NORTH EAST LINCOLNSHIRE SAFEGUARDING CHILDREN BOARD

FEMALE GENITAL MUTILATION

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1. DEFINITION

Female Genital Mutilation (FGM) is a collective term for "procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" (World Health Organisation, 2013).

The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. The procedure is typically performed on girls aged between 4 and 13, but in some cases it is performed on new-born infants or on young women before marriage or pregnancy.

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

The rights of women and girls are enshrined by various universal and regional instruments including the Universal Declaration of Human Rights, the United Nations Convention on the Elimination of all Forms of Discrimination Against women, the Convention on the Rights of the Child, the African Charter on Human and Peoples' Rights and Protocol to the African Charter on Human and Peoples' Rights on the rights of women in Africa. All these documents highlight the right for girls and women to live free from gender discrimination, free from torture, to live in dignity and with bodily integrity.

For more detail, please refer to the multi-agency statutory guidance - **Multi–agency Statutory Guidance on Female Genital Mutilation April 2016.**

Click here to access the GOV.UK Female Genital Mutilation Resource Pack.

2. PROCEDURES INVOLVED

There FGM is classified into four major types:

- 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);
- 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);
- 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;

- 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 detail, please refer to the statutory government Multi-Agency Guidelines on Female Genital Mutilation (issued in February 2011).

Click here to access the GOV.UK website for Female Genital Mutilation.

3. INDICATORS

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

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

A female child is born to a woman who has undergone FGM or whose older sibling or cousin has undergone FGM:

- The family belongs to a community in which FGM is practised; or have limited level of integration within UK community;
- The family indicate that there are strong levels of influence held by elders and/or elders are involved in bringing up female children;
- If a female family elder is present, particularly when she is visiting from a country of origin, and taking a more active / influential role in the family;
- The family makes preparations for the child to take a holiday, e.g. arranging vaccinations, planning an absence from school;
- The child talks about a 'special procedure/ceremony' that is going to take place;
- An awareness by a midwife or obstetrician that the procedure has already been carried out on a mother, prompting concern for any daughters, girls or young women in the family;
- Repeated failure to attend or engage with health and welfare services or the mother of a girl is very reluctant to undergo genital examination;
- Where a girl from a practising community is withdrawn from Sex and Relationship Education they may be at risk from their parents wishing to keep them uninformed about their body and rights.

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

1. The child has changed in behaviour after a prolonged absence from school; or

2. The child has health problems, particularly bladder or menstrual problems;

3.The child has difficulty walking, sitting or standing and may appear to be uncomfortable.

Children's social care will liaise with the Paediatric services where it is believed that FGM has already taken place to ensure that a Medical Assessment takes place.

It should be remembered that this will have lifelong consequences, and can be highly dangerous at the time of the procedure and directly afterwards.

If you are worried about a girl under 18 who is either at risk of FGM or who you suspect may have had FGM, you should share this information with Children's social care or the police immediately whichever is most appropriate see Protection and Action to be Taken.

From the 31st October 2015, regulated professionals in health and social care and teachers in England and Wales have a duty to report 'known' cases of FGM in under 18s to the police see Mandatory Reporting of FGM.

Professionals must take into consideration that by alerting the girl's or woman's family to the fact that she is disclosing information about FGM may place her at increased risk of harm. and professionals should therefore take sufficient steps to minimise this risk.

It should not be assumed that families from practising communities will want their girls and women to undergo FGM.

4. NHS ACTIONS

Since April 2014 NHS acute hospitals have been recording:

- If a patient has had Female Genital Mutilation;
- If there is a family history of Female Genital Mutilation;
- If a Female Genital Mutilation-related procedure has been carried out on a patient.

and from September 2014 all acute hospitals have reported this data centrally to the Department of Health on a monthly basis. This is the first stage of a wider ranging programme of work in development to improve the way in which the NHS will respond to the health needs of girls and women who have suffered Female Genital Mutilation and actively support prevention. A midwife/obstetrician/gynaecologist/General Practitioner may become aware that Female Genital Mutilation has occurred when treating a female patient. This should trigger concern for other females in the household.

From 1 April 2015, a new information standard, 'SCCI 2026 FGM Enhanced Dataset', revised what information was collected, and the method and frequency of collection, and it is now mandatory for acute Trusts to comply with these updates. The requirement to record FGM data has also been expanded to GP practices and Mental Health Trusts who will be required to submit information under the Enhanced Dataset when treating patients who have FGM, and ensure that they are compliant by October 2015 at the latest.

For further information, see **Health and Social Care Information Centre Female Genital Mutilation Datasets.**

5. MANDATORY REPORTING OF FGM

From the 31st October 2015, regulated professionals in health and social care and teachers in England and Wales have a duty to report 'known' cases of FGM in under 18s which they identify in the course of their professional work to the police. Following consultation with social care professionals as well as other relevant professionals, only then will the police take action to ensure the girl/young woman is safe and her needs are prioritised.

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

A failure to report the discovery in the course of their work could result in a referral to their professional body. The Home office has produced guidance **Mandatory Reporting of Female Genital Mutilation – procedural information** to support this duty and a fact sheet on the **New Duty for Health and Social Care Professionals and Teachers to Report Female Genital Mutilation (FGM) to Police.**

If there are suspicions that a girl under the age of 18 years may have undergone FGM or is at risk of FGM professionals must still report the issue by following their internal safeguarding procedures. Professionals must share the information about their concerns, potential risk and/or the actions which are to be taken. Next steps should be discussed with the safeguarding lead and if necessary a social care referral made.

5. PROTECTION AND ACTION TO BE TAKEN

Working Where concerns about the welfare and safety of a child or young person have come to light in relation to FGM a referral to Children's social care should be made in accordance with the Referrals Procedure.

Children's social care will undertake an assessment and, jointly with the Police, will undertake a Section 47 Enquiry if they have reason to believe that a child is likely to suffer or has suffered FGM. A strategy discussion/meeting should include the relevant Health professionals and, if the child is of school age, the relevant school representative.

Where a child has been identified as having suffered, or being likely to suffer, Significant Harm, it may not always be appropriate to remove the child from an otherwise loving family environment. Parents and carers may genuinely believe that it is in the girl's best interest to conform to their prevailing custom. Professionals should work in a sensitive manner with families to explain the legal position around FGM in the UK. The families will need to understand that FGM and re-infibulation (the process of resealing the vagina after childbirth) is illegal in the UK and that if they are insistent upon carrying out the practice, the health visitor and Children's social care must be informed that a female child may be at risk of significant harm. Interpretation services should be used if English is not spoken or well understood and the interpreter should not be an individual who is known to the family.

Where a child appears to be in immediate danger of mutilation, legal advice should be sought and consideration should be given, for example, to seek a Female Genital Mutilation Protection Order, an Emergency Protection Order or a Prohibited Steps Order, making it clear to the family that they will be breaking the law if they arrange for the child to have the procedure.

The 2003 Female Genital Mutilation Act makes it illegal for any residents of the UK to perform FGM within or outside the UK. The punishment for violating the 2003 Act carries 14 years imprisonment, a fine or both.

6. ISSUES

WHERE IS FGM PRACTISED?

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

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

CONSEQUENCES OF FGM

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

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

Long-term implications can entail:

1. Extensive damage of the external reproductive system;
2. Uterus, vaginal and pelvic infections;
3. Cysts and neuromas;

4. Increased risk of Vesico Vaginal Fistula;
5. Complications in pregnancy and child birth;
6. Psychological damage;
7. Sexual dysfunction;
8. Difficulties in menstruation.

In addition to these health consequences there are considerable psycho-sexual, psychological and social consequences of FGM.

JUSTIFICATIONS OF FGM

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

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

FGM is a complex and sensitive issue that requires professionals to approach the subject carefully. Good communication is essential when talking to individuals who have had FGM, may be at risk of FGM, or are affected by the practice. How the conversation is opened and the language used will vary according to the setting and who the conversation is with. More information can be found in the Multi-agency statutory guidance on female genital mutilation (April 2016)

An accredited female interpreter may be required. Any interpreter should ideally be appropriately trained in relation to FGM, and in all cases should not be a family member, not be known to the individual, and not be someone with influence in the individual's community.

In light of this, professionals must give careful thought and consideration to developing a safety and support plan for the girl/woman prior to meeting with her. If a girl/woman is seen by someone within the community who she perceives as 'hostile' this may pose a risk to her safety. By mutually agreeing in advance another reason why they are there and/or why they are meeting could potentially minimise this risk.

6. LAW

In England and Wales, criminal and civil legislation on FGM is contained in the Female Genital Mutilation Act 2003 ('the 2003 Act').

1. Makes it illegal to practice FGM in the UK;
2. Makes it illegal to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in that country;
3. Makes it illegal to aid, abet, counsel or procure the carrying out of FGM abroad;
4. Has a penalty of up to 14 years in prison and, or, a fine.

As amended by the Serious Crime Act 2015, the Female Genital Mutilation Act 2003 now includes:

1. Creating a new offence of failing to protect a girl from FGM with a penalty of up to 7 years in prison or a fine or both. - A person is liable if they are "responsible" for a girl at the time when an offence is committed. This will cover someone who has "parental responsibility" for the girl and has "frequent contact" with her and any adult who has assumed responsibility for caring for the girl in the manner of a parent. This could be for example family members, with whom she was staying during the school holidays;
2. Introduced Female Genital Mutilation Protection Orders ("FGMPO") - breaching an order carries a penalty of up to five years in prison. The terms of the order can be flexible and the court can include whatever terms it considers necessary and appropriate to protect the girl or woman;
3. Allowing for the lifelong anonymity of victims of FGM – prohibiting the publication of any information that could lead to the identification of the victim. Publication covers all aspects of media including social media;
4. Extended the extra-territorial reach of Female Genital Mutilation (FGM) offences to include "habitual residents" of the UK;
5. Created a new duty of Mandatory Reporting of Female Genital Mutilation for regulated professionals in health and social care professionals and teachers in England and Wales which came into force on the 31st October 2015.

6. FURTHER INFORMATION

AFRUCA (Child Protection of African Children)

Forward (Foundation for Women's Health Research and Development)

Multi–agency Statutory Guidance on Female Genital Mutilation April 2016

Female Genital Mutilation and its Management: Royal College of Obstetricians and Gynaecologists 2015

Female Genital Mutilation – Home Office

Mandatory Reporting of Female Genital Mutilation – procedural information

Female Genital Mutilation Risk and Safeguarding – Guidance for Professionals (DoH)