CHILDREN AND YOUNG PEOPLE
OVERVIEW AND SCRUTINY COMMITTEE

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FEMALE GENITAL MUTILATION

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Summary

This report provides an overview and analysis of how services in Medway respond to the practice and identification of Female Genital Mutilation (FGM).

The report:

- Outlines the duties for statutory agencies to safeguard and protect children and families who are at risk of or have had FGM.
- Examines the prevalence and nature of identification and reporting of FGM in Medway.
- Reviews compliance with the statutory duties outlined in s 70; 71 and 72 of the Serious Crime Act.
- Makes recommendations for Commissioners and Health Provider Services and outlines the financial and legal implication for addressing the practice of FGM.

1. Budget and Policy Framework

1.1 This report is consistent with the Council Plan Priority "Supporting Medway's people to realise their potential".

2. Background

2.1 Working Together to Safeguarding Children (2015) and the FGM Act 2003 defines Female Genital Mutilation (FGM) as a form of child abuse and an illegal act.

2.2 The practice of FGM is also defined by the World Health Organisation (2015) (WHO) as “the range of procedures which involves the partial or total removal of the external female genitalia or other injury to the female genital organ whether for cultural or other non-therapeutic reasons”.

2.3 FGM has been illegal in the UK following the introduction of the Prohibition of Female Circumcision Act 1985 restated and amended in the FGM Act 2003 and more recently in the Serious Crime Act 2015. Children who have had FGM also experience significant physical, social and psychological abuse often endure lifelong physical and emotional health consequences. The practice is often carried out in families who reside and or originate from the Horn of Africa, India, Egypt and areas of the Middle East such as Iraq, Iran and Yemen.

2.4 The UK government position statement on the practice of FGM asked that statutory agencies respond to the practice as:

- *A Crime,* FGM Act 2003;
- *A form of Child Abuse*: *Children who experience FGM also found to have overlapping vulnerabilities and enduring experiences of physical, sexual and emotional abuse;*
- *A Human Rights Abuse*; and
- A form of Violence Against Women And Girls (VAWG); *the enduring experience of physical and psychological health and social co-morbidity affecting women up to childbirth and beyond.*

3. Advice and analysis

3.1 Kent and Medway FGM Working Group has developed a work plan for 2017-19 set out under four key areas: Prevention; Protection; Partnership; and Prosecution. The Kent Safeguarding Children Board and Medway Safeguarding Children Board (KMSCB) Female Genital Mutilation Work Plan set out at Appendix A to the report includes the development of internal specific guidance in line with the Kent and Medway procedures they include.

- FGM training;
- Review of FGM cases;
- Consideration for local FGM activity;
- FGM champions; and
- Public awareness and information sharing.

3.2 The Kent and Medway FGM (KMFGM) Operational guidelines, set out at Appendix B to the report were developed by the group and are published within the Kent and Medway Safeguarding procedures.

3.3 Evidence about the practice of FGM in Medway is still emerging, however 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.

3.4 Twelve new adult cases were identified in Medway between April 2016 and November 2017, however no new cases of children having undergone FGM were identified. Reporting did not decipher the number of children who are at risk of FGM from the families identified.

3.5 Legislation

3.5.1 Key changes introduced by the Serious Crime Act 2015, identified specific legislative duties and or responsibilities for commissioner and statutory agencies to safeguard children. They include:

- **Responsibility for upholding the principles of the Extra-Territorial Jurisdiction**:
  Section 70(1) of the Serious Crime Act 2015 amends section 4 of the 2003 Act so that the Extra-Territorial Jurisdiction extends to prohibited acts done outside the UK by a UK national or a person who is resident in the UK.

- **Responsibility to protect the anonymity of victims of FGM**

- **Safeguarding responsibility to protect a girl from FGM**
  Section (72) of the 2015 Act inserts a new s (3A) into the 2003 Act; this creates a new offence of failing to protect a girl from FGM. If an offence of FGM is committed against a girl *under the age of 18,*

- **The introduction of FGM protection order**
  Section (73) of the 2015 Act provides for FGM Protection Orders (FGMPOs) for the purposes of protecting a girl against the commission of a genital mutilation offence or protecting a girl against whom such an offence has been committed.

- **Duty to notify police of FGM (introduction of Mandatory Reporting)**
  Section 74 inserts a new section 5B into the 2003 Act which creates a new mandatory reporting duty requiring specified regulated professionals in England and Wales to make a report to the police. The duty applies where:

  - A professional is informed by the girl *under the age of 18* that an act of FGM has been carried out on her, or the practitioner observes physical signs which appear to show an act of FGM has carried out. This includes piercings, scrapings and tattoos of the genitalia.

  - The duty applies to professionals working within health, social care and education. It therefore covers professionals regulated by a body overseen by the Professional Standards Authority (with the exception of the Pharmaceutical Society of Northern Ireland). This includes doctors, dentists, nurses, midwives and therapists, social workers and teachers.

- **The duty for statutory agencies to provide guidance about FGM to those at risk of and or have experienced FGM.**

3.6 How services in Medway respond to the practice of FGM

3.6.1 A review of how services in Medway respond to disclosure and identification of FGM began in December 2017 and concluded February 2018. The purpose of the service evaluation was to gain a better understanding of how services were responding to disclosures. In particular the review benchmarked services against the standards and principles set out in the Home Office Safeguarding Guidance for Professionals and the FGM Intercollegiate Recommendations. Together the framework evaluated the specific areas of safeguarding responses, cultural sensitives and the capacity to signpost service users to specific psychological and medical support.

3.6.2 The agencies who participated in this review included, Medway CCG, Medway NHS Foundation Trust (MFT), Medway Community Healthcare Trust (MCH), North East London NHS Foundation Trust (NELFT) and Kent and Medway Partnership Trust. However, as part of this project work will continue to support training and awareness for Children Social Care frontline staff.

3.6.3 The evidence provided by services taking part in this review were benchmarked against the standards set out in table 1 of this report and reflect compliance with: The Children Act; The FGM Act 2003; Serious Crime Act 2015; Working Together to Safeguard Children 2015 and the Kent and Medway FGM Operational Guideline 2018 and the Kent Safeguarding Children Board (KSCB), Medway Safeguarding Children Board (MSCB) FGM work plan 2018 and Medway CCG Service Evaluation 2017-18. The analysis of evidence provided demonstrates that good practice to identify and report FGM is explicit within the evidence provided and reporting to Health and Social Care Informatics Centre (HSCIC) for Medway.

3.6.4 The Kent and Medway Female Genital Mutilation Operational Guidelines (2017) Provides explicit guidance on how services should respond to FGM. In addition to specific FGM legislation, the Children Act 1989 provides a range of statutory orders that police and social care can use to protect a child or children e.g. Section 46: Police Protection Order; Section 44: Emergency Protection Order ; Section 31 and 38: Care Order /Supervision Order; Section 20: Voluntary Accommodation. These arrangements are already embedded within Medway child protection processes to protect children from abuse.

3.6.5 A range of additional resources are available through the Medway Safeguarding Children Board (MSCB) website, these include e-learning courses for professionals on FGM, Forced Marriage and Honour based Violence. There are also resources created by young people including a short awareness raising video created by students from The Robert Napier School with support from Kent Police and the Medway Safeguarding Children Board (MSCB) and a presentation developed by the Medway Youth Parliament (now Medway Youth Council).

4. Response from Key Agencies

Table 1 FGM Service Evaluation Report						
FGM STANDARDS	Medway CCG	NELFT	MFT	MCH	GP	KMPT
1.PREVENTION All staff should have the necessary understanding of FGM, their mandatory duty to report concerns and of local procedures	Evidence provided demonstrates that FGM training is routinely offered as part of the safeguarding training schedule in all agencies. Staff also have access to Health Education England eLearning available via the MSCB website. *Areas for improvement: Agencies to ensure that all new staff receive the FGM training according to role and responsibilities.*					
2.PREVENTION Staff in key settings should be equipped to sensitively enquire about service user experience of FGM and to respond effectively to disclosure of FGM e.g. assess risk and take appropriate action	Evidence provided in training material, training uptake, safeguarding policies and procedural documents provided. Agencies are all signed up to Kent and Medway FGM (KMFGM) operational guideline 2016-18 to respond to FGM disclosure sensitively. Areas for continual support. Areas for improvement: *All organisations to have a named FGM champion. Practice to reflect and implement the KMFGM Operational Guidelines including the therapeutic and risk management pathway*					
2.PROTECTION Safeguard girls and women affected and/or at risk of FGM through access to relevant effective and integrated services	Evidence provided with FGM assurance framework demonstrates that services have appropriate safeguarding processes in place to respond to FGM identification. Areas for improvement: *All services to circulate list of specialist clinics where women and girls who have had FGM can access specialist therapeutic and medical support.*					
3. PARTNERSHIP PRIORITIES Collate information on the incidence and prevalence of FGM within Kent and Medway, to aid prevention of FGM and provide protection/support for girls and women affected or who may have had FGM.	Evidence submitted with FGM assurance framework demonstrates that all appropriate agencies are registered with Health and Social Care Informatics Centre database and regularly submit FGM data. *Areas for improvement: Agencies to ensure that identified cases of FGM are shared appropriately and systematically to ensure that patient receive that correct therapeutic support.*					
Evidence compliant with safeguarding legislation			Minimal risk with recommendations for improving practice and services for FGM.			

5. Recommendations for Service Improvement

5.1 The review untaken identified the following recommendations:

5.1.1 Recommendations for Commissioners

- Areas for improvements identified from this review should be monitored via the Safeguarding Quality Assurance Metrix, which should measure how services respond to FGM.
- Implement and monitor the Kent and Medway FGM Operational Guidelines and work plan 2018.
- Commissioners should consider the Home Office recommendations for FGM as part of the overall commissioning strategy for children services.

5.1.2 Recommendations for Commissioned Services

- Agencies to sign up to the KMSCB FGM work plan to ensure a consistent approach to service delivery.
- Submit names of FGM champions to the Medway task and finish group as part of the service recommendations to improve expertise and support for frontline staff. This should include services such as Multi Agency Safeguarding Hub (MASH) and therapist services.
- Adopt and implement the KMFGM Operational Guidelines including the risk management pathway: this would enable a consistent approach to Safeguarding risk management.
- Specialist support for FGM must be embedded within the existing services for domestic violence.

6. Risk management

6.1 The findings from this report identified that all FGM risk were mitigated within the safeguarding strategies and reporting Metrix as outlined in table 1 of the report.

7. Consultation

7.1 The evidence from this review and report from HSCIC suggests that health services in Medway are working together to tackle FGM. In particular, the maternity services at Medway Maternity units are working proactively to identify and report FGM as well as support women who have had FGM. The agencies who participated in this review included, Medway CCG, Medway NHS Foundation Trust (MFT), Medway Community Healthcare Trust (MCH), North East London NHS Foundation Trust (NELFT) and Kent and Medway Partnership Trust. Medway Minority Ethnic Forum has welcomed this review and work will commence shortly to collaborate and raise awareness about the issue.

8. Implication for Looked After Children

8.1 There are no specific implications for Looked After Children directly arising from this report.

9. Financial implications

9.1 The cost to implement the legal recommendations for FGM are met through existing budgets from partner agencies as part of the existing safeguarding arrangements for children.

10. Legal implications

10.1 The legal implications are set out in the body of this report.

11. Recommendation

11.1 The Committee is asked to note the overview and analysis of Female Genital Mutilation (FGM) set out in the report and in particular how services in Medway respond to the practice and identification of FGM.

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Appendices

Appendix A - KMSCB FGM report
Appendix B - Service Review Framework

Background papers

The Children Act
http://www.legislation.gov.uk/ukpga/1989/41/contents

The FGM Act 2003
http://www.legislation.gov.uk/ukpga/2003/31/contents.

Serious Crime Act 2015
http://www.legislation.gov.uk/ukpga/2015/9/contents/enacted.

Working Together To Safeguard Children 2015
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2.

Multiagency Statutory guidance on Female Genital Mutilation 2016.
https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation.

Kent and Medway FGM Operational Guideline 2018 and the KSCB, MSCB FGM work plan 2018 and Medway CCG Service Evaluation 2017-18. (see attached).

Duty for Health and Social Care Professionals and Teachers to report female Genital mutilation to the police. https://www.gov.uk/government/publications/fact-sheet-on-mandatory-reporting-of-female-genital-mutilation.

Appendix A

MSCB Female Genital Mutilation Work Plan, 2017-2019

"I realise this [FGM] practice has been illegal since 1985 in this country, but the key to stopping FGM isn't just prosecution."

"What you have to remember is that the mother who has it done to her daughter is a victim too, even if she doesn't know it. She was also abused as a child in the same way and she doesn't realise its bad; she only thinks she is doing the right thing for her daughter - not to cause her pain - but to secure her future. The police fight against FGM has to be more about prevention than anything else, because even the ones who carry it out are victims themselves and the best thing you can do is help them to see this."

Hibo Wardere, *Cut - One woman's fight against FGM in Britain today* (2016)

1. Prevention

Strategic Priority	Actions	Outcome	Lead	Timescale	Progress/impact	RAG
All staff should have the necessary understanding of FGM, their mandatory duty to report concerns and of local processes and procedures.	Mandate FGM training for all multi-agency frontline staff.	All staff key frontline staff to be competent to identify and report FGM.	MSCB Learning and Development Group MSCB Learning and Development Group All agencies	April 2019	All agencies already providing bespoke training on FGM. The Evaluation of the effectiveness of this training to be monitored as part of the Section 11 audit as well as the MSCB Learning and Development subgroup.	Amber
	Staff to undertake FGM training, commensurate to their professional roles/responsibilities, including mandatory reporting duties.	All Agencies to provide access to FGM training as well as safeguarding polices that explain the role and responsibilities to safeguard children and families from FGM	MSCB Learning and Development Group MSCB Learning and Development Group		Health Education England (HEE) have developed a free FGM educational programme for all healthcare professionals. http://www.e-lfh.org.uk/programmes/female-genital-mutilation/	Green
Staff in key settings should be equipped to sensitively enquire about service user experience of FGM and to respond effectively to	Develop multi-agency guidance for front line staff and their organisations, to address FGM in Kent and Medway.	All statutory agencies to ensure that services have access to FGM champions to support safe and effective enquiries. As well as bespoke training	KSCB and MSCB Policy and Procedures Group	2016	The Kent and Medway Female Genital Mutilation Operational Guidelines were published in January 2016.	Green

disclosures of FGM e.g. assess risk and take appropriate action.	All statutory agencies will develop comprehensive internal guidance documents, that links to KSCB policies and procedures, to ensure their staff are confident and competent at identifying and responding appropriately.	All Agencies to provide clear policies and guidance to guide safe practice in relation to FGM	Individual Agencies		NHS England have produced a Safeguarding Guide app, providing a summary guidance for staff and reminds them of their mandatory reporting duty. https://itunes.apple.com/gb/app/nhs-safeguarding-guide/id1112091419?mt=8 NHS England have also produced an updated FGM Pocket Guide for healthcare professionals.	Green
	Staff to undertake FGM training, commensurate to their professional roles/responsibilities, including mandatory reporting duties.	Evidence that frontline Staff have appropriate access to FGM training.	KSCB Learning and Development Group MSCB Learning and Development Group		April 2014: MSCB working and development subgroup are currently progressing this action in line with safeguarding priorities.	Amber
	Support the implementation of a national FGM training strategy.	Evidence of the implementation of FGM training linked to safeguarding and supportive outcomes	KSCB Learning and Development Group MSCB Learning and Development Group		NHS England are working in partnership with Health Education England (HEE) had produced a FGM training guidance for all Health Care Professionals.	Green

2. Protection

Strategic Priority	Actions	Outcome	Lead	Timescale	Progress/impact	RAG
Safeguard girls and women affected and/or at risk of FGM through access to relevant, effective and integrated services.	Introduce a multi-agency process for cases where there is evidence of FGM and/or children suspected to be a t high risk of FGM are reviewed.	Safeguarding policies to protect children from abuse to provide clear guidance on safeguarding girls from FGM.	MSCB	November 2018	April 2018: community engagement work is progressing to ensure that women and children affected by FGM know where to seek help.	Amber
	Work to empower women to help them across services, addressing barriers to services and identifying care pathways for these women and girls.	All women and children affected by FGM to be signposted to specialist services For FGM.	MSCB KMSAB	April 2019	April 2018: work is progressing to ensure that FGM resources are available to all Medway residence affected by FGM.	Amber
	Deliver coordinated and consistent support/signposting services via a multi-agency response to those affected or who may be affected by FGM, including suitable information materials.	FGM services to be available resources to available to individual and families affected by FGM	MSCB	November 2018	April 2018; work is progressing to collate a list of national specialist services for FGM.	Amber
Collate information on the incidence and prevalence of FGM within Kent	The KSCB and MSCB FGM Working Group to receive and consider bi-monthly reports on local FGM	Consistent recording and reporting of FGM data, to inform responsive and high-	MSCB	November 2018	April 2018: this data is now accessible via the Health and Social Care National Database and NHS England and is	Green

and Medway, to aid prevention of FGM and provide protection/support for girls and women affected or who may be affected by FGM.	activity/referrals/prevalence.	quality service development and monitoring of services.			accessible by statutory agencies	

3. Partnership

Strategic Priority	Actions	Outcome	Lead	Timescale	Progress/impact	RAG
Work in partnership to encourage and support services to use materials available and to undertake opportunistic interventions with girls at risk.	All statutory agencies have at least one named professional with expertise on FGM in addition to the lead officer, where they are different individuals.	All services to have a Named FGM professionals	MSCB	November 2018	April 2018: All statutory agencies now have FGM champions	Green
	Information/updates etc. to be disseminated via the partner agencies FGM leads.	All services to receive national updates on FGM	MSCB	November 2018	April 2018: all statutory agencies receive regular updates via MSCB and KMSB working group activities.	Green
	Raise the profile of FGM with professionals, communities, religious groups and girls at risk, through FGM awareness campaigns e.g. FGM International Day, before school summer holidays and other key events.	Local communities as well as families affected by FGM are aware of the health and social impact of FGM.	MSCB	November 2018 and ongoing.	April 2018: community awareness activities undertaken within Medway schools.	Green
	The KSCB and MSCB FGM Working Group Chair to attend relevant regional/national FGM forums and provide timely feedback/updates to members.	The KSCB and MSCB FGM Working Group to attend and chair relevant meetings.	KSCB and MSCB	November 2018	April 2018: this action is now complete. However local champions continue involvement in national and regional FGM groups	Green

Through partnership working, improve Kent Police's response to FGM and increase opportunities for early and effective interventions in respect of victims and perpetrators.	Kent Police to work collaboratively with partners to create local processes for the submission and use of FGM intelligence.	Kent Police to work with partners to support the national data collection of FGM	MSCB	November 2018	April 2018: evidence from the National database for health and social care informatics suggests that this is already happening	Amber
	Follow local information sharing procedures.	Kent Police to share safeguarding information on FGM	MSCB	November 2018	April 2018: The Medway multi agency safeguarding hub to share key information and protect children and families already in place.	Green

4. Prosecution

Strategic Priority	Actions	Outcome	Lead	Timescale	Progress/impact	RAG
Gain assurance and oversight that the mandatory duty to report under 18 FGM victims to the Police is being implemented.	Compare the number of child protection referrals received by Kent and Medway Central Referral Units for FGM concerns with the number of cases reported to Kent Police.	All mandatory reporting cases are being reported to the Local Authority Children's Services and Kent Police.				
	Hard and soft intelligence provided, that support Kent Police progress their intelligence and provide data about communities/hot spots.	All girls and women presenting with FGM must be considered as potential victims of crime and should be referred to the Police and support services.	All agencies	April 2019	April 2019: Emerging evidence from MSCB section 11 audits suggests that this is already happening.	Amber
	Monitor referral outcomes to identify good practice and support learning for professionals/practitioners.		KSCB and MSCB FGM Working Group	April 2019	April 2019: Emerging evidence from MSCB section 11 audits suggests that this is already happening	Amber

Appendix B

Kent and Medway
Female Genital Mutilation
Operational Guidelines

February 2018
Review Date: February 2020

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FEMALE GENITAL MUTILATION (FGM)

1. Introduction

This protocol has been developed by the Kent and Medway FGM -Working Group to support frontline staff working across agencies in Kent and Medway in understanding their duty and the appropriate response to identify and protect girls at risk of FGM and to support those who have already been harmed by the practice.

The protocol must be read in conjunction with statutory guidance: Working Together to Safeguard Children (HM Government, 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf) ; *Female Genital Mutilation Multi-agency Practice Guidance* (HM Government, 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512906/Multi_Agency_Statutory_Guidance_on_FGM__-_FINAL.pdf) which introduced mandatory data recording and collection for particular agencies and the *Female Genital Mutilation Risk and Safeguarding* (Department of Health,2015) which extended mandatory reporting requirements and introduced the concept of a mandatory duty to report all cases of FGM identified in children/young people under 18 years of age **(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf)**

- The protocol includes a Kent and Medway FGM pathway (Appendix 1) to support agencies and practitioners in responding to potential or actual cases of FGM.
- The protocol is supported by the Kent Safeguarding Children Board, Medway Safeguarding Children Board, and the Kent and Medway Safeguarding Adults Board.
- The protocol advocates that professional/multi-agency decisions or plans regarding victims of FGM require robust assessments that consider the protected characteristics identified in the Equality Act (2010) to reduce potential for stigmatizing victims or their community.

2. Prevalence of FGM

2.1. International Prevalence

FGM is a deeply rooted practice, widely carried out mainly among specific ethnic populations in Africa and parts of the Middle East and Asia. It serves as a complex form of social control of women's sexual and reproductive rights. The exact number of girls and women alive today who have undergone FGM is unknown, however, UNICEF estimates that over 200 million girls and women worldwide have undergone FGM.

While FGM is concentrated in countries around the Atlantic coast to the Horn of Africa, and areas of the Middle East like Iraq and Yemen (Appendix 2), it has also been documented in communities in:

- Colombia
- Iran
- Israel
- Oman
- The United Arab Emirates
- India
- Indonesia
- Malaysia
- Pakistan
- Saudi Arabia

- The Occupied Palestinian Territories

It has also been identified in parts of Europe, North America and Australia.

2.2. England and Wales Prevalence

The Prevalence of FGM in England and Wales is difficult to estimate because of the hidden nature of the crime. However, a 2015 study 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.

2.3. Local Prevalence

The current demography in Kent and Medway would suggest the prevalence of FGM is low, but agencies must be alert to the consequences of FGM and have a duty to prevent and protect children and young people from this form of abuse (FGM is categorised under the headings of both Physical Abuse and Emotional Abuse).

- FGM is child abuse and against the law. It causes serious physical and emotional harm
- It is acknowledged that some FGM practicing families do not see it as an act of abuse. However, FGM is child abuse and has severe significant physical and mental health consequences in the short and long term, and as such must never be excused, accepted or condoned
- Professionals need to give families advice and information that is sensitive to their culture and beliefs, but they need to make clear that FGM is illegal
- The 'hidden' nature of FGM raises serious issues and concerns in relation to the safeguarding of girls and young women. It is vital that practitioners who come into contact with women, children and families from communities that practice FGM have an adequate knowledge and understanding of the issues in order to respond appropriately and act within contemporary legal frameworks RCN, (2015)
- A coordinated and appropriate multiagency response to potential or actual FGM cases will require professionals to work in partnership with local communities to empower and educate individuals and families to the harm and consequences of FGM and in doing so protect and prevent children from abuse
- It must always be remembered that fears of being branded 'racist' or 'discriminatory' must never weaken the protection that professionals are obliged to provide to protect vulnerable girls and women
- Professionals should discuss FGM with all women from FGM practicing countries/ communities and also with women who may be married to or in a relationship with a man from an FGM practicing country/community
- 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 professionals can and should have identified that the mother has had FGM
- Agencies will need to consider how girls are protected throughout their childhood either through specific agreements with parents or monitoring through universal services

FGM is included within the revised (2013) government definition of Domestic Violence and Abuse (https://www.gov.uk/government/publications/new-government-domestic-violence-and-abuse-definition)

3. Types of FGM

The World Health Organisation (WHO) classifies FGM into four types; the most extreme of which is Type III.

Type I: Clitoridectomy	Involves partial or total removal of the clitoris
Type II: Excision	Involves partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.
Type III: Infibulation	Involves narrowing of the vaginal orifice with creation of a covering seal by cutting the labia minora and/or labia majora with or without excision of the clitoris.
Type IV:	All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, incising, scraping and cauterization.

4. Why is FGM Practiced?

While the reasons for performing FGM are complex, tradition, custom and family honour are cited as a justification for it being practiced within families and communities. Indeed in certain communities it is considered a 'rite of passage' to prepare a girl for adulthood and marriage.

There is also a mistaken belief that FGM is a religious requirement within particular faith groups. However, there are no religious texts to support this perspective (Department of Health leaflet, 2015).
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300167/FGM_leaflet_ v4.pdf

Practitioners undertaking particular roles must have completed FGM training to understand and balance the need for a sensitive and proportionate response to a disclosure or concerns against the overarching need to safeguard, protect and support prospective or actual victims.

5. Consequences of FGM

FGM has no health benefits, as it involves removing and damaging healthy and normal female genital tissue, thereby interfering with and harming the natural functions of girls' and women's bodies. Health implications are identified in table 1.

Table 1: Health Implications following FGM	
Immediate/Short-Term Health Implications	**Chronic/Long-Term Health Implications**
• Serve pain; • Shock; • Haemorrhage; • Wound infections including Tetanus and blood borne viruses (e.g. HIV); • Urinary retention; • Injury to adjacent tissues/organs; • Fracture or dislocation as a result of restraint; • Genital Swelling; • Death	• Genital scarring; • Genital cysts and keloid scar information; • Infertility; • Difficulties in menstruation; • Chronic vaginal and pelvic infections; • Urinary problems/renal (kidney) damage and failure; • Possible increased risk of blood infections such as hepatitis B and HIV; • Mental health/psychosexual problems e.g. depression, anxiety, flashback, loss of libido; • Complications in pregnancy/childbirth for mother/baby; • Increase risk of stillbirth and death of child during or just after birth

6. Legislation

The UN Convention on the Rights of the Child, (ratified by the UK Government 1991) and the UN Convention on the Elimination of All Forms of Discrimination against Women (1981) have mandated the UK government to introduce legislation in respect of FGM.

Since 1985 it has been a serious criminal offence under the Prohibition of Female Circumcision Act to perform FGM or to assist a girl to perform FGM on herself. In 2003, the Female Genital Mutilation Act tightened this law to criminalise FGM being carried out on UK citizens overseas. Anyone found guilty of the offence faces a maximum penalty of 14 years in prison.

The Serious Crime Act (2015) further supports victims of FGM by:

- Extending legal protection to non-UK nationals residing even temporarily in UK
- Providing lifelong anonymity for victims
- Introduction of FGM Protection Orders (July 2015)
- Mandatory reporting to police for FGM identified in under 18's from October 2015
- Duty to report falls on individual professionals

Further information regarding the 2015 legislative amendments is available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416323/Fact_she et_-_FGM_-_Act.pdf

Information regarding mandatory reporting requirements introduced in October 2015 is available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/469448/FGM-Mandatory-Reporting-procedural-info-FINAL.pdf

In addition to specific FGM legislation, the Children Act 1989 provides a range of statutory orders that police and social care can use to protect a child or children e.g. Section 46: Police Protection Order; Section 44: Emergency Protection Order ; Section 31 and 38: Care Order /Supervision Order; Section 20: voluntary accommodation.

The decision regarding legislative interventions to protect girls from FGM should be discussed as part of the multiagency response to the risk or when it is suspected FGM has been

undertaken.

7. Multi- Agency Approach to Safeguarding and Referral

Agencies across Kent and Medway should work together to effectively safeguard girls (and adults) at risk from FGM. Practitioners must follow HM Government Multiagency Guidelines on FGM in addition to LSCB guidance.

Mandatory data recording and collection regarding FGM cases for acute hospital trusts has been in place since September 2014 and was extended to mental health trusts/GP from October 2015,

Information sharing is key to identifying, assessing, supporting and protecting victims and those at greatest risk.

With regard to children and adults at risk, where practitioners believe a child or adult at risk has signs or symptoms of FGM or there is good reason to suspect they are at risk of FGM then the practitioner must make a safeguarding referral in line with KSCB/MSCB procedures.

Professionals should be aware of the possibility of FGM and vigilant to the following potential indicators that FGM may take place and if present must clarify their concerns and consider seeking advice and/or implement child protection/safeguarding procedures.

There is no statutory requirement to refer pregnant women who have undergone FGM routinely to children's social care. Professionals must consider the risk on a case by case basis, discuss with their safeguarding lead and decide the level of support that may be required e.g. Early Help Referral/ Referral to Specialist FGM Health Services.

Practitioners need to consider the potential increased risk to girls/women of honour based violence from within the family or community when supporting the prevention of FGM.

8. Referral to Specialist FGM Health Services

Child and adult victims of FGM living in Kent and Medway may need to be referred to specialist FGM services in London to confirm the type of FGM that has been performed and to work in partnership with the victim to develop a treatment plan to meet both their physical and emotional needs. A list of specialist clinics/services and the referral process is available via the following link: http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual- health-services/Documents/List%20of%20FGM%20Clinics%20Mar%2014%20FINAL.pdf
A specialist paediatric FGM clinic is run at University College London Hospitals NHS Foundation Trust by Dr Deborah Hodes (consultant Paediatrician). Details regarding referral to this clinic are available in the above link or in Appendix 5.

9. Practice Guidance Pathway

To be read in conjunction with Statutory Guidance and KSCB and MSCB procedures.

All services must be vigilant to the risks posed to girls and women who have undergone FGM or where there is likelihood it may be performed. Professionals must be familiar with the

indications and the screening questions and have appropriate training and competency level commensurate to their role/duty.

Professionals should seek advice from their local safeguarding lead /advisor or via the NSPCC FGM Helpline on 0800 028 3550 or email to: fgmhelp@nspcc.org.uk.

The requirement to undertake a risk assessment with a woman or young person will depend on the practitioner's role and responsibility. Risk assessment tools are available to use regarding:

- Women who have undergone FGM
- Pregnant women who have undergone FGM
- Children under 18 yrs who have undergone FGM
- Children under 18 yrs who are identified as being at risk of FGM

Information regarding FGM should be documented in child's 'red book' (page 3 –example in **Appendix 3**) and risk assessment documents for use is assessing cases are available via the link to Department of Health guidance (2015, pages 17-21).

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf

10. Health services

Health professionals in universal services, GP surgeries, sexual health clinics, Women's Health, A&E and maternity services are the most likely to encounter a girl or woman who has been subjected to FGM. All girls and women who have undergone FGM should be given information about the legal and health implications of practicing FGM.

Health professionals have particular responsibilities to ensure appropriate questions are asked and information documented. Parents should be given information about the legal and health implications of practicing FGM in a respectful and sensitive manner.

Health professionals should use the risk assessment tools included in Department of Health publication 'Female Genital Mutilation Risk and Safeguarding Guidance for professionals' (March 2015).

All conversations must be fully documented and state the following:

- If the child, young person or woman has undergone FGM
- What type of FGM
- If there is a family history of FGM

Health professionals/agencies must fulfil mandatory reporting requirements as outlined by the Department of Health (**Appendix 4**).

Health professionals working with women who have undergone FGM and who have female children are required to document type of FGM in the child/ren's Personal Child Health Record (PCHR) red book **(Appendix 3 – example of red book sheet)**

11. Midwifery Services

Midwives should discuss FGM at the initial booking visit with all women who come from countries that practice FGM or if they are married to or in a relationship with men from FGM practicing communities.

Midwives must document that the woman has been informed about the health risks and the law and given a leaflet in an appropriate language (if available) that explains the health risks of FGM, the law and local support services.

Midwives/obstetricians must develop and document a plan for delivery in partnership with the woman and share information with relevant professionals (e.g. GP/HV/safeguarding lead).

Midwives should be aware that some women may be traumatised from their experience and have already resolved not to allow their daughters to undergo this procedure. Any concerns about a parent's attitude towards FGM should be taken seriously and appropriate referrals made.

If a girl or woman who has been de-infibulated requests re-infibulation/re-suturing after the birth of a child, she must be referred to Children's Social Care. Re-infibulation is illegal in the UK.

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

Risk can only be considered at a particular moment in time. Healthcare professionals should take the opportunity to continue discussions around FGM throughout the standard delivery of healthcare. If for example a health visitor or GP has been passed information from a midwife about potential risk of FGM, at the next appointment with the woman/child, the health visitor/GP should discuss this.

12. Guidance for Acute Hospital Trusts and Community Services

Practitioners should be vigilant to any health issues such as resistance to partake in cervical smear testing, recurrent urinary tract infections or vaginal infections that may indicate FGM has been carried out.

Women/families attending health checks or travel vaccinations from high risk countries provides an opportunity for health professionals to ask about FGM and advise about its health impacts and offer referral to additional support for women identified as having had FGM. (A referral must be made to social services for children identified as having had FGM or at risk of FGM).

Practitioners must document any advice of leaflets provided. Any concerns about a parent's attitude towards FGM should be taken seriously and appropriate referrals made. Professionals should consult with their child protection adviser and with the relevant Social Work Assessment Team about making a referral to them (Female Genital Mutilation Care for Patients and Safeguarding Children, BMA July 2011).

A question about FGM should be asked by all practitioners at routine new patient contacts with girls and women from communities that practice FGM, and information must be

documented in records / PCHR and FGM Leaflet / FGM Passport provided.

Health visitors /school nurses are in a good position to reinforce information about the health consequences and the law relating to FGM and work in partnership with women/families and partner agencies to inform, educate and support individuals and communities, thereby protecting girls from this abuse.

Health services for Asylum Seekers & Refugees must also be vigilant in discussing FGM and following the Kent and Medway FGM pathway.

13. Education

Children or young people who fear they may be at risk of FGM may come to the attention of or seek support from teaching staff. It is important schools and colleges create an open and supportive environment by displaying age appropriate literature, raising awareness amongst staff, and introducing FGM into the school curriculum as part of PHSE, citizenship, science.

Staff concerned about a student exhibiting some of the signs of FGM or reporting they have had FGM performed must seek advice from their safeguarding lead and children's social care in line with the Kent and Medway FGM pathway.

Further guidance for teachers: HM Government. *Multi-Agency Practice Guidelines: Female Genital Mutilation*, 2011. www.fco.gov.uk/fgm

14. Procedure within Social Care for Safeguarding Children and Adults at Risk of or who have undergone FGM

When information is received by specialist children's services at the Central Referral Unit (CRU) or Child Advice Duty Service (CADS) the referral must be discussed with the duty manager who will subsequently inform the appropriate team in line with local policies and procedures. In all cases, professionals should not discuss the referral with the parents/carers/family until a multi- agency action plan has been agreed.

On receipt of referral, a strategy meeting must be called within two working days or sooner as directed by CRU or CADS duty manager and must include relevant health professionals with appropriate competencies e.g. community paediatrician to inform decision making and planning to meet the needs of those identified as at risk of or having undergone FGM.

If a referral is received concerning one female in a family, consideration must be given to whether other females in that family are also at similar risk. There should be consideration of other females from other associated families once concerns are raised about an incident or the perpetrator of FGM.

A team manager (or their appointed deputy) from social care will convene and chair a Strategy Meeting. It will be the senior social care representative's responsibility to access relevant information on the practice, and identify specialist help to assist in the sensitive planning of enquiries. Sourcing specialists should not stop or delay any initial intervention from taking place. (see **Appendix 5**).

In addition to the team manager (or their appointed deputy) from social care chairing and coordinating the meeting, the Strategy Meeting should include representation from:

- The allocated Social Worker responsible for the enquiry
- A senior member of the Kent Police Public Protection Unit (PPU)
- Appropriate health services (e.g. Community Paediatrician)
- Statutory or Voluntary Sector (e.g. FGM Specialist/Lead)
- The lead agency or professional currently working with the child or young person
- Any other professionals deemed appropriate by the Social Care Manager

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

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

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

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

Where a female has been identified as at risk or has been mutilated, it may not be appropriate to take steps to remove the child or an adult at risk from an otherwise loving family environment. Experience has shown that often the parents themselves can experience pressure to agree to FGM and see it as the best thing they can do for their daughter's marriageable status. It is also important to recognise that those seeking to arrange the mutilation are unlikely to perceive it to be harmful and, one the contrary, believe it to be legitimised by longstanding traditions.

Therefore, it is essential that when first approaching a family about the issues of FGM, a thorough assessment should be undertaken, with particular focus on:

- Parental / carer attitudes and understanding about the practice and where appropriate
- Child /young person / adults' knowledge, understanding and views on the issue

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

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

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

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

Appropriate communication aids must be offered for affected females who have difficulties communicating due to disability/illness and this should be documented within the record.

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

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

Adults at risk need to be interviewed alone and a capacity assessment completed. Capacity is decision-specific; the decisions to be assessed may include whether they can consent to travel abroad when there is a risk of their family arranging for them to undergo FGM. If they are not able to make a decision or safeguard themselves, then a best interest's decision should be made. Where an adult lacks capacity and needs to be safeguarded the Local Authority can apply to the Court of Protection to give them powers to protect an individual.

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

- Legal Action
- Criminal Prosecution
- An Initial Child Protection Conference

If a Child Protection Conference is deemed necessary and a Child Protection Plan is to be formulated, the Category of Abuse or Neglect should be Physical Abuse.

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

Arranging a Medical Examination

A medical examination, if necessary, must only be undertaken with the child's and the parents' consent or the consent of the adult female.

If the adult lacks the capacity to consent to the examination; then a Best Interests Decision can be made for them. Where parents do not consent, legal advice should be sought.

In the majority of cases there should only be one medical examination of the child or woman. In

the case of a child or young person known to have had FGM performed /or where professionals believe they have had FGM performed, there must be discussion with a Consultant Community Paediatrician to decide on whether it is in the child's best interests to be seen locally or if a referral is to be made to the Specialist Paediatric FGM Clinic at University College London Hospital to access expert advice and support. (See Appendix 5 for contact details)

In cases where subsequent medicals are required, clear reasons for this decision should be recorded as part of the assessment. Strategy discussions must involve health representatives with the appropriate competencies in managing FGM e.g. Local Community Paediatrician/ SARC professional/Specialist FGM Paediatrician.

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

In the event of a suspicion about possible child sexual abuse, professionals must refer to the KSCB/MSCB procedures, including the Kent and Medway Pathway for Child Sexual Abuse http://www.kscb.org.uk/procedures/sexual-abuse2

Children in Immediate Danger

Where the child appears to be in immediate danger of FGM and parents cannot satisfactorily guarantee that they will not proceed with it, an appropriate legal order should be sought

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

Adults in Immediate Danger

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

If there is no evidence of risk

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

- Consult the female's GP and a child's Health Visitor or School Nurses about this conclusion and invite her/him to notify Social Care if any further information challenges it;
- Notify appropriate professionals involved with the family of the enquiry and the stage at which it was concluded;
- Inform the family and the refer that the enquiry has been concluded;
- Consider whether any child may be a Child in Need or if the adult requires a Community Care Assessment and, if so, offer appropriate services and offer the family/carers any appropriate support services.

If it appears that no other females are at risk

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

15. Procedures for Police Officers/Police Staff

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

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

If a girl is at risk of undergoing or has already undergone FGM, the duty inspector must be made aware and support should be sought from the Public Protection Unit (PPU) where the victim resides. Relevant safeguards should be put in place immediately in order to prevent any risk of harm to the child. Consideration should be given to:

- Risk to any other children should be acted upon immediately;
- Honour-Based Violence issues / Forced Marriage

If any officer believes that the girl could be at immediate risk of significant harm they should consider the use of FGM Protection Orders / Police Protection Powers.

The PPU should commence a strategy meeting with Children's Services and relevant agencies.

If it is believed or known that a girl has undergone FGM, an initial strategy meeting must be held within the agreed timeframe, to enable full consideration to be given to the implications for the child and the coordination of the criminal investigation.

A second Strategy Meeting should take place within the agreed timeframe of the Initial Referral.

Children and young people should be interviewed under the relevant procedure/guidelines (e.g. Achieving Best Evidence) to obtain the best possible evidence for use in any prosecution.

A medical examination should be conducted by a qualified doctor (or nurse) trained in identifying FGM (see list of specialist clinics **Appendix 5**).

Where an adult female has undergone/is about to undergo FGM

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

Part of the investigation should entail identification of any UK based excisors, with a view to identifying further victims.

If the adult female is considered an adult at risk then the adult safeguarding process should be initiated and an urgent multiagency meeting arranged. However if the adult has capacity and does not give consent the safeguarding process would not be taken forward unless there was a wider 'public interest' element to the case. Immediate protection may be secured through the Court of Protection or the High Court.

Appendix 1

Have you identified someone who has undergone or is at risk of FGM?

Is it a woman over 18 years? — Yes — **Is it a child under 18 years?**

Non-pregnant woman with FGM

- Discuss referral to a specialist FGM clinic and psychological support- see the NHS Choices website for further info
- Document in record type of FGM and reported complications in line with guidance
- Deinfibulation should be offered to women with type 3 FGM
- Safeguarding risk assessment must be undertaken if a woman presents with/ discloses she has had, FGM
- Consider adult safeguarding assessments for vulnerable women
- Share information with GP with consent
- Establish if woman has any female children and intentions re:FGM

Woman with FGMis pregnant

- Contact local safeguarding lead for advice
- Discuss complications of FGM and law in UK
- Complete FGM safeguarding risk assessment to establish potential areas of concern /risk
- Establish woman's/partners views regarding FGM
- Document in notes/record in line with statutory guidance
- Share information of any identified risk with GP/Health visitor
- FGM Health passport given
- Consider referral to social care-discuss with woman/partner and include all relevant information regarding type of FGM (if known) and risk to child/ren
- Consider referral to specialist support services

Child has undergone FGM

Disclosure/Professional concerns

- Mandatory Reporting duty applies- call to101Police to report
- Consult with local safeguarding lead
- Consultation with CRU/CADS
- Refer child/children to social care with parent (may need interpreter)
- Referral to specialist children services for possible joint investigation
- Consider referral to specialist support services
- Document concerns, risk and actions in child's notes e.g. school record/red book/ health record
- Share information with key professionals e.g. GP/HV/school nurses/school
- Consider siblings/extended family

Urgent/immediate risk of FGM?

- Contact Police immediately
- Urgent referral to specialist children's services
- Discuss with safeguarding lead
- Do not discuss referral with parent as child may be placed at further risk
- Document concerns/share information with key agencies staff
- Contribute to S47/safeguarding investigation
- Consider siblings/extended family

Information shared
woman/family aware of law around FGM
Woman /family have no intention of child undergoing FGM

For all cases consider other girls who may be at risk of FGM within the context of the family/household

Referral to specialist childrens service completed
Referrer involved in strategy discussions and outcome of referral known and actions agreed
Child/young person protected and supported

N.B ALL AGENCIES HAVE A LEGAL DUTY TO REPORT FGM See *Working together to safeguard children* Guidance

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

FGM Referral Received by Specialist Children's Service

Pregnant woman who has undergone FGM

t

-7 Referral received -further information may be required from referrer /agencies
-7 Establish what referrer has already done re: parents view on FGM, aware of health consequences and UK legislation, FGM health passport given
-7 Where it is clear woman is engaging with health services and there is a low risk, case can be monitored by existing services - referral closed
-7 Information shared with referrer/ professionals/ agencies involved with family and recorded
-7 High Risk/Non engagement-Strategy meeting convened to include referrer/health colleagues

Child under 18 who has undergone FGM

-7 Discuss requirement to refer child/children to social care with parent (may need interpreter)- consider siblings/extended family
-7 Strategy meeting convened and includes referrer (where possible) and health colleagues e.g. community paediatrician, local safeguarding lead, health lead, GP, HV/school nurse
-7 Referral to specialist FGM paediatric service
-7 Consider referral to specialist support services
-7 Document concerns, risk and actions in child's notes e.g. school record/red book/health record
-7 Share information with key professionals e.g. GP/HV/school nurses/school

Child thought to be at urgent or Immediate risk of FGM

-7 Urgent strategy meeting convened -to include health colleagues where possible to establish the facts, risk and if parents or the girl has had access to information about the harmful consequences of FGM and UK law.
-7 Single/joint visit to parents/family to see child and assess risk- consider siblings/extended family
-7 Parents/family provided with information regarding the harmful effects of FGM Discuss UK law re: FGM and seek collaboration with parents –consider need to include community worker/ organisation
-?Consider Comms strategy
-7 Establish the parents' views on FGM and confirm that the parents will not arrange FGM on the girl. The family should also be given the FGM Health Passport

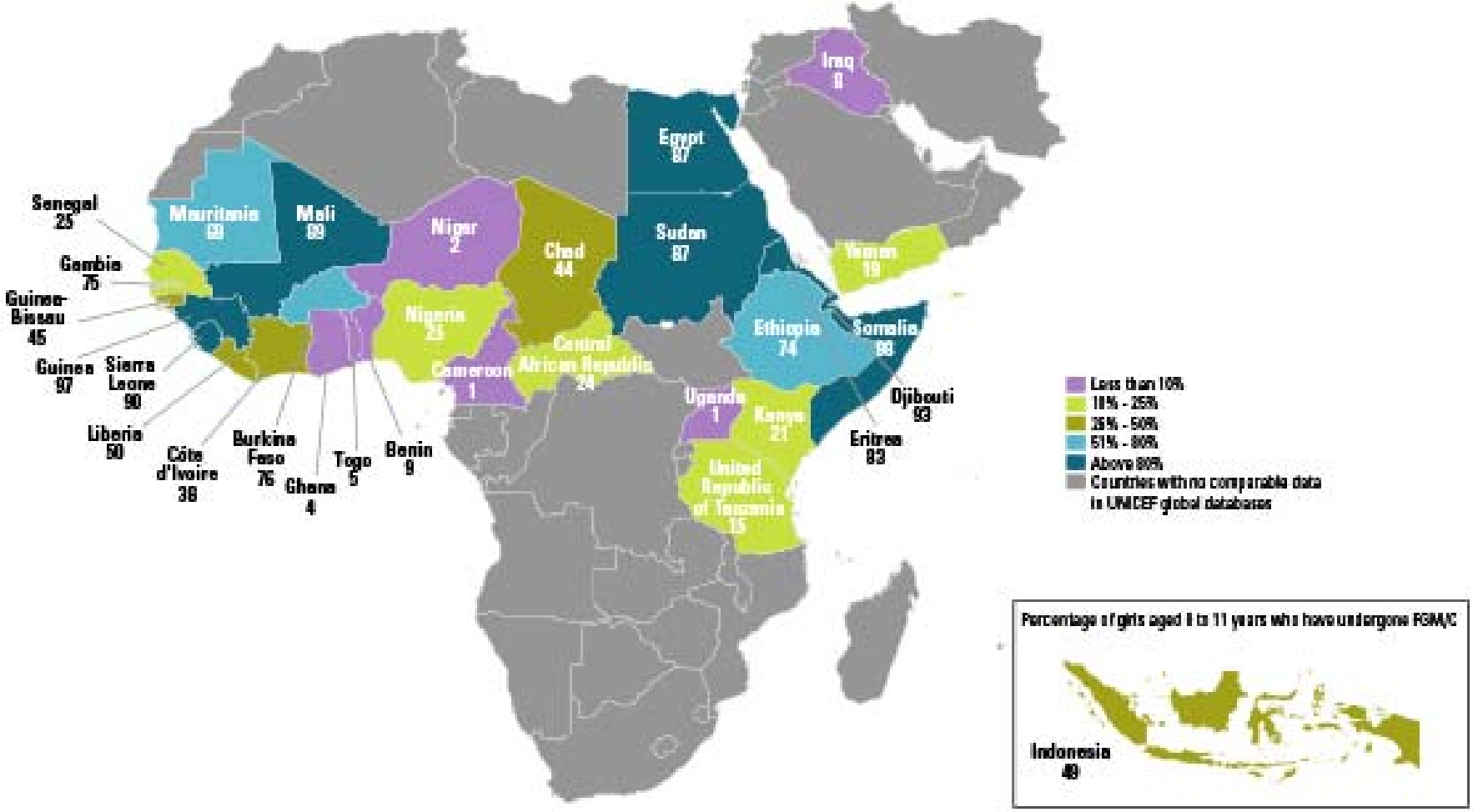
RISK FULLY ASSESSED AGREED MULTI AGENCY DECISION ON OUTCOME

Outcome of referral where low risk identified
-7 Mother/family aware of legislation around FGM and report having no intention of child undergoing FGM
-7 Letter to mother/family
-7 Universal services /professionals advised and to monitor

Outcome of referral if moderate /high risk of FGM being undertaken
-7 Further investigation required and formal plan may need to be put in place and monitored if female child delivered to ensure child protected
-7 Create a written agreement with parents that establishes parental views on FGM and clarifies that they will not arrange FGM for their child and will seek social care support if under family pressure
-7 Where there is no parental collaboration the childs needs are paramount – least intrusive legal approach taken but may need to consider EPO/Care Order/Supervision Order or removal off passport /inform airports/ports re: travel risk in order to protect
-7 Consideration preventative legislative measures (FGM Protection Order)
-7 Parents, referrer and agencies /professionals involved with child/family e.g. midwife/ safeguarding lead/ GP/HV/school nurse/school should be formally notified of outcome
-7 Outcome and plan/monitoring arrangements documented on database
-7 Needs of other female children currently within the family/household or females subsequently born into family /household must be considered and reviewed

N.B ALL ACTIONS AND OUTCOMES MUST FOLLOW LSCB THRESHOLDS AND GUIDANCE
See supporting documents for detail

Appendix 2

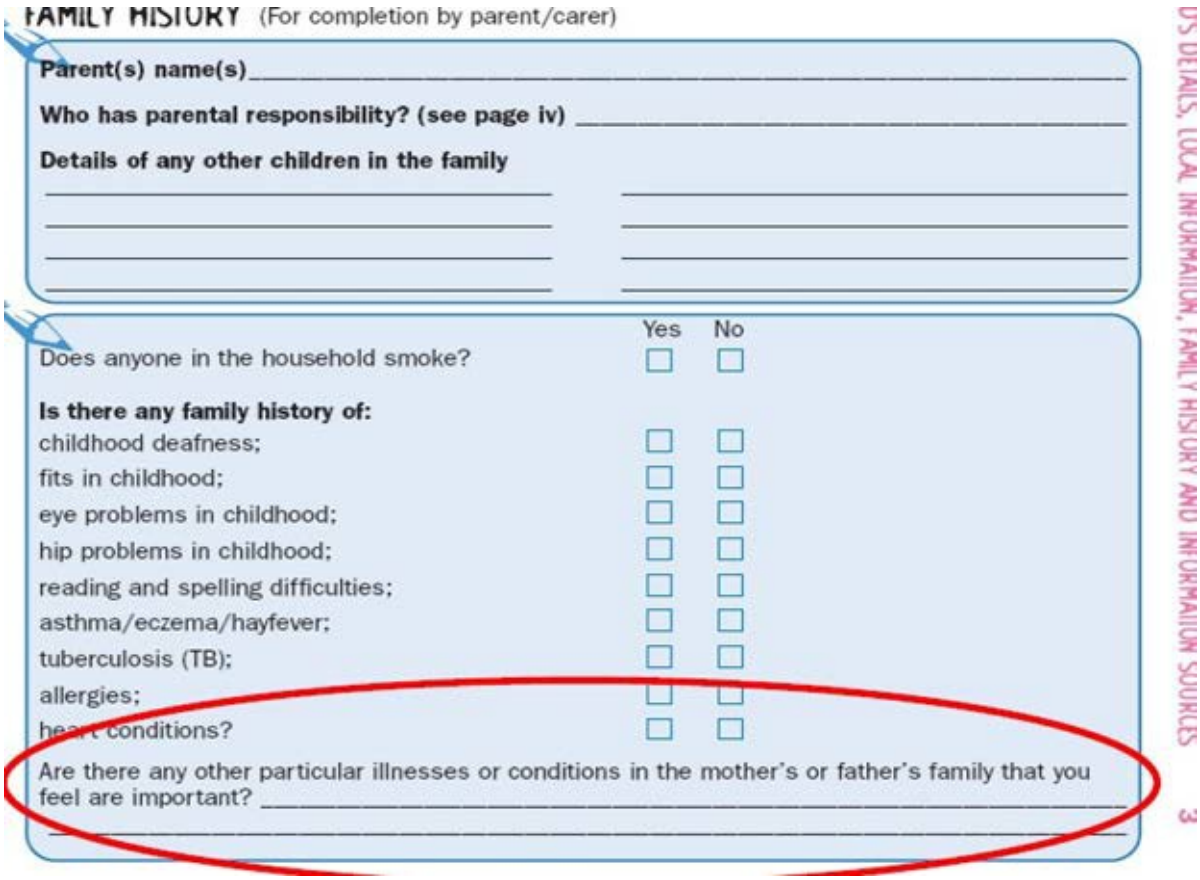


http://www.unicef.org/protection/files/00-FMGC_infographiclow-res.pdf

UNICEF (2015)

Appendix 3

Recording FGM in Red Book –page 3:



FAMILY HISTORY (For completion by parent/carer)

Parent(s) name(s) _____

Who has parental responsibility? (see page iv) _____

Details of any other children in the family

_____ _____

_____ _____

_____ _____

_____ _____

	Yes	No
Does anyone in the household smoke?	☐	☐
Is there any family history of:		
childhood deafness;	☐	☐
fits in childhood;	☐	☐
eye problems in childhood;	☐	☐
hip problems in childhood;	☐	☐
reading and spelling difficulties;	☐	☐
asthma/eczema/hayfever;	☐	☐
tuberculosis (TB);	☐	☐
allergies;	☐	☐
heart conditions?	☐	☐

Are there any other particular illnesses or conditions in the mother's or father's family that you feel are important? _____

_____

US DETAILS, LOCAL INFORMATION, FAMILY HISTORY AND INFORMATION SOURCES 3

Slide provided courtesy of Dr Deborah Hodes 2015

Appendix 4

Female Genital Mutilation Mandatory Reporting Duty from 31st October 2015

From 31st October 2015 there is a new professional duty for staff working in health, education or social care to report cases of FGM in girls under 18 to the police using 101 service where:

- A child under 18 discloses they have had FGM (Type 4 FGM includes genital piercing or cosmetic genital surgery including labioplasty)
- The professional observes a sign leading them to suspect the child/young person has had FGM

The professional must report after a case is discovered (ideally within 24 hours) and speak to their safeguarding lead if in exceptional circumstances longer timeframe required.

The duty to report is a personal duty to report FGM i.e. professional has accountability rather than their employing agency. Failure to comply with the duty will be managed through local disciplinary processes, with potential referral to the registrant's professional body for consideration of fitness to practice proceedings.

Please note: the duty does not apply to:

- **Children thought to be at risk cases of FGM**
- **A woman discloses having FGM as a child**

In such cases local safeguarding procedures must be followed and if child thought to be in imminent danger the professional should ring 999 immediately.

Further information available via:

Home Office: link to guidance regarding mandatory duty
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472691/FGM_guidance.pdf

Department of Health: links to support pack for all health professionals that includes:

https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare
Resources:

- Quick guidance – a 2 page summary of the duty including a process flowchart
- Poster – a poster got health organisations to display about the duty
- Training slides – a training presentation organisations can use to help deliver 10-15 minute updates to staff on the duty to report
- Video interviews with Vanessa Lodge, NHS National FGM Prevention Lead
- Information leaflet - a leaflet for parents and their families (will help professionals when discussion with families)

The website for written materials is: https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare / video can also be found at www.nhs.uk/fgmguidelines

Appendix 5

Specialist Services for Female Genital Mutilation (London Region)	
African Women's Clinic **University College London Hospitals NHS Foundation Trust** Elizabeth Garrett Anderson Wing Lower Ground Floor 25 Grafton Way London WC1E 6DB	**Dr Lata Kamble** (FGM Clinical Lead and Obstetrician) **Mrs Yvonne Saruchera** (Midwifery Lead) **Dr Sohier Elneil** (Urogynaecology Support) **Telephone**: 07944 241992 **E-mail**: For complex cases sohier.elneil@uclh.nhs.uk or fgmsupport@uclh.nhs.uk **Clinic times:** Three clinics/ month Procedure list on the first Monday of the month Other clinics on the third and fourth Mondays
Specialist Paediatric FGM Clinic **University College London Hospitals NHS Foundation Trust** Elizabeth Garrett Anderson Wing Lower Ground Floor 25 Grafton Way London WC1E 6DB	**Dr Hodes** (Lead Paediatrician) **Telephone**: 02034475241 **E-mail**: UCLH.PaediatricSafeguarding@nhs.net Referrals to Dr Hodes and Professor Creighton joint clinic (including for a second opinion on a DVD) where there is a suspicion of FGM or history of having has FGM can be made on the form requested from UCLH.PaediatricSafeguarding@nhs.net . Email the form, with the child's details, address, GP details, Social Worker and team details and a brief history to UCLH.PaediatricSafeguarding@nhs.net . Presently women and children are seen in separate clinics, but this may change in the future. http://www.uclh.nhs.uk/OurServices/OurHospitals/UCH/EG
Acton African Well Woman Clinic **Imperial College Healthcare NHS Trust** Acton Health Centre 35 -61 Church Road London W3 8QE **Queen Charlotte's & Chelsea Hospital African Well Woman Clinic** **Imperial College Healthcare NHS Trust** Du Cane Road London W12 0HS	**Juliet Albert** (Specialist FGM Midwife) **Deqa Dirie and Mushtag Kahin** (Health Advocates) **Melanie Mendel** (Counsellor) **Telephone:** 07956 001 065 0208 383 8761 07730970738 **Clinic times:** Monday to Friday 09:00-17:00 This service is for pregnant and non-pregnant women. They aim to see women within two weeks of contact. They provide counselling and support for women with FGM, a de- infibulation service for women with Type III FGM using local anaesthetic and a referral service for women with complex perineal trauma as a result of FGM

West London African Women's Service – Chelsea and Westminster Hospital NHS Trust **Chelsea and Westminster Hospital** 369 Fulham Road London SW10 9NH **West London Centre for Sexual Health** Charing Cross Hospital (South Wing) Fulham Palace Road London W6 8RF	**Maternity/Gynaecology** **Debora Alcayde** (Specialist FGM Midwife) **Telephone:** 020 3315 3344 **E-mail**: (all aspects of the service): caw-tr.fgmwestlondon@nhs.net **Sexual Health** **Telephone**: 0208 846 1579 (Health Advisors) **Fax:** 0203 311 7582 **Clinic times:** Thursday 9:30 - 12:30 (Chelsea and Westminster Hospital) 2nd and 4th Wednesday of every month 10:30 – 13:00 (West London Centre for Sexual Health) Provides sexual health, maternity and gynaecology advice and treatment for women affected by FGM. **No GP referral required.** This service is for pregnant and non-pregnant women. We aim to see women within two weeks of contact. We can see **children/young women aged 13 and above.** They can be seen in the same clinic. Alternatively, they can be seen in our **confidential walk-in Young People's Service held every Monday, Tuesday and Thursday 2:30 pm to 5:00 pm at the West London Centre for Sexual Health.**
African Well Women's Clinic **Whittington Hospital** Kenwood Wing Antenatal Clinic Level 5 Highgate Hill London N19 5NF	**Joy Clarke** (Specialist Lead) **Shamsa Ahmed** **Telephone**: 0207 2883482/3 07956257992 to make/change an appointment **E-mail**: joy.clarke@nhs.net or shamsa.ahmed@nhs.net http://www.whittington.nhs.uk/mini-apps/staff/staffpage.asp?StaffID=24&t **Clinic times:** Open every Wednesday from 08:30-16:30 The clinic is midwifery led and gender specific. Both pregnant and non-pregnant women can access the clinic. Our aim is to see women within two weeks of their referral. The clinic offers advice, counselling, ante natal care and assessment, de-infibulation, post-surgery and post-natal follow up. Home visits are offered to women living in the borough of Islington and Haringey.

African Well Women's Clinic **Guy's & St. Thomas's Hospital** 8th Floor – c/o Antenatal Clinic Lambeth Palace Road Lambeth London SE1 7EH	**Dr Comfort Momoh MBE** **Telephone**: 0207 188 6872 **E-mail**: comfort.momoh@gstt.nhs.uk **Clinic times:** Monday to Friday 09:00-16:00
Mile End Hospital- Barts Health NHS Trust Women's and Young People's Services Sylvia Pankhurst Health Centre 3rd Floor Bancroft Road London E1 4DG	**Vanessa Apea** **Telephone:** 0207 377 7898 0207 377 7870 0208 223 8322 **E-mail**: Vanessa.apea@bartshealth.nhs.uk www.bartsandthelondon.nhs.uk **Clinic times:** Monday to Thursday 12:00-20:00 Friday 09:30-17:30
African Well Women's Clinic **North West London Hospitals NHS Trust** Antenatal Clinic Watford Road Harrow Middlesex HA1 3UJ	**Central Middlesex Hospital Park Royal (**Antenatal Clinic) **Telephone:** 020 8453 2108 **Northwick Park Hospital Harrow (**Antenatal Clinic) **Telephone:** 020 8869 2880 **E-mail**: lnwh-tr.PALS@nhs.net http://www.nwlh.nhs.uk/services/antenatal-care/ **Clinic times:** This clinic is held on Friday mornings. It is run by specialist midwives who will refer to a consultant if necessary.
Well Women Clinic **St Marys Hospital: Imperial College Healthcare NHS Trust** Gynaecology & Midwifery Dept Praed Street London W2 1NY	These services are only available for those women who are formally booked at St Marys **Telephone:** 0207 886 6691 0207 886 1443 **Helpline**: 0203 312 6135 **Clinic times:** Once a month from 09:00-17:00 structured appointments in mornings for consultation, and afternoon for procedures.

Appendix 6

Organisations that can help:

NSPCC FGM Helpline
0800 028 3550
fgmhelp@nspcc.org.uk

Foundation for Women's Health Research & Development (Forward)
Unit 4, 765-767 Harrow Road, London NW10 5NY Tel:
020 8960 4000
http://www.forwarduk.org.uk/key-issues/fgm

British Medical Association
BMA House, Tavistock Square, London WC1H 9JP
Switchboard: 020 7387 4499
Fax: 020 73836400
http://www.bma.org.uk/ap.nsf/Content/FGM

AFRUCA – Africans Unite Against Child Abuse
Unit 3D/F, Leroy House, 436 Essex Road, London N1 3QP Tel:
020 7704 2261
http://www.afruca.org

Iranian and Kurdish Women's Rights Organisation Tel: 020 7920 6460
http://www.ikwro.org.uk/index.php?option=com_content&task=view&id=93&Itemid=50

Woman Kind Worldwide
Development House, 56-64 Leonard Street, London EC2A 4LT
Womankind.org.uk
Tel: 020 7201 9982

FGM National Clinical Group
c/o University College London Hospital NHS Trust, Elizabeth Garret Anderson & Obstetric Hospital, Huntley Street, London WC1E 6DH
http://www.fgmnationalgroup.org/

UNICEF
UK Helpdesk: 0870 606 3377
http://www.unicef.org.uk/

World Health Organisation (WHO)
European Observatory on Health Systems & Policies, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT
Tel: 020 7927 2833
www.euro.who.int

Appendix 7: Kent and Medway FGM Letter template

CRU/CADS/District
(Add as appropriate)

m/r

y/r *date*

The person dealing with this matter is:

PRIVATE AND CONFIDENTIAL

Addressee details

Dear Mrs

I am writing to advise you that xxxx Children's Social Care have received a referral from your Midwife, advising that you had Female Genital Mutilation [FGM] performed on you as a child. You may be aware that FGM is illegal in the UK (Female Genital Mutilation Act 2003) and that female children of women who have had FGM are considered to be at risk of being subjected to FGM.

All Local Authorities have a duty to safeguard children residing in their area who may be affected by FGM. Your Midwife has informed me that she has already discussed FGM with you and that you have confirmed that you are against the practice; do not intend to subject any female child of yours to FGM and are able to protect them from any cultural pressure to do so from members of your community or family.

Having now established your views in respect of FGM there are no concerns about any female children you may have. However, your Midwife, or Health Visitor, will discuss FGM again with you when your baby is born.

If you would like support about any of the issues raised in this letter, are worried about your child or would like further information, please do not hesitate to contact x xx Social Care.

A copy of this letter has been sent to the referring Midwife and General Practitioner for information

Kind regards.

XXX Team
Children's Social Care

cc: Midwife –
Lead Midwife Safeguarding –

References

1. HM Government (2014) Multi-agency Practice Guidelines: Female Genital Mutilation; Available at:https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512906/Multi_Agency_Statutory_Guidance_on_FGM__-_FINAL.pdf

2. Dept of Education: (2015) Working Together to Safeguard Children; Available at: 3.Africans Unite Against Child Abuse (AFRUCA)

3. British Medical Association (2004), Female Genital Mutilation: Caring for Patients and Child Protection. Guidance from the BMA Ethics Department

4. Female Genital Mutilation Act (2003)

5. The Children Act(1989/2004/2014)

6. The UN Convention on the Elimination of All Forms of Discrimination against Women (1981)

7. United Nations Convention on the Rights of the Child (1989): Ratified December (1991)

8. Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the Welfare of Children. HM Government (2015)

9. Royal College of Nursing: *Female genital mutilation: An RCN educational resource for nursing and midwifery staff*, 2015

10. http://www.rcn.org.uk/ data/assets/pdf_file/0010/608914/RCNguidance_FGM_WEB2.pdf

11. Dept of Health: Female Genital Mutilation Risk and Safeguarding Guidance for professionals (March 2015)

Glossary of Terms

Female Genital Mutilation	Sometimes called Female Circumcision or Female Cutting
Closed	The term "Closed" refers to type III female genital mutilation where there is a long scar covering the vaginal opening. This term is particularly understood by the Somali and Sudanese communities
KSCB	Kent Safeguarding Children Board
MSCB	Medway Safeguarding Children Board
Infibulation	The term "Infibulation" is derived from the name given to the Roman practice of fastening a 'fibular' or 'clasp' through the large lips of a female genitalia (usually within marriage) in order to prevent illicit sexual intercourse
Sunna	Type I, Female Genital Mutilation may be known to some communities as Sunna which is an Islamic word used to describe an action by the Prophet Mohammed.
UNICEF	The United Nations Children's Fund
CRU	Central Referral Unit