PROCEDURES AND GUIDANCE

Female Genital Mutilation

Date of original document	January 2015	
Date document reviewed	April 2016, February 2018 April 2021	
Date for next review	December 2023	

FEMALE GENITAL MUTILATION

1. Definition

Female genital mutilation (FGM) is a collective term for procedures, which include the removal of part or all of the external female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization for cultural or other non-therapeutic reasons. The World Health Organisation has classified FGM into four types; Type 1 – Clitoridectomy, Type 2 – Excision, Type 3 – Infibulation, and Type 4 – Other (all other procedures). 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. The procedure is typically performed on girls aged between 4 and 13, but in some cases it is performed on new-born infants or on young women before marriage or pregnancy.

FGM has been a criminal offence in the U.K. since the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003 replaced the 1985 Act and makes it an offence for the first time for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal.

For more detail, please refer to the government guidance: Female Genital Mutilation: Multi-Agency Practice Guidelines (updated March 2016).

Click here to access the Gov.uk website for Female Genital Mutilation.

Globally it is estimated that between 100 million – 140 million women have undergone FGM; this equates to 3 million per year. Within England and Wales it is estimated that 66,000 women have undergone FGM and 24,000 girls under the age of 15 are at risk.

2. Indicators

These indicators are not exhaustive and whilst the factors detailed below may be an indication that a child is facing FGM, it should not be assumed that is the case simply on the basis of someone presenting with one or more of these warning signs. These warning signs may indicate other types of abuse such as forced marriage or sexual abuse that will also require a multi-agency response.

The following are some signs that the child may be at risk of FGM:

- The family belongs to a community in which FGM is practised;
- Maternal or other family member disclosure;
- An awareness by a midwife or obstetrician that the procedure has already been carried out on a mother, prompting concern for any daughters, girls or young women in the family;
- Any female child whose older sibling has undergone FGM;
- The family makes preparations for the child to take a holiday, e.g. arranging vaccinations, planning an absence from school;
- The child talks about a 'special procedure/ceremony' that is going to take place.

Consider whether any other indicators exist that FGM may have or has already taken place, for example:

1. The child has changed in behaviour after being absent from school; or
2. The child has health problems, particularly bladder or menstrual problems.

3. Where is FGM Practised?

FGM is practised in at least 28 African countries (in particular, Egypt, Ethiopia, Somalia and Sudan, as well as Nigeria and Kenya, Togo and Senegal) as well as countries in the Middle East (including Yemen, Oman, Iraqi Kurdistan).

However, as a result of immigration and refugee movements, FGM is now being practiced by ethnic minority populations in other parts of the world, such as USA, Canada, Europe, Australia and New Zealand. FORWARD estimates that as many as 6,500 girls are at risk of FGM within the UK every year.

There is no religious justification for FGM and religious leaders from all faiths have spoken out against the practice.

4. Consequences of FGM

Depending on the degree of mutilation, FGM can have a number of short-term health implications:

1. Severe pain and shock;
2. Infection;
3. Urine retention;
4. Injury to adjacent tissues;
5. Immediate fatal haemorrhaging;
6. Death.

Long-term implications can entail:

1. Extensive damage of the external reproductive system;
2. Uterus, vaginal and pelvic infections;
3. Cysts and neuromas;
4. Increased risk of Vesico Vaginal Fistula;
5. Complications in pregnancy and child birth;
6. Psychological damage;
7. Pain during sexual intercourse;
8. Sexual dysfunction;
9. Difficulties in menstruation and urination;
10. Urine infections.

In addition to these health consequences there are considerable psycho-sexual, psychological and social consequences of FGM. Internationally 10% of child victims of Type 3 FGM die.

5. Cultural underpinnings

The justifications given for the practise are multiple and reflect the ideological and historical situation of the societies in which it has developed. Reasons include:

1. Custom and tradition;
2. Religion, in the mistaken belief that it is a religious requirement;
3. Preservation of virginity/chastity;
4. Social acceptance, especially for marriage;
5. Hygiene and cleanliness;
6. Increasing sexual pleasure for the male;
7. Family honour;
8. A sense of belonging to the group and conversely the fear of social exclusion;
9. Enhancing fertility.

6. Legal Position

The Female Genital Mutilation (FGM) mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015). This reporting duty came into effect in England on the 31st of October 2105.The legislation requires regulated health and social care professionals and teachers in England and Wales to make a report to the police where, in the course of their professional duties, they either:

1. Are informed by a girl under 18 that an act of FGM has been carried out on her; or

2. Observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth (see section 2.1a for further information).

Failure to do so may lead to prosecution of the Professional.

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

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

The duty is a personal duty which requires the individual professional who becomes aware of the case to make a report; the responsibility cannot be transferred.

The only exception to this is if you know that another individual from your profession has already made a report; there is no requirement to make a second. The duty does not apply in relation to at risk or suspected cases or in cases where the woman is over 18.

A copy of the FGM Mandatory Reporting Duty can be found here:

FGM Mandatory Reporting Duty

Making a Report
The statutory reporting duty recommends that a report is made orally by **calling 101**, the single non-emergency number. However, in the East Riding, where concerns relate to a child or young person, reports should also be made by telephone the Children's Safeguarding Hub (SaPH) on Tel. **01482 395500** (out of hours 01482 393939) as this includes children's social care and the Police.

Reports under the duty should be made as soon as possible after a case is discovered, and best practice is for reports to be made by the close of the next working day, unless any of the factors described below are present. You should act with at least the same urgency as is required by your local safeguarding processes.

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

A longer timeframe than the next working day may be appropriate in exceptional cases where, for example, a professional has concerns that a report to the police is likely to result in an immediate safeguarding risk to the child (or another child, e.g. a sibling) and considers that consultation with colleagues or other agencies is necessary prior to the report being made. If you think you are dealing with such a case, you are strongly advised to consult colleagues, including your designated safeguarding lead, as soon as practicable, and to keep a record of any decisions made. It is important to remember that the safety of the girl is the priority.

7. Protection and action to be taken

A child for whom FGM is planned is at risk of significant harm through physical abuse and emotional abuse, which is also categorised, by some, as sexual abuse. This is therefore classed as a child protection issue and a referral must be made through the Children's Safeguarding Hub (SaPH) to enable enquiries under S47 to be made if the practice is suspected. See Appendix One for pathway.

Any situation where an intentional or actual FGM is suspected should also be reported to East Riding Safeguarding Children Partnership.

8. Responding to FGM

8.1 General guidance

Preventing FGM is no easy task and has many complicating factors. Most practicing families do not see it as an act of abuse. FGM is a form of child abuse and violence against children and women and the needs of the child must always take priority.

It is unlikely a single agency would be able to meet the multiple needs of someone affected by FGM, therefore it is important all agencies work together to achieve the best outcomes for somebody affected by FGM, as well as those at risk.

If professionals can identify signs that FGM has already taken place:

- The girl or women affected can be offered help to deal with the consequences of FGM;
- Enquiries can be made about other family members who may need to be safeguarded from harm;
- Criminal investigations into the perpetrators can be considered to prosecute those breaking the law and to protect others from harm.

Any indication or concern that a child is at immediate risk of, or has undergone, female genital mutilation should result in a child protection referral to the Children's Safeguarding Hub 01482 395500 (out of hours 01482 3939390). Where a child is thought to be at risk of FGM, practitioners should be alert to the need to act quickly - before the child is abused through the FGM procedure in the UK or taken abroad to undergo the procedure.

Professionals should not complete their own investigation. Children's Social Care is able to bring together different professionals to support the investigation process with the Police.

When talking about FGM, professionals should:

- Ensure that a female professional is available to speak to, if the girl or women 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 matter;
- Be sensitive to the fact that the individual may be loyal to their parents and community.

Every attempt should be made to work with the 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 co-operation can be achieved, including the use of community organisations and/ or community leaders to facilitate the work with parents/ family. However the child's interest is always paramount.

Professionals have a responsibility to ensure that parents and carers of children know that FGM is illegal, and that families know the authorities are actively tackling the issue. Every attempt should be made to work with parents on a voluntary basis to prevent the abuse. This knowledge alone may deter families from having FGM performed on their children, and save girls and women from harm.

If no agreement is reached, the first priority is the protection of the child and the least intrusive legal action should be taken to ensure the child's safety.

If the strategy meeting decides that the child is in immediate danger of mutilation and the parents cannot satisfactorily guarantee that they will not proceed with it, than an emergency protection order should be sought.

If the child has already undergone FGM, the strategy meeting will need to consider carefully whether to continue enquiries or whether to assess the need for support services. If any legal actions are being considered, legal advice must be sought.

A child protection conference should only be considered necessary if there are unresolved child protection issues once the initial investigation and assessment have been completed.

Where FGM has been practiced, the Police will take the lead role in the investigation of a serious crime, working to common joint investigative practices and in line with strategy agreements.

8.2 The role of Health Professionals

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

- Younger siblings;
- Daughters or daughters she may have in the future;
- Extended family members.

All girls/ women who have undergone FGM (and their boyfriends/ partners or husbands) must be told that re-infibulation is against law and will not be done under any circumstances. Each woman should be offered counselling to address how things will be different for her afterwards.

After childbirth, a girl/ woman who has been de-infibulated (incision to enable the woman to give birth) may request and continue to request re-infibulation. This should be treated as a child protection concern, as the girl/ woman's apparent reluctance to comply with UK law and /or consider that the process is harmful raises concerns in relation to girl child/ren she may already have or may have in the future.

Following the publication in April 2014 of an Information Standard Notice, 'Female Genital Mutilation Prevalence Dataset':

- Where FGM is identified through the delivery of NHS healthcare, healthcare professionals must now record this in the patient's health record; and
- All acute Trusts must report the number of patients who have FGM in their active caseload to the Department of Health every month.

There are a number of FGM clinics across the country run by specially trained doctors, nurses or midwives who understand FGM, providing a range of treatment and support, including de-infibulation and counselling. A GP or midwife referral is usually required. You can find a list of specialist FGM support clinics below:

https://www.nhs.uk/conditions/female-genital-mutilation-fgm/national-fgm-support-clinics/

In all cases it is good practice to discuss support options provided by NHS FGM clinics. Professionals also have a responsibility to ensure that families know that FGM is illegal, and 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.

8.3 The role of Children's Social Work Service

FGM is child abuse and should be dealt with in the same way as any other Child Abuse investigations, guidance in relation to FGM includes:

- Explain FGM in culturally appropriate ways to families where girls may be deemed at risk.
- Consider and address potential barriers in engaging with families and children e.g. language, gender dynamics;
- Keep an open and enquiring mind, an offender/victim/witness is unlikely to tell you directly that FGM is being considered/has taken place. A robust investigation must be carried out;
- If medical examinations are required these can only take place with consent, and within the bounds of appropriate protection orders which must be applied for;
- Make good records and documents in line with procedures;
- Keep the individual who has made the referral informed of any assessment or actions unless this breaches confidentiality;

- Encourage the individual who made the referral to keep you updated with any new information;
- If a child is deemed to be at risk of FGM, organise a strategy meeting to assess risk and agree a care plan, involving appropriate agencies;
- Where a child is considered to be at risk always consider whether others in the household or extended family are also at risk of FGM;
- Work jointly with the police to deal with FGM from the early stages and to ensure that all information regarding FGM cases is shared;
- Remember, a child may not disclose to you but may to a teacher or other known adult;
- Where FGM is concerned, there are likely to be no prior signs of physical or emotional abuse as with other child protection cases. This does not mean that a child will not be at imminent risk. Social care professionals must consider the risk factors relevant to FGM when assessing the risks to children;
- Work with specialist community organisations to build links with affected communities and to raise awareness, provide support and access those most at risk;
- Find out if the child is already known to children's services or the police following a previous incident, either locally or elsewhere.

8.4 The role of the Police

Ensure you understand the relevant laws relating to FGM. If you are unsure speak to a child protection officer or liaise with your supervisor. Consider immediate medical attention in any FGM investigation.

Be aware that you may come across a girl or young women at potential or actual risk of FGM at any time while carrying out other duties. In non-urgent cases consider use of Emergency Protection Orders, care orders and supervision orders, inherent jurisdiction, application for wardship and repatriation (if the victim is abroad). Officers should:

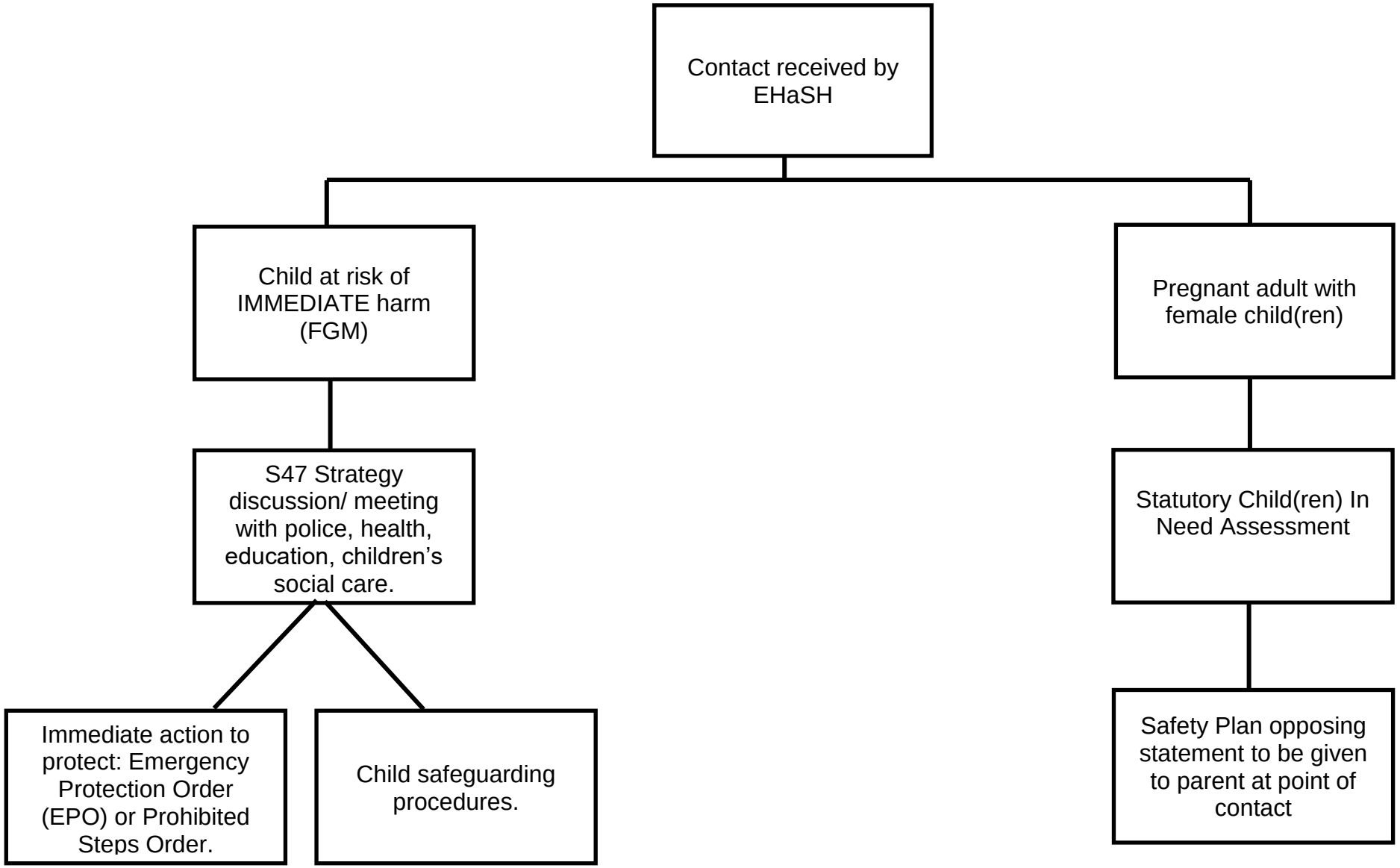
- Consider the health, well-being and safety, under local safeguarding, of any girl or young women who is at risk of, or has undergone FGM;
- Gather intelligence through local force, national and international intelligency e.g. Police National Database (PND). Consider checks with Partnership Force who hold potentially relevant information and can advise on status;
- Consider the risk to the girl or young women, or other siblings and relatives, where a child is at risk of, or has undergone, FGM;
- If you believed that a girl could be at immediate risk of significant harm consider the use of police protection powers (section 46 of the Children Act 1989).

8.5 The role of Education

- Speak to your designated safeguarding lead or school nurse if you have any concerns about a child. They should be able to offer advice on contacting children's social services or the police;
- As an education professional, you can refer a case to Children's Social Care or the Police;
- Keep Children's Social Care/Police informed with any further information if you refer a case;
- Identify girls who may be at risk in school, based on their countries of origin. Identify any familial links, i.e. sisters, cousins, etc;
- Be aware of language barriers and do not use family members as interpreters;
- Raise awareness about FGM and the law in the school. Display the number of the FGM helpline in toilets;
- Be observant regarding prolonged holidays or absences, notes excusing from participation in PE, etc;
- Seek specialist training for your staff and students by suitable providers (for a list of training resources and providers consult the online resource pack https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack)
- Take steps to engage with local communities, including working with community agencies to educate on FGM;
- Consider the most appropriate way to educate and communicate FGM for your school's demographic. It can be included as part of formal lessons or one to one/small group conversations;
- Incorporate FGM into safeguarding policies and training;

- Work with other professionals and agencies to prevent FGM, including health professionals, welfare officers, Children's Centres, Children's Social Work Service and the Police
- Do not remove a child from the schools register after prolonged or unexplained absences.

APPENDIX ONE **FEMALE GENITAL MUTILATION (FGM) - PATHWAYS**



SECTION 74 OF THE SERIOUS CRIME ACT 2015