Suffolk Safeguarding Children Board

Safeguarding Children At Risk of Female Genital Mutilation (FGM)

SCB Adopted: July 2011

Version Number: 1

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1. Introduction

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

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

All agencies should be alert to the possibility of FGM, and their policy should include a preventative strategy that focuses upon education, as well as the protection of children at risk of significant harm.

This procedure provides guidance for frontline professionals and their managers, volunteers and community members in local communities and community groups such as faith and leisure groups on:

- Identifying when a child may be at risk of being subjected to FGM and responding appropriately to protect the child;
- Identifying when a child has been subjected to FGM and responding appropriately to support the child; and

This procedure should be read in conjunction with the *Suffolk Child Protection Procedures.*

2. Context

FGM is a collective term for all procedures, which include "the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons" (World Health Organisation) or any other injury to the genital organs for non-medical reasons.

FGM is very harmful. It is not like male circumcision. It causes long-term mental and physical suffering, difficulty in giving birth, infertility and even death.

The procedure has no health benefits for girls and women and is internationally recognised as violation of Human Rights.

FGM is much more common than most people realise. It is estimated that there are around 74,000 women in the UK who have undergone the procedure, and about 24,000 girls from the age of 4-15 who are at risk.

This estimate is based on the number of women and girls living in the UK who originate from countries where FGM is traditionally practised, such as Yemen, Oman, Malaysia, Indonesia and the United Arab Emirates as well as 28 countries in Africa including Somalia, Sudan and Sierra Leone.

Girls and women in the UK who have undergone FGM may be British citizens born to parents from FGM practicing communities or they may be women living in Britain who are originally from those communities e.g. women who are refugees, asylum seekers, overseas students or the wives of overseas students.

3. Legal Position

F.G.M has been illegal in the UK since the Female Circumcision Prohibition Act 1985. On 3rd March 2004, the Female Genital Mutilation Act 2003 came into force, replacing the 1985 Act. This Act amends and strengthens the 1985 Act and makes it an offence to:

- Take UK nationals and those with permanent UK residence, overseas for the purpose of circumcision,
- Aid and abet, counsel, or procure the carrying out of FGM. The Act makes it illegal for anyone to circumcise children or women for cultural or non-medical reasons.

The 2003 Act https://www.gov.uk/government/publications/the-female-genital-mutilation-act-2003 increases the maximum penalty for committing or aiding the offence from 5 years to 14 years in prison.

4. Main Forms of Female Genital Mutilation

There are many types but the World Health Organisation (W.H.O) has classified four main ones:

a) Excision type 1-removal of the hood of the clitoris.

b) Excision type 2- removal of the clitoris with partial or total excision of the labia minora.

c) Infibulation-removal of the clitoris, labia minora with narrowing/stitching of the vaginal opening.

d) All other types including piercing, inserting substances or any of the above.

5. Consequences of Female Genital Mutilation

There are both short term and long-term consequences for children who are subjected to female genital mutilation:

Short Term Health Implications

a) Severe pain and shock;
b) Infections;
c) Urine retention;
d) Injury to adjacent tissues;
e) Fracture or dislocation as a result of restraint;
f) Damage to other organs;
g) Death e.g. from immediate haemorrhaging.

Long-term Health Implications

a) Excessive damage to the reproductive system;
b) Uterus, Vaginal and Pelvic infections;
c) Difficulties in menstruation;
d) Difficulties in passing urine;
e) Increased risk of HIV transmission;
f) Infertility;
g) Cysts;
h) Complications in pregnancy and childbirth;
i) Psychological damage;
j) Sexual dysfunction.

6. Reasons why FGM is practised:

- Custom and tradition;
- Family honour;
- Hygiene and cleanliness;
- Preservation of virginity/chastity;
- Social acceptance especially for marriage (bride price is guaranteed);
- The mistaken belief that it is a religious requirement;
- A sense of belonging to the group and conversely the fear of social exclusion.

7. Signs and Indicators That a Child May Be At Risk of Female Genital Mutilation

Some indicators that FGM may be about to or has already taken place:

- If a family originates from a country that is known to practice FGM;
- A prolonged family trip to the country of origin (see guidance for schools on requests for extended leave);
- Midwife/obstetrician/gynaecologist/general practitioner may become aware that FGM has occurred when treating a female patient. This should trigger concern for other females in the household;
- A conversation with a child may refer to FGM i.e. she may express anxiety about a "special procedure" or event that is to take place;
- A prolonged absence from school and a noticeable change in the child's behaviour on their return, including a reluctance or inability to take part in physical activity;
- A child may spend long periods of time away from class during the day- perhaps indicating bladder or menstrual problems;
- Health professionals may identify FGM as part of other health checks/ Interventions

8. Professional Response

Professionals and Volunteers from All Agencies Responding To Concerns

8.1. Summary Response

Any information or concern that a child is at immediate risk of, or has undergone, female genital mutilation should result in a child protection referral to Children's Social Care or Police:

Children's Social Care: Customer First (24hr service) - 0808 800 4005
or
Suffolk Police: 01473 613500 - ON Call DI Public Protection to be consulted

Following the telephone referral, the worker should confirm their concerns in writing within **24 hours**.

In all cases there should be early liaison between Children Social Care and the Police and a decision made about the need for a Strategy Meeting.

Where a child is thought to be at risk of FGM, practitioners should be alert to the need to act quickly – before the child is abused through the FGM procedure in the UK or taken abroad to undergo the procedure.

8.2 Education/Leisure and Community and Faith Groups

Concerns that a child is at risk of being abused through FGM:
Teachers, other school staff, volunteers and members of community groups may become aware that a child is at risk of FGM through a parent/other adult, a child or other children disclosing that:

- The procedure is being planned;
- An older child in the family has already undergone FGM.

School nurses are in a particularly good position to identify FGM or receive a disclosure about it.

A professional, volunteer or community group member who has information or suspicions that a child is at risk of FGM should consult with their designated child protection adviser (if they have one) and should make an immediate referral to Children's Social Care.

If there is a concern about one child, consideration must be given to whether siblings are at similar risk. Once concerns are raised about FGM there should also be consideration of possible risk to other children in the practicing community.

Concerns that a child has already been abused through FGM:
Teachers, other school staff, volunteers and members of community groups may become aware that a child has been subjected to FGM through:

- A child presenting with the signs and indicators described in section 7 above;
- A parent / other adult, a child or other children disclosing that the child has been subjected to FGM.

A professional, volunteer or community group member who has information or suspicions that a child has been subjected to FGM should consult with their designated child protection adviser (if they have one) and make a referral to LA Children's Social Care.

If the child appears to be in acute physical and / or emotional distress, they should make an immediate referral to LA Children's Social Care (in line with section 11 below - LA Children's Social Care - and *section 6.* and to the local health service*.*

If there is a concern about one child, the child's siblings and the children in the extended family should be considered to be at risk.

Once concerns are raised about FGM in relation to one child / family there should also be consideration of possible risk to other children in the practicing community.

8.3 Health

Concerns in relation to a girl or mother who has undergone FGM:

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

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

Health professionals in GP surgeries, sexual health clinics 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 visitors are in a good position to reinforce information about the health consequences and the law relating to FGM. Currently, FGM is not always provided on post-natal discharge reports and is not recorded routinely in health visiting records. Health visitors should seek to record this information wherever possible.

If a girl or woman who has been de-infibulated requests re-infibulation after the birth of a child, where the child is female or there are daughters in the family, health professionals should consult with their designated child protection adviser and with LA Children's Social Care about making a referral to them.

After childbirth a girl/woman who has been de-infibulated may request and continue to request re-infibulation. This should be treated as a child protection concern. This is because, whilst the request for re-infibulation is not in itself a child protection issue, the fact that the girl or woman is apparently not wanting to comply with UK law and / or consider that the process is harmful raises concerns in relation to girl child/ren she may already have or may have in the future. Professionals should consult with Children's Social Care

8.4 The Police

The police have a key role in the investigation of serious crime.

All Child Abuse Investigation Units In Suffolk have an awareness of FGM and is developing a policy to deal with allegations of FGM. The police response recognises the need for an effective investigative response to what is regarded as an extremely severe form of child abuse, recognising the immediate and long term pain, suffering and risks to health associated with this practice.

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

8.5 Children's Social Care

Children's Social Care will investigate (initially) under Section 47 of the Children Act (1989).

If a referral is received concerning one child, consideration must be given to whether siblings are at similar risk.
Once concerns are raised about FGM, there should also be consideration of possible risk to other children in the practicing community. Professionals should be alert to the fact that any one of the girl children amongst these could be identified as being at risk of FGM and will then need to be responded to as a child in need or a child in need of protection.

Children's Social Care will convene a **Strategy meeting** within 48 hours and should involve representatives from police, Children's Social Care, education, health and voluntary services. Health providers or voluntary organisations with specific expertise e.g. FGM, domestic violence and / or sexual abuse, must be invited; and consideration may also be given to inviting a legal advisor.

(See Information about specialist local and national advisors/ resources)

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

Every attempt should be made to work with parents on a voluntary basis to prevent the abuse. It is the duty of the investigating team to look at every possible way that parental co-operation can be achieved, including the use of community organisations and / or community leaders to facilitate the work with parents / family. However, the child's interests are always paramount.

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

9. Children at Immediate Risk of Harm

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

10. If a Child has Already Undergone Female Genital Mutilation

A strategy meeting must be convened within two days. The strategy meeting will consider how, where and when the procedure was performed and the implication of this.

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

A second strategy meeting should take place within ten working days of the referral, with the same chair. This meeting must evaluate the information collected in the enquiry and recommend whether a child protection conference is necessary, according to SCB procedures.

A girl who has already undergone FGM should not normally be subject to a child protection conference or registered unless additional child protection concerns exist. However, she should be offered counselling and medical help as a Child In Need. Consideration must be given to any other female siblings at risk

11. If a Woman Has Already Undergone Female Genital Mutilation

If a woman has already undergone FGM and this comes to the attention of any professional, consideration needs to be given to any child protection implications e.g. her own siblings, extended family members and a referral made to Children's Social Care or the Police Child Protection Investigation Unit, if appropriate.

If the woman is the mother of a female child or has/ will have the care of female children, professionals need to assess the potential risk to female children in the family and need to identify the most appropriate way of informing parents of the legal and health implications of F.G.M. This should be done in consultation with the Child Protection Unit at Social Services.

Resources

Suffolk Constabulary Bal Howard, Project Manager, Honour Based Abuse, Forced Marriage, Female Genital Mutilation	01473 613500
Foreign & Commonwealth Office	020 7008 1500
Forced Marriage Unit	020 7008 0151
Metropolitan Police - Project Azure	020 7161 2888
Foundation for Women's Health Research & Development (FORWARD)	020 8960 4000
ACCM	07712 482568
NSPCC	0808 800 5000