# City and Hackney Female Genital Mutilation (FGM) Protocol

Hackney

CITY OF LONDON

## Contents

## 1. Purpose

1.1 This protocol follows the Multi-agency statutory guidance on female genital mutilation and sets out local referral pathways.

1.2 No single agency can eradicate Female Genital Mutilation (FGM); there is a need for different agencies to work together to help prevent and tackle it, as well as to support FGM survivors using a trauma-informed approach.

1.3 This protocol provides agencies with an understanding of FGM and what actions they should take to safeguard girls and women who they believe are at risk or who have already undergone FGM.

1.4 FGM is dealt with primarily by the Female Genital Mutilation Act 2003 and sits alongside Working Together to Safeguard Children 2018

1.5 NHS staff should also refer to Female Genital Mutilation Risk and Safeguarding Guidance for professionals

1.6 This protocol forms part of Hackney's Eliminating Violence Against Women and Girls Strategy 2022 - 2025 and will be monitored by Hackney's Violence Against Women and Girls Strategic Board. This protocol forms part of the City of London Violence against Women and Girls Strategy 2019 - 2023 and will be monitored by the City of London Violence Against Women & Girls Delivery Group.

## 2. Definition of Female Genital Mutilation

2.1 FGM refers to procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

2.2 FGM has been classified by the World Health Organisation into four types:

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| 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 cauterising the genital area. |

2.3 Some who support the practice have sought to eliminate risks of infection (by, for example, carrying it out in a medical environment) to legitimise FGM. However, in addition to the immediate risks associated with FGM being carried out, it can have serious and harmful long-term psychological and physical effects, regardless of how the procedure was done.

Re-Infibulation

2.4 Re-infibulation is when the raw edges of the FGM wound are sutured again following childbirth, recreating a small vaginal opening similar to the original FGM Type 3 appearance. Section 1 of the 2003 Act does not refer explicitly to re-infibulation but, as a matter of common sense, if it is an offence to infibulate it must equally be an offence to re-infibulate.

Female Genital Surgery

2.5 The 2003 Act contains no specific exemption for 'cosmetic' surgery or female genital cosmetic surgery (FGCS). If a procedure involving any of the acts prohibited by section 1 of the 2003 Act is not necessary for physical or mental health or is not carried out for purposes connected with childbirth then it is an offence (even if the girl or woman on whom the procedure is carried out consented).

2.6 Virginity testing and hymenoplasty are often correlated with FGM. The Health and Care Act 2022 makes it an offence to carry out, offer or aid and abet virginity testing and hymenoplasty in the United Kingdom. These offences carry extra territorial jurisdiction and carry a maximum sentence of 5 years imprisonment and/or an unlimited fine. This includes offering services, aiding and abetting and carrying out the procedures. A woman or girl cannot consent as it is illegal.

The law defines 'virginity testing' as "the examination of female genitalia, with or without consent, for the purpose (or purported purpose) of determining virginity."

The law defines 'hymenoplasty' as "the reconstruction of the hymen (with or without consent)."

## 3. Female Genital Mutilation and the law

3.1 FGM is illegal if perpetrated against any woman or girl of any age in England and Wales under the Female Genital Mutilation Act 2003.

3.2 If it is suspected that FGM has happened or is imminently going to happen, the police should be contacted on either 101 or 999 depending on the level of urgency.

3.3 Professionals subject to the mandatory reporting duty **must** report known cases of FGM in under 18s to the police (see 11.8 - 11.14 of this Protocol and this flowchart).

3.4 As amended by the Serious Crime Act 2015, the FGM Act 2003 now includes:

- An offence of failing to protect a girl from the risk of FGM;
- Extra-territorial jurisdiction over offences of FGM committed abroad by UK nationals and those habitually (as well as permanently) resident in the UK
- Lifelong anonymity for victims of FGM;
- FGM Protection Orders which can be used to protect girls at risk; and
- A mandatory reporting duty which requires specified professionals to report known cases of FGM in under 18s to the police.

Failing to Protect a Girl from Risk of FGM

3.5 Section 3A of the 2003 Act 22 provides for an offence of failing to protect a girl from the risk of FGM. This means that if an offence under section 1, 2 or 3 of the 2003 Act is committed against a girl under the age of 16, each person who is responsible for the girl at the time the FGM occurred could be liable under the offence.

The term “responsible” covers two classes of person:

- a person who has “parental responsibility” for the girl and has “frequent contact” with her
- a person aged 18 or over who has assumed (and not relinquished) responsibility for caring for the girl “in the manner of a parent”.

3.6 Any person found guilty of an offence under section 3A of the 2003 Act is liable to a maximum penalty of 7 years’ imprisonment or a fine (or both).

Extra-Territorial Offences

3.7 Section 4(1) of the 2003 Act extends sections 1 to 3 to extra-territorial acts so that it is also an offence for a UK national or UK resident to:

- perform FGM outside the UK
- assist a girl to perform FGM on herself outside the UK
- assist (from outside the UK) a non-UK national or UK resident to carry out FGM outside the UK on a UK national or UK resident

3.8 The extra-territorial offences are intended to cover taking a girl abroad to be subjected to FGM. By virtue of section 1(4) of the 2003 Act, the exceptions set out in sections 1(2) and (3) also apply to the extra-territorial offences.

Other Offences

3.9 It is also an offence to:

- aid, abet, counsel or procure a person to commit an FGM offence
- encourage or assist a person to commit an FGM offence
- attempt to commit an FGM offence
- conspire to commit an FGM offence

3.10 Any person found guilty of such an offence faces the same maximum penalty (7 years' imprisonment, a fine or both as for the offences under the 2003 Act.

3.11 For further detail on the law see Multi-agency statutory guidance on FGM and Female Genital Mutilation | The Crown Prosecution Service (cps.gov.uk)

## 4. Understanding Female Genital Mutilation

When does FGM occur?

4.1 The age at which girls and women undergo FGM varies enormously between different communities. The procedure may be carried out when a girl is a newborn, during childhood or adolescence, just before marriage or during or after pregnancy.

4.2 Girls of school age who are subjected to FGM overseas are likely to be taken abroad (often to the family's country of origin) at the start of the school holidays, particularly in the summer, in order for there to be sufficient time for her to recover before returning to school. The winter holiday period is also a high risk time due to not only a significant period of absence from school but also cultural festivals during that time.

Why does FGM occur?

4.3 FGM is a traditional practice often carried out by a family who believe it is beneficial and is in a girl's or woman's best interests. The justifications given for FGM may be based on a belief that, for example, it:

- brings status and respect to the girl;
- preserves a girl's virginity/chastity;
- is part of being a woman and/or is a rite of passage;
- gives a girl social acceptance, especially for marriage;
- upholds the family "honour";
- cleanses and purifies the girl;
- gives the girl and her family a sense of belonging to the community;
- fulfils a religious requirement believed to exist;
- perpetuates a custom/tradition;
- helps girls and women to be clean and hygienic;
- is aesthetically desirable;
- makes childbirth safer for the infant; and
- rids the family of bad luck or evil spirits.

4.4 Infibulation (Type 3) is strongly linked to virginity and chastity, and used to 'protect' girls from sex outside marriage and from having sexual feelings. In some cultures, it is considered necessary at marriage for the husband and his family to see her 'closed' and, in some instances, both mothers will take the girl to be cut open enough to be able to have sex.

4.5 Although FGM is practised by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. However, FGM predates Christianity, Islam and Judaism. The Bible, Koran, Torah and other religious texts do not advocate or justify FGM.

## 5. The consequences of Female Genital Mutilation

5.1 FGM involves removing and damaging healthy and normal female genital tissues so can interfere with the natural function of female bodies.

Immediate / Short-Term Consequences of FGM

5.2 The immediate/short-term consequences of FGM can include:

- severe pain;
- shock;
- haemorrhage;
- wound infections;
- urinary retention or infections;
- abscesses
- injury to adjacent tissues;
- genital swelling; and/or
- death.

Long-Term Consequences of FGM

5.3 The long-term consequences of FGM can include:

- genital scarring;
- genital cysts and keloid scar formation;
- recurrent urinary tract infections and difficulties in passing urine;
- possible increased risk of blood infections such as hepatitis B and HIV;
- pain during sex, lack of pleasurable sensation and impaired sexual function;
- psychological concerns (anxiety, flashbacks, post traumatic stress disorder);
- difficulties with menstruation (periods);
- difficulties in forming trusting relationships;
- complications in pregnancy or childbirth (including prolonged labour, bleeding or severe tears during childbirth, increased risk of caesarean section);
- increased risk of stillbirth and death of a child during or just after birth.

## 6. Female Genital Mutilation: protective factors and predictive risk indicators

6.1 The most significant factor to consider when deciding whether a girl or woman may be at risk of FGM is whether her family has a history of practising FGM. In addition, it is important to consider whether FGM is known to be practised in her community or country of origin. See https://www.fgmcri.org/research-resources/ and Annex A of this Protocol.

6.2 The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is new-born, during childhood or adolescence, at marriage or during a first pregnancy.

6.3 Given the hidden nature of FGM, individuals from communities where it takes place may not be aware of the practice. Women and girls who have undergone FGM may not fully understand what FGM is, what the consequences are, or that they themselves have had FGM.

6.4 It is believed that FGM may happen to girls in the UK as well as overseas.

Protective factors

6.5 Professionals should not assume that all women and girls from a particular community are supportive of, or at risk of FGM.

6.6 Girls living in families and within communities in which FGM has historically been practised will not always be subjected to FGM themselves. The following are factors that can indicate a reduced risk to girls from communities in which FGM has historically been practised:

- within the family culture there is a high level of agency for women e.g. the ability to make choices about relationships, education, engaging in paid work outside the home and community, financial independence, friendship groups, whether and when to have children;
- a girl's mother comes from a community that does not practise FGM;
- a girl's father comes from a community that does not practise FGM;
- the family indicate that there there is little or no influence held by elders who are from communities that practise FGM;
- a girl's mother has been subjected to FGM and this has shaped her view that her daughter should not experience the same harmful experience;
- the parents believe that FGM is not endorsed or required as part of their religion;
- the parents believe that FGM has no medical / gynaecological / aesthetic benefits;
- the parents do not subscribe to other beliefs associated with harmful practices e.g. in witchcraft / possession / 'honour' based violence / forced marriage
- the parents believe that FGM is harmful in both the short- and long-term;
- a girl articulates to friends / teachers that she and her parents are aware of FGM and do not approve of it;

- the parents actively migrated internally within the UK / Europe or from a country in which FGM is prevalant in order to avoid girls being subjected to FGM;
- where extended family or community do endorse FGM, the girl's parents avoid visiting them and/or do not allow them to have care of their daughter;
- a girl has positive and consistent attendance at school;
- a girl engages fully in the school curriculum e.g. PHSE, physical education / sports
- a girl/family has a high level of integration within the UK / a diverse local community;

Predictive risk indicators

6.7 Potential risk factors that FGM may in future occur can include:

- a girls is born to a woman who has undergone FGM;
- a girl has an older sibling or cousin who has undergone FGM;
- a girl's father comes from a community known to practise FGM;
- the family indicate that there are strong levels of influence held by elders who are from communities that practise FGM and these elders are involved in bringing up girls;
- a woman/family believe FGM is integral to cultural or religious identity;
- a girl/family has limited level of integration within UK / their diverse local community;
- parents have limited access to information about FGM and do not know about the harmful effects of FGM or UK law;
- a girl confides to a professional that she is to have a 'special procedure' or to attend a special occasion to 'become a woman';
- a girl talks about a long holiday to her extended family's country of origin or another country where the practice is prevalent (see Annex A for the countries in which women and girls are most commonly subjected to FGM);
- parents state that they or a relative will take the girl out of the country for a prolonged period;
- a parent or family member expresses concern that FGM may be carried out on the girl;
- a family is not engaging with professionals (health, education or other);
- a girl requests help from a teacher or another adult because she is aware or suspects that she is at immediate risk of FGM;
- a girl talks about FGM in conversation, for example, a girl may tell other children about it (see Annex B for commonly used terms in different languages - it is important to take into account the context of the discussion in which FGM is mentioned);
- a girl from a practising community is withdrawn from Personal, Social, Health and Economic (PSHE) education or its equivalent;
- a girl is unexpectedly absent from school;
- sections are missing from a girl's Red book; and/or
- a girl has attended a travel clinic or equivalent for vaccinations / anti-malarials.

6.8 Remember that this is not an exhaustive list of risk factors. There may be additional risk factors specific to particular communities. For example, in certain communities FGM is closely associated with when a girl reaches a particular age.

6.9 It is understandable that families who may already experience systemic racism may feel labelled or pre-judged by professional concern that they may subject a girl to FGM; be clear as to the reasons why the discussion is taking place e.g. due to known risk factors

6.10 Women who recognise that their ongoing physical and/or psychological problems are a result of having had FGM and/or women who are involved in or highly supportive of FGM eradication work may be less likely to support or carry out FGM on their own children. However, any such woman may nonetheless be under pressure from her husband, partner or other family members to allow or arrange for her daughter to undergo FGM. Wider family engagement and discussions with both parents, and potentially wider family members, may be appropriate.

## 7. Indicators that Female Genital Mutilation May Have Already Taken Place

7.1 There are a number of indications that a girl or woman has already been subjected to FGM:

- a girl or woman confides in a professional that FGM has taken place;
- a mother/family member discloses that female child has had FGM;
- a girl or woman has difficulty walking, sitting or standing or looks uncomfortable;
- a girl or woman finds it hard to sit still for long periods of time, and this was not a problem previously;
- a girl or woman spends longer than normal in the bathroom or toilet due to difficulties urinating;
- a girl spends long periods of time away from a classroom during the day with bladder or menstrual problems;
- a girl or woman has frequent urinary, menstrual or stomach problems;
- a girl avoids physical exercise or requests to be excused from physical education (PE) lessons without a GP's letter;
- there are prolonged or repeated absences from school or college (see guidance on children missing education);
- increased emotional and psychological needs, for example withdrawal or depression, or significant change in behaviour;
- a girl or woman is reluctant to undergo any medical examinations;
- a girl or woman asks for help, but is not explicit about the problem;
- a girl talks about pain or discomfort between her legs.
- a girl has attended the GP reporting recurrent urine infections.

7.2 Remember that this is not an exhaustive list of indicators and that some of these can indicate issues other than FGM.

## 8. How to talk to someone about Female Genital Mutilation

8.1 If a professional does not give a girl or woman the opportunity to talk about FGM , it can be very difficult for a girl or woman to bring this up herself;

8.2 Families who travel to countries with a high incidence of FGM will often themselves experience systemic racism; any discussion needs to acknowledge this and be clear about the reasons for professional curiosity or concern

8.3 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, however, the key principles set out below should apply in all cases.

8.4 Talking about FGM can be difficult and upsetting. Professionals may wish to speak with their supervisor if they are affected by what they have heard.

8.5 Professionals may themselves have been victims of FGM so it is important that agencies have processes in place to provide trauma-informed support to staff

8.6 It is important to acknowledge and understand the motives, demographics and consequences of FGM. Equally, it is important that professionals take the time to think about their own concerns, feelings and values, so they can discuss FGM with clarity and confidence.

8.7 See **Appendix 5 of this practitioners' guidance**. When initiating a conversation about FGM, professionals should:

- ensure that the conversation is conducted sensitively;
- be open about the reason for having the discussion, citing what is known re prevalence in certain countries and the pressure that can be placed on families
- be aware of the specific circumstances of the individual when a discussion about FGM needs to take place
- be non-judgmental.

8.8 Creating and maintaining a good rapport with the girl or woman is essential. This can be achieved by:

- allowing the girl or woman to speak - actively listening, gently encouraging, and seeking the girl or woman's permission to discuss sensitive areas;
- not being afraid to ask about FGM, using appropriate and sensitive language. It is not unusual for women to report that professionals have avoided asking questions about FGM, and this can lead to a breakdown in trust.
- asking only one question at a time – it can be difficult to think through the answers to several questions at the same time;

- making sure there is appropriate time to listen; a girl or woman may relate information she has not disclosed previously. Interrupting her story part way through is likely to cause distress and may either damage the relationship with her, or affect her relationship with professionals in future; and
- preparing by understanding what written materials are available to support conversations, and what other community and third-sector organisations are able to offer support and additional information within the area. For resources and advice on how to find services, see **Annex E**.

8.9 It is important that professionals understand the appropriate language to use and maintain a professional approach. Professionals should:

- ensure sensitive language is used
- hear and recognise the girl or woman's wishes, culture and values but challenge beliefs or practices where these are known to be harmful e.g. FGM
- be aware that different communities may have different terms for FGM (see **Annex B**);
- remember that women or girls may not be aware that they have had FGM; professionals may need to explain that FGM is the cause of symptoms; and
- consider some of the following ways to start a discussion about FGM:

  "I can see in your notes from the obstetrician or midwife that you have been cut. Could you tell me a bit more about this?"

  "I know that some women in your country have been cut. How do you feel about this? Could you tell me a bit more?"

  "You have talked about your cutting and the traditions in your country. Is there anything else you want to tell me about this?"

  "How do you, and how does your partner, feel about female genital cutting? How do the people around you feel about this? Are you still in touch with relatives in your country? How do they feel about it? At what age is it usually performed?"

8.10 Professionals have a responsibility to ensure families understand that FGM is illegal in the UK, and to explain the harmful consequences it can have.

## 9 How to assess the risk of girls being subjected to Female Genital Mutilation

9.1 In addition to a Child and Family Assessment there are specific tools that can assist practitioners gain a sense of risk of FGM.

9.2 The **FGM Good Practice Guidance and Assessment Tool** is an excellent practical resource. See in particular:

Appendix 2: Legislation relevant to safeguarding a girl at risk of FGM
Appendix 3: Traditional Terms for FGM in a Variety of Languages
Appendix 4: FGM Prevalence - Global Map showing where FGM is most common
Appendix 5: Questions to assist FGM Assessment when talking to girls and families

9.3 The **Online FGM assessment tool** takes practitioners through a series of questions and helps evaluate risk

## 10 What to do if concerned that Female Genital Mutilation is going to happen

Children under 18

10.1 FGM is a serious offence and must be reported to police by regulated professionals as soon as possible as part of mandatory reporting (see flowchart).

10.2 If concerned that FGM is going to happen imminently to a girl then an urgent statutory safeguarding response is required involving Children's Social Care, Police, NHS and the child's school. If there is an immediate risk of FGM happening, then **call Police on 999**.

10.3 If a child has a social worker notify them and their managers straight away in parallel with notifying police; if they don't have an allocated worker refer to the Hackney Multi Agency Safeguarding Hub (MASH) / City of London Children and Families Service

10.4 Child protection processes and legal interventions can be considered as they would for any child at risk of significant harm and am additional remedy that can be considered is a FGM Protection Order (FGMPO) which schools, Local Authorities and others can apply for.

10.5 Once a referral is received, the relevant Children's Social Care service will decide whether to undertake a statutory assessment of the child(ren) identified at risk. Assessments will be informed by the FGM Good Practice Guidance and Assessment Tool and will explore (but will not be limited to) the following:

- the circumstances which led to the girl or woman being subjected to FGM
- the immediate and wider family's belief system in relation to the practice of FGM
- the family's contact with community and/or faith groups that support FGM
- if the family are likely to be in contact with those who have previously or currently perform FGM
- the influence of family and community beliefs and practices on the family
- if there are other risks including so-called 'Honour' Based Violence, Early Forced Marriage or Child Trafficking
- whether there are any plans for female children in the household to visit a country in which FGM is practiced
- the capacity of the child's parents/carers to resist community and familial pressure regarding FGM and to protect female children in their care from FGM
- the child(s) views, knowledge and understanding of FGM (depending on age and

understanding)

- the child's experience of family life and family / community belief systems
- whether female children in the household are able to access social / educational and health resources with an age-appropriate degree of autonomy
- whether the child has a safe adult(s) she can access if she is worried about her safety or welfare
- whether the child has experienced or is likely to experience FGM during childhood
- whether a professional response is required to meet the child's needs, reduce risk or provide immediate protection

10.6 The family will be informed of the outcome of the assessment and other relevant organisations, such as schools and GP practices will also be notified.

10.7 Protective action will be taken at any point where this is deemed necessary as would be the case with any safeguarding matter; steps may include Police Protection, Emergency Protection Orders, Interim Care Orders etc.

FGM Protection Orders (FGMPO)

10.8 An FGMPO is a civil order which may be made for the purposes of protecting a girl against the commission of an FGM offence – that is, protecting a girl at risk of FGM - or protecting a girl against whom an FGM offence has been committed.

10.9 Children's Social Care are the lead agency in applying for this civil remedy obtained in Family Court. The court has wide discretion to make protective orders, and the criminal standard of proof is not required.

10.10 The threshold for an FGMPO is not equivalent to the threshold within care proceedings. The orders granted are distinct. An order should be applied for where there is concern that FGM could be performed upon a protected person in England and Wales and/or outside of the jurisdiction and this can be addressed within a witness statement. Whilst they are open for anyone to apply, these orders can be secured at the early stage as they allow an individual to remain with family (if safe to do so), can help change behaviour, are useful if a victim is out of jurisdiction and the conditions sought are bespoke to the victims and the case

10.11 In deciding whether to make an order a court must have regard to all the circumstances of a case including the need to secure the health, safety and well-being of the potential or actual victim. The court can make an order which prohibits, requires, restricts or includes any other such other terms as it considers appropriate to stop or change the behaviour or conduct of those who would seek to subject a girl to FGM or have already arranged for, or committed, FGM.

10.12 Examples of the types of orders the court might make are:

- to protect a victim or potential victim at risk of FGM from being taken abroad;

- to order the surrender of passports or any other travel documents, including the passport/travel documentation of the girl to be protected;
- to prohibit specified persons ('respondents') from entering into any arrangements in the UK or overseas for FGM to be performed on the person to be protected;
- to include terms which relate to the conduct of the individuals named in the order both inside and outside of England and Wales; and
- to include terms which cover individuals who are, or may become involved in other respects (or instead of the original respondents) and who may commit or attempt to commit FGM against a girl.

10.13 Orders may also be made against people, who are not named in the application. This is in recognition of the complexity of the issues and the numbers of people who might be involved in the wider community.

Vulnerable Adults Suspected to be at Risk of FGM

10.14 In the case of a vulnerable adult, an initial referral should be made to adult social services. For Hackney residents please report to the Adult Safeguarding Team. For the City of London please refer to the Adult Social Care Team.

10.15 Where there is an imminent or serious risk, an emergency response may be required so police should be contacted in parallel with Adult Social Care services.

10.16 Where a woman, given her individual circumstances, is identified as being at risk of FGM, but the current situation does not indicate that the risk is imminent or significant appropriate safeguarding actions should be taken, making sure that this information is shared appropriately. This will help to make sure that, if other agencies or professionals have a wider scope or understanding of the woman's circumstances, they will be able to use the most up to date information to consider the risk the girl or woman currently faces

## 11 What to do if concerned that Female Genital Mutilation has happened

Child Safeguarding

11.1 Everyone who works with children has a responsibility to ensure that procedures for safeguarding children are adhered to. Statutory organisations, under Section 11 of the Children Act 2004, have a duty to safeguard and promote the welfare of children.

11.2 FGM is a serious offence and should be reported to police via 101 asap as part of a general safeguarding response. See also details of the mandatory reporting duty.

11.3 If FGM has happened a statutory safeguarding response is required involving Children's Social Care, Police, local NHS provider and the child's school. The need for a medical examination will also be considered, and where necessary advice can be sought from the University College London Hospital's FGM Clinic.

11.4 If a child has a social worker notify them and their managers straight away in parallel with notifying police; if they don't have an allocated worker refer to the Hackney Multi Agency Safeguarding Hub (MASH) / City of London Children and Families Service

11.5 Child protection processes and legal interventions can be considered as they would for any child who has experienced significant harm and an additional remedy that can be considered is a FGM Protection Order (FGMPO) which schools, Local Authorities and others can apply for.

11.6 If a girl within a family has been subjected to FGM, professionals must consider and assess the heightened risk to other female children within the family.

11.7 FGM often does not happen in isolation of other Harmful Practices. Depending on the context (and the family) there is likely to be a complex relationship with other Harmful Practices such as Forced Marriage, Abuse Linked to Witchcraft and Spirit Possession Accusations and Breast Flattening.

Children and FGM Mandatory Reporting Duty

11.8 Section 5B of the 2003 Act introduced a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to **immediately report 'known' cases of FGM in under 18s which they identify in the course of their professional work to the police and Children's Social Care. See flowchart for an overview of the mandatory duty and process.**

11.9 The duty applies to all regulated professionals (as defined in section 5B(2)(a), (11) and (12) of the 2003 Act) working within health or social care, and teachers. It covers:

- health and social care professionals regulated by a body which is overseen by the Professional Standards Authority for Health and Social Care. 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

11.10 The legislation requires regulated health and social care professionals and teachers in England and Wales 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 which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

11.11 Reports under the duty should be made as soon as possible after a case is discovered, and best practice is for reports to be made by the close of the next working day. In order to allow for exceptional cases, a maximum timeframe of one month from when the discovery is made applies for making reports. However, the expectation is that reports will be made much sooner than this.

A mandatory report is to be made via 101 and the following information will be required: You will need to provide your details, the details of your organisation's safeguarding lead and the name, date of birth and address of the girl. '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. Mandatory Reporting is a personal duty to report to police and cannot be delegated to others.

11.12 A longer timeframe than the next working day may be appropriate in exceptional cases where, for example, a professional has concerns that a report to the police is likely to result in an immediate safeguarding risk to the child (or another child, e.g. a sibling) and considers that consultation with colleagues or other agencies is necessary prior to the report being made.

11.13 Cases of failure to comply with the duty will be dealt with in accordance with the existing performance procedures in place for each profession and may result in a referral by the agencies' employer to the Disclosure and Barring Service. FGM is child abuse, and employers and the professional regulators are expected to pay due regard to the seriousness of breaches of the duty.

11.14 While the duty is limited to the specified professionals described above, nonregulated practitioners also have a general responsibility to report cases of FGM, in line with wider safeguarding frameworks. If a non-regulated professional becomes aware that FGM has been carried out on a girl under 18, they should still share this information within their local safeguarding lead, and follow their organisation's safeguarding procedures.

Vulnerable Adults who have experienced FGM

11.15 No mandatory reporting duty exists regarding adults, including vulnerable adults

11.16 In the case of a vulnerable adult, an initial referral should be made to adult social services. For Hackney residents please report to the Adult Safeguarding Team. For the City of London please refer to the Adult Social Care Team.

11.17 Where an offence is known to have occurred to a vulnerable adult, police should be contacted in parallel with Adult Social Care services

Adults who are not vulnerable who have undergone FGM

11.18 FGM is a criminal offence if perpetrated against any woman of any age. Although there is no mandatory reporting duty, adult survivors should be supported to report an offence if they wish to do so.

11.19 Health professionals may encounter a woman who in the course of treatment discloses she has been a victim of FGM. It is important that professionals look out for signs that FGM has already taken place so that:

- the woman receives the care and support she needs to deal with its effects (see Annex F);
- enquiries can be made about other female family members who may need to be safeguarded from harm; and/or
- criminal investigations into the perpetrators, including those who carry out the procedure, can be considered to prosecute those who have broken the law and to protect others from harm.

NHS Professionals and the FGM Enhanced Dataset Information Standard

11.20 Professionals working in healthcare in England should have due regard to the FGM Enhanced Dataset Information Standard (SCCI2026) which instructs all clinicians on how and what to record in health records when a patient with FGM is identified, including additional details for example the type of FGM. The standard also instructs upon standardised information sharing protocols to support safeguarding against FGM.

11.21 The FGM Enhanced Dataset Information Standard also instructs NHS acute and mental health trusts and GP practices on how they should submit data about patients who have FGM to NHS Digital. NHS Digital collect and publish anonymised statistics on behalf of the Department of Health and Social Care and NHS England and NHS Improvement. The information is used nationally and locally to improve the NHS response to FGM and to help commission the services to support women who have experienced FGM and safeguard women and girls at risk of FGM. Please see the new National FGM Support Clinics as an example of this.

11.22 It is important to note that the personal information held and collected under the FGM Enhanced Dataset Information Standard is not released to anyone outside of NHS Digital. If these arrangements were to change, any information which was held prior to such a change would continue to be protected under the current arrangements.

11.23 It is best practice to share information between healthcare professionals to support the ongoing provision of care and effort to safeguard women and girls against FGM.

11.24 Ater a woman has given birth, information about her FGM status should be included in the discharge summary record which is sent to the GP and Health Visitor. In addition, it is useful to include that there is a history of FGM in a family within the Personal Child Health Record (often called the “Red Book”).

11.25 Healthcare professionals, using an ‘early intervention’ approach, should have discussions with women who have undergone FGM about their health needs, any support they require and any help they would like in reporting the offence to police. Professionals should also explore risks to any girls they already have care of or are planning to have.

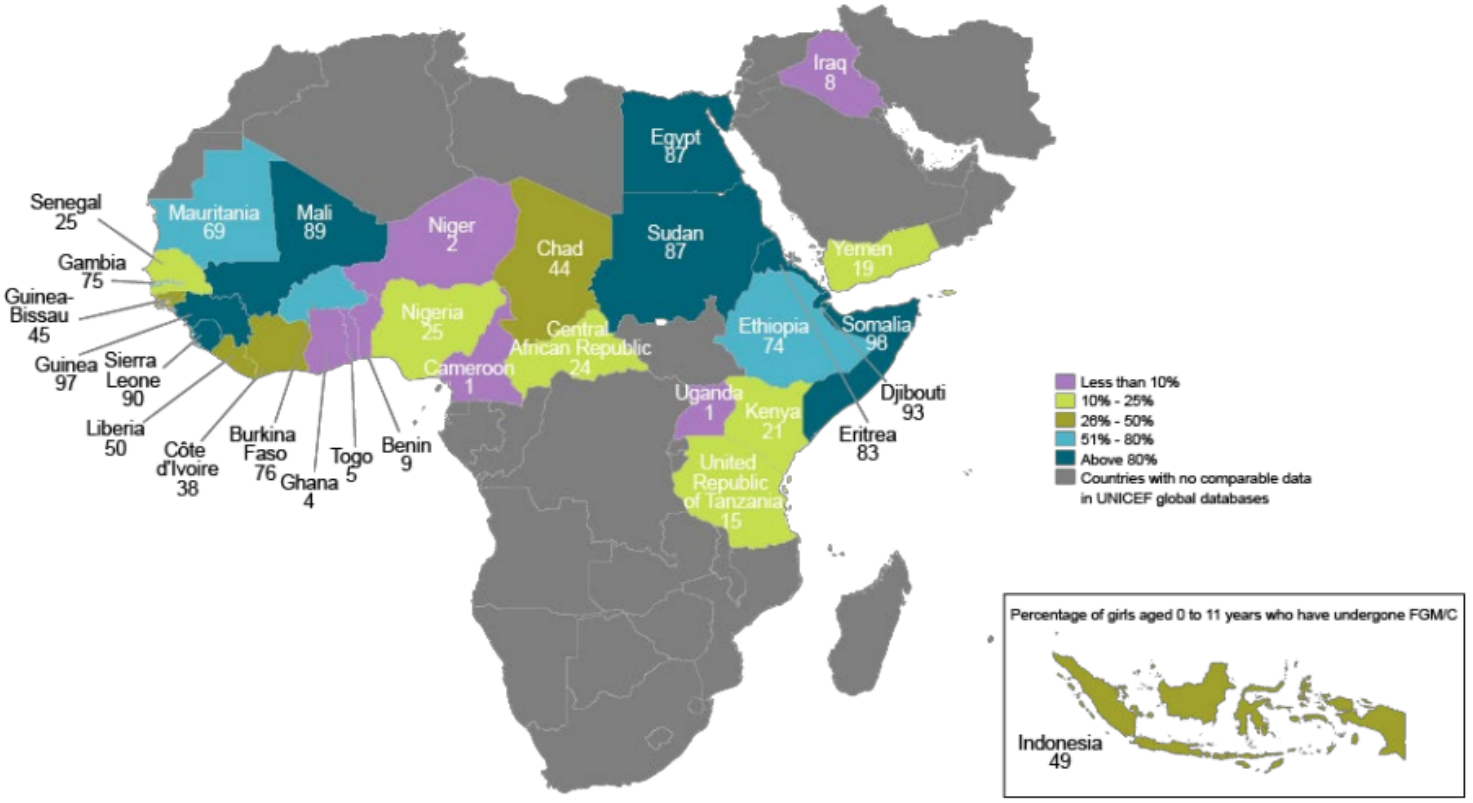
## 12 Protocol Governance

12.1 The City and Hackney FGM Protocol is overseen by the City and Hackney Safeguarding Children Partnership (CHSCP).

12.2 The FGM Protocol is reviewed on an annual basis

## Annex A: Global Prevalance Map of Female Genital Mutilation

**Figure 1: Percentage of girls and women aged 15-49 who have undergone FGM in Africa, the Middle East, and Indonesia**




**Notes:** In Liberia, girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM since it is performed during initiation into the society. Data for Indonesia refer to girls aged 0 to 11 years since prevalence data on FGM among girls and women aged 15 to 49 years is not available. **Source:** UNICEF global databases, 2016, based on DHS, MICS and other nationally representative surveys, 2004-2015. Map disclaimer

## Annex B: Terms used for Female Genital Mutilation

| Country | Language | Term(s) Used | Meaning |
|---|---|---|---|
| Benin | French | L'excision | Excision |
| Burkina Faso | French | L'excision | Excision |
| Burundi | Swahili | L'excision | Excision |
| | Swahili | Tohara kwa wanawake | Circumcision of women |
| Central African Republic | French/Sango | Ganza | |
| Chad | Nilo Sudanic Language | Bagne | |
| | Nilo Sudanic Language | Gadja | |
| Colombia | Embera | Curacion | Cure/healing/treatment |
| Cote d'Ivoire | French | L'excision | Excision |
| | English | Excision | Excision |
| Democratic Republic of the Congo | Swahili | Kukeketwa | Female Circumcision |
| | Swahili | Tohara kwa wanawake | Circumcision of women |
| Djibouti | Somali | Gudnin | Circumcision |
| | French | L'excision | Excision |
| Gambia | Mandinka | Niaka | Literally to cut/weed clean |
| | Mandinka | Kuyungo | The affair'/name given to the shed built for initiates |
| | Mandinka | Musolula Karoola | The women's side/that which concerns women |
| Ghana | English | Female circumcision | Female Circumcision |
| Guinea | English | Female circumcision | Female Circumcision |
| | English | Excision | Excision |
| | French | L'excision | Excision |
| Guinea-Bissau | Creole | Fanado | Circumcision |
| Egypt | Arabic | Khitan | Circumcision |
| | Arabic | Khifad | To lower |
| | Arabic | Thara | To clean/purify |
| Ethiopia | Amharic | Megrez | Circumcision/cutting |
| | Harrari | Absum | Name giving ritual |

## Annex C Local Authority Referral Pathway Details

For cases involving Hackney residents:

| Team Contact details | |
|---|---|
| **Hackney**<br>**Children's and Families** | Telephone: 020 8356 5500<br>(Monday to Friday, 9am to 5pm)<br>Outside office hours (emergency only):<br>020 8356 2710<br>Email: mash@hackney.gov.uk |
| **Hackney**<br>**Safeguarding Adults** | Telephone: 020 8356 5782<br>(Monday to Friday, 9am to 5pm)<br>Outside office hours (emergency only):<br>020 8356 2300<br>Email: adultsafeguarding@hackney.gov.uk |

For cases involving City of London residents:

| Team Contact details | |
|---|---|
| **City of London**<br>**Children and Families** | Telephone: 020 7332 3621<br>(Monday to Friday, 9am to 5pm)<br>Outside office hours (emergency only):<br>020 8356 2710<br>Email: children.duty@cityoflondon.gov.uk |
| **City of London**<br>**Safeguarding Adults** | Telephone: 020 7332 1224<br>(Monday to Friday, 9am to 5pm)<br>Outside office hours (emergency only):<br>020 8356 2300<br>Email: adultsduty@cityoflondon.gov.uk |

## Annex D: City and Hackney Partnership Safeguarding Leads

| Organisation Safeguarding Leads | |
|---|---|
| **City and Hackney ICB** | Mary Lee<br>(Designated Nurse)<br>Email: Mary.Lee1@nhs.net<br>Sam Martin<br>(Designated Nurse)<br>Email: samanthamartin1@nhs.net<br>Nick Lessof<br>(Designated Doctor)<br>Email: nick.lessof@nhs.net |
| **City of London Children's Social Care & Early Help** | Rachel Talmage<br>(Head of Services Children's Social Care)<br>Email: Rachel.Green@cityoflondon.gov.uk<br>Telephone: 020 7332 3501 |
| **Hackney Children's Social Care** | Operational Lead:<br><br>Frida Lannemyr<br>Service Manager, MASH<br>Children and Families Service<br>frida.lannemyr@hackney.gov.uk<br>Telephone: 020 8356 2382<br><br>Strategic Lead:<br><br>Lisa Aldridge<br>Head of Safeguarding and Quality Assurance<br>Children and Families Services<br>lisa.aldridge@hackney.gov.uk |
| **Hackney Domestic Abuse Intervention Service + Violence Against Women and Girls (VAWG)** | Cathal Ryan<br>Service Manager<br>Domestic Abuse Intervention Service<br>Children and Families Service<br>Email: Cathal.Ryan@hackney.gov.uk<br>Telephone: 020 8356 2806 |
| **Hackney Education** | Katherine Cracknell<br>Head of Wellbeing and Education<br>Safeguarding) Email:<br>Katherine.Cracknell@hackney.gov.uk<br>Telephone: 07747 631 098 |

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|---|---|
| **HCVS** | Olivia Pethwick<br>Director for Young People & Families<br>Email: olivia@hcvs.org.uk<br>Telephone: 020 7923 |
| **Homerton University Hospital NHS Foundation Trust** | Marcia Smikle<br>Head of Safeguarding Children<br>Email: Marcia.Smikle@homerton.nhs.uk<br>Telephone: 020 7683 4288 / 020 8510 5750<br><br>Jennie Wood<br>Lead Nurse Adult Safeguarding<br>Email: jennie.wood@nhs.net<br>Mobile : 07920029193<br>Landline : 0208 5107342 |
| **Homerton University Hospital NHS Foundation Trust<br>Maternity Services<br>Lead for FGM / Clinic** | Georgia Tierney<br>Public Health Programmes Midwife<br>Email: Georgia.tierney@nhs.net<br>Mobile 07909533107 |
| **Homerton Sexual Health Service** | Taslima Rashid<br>Consultant in HIV/GUM<br>Lead for safeguarding and clinical governance<br>Homerton Sexual Health Services<br>Homerton University Hospital,<br>taslima.rashid@nhs.net |
| **Metropolitan Police (Hackney Child Abuse Investigation Team)** | Jonathan Maharaj \| Acting / Detective Inspector<br>CAIT - Public Protection - Central East (Hackney & Tower Hamlets) \| Metropolitan Police Service<br>Address: Bethnal Green Police Station, 12 Victoria Park Square, London, E2 9NZ \| Mobile: 07776668057 \| Email: jonathan.maharaj@met.police.uk |
| **City of London Police** | Alistair Marman<br>(Detective Inspector – Police Public Protection)<br>Email:alistair.marman@cityoflondon.police.uk<br>Telephone: 07523 937288 |

## Annex E: Support organisations for FGM Survivors

You can search for local support by entering in a postcode in the following link: https://www.gov.uk/female-genital-mutilation-help-advice

| Organisation | Contact details |
|---|---|
| **Homerton University Hospital NHS Foundation Trust**<br>**FGM Clinic** | Every woman who books her pregnancy with Homerton hospital and discloses experience of FGM/C is offered a face-to-face or telephone appointment in FGM/C clinic. Using a trauma informed approach, the appointment assesses any ongoing physical or emotional unmet needs of the woman and offers and provides referrals to relevant services. These referrals include, obstetric, gynaecological, psycho-sexual, and psychological. The appointment also assesses any safeguarding concerns regarding to FGM/C in the pregnancy.<br><br>For more information:<br><br>huh-tr.maternitysafeguarding@nhs.net |
| **IKWRO - Women's Rights Organisation** | **Website: www.ikwro.org.uk**<br>**Email: info@ikwro.org.uk**<br><br>"IKWRO is a registered charity which provides advice and support to Middle Eastern, North African and Afghan women and girls living in the UK, who have experienced, or are at risk of all forms of "honour" based abuse, including; forced marriage, child marriage and female genital mutilation (FGM), or domestic abuse.<br><br>We work with women and girls of all ages, including lesbian women, bisexual women and trans women. We offer services in Kurdish, Farsi, Arabic, Dari, Pashto, Turkish and English.<br><br>IKWRO offers free advice, advocacy and counselling services and operates a refuge which provides safe accommodation and specialist support to single women at risk of "honour" based abuse, forced marriage and domestic abuse." |
| **University College London Hospital – FGM Clinic** | **Website:**<br>**https://www.uclh.nhs.uk/our-services/find-service/womens-health-1/gynaecology/female-genital-mutilation-fgm-clinic**<br>**Email: uclh.fgmreferrals@nhs.net**<br>**Patient enquiries:**<br>**020 3447 9411 or 07944 241 992**<br><br>"Consultation and procedures |

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|---|---|
| | Clinics at UCLH<br>'One-stop' clinics for assessments and the procedures for reversal if woman chooses to<br>Choice of local or general anaesthetic for the 'reversal' procedure.<br><br><u>Assessments</u><br><br>Pregnant women before childbirth<br>Women hoping to conceive<br>Women with a history of incontinence/prolapse and sexual dysfunction and other pelvic floor disorders<br><br><u>Support</u><br><br>Advocacy<br>Counselling/psychology<br><br><u>Referral to other services where clinically indicated</u><br><br>Urogynaecology services via FPMRS<br>Chronic Lower Urinary Tract Symptoms clinic (Chronic UTI)<br>Abdominal and Pelvic Pain services<br>Rheumatology services |
| **HAWA Trust** | **Website: http://hawatrust.org.uk/**<br>**Email: info@hawatrust.org.uk**<br>**Telephone: 020 7281 7694**<br><br>"Hawa Trust provides confidential, one-to-one, non-judgemental support based on your needs. We provide emotional support as well as supporting you to access health care to help you maintain your physical and emotional wellbeing.<br><br>Hawa Trust is a local charity foundation that works with different people and organisations in the fighting against FGM/C related with HIV and order harmful abuse to women and girls. Our aim is to reduce risk of girls and young women undergo FGM here in the UK, Sierra Leone and abroad. Hawa Trust is based in Hackney" |
| **Manor Gardens (Dahlia Project)** | **Website: https://www.dahliaproject.org/**<br>**Email: alev@manorgardenscentre.org**<br>**Telephone: 020 3441 4688 or 07852 360 272**<br><br>"Therapeutic Support Groups and Individual Counselling<br><br>Tailored to the needs of women themselves, we provide a safe, confidential and non-judgemental space where participants can discuss their experiences with trained counsellors, begin to understand the |

| | |
|---|---|
| | effects of FGM on their physical and mental health and rebuild their emotional wellbeing and resilience. These groups are held in neutral spaces such as libraries that women can access easily. We pay childcare and travel costs to ensure that all barriers to access are removed.<br><br>Additional Support and Advocacy<br><br>We provide additional support and advocacy for women accessing the service ensuring that they are supported to attend the sessions and providing referrals to onward organisations that they may need for their wider wellbeing." |
| **National FGM Centre** | **Website: https://nationalfgmcentre.org.uk/about-us/**<br><br>Website contains resources agencies can use and training agencies can commission<br><br>Website also contains an extensive list of pan-London specialist services |
| **NSPCC FGM Helpline** | **Email: fgmhelp@nspcc.co.uk**<br>**Telephone: 0800 028 3550** |

## Annex F: Care and Support for Women and Girls

Health Services

Women and girls who have had FGM can have a variety of different needs for care and support, and may seek help from a range of places.

The appropriate treatment will depend on the girl/woman's individual circumstances and an assessment of her needs. This will normally include considering her symptoms, type of FGM and whether she is pregnant. As with all health services, an individual care plan should be agreed with the patient and put in place to meet her specific needs. When developing a new service or care pathway within an area, organisations are encouraged and advised to work with patient representatives and groups who can advise on the wishes and needs of service users.

Health Services: Additional Resources

For clinical guidelines on the care of women who have undergone FGM, please see Female Genital Mutilation and its Management (Green-top Guideline No. 53), published by Royal College of Obstetrics and Gynaecology.

Counselling and Psychological Services

Case histories and personal accounts taken from women indicate that FGM can be an extremely traumatic experience which stays with them for the rest of their lives. Young women receiving psychological counselling in the UK report feelings of betrayal by parents, incompleteness, regret, and anger.

There is increasing awareness of the severe psychological consequences of FGM for girls and women, which can become evident in mental health problems. Support should be provided following an assessment of individual needs, and clinicians should discuss the care pathway with the patient, however, services should also consider allowing patients to access them directly without the need for a referral.

Safety of Service Users

When support is provided, appropriate consideration is required to ensure the safety of patients. Any written materials and clinic names should be developed with due care and consideration that references to FGM may pose a safety risk if family members do not support the woman's actions to access support services.

Child Protection Examinations

If a girl has been referred to social services, it is standard practice to refer her in a timely manner for a child protection examination. A child protection examination is carried out to look for signs that a child or young person has been abused or neglected. This is different from a

clinical examination, which aims to establish what is wrong with the child or young person and what treatment may be needed. If there is a delay in accessing a child protection examination appointment, this can cause unnecessary distress for a girl and her family, as an appropriate safeguarding response is normally informed by the details obtained within such an appointment. As such, organisations and professionals should make sure that the appointments are commissioned on an appropriate basis, and that professionals refer to them without delay after a referral is made.

The multi-agency safeguarding response should also consider whether the girl needs to attend a clinical examination to consider what her care needs are. The General Medical Council has issued guidance on child protection examinations. This guidance covers the considerations around obtaining consent (required), and what to do if consent is not given.