SOUTHWARK

Female Genital Mutilation Guidance Document for safeguarding children and vulnerable adults

Version 2.0

Completed August 2016

Next Revision: August 2017

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Message from the Independent LSCB Chair Southwark

Southwark Children's Safeguarding Board has agreed a multi-agency intervention framework for identifying, assessing and responding to Female Genital Mutilation across the multi-agency partnership. This protocol focuses on female children and adolescents under the age of 18 who are at risk of or have undergone FGM.

Southwark Safeguarding Children's Board has engaged with strategic partners to raise awareness of the risks of FGM, to educate communities who traditionally practice FGM about the law relating child abuse. The Board has worked diligently to ensure the FGM strategy has an equal balance in prevention as well as detection of FGM.

We are totally committed to working together with all partners to ensure that early help and intervention be provided to enable and support vulnerable female children and reduce the prevalence of FGM. This commitment is set within the context of the existing legal and statutory guidance that FGM is an illegal practice and a collaborative effort is essential to ensure that children and families are safe and protected.

Michael O'Connor- Chair of Southwark LSCB

1.0 Introduction

FGM is an illegal, extremely harmful practice and a form of child abuse and violence against women and girls, and therefore should be dealt with as part of existing child and adult safeguarding/ protection structures, policies and procedures.

The World Health Organization[1], defines female genital mutilation (FGM) 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 has been a criminal offence in the UK since the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003 and more recently the Serious Crime Act 2015 have further extended this to protect children who may be taken abroad to undergo FGM and charge offenders. In Scotland FGM is illegal under the Prohibition of FGM (Scotland) Act 2005. For more detail, please refer to the government's Multi-agency Statutory Guidance on Female Genital Mutilation (issued April 2016).

This guidance is primarily focused on:

- Victims of FGM who are under 18 years of age. (Women over 18 years of age should be reviewed under the Safeguarding Adults process. Any adult assessment must consider the potential risks of FGM to any other women or girls living in the same family).
- Identifying when a girl (including an unborn girl) or young woman may be at risk of FGM and responding appropriately to protect them.
- Identifying when a girl or young woman has had FGM and ensuring an appropriate joined up response.
- Identifying safety measures that can be implemented to respond, reduce and ultimately eradicate the practice of FGM.
- How to undertake risk assessment and respond to children who may have had FGM or those deemed to be at risk. It is essential to ensure good quality consistent support and intervention to female children and their families.

1.1 Definition

Female genital mutilation (FGM) is a collective term for procedures, which include the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons. 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.

[1] http://www.who.int/topics/female_genital_mutilation/en/

The Female Genital Mutilation Act 2003 and the Serious Crime Act 2015 define FGM offences including:

- Performing FGM in or outside the UK;
- assisting a girl to perform FGM on herself;
- assisting someone to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal;
- failing to protect a girl from FGM.

1.2 FGM Risk Identification and Risk Factors

Female genital mutilation has been classified by the World Health Organization into four types:

- Type 1: Circumcision - Excision of the prepuce with or without excision of part or all of the clitoris
- Type 2: Excision (Clitoridectomy) - Excision of the clitoris with partial or total excision of the labia minora. After the healing process has taken place, scar tissue forms to cover the upper part of the vulva region
- Type 3: Infibulation (also called Pharaonic Circumcision) -This is the most severe form of female genital mutilation. Infibulation often (but not always) involves the complete removal of the clitoris, together with the labia minora and at least the anterior two-thirds and often the whole of the medial part of the labia majora
- Type 4: Unclassified - This includes all other procedures on the female genitalia, and any other procedure that falls under the definition of female genital mutilation given above

1.3 Specific factors which may heighten a girl's or woman's risk of being affected by FGM

There are a number of factors in addition to a girl's or woman's community that could increase the risk that she will be subjected to FGM:

- The position of the family and the level of integration within UK society – it is believed that communities less integrated into British society are more likely to carry out FGM
- Any girl born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family
- Any girl who has a sister who has already undergone FGM must be considered to be at risk, as must other female children in the extended family
- Any girl withdrawn from personal, social or health education may be at risk as a result of her parents wishing to keep her uninformed about her body and rights

1.4 Indications that FGM may be about to take place soon:

The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is newborn, during childhood or adolescence, at marriage or during the first pregnancy. However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 and therefore girls within this age bracket are at a higher risk. It is believed that FGM happens to British girls in the UK as well as overseas (often in the family's country of origin). Girls of school age who are subjected to FGM overseas are thought to be taken abroad at the start of the school holidays, particularly in the summer, in order for there to be sufficient time for them to recover before returning to their studies.

1.5 Clearer signs that FGM is imminent:

- It may be possible that families will practise FGM in the UK when a female family elder is around, particularly when she is visiting from a country of origin
- A professional may hear reference to FGM in conversation. For example, a girl may tell other children about it. (See Appendix 4)
- A girl may confide that she is to have a 'special procedure' or to attend a special occasion to 'become a woman'
- A girl may request help from a teacher or another adult if she is aware or suspects that she is at immediate risk
- The girl's parents or close relatives may indicate they plan to take the child out of the country for a prolonged period
- A girl may talk about a long holiday to her country of origin or another country where the practice is prevalent (See Appendix 3)

1.6 Indicators that a girl or woman has already been subjected to FGM:

- A girl or woman may have difficulty walking, sitting or standing
- A girl or woman may spend longer than normal in the bathroom or toilet due to difficulties urinating
- A girl may spend long periods of time away from a classroom during the day with bladder or menstrual problems

It is important that professionals look out for signs that FGM has already taken place so that:

- The girl/ woman affected can be offered help to deal with the consequences of FGM
- Enquiries can be made about other female family members who may need to be safeguarded from harm
- Criminal investigations into the perpetrators, including those who carry out the procedure, can be considered, with a view to prosecuting those who break the law

1.7 Why FGM continues to be practised

The World Health Organisation (WHO) cites a number of reasons for the continuation of FGM, such as:

- Custom and tradition
- A mistaken belief that FGM is a religious requirement
- Preservation of virginity/chastity
- Social acceptance, especially for marriage
- Hygiene and cleanliness
- Increasing sexual pleasure for the male
- Family honour
- A sense of belonging to the group and conversely the fear of social exclusion
- Enhancing fertility

The WHO[2] states that in every society where it is practised, FGM is the manifestation of gender inequality that is entrenched in social, economic and political structures. FGM is a form of violence against women and girls.

1.8 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, self-esteem and social consequences of FGM where additional support may need to be provided.

[2] *Eliminating female genital mutilation: an interagency statement* WHO, 2008

1.9 Person Centred Approach

- Whatever someone's circumstances, they have rights that should always be respected such as personal safety and accurate information about their rights and choices. Practitioners should listen to the victim and respect their wishes whenever possible. However, there may be times when a victim wants to take a course of action that may put them at risk – on these occasions, practitioners should explain all the risks to the victim and take the necessary child or adult protection precautions.
- Young people, especially those aged 16 and 17, can present specific difficulties to agencies as there may be occasions when it is appropriate to use both child and adult protection frameworks.

1.10 Legal Framework

The Female Genital Mutilation (FGM) Act 2003 and the Serious Crime Act 2015 clarifies the following:

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. Makes to illegal to fail to protect a girl from risk of FGM
   Imposes a penalty of up to 14 years in prison and, or, a fine

The Serious Crime Act 2015 also includes a mandatory reporting duty to notify the police of FGM and provides greater protection for victims, including a new Female Genital Mutilation Protection Order and protecting the anonymity of victims.

1.11 Mandatory Reporting Duty

The Serious Crime Act 2015 introduces a new mandatory duty to report cases of FGM, applying to all regulated health and social care professionals and teachers. Professionals are required to make a report to the police where, in the course of their professional duties, they either:

- Are informed by a girl under 18 that an act of FGM has been carried out on her; **or**
- Observe physical signs why appear to show that an act of FGM has been carried out on a girl under 18.

Professionals should report to the police via the 101 number as soon as possible (within 48 hours), as well as report into Southwark Multi-Agency Safeguarding Hub (MASH).

1.12 Multi-Agency Threshold Considerations and Response

If a child under the age of 18 has had FGM, or if you have good reason to suspect they are at risk of FGM (having considered their family history or other relevant factors), ***they must be referred using standard existing safeguarding procedures, as is the procedure with all other instances of child abuse.***

Working across agencies is essential to effective safeguarding efforts. This is reflected throughout the government's Multi-agency Statutory Guidance on Female Genital Mutilation[3] and should be a central consideration whenever discussing safeguarding girls from FGM.

Appendix 1 - This chart has been produced to support the policy of asking all women whether they have experienced any form of surgery to their genitals including female genital mutilation.

Appendix 2a - This chart sets out the roles and expectations of Children's Social Care once a child has been deemed to be at risk or has suffered FGM.

Appendix 2b - This chart sets out the roles and expectations for Adult Safeguarding should a vulnerable, non- vulnerable adult or pregnant woman be deemed to be at risk or has suffered FGM.

1.13 Child Suspected to be at Risk of FGM

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.

There are three circumstances relating to FGM which require identification and intervention:

- Where a child is at risk of FGM
- **Where a child has been abused through FGM (ring the 101 number)**
- Where a prospective mother has undergone FGM

All agencies in Southwark will be expected to undertake a risk assessment and information gathering exercise prior to making a formal referral to Children's Social Care. **If the matter is urgent, ring the police and MASH team without delay**. All agencies are expected to use the multi-agency brief risk assessment tool shown in Appendix 1. It is always important to be clear about what you are worried about and why.

Professionals and volunteers should not promise complete confidentiality (blanket confidentiality cannot be given to the individual as this is both a crime and child abuse that must be reported). 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.

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

If the information gathered suggests likelihood of significant harm or harm suffered, then further to existing Child Protection Procedures a Section 47 investigation should be initiated.

On receipt of a referral, a strategy meeting / discussion must be convened within two working days, and should involve representatives from the police, children's social care, health and where appropriate, education, 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. (Please refer to Appendix 2a).

In all cases involving children, an experienced paediatrician should be involved in setting up the medical examination. Examining older children and teenagers needs to be approached with sensitivity, remembering that intimate examination requires the young person's full consent and co-operation. It is important that young women can maintain a healthy body image whenever possible, particularly if they were previously unaware they had been subjected to FGM, and sensitive language needs to be used in these discussions.

It is important any medical exam undertaken employs a holistic approach which explores any other medical, support and safeguarding needs of the girl or young woman, and that appropriate referrals are made as necessary.

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 interest is 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.

If the outcome of the strategy meeting / discussion determines 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.

1.14 For children who have already undergone FGM

If the child has already undergone FGM (**report to the police via the 101 number and the MASH)**, the strategy meeting / discussion will need to consider carefully whether to continue enquiries or whether to assess the need for support services. The meeting needs to consider if the child or young person has health needs resulting from FGM and how they will access appropriate health care if needed. 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 concluded.

Where FGM has been practiced, 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.

1.15 Adults at Risk of or have had FGM

The wishes of the woman must be respected at all times. There is no requirement for automatic referral of adult women with FGM to adult social services or the police- unless the women is an 'adult at risk' under Safeguarding Adults regulations (and therefore is considered to be unable to protect herself from harm). For example, an adult may have a physical or learning disability and therefore the issues of mental capacity and ability to consent need to be formally investigated. Safeguarding adults procedures would seek to provide a protection plan for and with that adult at risk who might otherwise be entirely vulnerable to harm. All professionals should be aware that any disclosure may be the first time that a woman has ever discussed FGM with anyone.

Referral to the police must not be introduced as an automatic response when identifying adult women with FGM, and each case must continue to be individually assessed. (see appendix 2b).

If a person over the age of 18 has had FGM, or if you have good reason to suspect they are at risk of FGM having considered their family history or other relevant factors, you will need to consider what action should be taken.

Professionals should seek to support women by offering referrals to community groups who can provide support, clinical intervention or other services as appropriate, for example through an NHS FGM clinic.

Many women may still be under pressure from her husband, partner or other family members to allow or arrange for her daughter to be cut. Wider family engagement and discussions with both parents and potentially wider family members may be appropriate if it is safe to do so.

If pregnant, the welfare of her unborn child or others in her extended family must be considered at this point, as these children are potentially at risk and safeguarding action must be taken.

If a woman discloses she has adult daughter(s) over 18 who have already undergone FGM, even if the daughter does not want to take her case to the police, it is likely to be important to establish when and where this took place. This should lead to enquiries about other daughters, cousins or girls in the wider family context.

If a decision has been taken within the family not to carry out FGM on a UK-born female child, this can allow for a useful conversation to ascertain whether this was as a result of a change in attitude, a fear of prosecution, or due to a lack of opportunity or other motivations.

This is a complex area, and many women have greater influence in decision-making with regards to FGM when they are outside their country of origin, and may therefore elect to discontinue FGM practice. **All information should be recorded and shared with the appropriate multi-agency partners.**

Guide to asking about FGM

- Different terminology will be culturally appropriate to the different cultures. Alternative approaches are to ask a woman whether she has undergone FGM by 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/ circumcised?'

- To ask about infibulation 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 or woman's wellbeing and the welfare and wellbeing of any daughters she may have, or girl's she may have access to.

Remember:

- They may wish to be interviewed by a practitioner of the same gender.
- They may not want to be seen by a practitioner from their own community.
- Develop a safety and support plan in case they are seen by someone "hostile" at or near the department, venue or meeting place e.g. prepare another reason why they are there.

If they insist on being accompanied during the interview e.g. by a teacher or advocate, ensure that the accompanying person understands the full implications of confidentiality especially with regard to the person's family. For some, an interview will require an authorised accredited interpreter who speaks their dialect.

Never use family members, friends, neighbours or those with influence in the community as interpreters. People may feel embarrassed to discuss personal issues in front of them and sensitive information may be passed on to others and place the person at risk of FGM in further danger. Furthermore, such an interpreter may deliberately mislead practitioners and or encourage the person to drop the complaint and submit to their family's wishes. If possible, do not use a male interpreter when talking to women.

Single Agency Practice Guidance

2.1 Social Care Departments

Key principles

- All referrals received by children's social care specifying a risk of FGM will be fully investigated. (See Children's Social Care referral pathway flow chart appendix 2a)
- Every attempt should be made to work in partnership with the family;
- FGM constitutes a significant risk of harm and should be fully and thoroughly investigated. If the threshold for an assessment is not met, the full management rationale must be shared with referring agency.
- If threshold for a Section 47 investigation is not met, the management rationale must be provided and shared with partners.
- Where the threshold for a Section 47 enquiry is met a strategy discussion should be held in line with statutory guidance. Undue delay may place the child at risk of harm.

In cases of possible and actual FGM the Strategy discussion should be a meeting of the following:

- Children's social care Social Work Assessment Team TM and SW
- Community Paediatrician and a Health specialist in FGM
- Police CAIT
- Education (school attended by child/young person where appropriate)
- Voluntary agencies, (where appropriate)
- Legal advice (there may be a need to consider the use of specific legal orders to protect the child concerned)
- The referring agency as recommended by Working Together Guidance 2015

The following issues should be part of the agenda in any strategy discussion regarding FGM:

- Use of an interpreter in all dealings with the family
- Provision of appropriate advice and information to the family where this has not already occurred, regarding the law and harmful consequences of FGM
- Where FGM has already occurred the Strategy Discussion should discuss how, where and when the procedure was performed and the implication of this
- The provision of counselling and support services to the child/young person
- Risk to siblings and other children in the community
- Any intelligence on who has or is to perform the mutilation
- The immediate health needs of the child
- The possibility for prosecution

Where the S.47 Enquiry finds that the child is at risk of harm a Child Protection Conference may be appropriate in order to consider whether a Child Protection Plan is needed.

Where the risk is considered to be more immediate it may be necessary to seek appropriate legal orders to protect the child. If there is any suggestion that the family still intends to subject that child to FGM, the first priority is the protection of the child and the least intrusive legal action should be taken to ensure the child's safety. The first consideration should be informing the parents of the law and the dangers of FGM. This can be done by representatives from schools, local authority children's social care, health professionals and/or the police.

2.2 Health Practitioners

Female Genital Mutilation (FGM) is child abuse and the Department of Health and NHS England are committed to caring for FGM survivors, protecting girls from FGM, and preventing future generations from having to undergo FGM.

It is now mandatory for any NHS healthcare professional to record within a patient's clinical record if they identify through the delivery of healthcare services that a woman or girl has had FGM.

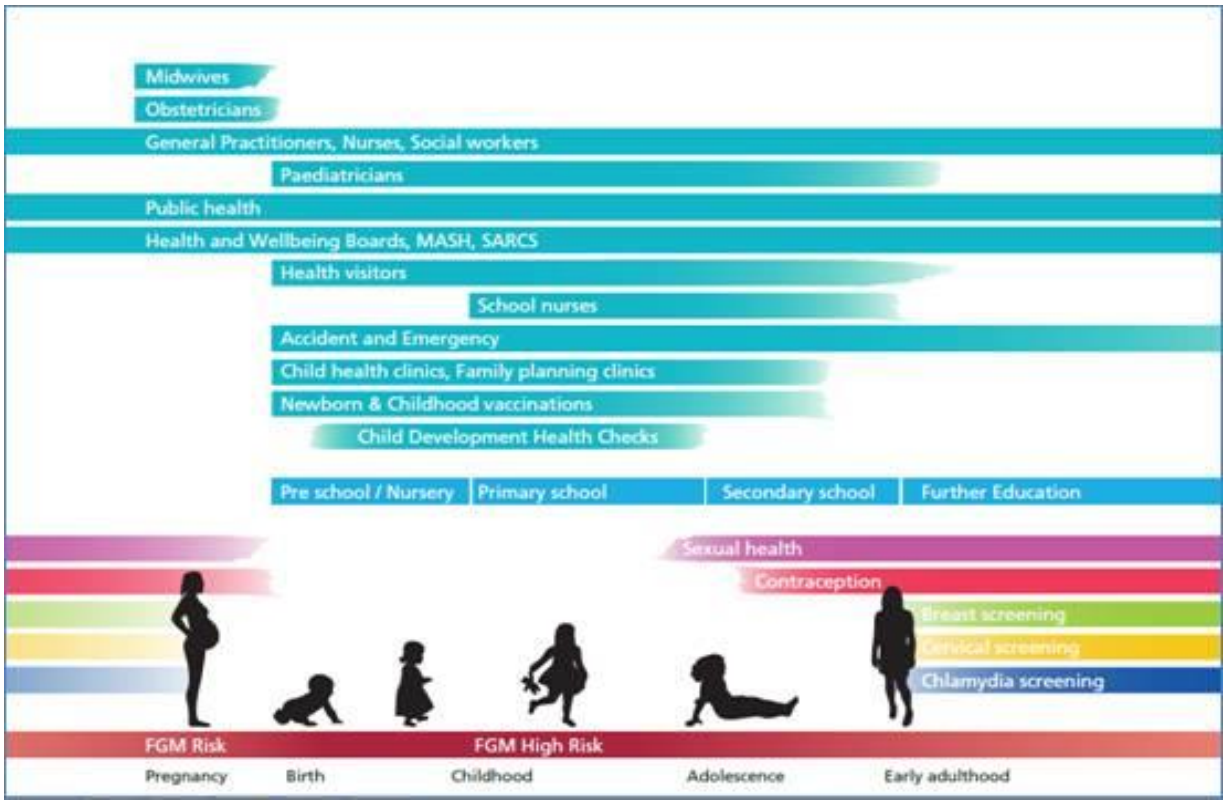
For Acute Trusts from September 2014, it became mandatory to collate and submit basic anonymised details about the number of patients treated who have had FGM to the Department of Health every month.

The requirement is to record FGM in a patient's healthcare record only if and when it is identified during the delivery of any NHS healthcare. Professionals are reminded to be aware of the risk factors, including country of origin (refer to Appendix 3), and to use their professional judgement to decide when to ask the patient if they have had FGM. Be mindful whilst a woman may not be from a practicing country, her partner might be.

When a woman who has undergone FGM becomes pregnant the midwife should ascertain the woman's view on FGM. If the woman is clear that she will protect a female infant from FGM the midwife should provide supporting information about FGM and make a record in the medical notes. The G.P and health visitor should be notified that the woman has undergone FGM. If the midwife is concerned that the woman may not safeguard her female infant a safeguarding referral must be made to social care. This referral should lead to enquiries about girls within the wider family. (refer to Appendix 1).

It remains best practice to share information between healthcare professionals to support the ongoing provision of care and efforts to safeguard women and girls against FGM. For example, after a woman has given birth, it is best practice to include information about her FGM status in the discharge summary record sent to the GP and Health Visitor, and to include that there is a family history of FGM within the Personal Child Health Record (PCHR), often called the 'red book'. Children at risk of FGM will be monitored through to school leaving age using routine opportunities such as developmental checks, national child measurement programme and immunisation. These existing systems can effectively "track" or monitor and act on risk to ensure children are protected during vulnerable periods (such as school holidays, onset of puberty), by taking a proactive approach to engaging schools,

families and children themselves in an age appropriate way. The illustration below taken from the **Intercollegiate Guidelines on FGM** clearly illustrates the routine opportunities that are already in place and should be utilised to measure and monitor FGM risk.



2.3 Education

These questions are for guidance. Each case should be dealt with sensitively and considered individually and independently. Using this guidance is at the discretion of the Head Teacher.

If you suspect that a child is a victim of FGM or may be at risk of FGM.
You may want to ask some of the following exploratory questions:

- Your family is originally from a country where girls or women are circumcised – Do you think you have gone through this? What about any older sisters?
- Has anything been done to you 'down there' or on your bottom?
- Do you want to talk to someone who will understand you better?
- Would you like support in contacting other agencies for help or advice?

Holiday Plans

- Ask children to tell you about their holiday. Sensitively and informally ask the family about planned extended holiday ask questions like such as:
- Who is going on the holiday with you?
- How long they plan to go for, and is there a special occasion planned?
- Have they told you what they will be doing during the holiday?

- Do you have any concerns, fears, or anxieties about the holiday?
- Where are you going?
- Have you been told what you will be doing whilst on holiday?

Questions for the parents

- Are they aware that the school cannot keep their child on roll if they are away for a long period?
- Are they aware that FGM including Sunna is illegal in the U.K even if performed abroad?

Record

All interventions should be accurately recorded by the persons involved in speaking with the child or young person. All recording should be dated and signed and give the full name and role of the person making the recording. Whenever a child transfers schools, it is important to ensure that the record and all assessment with regard to FGM are transferred.

Refer

The Designated Child Protection Lead/Headteacher should follow the guidance outlined in Flowchart 1: Multi-Agency Risk Assessment, and should seek advice when making referrals to the Children's Social Care.

2.4 Police

If officers or members of police staff believe that a girl may be at risk of undergoing FGM, the duty inspector must be made aware and an immediate referral should be made to their local child abuse investigation team (CAIT).

Outside the core hours, the duty inspector must ensure that appropriate protection measures are put in place and the on-call CAIT DS is spoken to. The CAIT will in turn make an immediate referral to the relevant local authority children's social care team.

Initial steps when a girl may be at risk of FGM

If any officer believes that the girl could be at immediate risk of significant harm, they should consider the use of police protection powers under section 46 of the Children Act 1989 and remove the girl to a place of safety. The FGM Protection Order (FGMPO) can be made to protect the girl against the risk of FGM or against whom an FGM offence has been committed. In addition, local authority children's social care should consider the use of a Prohibitive Steps Order or Emergency Protection Order. The welfare of other children within the family, in particular female siblings, should be reviewed. A full Guardian incident should be created as this will enable CAIT to record strategy discussions later.

The investigation should be the subject of regular on-going multi-agency reviews to discuss the outcome and any further protective steps that need to be taken with regard to that girl and any other siblings.

Next steps when a girl is thought to have already undergone FGM

If it is believed or known that a girl has undergone FGM, a strategy meeting must be held as soon as practicable (and in line with statutory guidance) to discuss the implications for the child and the coordination of the criminal investigation.

This should also be used as an opportunity to assess the need for support services such as counselling and medical help as appropriate. Police officers may want to refer to the Crown Prosecution Service's guidance document entitled '**Provision of Therapy for Child Witnesses Prior to a Criminal Trial[4]'**. A second strategy meeting should take place within ten working days of the initial referral.

Conducting interviews about FGM.

As with all criminal investigations, children and young people should be interviewed under the relevant procedure/guidelines (e.g. Achieving Best Evidence) to obtain the best possible evidence for use in any prosecution. Consent should be obtained to record the interview and for allowing the use of the interview in family and/or criminal courts, unless this would hinder the investigation.

In addition, information gained from the interview process will enable a risk assessment to be conducted as to the risk to any other children or siblings. Medical examinations, corroborative evidence should be sought through a medical examination conducted by a qualified doctor trained in identifying FGM.

The statutory multi-agency FGM guidance[5] sets out additional information on legal interventions at Annex E, and guidance for professionals talking about FGM at Annex C.

2.5 Community /Voluntary Groups

Any volunteer or community group member who is concerned that a child is at risk or has had FGM should, if possible, consult with their agency child protection adviser (if they have one). If concerns persist, a referral should be made to Lambeth /Southwark Children's Social Care. If you are imminently worried, you should ring the police on 999.

The referral should not be delayed in order to consult with your child protection adviser, a manager or group leader, as multi-agency safeguarding intervention needs to happen quickly. If there is a concern about one child, consideration must be given to whether siblings are at similar risk.

It is expected that individuals that make a referral to the police or children's social care in their role with a voluntary sector organisation will not normally be able to remain

[4] https://www.cps.gov.uk/publications/prosecution/therapychild.html

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

anonymous. However, given the heightened sensitivity within communities that practise FGM and potential risk to those individuals, referrals made by members of the community who are working with a voluntary sector organisation can reasonably expect not to have this information passed to the family involved. They should still give their details and organisation contact information when making a referral but can request that they remain 'anonymous' with regard to the family or child who is the subject of the referral.

2.6 Community Responsibility to eradicate FGM

Community engagement is essential to prevent and eradicate FGM – focusing on the removal of barriers to empower women and girls to seek support and assistance. This should be facilitated by promoting open dialogue and active involvement. This is key to changing attitudes towards FGM in communities where it is still an accepted practice, using key community figures and faith leaders. Engagement is an essential part of change, as prevailing attitudes to the practice simply by "telling" people not to do it will not ultimately lead to full eradication of the practice.

3.0 Review of Protocol

This protocol will be reviewed within the first six month of publication followed by annual reviews by the FGM Steering Group. Any amendments, changes and additions will be ratified by the Southwark Safeguarding Children's Boards.

4.0 Escalation Procedure

Please refer to the London Child Protection Procedures
http://www.londonscb.gov.uk/procedures/

5.0 Local Authority Contact Details

Southwark Children Services Important Contact Details

Multi Agency Safeguarding Hub (MASH)
Children's Social Care
Sumner House,
Sumner Road
SE15 5QS
Telephone number: 0207 525 1921
Email: mash@southwark.gov.uk
Fax: 0207 525 7992

For Further information:
http://www.southwark.gov.uk/info/266/child_protection/2951/multi-agency_safeguarding_hub_mash
All referrals should be sent using the common assessment framework form (CAF)
http://www.southwark.gov.uk/info/878/common_assessment_framework

Southwark Adult Social Care Important Contact Details

Safeguarding Adults Team

Address: PO Box 64529
London
SE1P 5LX
Tel: 020 7525 1754
Fax: 020 7525 1711
Email: **safeguardingadultscoordinator@southwark.gov.uk**

6.0 Community Based Support Agencies

Organisation:	**Solace Advocacy and Support Service(SASS) Southwark**
Telephone number:	0207 593 1290
Email address:	southwark@solacewomensaid.org
Web address:	www.solacewomensaid.org
Opening hours:	9:00 – 18:00 (with additional out-of-hours on-call service provided via same contact number)
Referral criteria:	Women and Men aged 16 or over who live in Southwark and are experiencing abuse.
Project Description	Solace offers and provides help through advice and support to women and men who are or have suffered abuse which can be physical, sexual, emotional or financial abuse which takes place within an intimate or family relationship. Abuse can include neglect, controlling behaviour, forced marriage, honour based violence or female genital mutilation. Help is provided through advice and support with: • Improving your safety • Housing and homelessness • Finances and welfare benefits • Access to legal services • Parenting and children • Emotional support • Making your home safer.

Organisation:	Africa Advocacy Foundation
Telephone number:	0208 698 4473
Email address:	mulkaht@a-af.org or shani@a-af.org
Web address:	www.sacredbodies.org
Opening hours:	Monday-Friday 10am-6pm
Referral criteria:	Women and girls affected /at risk of Female Genital Mutilation.
Project description:	The Sacred Bodies Project works to reduce the risk of FGM to young Girls in Lambeth, Southwark and Lewisham. We educate and empower men, women and youth about the health implications of FGM and the law. Our services include one to one counselling, community outreach support, advice and referral for women affected by FGM, delivered in culturally appropriate manner.

Organisation:	African Well Women's Clinic @ Guy's and St Thomas' Hospital
Telephone number:	020 7188 6872 or 07956542576 or via Geraldine Joyce, Safeguarding Midwife on 0207 188 2316 / 07930 314 118.
Email address:	Comfort.Momoh@gstt.nhs.uk
Opening hours:	Monday to Friday 9:00 - 17:00
Referral criteria:	Women who have experienced female genital mutilation.
Project description:	The clinic provides counselling, support, advice for women who have experienced female genital mutilation (FGM), as well as advice for practitioners. The clinic also provides the reversal or de-infibulation for type III FGM. Women from anywhere across the UK can access the service.

Organisation:	FGM Hotline
Telephone number:	0800 028 3550
Email address:	fgmhelp@nspcc.org.uk
Web address:	
Opening hours:	24 hour hotline
Referral criteria:	Anyone affected by FMG
Project description:	A 24/7 UK-wide service staffed by specially trained child protection helpline counsellors who can offer advice, information, and assistance to members of the public and to professionals. Helpline counsellors will also be able to make referrals, as appropriate, to statutory agencies and other services.

7.0 Document Contributors

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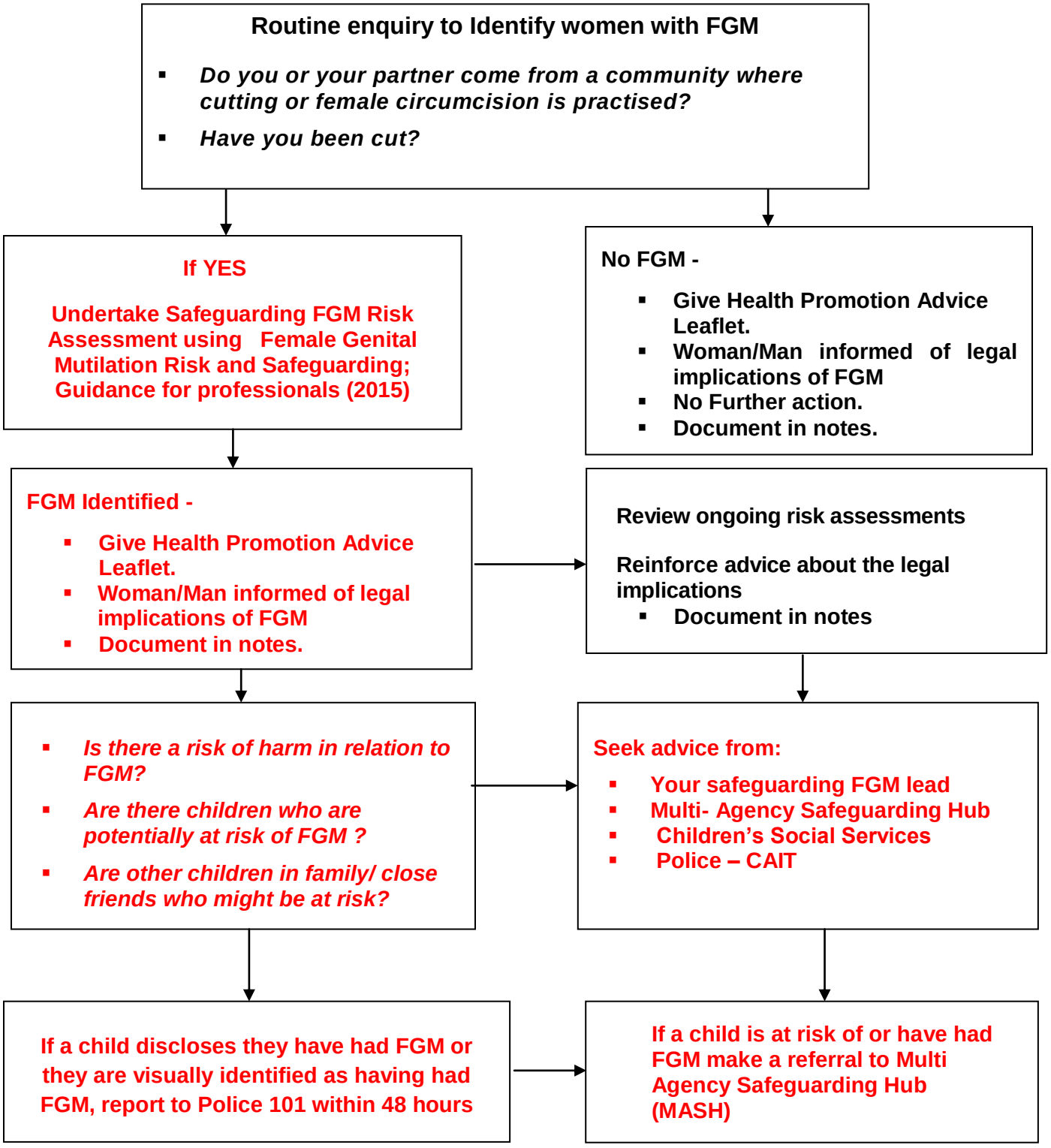
Angela Craggs	DI CAIT Southwark and Lambeth

8.0 Documents Consulted

- Multi-agency Statutory Guidance on Female Genital Mutilation (2016)
- **Department of Health Guidance: Female Genital Mutilation Risk and Safeguarding. Guidance for Professionals (March 2015)**
- **FGM Risk Assessment Safeguarding Tool for Health Colleagues as contained in the Department of Health 2015 guidance**
- **Commissioning Services to Support Women and Girls with Female Genital Mutilation**
- **London Child Protection Procedures**
- **London Safeguarding Children Board FGM Guidelines and toolkit (2009)**
- **Children Act of 1989**
- **Working Together Guidance (2015)**
- **World Health Organization FGM Guidance**
- **Provision of Therapy for Child Witnesses Prior to a Criminal Trial'**

- **Department of Health Multi-Agency Practice Guidelines on FGM**
- **The United Nations Declaration of Human Rights**
- **Eliminating Female Genital Mutilation: An Interagency Statement , World Health Organization, 2008**
- **'Provision of Therapy for Child Witnesses Prior to a Criminal Trial'**
- **Serious Crime Act 2015**
- **Tacking FGM in the UK: Intercollegiate recommendations for identifying, recording and reporting (2013)**

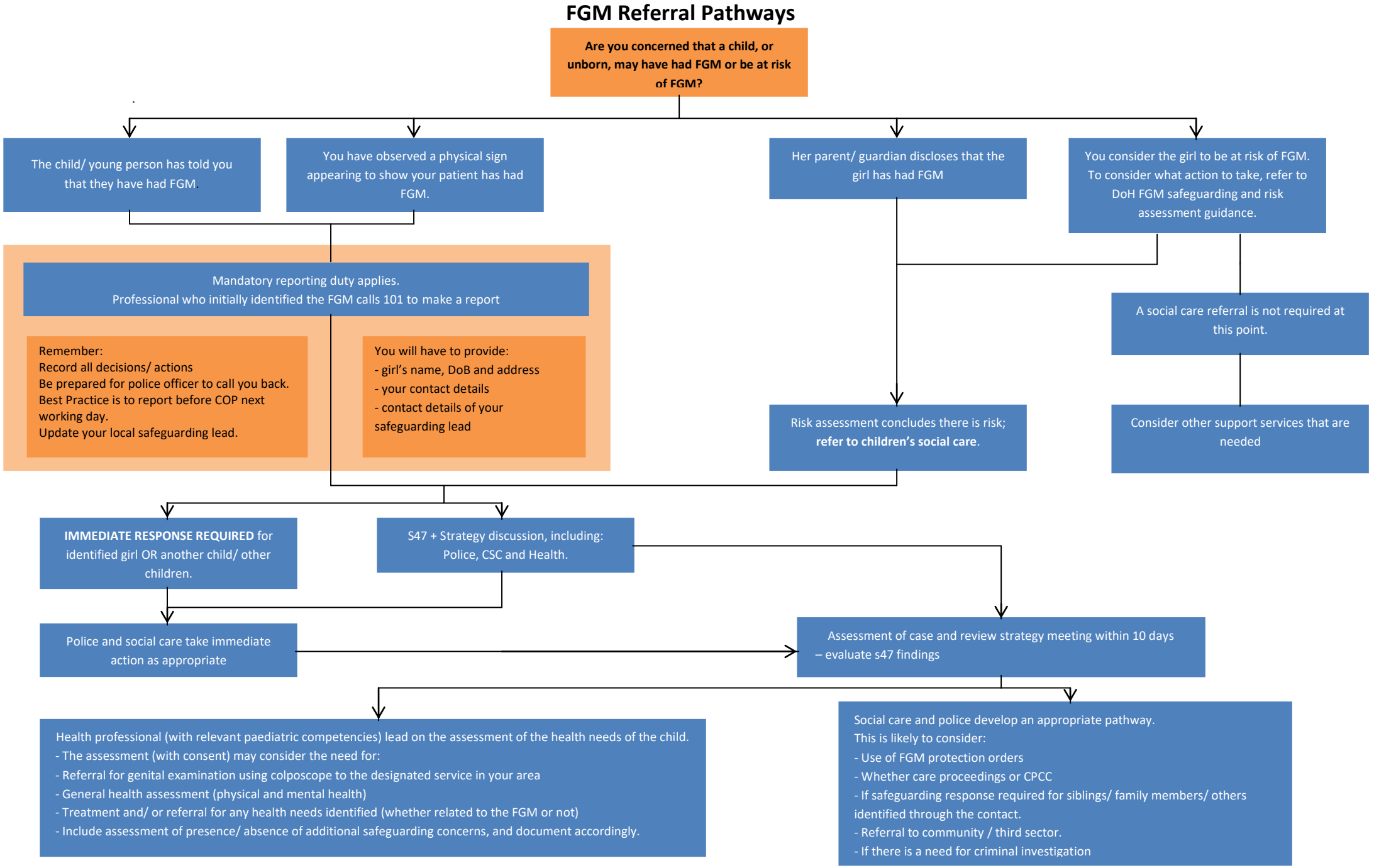
Appendix 1: Brief Multiagency Risk Assessment Flowchart



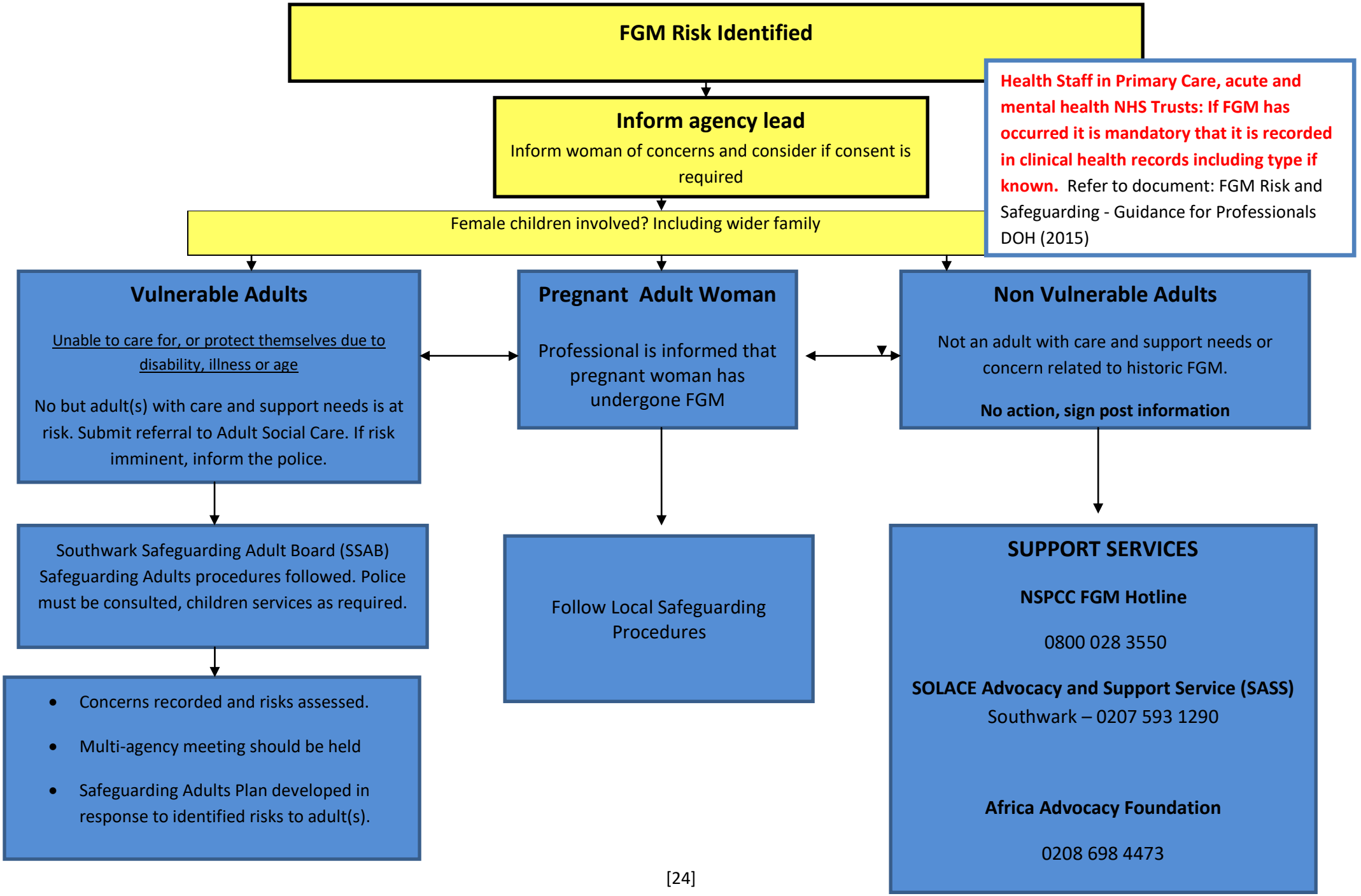
You should attempt to use an interpreter whose values on FGM are known when talking to the family. Do NOT use family members.

If you think the child/young person is at immediate risk and speaking with the family will increase the risk, then refer to Children Social Care or call 999 if the child is in imminent danger.

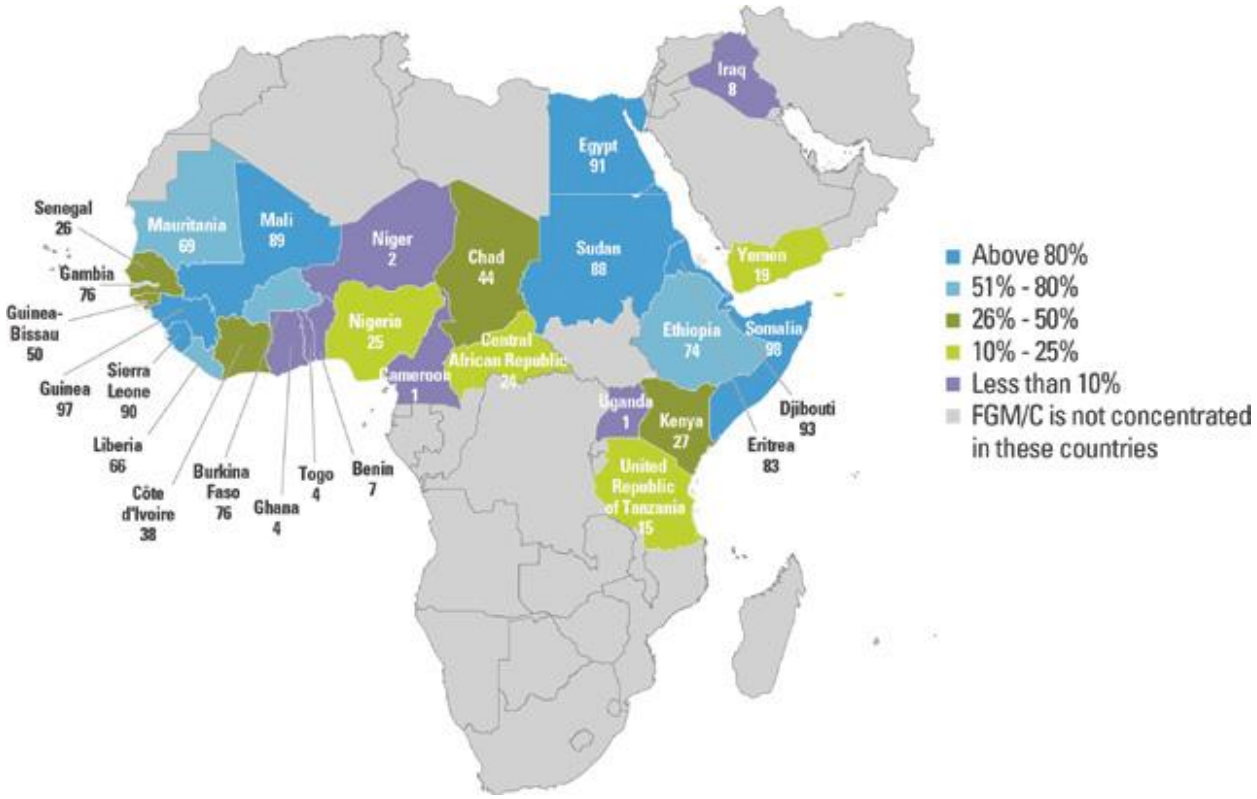
Appendix 2a: Reporting to Police and Social Care Duties



Appendix 2b: Adult FGM Pathway



Appendix 3: Countries where FGM is practised



FGM has also been documented in communities including:

- Iraq
- Israel
- Oman
- the United Arab Emirates
- the Occupied Palestinian Territories
- India
- Indonesia
- Malaysia
- Pakistan

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.

Source: UNICEF global databases, 2014, based on DHS, MICS and other nationally representative surveys, 2004-2013. **http://www.data.unicef.org/child-protection/fgmc** as found in the **Female Genital Mutilation Risk and Safeguarding: Department of Health Guidance for Professionals March 2015**

Appendix 4: Traditional and Local terms for FGM

Country	Term Used for FGM	Language	Meaning
Egypt	Thara	Arabic	Deriving from the Arabic word 'Tahar' meaning to clean/purify
	Khitan	Arabic	Circumcision- used for both FGM and male
	Khifad	Arabic	Deriving from Arabic word 'khafad' meaning to lower (rarely used in everyday language
Ethiopia	Mergez	Amharic	Circumcision/cutting
	Abusm	Harrari	Name giving ritual
Eritrea	Mekhnishab	Tigrena	Circumcision/Cutting
Kenya	Kutari	Swahili	Circumcision-used for both FGM and male circumcision
	Kutairi	Swahili	Circumcision of girls
Nigeria	Ibi/Ugwu	Igbo	The act of cutting-used for both FGM and make circumcision
	Sunna	Mandingo	Religious tradition/obligation for Muslims
Sierra Leone	Sunna	Soussou	Religious tradition/obligation-for Muslims
	Bondo	Temenee/Mandingo/Limba	Integral part of the initiation into adulthood-for Muslims
	Bondo/Sonde	Mendee	Integral part of an initiation rite into adulthood
Somalia	Gundiniin	Somali	Circumcision used for both FGM and male circumcision
	Halalays	Somali	Derived from Arabic 'halal' ie. 'sanctioned'-implies purity. Used by Northern & Arabic speaking Somalis
	Qodiin	Somali	Stitching/tightening/sewing refers to infibulation
Sudan	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
	Tahoor	Arabic	Deriving from the Arabic work 'tahar' meaning to purify
Chad- the Ngama	Bagne		Used by the Sara Madjingaye
Sara subgroup	Gadja		Adapted from 'ganza' used in the Central African Republic
Guinea Bissau	Fanadu di Mindjer	Kriolu	'Circumcision of girls'
Gambia	Niaka	Mandinka	Literally to 'cut/weed clean'
	Kuyango	Madinka	Meaning "the affair " but also the name for the shed built for initiates
	Musolula Karoola	Mandika	Meaning 'the women's side/that which concerns women

As found in the **Female Genital Mutilation Risk and Safeguarding: Department of Health Guidance for Professionals March 2015**