Kingston and Richmond LSCB

Female Genital Mutilation Policy

Updated March 2017

This guideline has been adopted from Wandsworth’s Female Genital Mutilation: Prevention Guidelines
1 Introduction

1.1 Purpose

The purpose of this policy is to provide guidance to professionals and practitioners who have the responsibility to safeguard children and protect adults from abuse related to female genital mutilation (FGM) and sets out guidance for the multi-agency response to such incidents as FGM.

Specifically, this guidance will aim to support frontline professionals and practitioners to:

- Identify and prevent FGM;
- Appropriately record FGM on health records and share information;
- Ensure that survivors and potential victims receive appropriate responses;
  - Provide practical guidance for professionals about working with clients who survive FGM;
  - Report to the police if they are informed by a girl under the age of 18 that an act of Female Genital Mutilation (FGM) has taken place or observe physical signs that an act of FGM may have been carried out on a girl under the age of 18. This is a mandatory requirement.

This guidance has referenced various other sources and in particular the Kingston and Richmond LSCB would like to extend our appreciation to Wandsworth LSCB for allowing us to adopt this policy.

1.2 Definition

According to the World Health Organisation (WHO) female genital mutilation (FGM) is defined as: "all procedures (not operations) which involve partial or total removal of the external female genitalia or injury to the female genital organs whether for cultural or other non-therapeutic reasons" (WHO, 1996).

FGM is classified under four major types:

Type 1 - Clitoridectomy:
“Partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).”

Type 2 - Excision:
“Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).”

**Type 3 - Infibulation:**
“Narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.”

**Type 4 - Other:**
“All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.”

For more information on WHO’s classification of FGM refer to Appendix 6.

### 1.2.1 Other Terms for FGM

The term FGM is more commonly utilised by professional communities and has little significance to communities where FGM is ‘high risk’. The general public may refer to FGM as female genital ‘cutting’, ‘circumcision’ or ‘cut’, however these terms may not be understood by practising communities as they are English terms. For example the Somalian Community may refer to FGM as ‘Gudiniin’ and in Sierra Leone, FGM is referred to as ‘Sunna’. Please see the glossary in Appendix 2 for terms associated with FGM.

### 1.3 Scope

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

- Safeguard children and young people from abuse;
- Protect young women from abuse.

This includes, but is not limited to, health and social care professionals, police officers, teachers and other educational professionals.

*For child protection purposes a child is anyone who has not yet reached their 18th birthday.*

### 1.4 National Context and legislative framework

#### 1.4.1 Mandatory reporting of FGM

On the 31st October 2015, a new mandatory reporting duty was introduced via the Serious Crime Act 2015. Health and Social Care Professionals and teachers must report to the police any FGM cases they come across in their work for girls under the age of 18 years old.

FGM is an illegal practice and is child abuse whether carried out in the UK or abroad. It is also illegal to send a child abroad for the procedure or assist in helping someone to carry out the procedure in any way.

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Please visit https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472691/FGM_guidance.pdf to read more about mandatory reporting of FGM. In response to the mandatory FGM reporting, London Child Protection procedures have also provided a procedure update - http://www.londoncp.co.uk/

1.4.2 Legal Framework on FGM

Internationally FGM is recognised as the violation of the human rights of girls and women. The United Kingdom (UK) is a signatory to two key international Conventions: the UN Convention on the Rights of the Child (CRC) and the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Article 24 of the CRC calls for the prohibition of all traditional practices that are prejudicial to the health and wellbeing of children across the globe.

Under the Female Genital Mutilation Act 2003, FGM is illegal in England, Wales and Northern Ireland and under the Prohibition of Female Genital Mutilation Act 2005 in Scotland. This means that these Acts make it an offence to:

- to excise, infibulate or otherwise mutilate the whole or any part of a person’s labia majora, labia minora or clitoris; or
- to aid, abet, counsel or procure any form of FGM for a girl or woman for cultural or non-medical reasons; or
- To take a UK national or resident overseas for the purpose of or to aid, abet, procure or perform FGM abroad; or
- A trained medical practitioner to perform any surgical procedure for FGM or to re-infibulate a girl or woman.
- However, both Acts outline there is no offence for an appropriately registered practitioner carrying out the procedure and permit surgical and obstetric procedures where necessary for a girl or woman’s mental or physical health e.g. for gender reassignment, cosmetic surgery resulting from perceived abnormality, and operations to remove malignant tumours, or during childbirth.

If these acts are carried out, then they carry a maximum of 14 years’ imprisonment.

1.4.3 National Policy documents for professionals

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3 http://www.who.int/mediacentre/factsheets/fs241/en/
5 http://www.legislation.gov.uk/ukpga/2003/31/contents
Within this policy and legal framework, professionals and volunteers from all agencies have a statutory responsibility to safeguard children from being abused through FGM.

1.5 Principles

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

- The safety and welfare of the child is paramount;
- All agencies will act in the interest of the Rights of the Child as stated in the UN Convention (1989);
- FGM is illegal and is prohibited by the Female Genital Mutilation Act 2003 and Prohibition of Female Genital Mutilation (Scotland) Act 2005;
- FGM causes significant harm both in the short and long term and constitutes physical and emotional abuse to children;


[http://www.workingtogetheronline.co.uk/](http://www.workingtogetheronline.co.uk/)

[http://www.londoncp.co.uk/](http://www.londoncp.co.uk/)


[https://www.rcm.org.uk/tags/fgm](https://www.rcm.org.uk/tags/fgm)


[bma.org.uk/-/media/Files/PDFs/.../Ethics/femalegenitalmutilation.pdf](bma.org.uk/-/media/Files/PDFs/.../Ethics/femalegenitalmutilation.pdf)


• All decisions or plans for the child/ren should be based on good quality assessments and be sensitive to the issues of race, culture, gender, religion and sexuality, and avoid as far as possible, stigmatising the child or the practising community;
• Accessible, acceptable and sensitive Health, Education, Police, Children’s Social Care and Voluntary Sector services must underpin all procedures relating to FGM;
• All agencies should work in partnership with members of local communities, to empower individuals and groups to develop support networks and education programmes.

*(Section adopted from Wandsworth’s Female Genital Mutilation Prevention Guidelines)*

2. Risk Factors

There is not one single factor which could be considered as a significant suggestion that a girl may be at risk of undergoing FGM. However, there may be specific factors combined together which could increase the risk of a child undergoing the practice. The following factors are intended to provide guidance to professionals and practitioners, in order to raise their indices of suspicion if one or more of these factors come to their attention when they have any contact with the child and family from countries, that are categorised as ‘high risk’ communities (see Appendix 3 Map of FGM prevalence). Also the following must prompt intervention to protect any child that is at risk of FGM.

The following guidelines have been adopted from best practice, national and regional guidelines. Table 1 demonstrates risk factors that the child may be at risk or that FGM has taken place. The table has been adopted from Wandsworth FGM: Prevention Guidelines.

The risk of FGM should be considered in a family when it is known that the family comes from a community that is known to practise FGM and/or if there is information that a female family member has undergone the procedure herself. This is particularly important if the community is believed to be less integrated into British society. Furthermore, if there is any consideration that a girl has undergone or is at serious risk of FGM, this should lead to a wider consideration about the welfare of other girls, who belong to the immediate or extended family.

**Table 1: FGM Risk Identification tool**

<table>
<thead>
<tr>
<th>Factors suggesting a girl has undergone FGM:</th>
<th>Factors suggesting a girl is at risk of FGM:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prolonged absence from school without a medical indication and on return to school:</td>
<td>From the “high risk” communities (see Appendix 3) and:</td>
</tr>
<tr>
<td>1. Has difficulty in walking, sitting or standing;</td>
<td>1. Aged 0 - 14 years old;</td>
</tr>
<tr>
<td>2. Has noticeable behaviour changes;</td>
<td>2. Withdrawn from Personal, Social, Health and Economic Education (PSHE) lesson by parents;</td>
</tr>
<tr>
<td>3. Requests to be excused from physical exercise lessons.</td>
<td>3. Parent or female child states the girl will be taken out of the country for an extended holiday;</td>
</tr>
<tr>
<td>Confiding in a professional that FGM has taken place *.</td>
<td>4. Mother had FGM.</td>
</tr>
</tbody>
</table>

Confiding in a professional about an impending ‘special
procedure’ or special holiday or ceremony *

<table>
<thead>
<tr>
<th>Requesting help to manage any of the complications Associated with the practice *</th>
<th>Requesting help from a teacher or another professional or adult to avoid FGM *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spending longer than normal in the toilet due to difficulties urinating.</td>
<td>An older sister had FGM *</td>
</tr>
<tr>
<td>Frequent urinary tract infections or menstrual problems.</td>
<td>A mother who had FGM requesting re-infibulation after de-infibulation*</td>
</tr>
<tr>
<td>Recent onset of signs of emotional and psychological trauma (e.g. withdrawal, depression and/or anger).</td>
<td>Talking about a long holiday to country of origin or another country where the practice is prevalent.</td>
</tr>
<tr>
<td>Reluctance to undergo normal medical examinations. (e.g. cervical smears)</td>
<td>A professional hears reference to FGM</td>
</tr>
</tbody>
</table>

* Note: Occurrence of any one of these factors should prompt immediate action

3. Professional Response

3.1 All professional groups

The appropriate response to FGM should follow Child Protection Procedures as it is considered as a child protection issue. It should ensure that there is compliance with Section 11 of the Children Act 2004. This will ensure:

- That there is immediate support and protection to the child/ren affected;
- The practice is not perpetuated.

Professionals who come into contact with a girl or woman, who has undergone the FGM procedure should be attentive to the risk posed in relation to:

- Sisters of the affected girl;
- Daughters an affected woman/girl has or may have in the future;
- Extended family members.

Any information or concern that a child is at risk of, or has undergone, FGM, should result in a child protection referral to the Kingston and Richmond Single Point of Access or the local police.

Kingston and Richmond Child Protection Procedures can be found on Kingston and Richmond Safeguarding Children Board website: [www.kingstonanddricmfordicb.org.uk](http://www.kingstonanddricmfordicb.org.uk).

It is important that Children Social Care, Police and the referrer work together in approaching and working with the family/girl, ensuring partners approach the case with sensitivity at all times.

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Pathways for individual frontline professions on how to identify and refer a child at risk or has undergone FGM can be found within Appendix 6.

The police run an FGM project called Project Azure: [http://content.met.police.uk/Article/Female-genital-mutiliation/1400009693144/1400009693144](http://content.met.police.uk/Article/Female-genital-mutiliation/1400009693144/1400009693144)

All professionals should make sure that they and their staff have undergone up-to-date safeguarding training (inclusive of FGM) and/or FGM training. This is to ensure that staff have the skills and knowledge of what their responsibilities are, and how they can handle cases appropriately where a woman/child with or is at risk of FGM.

Contact details for the Single Point of Access in Kingston and Richmond:

**Richmond & Kingston Single Point of Access:**
First Floor,
Guildhall 2
High Street
Kingston upon Thames
KT1 1EU

Tel: 020 8547 5008 8am-6pm Mon to Fri
Out of Hours: If you need to speak to someone urgently outside of office hours, please ring the Duty Social Worker on 020 8770 5000

Contact details for the Police Child Abuse Investigation Team (CAIT) in Kingston and Richmond

**Child Abuse Investigation Team – Kingston and Richmond**

0208 785 8529
Contact details for Local Safeguarding Leads in Kingston and Richmond

<table>
<thead>
<tr>
<th>Kingston</th>
<th>Local Safeguarding Leads</th>
<th>Richmond</th>
</tr>
</thead>
<tbody>
<tr>
<td>0208 274 7803</td>
<td>Designated Nurse for Child Safeguarding</td>
<td>0208 734 3061</td>
</tr>
<tr>
<td>0208 934 3405</td>
<td>Designated Doctor for Child Safeguarding</td>
<td>0208 891 8188</td>
</tr>
<tr>
<td></td>
<td>Named GP Safeguarding Children</td>
<td>07932 510 884</td>
</tr>
<tr>
<td>0208 547 5008</td>
<td>Safeguarding Children Team</td>
<td></td>
</tr>
</tbody>
</table>

3.1.1 Actions to take:

- If a child is at **immediate risk** of FGM contact the Police on **999**
  - Police in turn are to follow the pathway to notify the local CAIT and Kingston and Richmond Single Point of Access (SPA).

- If a professional is concerned about a child who may be **at risk or has had FGM** they can:
  - Refer to:
    - Kingston or Richmond SPA
    - The local Police – **101**
    - The local CAIT team
  - Consult their Local Safeguarding leads within working hours
  - Seek advice from:
    - NSPCC Child Protection Helpline on **0808 800 5000**
    - FORWARD on **020 8960 4000**

- Where a child is thought to be at risk of FGM, practitioners should be attentive to their needs and act quickly in order to prevent the child being abused in the UK or abroad

Please see link below for flowchart.

See Box 1 and Box 2 for examples of specific actions to be taken.\textsuperscript{20, 21}

For detailed professional specific guidance, the following documents are recommended:

\textbf{Box 1: An appropriate response to a child suspected of having undergone FGM as well as a child at risk of undergoing FGM could include:}

- If it is necessary and appropriate an interpreter should be arranged;
- Creating an opportunity for the child to disclose, for example, seeing the child on their own;
- Using simple language and asking straightforward questions;
- Using terminology that the child will understand, e.g. the child is unlikely to see the procedure as abuse;
- Being sensitive to the fact that the child will be loyal to their parents;
- The child should be given time to talk;
- If the child is at risk of being subjected to the procedure, accurate information should be given about the urgency of the situation;
- The child should be given the message that s/he can come to you again.

\textbf{Box 2: An appropriate response by professionals who encounter a girl or woman who has undergone FGM includes:}

- Arranging for a professional interpreter and not agreeing to friends / family members interpreting on their behalf;
- Being sensitive to the intimate nature of the subject;
- Make no assumptions;
- Asking straightforward questions;
- Being willing to listen;
- Being non-judgemental (condemning the practice, but not blaming the girl/woman);
- Understanding how she may feel in terms of language barriers, culture shock, that she, her partner, her family are being judged;
- Giving a clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM if / when they have daughters.

\textbf{3.2 Education, leisure settings, and community and faith groups}

\textbf{3.2.1 Concerns that a child is at risk of FGM}

\textsuperscript{20}http://www.wscb.org.uk/wscb/info/88/local_multi-agency_strategies/99/local_multi-agency_strategies/6
\textsuperscript{21}Safeguarding Children at Risk of Abuse through Female Genital Mutilation
Teachers, classroom assistants and school staff are in an important position to identify girls being at risk of FGM or to receive disclosures concerning it. Teachers, other school staff, volunteers and members of community groups may become aware that a child is at risk of FGM through a child/other children, or parent/other adult disclosing information that the procedure is planned or any of the risks factors are present outlined in Section 2.

If this does occur, all school staff, volunteers and community groups should refer this to their Designated Safeguarding Lead (DSL) (if they have one) and follow the pathway outlined for schools in order to make a referral Appendix 6. If the child should be deemed ‘at risk’, Kingston and Richmond SPA and the Police should be contacted in order to determine the best way forward to approach the family/girl. It is critical to remember the sensitivity to the situation and the welfare of the child is paramount.

**Note:** A referral should not be delayed in order to consult with the Designated Safeguarding Lead, a manager or group leader, but rather a referral to Kingston and Richmond SPA or Police to protect the child needs to happen quickly.

Moreover, the school and educational settings have the responsibility to raise awareness about FGM amongst pupils and parents; however they also need to ensure that the adequate support is available to girls and/or parents, who then may seek advice or support. Raising awareness about FGM can be undertaken in a variety of ways, for example through Personal, Social, Health and Education (PSHE) lessons, posters, leaflets, assemblies or parents evening. Teachers and School Nurses play a fundamental role in educating children on the law and health consequences surrounding FGM, children’s Human Rights and support services available to children and young people to being inclusive of children wanting to stand against FGM.

Advice and support can be found through NSPCC and FORWARD.

### 3.2.2 Concerns that a child has already undergone 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 risk factors described in Section 2;
- 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 suspects or has information that a child has been subjected to FGM they should refer this to their DSL and should follow the pathway outlined for schools (Appendix 6) make a referral.

Should the child be deemed to have undergone FGM, Kingston and Richmond SPA and the Police need to be contacted (who should contact the CAIT team) to determine the best way forward to approach the family/girl. It is critical to remember the sensitivity to the situation and the welfare of the child and another female sibling is paramount.
3.3 Health care settings

3.3.1 Concerns in relation to a mother who has undergone FGM

Health professionals in GP surgeries, sexual health clinics, maternity services and A&E services are more likely to encounter a girl/woman who has been subjected to FGM due to the nature of the services they provide. All health staff are ideally placed to:

- Identify a girl/woman who has undergone FGM;
- Record the presence and type of FGM;
- Facilitate information sharing between agencies (especially between midwifery and GPs);
- Inform the girl/woman of the legal and health implications of practising FGM; and
- Provide information on supportive services available.

With effect from 1st April 2014 the ISB 1610 FGM Prevalence Dataset “requires organisations to record and collect information about the prevalence of FGM within the patient population as treated by the NHS in England. The requirement to submit the FGM Prevalence Dataset is mandatory for all Acute (Foundation and non-Foundation) Trusts, including A&E departments, however other organisations (which may include GPs) may wish to support the standard and provide an FGM Prevalence Dataset centrally”.

Therefore, all health professionals (such as but not restricted to midwives, GPs and Practice Nurses) should ask all pregnant women despite country of origin, in addition to all women and new registrations from the “high risk” countries (see Section 6.3), the question of “have you been cut/circumcised?” or “are you closed or open?” in consultation, and to record the response. It is encouraged that these questions are asked to the woman alone or with an interpreter and that a relative is not present during a consultation. This allows the health professional to be in a good position to inform the woman of the law and health consequences of FGM, Human Rights of children and support services that are available. The information gathered on the mother regarding FGM should be shared with other agencies to ensure that girls within the family are safeguarded against FGM occurring.

Maternity services and Health Visitors should record if a woman presents with FGM, and ensure that this information is appropriately passed on to other relevant services (e.g. GPs, Kingston and Richmond SPA). GP Practices are encouraged to upload the information on their discharge summary regarding the mother’s status of FGM onto the relevant patient electronic system in both the mother and the child’s (regardless of gender) health records with the appropriate code. If the family decide to move, the information uploaded onto the system will follow the child, and safeguard any/future daughter from FGM.

Front line staff must report to the police if they are informed by a girl under the age of 18 that an act of Female Genital Mutilation (FGM) has taken place or observe physical signs that an act of FGM may have been carried out on a girl under the age of 18. This is a mandatory requirement.

Please refer to Section 6.6.4 for the Health Pathway which should be followed by all health professionals to eradicate FGM.

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Health Visitors and Community Nurses are in an important position to reinforce information about the health implications and the law relating to FGM, and make referrals to other services. They have a duty to take appropriate action to prevent the prospect of any child they care for coming to harm.

A professional attending to a girl or woman, who has been de-infibulated during child birth, and who subsequently requests re-infibulation must consult their Designated Safeguarding Lead or Named Nurse and Children’s Social Care about making a referral, regardless of the gender of the baby, as there may be girls in the family at risk of FGM. This is because, whilst the request for re-infibulation is not in itself a child protection issue, the fact that the girl or woman appears to not want to comply with UK law and/or does not consider that the practice is harmful, raises concerns in relation to any daughters she may already have, or may have in the future.  

See also the BMA Guidance: FGM: Caring for patients and child protection.†

3.4 The Police

FGM is regarded by the Metropolitan Police to be an extremely severe form of child abuse and they recognises the immediate and long term pain and health risks associated with the procedure/practice.

The Police Service including Child Abuse Investigation Teams (CAIT) is committed to eradicating FGM and will work in partnership with health and social care agencies to investigate and prosecute perpetrators of FGM, if appropriate. Police and Children’s Social Care will work together with girls who have suffered or are likely to suffer FGM following the processes set out in the 2015 London Child Protection Procedures. A protocol was signed between the Metropolitan Police and Crown Prosecution Service in July 2013 ensuring that all cases involving FGM are investigated and prosecuted thoroughly, as well as setting out how each case will be carefully and consistently considered, ensuring that the welfare of the woman/girl is paramount at all times.

The extension of the police investigation will identify established excisors with a view to also identify further victims and ensure these networks are closed down where children are affected.

In collaboration with Project Azure and the local CAIT team, the pathway for local police to follow on notification of a concern that FGM has occurred, or is at risk of occurring, has been accepted and is to be embedded within workforce practice (see Section 6.6.2).

3.5 Local Authority Children’s Social Care

Section 47 Children Act 1989 sets out the LA legal duty to assess a child’s circumstances where there is likelihood that the child has or is at risk of suffering significant harm and FGM is significant harm. When Kingston or Richmond SPA Children’s Social Care via the Multi Agency Safeguarding Hub (MASH) receives a referral that a child in a family is at risk of significant harm, appropriate child protection procedures should be followed and all children within that family should be assessed alongside working with the Police, GPs,

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Health Visitors and support services to advise the family and protect the child/ren (refer to Section 6.6.5 for the MASH Pathway which should be followed by all staff to eradicate FGM).

### 3.6 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.

The London Child Protection Procedures (Section 24.6) outlines that “on receipt of a referral, a strategy meeting / discussion must be convened within two working days, and should involve representatives from the police, LA children’s social care, education, health and third sector services. Health providers or third sector 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.”

Within the strategy meeting, it should be first established whether the parents or child has had access to information regarding the harmful consequences FGM and the law in the UK. If this is not the case, the parent/child should be given appropriate information on the harmful consequences of FGM and the law. During the interviews with the family and child, a female interpreter (who is not the family) should be used or if it is possible, a community advocate (Community Champion) who is appropriately trained in all aspects of FGM should also be involved.

“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.

#### 3.6.1 Child is at immediate risk of harm

If the strategy meeting/discussion decides that the child is in immediate danger of mutilation and parents cannot satisfactorily guarantee that they will not proceed with it, the Police have powers to carry out immediate safeguarding action using Powers of Police Protection (Section 6.4), if appropriate, whilst the Local Authority can seek an Emergency Protection Order within a short period of time, if necessary.

#### 3.6.2 Child has already undergone FGM

If the child has already undergone FGM, a second strategy meeting should take place within 10 working days of the referral, with the same Chair. The strategy meeting/discussion 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 child protection conference should only be considered necessary if there are unresolved child protection issues, once the initial investigation and assessment have been completed. Where FGM has been practised,

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25 [http://www.londoncp.co.uk/chapters/sg_ch_risk_fgm.html#responding](http://www.londoncp.co.uk/chapters/sg_ch_risk_fgm.html#responding)
The police child abuse investigation team (CAIT) will take a lead role in the investigation of this serious crime, working to common joint investigative practices and in line with strategy agreements.26

4. Information sharing and FGM monitoring among agencies

The statutory guidance on Section 11 of the Children Act 200427 states that in order to safeguard and promote children’s welfare, the agencies covered by Section 11 should make arrangements to ensure that:

- All professionals in contact with children understand what to do and the most effective ways of sharing information if they believe that a child and family may require particular services in order to achieve positive outcomes;

- All professionals in contact with children understand what to do and when to share information, if they believe that a child may be a child in need, including those children suffering or at risk of suffering harm;

The statutory guidance in Section 10 of the Children Act 200428 makes it clear that effective information sharing supports the duty to co-operate to improve the well-being of children. Professionals in all agencies need to be confident and competent in sharing information appropriately, both to safeguard children against having FGM and to enable children and women who have had FGM to receive physical, emotional and psychological help.29

Tackling FGM in the UK Intercollegiate recommendations16 highlight the need for a robust data system to be developed for monitoring and auditing of FGM by those who are charged with leading a preventative response. By implication, this system should also consider the mobility of populations, particularly where there may be a large refugee cohort.

5. The role of Local Safeguarding Children Boards in reducing FGM

The duties and responsibilities of the Local Safeguarding Children Boards (LSCBs) consist of promoting activity amongst the community, local agencies and partners to:

- Recognise, identify and prevent maltreatment of health or development impairment and ensure that children grow up in an environments and circumstances with effective and safe care;

- Safeguard and promote the welfare of children, who may potentially be more vulnerable than the general population;

26 http://www.londoncp.co.uk/chapters/sg_ch_risk_fgm.html#responding
- Ensure that there is an increased understanding of safeguarding children issues within the professional and wider community through promoting messages that safeguarding is everybody’s responsibility.

Kingston and Richmond LSCB are responsible for ensuring that training is available to agencies on safeguarding and promoting the welfare of children in order to meet local needs. Professionals that have safeguarding and child protection responsibilities should be familiar with child protection procedures relating to FGM. Staff should be confident with local preventative programmes in relation to FGM.

6. Appendices

6.1 Appendix 1: Detailed WHO classification of FGM

- **Type 1** — Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
  - When it is important to distinguish between the major variations of Type I mutilation, the following subdivisions are proposed:
    - Type I (a), removal of the clitoral hood or prepuce only;
    - Type I (b), removal of the clitoris with the prepuce.
• **Type 2** — Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
  - When it is important to distinguish between the major variations that have been documented, the following subdivisions are proposed:
    - Type II (a), removal of the labia minora only
    - Type II (b), partial or total removal of the clitoris and the labia minora
    - Type II (c), partial or total removal of the clitoris, the labia minora and the labia majora.
• **Type 3** — Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
  - Type III (a), removal and apposition of the labia minora
  - Type III (b), removal and apposition of the labia majora.
• **Type 4** — All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.
### 6.2 Appendix 2: Glossary of Terms used for FGM

Table 3: Terms used for FGM in various languages

<table>
<thead>
<tr>
<th>Country</th>
<th>Term used for FGM</th>
<th>Language</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egypt</td>
<td>Thara</td>
<td>Arabic</td>
<td>Deriving from the Arabic word 'tahar' meaning to clean / purify</td>
</tr>
<tr>
<td></td>
<td>Khitan</td>
<td>Arabic</td>
<td>Circumcision - used for both FGM and male circumcision</td>
</tr>
<tr>
<td></td>
<td>Khifad</td>
<td>Arabic</td>
<td>Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Megrez</td>
<td>Amharic</td>
<td>Circumcision / cutting</td>
</tr>
<tr>
<td></td>
<td>Absum</td>
<td>Harrari</td>
<td>Name giving ritual</td>
</tr>
<tr>
<td>Eritrea</td>
<td>Mekhnishab</td>
<td>Tigregna</td>
<td>Circumcision / cutting</td>
</tr>
<tr>
<td>Kenya</td>
<td>Kutairi</td>
<td>Swahili</td>
<td>Circumcision - used for both FGM and male circumcision</td>
</tr>
<tr>
<td></td>
<td>Kutairi was ichana</td>
<td>Swahili</td>
<td>Circumcision of girls</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Ibi / Ugwu</td>
<td>Igbo</td>
<td>The act of cutting - used for both FGM and male circumcision</td>
</tr>
<tr>
<td></td>
<td>Sunna</td>
<td>Mandingo</td>
<td>Religious tradition / obligation - for Muslims</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>Sunna</td>
<td>Soussou</td>
<td>Religious tradition/ obligation - for Muslims</td>
</tr>
<tr>
<td></td>
<td>Bondo</td>
<td>Temenee/Mandingo/Limb/</td>
<td>Integral part of an initiation rite into adulthood</td>
</tr>
<tr>
<td>Somalia</td>
<td>Bondo / Sonde</td>
<td>Mendee</td>
<td>Integral part of an initiation rite into adulthood</td>
</tr>
<tr>
<td></td>
<td>Gudiniin</td>
<td>Somali</td>
<td>Stitching/tightening/sewing refers to infibulation</td>
</tr>
<tr>
<td></td>
<td>Halalays</td>
<td>Somali</td>
<td>Deriving from the Arabic word ‘khafad’ meaning to lower (rarely used in everyday language)</td>
</tr>
<tr>
<td></td>
<td>Qodiin</td>
<td>Somali</td>
<td>Deriving from the Arabic word ‘tahar’ meaning to clean / purify</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Country</th>
<th>Word</th>
<th>Language</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudan</td>
<td>Khifad</td>
<td>Arabic</td>
<td>Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)</td>
</tr>
<tr>
<td></td>
<td>Tahoor</td>
<td>Arabic</td>
<td>Deriving from the Arabic word 'tahar' meaning to purify</td>
</tr>
<tr>
<td>CHAD – the Ngama</td>
<td>Bagne</td>
<td></td>
<td>Used by the Sara Madjingaye</td>
</tr>
<tr>
<td>Sahara subgroup</td>
<td>Gadja</td>
<td></td>
<td>Adapted from ‘ganza’ used in the Central African Republic</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>Fanadu di Mindjer</td>
<td>Kriolu</td>
<td>'Circumcision of girls'</td>
</tr>
<tr>
<td></td>
<td>Fanadu di Omi</td>
<td>Kriolu</td>
<td>'Circumcision of boys'</td>
</tr>
<tr>
<td>Gambia</td>
<td>Niaka</td>
<td>Mandinka</td>
<td>Literally to ‘cut /weed clean’</td>
</tr>
<tr>
<td></td>
<td>Kuyango</td>
<td>Mandinka</td>
<td>Meaning 'the affair' but also the name for the shed built for initiates</td>
</tr>
<tr>
<td></td>
<td>Musolula Karoola</td>
<td>Mandinka</td>
<td>Meaning 'the women's side' / 'that which concerns women'</td>
</tr>
</tbody>
</table>

6.3 Appendix 3: Map of Prevalence of FGM

FGM has also been documented in communities including:

- Iraq
- Israel
- Oman
- The United Arab Emirates
- The Occupied Palestinian Territories
- India
- Indonesia
Percentage of girls and women aged 15 to 49 years who have undergone FGM/C

Note: In Liberia, girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM/C since it is performed during initiation into the society.


http://www.data.unicef.org/child-protection/fgmc
6.4 Appendix 4: Definition of Police Protection

Children Act 1989 Police Protection Powers
Police Officers have powers under section 46 of the Children Act 1989 to protect children. If Police Officers have reasonable cause to believe that a child would otherwise be likely to suffer harm, then they can remove the child to suitable accommodation and keep him/her there; or take such steps as are reasonable to ensure that the child’s removal from any hospital, or other place, in which he/she is then being accommodated is prevented. The child is considered to be in police protection when these powers have been exercised by the police. This is not an Order granted by a court so therefore should not be referred to as a police protection order. A child cannot be kept in police protection for more than 72 hours.

When should I take a child into Police Protection?
Only in an emergency and when necessary should Police Protection be used. The principle being that wherever possible the decision to remove a child from a parent or carer should be made by a court. Police Protection should be carried out if it means leaving the child in a situation where they are found to be in imminent danger or risk of coming into significant harm. However like all powers the police officer needs to justify their actions. The justification of actions will lead to a detailed explanation of the circumstances and allowing others to assess the risks the officer felt the child was exposed to. The risk(s) could be of an immediate nature or of more prolonged exposure to risk(s).

Who is a Child?
'Child' - means any person under the age of 18 years or a disabled child aged under 19 years.

What is significant harm?
Section 31 (9) of the Children Act 1989 introduced the concept of significant harm (or the likelihood of it) as the threshold that justifies compulsory intervention in family life in the best interests of children:
- 'Significant’ is a term not specifically defined, however, where the question of whether the harm suffered by a child is significant turns on a child's health or development, then that child’s health or development shall be compared to that which could reasonably be expected of a similar child;
- 'Harm' means ill-treatment or the impairment of health or development e.g. impairment suffered from seeing or hearing the ill-treatment of another; such as Domestic violence;
- 'Development' means physical, intellectual, emotional, social or behavioural development;
- 'Health' means physical or mental health;
- 'ill-treatment' includes sexual abuse and forms of ill-treatment which are not physical.

When does Police Protection end?
Police Protection ends after 72 hours. It can end before this if the Designated Officer (Inspector rank) and Children's Social Care have decided jointly that circumstances have changed, and it is now safe for the child to return home. The Police Protection can also end if Children’s Social Care has obtained an Emergency Protection Order. Police Protection does not simply end, because the child has been handed over to Children Social Care to be provided with temporary accommodation. The police still have a legal duty to be involved in any decisions regarding that child and their safety, until Police Protection has formally ended.
6.5 Appendix 5: List of FGM Specialist Services in London

1. St George’s FGM Services
   Tel: 0208 725 5949
   Open: 2 Fridays each month 2 – 5pm
   Contact: Denise Henry, Specialist Perineal Midwife

2. Acton African Well Women Centre
   Acton Health Centre 35 – 61 Church Road London, W3 8QE
   Tel: 0208 383 8716; 0208 383 8712; 07730 970738
   Open: Mon, Tue, Thurs: 8:30am - 6:30pm Wed: 8:30am - 4:00pm Fri: 8:30am - 8:00pm
   Contact: Juliet Albert: Juliet.albert@nhs.net Hayat Arteh: Hayat.arteh@nhs.net

3. African Well Women’s Clinic
   Guy’s & St. Thomas’s Hospital 8th Floor – c/o Antenatal Clinic Lambeth Palace Rd. London, SE1 7EH
   Tel: 0207 188 6872
   Mobile: 07956 542 576
   Open: Monday – Friday, 9am – 4pm
   Contact: Comfort Momoh MBE comfort.momoh@gstt.nhs.uk

4. African Women’s Clinic
   University College Hospital Clinic 3; Elizabeth Garrett Anderson Wing Euston Road, London, NW1 2BU
   Tel: 0845 155 5000
   Open: Monday afternoon 2 - 5 pm
   Contact: Maligaye Bikoo maligaye.bikoo@uclh.nhs.uk

5. Gynaecology & Midwifery Department
   St. Mary’s Hospital Praed St. London, W1 1NY
   Tel: 0207 886 6691 or 0207 886 1443
   Helpline: 0203 312 6135
   Open: 9 am – 5 pm
   Contact: Judith Robbins or Sister Hany foong.han@imperial.nhs.uk

6. Women’s & Young People’s Services
   African Well Women’s Clinic - Antenatal Clinic Central Middlesex Hospital Acton Lane, Park Royal London, NW10 7NS
   Tel: 0208 963 7177; 0208 965 5733
   Open: Friday, 9am – 12pm
   Contact: Kamal Shehata Iskander: kamal.shehataiskander@nw lh.nhs.uk
   Jacky Deehan: Jacqueline.deehan@nw lh.nhs.uk

7. African Well Women’s Clinic
   Whittington Hospital Level 5 Highgate Hill London, N19 5NF
Tel: 0207 288 3482 ext. 5954  
Mobile: 0795 625 7992  
Open: Last Wed of every month, 9am – 5pm  
Contact: Joy Clarke or Shamsa Ahmed: joy.clarke@whittington.nhs.uk

8. Sylvia Pankhurst Health Centre  
Mile End Hospital, 3rd floor Bancroft Rd, London, E1 4DG  
Tel: 0207 377 7898 or 0207 377 7870 0208 223 8322  
Open: Monday – Thursday 12pm-8pm; Friday, 9:30am - 5:30 pm  
Contact: Dr. Geetha Subramanian geetha.subramanian@thpct.nhs.uk

9. West London African Women’s Community Clinic  
West London Centre for Sexual Health Charing Cross Hospital (south Wing) Fulham Palace Road London, W6 8RF  
Tel: 0208 383 0827; 07920 450045  
Contact: Lazara Garcia Dominguez Lazara.DominguezGarcia@chelwest.nhs.uk

10. Woodfield Medical Centre  
Antenatal Clinic 7e Woodfield Road London, W9 3XZ  
Tel: 0207 266 8822  
Open: Tues morning  
Contact: Miss Katy Clifford

11. West London African Women’s Hospital Clinic  
Gynaecology and Antenatal Clinics Chelsea and Westminster Hospital 369 Fulham Road, London, SW10 9NH  
Tel: 0203 315 3344  
Contact: caw-tr.fgmwestlondon@nhs.net

12. ACCM (UK)  
Non-Government Organisation working to Reaching Communities to improve the health, social and economic position of BME, asylum seekers, migrant and vulnerable communities  
King’s House, 245 Ampthill Road, Bedford MK42 9AZ  
Tel: 0044 (0) 77 1248 2568  
Mobile: 0044 (0) 1234 356 910  
Website: http://www.accmuk.com

13. Daughters of Eve (DoE)  
A non profit organisation that works to advance and protect the physical, mental, sexual and reproductive health rights of young people from FGM practising communities  
Tel: 07983030488  
Website: http://www.dofeve.org

14. The Green House  
Counselling for girls aged 5 and upwards who have had FGM  
Tel: 0117 9351707  
Website: http://www.the-green-house.org.uk/
E-mail: info@the-green-house.org.uk

16. NHS list of services in London

http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Documents/List%20of%20FGM%20Clinics%20Mar%202014%20FINAL.pdf
6.6 Appendix 6: Flowcharts for the workforce

FGM PATHWAY INITIAL STEPS

Child identified as “at risk”

Strategy Meeting to decide on the S.47 enquiry, must be had (Within 2 days)

Strategy Meeting to include:
- Children’s Social Care to lead on and coordinate the Strategy Meeting;
- Lead Child Protection officer or Named safeguarding officer/nurse;
- Community Paediatrician and a Health specialist in FGM;
- Police and/or Child Abuse Investigation Team (CAIT);
- Education (school attended by child/young person where appropriate);
- Voluntary agencies;
- Legal advice (there may be a need to consider the use of specific legal orders to

Strategy Meeting Agenda to include, but not limited to, the following:
- Use of an interpreter in dealing with the family;
- Provision of appropriate advice and information to the family regarding the law and
  harmful consequences of FGM;
- Where FGM has already occurred, the Strategy Meeting should discuss how, where
  and when the procedure was performed and the legal and health implications of
  this;
- The provision of counselling and support services to the child/young person;

Where S.47 finds child is at risk of FGM

Child Protection Plan

Where risk of FGM is immediate

Seek appropriate legal action to protect the child
Child identified as “at risk”

Child NOT in imminent risk of FGM

Child is at imminent risk of FGM
  □ Consider Police Protection

A Strategy Meeting to be held within 48 hours, to consider:
  - Work with family (inform them of the law and dangers of FGM, and how to access support services);
  - Community Organisations;
  - Other female siblings;
  - Legal Action Police Powers;
  - Court Order (via Children’s Social Care);
  - Seek CPS advice at an early stage.

Possible Investigation:
  - Interview child/children and any female siblings if applicable. Consider significant witnesses;
  - Medical Examination;
  - Counselling & support to any girl who has undergone FGM;
  - assistance via intermediaries or Community/Voluntary organisations;
  - Investigative Strategy – identify established excisors and any intelligence opportunities;
  - Second Strategy meeting and continual liaison with other Agencies;
  - Consider Cultural and Community Resources Unit (CCRU) Contact details found on intranet;
  - Interpreters;
  - Liaise with local Crime Scene Management;
  - Consider assistance from international agencies and other agencies (i.e. Foreign Commonwealth Office, International Social Services, Borders and Immigration Agency);
FGM Pathway: Schools

Record

- Accurately record all interventions noting date, full name and role of person making the recording and sign.

Refer

Child is at risk of

- Refer to Kingston or Richmond SPA:
  - Kingston (020 8547 5008 or out of hours 020 8770 5000)

Child has had

Child is at immediate risk

- Call 999

Follow initial steps

Seek advice of Child Protection Lead or Head Teacher about making a referral to the SPA or Police only if by doing so the child is not placed at further risk. To be clear - do not delay referral to speak to DSL or Headteacher.

Percentage of girls and women who have undergone FGM by Country

- Somalia: 98%
- Guinea: 96%
- Djibouti: 93%
- Egypt: 91%
- Eritrea: 89%
- Mali: 89%
- Sierra Leone: 88%
- Sudan: 88%
- Gambia: 76%
- Burkina Faso: 76%
- Ethiopia: 74%
- Mauritania: 69%
- South Africa: 66%
- Guinea-Bissau: 50%
- Chad: 44%
- Cote d'Ivoire: 38%
- Kenya: 27%
- FMGC: 27%
- Senegal: 26%
- Central African Republic: 24%
- Yemen: 23%
- United Republic of Tanzania: 15%
- Benin: 13%
- Iraq: 8%
- Togo: 4%
- Ghana: 4%
- Niger: 2%
- Cameroon: 1%
NOTE: On encountering a woman or girl who has undergone FGM, be alert to the risk of FGM in relation to: Her daughter(s); Any other girl siblings or girls in the extended family; Any daughters she may have in the future.

- **FGM Pathway: Health**

  **Source:** www.uknife.org/practition/files/00-FMG-GC_info-graphic-3res.pdf

### Families with parents from practising countries

- Reinforce information on the law of FGM, the health consequences, the rights of the woman/child, and support services available to families of children from practising countries through meetings and PSHE.
- Document information given on the parent’s response to FGM.
- Work with the child’s school to support them with any concerns.
- Flag up child “at risk” of FGM on System 1 (under ‘Alert’, in the ‘Vulnerable child’ tab input FGM).
- Inform GPs of history of FGM and outcomes of discussion.
- Be vigilant to any health issues suggesting FGM.
- Provide advice on FGM to families requesting foreign travel vaccinations.
- Consult the Named Safeguarding Nurse if concerned about a child.
- Child Protection Officer for advice.

### Ask ALL expectant mothers

- (especially those from the “high risk” countries) at the early antenatal appointment if they have been “cut”, “circumcised”; or if they are “open or closed”; or if they had a procedure that will make it difficult to give birth. **Note: ask the women on her own or with an interpreter**

### If after examination FGM is confirmed

- Plan for delivery and record FGM specifying the type on the relevant electronic database.
- Give expectant parents before and/or after delivery information on the law of FGM, the health consequences, the rights of the woman/child, and support services available; record discussion.
- Record mother’s FGM status on the discharge summary sent to GPs and health visitors handing over notes (under the category “perineum” on summary sheet), regardless of gender of child. **NB: Nil reporting is as important as a positive report**.
- If concerned about a child, consult the Named safeguarding nurse.

### Midwives

- Ask ALL expectant mothers at registration and cervical screening if they have been “cut”, “circumcised”, or if they are “open or closed” which will make examination difficult.
- Ask all expectant mothers the same questions.
- Note: ask the women on her own or with an interpreter.

### Health Visitors

- Record the presence and type of FGM of the mother on EMIS for both the mother and child; link to sibling records (regardless of the gender).
- Upload maternity discharge summary information on FGM to mother and child health records electronic patient records.
- Ensure such records are transferred if clients change practice.
- Consider the possibility of any female siblings with FGM and potential risks to other female siblings.
- Inform GP and School Nurse of history of FGM and outcomes of discussion with parents on FGM.
- Consult the Named Safeguarding Nurse.

### School Nurse

- Reinforce information on the law of FGM, the health consequences, the rights of the woman/child, and support services available, to families of children from practising countries through parent meetings and PSHE.
When a patient is treated by an acute hospital, and FGM is identified, record presence and type of FGM in the patient’s clinical record, as part of the full clinical history (follow guidelines 13).

For all girls/women presenting with having recently undergone FGM:
- Consult your Safeguarding Lead
- Follow Safeguarding procedures for Child Abuse and refer (as below)
- Record all details pertaining to FGM on hospital records
- Ensure all information is passed on to the GPs and School Nurse

Consider the risks associated to FGM if girls from FGM practising countries attend with UTI (especially if recurrent), menstrual pain, abdominal pain or altered gait etc.

Assessment must include analysing the risks associated with FGM
- Record assessment on relevant database
- Provide information on the law of FGM, the health consequences, the rights of the woman/child and support services available to all women/children with a concern or from “at risk” countries
- Inform GPs and School Nurse of history of FGM and outcome of discussion – record FGM on the relevant database/clinical system
- Consult your Safeguarding/Child Protection Lead about referral if you are concerned

*All data regarding FGM to be reported to Department of Health monthly (follow guidelines) 13*
Other words for FGM: Cut / circumcised; Open or closed; Sunna (Type 1/2); Gudiniin/Guudninka/; Pharaoic (Type 3)

All MASH referrals should be supported by a completed Early Help Assessment. But if the child is at “immediate risk” of FGM, the EHA is not required – contact MASH immediately who will act immediately.

MASH is inclusive of:
- Children’s Social Care
- Community Health
- Education Welfare
- Police
- Probation
- Housing
- Family Information Services
- Early Help

Source: www.unic.org/protect/filmes/00-FMG_C_infographic.pdf

Child referred as “at future potential risk” of FGM

- Undertake a child/family assessment
- Provide information to the family on the law and health consequences of FGM, the rights of the child and supportive services available
- Engage/signpost to Health Visiting to work with the family
- Engage the Community Champions to work with the family
- Record all information given to the family and action taken

All information to be shared with GPs and Health Visitors

Should a member of MASH/Children Social Care have a serious concern about a child call 999

Child referred as “at immediate risk” of FGM

- Possibility of Police Protection to be considered on receiving referral
- Strategy Discussion to be held within 2 days

**Strategy Discussion to include:**
- Children’s Social Care
- Lead Child Protection officer
- Community Paediatrician and a Health specialist in FGM
- Police CAIT (DS or higher rank)
- Education (school attended by child/young person where appropriate)
- Voluntary agencies
- Legal advice
- The referring agency

Offer counselling and medical help
Strategy meeting to be held within 2 days

- How, where and when procedure occurred
- Whether to continue enquiries or to assess the need for support services
- If legal action needs to be taken
- Second strategy meeting to be held within 2 days (with the same chair)

Evaluate the information collected in the enquiry

Child referred as having had FGM

All information to be shared with GPs and Health Visitors and/or School Nurse

Seek appropriate legal action to protect the child

Or

Convene Child Protection Conference

Only where additional child protection concerns exist should a Child Protection Conference happen

All information to be shared with GPs, Health Visitors and/or School Nurse

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