor and GP should be informed that she has undergone FGM so they can ensure that she receives any medical and mental health support needed, reinforce the messages about the practice's illegality, and safeguard her daughters and other female family members.

6.5 OTHER HEALTHCARE PROFESSIONALS

Children and young people are cared for across health services within both children's and adult services, and in specialist areas such as gynaecology.

All health professionals must be aware of the issues around FGM (see Chapter 2), and be able to recognise when girls or young women may be at risk of FGM or have already had FGM performed on them (see Chapter 3) and to work with other agencies to protect girls and young women who may be at risk.

6.6 CLINICAL ISSUES AND PROCEDURES

Health professionals, particularly nurses and midwives, need to be aware of how to care for women and girls who have undergone FGM, particularly when giving birth.

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

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

All women who have undergone Type 3 of FGM (infibulation) should be informed that deinfibulation is an option and be informed about the benefits of this. Women should be referred to a service with the relevant skilled and experienced healthcare professionals to carry out the procedure. Further information on specialist services can be found in Appendix C.

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

6.7 RE-SUTURING OR REINFIBULATION

Re-suturing, often known as reinfibulation or closing, should never be performed because it is illegal for any professional to do this in the UK.

This may mean that careful discussions have to be held with the woman, her partner and family to explain the law and why reinfibulation has to be refused. Women may themselves request reinfibulation for social reasons or because they have known nothing else. It is necessary to follow up with the woman during the postnatal period as reinfibulation may be performed illegally at this point. Support, information and counselling continue to be very important. Healthcare professionals who participate in FGM or reinfibulation will be breaking the law and would also be answerable to the respective professional registers.

For women who have undergone deinfibulation, health professionals should communicate equally the disadvantages of infibulation and the benefits of not being reinfibulated after childbirth:

- It is more hygienic.
- It means that sex will be much more comfortable and better once both partners get used to it.

- It will make future births much easier and less risky.
- It increases the likelihood of conception.
- It reduces the risk of complications in future pregnancies and the subsequent chance of perinatal death.

Once girls and women know all the facts and the benefits of not undergoing reinfibulation, most are happy not to do so. However, health professionals should not assume that this means that the woman will be more able to resist the pressure from her community to subject any daughter(s) she may have to FGM; therefore steps must be taken to protect the daughter(s) as well as any girl children in the family or extended family.

6.8 COUNSELLING

All girls or women who have undergone FGM should be offered counselling to address how things will be different for her afterwards.

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

Boyfriends, partners and husbands should also be offered counselling.

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

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

7.1 HOW POLICE OFFICERS CAN MAKE A DIFFERENCE

FGM is not a matter that can be left to be decided by personal preference or tradition; it is an extremely harmful practice. FGM is child abuse, a form of violence against women and girls, and is against the law with a maximum prison sentence of 14 years. Officers should not let fears of being branded 'racist' or insensitive to cultural traditions weaken their investigative strategy. Although officers should consider and research cultural matters around this issue, FGM investigation should be robust and enforce the law.

Criminal investigations should follow police forces' standard operating procedures (SOPs), and those for child protection investigations.

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

- *Guidance on Investigating Child Abuse and Safeguarding Children* (2005)
- *Guidance on Investigating Domestic Abuse* (2008)
- *Practice Guidance for Specialist Staff – Domestic Abuse, Stalking and Harassment and Honour Based Violence* (2009)
- *Practice Guidance for First Response Police Staff – Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH)* (2009)
- *Risk Identification and Assessment Model for Police Staff – Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH)* (2009).

All these documents can be found on force intranet sites.

Police officers can also contact the Metropolitan Police Service's specialist Project Azure team on 020 7161 2888 for information.

7.2 EXAMPLE OF STANDARD OPERATING PROCEDURES

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

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

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

If officers or members of police staff believe that a girl may be at risk of undergoing FGM, the duty inspector must be made aware and an immediate referral should be made to their local child abuse investigation team (CAIT). If this is outside the core hours, the duty inspector must ensure that appropriate protection measures are put in place. The CAIT will in turn make an immediate referral to the relevant local authority children's social care team.

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

Officers should carry out the following actions:

- Complete appropriate checks, e.g. child protection register.
- Submit an appropriate intelligence log.
- Complete relevant risk assessment and management plans.

- Complete a crime report, ensuring that the incident is flagged in accordance with force procedures.
- Inform their supervisor, who must be at least the rank of inspector (the on-call superintendent should also be made aware of the referral).
- All officers and staff must consider whether this could be a critical incident and deal with the matter accordingly.

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

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

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

Officers should consider the use of police protection powers under section 46 of the Children Act 1989 and remove the girl to a place of safety (see Section 5.1). In addition, local authority children's social care should consider the use of a Prohibitive Steps Order

or Emergency Protection Order (see Section 5.2). **The welfare of other children within the family, in particular female siblings, should be reviewed.** The investigation should be the subject of regular ongoing multi-agency reviews to discuss the outcome and any further protective steps that need to be taken with regard to that girl and any other siblings.

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

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

Officers should carry out the following actions:

- Complete appropriate checks, e.g. child protection register.
- Submit an appropriate intelligence log.
- Complete relevant risk assessment and management plans.
- Refer to local authority children's social care (unless they were the referrer).
- Complete a crime report, ensuring that the incident is flagged in accordance with force procedures.
- Inform their supervisor, who must be at least the rank of inspector.
- Ensure that the on-call superintendent is made aware of the referral.
- All officers and staff must consider whether this could be a critical incident and deal with the matter accordingly.

- The investigative strategy should consider identifying the excisors (people who carry out FGM for payment or otherwise) and investigating these individuals with a view to identifying further victims and closing down these networks.

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

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

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

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

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

7.2.5 CONDUCTING INTERVIEWS ABOUT FGM

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

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

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

7.2.6 MEDICAL EXAMINATIONS

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

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

7.2.7 STEPS WHEN AN ADULT FEMALE HAS UNDERGONE FGM

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

The investigative strategy should consider identifying any excisors in the UK (people who carry out FGM for payment or otherwise) and investigating these individuals with a view to identifying further victims and closing down these networks.



CHAPTER EIGHT

GUIDELINES FOR CHILDREN'S SOCIAL CARE

All children's social care professionals should work in accordance with the guidelines in *Working Together to Safeguard Children (2010)* in England and *Safeguarding Children – Working Together Under the Children's Act 2004 (2004)* in Wales.

8.1 HOW CHILDREN'S SOCIAL CARE CAN MAKE A DIFFERENCE

Children's social care has a clear duty to safeguard children and so should work to prevent FGM taking place, and offer support to any girls affected by the practice.

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

Each Local Safeguarding Children Board will have local safeguarding protocols and procedures for helping children and young people who are facing abuse. Every social care office should, as part of domestic violence and safeguarding children protocols, have multi-agency policies and procedures that include handling cases where FGM is alleged or known about.

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

8.2 STRATEGY MEETING

On receipt of a referral, a strategy meeting must be convened as soon as practicable (and in any case within two working days), and should involve representatives from the police, children's social care, education professionals, and health services.

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

The strategy meeting must first establish whether the parents or girl has had access to information about the harmful aspects of FGM and the law in the UK. If not, they should be given appropriate information regarding the law and harmful consequences of FGM.

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

Every attempt should be made to work with parents on a voluntary basis to prevent the abuse. It is the duty of the investigating team to look at every possible way that parental cooperation can be achieved, including the use of community organisations and/or community leaders (whose views on FGM are known and approved) to facilitate the work with the family.

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

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

8.3 STEPS WHEN A GIRL IS AT IMMEDIATE RISK OF FGM

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

8.4 STEPS WHEN A GIRL HAS ALREADY UNDERGONE FGM

A strategy meeting should be convened as soon as practicable and, in any case, within two working days. The strategy meeting will consider how, where and when the procedure was performed and the implication of this. The strategy meeting will need to consider carefully whether to continue enquiries or whether to assess the need for support services. If there is evidence of any criminal act having taken place (for example, if the FGM took place in the UK or was performed or assisted by a British resident overseas), legal advice must be sought and a criminal investigation conducted.

A second strategy meeting should take place within ten working days of the referral. This meeting must evaluate the information collected in the enquiry and recommend whether a child protection conference is necessary to make a decision about whether the girl continues to be at risk of significant harm and needs further protection, and possibly to agree a child protection plan.

A girl who has already undergone FGM should not normally be subject to a child protection conference or be included on the child protection register unless additional child protection concerns exist. However, she should be offered counselling and medical help, and consideration should be given to any other female siblings at risk.



CHAPTER NINE

GUIDELINES FOR SCHOOLS, COLLEGES AND UNIVERSITIES

9.1 HOW STAFF CAN MAKE A DIFFERENCE

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

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

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

Schools, colleges and universities can create an 'open' and supportive environment by:

- circulating and displaying materials about FGM (see Appendix E for details);
- displaying relevant information, e.g. details of the NSPCC's Helpline and ChildLine services, Careline, National Domestic Violence Helpline and appropriate black and minority ethnic women's groups (see Appendix D for more information);
- ensuring that a private telephone is made available should students need to seek advice from the above organisations or other relevant groups discreetly;
- informing/raising awareness about issues around FGM with colleagues – as well as including appropriate training in continuing professional development;
- ensuring that the designated member of staff with responsibility for safeguarding children is well versed in the issues around FGM;
- referring students to an education welfare officer, a child protection lead, pastoral tutor, learning mentor or school counsellor as appropriate;
- encouraging young people to access appropriate advice, information and support (see Appendix D);
- making materials such as books and DVDs available (see Appendix E);
- introducing FGM into the school curriculum within relevant classes, such as:
 - Personal, Social and Health Education (PSHE) in England, and Personal and Social Education (PSE) in Wales – particularly in 'Sex and the Law' for Key Stages 3, 4 and 5, and ensuring accurate naming of body parts in Key Stage 1 which can be the first stage in ensuring that girls are aware of their bodies and rights
 - Citizenship
 - Religious Knowledge
 - Drama
 - History
 - Sociology.

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

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

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

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

Staff should:

- ✓ talk about FGM in a professional and sensitive manner, in line with Section 4.2;
- ✓ explain that FGM is illegal in the UK and that they will be protected by the law;
- ✓ recognise and respect their wishes where possible, but child welfare must be paramount. FGM is child abuse and against the law. If a member of staff believes that the girl is at risk of FGM, or has already undergone FGM, the police and social services must be informed even if this is against the girl's wishes. If you do take action against the student's wishes, you must inform them of the reasons why;
- ✓ activate local safeguarding procedures, using existing national and local protocols for multi-agency liaison with the police and children's or adults' social care;
- ✓ ensure that the girl is informed of the long-term health consequences of FGM to

encourage her to seek and accept medical assistance;

- ✓ liaise with the designated teacher with responsibility for safeguarding children;
- ✓ refer the student, with their consent, to appropriate medical help, counselling and local and national support groups (see Appendix D for details);
- ✓ ensure that safeguarding and protection is considered for any female family members.

Staff should not:

- ✗ treat such allegations merely as a domestic issue;
- ✗ ignore what the student has told them or dismiss out of hand the need for immediate protection;
- ✗ decide that it is not their responsibility to follow up the allegation;
- ✗ approach the student's family or those with influence within the community, in advance of any enquiries by the police, adult or children's social care, either by telephone or letter.

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

Remember:

- The student may not wish to be referred to a social worker, police officer or a guidance/pastoral/head teacher from her own community.
- Consult other professionals, particularly an experienced manager/colleague, the local police child protection or domestic violence unit.

- Speaking to the student's parents about the action you are taking may place the student at risk of emotional and/or physical harm. Therefore, do not approach the family as they may deny the allegations, expedite any travel arrangements and hasten their plans to carry out the procedure.

9.3 WHAT TO DO WHEN A STUDENT STOPS ATTENDING SCHOOL

Details of the steps that local authorities need to take to meet their duty to identify all children not receiving a suitable education are described in *Statutory Guidance for Local Authorities in England to Identify Children not Receiving a Suitable Education* or *Statutory Guidance to Help Prevent Children and Young People from Missing Education: Welsh Assembly Government Circular 006/2010*.

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

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

Remember:

- There may be occasions when an education welfare officer or teacher visits the family in the UK to find out why the student is not attending school or college. The family may tell the teacher that the student is being educated overseas. Sometimes, the family may suggest that the teacher speaks to the student on the telephone.
- If this occurs, the teacher should refuse to speak on the telephone and (if the student is a British national) insist that the student is presented at the nearest British Embassy or High Commission. There have

been occasions when students have not been able to talk freely over the telephone or a different individual has spoken to the teacher.

Staff should not:

- × remove the student from the school register without first making enquiries and/or referring the case to the police and local authority adult or children's social care;
- × dismiss the student as taking unauthorised absence.



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

10.1 THE ROLE OF LOCAL SAFEGUARDING CHILDREN BOARDS

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

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

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

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

LSCBs may consider developing and supporting a centralised virtual team of experts (including community groups and specialist women's groups) to advise professionals on the prevention of FGM in the community and the appropriate professional response to individual cases.

10.2 PROFESSIONAL LEARNING REQUIREMENTS

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

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

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

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

See Appendix E for details on materials available to professionals.

10.3 WORKING WITH COMMUNITIES TO ABANDON FGM

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

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

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

“ Before attending [a community workshop run by the Manor Gardens Centre], we thought that it was our religious obligation to have circumcision. Now we understand it's not. ”



GLOSSARY OF TERMS USED

ADULT

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

CHILD, CHILDREN AND YOUNG PEOPLE

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

CHILD ABUSE AND NEGLECT

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

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

CHILD IN NEED

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

DEINFIBULATION

See 'Infibulation'.

DOMESTIC VIOLENCE

The government defines domestic violence as: "any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members,

regardless of gender or sexuality. This includes issues of particular concern to black and minority ethnic (BME) communities such as so-called 'honour-based violence', **female genital mutilation** (FGM) and forced marriage."¹⁵

FORCED MARRIAGE

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

INFIBULATION

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

Deinfibulation is the procedure to 're-open' a vaginal opening.

Reinfibulation (also known as re-suturing) is the procedure to narrow a vaginal opening after it has been deinfibulated for childbirth, for example. Reinfibulation is illegal in the UK – see Section 6.7.

REINFIBULATION OR RE-SUTURING

See 'Infibulation'.

SIGNIFICANT HARM

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

¹⁵ Home Office (2005) *Domestic Violence: A National Report*.

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

APPENDIX B

TERMS USED FOR FGM IN OTHER LANGUAGES

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

Thanks to FORWARD and IKWRO for details – contact details for both organisations can be found in Appendix D.

APPENDIX C

FGM SPECIALIST HEALTH SERVICES IN ENGLAND AND WALES

London	
<p>African Well Women's Clinic Guy's & St Thomas's Hospital 8th Floor – c/o Antenatal Clinic Lambeth Palace Road London, SE1 7EH Tel: 020 7188 6872 Open: Monday – Friday, 9am – 4pm Contact: Comfort Momoh MBE (FGM / Public Health Specialist) comfort.momoh@gstt.nhs.uk Mobile: 07956 542 576</p>	<p>African Well Women's Clinic - Antenatal Clinic Central Middlesex Hospital Acton Lane, Park Royal London, NW10 7NS Tel: 020 8963 7180 Open: Friday, 9am – 12pm (appointments only) Contact: Jackie Dehan</p>
<p>African Well Women's Clinic - Antenatal Clinic Northwick Park & St Mark's Hospital Watford Road Harrow Middlesex, HA1 3UJ Tel: 020 8869 2880 Open: Friday, 9am – 5pm Contact: Jeanette Carlsson</p>	<p>African Well Women's Clinic Whittington Hospital Level 5 Highgate Hill London, N19 5NF Tel: 020 7288 3482 Open: Last Wednesday of every month, 9am – 5pm Contact: Joy Clarke or Shamsa Ahmed joy.clarke@whittington.nhs.uk Mobile: 07956 257 992</p>
<p>Women's & Young People's Services Sylvia Pankhurst Health Centre Mile End Hospital Bancroft Road London, E1 4DG Tel: 020 7377 7898 or 020 7377 7870 Open: Monday – Thursday, 12 noon – 8pm; Friday 9.30am-5.30pm Contact: Dr Geetha Subramanian (Consultant Gynaecologist) geetha.subramanian@thpct.nhs.uk</p>	<p>African Women's Clinic University College Hospital Clinic 3 Elizabeth Garrett Anderson Wing London, NW1 2BU Tel: 0845 155 5000 ext. 2531 Open: Monday afternoon Contact: Maligaye Bikoo (Clinical Nurse Specialist) maligaye.bikoo@uclh.nhs.uk</p>
<p>Gynaecology & Midwifery Departments Chelsea & Westminster Hospital 3rd Floor 369 Fulham Road London, SW10 9NH Tel: 020 3315 8000 By appointment only Contact: Gubby Ayida (Obstetrics Service Director) gubby.ayida@chelwest.nhs.uk</p>	<p>Gynaecology Department St. Mary's Hospital Praed Street London, W2 1NY Tel: 020 3312 6907 Appointments through GP referral Contact: Professor Jenny Higham</p>

<p>Waltham Forest African Well Women's Services Oliver Road Polyclinics Upper Ground Floor 75 Oliver Road, Leyton London, E10 5LG Open: Drop-in Thursday, 10am – 3pm Tel: 020 8430 8210</p>	<p>Acton Health Centre 35 – 61 Church Road Acton W3 8QE Tel: 020 8383 8761 Contact: Julia Albert (Midwife) Juliet.albert@nhs.net Hayat Arteh (Health Advocate) Hayat.arteht@nhs.net Self referral for free confidential services</p>
<p>South West</p>	
<p>Minority Ethnic Women's & Girls' Clinic Charlotte Keel Health Centre Seymour Road Easton Bristol BS5 0UA Tel: 0117 902 7100 Open: Drop-in last Wednesday of every month, 9.30am – 12pm Contact: Dr Hilary Cooling</p>	
<p>North West</p>	
<p>St Mary's Hospital Hathersage Road Manchester, M13 0JH Tel: 0161 276 6673 Contact: Dr Fiona Reid (consultant) fiona.reid@cmft.nhs.uk (referral necessary)</p>	
<p>Multi-Cultural Antenatal Clinic Liverpool Women's Hospital Crown Street Liverpool, L8 7SS Tel: 0151 708 9988 Open: Monday, 9am – 2pm Contact: Ronnie Gilbertson or Joanne Topping</p>	

East Midlands

Antenatal Clinic

Nottingham University Hospitals

Queen's Medical Centre

Derby Road

Nottingham, NG7 2UH

Tel: 0115 9691169 ext 55124 / 55127

Open: Monday, 1.30pm – 5pm

Contact: Carol McCormick (Consultant Midwife)

Carol.mccormick@nuh.nhs.uk

West Midlands

African Well Women's Clinic

Princess of Wales Women's Unit Labour Ward

Birmingham Heartlands Hospital

Bordesley Green East

Birmingham, B9 5SS

Tel: 0121 424 3909 or 07817 534 274

Open: daily

Contact: Allison Byrne allison.hughes@heartofengland.nhs.uk

Yorkshire and the Humber

Leeds Teaching Hospital

Haamla Service

St James's Teaching Hospital

Antenatal Clinic

Level 4 Gledhow Wing

Leeds, LS9 7TF

Open: Monday – Friday, 9am – 5pm

Tel: 01132 066392

Contact: Nicolette Clark RM or Dr Tracey Glanville

leedsth-tr.fgmleeds@nhs.net

APPENDIX D

ORGANISATIONS WORKING ON ISSUES AROUND FGM

POLICE SERVICE

Metropolitan Police Service

Child Abuse Investigation Command/Project
Azure
020 7161 2888

UK GOVERNMENT

www.fco.gov.uk/fgm

HELPLINES

Black Association of Women Step Out (BAWSO)

02920 644633
24-hour Helpline: 0800 731 8147
www.bawso.org.uk

ChildLine

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

National Domestic Violence Helpline

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

National Society for the Prevention of Cruelty to Children (NSPCC) Helpline

Free phone 0808 800 5000
help@nspcc.org.uk
NSPCC Helpline, Weston House, 42 Curtain Road, London, EC2A 3NH

NSPCC British Sign Language Helpline for deaf or hard-of-hearing callers

ISDN videophone: 020 8463 1148
Webcam: nspcc.signvideo.tv (available Monday – Friday, 9am – 5pm, in English language only)
Text: 0800 056 0566

OTHER ORGANISATIONS

Agency for Culture and Change Management UK (ACCM UK)

info@accmuk.com

Agency for Cultural Change and Management – Sheffield

www.accmsheffield.org

Birmingham Against FGM

cypfcomms@birmingham.gov.uk
0121 303 8200

Bristol FGM Network

www.bristol.nhs.uk/Patients/BCH/default.asp

Council for Ethnic Minority Communities & FGM Northamptonshire

www.fgmnorthamptonshire.btik.com

Equality Now

020 7839 5456
www.equalitynow.org

FGM National Clinical Group

www.fgmnationalgroup.org/index.htm

Foundation for Women's Health Research & Development (FORWARD)

020 8960 4000
www.forwarduk.org.uk

Iranian and Kurdish Women's Rights Organisation (IKWRO)

020 7920 6460
www.ikwro.org.uk

London Black Women's Health and Family Support

www.bwhafs.com

London Safeguarding Children Board

www.londonscb.gov.uk/fgm_resources

Manor Gardens Health Advocacy Project, North London

www.manorgardenscentre.org
020 7281 7694

Teesside African Health Community

www.tahc.co.uk

MATERIALS AVAILABLE ABOUT FGM

GUIDANCE AND GUIDELINES FOR PROFESSIONALS

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

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

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

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

Information about the government's strategy to eradicate violence against women and girls can be found at www.homeoffice.gov.uk/crime/violence-against-women-girls

Information about the Department of Health campaign to end violence against women and children can be found at www.dh.gov.uk/vawc

Information from the Department for Education about safeguarding children can be found at www.education.gov.uk/childrenandyoungpeople/safeguarding

Clinical guidance on FGM developed by Leeds Teaching Hospital Trust (LTHT) is available from the LTHT Haamla Service – contact details are available in Appendix C.

GOVERNMENT-PRODUCED LEAFLETS AND POSTERS

Professionals, civil society partners and members of the public can download copies of the government's leaflet and poster about FGM from www.fco.gov.uk/fgm

Hard copies can be requested via fgm@fco.gov.uk

TOOLS

- London Safeguarding Children Board (2009) London FGM Resource Pack

BOOKS ABOUT FGM

- Waris Dirie, *Desert Flower* (ISBN 9780688158231)
- Layli Miller Bashir and Fauziya Kassindja, *Do They Hear You When You Cry?* (ISBN 9780553505634)
- Alice Walker, *Possessing the Secret of Joy* (ISBN 9780671789428)

FILMS ABOUT FGM

- Mooladé (2004)
- Fire Eyes (2004)
- Africa Rising (2009)

RESEARCH ABOUT FGM IN THE UK

- FORWARD (2007) *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales*
- FORWARD (2009) *FGM is Always with Us: Experiences, Perceptions and Beliefs of Women Affected by Female Genital Mutilation in London: Results from a PEER Study*





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