



Home Office

# **Annex A: Draft Multi-Agency Statutory Guidance on Female Genital Mutilation (for consultation)**

# CHAPTER ONE: STATUS AND PURPOSE OF THIS DOCUMENT

This guidance is issued as statutory guidance under section 5C(1) of the Female Genital Mutilation Act 2003 (as amended by the Serious Crime Act 2015). Section 5C(1) states:

“(1)The Secretary of State may issue guidance to whatever persons in England and Wales the Secretary of State considers appropriate about—

- (a)the effect of any provision of this Act, or
- (b)other matters relating to female genital mutilation.

(2)A person exercising public functions to whom guidance is given under this section must have regard to it in the exercise of those functions.

(3)Nothing in this section permits the Secretary of State to give guidance to any court or tribunal.”

As statutory guidance issued under section 5C of the 2003 Act, a person exercising public functions to whom this guidance is given must have regard to it in the exercise of those functions. This means that a person to whom the guidance is given must take the guidance into account and, if they decide to depart from it, have clear reasons for doing so.

Female genital mutilation (FGM) is a criminal offence – it is child abuse and a form of violence against women and girls, and therefore should be treated as such. Cases should be dealt with as part of existing child and adult safeguarding/protection structures, policies and procedures.

## AUDIENCE

This multi-agency statutory guidance should be read and followed by all persons and bodies in England and Wales who are under statutory duties to make arrangements to discharge their functions having regard to the need to safeguard and promote the welfare of children<sup>1</sup>. Such persons and bodies include: local authorities and district councils, NHS service providers including GP practices, the police, governing bodies of maintained schools and further education colleges, and proprietors of independent schools (including Academies and free schools) and non-maintained special schools. Professionals working in agencies with these duties are responsible for ensuring that they fulfil their role and responsibilities in a manner consistent with the statutory duties of their employer.

The information within this guidance 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.

This guidance extends to England and Wales only.

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<sup>1</sup> For example, under section 11(1) or section 28(1) of the Children Act 2004, section 175(2) of the Education Act 2002; paragraph 7(a) of the Schedule to the Education (Independent School Standards) Regulations 2014 and paragraph 3 of the Schedule to the Education (Non-Maintained Special Schools) (England) Regulations 2011.

## AIMS

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

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

It also includes guidance on the amendments to the FGM Act 2003 introduced by the Serious Crime Act 2015, including the mandatory duty to notify the police of cases of FGM in under 18s.

## PRINCIPLES SUPPORTING THE GUIDANCE

It is acknowledged that some FGM practising families do not see it as an act of abuse (for more information, see Section 2.8) but it is a crime that must never be excused, accepted or condoned. 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 2.4);
- responding to FGM is not a matter that can be left to chance or personal choice – it is an extremely harmful practice. Professionals should not let fears of being branded ‘racist’ or ‘discriminatory’ weaken the protection and support required by vulnerable girls and women. Nor should they avoid asking questions. This is a sensitive subject, but professionals should not be afraid of causing embarrassment;
- accessible, high quality and sensitive health, education, police, social care and voluntary sector services must underpin any and all interventions;
- as an often embedded ‘cultural practice’, engagement with families and communities will be required to achieve the long-term abandonment and eradication of FGM; and
- all decisions or plans should be based on high quality assessments (which follow the principles and parameters of good assessments outlined in *Working Together to Safeguard Children*<sup>2</sup> statutory guidance in England, and the Framework for the Assessment of Children in Need and their Families in Wales) and be sensitive to the issues of race, culture, gender, religion and sexuality. They should avoid stigmatising the girl or woman affected and the practising community as far as possible, given the other principles above.

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<sup>2</sup> <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

# CHAPTER TWO: UNDERSTANDING THE ISSUES AROUND FGM

## SUMMARY

- FGM is illegal in the UK. For the purpose of the criminal law in England and Wales (and Northern Ireland), FGM is mutilation of the labia majora, labia minora or clitoris.
- FGM is prevalent in 28 African countries as well as in parts of the Middle East and Asia.
- It is estimated that approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM<sup>3</sup>.
- 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.

## 2.1 WHAT IS FGM?

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

## 2.2 TYPES OF FGM

FGM has been classified by the World Health Organisation 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; and
- 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.

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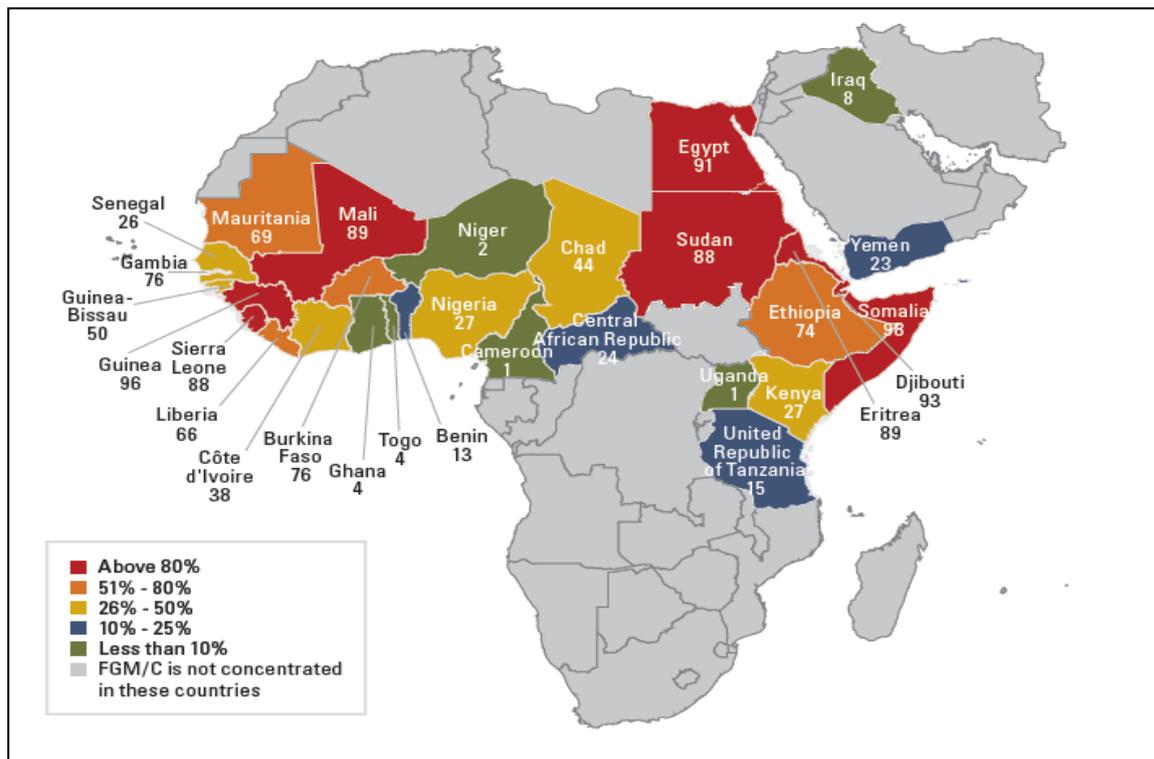
<sup>3</sup> Macfarlane A, Dorkenoo E. Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk. Interim report on provisional estimates. London: City University London and Equality Now, 2014.

The age at which girls undergo FGM varies enormously according to the community. **The procedure may be carried out when the girl is newborn, during childhood or adolescence, just before marriage or during the first pregnancy.**

## 2.3 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 Organisation estimates that between 100 and 140 million girls and women worldwide have experienced FGM and around 3 million girls undergo some form of the procedure each year in Africa alone. FGM has also been documented in communities in **Iran, Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan**

FIGURE 1: PREVALENCE OF FGM AMONG WOMEN AGED 15-49 IN AFRICA AND THE MIDDLE EAST<sup>4</sup>



## 2.4 UK OFFENCES OF FGM

FGM is illegal in the UK. In England and Wales (and Northern Ireland), criminal and civil legislation on FGM is contained in the Female Genital Mutilation Act 2003 (“the 2003 Act”); in Scotland, FGM legislation is contained in the Prohibition of Female Genital Mutilation (Scotland) Act 2005.

<sup>4</sup> Source: UNICEF (July 2013), global databases based on data from Multiple Indicator Cluster Survey, Demographic and Health Survey and other national surveys, 1997–2012.11

Under section 1 of 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 surgical operations performed by a registered medical practitioner on physical and mental health grounds; or an operation performed by a registered medical practitioner or midwife (including 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 2003 Act.

Other than in the excepted circumstances, it is an offence for **any person<sup>5</sup> (regardless of their nationality or residence status)** to:

- perform FGM in England and Wales (section 1 of the Act);
- assist a girl to carry out FGM on herself in England and Wales (section 2 of the Act); and
- assist (from England and Wales) a non-UK person to carry out FGM outside the UK on a **UK national or UK resident<sup>6</sup>** (section 3 of the Act).

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

**Any person found guilty of an offence under section 1, 2, or 3 of the 2003 Act is liable to a maximum penalty of 14 years' imprisonment, or a fine, or both.**

### 2.4.1 OFFENCE OF FAILING TO PROTECT A GIRL AT RISK FROM FGM

Section 3A of the 2003 Act<sup>7</sup> provides for an offence of failing to protect a girl from the risk of FGM. This means that if an offence under section 1, 2 or 3 of the FGM Act is committed against a girl under the age of 16, each person who is responsible for the girl at the time the FGM occurred could be liable under the offence.

The term "responsible" covers two classes of person:

- a person who has "parental responsibility" for the girl and has "frequent contact" with her); and
- a person aged 18 or over who has assumed responsibility for caring for the girl "in the manner of a parent".

Parental responsibility is defined in section 2 of the Children Act 1989 (in the case of England and Wales), and includes mothers, fathers married to the mothers at the time of the child's birth, guardians, and persons named in a Child Arrangements Order.

The requirement in the first case for "frequent contact" is intended to ensure that a person who, in law, has parental responsibility for a girl, but who in practice has little or no contact with her, would not be liable. For example, where the parents of a girl were separated and lived apart with one parent having little or no contact with the daughter, the intention is that that parent would not be liable for the offence.

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<sup>5</sup> The provisions in sections 1, 2 and 3 of the Act apply to Northern Ireland also.

<sup>6</sup> A "UK resident" is defined as an individual who is habitually resident in the UK"

<sup>7</sup> As inserted by section 72 of the Serious Crime Act 2015

Similarly, the requirement in the second case that the person should be caring for the girl “in the manner of a parent” is intended to ensure that a person who is looking after a girl for a very short period – such as a babysitter – would not be liable. A person who has assumed responsibility for caring for the girl in the manner of a parent may include, for example, grandparents with whom the girl has gone to stay for an extended summer holiday. In such circumstances, those persons with parental responsibility for the girl would continue to be liable for the offence.

In either case, liability for the offence is subject to two statutory defences. The first defence is that the defendant did not think that there was a significant risk of FGM being committed, and they could not reasonably have been expected to be aware of such a risk. The second defence is that the defendant took such steps as he or she could reasonably have been expected to take to protect the girl from becoming a victim of FGM. If the defendant produces sufficient evidence of either defence, the onus would then be on the prosecution to prove that the defence does not apply.

What constitutes reasonable steps would depend on the circumstances of the case. For example, the steps considered reasonable for a woman to take in the case where her overbearing and violent husband has arranged for FGM to be carried out on their daughter will differ from those taken by a woman who is not subject to those pressures. Whether commensurate steps have been taken will need to be assessed on a case-by-case basis.

**Any person found guilty of an offence under section 3A of the 2003 Act is liable to a maximum penalty of 7 years’ imprisonment, or a fine, or both.**

## 2.4 FGM TAKING PLACE OVERSEAS

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

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

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

Section 4(1A) of the 2003 Act provides that an offence under section 3A can be committed wholly or partly outside the UK by a person who is a UK national or UK resident.

## 2.6 PREVALENCE OF FGM IN THE UK

The prevalence of FGM in the UK is difficult to estimate because of the hidden nature of the crime. However, a 2014 study<sup>8</sup> estimated that:

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

The Health and Social Care Information Centre published experimental statistics from October 2014 to April 2015. The Female Genital Mutilation Prevalence Dataset (ISB 1610<sup>9</sup>) was a monthly return of data from acute hospital providers in England. It is an aggregated return of the incidence of FGM, including women who have been previously identified and are currently being treated (for FGM related or non-FGM related conditions as at the end of the month) and newly identified women within the reporting period.

For the period of September 2014 to March 2015:

- 3,963 newly identified cases<sup>10</sup> of FGM reported nationally; and
- 60 newly identified<sup>11</sup> cases of FGM reported nationally were under the age of 18.

There is 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 2.3). The statistics published from the NHS information collection support this. 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 terms '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 and Section 4.3 for advice about how to talk about FGM.

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<sup>8</sup> Macfarlane A, Dorkenoo E. Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk. Interim report on provisional estimates. London: City University London and Equality Now, 2014.

<sup>9</sup> <http://www.hscic.gov.uk/isce/publication/SCCI2026>

<sup>10</sup> Patients identified as having a history of any FGM type prior to the reporting period and still being actively seen/treated for FGM-related conditions or any other non-related condition at the end of the month. Note: does not include those patients within NUMBER OF PATIENTS WITH FGM NEWLY IDENTIFIED IN REPORTING PERIOD (i.e. identified within this reporting period).

<sup>11</sup> Patients first identified during the reporting period as having undergone FGM. This will include those diagnosed/identified within the provider within the month. All statistical publication from the *ISB 1610 FGM Prevalence Dataset* are published at [www.hscic.gov.uk/fgm](http://www.hscic.gov.uk/fgm).

## 2.8 CULTURAL UNDERPINNINGS AND MOTIVES OF FGM

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

### Reasons given for practising FGM:

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

FGM is often seen as a natural and beneficial practice carried out by an otherwise loving family who believe that it is in a girl 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.

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.

These reasons, cultural or apparently linked to religion, are based on misunderstanding or lack of awareness.

## 2.9 FGM PROCEDURE

*“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.”<sup>12</sup>”*

Those who support the practice have sought to eliminate risks of infection in order to legitimise FGM. While infection and health risks immediately after the procedure are a real consideration, the longer term psychological and physical effects will persist regardless of how the procedure was done.

## 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 IMPLICATIONS FOR A GIRL’S HEALTH AND WELFARE FELT IMMEDIATELY OR SHORTLY AFTER THE PROCEDURE

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

- severe pain;
- emotional and psychological shock;
- 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; and/or
- death.

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<sup>12</sup> 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.

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

The long-term health implications of FGM can include:

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

## 2.11 PSYCHOLOGICAL AND MENTAL HEALTH PROBLEMS

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

Young women receiving psychological counselling in the UK have reported feelings of betrayal by parents, incompleteness, regret and anger<sup>13</sup>. There is increasing awareness of the severe psychological consequences of FGM for girls and women, which can become evident in mental health problems, drug and alcohol dependency.

The results from research<sup>14</sup> in practising African communities are that women who have had FGM have the same levels of Post Traumatic Stress Disorder (PTSD) as adults who have been subjected to early childhood abuse, and that the majority of the women (80 per cent) suffer from affective (mood) or anxiety disorders.

The fact that FGM is 'culturally embedded' in a girl's or woman's community does not protect her against the development of PTSD and other psychiatric disorders. Professionals, particularly those in the health sector, should ensure that mental health support is made available to assist girls and women who have undergone FGM, as well as treatment for any physical symptoms or complications.

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<sup>13</sup> Haseena Lockhat (2004) *Female Genital Mutilation: Treating the Tears*, London: Middlesex University Press

<sup>14</sup> Behrendt, A. et al (2005) Posttraumatic Stress Disorder and Memory Problems after Female Genital Mutilation, *American Journal of Psychiatry* 162:1000–1002, Ma

# CHAPTER THREE: IDENTIFYING GIRLS AND WOMEN AT RISK

Professionals in all agencies, and individuals and groups in relevant communities, need to be alert to the possibility of a girl or woman being at risk of, or already having undergone, FGM. **There is a range of potential indicators that a child or young person may be at risk of FGM. The indicators need to be considered in relation to the overall situation of a child and whether as a whole 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 2.3 for the nationalities that traditionally practise FGM), but more recently there have been reports of individuals marrying into practising communities and having to go through FGM.

Girls and women at risk of FGM may not yet be aware of the practice or that it may be conducted on them, or that they have already undergone FGM. Discussions about FGM should always be undertaken with appropriate care and sensitivity.

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

There is a number of factors in addition to a girl's or woman's community or country of origin that could indicate a risk that she will be subjected to FGM. Risk must be considered if:

- a female child is born to a woman who has undergone FGM;
- a female child has an older sibling or cousin who has undergone FGM;
- the family indicate that there are strong levels of influence held by elders and/or elders are involved in bringing up female children;
- girl/family has limited level of integration within UK community;
- girl/women repeated fail to attend or engage with health and welfare services;
- the mother of a girl is very reluctant to undergo genital examination; and/or
- any girl from a practising community is withdrawn from Sex and Relationship Education or its equivalent may be at risk as a result of her parents wishing to keep her uninformed about her body and rights.

Organisations may wish to consider adopting the risk assessment processes within the Department of Health guidance, *Female Genital Mutilation Risk and Safeguarding; Guidance for professionals*<sup>15</sup>

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<sup>15</sup>[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/418564/2903800\\_DH\\_FGM\\_Accessible\\_v0.1.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf)

## 3.2 INDICATIONS THAT FGM MAY BE ABOUT TO TAKE PLACE

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.**

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 likely 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 be other signs that FGM may be imminent. Professionals must look out for risk factors such as the below, and take appropriate action if identified:

- if a female family elder is present, particularly when she is visiting from a country of origin, and taking a more active / influential role in the family;
- if there are references 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. Opportunities to discuss this may be within the school environment or travel clinics when asking for vaccinations in preparation of travel;
- a girl may talk about a long holiday to her country of origin or another country where the practice is prevalent (see Section 2.3 for the nationalities that traditionally practise FGM); and/or
- parents seeking to withdraw their children from learning about FGM.

## 3.3 INDICATIONS THAT FGM MAY HAVE ALREADY TAKEN PLACE

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

- the girl or woman receives the care and support she will need to deal with the effects 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; and/or
- 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 has difficulty walking, sitting or standing and may appear to be uncomfortable;
- a girl or woman spends longer than normal in the bathroom or toilet due to difficulties urinating. A girl spends long periods of time away from a classroom during the day with bladder or menstrual problems;
- a girl or woman has frequent urinary, menstrual or stomach problems;
- there may be prolonged or repeated absences from school or college;
- increased emotional and psychological needs for example withdrawal or depression, or significant change in behaviour;
- a girl or woman is reluctant to undergo any medical examinations;
- a girl or woman asks for help, but may not be explicit about the problem; and/or
- a girl talks about pain or discomfort between her legs.

# CHAPTER FOUR: REPORTING RESPONSIBILITIES AND GOOD PRACTICE

## 4.1 MANDATORY REPORTING DUTY

**THE MANDATORY REPORTING DUTY WILL COME INTO FORCE IN AUTUMN 2015. PROCEDURAL GUIDANCE FOR THOSE SUBJECT TO THE DUTY ON THE PROCESS FOR REFERRALS WILL BE ISSUED SEPARATELY.**

Section 5B of the FGM Act 2003 (“the 2003 Act”)<sup>16</sup> introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report ‘known’<sup>17</sup> cases of FGM in under 18s to the police.

The duty applies to all regulated professionals (as defined in section 5B(2)(a), (11) and (12) of the 2003 Act) working within healthcare or social care, and teachers. It therefore covers:

- healthcare professionals regulated by a body which is overseen by the Professional Standards Authority for Health and Social Care (with the exception of the Pharmaceutical Society of Northern Ireland). This includes doctors, nurses, midwives, and, in England, social workers;
- teachers<sup>18</sup>; and
- social care workers in Wales.

The duty applies where, in the course of their professional duties, the professional either:

- is informed by the girl that an act of FGM has been carried out on her; or
- observes physical signs which appear to show an act of FGM has been carried out and has 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.

Where a professional discovers such a case, they must make a report to the police force in the area where the girl resides, either orally or in writing, within one month. However, the working expectation is that the report should be made by the close of the next working day. **The duty to report does not breach any confidentiality requirement or other restriction on disclosure which might otherwise apply.**

Professionals will be expected to carry out this duty in line with existing safeguarding standard practice. For example, professionals will need to record the decisions they have made, and inform local safeguarding leads in their organisation of action taken. Professionals will also need to discuss the report and what it means and what action the family can expect to follow at the appropriate time.

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<sup>16</sup> As inserted by section 74 of the Serious Crime Act 2015

<sup>17</sup> “Known” cases are those where either a girl informs the person that an act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was, or was part of, a surgical operation within section 1(2)(a) or (b) of the FGM Act 2003.

<sup>18</sup> Section 5B(11) of the FGM Act 2003 (as inserted by section 74 of the Serious Crime Act 2015) provides the definition for the term “teacher”.

The duty does not apply in relation to at risk or suspected cases or over 18s. However, professionals must follow appropriate safeguarding procedures whenever they identify safeguarding concerns around FGM or, indeed, any other form of abuse. In addition, the duty does not apply if a professional can identify that another individual working in the same profession has previously made a report to the police in connection with the same act of FGM<sup>19</sup>.

While the duty is limited to the specified professionals described above, non-regulated practitioners still have a general responsibility to report cases of FGM (whether these are disclosed or visually identified, or suspected, or at risk), in line with wider safeguarding frameworks.

### 4.1.1 FAILURE TO COMPLY WITH THE DUTY

Cases of failures to comply with the duty will be dealt with in accordance with existing disciplinary procedures in place each profession.

For health or social care professionals, breaches of the duty may result in fitness to practice proceedings by the regulator with whom the professional is registered, for example, the General Medical Council for doctors and Health and Care Professions Council for social workers (in England). This can result in a wide variety of recommendations as to suitable action (e.g. re-training or supervision).

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

Employers and the professional regulators are expected to pay due regard to the seriousness of breaches of the duty.

### 4.1.2 GOOD PRACTICE

If you are worried about a girl under 18 who is either at risk of FGM or who you suspect may have had FGM, you should<sup>20</sup> share this information with social care or the police, whichever is most appropriate.

In addition, if your profession is one which falls outside the mandatory reporting duty and you become aware that FGM has been carried out on a girl under 18, you should still share this information within your local safeguarding lead, and follow your organisation's safeguarding procedures.

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<sup>19</sup> For these purposes, professionals regulated by a body which belongs to the Professional Standards Authority for Health and Social Care are considered as belonging to the same profession.

<sup>20</sup> in cases that fall under the mandatory reporting duty provided for by section 5B of the FGM Act 2003 must be referred to the police.

## 4.2 DUTY TO SAFEGUARD CHILDREN

Certain organisations are obliged to make arrangements to discharge their functions having regard to the need to safeguard and promote the welfare of children<sup>21</sup>. Safeguarding girls at risk of harm of FGM poses specific challenges because it is often at the birth of a female child when the potential risk is identified, but the risk of FGM may become imminent either days after her birth, or it may not become imminent until she is 5 years old, or any later age. This means that professionals need to identify and share the information that a girl may be at risk of FGM when this is known, and make sure that all professionals remain alert to a change in the situation which might highlight an increased or imminent risk. However challenging it is to identify and protect girls at risk of FGM, **it is important that all professionals act to safeguard girls at risk**, consistent with the statutory duties of their employer.

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

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

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

Where professionals believe that an individual has undergone FGM, they should 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, these girls and young women may also be at significant risk of harm.

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

As described in Sections 2.4, it is unlawful for any person to perform FGM, or to assist a girl or woman to perform FGM on herself, in England or Wales<sup>22</sup>. It is also an offence for a UK national or UK residents to perform FGM, or to assist a girl to perform FGM on herself, abroad.

In addition, it is an offence for a UK national or 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 an FGM Protection Order, 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.

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<sup>21</sup> See sections 11 and 28 of the Children Act 2004 for details of the bodies in England and Wales, respectively, with a duty to safeguard and promote the welfare of children; similar duties apply to other bodies, e.g. the UK Border Agency under section 55 of the Borders, Citizenship and Immigration Act 2009; schools and further education colleges under section 175(2) of the Education Act 2002, paragraph 7(a) of the Schedule to the Education (Independent School Standards) Regulations 2014 and paragraph 3 of the Schedule to the Education (Non-Maintained Special Schools) (England) Regulations 2011.

<sup>22</sup> Northern Ireland also.

## 4.3 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;

√√ use simple language and ask straightforward questions such as:

- “Have you been closed?”
- “Were you circumcised?”

√√ be direct, as indirect questions can cause the woman or girl to have to relive the experience when she may not be fully supported, and cause further emotional trauma or trigger a flashback. Having asked directly with sensitivity, 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?”

√√ make no assumptions;

√√ give the individual time to talk and be willing to listen;

√√ create an opportunity for the individual to disclose, for example, 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 her parents;

√√ be non-judgemental (pointing out the illegality and health risks of the practice, but not blaming the girl/woman);

√√ get accurate information about the urgency of the situation if the individual is at risk of being subjected to the procedure;

√√ ensure a detailed record is made and kept;

√√ record FGM in the patient’s healthcare record, as well as details of any conversations;

√√ be aware that a women or girl may not be aware that she has had FGM;

√√ give the message that the individual can come back to you at another time if they wish;

√√ give a very clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM if/when they have daughters;

√√ explain the health consequences of FGM; and

√ offer support for example counselling, NHS FGM clinics/services, “Statement Opposing FGM leaflet” etc.

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

Professionals may need to consider developing a safety and support plan in case the woman is seen by someone ‘hostile’ at or near the department, venue or meeting place, e.g. agree another reason why they are there. If they insist on being accompanied during the interview, e.g. by a teacher or advocate, ensure that the accompanying person understands the full implications of confidentiality, especially with regard to the person’s family (see Section 4.6 for more details about disclosure). For some, an interview may require an authorised accredited interpreter who speaks their dialect.

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

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

*“Sometimes when circumcised women go to the hospital, the nurses call each other to see the circumcised woman. This is an unhappy experience for many women. The nurses ask a lot of questions and they stare.”<sup>23</sup>*

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.

All NHS employees can complete the e-learning session, ‘Communication Skills for FGM consultations’ at [www.e-lfh.org.uk](http://www.e-lfh.org.uk) which provides advice and training to support these discussions.

Professionals can watch a video on NHS Choices where women who have had FGM discuss how they would like to see professionals hold sensitive conversations about FGM: <http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Pages/fgm-for-professionals.aspx>

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<sup>23</sup> 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.

## Remember:

- a girl may wish to be interviewed by a female professional;
- she may not want to be seen by a professional from her own community;
- alerting the girl's or woman's family to the fact that she is disclosing information about FGM may place her at increased risk of harm;
- develop a safety and support plan in case the girl/woman is seen by someone 'hostile' at or near the department, venue or meeting place, e.g. agree another reason why they are there. If they insist on being accompanied during the interview, e.g. by a teacher or advocate, ensure that the accompanying person understands the full implications of confidentiality, especially with regard to the person's family (see Section 4.6 for more details about disclosure). For some, an interview may require an authorised accredited interpreter who speaks their dialect; and
- 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.”<sup>24</sup>*

## 4.4 THINGS TO BE AWARE OF IN DEALING WITH CASES OF FGM

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

**Children:** FGM is child abuse and should be dealt with as such. Professionals must always respond by complying with local safeguarding procedures if anyone is concerned that they may have identified a child at risk of FGM. Regulated health and social care professionals and teachers are subject to a mandatory reporting duty which requires them to report 'known' cases of FGM they discover in under 18s to the police (see section 4.1).

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<sup>24</sup> 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.

**Adults:** It is important to note that, as with domestic violence and rape, if an adult woman has had FGM and this is identified through the delivery of NHS healthcare, the patient's right to confidentiality should be respected if they do not wish to take the matter any further with the police. Professionals should also remain aware if the adult with whom they are in contact is at risk of further risk of abuse, for example, if she is at risk of reinfibulation, and, if so, must consider what adult safeguarding actions should be undertaken. However, in all circumstances, professionals must consider whether the adult with FGM has girls in her immediate or wider family who may be at risk of or have potentially also undergone FGM. If other girls or women are identified, appropriate safeguarding actions must be taken, which may mean that details of the woman are provided to the social services and/or police as part of safeguarding actions. If, having considered the wider situation, there are no women or girls identified as needing help and support, and there is no overriding public interest identified, it is the woman's decision whether or not a report is made to social services or the police.

For many people, taking forward a prosecution against a member or members of their family is something they simply will not consider. If the girl or woman is from overseas, fleeing potential FGM and applying to remain in the UK as a refugee is a complicated process and may require professional immigration advice (see <https://www.gov.uk/claim-asylum> for more information about the asylum application process).

Many individuals, especially women, may be 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.

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

## 4.5 MEDICAL EXAMINATIONS

In some cases, a female may need to be examined. Professionals should contact a health professional, either a local FGM service or the GP of the individual in question, to assess what the appropriate health pathway would be. It may also be appropriate to help the female understand what services are on offer, how they can access them, and support them to make contact.

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

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

It is mandatory for health professionals to document in their healthcare record if a patient has FGM whenever it is identified in the course of NHS treatment.

## 4.6 DISCLOSURE AND CONFIDENTIALITY

To safeguard children and young people in line with relevant statutory requirements and guidance it may be necessary to give information to people working in other agencies or departments.

The **law allows 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.

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, 2015)<sup>25</sup>;
- Nursing and Midwifery Council's advice on confidentiality (2009);
- information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers (HMG 2015);
- General Medical Council's guidance on confidentiality (2009); and
- guidance on the Management of Police Information <http://www.app.college.police.uk/> .

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

## 4.7 A VICTIM-CENTRED APPROACH

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

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

## 4.8 FORCED MARRIAGE AND FGM

There have been reports of cases where individuals have been subjected to both FGM and forced marriage<sup>26</sup>. If a professional has a concern about an individual who may be at risk of both practices, they should consult the multi-agency practice guidelines on handling cases of forced marriage. These can be found at: <https://www.gov.uk/forced-marriage#guidance-for-professionals>

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

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<sup>25</sup> <https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2>

<sup>26</sup> Civil protection for (potential) victims of forced marriage is covered by the Forced Marriage (Civil Protection) Act 2007

# CHAPTER FIVE: LEGAL INTERVENTIONS

**FGM is illegal throughout the UK (see Section 2.4 for more details), though this guidance sets out expectations and advice on the response in England and Wales. It 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 sets out the relevant statutory procedures that may be used in cases of FGM.

## 5.1 POLICE PROTECTION

Children's social care may approach the police and ask for their assistance in undertaking a joint investigation. The way in which this is to be handled should be covered in the procedures prepared by the Local Safeguarding Children Board and in accordance with *Working Together to Safeguard Children* in England or *Safeguarding Children: Working Together Under the Children Act 2004* in Wales. A joint approach can be particularly effective 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 would otherwise be likely to suffer significant harm, a police officer may (with or without the cooperation of social care) remove that child 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 who must assist in finding safe and secure accommodation for the girl or young woman if requested to do so. Children's social care must assist the police, 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.

Children's social care must commence child protection enquiries under section 47 of the Act when they are informed that a child who lives, or is found in their area, is in police protection<sup>27</sup>.

Children's social care may apply for an Emergency Protection Order (EPO) (see Section 5.3) at any point within the 72 hours if there is reasonable cause to believe the child is likely to suffer significant harm if she is not removed to accommodation provided by or on behalf of the local authority or does not remain in the place in which she is then being accommodated. The police have the power to make their own application for an EPO on behalf of the relevant local authority, but as a matter of practice this is done by children's social care.

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<sup>27</sup> Section 47(1)(a)(ii) of the Children Act 1989

## 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 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 under protection, but this does not have to be granted if it is not, in the opinion of the officer designated for the purposes of section 46, both reasonable and in the best interests of the child, 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 under police protection;
- a girl may wish to see a female police officer;
- the girl may, or may not, want to see a police officer from her own community – try to give the child the choice;
- in all cases, ensure that the child protection register has been checked; and
- the police do not have parental responsibility with respect to the child while it is under police protection, but they must do what is reasonable in the circumstances for the purposes of safeguarding or promoting its welfare.

## 5.2 FGM PROTECTION ORDERS

Section 5A of and Part 1 of Schedule 2 to the FGM Act 2003 (“the 2003 Act”)<sup>28</sup> provide for the making of FGM Protection Orders (FGMPOs) in England and Wales<sup>29</sup>.

An FGMPO is a civil order which may be made for the purposes of protecting a girl<sup>30</sup> against the commission of an FGM offence – that is, protecting a girl at risk of FGM - or protecting a girl against whom an FGM offence has been committed. In deciding whether to make an order a court must have regard to all the circumstances of a case including the need to secure the health, safety and well-being of the potential or actual victim. The court can make an order which prohibits, requires, restricts or includes any other such other terms as it considers appropriate to stop or change the behaviour or conduct of those who would seek to subject a girl to FGM or have already arranged for, or committed, FGM on a victim.

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<sup>28</sup> As inserted by section 73 of the Serious Crime Act 2015

<sup>29</sup> Part 2 of Schedule 2 to the 2003 Act makes similar provision in Northern Ireland.

<sup>30</sup> “girl” is used throughout this section, but by virtue of section 6(1) of the 2003 Act, “girl” includes woman’, i.e. a woman of any age can be protected by an FGMPO.

Examples of the types of orders the court might make are:

- to protect a victim or potential victim at risk of FGM from being taken abroad;
- to order the surrender of passports or any other travel documents, including the passport/travel documentation of the girl to be protected;
- to prohibit specified persons from entering into any arrangements in the UK or abroad for FGM to be performed on the person to be protected;
- to include terms which relate to the conduct of the individuals named in the order both inside and outside of England and Wales; and
- to include terms which cover individuals who are, or may become involved in other respects (or instead of the original respondents) and who may commit or attempt to commit FGM against a girl.

Orders may also be made against other people, who may not be named in the application. This is in recognition of the complexity of the issues and the numbers of people who might be involved in the wider community.

### 5.2.1 APPLICATIONS

An application for a FGMPO can be made to the High Court or the family court by the person to be protected (the victim), or a “relevant third party” (a person or body specified, or in a class specified by the Lord Chancellor for this purpose) without the leave of the court. Local authorities have been specified as a “relevant third party”<sup>31</sup>. An application can also be made by ‘any other person’ with the leave of the court. In deciding whether to grant leave, the court must have regard to all the circumstances, including the applicant’s connection with, and knowledge of, the circumstances of the girl.

A court can also make an FGMPO without application being made to it in certain family proceedings. In addition, a criminal court can also make an FGMPO, without application, in criminal proceedings for a genital mutilation offence where the person who would be a respondent to any proceedings for an FGMPO is a defendant in the criminal proceedings. An FGMPO can be made in such criminal proceedings to protect a girl at risk, whether or not they are the victim of the offence in relation to the criminal proceedings. For example, the younger sister of the victim of a genital mutilation offence could also be protected by the court in criminal proceedings.

An application for a FGMPO is not an alternative to the work of the police and Crown Prosecution Service investigating and prosecuting crimes. Crimes may be investigated and offenders prosecuted at the same time as an application is made for an FGMPO or an order is in force.

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<sup>31</sup> SI 2015 No. 1422

## 5.2.2 CONDITIONS OF AN ORDER

The terms of an FGMPO may relate to conduct inside and/or outside of England and Wales (or Northern Ireland).

An FGMPO may be made for a specified period or until varied or discharged.

A copy of the order must be provided to the police.

For relevant third parties, once a FGMPO is in place it is essential that local authorities work closely with the victim and the relevant support service, if there is one, to ensure it offers the level of protection that was envisaged. Links need to be established with other agencies, in particular the police, to ensure ongoing support is available to victims as needed.

## 5.2.3 BREACH

Breach of an FGMPO is a criminal offence with a maximum penalty of up to 5 years' imprisonment. As an alternative to prosecution, a breach of an FGMPO may be dealt with by the civil route as a contempt of court, punishable by up to 2 years' imprisonment, a fine, or both.

If the police investigate a possible breach as a criminal offence, they can arrest those suspected of breaching the terms of the order. Following a police investigation, the Crown Prosecution Service will decide whether to proceed with a prosecution for the breach and/or any other offences that might be disclosed. Where the decision is taken, however, to pursue breach as a contempt of court matter, an application should be made to the family court for an arrest warrant. This should be supported by a statement setting out how the order has been breached. The order will need to be served on the respondents.

Although FGMPOs are specifically designed to protect actual or potential victims of FGM, one or more of the orders or applications in Sections 5.3 to 5.7 may also be considered alongside an FGMPO, depending on the particular circumstances of each case. Referral to an accredited family law practitioner to deal with wider issues of private or public family law may be equally important to meet the girl's needs.

## **5.3 EMERGENCY PROTECTION ORDERS (EPO) UNDER SECTION 44 OF THE CHILDREN ACT 1989**

An application for an EPO 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 can only be granted in specific circumstances:

(a) where any applicant makes an application for an EPO, the court can only grant the EPO if there is reasonable cause to believe that the child is likely to suffer significant harm if she is not removed to accommodation provided by or on behalf of the applicant; or she does not remain in the place in which she is then being accommodated; or

(b) where the application is being made by the local authority when it is undertaking section 47(1)(b) enquiries, the court must be satisfied that this is because the section 47 enquiries are being frustrated by access to the child being unreasonably refused to a person authorised to seek access and that the applicant has reasonable cause to believe that access to the child is required as a matter of urgency; or

(c) where the application is made by the NSPCC, the court must be satisfied that the NSPCC has reasonable cause to believe the child is suffering, or likely to suffer, significant harm, and that enquiries being made by the NSPCC are being unreasonably refused to a person authorised to seek access and the NSPCC has reasonable cause to believe that access to the child is required as a matter of urgency.

An EPO authorises the applicant to remove the girl and keep her in safe accommodation, but this power can only be exercised in order to safeguard the girl's welfare. In addition, the EPO operates to require any person in a position to do so to comply with any request to produce the child to the applicant. An EPO may also include directions as to the medical examination of the child (or that such examinations should not take place), although if the child is of sufficient understanding, she may refuse to submit to such an examination.

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<sup>32</sup> and the local authority must then undertake section 47 enquiries. The local authority has the power, having consulted the applicant and ascertained the wishes and feelings of the child, to take over the order and responsibility for the child (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. In exceptional cases, where the application is particularly urgent, it can be made by telephone. Where an EPO is granted as a result of such an application, any person who has actual care of the child or who had such care immediately prior to the making of the order must be informed of the EPO having been granted within 48 hours<sup>33</sup>.

## Remember:

- An EPO is open to challenge by the child's parents or any person with parental responsibility, or any person with whom the child was living immediately before the order was made, who may apply to the court for the EPO to be discharged;
- once an EPO is made, the applicant / 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;
- 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, the court should be asked for an order that states there be no contact (or only restricted contact) with the girl's parents or those with whom she was living prior to the EPO having been made during the period of the EPO. If this is not asked for, there is a presumption of reasonable contact. In addition, it is possible to ask the court to include an exclusion requirement in the EPO in specified circumstances<sup>34</sup>; and

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<sup>32</sup> Rule 12.16(5) of the Family Procedure Rules 2010 requires the local authority in whose area the child lives, or is found, to be informed within 48 hours of an EPO having been granted where the application was made without notice.

<sup>33</sup> Rule 12.16(5) of the Family Procedure Rules 2010

<sup>34</sup> See section 44A of the Children Act 1989

- children’s social care has a duty to make enquiries (under section 47) when a child living in their area is the subject of an EPO, 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: court orders (2014).

## 5.4 CARE ORDERS AND SUPERVISION ORDERS

Sometimes an EPO is followed by an application from the local authority for a Care Order or Supervision Order (sections 31 and 38 of the Children Act 1989). Without either a Care Order or an Interim Care Order, once the EPO has lapsed, 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 concerned is suffering, or is likely to suffer, significant harm; and
- the harm, or likelihood of harm, is attributable to the care given to the child, 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 them; or
- the child is beyond parental control.

Note: the term “harm” is defined in section 31(9) of the Children Act 1989 as meaning “ill-treatment or the impairment of health or development including, for example, impairment suffered from seeing or hearing the ill-treatment of another”. This should be taken to include all forms of abuse – physical, sexual, emotional, neglect, 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 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 child 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, as the local authority will have parental responsibility for the child and they may obtain an order that there be no contact with the family and may conceal the whereabouts of the child if that is necessary to ensure adequate protection.

When a Care Order or Supervision Order is not available due to the age of the child, children’s social care should be aware of the opportunities presented by an FGM Protection Order or a Ward of Court Order. A Ward of Court Order is available up to 18 years old. A child who is the subject of a Care Order cannot be made a ward of court. A local authority cannot have a child ‘warded’ without leave of the court under section 100 of the Children Act 1989, the child or an adult friend or advocate can apply for wardship and various injunctions can be attached as required. Very commonly, for a child in fear of being taken abroad, the injunctions will relate to surrendering passports to the court so that the child 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. Only a local authority or an authorised person can apply for a care order in relation to a child:

- a Care Order cannot be made once a child 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 child reaches the age of 18 unless it is discharged before this date;
- whilst a Care Order is in force, no person may cause the child to be known by a new surname or remove the child from the UK, without the written consent of every person who has parental responsibility for the child, or the leave of the court; and
- when a Care Order is not appropriate, an FGM Protection Order (see Section 5.2) or wardship (see Section 5.6) may still be an option.

The parents may agree to the child being voluntarily accommodated by the local authority under section 20 of the Children Act 1989, and sometimes this may be done in a bid to put off care proceedings and also to avoid an interim Care Order being made. When a child or young person is accommodated under section 20, the local authority does not get parental responsibility.

If there is a relative or other adult whom the child can trust, that person could apply for a Child Arrangements Order which makes provision about who the child is to live with. Although the person in whose favour the Child Arrangements Order was made would get parental responsibility for the child as long as the order subsisted, the parents would retain their parental responsibility and would know where the child or was living. However, the holder of the Child Arrangements Order could also apply for a Prohibited Steps Order or a Specific Issue Order to keep the whereabouts of the child or young person undisclosed.

A Supervision Order places a duty on the supervisor to advise, assist and befriend the supervised child, but the order would not give the local authority parental responsibility.

If the child is not in the care of the local authority, it is also possible for a local authority to obtain a Prohibited Steps Order under section 8 of the Children Act 1989 with the leave of the court. Such an order could prohibit the parents from removing the child or young person from the country without the permission of the court. 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.

## 5.5 INHERENT JURISDICTION

A children's social care department may ask the High Court to exercise its inherent jurisdiction to protect the child. Any person with a genuine interest in the child, including the child themselves, a private individual or the Children and Family Court Advisory Support Service (CAFCASS/CAFCASS CYMRU) legal services department can apply to have a child made a ward of court.

A local authority may only apply for an order under the High Court's inherent jurisdiction if it has permission from the court to do so (under section 100 of the Children Act 1989). Leave to apply may only be granted if the court is satisfied that the result the local authority wishes to achieve could not be achieved through the making of any order, other than one under the court's inherent jurisdiction, which the local authority is entitled to apply for; and there is reasonable cause to believe that if the court's inherent jurisdiction is not exercised, the child is likely to suffer significant harm.

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<sup>35</sup>. All 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 child being subjected to FGM. Where there is a fear that a child 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 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.

## 5.6 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<sup>36</sup>, 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. 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.

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<sup>35</sup> See paragraph 1.3 of Practice Direction 12D of the Family Procedure Rules 2010 that provides guidance on the distinguishing characteristics of wardship.

<sup>36</sup> Rule 12.36(1) of the Family procedure Rules 2010

## 5.7 REPATRIATION

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

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

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

### Remember:

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

## 5.8 ANONYMITY OF VICTIMS OF FGM

Section 4A and Schedule 1 of the 2003 Act<sup>37</sup> make provision for the anonymity of victims of FGM in England and Wales (and Northern Ireland). The provisions are modelled on those in the Sexual Offences (Amendment) Act 1992 which protect the anonymity of victims of certain sexual offences, such as rape, as soon as an allegation is made.

The effect of these provisions is to prohibit the publication of any matter that would be likely to lead members of the public to identify a person as the alleged victim of an offence under the 2003 Act (including the offence of failing to protect a girl at risk of genital mutilation under section 3A of the 2003 Act, as well as aiding, abetting, counselling and procuring the “principal offence”). The prohibition lasts for the lifetime of the alleged victim. The prohibition covers not just more immediate identifying information, such as the name and address or a photograph of the alleged victim, but any other information which, whether on its own or pieced together with other information, would be likely to lead members of the public to identify the alleged victim. “Publication” is given a broad meaning and would include traditional print media, broadcasting and social media such as Twitter or Facebook.

### 5.8.1 EXEMPTIONS

There are two limited circumstances where the court may disapply the restrictions on publication:

- the first is where a person being tried for an FGM offence could have their defence substantially prejudiced if the restriction to prevent identification of the person against whom the allegation of FGM was committed is not lifted; and
- the second circumstance is where preventing identification of the person against whom the allegation of FGM was committed could be seen as a substantial and unreasonable restriction on the reporting of the proceedings and it is considered in the public interest to remove the restriction.

### 5.8.2 BREACH OF THE RESTRICTIONS

Contravention of the prohibition on publication is an offence. It will not be necessary for the prosecution to show that the defendant intended to identify the victim. In relation to newspapers or other periodicals (whether in print form or online editions) and radio and television programmes, the offence is directed at proprietors, editors, publishers or broadcasters rather than individual journalists. Any prosecution for the offence requires the consent of the Attorney General or the Director of Public Prosecutions for Northern Ireland as the case may be.

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<sup>37</sup> As inserted by section 71 of the Serious Crime Act 2015

### 5.8.3 DEFENCE

There are two defences:

- the first is where the defendant had no knowledge (and no reason to suspect) that the publication included content that would be likely to identify a victim or that a relevant allegation had been made; and
- the second is where the victim (where aged 16 or over) had freely given written consent to the publication. These defences impose a reverse burden on the defendant, that is, it is for the defendant to prove that the defence is made out on a balance of probabilities, rather than imposing a requirement on the prosecution to show, beyond reasonable doubt, that the defence does not apply.

# CHAPTER SIX: GUIDELINES FOR HEALTH PROFESSIONALS

## 6.1 HOW HEALTH PROFESSIONALS CAN MAKE A DIFFERENCE

Health professionals are key to providing the needed care and support to women with FGM, and taking safeguarding actions to prevent girls and women at risk of FGM from being harmed.

*“They fear that if they tell the midwife or another health professional, that they will not understand our culture and tradition and think that we are illiterate or have bad traditions”<sup>38</sup>*

## 6.2 HEALTHCARE SERVICES OFFERED

Health professionals, particularly nurses and midwives, need to be aware of the care required by women and girls who had FGM. The care needs may become more pressing during labour and childbirth, however as and when a woman or girl presents to health services with FGM, a full assessment of her physical and mental health needs should be undertaken and an appropriate care plan put in place.

Local healthcare commissioners should consider the guidance available in the Department of Health publication, *Commissioning services to support women and girls with FGM*: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/418549/2903842\\_DH\\_FGM\\_Commissioning\\_Accessible.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418549/2903842_DH_FGM_Commissioning_Accessible.pdf).

This document outlines the wider considerations, describing different care delivery models, and what services should be offered, as well as highlighting specific considerations for example, location of services, interpreter services. Development of services should include consultation with community and patient groups, and identify how and when health and third sector organisations can work together to meet the needs of patients and survivors.

All professionals should also be familiar with the full relevant clinical guidance when dealing with any case of suspected FGM.

A women or girl may present at many different care settings. After an initial discussion and having met any urgent health needs, she would often be referred to an FGM service. This may be at a dedicated FGM clinic or may be an appointment at another outpatient clinic, where an appropriately trained professional is able to provide treatment.

The appropriate treatment will depend on the symptoms, type of FGM and whether the woman is pregnant or not.

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<sup>38</sup> 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.

Most women with Type 3 FGM where the vagina is narrowed should be offered de-infibulation. This is a minor surgical procedure to divide the scar tissue sealing the vaginal opening. If the woman is pregnant this is best performed in the second trimester. However, some women prefer to undergo de-infibulation in labour and this should be documented in the medical notes. Most de-infibulation procedures can be performed under local anaesthetic in an outpatient setting with an appropriate healthcare professional. The presence of extensive scarring, clitoral cysts or psychological trauma such as flashbacks may mean that some women require de-infibulation under general anaesthetic, usually as a day case procedure. In pregnant women, a spinal anaesthetic is usually preferred to a general anaesthetic.

Some women and girls will require psychological intervention. It is unlikely that this will be a core component offered at the same location/clinic at most FGM services but clear referral pathways must exist. Mental health input may be provided by various health professionals at different levels depending on the need:

- psychosexual – usually a counsellor;
- psychological – qualified clinical psychologist;
- trauma e.g. Post-traumatic Stress Disorder – psychiatrist;
- family issues (children referred with FGM) – child psychologist/psychotherapist; and/or
- support from third sector organisations with specialist experience of supporting women who have undergone FGM.

Women with gynaecological symptoms such as pelvic or genital pain, incontinence or prolapse and menstrual dysfunction may need referral on to gynaecological services such as general gynaecology and urogynaecology. Clear local referral pathways should exist into established services.

## 6.3 COUNSELLING AND PSYCHOLOGICAL SERVICES

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<sup>39</sup>. 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 research in practising African communities are that women who have had FGM have the same levels of Post-Traumatic Stress Disorder (PTSD) as adults who have been subjected to early childhood abuse, and that the majority of the women (80 per cent) suffer from affective (mood) or anxiety disorders. The fact that FGM is 'culturally embedded' in a girl's or woman's community does not protect her against the development of PTSD and other psychiatric disorders.

Local commissioners must consider the provision of mental health support and services, and that girls and women who have undergone FGM are able to access this treatment as required. The support should be provided following an assessment of individual needs, and clinicians should discuss the care pathway with the patient, however, services should also consider allowing patients to access them directly without the need for a referral.

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<sup>39</sup> Haseena Lockhat (2004) *Female Genital Mutilation: Treating the Tears*, London: Middlesex University Press.

## 6.4 SAFEGUARDING WOMEN AND GIRLS AT RISK

Healthcare organisations and professionals, in line with the multi-disciplinary approach to safeguarding described in chapter 4 need to make sure their local safeguarding frameworks and procedures appropriately reflect what to do when a professional identified a risk of FGM. This must also reflect the mandatory reporting duty to report known cases of FGM in under 18s to the police.

Organisations may wish to consider adopting the risk assessment processes within the Department of Health guidance, *FGM Risk and Safeguarding; Guidance for professionals*: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/418564/2903800\\_DH\\_FGM\\_Accessible\\_v0.1.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf)

FGM is not an issue that can be decided on by personal preference – it is an illegal, extremely harmful practice and a form of child abuse and violence against women and girls.

Each NHS organisation will have local safeguarding protocols and procedures for helping children and young people who are at risk of or facing abuse. These should include multi-agency policies and procedures, consistent with those developed by their Local Safeguarding Children Board. These should recognise handling cases where FGM is alleged or known about, or where a potential risk of FGM is identified.

One specific consideration when putting in place safeguarding measures against FGM is that the potential risk to a girl born in the UK can usually be identified at birth, because through the ante-natal care and delivery of the child, NHS professionals can and should have identified that the mother has had FGM. However, FGM can be carried out at any age throughout childhood, meaning that identifying FGM at birth can mean that any safeguarding measures adopted may have to be in place for more than 15 years over the course of the girl's childhood. This is a significantly different timescale and profile compared to many of the other forms of harm, against which the safeguarding framework provides protection. This difference in approach should be recognised when putting in place policies and procedures to protect against FGM.

The Royal College of Paediatrics and Child Health (RCPCH) publish the *Safeguarding Children and Young People: roles and competences for health care staff INTERCOLLEGIATE DOCUMENT*<sup>40</sup>. This document is used across the NHS and includes references to FGM at multiple levels of professional practice.

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<sup>40</sup> <http://www.rcpch.ac.uk/system/files/protected/education/Safeguarding%20children%20and%20young%20people%20-%20roles%20and%20competencies%20for%20health%20care%20staff%20-%20Intercollegiate%20document%20March%202014.pdf>

## 6.5 SUPPORT

When services are commissioned, appropriate consideration is required to ensure the safety of patients.

Any written materials and clinic names should be developed with due care and consideration that references to FGM may pose a safety risk if family members do not support the woman's actions to access support services.

If a woman or child is accompanied by a partner or parent/relative/guardian respectively, the health and social care professional must be vigilant and aware of the signs coercion and control as detailed by the Crown Prosecution Service:

[http://www.cps.gov.uk/publications/equality/domestic\\_violence.html](http://www.cps.gov.uk/publications/equality/domestic_violence.html)

## 6.6 TRAINING FOR HEALTHCARE PROFESSIONALS

NHS organisations and professionals can access an FGM e-learning programme on the eLearning for Healthcare website, [www.e-lfh.org.uk](http://www.e-lfh.org.uk), consisting of 5 sessions providing training on all aspects of FGM and standard care provision principles.

NHS organisations should consider the training need within their organisation, and implement a training plan accordingly.

## 6.7 INFORMATION SHARING AND RECORDS MANAGEMENT

Comprehensive information sharing practices should be introduced in order to develop a resulting effective and long term approach to safeguarding against FGM.

Any concerns should be recorded within the patient's records by the healthcare professional who has obtained the information, including record details of action taken.

Information relating to safeguarding concerns should routinely be shared with other key professionals within the child's life, as per *Working Together to Safeguard Children 2015* and other safeguarding best practice. In practice this is likely to mean that concerns identified should be shared with the patient's GP and her health visitor (HV) or school nurse (SN), depending on the age of the child who is potentially at risk of FGM.

Organisations may wish to consider adopting the risk assessment processes within the Department of Health guidance, *FGM Risk and Safeguarding; Guidance for professionals*:  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/418564/2903800\\_DH\\_FGM\\_Accessible\\_v0.1.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf)

On completion of an initial assessment, it is good practice to share the outcome with the GP and HV/SN. This is whether the information is identified within a maternity setting, in an accident and emergency department, within a travel clinic, or any other healthcare setting. GPs and HV/SNs themselves should not forget to routinely share information themselves; if risks are identified within the GP practice, this should be shared with the HV/SN, and vice versa.

At birth, when a family history of FGM is identified, it is a requirement to record this detail within the Personal Child Health Record (or red book).

All maternity discharge records must include relevant information, if the mother has FGM, and this must be shared with the GP and the health visitor.

All maternity departments should routinely ask all women from all backgrounds and ethnicities during ante-natal care whether she has had FGM, using appropriately sensitive language.

On 1 April 2015, the Standardisation Committee for Care Information (SCCI) published the *SCCI 2026 – FGM Enhanced Dataset Requirements* and supporting documentation. This standard required all NHS organisations and professionals to record information about FGM within the patient population in healthcare records, when it is identified through the standard delivery of healthcare services.

The standard also requires all acute and mental health trusts and GP practices to report information to the Health and Social Care Information Centre on a quarterly basis, submitting data items in compliance with a specified dataset.

# CHAPTER SEVEN: GUIDELINES FOR POLICE OFFICERS

## 7.1 HOW POLICE OFFICERS CAN MAKE A DIFFERENCE

FGM is not a matter that can be left to be decided by personal preference or tradition; it is an extremely harmful practice and is against the law with a maximum prison sentence of 14 years<sup>41</sup>. Failing to protect a girl from the risk of FGM is also an offence, with a maximum prison sentence of 7 years. Officers must not let fears of being branded 'racist' or insensitive to cultural traditions weaken their investigative strategy or decision(s) to arrest suspects. Investigation must be robust and follow national and local guidance for safeguarding and child abuse investigations. In addition officers should be culturally aware and understand all the people they are dealing with as part of any investigation.

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

Further reference may be made to a number of College of Policing guidance documents:

- FGM authorised professional practice, and guidance on child abuse investigations <https://www.app.college.police.uk/>;
- guidance on investigating domestic abuse (2008); and
- 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<sup>42</sup>.

## 7.2 EXAMPLE OF PROTOCOLS

The procedures described apply in particular to officers and staff in the following roles:

- child abuse investigation teams;
- community safety units;
- public protection units;
- missing persons teams;
- specialist sexual offences investigation teams; and
- all police officers and police staff who in the course of their duty deal with or come into contact with children and young people.

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<sup>41</sup> Any person found guilty of an offence under section 1, 2, or 3 of the FGM Act 2003 is liable to a maximum penalty of 14 years' imprisonment, a fine, or both.

<sup>42</sup> Police officers can also contact the Metropolitan Police Service's specialist Project Azure team on 020 7161 2888 for information or their own Force's Honour Based Violence and Public Protection Leads.

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

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

If any officer believes that the girl could be at immediate risk of significant harm, they should consider the use of police protection powers under section 46 of the Children Act 1989. Officers should carry out the following actions:

- complete appropriate checks, e.g. PND, PNC, Children's Social Care;
- submit an appropriate intelligence log;
- complete relevant risk assessment and management plans (as per Force Policy);
- complete a crime report, ensuring that the incident is flagged in accordance with force procedures;
- complete a MERLIN entry or similar in accordance with *Every Child Matters* principals;
- inform their supervisor, who must be at least the rank of inspector (the on-call superintendent should also be made aware of the referral);
- all officers and staff must consider whether this could be a critical incident and deal with the matter accordingly; and
- consider 'Golden Hour' principles in relation to evidence gathering.

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

Depending on the circumstances of the case, FGM related referrals may lead to 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). Such a meeting should take place as soon as practicable (and in any case within two working days).

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 general responsibility 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 an FGM Protection Order (see Section 5.2), and/or other protective order as appropriate. **The welfare of other children within the family, in particular (but not exclusively) female siblings, should be reviewed.** The investigation should be the subject of regular ongoing multi-agency reviews to discuss the outcome and any further protective steps that need to be taken with regard to that girl and any other siblings.

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

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

Officers should carry out the following actions:

- complete appropriate checks, e.g. PND, PNC, Children's Social Care;
- submit an appropriate intelligence log;
- complete relevant risk assessment and management plans (as per Force Policy);
- refer to local authority children's social care (unless they were the referrer).
- complete a crime report, ensuring that the incident is flagged in accordance with force procedures;
- inform their supervisor, who must be at least the rank of inspector;
- ensure that the on-call superintendent is made aware of the referral;
- complete a MERLIN entry or similar in accordance with Every Child Matters principals;
- all officers and staff must treat this crime as a critical incident and deal with the matter effectively;
- the investigative strategy should consider obtaining evidence or intelligence identifying the excisors (people who carry out FGM for payment or otherwise) and investigating these individuals with a view to identifying further victims and closing down such networks; and
- investigating officers must refer to the Police/Crown Prosecution Service (CPS) Protocol for the investigation and prosecution of FGM cases. The 43 English and Welsh police forces have signed this protocol.

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

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

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

Police officers should refer to the CPS's guidance document entitled *Provision of Therapy for Child Witnesses Prior to a Criminal Trial*. As highlighted above investigating officers must refer to the Police/CPS Protocol for the investigation and prosecution of FGM cases, which has been signed by the 43 police forces in England and Wales.

A second strategy meeting should take place within a reasonable as appropriate to support the operational response.

## 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 4.3 for more information on talking about FGM with those affected.

## 7.2.6 MEDICAL EXAMINATIONS

Corroborative evidence should be sought through a medical examination conducted by a qualified medical professional trained in identifying the different types of FGM.

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.

## 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 disciplinary approach must be taken to consider the risks to the woman. This should consider any potential risk to any girls within the family (and extended family) and consider initial and core assessments of those girls. Consideration should also be given to providing supportive services for the woman, including counselling and medical assistance and signposting the FGM survivor to specialist non-government organisation support networks.

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

# CHAPTER EIGHT: GUIDELINES FOR CHILDREN'S SOCIAL CARE

**All children's social care professionals should work in accordance with the guidelines in Working Together to Safeguard Children (2015) in England and Safeguarding Children – Working Together under the Children Act 2004 (2004) in Wales.**

## 8.1 HOW CHILDREN'S SOCIAL CARE CAN MAKE A DIFFERENCE

FGM is not a matter that can be left to be decided by personal preference – it is illegal<sup>43</sup>, extremely harmful and is child abuse. Social workers and other professionals should not let fears of being branded 'racist' or 'discriminatory' weaken the protection that they give to vulnerable girls and women.

Local authorities have overarching responsibility for safeguarding and promoting the welfare of all children and young people in their area. They have a number of statutory functions under the 1989 and 2004 Children Acts which make this clear, including specific duties in relation to children in need and children suffering, or likely to suffer, significant harm, regardless of where they are found, under sections 17 and 47 of the Children Act 1989. These duties are, in practice, discharged by local authorities' children's social care departments who, as part of their responsibilities, should work to prevent FGM taking place, and protect and offer support to any girls affected by the practice.

Local authorities, with their partners, should develop and publish local protocols for assessment. A local protocol should set out clear arrangements for how cases will be managed once a child is referred into local authority children's social. The detail of each protocol will be led by the local authority in discussion with their partners and agreed with the relevant Local Safeguarding Children Board. Such protocols should include clear procedures for handling cases where FGM is alleged or known about, or where there are concerns that a girl may be at risk of undergoing FGM.

In circumstances where FGM is known to have been performed to a child with siblings, consideration should be given to the possible risk to other girls in the family and practising community. Depending on the particular circumstances of each case, the risk might be immediate or longer term. In the case of the former, consideration should be given to using child protection procedures to protect other children from undergoing FGM. In the case of the latter, children's social care should consider what other support may be necessary, including considering whether siblings should be considered to be children in need .

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<sup>43</sup> See sections 2.4 and 2.5 above.

## 8.2 WORKING WITH CHILDREN AND FAMILIES WHERE A FUTURE RISK OF FGM HAS BEEN IDENTIFIED

Where a future, but probably not immediate, risk of FGM taking place has been identified, every attempt should be made to work with parents on a voluntary basis to prevent the abuse. It is the responsibility 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, and for a written agreement to be undertaken with parents not to arrange for FGM to be performed on the girl. However, the child's interests are always paramount, and any agreement reached must be carefully monitored and enforced by all agencies.

The priority must always be the protection of the child. 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 OR HAS UNDERGONE FGM

Where there are concerns about a child's immediate safety, an immediate strategy discussion should be set up involving all other relevant agencies: the police, children's social care, education professionals, and health services. Voluntary organisations with specific expertise – for example on FGM, domestic violence and/or sexual abuse – should also be invited; and consideration may also be given to taking legal advice (see *Working Together to Safeguard Children (2015)* statutory guidance for further information). Such a strategy discussion will be used to determine the child's welfare and plan whether rapid future action is necessary to protect the child.

The strategy discussion will also establish whether the parents or girl has had access to information about the harmful aspects of FGM and the law in the UK. If not, they should be given appropriate information regarding the law and harmful consequences of FGM. The girl should be provided with information on specialist therapeutic counselling services to assist her in understanding the psychological impact of this harmful practice. Any interviews with the girl or her family should follow the guidance set out in Section 4.3.

If the strategy meeting decides that the girl is in immediate danger of FGM and/or professionals consider that her parents will allow or facilitate FGM in the near future, then an FGM Protection Order or Emergency Protection Order, or both, should be sought (see Sections 5.2 and 5.3). Local authorities are 'relevant third parties' for the purposes of applying for an FGMPO, i.e. they can apply for such an order without needing prior leave from the court to do so.

If a child has already undergone FGM, the strategy discussion will similarly decide whether any immediate safeguarding action is needed, and who to give information to about what is happening (especially whether to give information to the parents). The strategy discussion will also need to consider how, where and when the procedure was performed and the implications of this. In addition, the strategy discussion will need to consider carefully whether to continue enquiries and 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 should be sought and a criminal investigation conducted.

Whether a child is at immediate risk of FGM or has already undergone FGM, the strategy discussion may conclude that there are grounds to initiate an enquiry under section 47 of the Children Act 1989 to decide what action is needed to safeguard and promote the child's welfare. If concerns are substantiated and the child is suffering, or likely to suffer, significant harm, the social work manager should convene an initial child protection conference. Any such initial child protection conference will decide what actions should be taken, by whom and to what timescales – this will be set out in a child protection plan. A child protection plan may not be appropriate in all cases. For example, a girl who has already undergone FGM might not be subject to a child protection plan, unless additional child protection concerns are identified.

Further information about the child protection process is available in Working Together to Safeguard Children (2015) statutory guidance.

# CHAPTER NINE: GUIDELINES FOR SCHOOL, COLLEGES AND UNIVERSITIES

Schools' and colleges' statutory safeguarding responsibilities<sup>44</sup> are set out in Keeping Children Safe in Education, published on 26 March 2015. These apply to FGM as to any other risk.

**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.**

## 9.1 HOW STAFF CAN MAKE A DIFFERENCE

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

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

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

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

**It is for schools and colleges to decide exactly how they address this issue, taking account of the numbers of pupils from relevant communities.**

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<sup>44</sup> Section 175(2) of the Education Act 2002, paragraph 7(a) of the Schedule to the Education (Independent School Standards) Regulations 2014 and paragraph 3 of the Schedule to the Education (Non-Maintained Special Schools) (England) Regulations 2011 require governing bodies of maintained schools and further education institutions, and proprietors of independent schools (including Academies and free schools) and non-maintained special schools to make arrangements to ensure their functions are discharged having regard to the need to safeguard and promote the welfare of children / pupils at their institutions.

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

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

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

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

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

Once the full facts have been established, the member of staff should be able to decide on the level of response required. If there is an indication that the child is at risk of FGM or it is suspected that she has undergone FGM, or she has expressed fear of reprisals or violence, the information should, subject to the duty in section 5B of the 2003 Act, be shared with both the police and children's social care immediately.

Section 5B of the FGM Act 2003<sup>45</sup> introduces a mandatory requirement for teachers who become aware that a child or young person under 18 has undergone FGM to report such cases to the police (see Section 4.1)

Staff should:

- √√ talk about FGM in a professional and sensitive manner, in line with Section 4.3;
- √√ 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 should be informed even if this is against the girl's wishes. If you do take action against the student's wishes, you should 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; and
- √√ ensure that safeguarding and protection is considered for any female family members.

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<sup>45</sup> Inserted by the Serious Crime Act 2015

Staff should not:

xx treat such allegations merely as a family issue;

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

xx decide that it is not their responsibility to follow up the allegation; or

xx 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.

## 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; and
- 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, the family should not be approached without careful consideration of the specific circumstances, 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 (of compulsory school age<sup>46</sup>) not receiving a suitable education are described in (England) Children missing education – statutory guidance for local authorities (Nov 2013) <https://www.gov.uk/government/publications/children-missing-education> or Statutory Guidance to Help Prevent Children and Young People from Missing Education: Welsh Assembly Government Circular 006/2010 .

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

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

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<sup>46</sup> As defined in section 8 of the Education Act 1996

## Remember:

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

### Staff should not:

- delete a pupil from the school's admission register, except in certain circumstances. These are prescribed in The Education (Pupil Registration) (England) Regulations 2006. In certain circumstances, schools are required to inform the relevant local authority of a pupil who is to be removed from the admission register;
- dismiss the student as taking unauthorised absence; or
- the above regulations require all schools to inform the relevant local authority, at intervals agreed between them (or in default of such agreement, at intervals determined by the Secretary of State), of the names and details of every pupil who fails to attend school regularly, or who has been absent from the school without authorisation for a continuous period of 10 school days or more.

# CHAPTER TEN: REDUCING THE PREVALENCE OF FGM

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

## 10.1 THE ROLE OF LOCAL SAFEGUARDING CHILDREN BOARDS

The objectives of the Local Safeguarding Children Board (LSCB) are:

- (a) to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and
- (b) to ensure the effectiveness of what is done by each such person or body for those purposes<sup>47</sup>.

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 of how best this can be done, and encouraging them to do so.

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

## 10.2 PROFESSIONAL LEARNING REQUIREMENTS

Raising awareness about the socio-cultural, ethico-legal, sexual health and clinical care implications involved in FGM is essential. Education and training need to be provided for all health and social care professionals who may work with affected women and girls, or those at risk, 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 monitoring and evaluating the effectiveness of single agency and inter-agency training on safeguarding and promoting the welfare of children provided within their area<sup>48</sup>. This is in line with their function to develop policies and procedures in relation to training of those persons who work with children or in services affecting the safety and welfare of children<sup>49</sup>. Such policies and procedures may include specific training in relation to FGM.

<sup>47</sup> Sections 14(1) and 32(1) of the Children Act 2004 apply to LSCBs in England and Wales respectively

<sup>48</sup> See Chapter 3 of Working Together to Safeguard Children 2015 for further information on the role of LSCBs in England

<sup>49</sup> Regulation 5(1)(a)(ii) of the Local Safeguarding Children Boards Regulations 2006 for LSCBs in Wales

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; and
- roles of different 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 should include both top down direction as appropriate and a community-led approach.

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

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

# **APPENDIX A**

## **GLOSSARY OF TERMS USED**

### **ADULT**

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

### **CHILD, CHILDREN AND YOUNG PEOPLE**

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

### **CHILD ABUSE AND NEGLECT**

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

- physical abuse
- emotional abuse
- sexual abuse
- neglect

### **CHILD IN NEED**

Children who are defined as being 'in need' under section 17 of the Children Act 1989 are those whose vulnerability is such that they are unlikely to achieve or maintain, or have the opportunity to achieve 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 have a duty to safeguard and promote the welfare of children in need.

## **DOMESTIC VIOLENCE**

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members<sup>50</sup> regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

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

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

The Government definition, which is not a legal definition, includes so called 'honour' based violence, including FGM and forced marriage, and is clear that victims are not confined to one gender or ethnic group

## **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**

De-infibulation is a minor surgical procedure to divide the scar tissue sealing the vaginal introitus in type 3 FGM. De-infibulation is sometimes termed a 'reversal' of FGM; however, this is incorrect as it does not replace genital tissue or restore normal genital anatomy and function.

## **REINFIBULATION OR RE-SUTURING**

Re-infibulation refers to the resuturing (usually after childbirth) of the incised scar tissue in a woman with FGM type 2 or 3.

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<sup>50</sup> Family members are: mother, father, son, daughter, brother, sister & grandparents; directly-related, in-laws or step-family.

## **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. Harm is defined at section 31(9) of the Children Act 1989, whilst section 31(10) provides limited guidance as to what will be considered significant harm. Local authorities have 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 under section 47 of the Children Act 1989. The definition of harm at section 31(9) was amended by the Adoption and Children Act 2002 to include, "for example, impairment suffered from seeing or hearing the ill-treatment of another"<sup>51</sup>.

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<sup>51</sup> HM Government (2015) Working Together to Safeguard Children, Section 1.23; and Welsh Assembly Government (2006) Safeguarding Children: Working Together Under the Children Act 2004, Section 6.31.

## APPENDIX B

### TERMS USED FOR FGM IN OTHER LANGUAGES

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