Procedure for identifying and responding to concerns about Female Genital Mutilation

This is an approved North Somerset Safeguarding Children Board document and should not be edited in any way.

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Procedures to be followed regarding recognising and responding to children at risk/ who have suffered FGM

When a risk of FGM is identified the first steps when safeguarding girls will be to undertake a strategy discussion to agree amongst professional an approach to the family. It is imperative that this happens before any direct approach to the parents/carers as this may put the child at further risk or compromise evidence.

This may led to a discussion with the girl, her parents and other family members (see LSCB guidance document for advice on how to do this.)

These procedures should be read in conjunction with the LSCB guidance on identifying and responding to concerns about FGM.

Professionals should be aware of and act upon the wide range of risk factors in relation to FGM (see LSCB guidance document and Multi agency statutory guidance on FGM.)

It is illegal in the UK to subject a child to female genital mutilation (FGM) or to take a child abroad to undergo FGM.

Having established that there are recognised signs of the risk of FGM, a professional should undertake a risk assessment. As part of the risk assessment, professionals should make sure that the girl and/ or appropriate family members understand that it is:

- illegal
- the potential health consequences of FGM
- any actions taken

- that information will be shared about this with colleagues and partner organisations as appropriate

When deciding on the course of action professionals should consult with their local / designated safeguarding lead and always ensure that actions are consistent with LSCB procedures. The course of action should be based on the needs of the girl identified at risk and will vary on the circumstances.

Girl (under 18 years) who is suspected to have undergone FGM

If any professional suspects that a girl has undergone FGM their named/ designated safeguarding lead must be made aware and an immediate referral made to Children's Social Care on 01275…

The practitioner must notify the police when they identify that an act of Female Genital Mutilation appears to have been carried out on a girl under the age of 18.
All cases should be handled in accordance with LSCB Chapter 1 procedures. The initial referral should be made to children's social care, if the risk is not considered imminent or significant appropriate safeguarding actions should be undertaken making sure information is shared appropriately. This will help make sure that if other agencies or professionals have a wider scope of understanding of the child's circumstances they will be able to use the most up to date information to consider the risk the girl faces.

Where there is imminent or serious risk, an emergency response may be required, either an urgent referral to social services and/ or contacting the police. Where it is considered that there is an immediate risk to a girl the local authority should consider whether to apply for an FGM Protection order and / or an Emergency Protection Order.

You should:
- Keep a record of the discussion
- Share the information with children's social care
- If identified by a healthcare professional share the information with the girls GP, health visitor or school nurse (depending on age of the child) and potentially other health care professionals delivering care to the child depending on circumstances
- In healthcare setting make sure that the FGM risk is identified and an indicator placed upon the girl's record as appropriate.
- In all cases professionals should consider the risk to other children and women in the family.

On receipt of a referral, a social worker should acknowledge receipt, discuss it with their manager and decide on the next course of action within one working day. Where there are concerns about a child's immediate safety, an immediate strategy discussion must be set up involving all other relevant agencies: the police, children's social care, education professionals, and health services. The meeting should be chaired by a social work team manager.

The strategy discussion will:
- Make a decision will be whether the child or young person, the unborn child, or sibling of a child in questions has suffered or is likely to suffer significant harm as a consequence of FGM. If so, a Section 47 Enquiry will be initiated. If so this should be undertaken jointly with the police.

When undertaking an assessment/ section 47 assessment:

- Consider if the procedure has already been performed how, where and when the procedure was performed and the implication of this.

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

- Consider whether a criminal act has taken place and liaise with the police and where necessary consult legal advice

- Where a child appears to be in immediate danger of mutilation, legal advice should be sought and consideration should be given, for example, to seeking an 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.

- Consider the need for support services

- If concerns are substantiated consider whether a child protection plan is necessary

- The child's interests are always paramount, and any agreement must be carefully monitored and enforced by all agencies

Child Protection Medical Examination

Consent for a Child Protection Medical Examination should be sought. If consent is not given, legal advice must be sought. A Child Assessment Order may need to be applied for.

Parental consent is not required if a young person is aged 16 or 17. A child under 16 who has the capacity to understand and make their own decisions, and may give (or refuse) consent to share information.

The Paediatrician who carries out the Child Protection Medical Examination should provide immediate verbal feedback on the outcome of the examination to the attending Social Worker (and / or Police officer is applicable). The Paediatrician should develop a written report for the second strategy meeting.

Girl under 18 years who has previously been identified as at risk of FGM

Professionals should always take opportunities to discuss and understand changes to the girl's family circumstances and look out for whether there is a change in relation to any of the known risk factors, eg if the professional becomes aware of new travel plans. The information should be shared with appropriate partner agencies and the risk assessment reviewed in light of the new information. The outcome of this should inform what additional action should be undertaken.

FGM disclosed by or visually identified in a girl (under 18 years)

Where a case of FGM is disclosed by or visually identified in a girl under the age of 18, regulated health or social care professionals and teachers are legally required to make a report to the police under the FGM Mandatory reporting duty.

The Female Genital Mutilation Act 2003, as amended by section 74 of the Serious Crime Act 2015 , has introduced the legal duty for regulated health and social care professionals and teachers to make a report to the police if:

- they are informed by a girl under the age of 18 that she has undergone an act of FGM

or

- they observe physical signs that an act of FGM may have been carried out on a girl under the age of 18 and have no reason to believe that the act was, or was part of, a surgical operation within the parameters of the FGM Act 2003.

The duty came into force on 31 October 2015.

It covers:

Health and social care professionals regulated by a body which is overseen by the Professional Standards Authority for Health and Social Care (with the exception of the Pharmaceutical Society of Northern Ireland). This includes those regulated by the:

- General Chiropractic Council
- General Dental Council
- General Medical Council
- General Optical Council
- General Osteopathic Council
- General Pharmaceutical Council
- Health and Care Professions Council (whose role includes the regulation of social workers in England)
- Nursing and Midwifery Council teachers - this includes qualified teachers or persons who are employed or engaged to carry out teaching work in schools and other institutions, and, in Wales, education practitioners regulated by the Education Workforce Council;

If someone else, such as a parent or guardian, discloses that a girl under 18 has had FGM, a report to the police is not mandatory. However, in these circumstances disclosures should still be handled in line with safeguarding responsibilities.

Professionals should make the report as soon after the case has been discovered.

Best practice is within 1 working day

Any person found guilty of an offence under the FGM Act 2003 is liable to a maximum penalty of 14 years imprisonment or a fine, or both.

Complying with the duty does not breach any confidentiality requirement or other restriction on disclosure which might otherwise apply.

The duty is a personal duty which requires the individual professional who becomes aware of the case to make a report; the responsibility cannot be transferred. The only exception to this is if you know that another individual from your profession has already made a report; there is no requirement to make a second.

The duty does not apply in relation to at risk or suspected cases or in cases where the woman is over 18. In these cases, you should follow local Safeguarding Adult Board Procedures.

Where there is a risk to life or likelihood of serious immediate harm, professionals should report the case immediately to police, including dialling 999 if appropriate. You should consult your Designated Safeguarding Lead as soon as practicable and keep a record of any decisions made. It is important to remember the safety of the girl is a priority.

Where you become aware of a known case, the legislation requires you to make a report to the Humberside police. The legislation allows for reports to be made orally or in writing.

You should make a report orally by calling 101, the single non-emergency number. The call handler will log the call and refer it to the Safeguarding team within the force, who will call you back to ask for additional information and discuss the case in more detail.

You should be prepared to provide the call handler with the following information:

- Explain that you are making a report under the FGM mandatory reporting duty.

- Your details:
  - Name
  - Contact details (work telephone number and e-mail address) and times
  - When you will be available to be called back
  - Your role
  - Your place of work

- Details of your organisation's designated safeguarding lead:
  - Name
  - Contact details (work telephone number and e-mail address)
  - Place of work

- The girl's details:
  - Name
  - Age/date of birth
  - Address

Throughout the process, you should ensure that you keep a comprehensive record of any discussions held and subsequent decisions made, in line with standard safeguarding practice. This will include the circumstances surrounding the initial identification or disclosure of FGM, details of any safeguarding actions which were taken, and when and how you reported the case to the police (including the case

reference number). You should also ensure that your organisation's designated safeguarding lead is kept updated as appropriate

Upon receipt of a report, the police will record the information and initiate the multi-agency response, in line with Chapter 1 of LSCB procedures. If the police consider that emergency action is needed to protect the child, they may take action in advance of the multi-agency response.

While the multi-agency response will be initiated by the police, as they are the agency receiving the report, they will consult children's social care prior to taking action.

The protection of the child must be paramount at all times. The multi-agency response should consider any wider health or emotional support that the child may need. In considering the case and next steps, local safeguarding processes should continue to be followed.

NHS Actions

Since April 2014 NHS hospitals have been required to record the following information:

- 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.

Since September 2014, all acute hospitals have been required to report this data centrally to the Department of Health on a monthly basis. This was 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. 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.

If the girl / woman is from a community which traditionally practices FGM, information gathering should be approached sensitively. A question about FGM should be incorporated when the routine patient history is being taken. A female interpreter may be required. The interpreter should be appropriately trained in relation to FGM and must not be a family member.

A suitable form of words should be used. 'Circumcised' is not medically correct and although 'mutilation' is the most appropriate term, it might not be understood or it may be offensive to a woman from a practising community who does not view FGM in that way. Different terminology will be culturally appropriate to the different cultures.

A health professional may make an initial approach by asking a woman whether she has undergone FGM saying: 'I'm aware that in some communities women undergo

some traditional operation in their genital area. Have you had FGM or have you been cut?' To ask about infibulation health professionals can use the question: 'are you closed or open?'. This may lead to the woman providing the terminology appropriate to her language / culture.

Asking the right questions in a simple, straightforward and sensitive way is key to establishing the understanding, information exchange and relationship needed to plan for the girl / woman's wellbeing and the welfare and wellbeing of any daughters she may have, or girl children she may have access to.

At antenatal booking, the holistic assessment may identify women who have undergone FGM. Midwives and obstetricians should then plan appropriate care for pregnancy and delivery.

Women with FGM Type 3 require special care during pregnancy and childbirth. Early antenatal registration is important in providing midwives with the opportunity to plan for this. Unfortunately, many women only access services very late in their pregnancy.

The plan should be an extension of NICE guidelines that midwives are already familiar with - i.e. history taking, offering individual care and being culturally sensitive.
However, the woman should be told that ideally she should be de-infibulated during the second trimester.

This procedure should be read in conjunction with **Multi agency statutory guidance on FGM**

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512906/Multi_Agency_Statutory_Guidance_on_FGM__-_FINAL.pdf

For information about types of FGM, prevalence and support please see FGM guidance document.