



HM Government

Multi-agency statutory guidance on female genital mutilation

April 2016

Contents

| | |
|-------------------------------------------------------------------|-----------|
| Chapter 1: Status and Purpose of this Document | 1 |
| 1.1. Status | 1 |
| 1.2. Audience | 2 |
| 1.3. Aim and Purpose | 3 |
| 1.4. Principles Supporting the Guidance | 4 |
| 1.5. Definitions | 5 |
| Chapter 2: Understanding FGM | 8 |
| 2.1. What is FGM? | 8 |
| 2.2. Types of FGM | 9 |
| 2.3. International Prevalence of FGM | 9 |
| 2.4. Prevalence of FGM in England and Wales | 11 |
| 2.4.1 Prevalence of FGM at a Local Level | 11 |
| 2.5. Names for FGM | 12 |
| 2.6. FGM and Other Forms of Violence Against Women and Girls..... | 12 |
| Chapter 3: The Law in England and Wales | 13 |
| 3.1. Female Genital Mutilation Act 2003 | 14 |
| 3.1.1 Failing to Protect a Girl from Risk of FGM..... | 14 |
| 3.1.2 Extra-Territorial Offences | 16 |
| 3.1.3 Other Offences | 16 |
| 3.1.4 WHO Classifications of FGM and the 2003 Act..... | 17 |
| 3.1.5 Significant Harm | 18 |
| 3.1.6 Exemptions Under the 2003 Act..... | 18 |
| 3.1.7 Re-Infibulation | 19 |
| 3.1.8 Female Genital Surgery | 19 |
| 3.2. Anonymity of Victims of FGM..... | 19 |
| 3.2.1 Exemptions..... | 20 |
| 3.2.2 Breach of the Restrictions | 20 |
| 3.2.3 Defences | 20 |
| 3.3. FGM Protection Orders (FGMPO) | 21 |
| 3.3.1 Applications..... | 22 |
| 3.3.2 Conditions of an Order | 22 |
| 3.3.3 Breach..... | 23 |

| | | |
|-------------------|----------------------------------------------------------------------|-----------|
| 3.3.4 | Sharing Information about an FGMPO | 23 |
| 3.4. | FGM Mandatory Reporting Duty | 24 |
| 3.4.1 | Professionals Not Subject to the Mandatory Reporting Duty | 26 |
| 3.4.2 | Safeguarding Duty in Wales | 26 |
| Chapter 4: | Working Together to Tackle FGM..... | 27 |
| 4.1. | Introduction | 27 |
| 4.2. | A Strategic Response / Actions for Heads of Organisations | 28 |
| 4.3. | A Victim-Centred and Multi-Agency Approach | 28 |
| 4.4. | Commissioning Services..... | 29 |
| 4.5. | Awareness and Training | 30 |
| 4.6. | Working with Communities and Community Groups..... | 31 |
| 4.6.1 | Working with Communities to End FGM..... | 31 |
| 4.6.2 | Community Groups | 32 |
| 4.6.3 | Working with Survivors..... | 32 |
| | CASE STUDY: Working with community groups - North East FGM Forum ... | 33 |
| 4.7. | Information Sharing..... | 34 |
| Annex A: | Background on FGM..... | 36 |
| A.1. | Cultural Underpinnings and Motives of FGM | 36 |
| A.2. | Medicalisation of FGM | 36 |
| A.3. | Consequences of FGM | 37 |
| A.3.1 | Immediate/Short-Term Consequences of FGM..... | 37 |
| A.3.2 | Long-Term Consequences of FGM | 37 |
| Annex B: | Risk | 38 |
| B.1. | Risk Factors | 38 |
| B.1.2 | Indicators that FGM May Have Already Taken Place..... | 40 |
| Annex C: | Talking About FGM | 42 |
| C.1. | Introduction to Talking About FGM | 42 |
| C.2. | Preparing to Speak to Individuals and Families | 43 |
| C.2.1 | Using Translators | 45 |
| C.3. | Communicating in Written and Public Formats | 45 |
| Annex D: | Safeguarding..... | 46 |
| D.1. | FGM: Part of Wider Safeguarding Responsibilities | 46 |

| | | |
|--------|-----------------------------------------------------------------------------------------------|-----------|
| D.2. | Safeguarding Effectively | 47 |
| D.2.1 | Girl (Under 18) who is Suspected to have Undergone FGM | 49 |
| D.2.2 | Girl (Under 18) or Vulnerable Adult who is Suspected to be at Risk | 49 |
| D.2.3 | Girl (Under 18) or Vulnerable Adult who has Previously Been Identified as at Risk of FGM..... | 50 |
| D.2.4 | FGM Disclosed by or Visually Identified in a Girl (Under 18)..... | 51 |
| D.2.5 | Adult who has had FGM | 51 |
| D.2.6 | Professionals Working in Wales: Additional Considerations | 51 |
| D.2.7 | Safeguarding Other Family Members..... | 52 |
| D.2.8 | Women and Girls from Overseas | 52 |
| D.2.9 | NHS Staff in England: Additional Considerations | 53 |
| D.2.10 | Police: Additional Considerations | 54 |
| D.2.11 | School, Colleges and Universities: Additional Considerations | 59 |
| | CASE STUDY: Norbury School | 61 |
| | Annex E: Legal Interventions | 62 |
| E.1. | Police Protection | 63 |
| E.2. | FGM Protection Orders | 64 |
| E.3. | Emergency Protection Orders (EPO) Under S. 44 of the Children Act 1989.. | 65 |
| E.4. | Care Orders and Supervision Orders..... | 65 |
| E.5. | Inherent Jurisdiction | 66 |
| E.5.1 | Applications for Wardship..... | 66 |
| E.6. | Repatriation..... | 68 |
| | Annex F: Care and Support | 69 |
| F.1. | Health Services..... | 69 |
| F.2. | Counselling and Psychological Services..... | 69 |
| F.3. | Safety of Service Users..... | 70 |
| F.4. | Child Protection Examinations | 70 |
| | Annex G: Terms Used for FGM In Other Languages | 71 |
| | Annex H: Contact Information..... | 72 |
| | Annex I: Resources | 74 |
| | Annex J: Making an Application for an FGM Protection Order (FGMPO)..... | 78 |

Chapter 1: Status and Purpose of this Document

1.1. Status

This statutory guidance is being issued under section 5C(1) of the Female Genital Mutilation Act 2003¹ and extends to England and Wales only. Section 5C(1) states:

“(1) The Secretary of State may issue guidance to whatever persons in England and Wales the Secretary of State considers appropriate about—

- (a) the effect of any provision of this Act, or
- (b) other matters relating to female genital mutilation.

(2) A person exercising public functions to whom guidance is given under this section must have regard to it in the exercise of those functions.

(3) Nothing in this section permits the Secretary of State to give guidance to any court or tribunal.”

As statutory guidance issued under section 5C of the 2003 Act, a person exercising public functions to whom this guidance is given must have regard to it in the exercise of those functions. This means that a person to whom the guidance is given must take the guidance into account and, if they decide to depart from it, have clear reasons for doing so.

It contains guidance which should be followed by all; these sections are generally identified by the use of the word ‘should’ and are contained within the main body of the guidance. It also contains guidance that may be appropriate for some individuals, but may not be required by others. This latter guidance is identified by terminology such as ‘you may find it useful to’ and is set out within the Annexes.

¹ As amended by the Serious Crime Act 2015.

1.2. Audience

This multi-agency statutory guidance should be read and followed by all persons and bodies in England and Wales who are under statutory duties to make arrangements to discharge their functions having regard to the need to safeguard and promote the welfare of children² and vulnerable adults. The following list is not exhaustive, however such persons and bodies include:

- local authorities and district councils;
- National Health Service (NHS) and independent service providers;
- NHS England;
- NHS Wales;
- clinical commissioning groups (CCGs);
- NHS Trusts;
- NHS Foundation Trusts;
- the police;
- governing bodies of maintained schools and colleges;
- proprietors of independent schools (including academies, free schools and alternative provision academies) and non-maintained special schools; and
- management committees of pupil referral units (PRUs).

Professionals working in these organisations and who undertake these duties are responsible for ensuring that they fulfil their role and responsibilities in a manner consistent with the statutory duties of their employer.

The information within this guidance may also be relevant to bodies working with women and girls at risk of female genital mutilation (FGM) or dealing with its consequences.

² For example, under section 11(1) or section 28(1) of the Children Act 2004, section 175(2) of the Education Act 2002; section 55 of the Borders, Citizenship and Immigration Act 2009, paragraph 7(a) of the Schedule to the Education (Independent School Standards) Regulations 2014 and paragraph 3 of the Schedule to the Education (Non-Maintained Special Schools) (England) Regulations 2011.

1.3. Aim and Purpose

This guidance should be considered in conjunction with other relevant safeguarding guidance, including, but not limited to, *Working Together to Safeguard Children (2015)*³ in England or *Safeguarding Children: Working Together under the Children Act 2004 (2007)*⁴ in Wales. **This document is not intended to replace wider safeguarding guidance, but to provide additional advice on FGM.**

This statutory guidance sets out the responsibilities of chief executives, directors, senior managers and front-line professionals within agencies involved in safeguarding and supporting women and girls affected by FGM.

This guidance has three key functions:

- **to provide information on FGM**, including on the law on FGM in England and Wales. This is set out in the main body of this document;
- **to provide strategic guidance on FGM** for chief executives, directors and senior managers of persons and bodies mentioned above, or of third parties exercising public protection functions on behalf of those persons or bodies. This guidance is set out in the main body of this document; and
- **to provide advice and support to front-line professionals** who have responsibilities to safeguard and support women and girls affected by FGM, in particular to assist them in:
 - identifying when a girl or young woman may be at risk of FGM and responding appropriately;
 - identifying when a girl or woman has had FGM and responding appropriately; and
 - implementing measures that can prevent and ultimately help end the practice of FGM.

This guidance encourages agencies to cooperate and work together to protect and support those at risk of, or who have undergone, FGM.

³ www.gov.uk/government/publications/working-together-to-safeguard-children--2

⁴ www.gov.wales/topics/health/publications/socialcare/circular/nafwc1207/?lang=en

1.4. Principles Supporting the Guidance

FGM is a criminal offence – it is child abuse and a form of violence against women and girls, and therefore should be treated as such. Cases should be dealt with as part of existing structures, policies and procedures on child protection and adult safeguarding. There are, however, particular characteristics of FGM that front-line professionals should be aware of to ensure that they can provide appropriate protection and support to those affected.

The following principles should be adopted by all agencies in relation to identifying and responding to those at risk of, or who have undergone FGM, and their parent(s) or guardians:

- the safety and welfare of the child is paramount;
- all agencies should act in the interests of the rights of the child, as stated in the United Nations Convention on the Rights of the Child (1989);
- FGM is illegal in the UK (see [Chapter 3](#));
- FGM is an extremely harmful practice - responding to it cannot be left to personal choice;
- accessible, high quality and sensitive health, education, police, social care and voluntary sector services must underpin all interventions;
- as FGM is often an embedded social norm, engagement with families and communities plays an important role in contributing to ending it; and
- all decisions or plans should be based on high quality assessments (in accordance with *Working Together to Safeguard Children (2015)*⁵ statutory guidance in England, and the *Framework for the Assessment of Children in Need and their Families in Wales (2001)*⁶).

⁵ www.gov.uk/government/publications/working-together-to-safeguard-children--2

⁶ <http://gov.wales/topics/health/publications/socialcare/guidance1/childreninneed/?lang=en>

1.5. Definitions

For the purpose of this guidance, the following definitions apply:

Adult/Woman

'Adult' is defined as a person aged 18 years or over.

Child/Girl/Young Person

As defined in the Children Acts 1989 and 2004, 'child' means a person under the age of 18. This includes young people aged 16 and 17 who are living independently; their status and entitlement to services and protection under the Children Act 1989 is not altered by the fact that they are living independently.

Child Abuse and Neglect

Throughout this document, the recognised categories of maltreatment are those set out in *Working Together to Safeguard Children (2015)*⁷ (for England) and *Safeguarding Children – Working Together under the Children's Act 2004(2007)*⁸ (for Wales). These are:

- physical abuse
- emotional abuse
- sexual abuse
- neglect

Child in Need

Children shall be taken to be 'in need' under section 17 of the Children Act 1989, for the purposes of Part III of that Act, where:

- they are unlikely to achieve or maintain, or have the opportunity to achieve or maintain, a reasonable standard of health or development;
- their health or development is likely to be significantly impaired, or further impaired, without the provision of services by a local authority under Part III of that Act;
- they are disabled.

Under section 17 of that Act, local authorities have a general duty to safeguard and promote the welfare of children within their area who are in need and, so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs.

⁷ www.gov.uk/government/publications/working-together-to-safeguard-children--2

⁸ <http://gov.wales/topics/health/publications/socialcare/circular/nafwc1207/?lang=en>

Domestic Violence/Abuse

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members⁹ regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

The Government definition, which is not a legal definition, includes so called 'honour' based violence, including FGM and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Forced Marriage

A forced marriage is a marriage in which one or both spouses do not (or, in the case of some adults with learning or physical disabilities or mental incapacity, cannot) consent to the marriage and violence, threats or any other form of coercion is involved. Coercion may include emotional force, physical force or the threat of physical force and financial pressure.

Infibulation

Infibulation ([Type 3 FGM](#)) is the 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.

⁹ Family members are: mother, father, son, daughter, brother, sister & grandparents; directly-related, in-laws or step-family.

De-infibulation

De-infibulation is a minor surgical procedure to divide the scar tissue sealing the vaginal entrance in [Type 3 FGM](#). De-infibulation is sometimes termed a 'reversal' of FGM. This, however, is incorrect as it does not replace genital tissue or restore normal genital anatomy and function.

Re-infibulation or Re-Suturing

Re-infibulation refers to the re-suturing (usually after childbirth) of the incised scar tissue in a woman with FGM [Type 2](#) or [3](#).

Significant Harm

The Children Act 1989 introduced the concept of 'significant harm' as the threshold that justifies compulsory intervention in family life in the best interests of children and young people. Harm is defined at section 31(9), Children Act 1989, whilst section 31(10) provides limited guidance as to what will be considered significant harm. Local authorities have a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm under section 47 of the Children Act 1989. The definition of harm at section 31(9) was amended by the Adoption and Children Act 2002 to include, "for example, impairment suffered from seeing or hearing the ill-treatment of another".

Note on the use of 'victim': The term 'victim' is used in this document to denote women or girls who have undergone FGM. This term is used particularly in the context of explanation of the law on FGM to describe those who have been the subject of a criminal offence. It should be noted that not everyone who has been subjected to FGM chooses to describe themselves as a 'victim' and may prefer another term, for example, 'survivor'.

Chapter 2: Understanding FGM

This chapter provides information for heads of organisations and front-line professionals who have a statutory duty to protect children and vulnerable adults.

Key points

- **FGM is illegal in the UK.** For the purpose of the criminal law in England and Wales, FGM is mutilation of the labia majora, labia minor or clitoris.
- FGM is an unacceptable practice for which there is no justification. **It is child abuse and a form of violence against women and girls.**
- FGM is **prevalent in 30 countries.** These are concentrated in countries around the Atlantic coast to the Horn of Africa, in areas of the Middle East, and in some countries in Asia.
- It is estimated that approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM.
- **FGM is a deeply embedded social norm, practised by families for a variety of complex reasons.** It is often thought to be essential for a girl to become a proper woman, and to be marriageable. The practice is not required by any religion.

2.1. What is FGM?

FGM is a procedure where the female genital organs are injured or changed and there is no medical reason for this. It is frequently a very traumatic and violent act for the victim and can cause harm in many ways. The practice can cause severe pain and there may be [immediate](#) and/or [long-term health consequences](#), including mental health problems, difficulties in childbirth, causing danger to the child and mother; and/or death.

The age at which FGM is carried out varies enormously according to the community. The procedure may be carried out shortly after birth, during childhood or adolescence, just before marriage or during a woman's first pregnancy.

2.2. Types of FGM

FGM has been classified by the World Health Organisation (WHO) into four types:

- Type 1 – Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris);
- Type 2 – Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the ‘lips’ that surround the vagina);
- Type 3 – Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris; and
- 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.

The extent to which the WHO classifications of FGM come within the ambit of the criminal law is discussed at [Section 3.1.4](#).

2.3. International Prevalence of FGM

FGM is a deeply rooted practice, widely carried out mainly among specific ethnic populations in Africa and parts of the Middle East and Asia. It serves as a complex form of social control of women’s sexual and reproductive rights. The exact number of girls and women alive today who have undergone FGM is unknown, however, UNICEF estimates that over 200 million girls and women worldwide have undergone FGM¹⁰.

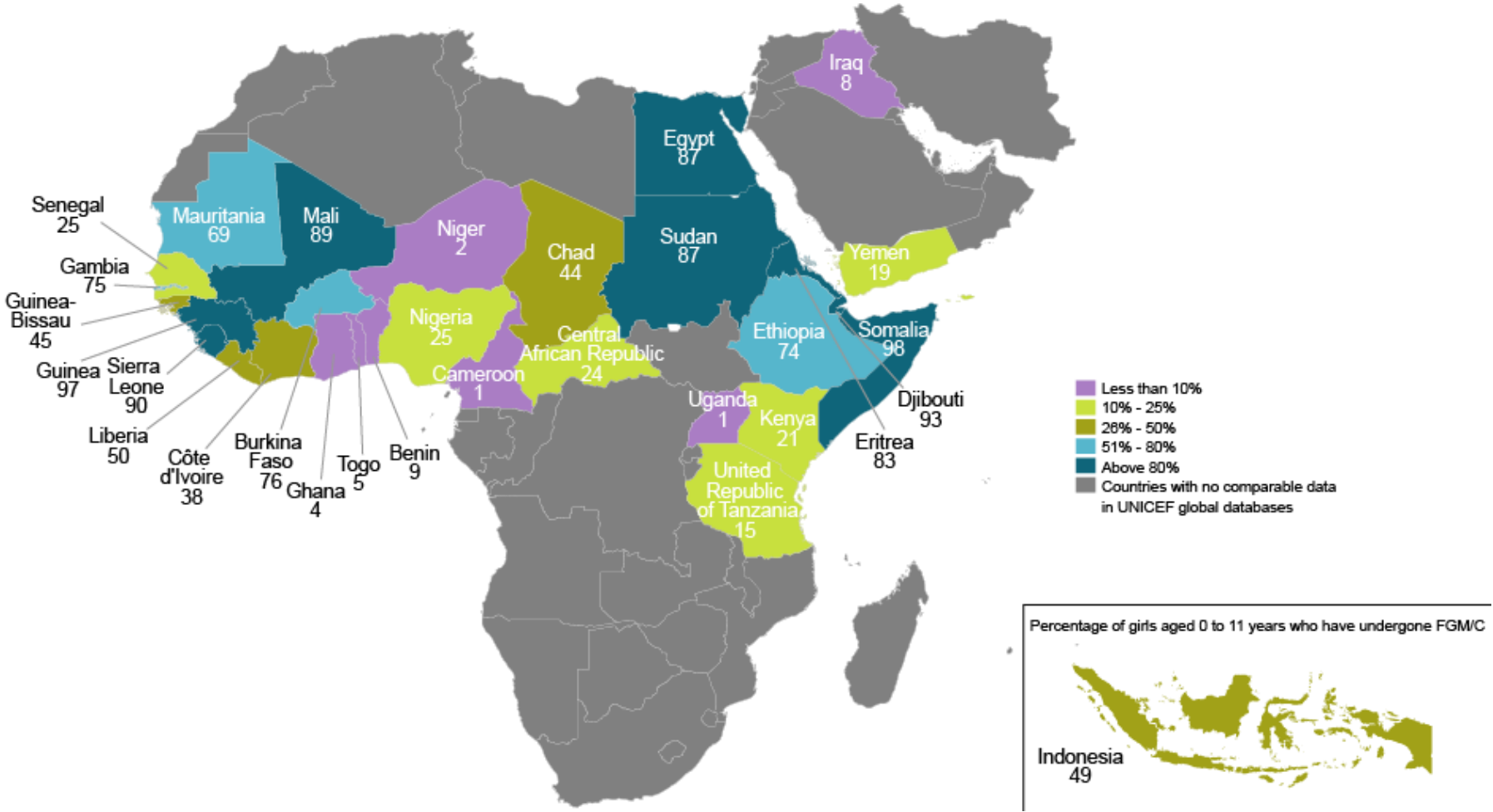
While FGM is concentrated in countries around the Atlantic coast to the Horn of Africa, and areas of the Middle East like Iraq and Yemen, it has also been documented in communities in:

- Colombia;
- Iran;
- Israel;
- Oman;
- The United Arab Emirates;
- The Occupied Palestinian Territories;
- India;
- Indonesia;
- Malaysia;
- Pakistan; and
- Saudi Arabia.

It has also been identified in parts of Europe, North America and Australia.

¹⁰ UNICEF (2016) *Female Genital Mutilation/ Cutting: a Global Concern*:
www.data.unicef.org/resources/female-genital-mutilation-cutting-a-global-concern.html

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](#)

2.4. Prevalence of FGM in England and Wales

The prevalence of FGM in England and Wales is difficult to estimate because of the hidden nature of the crime. However, a 2015 study¹¹ estimated that:

- approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM (see [Annex B](#) for risk factors); and
- approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM.

2.4.1 Prevalence of FGM at a Local Level

Local data should be used to understand the scale and needs of the population affected by FGM in a particular area.

The 2015 study¹² reported that no local authority area in England and Wales is likely to be free from FGM entirely.

Regional breakdowns of these prevalence estimates¹³ show that while urban areas, and specifically London, have the highest estimated prevalence, every area is likely to be affected in some way. It should also be noted that women and girls from affected communities living in low prevalence areas may be more isolated and in greater need of targeted support.

The Health and Social Care Information Centre publishes quarterly statistics¹⁴ on the profile of patients treated within the National Health Service in England who are identified through their treatment as having had FGM¹⁵.

In Wales, each health board's FGM lead collates instances of FGM identified within their organisation.

¹¹ Macfarlane A, Dorkenoo E. (2015) *Prevalence of Female Genital Mutilation in England and Wales: National and local estimates*. London: City University London and Equality Now <http://openaccess.city.ac.uk/12382/>

¹² Macfarlane A, Dorkenoo E. (2015) *Prevalence of Female Genital Mutilation in England and Wales: National and local estimates*. London: City University London and Equality Now <http://openaccess.city.ac.uk/12382/>

¹³ <http://openaccess.city.ac.uk/12382/> (see dataset)

¹⁴ www.hscic.gov.uk/searchcatalogue?q=%22female+genital+mutilation%22&area=&size=10&sort=Relevance

¹⁵ www.hscic.gov.uk/fgm

2.5. Names for FGM

FGM is known by a variety of names, including ‘female genital cutting’, ‘circumcision’ or ‘initiation’. The term ‘female circumcision’ is anatomically incorrect and misleading in terms of the harm FGM can cause. The terms ‘FGM’ or ‘cut’ are increasingly used at a community level, although they are not always understood by individuals in practising communities, largely because they are English terms. See [Annex G](#) for terms used for FGM in different languages and [Annex C](#) for advice about how to talk about FGM.

2.6. FGM and Other Forms of Violence Against Women and Girls

FGM is a form of violence against women and girls which is, in itself, both a cause and consequence of gender inequality¹⁶. Whilst FGM may be an isolated incident of abuse within a family, it can be associated with other behaviours that discriminate against, limit or harm women and girls. These may include other forms of honour-based violence (e.g. forced marriage) and domestic abuse.

There have been reports of cases where individuals have been subjected to both FGM and forced marriage¹⁷. If a professional has a concern about an individual who may be at risk of forced marriage, they should consult the multi-agency practice guidelines on handling cases of forced marriage¹⁸.

Further information about FGM, including the motives for and consequences of it, can be found in [Annex A](#).

¹⁶ www.who.int/violence_injury_prevention/violence/4th_milestones_meeting/publications/en/

¹⁷ Civil protection for (potential) victims of forced marriage is covered by the Forced Marriage (Civil Protection) Act 2007.

¹⁸ www.gov.uk/forced-marriage#guidance-for-professionals

Chapter 3: The Law in England and Wales

This chapter provides information for heads of organisations and front-line professionals who have a statutory responsibility to protect children and vulnerable adults.

Key points

FGM is illegal in England and Wales under the Female Genital Mutilation Act 2003.

As amended by the Serious Crime Act 2015, the Female Genital Mutilation 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.

In England and Wales, criminal and civil legislation on FGM is contained in the Female Genital Mutilation Act 2003¹⁹ (“the 2003 Act”).

¹⁹ Parts of the 2003 Act also apply in Northern Ireland. In Scotland, FGM legislation is contained in the Prohibition of Female Genital Mutilation (Scotland) Act 2005.

3.1. Female Genital Mutilation Act 2003

Under section 1(1) of the 2003 Act, a person is guilty of an offence if they excise, infibulate or otherwise mutilate the whole or any part of a girl's labia majora, labia minora or clitoris. Section 6(1) of the 2003 Act provides that the term "girl" includes "woman" so the offences in sections 1 to 3 apply to victims of any age.

Other than in the excepted circumstances set out in sections 1(2) and (3), it is an offence for **any person (regardless of their nationality or residence status)** to:

- perform FGM **in England or Wales** (section 1 of the 2003 Act);
- assist a girl to carry out FGM on herself **in England or Wales** (section 2 of the 2003 Act); and
- assist (**from England or Wales**) a non-UK national or UK resident to carry out FGM outside the UK on a **UK national or UK resident**²⁰ (section 3 of the 2003 Act).

Provided that the FGM takes place in England or Wales, the nationality or residence status of the victim is irrelevant.

Any person found guilty of an offence under section 1, 2, or 3 of the 2003 Act is liable to a maximum penalty of 14 years' imprisonment or a fine (or both).

3.1.1 Failing to Protect a Girl from Risk of FGM

Section 3A of the 2003 Act²¹ 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; and
- a person aged 18 or over who has assumed (and not relinquished) responsibility for caring for the girl "in the manner of a parent".

²⁰ A "UK resident" is defined as an individual who is habitually resident in the UK.

²¹ As inserted by section 72 of the Serious Crime Act 2015.

Those who have parental responsibility and the means by which they can acquire it are set out in the Children Act 1989 (in the case of England and Wales). It includes, for example:

- a child's biological mother;
- a father who is married to the mother of the child when the child is born;
- an unmarried father registered on the child's birth certificate at the time of their birth;
- guardians; and
- persons named in a Child Arrangements Order.

The requirement in the first case for "frequent contact" is intended to ensure that a person who, in law, has parental responsibility for a girl, but who in practice has little or no contact with her, would not be liable. For example, where the parents of a girl were separated and lived apart with one parent having little or no contact with the daughter, the intention is that that parent would not be liable for the offence.

Similarly, the requirement in the second case that the person should be caring for the girl "in the manner of a parent" is intended to ensure that a person who is looking after a girl for a very short period – such as a babysitter – would not be liable. A person who has assumed responsibility for caring for the girl in the manner of a parent may include, for example, grandparents with whom the girl has gone to stay for an extended summer holiday. In such circumstances, those persons with parental responsibility for the girl would continue to be liable for the offence. It is not intended, for example, to include teachers working in their professional capacity.

In either case, liability for the offence is subject to two statutory defences. The first defence is that the defendant did not think that there was a significant risk of FGM being committed, and they could not reasonably have been expected to be aware of such a risk. The second defence is that the defendant took such steps as he or she could reasonably have been expected to take to protect the girl from becoming a victim of FGM. If the defendant produces sufficient evidence of either defence, the onus would then be on the prosecution to prove that the defence does not apply.

What constitutes reasonable steps would depend on the circumstances of the case. For example, the steps considered reasonable for a woman to take in the case where her overbearing and violent husband or another family member has arranged for FGM to be carried out on their daughter may well differ from those taken by a woman who is not subject to those pressures. Whether a defendant has taken such steps as could reasonably have been expected will need to be assessed on a case-by-case basis.

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).

3.1.2 Extra-Territorial Offences

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** (sections 4 and 1 of the 2003 Act);
- assist a girl to perform FGM on herself **outside the UK** (sections 4 and 2 of the 2003 Act); and
- 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 (sections 4 and 3 of the 2003 Act).

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.

Section 4(1A) of the 2003 Act provides that an offence under section 3A can be committed wholly or partly outside the UK by a person who is a UK national or UK resident.

3.1.3 Other Offences

Under provisions of the law which apply generally to criminal offences it is also an offence to:

- aid, abet, counsel or procure a person to commit an FGM offence²²;
- encourage or assist a person to commit an FGM offence²³;
- attempt to commit an FGM offence²⁴: and
- conspire to commit an FGM offence²⁵.

Any person found guilty of such an offence faces the same maximum penalty as for the offences under the 2003 Act.

²² Common law.

²³ Sections 44-46 of the Serious Crime Act 2007.

²⁴ Section 1 of the Criminal Attempts Act 1981.

²⁵ Section 1 of the Criminal Law Act 1977.

3.1.4 WHO Classifications of FGM and the 2003 Act

Excision and infibulation are examples of what constitutes mutilation for the purpose of the 2003 Act but the term “mutilate” is not defined in the Act. The interpretation of the legislation, including whether a particular procedure amounts to mutilation, is a matter for the criminal courts to determine in cases brought before them. In the absence of any conviction for FGM, there is currently no criminal case law on what does or does not amount to mutilation for the purpose of the 2003 Act.

The World Health Organisation (WHO) classifications of FGM and section 1 of the 2003 Act were, however, considered by the Family Court in the context of care proceedings in the case of *B and G (Children) (No 2)*²⁶. In his judgment of 15 January 2015²⁷, the President of the Family Division said (at paragraph 11):

“It will be seen that for the purposes of the criminal law what is prohibited is to “excise, infibulate or otherwise mutilate” the “whole or any part” of the “labia majora, labia minora or clitoris.” This brings within the ambit of the criminal law all forms of FGM of WHO Types I, II and III (including, it may be noted, Type 1a²⁸). **But WHO Type IV comes within the ambit of the criminal law only if it involves “mutilation”** [emphasis added].”

The President went on to say (at paragraph 70):

“**whether a particular case of FGM Type IV....involves mutilation** is in my determination not a matter for determination by the family court and certainly not a matter I need to determine in the present case. **It is a matter properly for determination by a criminal court as and when the point arises for decision in a particular case** [emphasis added].”

It follows from the above that, unless and until a criminal court decides the point in a particular case, there can be no certainty that any of the procedures classified by WHO as Type 4 FGM, including piercing, amounts to mutilation. The most that can be said is that **Type 4 FGM may be an offence** under section 1 of the 2003 Act. Whether it does in fact constitute such an offence would depend on the particular circumstances.

For the purpose of complying with the statutory duty under section 5B of the 2003 Act to notify the police of FGM, relevant professionals are not required to be satisfied that the circumstances disclosed to them or the physical signs they have observed involve the commission of a criminal offence under the 2003 Act.

²⁶ [2015] EWFC 3.

²⁷ www.judiciary.gov.uk/wp-content/uploads/2015/01/BandG_2_.pdf

²⁸ Removal of the clitoral hood or prepuce only.

The duty to report applies where the relevant professional observes physical signs on the girl which appear to show that an act of FGM has been carried out on her, and the relevant professional has no reason to believe that the act was part of a permitted surgical operation; or where the girl informs the relevant professional that an act of FGM has been carried out on her.

It is for the police, upon receipt of a report, to investigate the circumstances and to conduct enquiries into any alleged offence. The Crown Prosecution Service (CPS) will decide whether a person should be charged with a criminal offence and, if so, what that offence should be and whether a prosecution will take place. As with every criminal offence, the CPS will apply the two-stage test in the Code for Crown Prosecutors in deciding whether to proceed with a prosecution: (1) whether there is sufficient evidence to provide a realistic prospect of conviction; and, if so, (2) whether a prosecution is in the public interest.

3.1.5 Significant Harm

In the case of *B and G (Children) (No 2)*, the President of the Family Division concluded that **all types of FGM (including Type 4) constitute “significant harm” for the purposes of family law**. Professionals should, therefore, have regard to their wider safeguarding responsibilities in relation to FGM as well as to the statutory duty in section 5A of the 2003 Act.

3.1.6 Exemptions Under the 2003 Act

In strict anatomical terms, there is little to distinguish some of the procedures involved in carrying out FGM from those involved in carrying out legitimate surgery. The 2003 Act therefore contains general exemptions for:

- a surgical operation performed by a registered medical practitioner which is necessary for a girl’s physical or mental health; or
- an operation performed by a registered medical practitioner or midwife (including a person undergoing training with a view to becoming a medical practitioner or midwife) on a girl who is in labour or has just given birth, for purposes connected with the labour or birth.

These exemptions are set out in sections 1(2) and (3) of the 2003 Act.

Section 1(5) of the 2003 Act provides that for the purposes of determining whether an operation is necessary for the mental health of a girl it is immaterial whether she or any other person believes that the operation is required as a matter of custom or ritual. So FGM could not legally occur on the ground that a girl’s mental health would suffer if she does not follow the prevailing custom of her community.

3.1.7 Re-Infibulation

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. The first prosecution for FGM in February 2015, which concerned an alleged act of re-infibulation, provides support for that view. Although the case did not result in a conviction, it is clear that the court, by agreeing that the evidence should be considered by a jury, proceeded on the basis that re-infibulation is covered by section 1 of the 2003 Act.

3.1.8 Female Genital Surgery

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).

The Royal College of Obstetricians and Gynaecologists is clear in its guideline (*“Female Genital Mutilation and its Management (Green-top Guideline No. 53)”*, published on 10 July 2015) that “All surgeons who undertake FGCS must take appropriate measures to ensure compliance with the FGM Act”.

As set out above, it is for the police to investigate any alleged offence and for the CPS to decide whether a prosecution under the 2003 Act is appropriate and it would ultimately be for a criminal court to determine, as and when the point arises for decision in a particular case, if non-medically indicated genital surgery constitutes mutilation and is therefore an offence under the 2003 Act.

3.2. Anonymity of Victims of FGM

Section 4A and Schedule 1 of the 2003 Act²⁹ make provision for the anonymity of victims of FGM in England and Wales (and Northern Ireland). The provisions are modelled on those in the Sexual Offences (Amendment) Act 1992 which protect the anonymity of victims of certain sexual offences, such as rape, as soon as an allegation is made.

²⁹ As inserted by section 71 of the Serious Crime Act 2015.

The effect of these provisions is to prohibit the publication of any matter that would be likely to lead members of the public to identify a person as the alleged victim of an offence under the 2003 Act (including the offence of failing to protect a girl at risk of genital mutilation under section 3A of the 2003 Act, as well as aiding, abetting, counselling and procuring the “principal offence”). The prohibition lasts for the lifetime of the alleged victim. The prohibition covers not just more immediate identifying information, such as the name and address or a photograph of the alleged victim, but any other information which, whether on its own or pieced together with other information, would be likely to lead members of the public to identify the alleged victim.

“Publication” is given a broad meaning and would include traditional print media, broadcasting and social media such as Twitter or Facebook.

3.2.1 Exemptions

There are two limited circumstances where the court may disapply the restrictions on publication:

- the first is where a person being tried for an FGM offence could have their defence substantially prejudiced if the restriction to prevent identification of the person against whom the allegation of FGM was committed is not lifted; and
- the second is where preventing identification of the person against whom the allegation of FGM was committed is to impose a substantial and unreasonable restriction on the reporting of the proceedings and it is in the public interest to remove the restriction.

3.2.2 Breach of the Restrictions

Contravention of the prohibition on publication is an offence. It will not be necessary for the prosecution to show that the defendant intended to identify the victim. In relation to newspapers or other periodicals (whether in print form or online editions) and radio and television programmes, the offence is directed at proprietors, editors, publishers or broadcasters rather than individual journalists. Any prosecution for the offence requires the consent of the Attorney General or the Director of Public Prosecutions for Northern Ireland as the case may be.

3.2.3 Defences

There are two defences:

- the first is where the defendant had no knowledge (and no reason to suspect) that the publication included the relevant content or that a relevant allegation had been made; and
- the second is where the victim (where aged 16 or over) had freely given written consent to the publication. These defences impose a reverse burden on the defendant, that is, it is for the defendant to prove that the defence is made out on a balance of probabilities, rather than imposing a requirement on the prosecution to show, beyond reasonable doubt, that the defence does not apply.

3.3. FGM Protection Orders (FGMPO)

An FGMPO is a civil order which may be made for the purposes of protecting a girl³⁰ 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. 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.

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.

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.

Additional information on legal interventions is contained at [Annex E](#).

³⁰ "girl" is used throughout this section, but by virtue of section 6(1) of the 2003 Act, "girl" includes woman', i.e. a woman of any age can be protected by an FGMPO.

3.3.1 Applications

An application for an FGMPO can be made to the High Court or the family court by the person to be protected (the victim), or a “relevant third party” (a person or body specified, or in a class specified by the Lord Chancellor for this purpose) without the leave of the court. Local authorities have been specified as a “relevant third party”³¹. An application can also be made by ‘any other person’ with the leave of the court. In deciding whether to grant leave, the court must have regard to all the circumstances, including the applicant’s connection with, and knowledge of, the circumstances of the girl. More information on applying for FGMPOs can be found on GOV.uk³².

A court can also make an FGMPO without application being made to it in certain family proceedings. In addition, a criminal court can also make an FGMPO, without application, in criminal proceedings for a genital mutilation offence where the person who would be a respondent to any proceedings for an FGMPO is a defendant in the criminal proceedings. An FGMPO can be made in such criminal proceedings to protect a girl at risk, whether or not they are the victim of the offence in relation to the criminal proceedings. For example, the younger sister of the victim of a genital mutilation offence could also be protected by the court in criminal proceedings.

An application for a FGMPO is not an alternative to the work of the police and CPS in investigating and prosecuting crimes. Crimes may be investigated and offenders prosecuted at the same time as an application is made for an FGMPO or an order is in force.

3.3.2 Conditions of an Order

The terms of an FGMPO may relate to conduct inside and/or outside of England and Wales (or Northern Ireland).

An FGMPO may be made for a specified period or until varied or discharged.

The applicant or the court must serve the order on the police, including the local police station of the girl being protected.

When local authorities have obtained a FGMPO or are aware that one is in place, it is essential that they work closely with the victim and the relevant support service, if there is one, to ensure it offers the level of protection that was envisaged. Links need to be established with other agencies, in particular the police, to ensure ongoing support is available to victims as needed.

³¹ SI 2015 No. 1422.

³² www.gov.uk/female-genital-mutilation-protection-order

3.3.3 Breach

Breach of an FGMPO is a criminal offence with a maximum penalty of up to five years' imprisonment. As an alternative to prosecution, a breach of an FGMPO may be dealt with by the civil route as a contempt of court, punishable by up to two years' imprisonment, a fine, or both.

If the police investigate a possible breach as a criminal offence, they can arrest those suspected of breaching the terms of the order. Following a police investigation, the CPS will decide whether or not to proceed with a prosecution for the breach and/or any other offences that might be disclosed. Where the decision is taken, however, to pursue breach as a contempt of court matter, an application should be made to the family court for an arrest warrant. This should be supported by a statement setting out how the order has been breached. The order will need to be served on the respondents.

Although FGMPOs are specifically designed to protect actual or potential victims of FGM, one or more of the orders or applications in [Annex E](#) may also be considered alongside an FGMPO, depending on the particular circumstances of each case. Referral to an accredited family law practitioner to deal with wider issues of private or public family law may be equally important to meet the girl's needs.

3.3.4 Sharing Information about an FGMPO

Where an agency has obtained an FGMPO it should consider which, if any, other agencies need to be aware of the FGMPO, i.e. those not served with a copy of the order by the court, and whether it is necessary for that information to be shared in order to secure the protection of the girl at risk. Care should, however, be exercised in sharing information, particularly if it could have the adverse effect of leading to either reprisals for the victim and/or other members of their family.

When the court has made an order, the applicant or the court, (where requested or if the court makes an order of its own initiative), should serve a copy of the order on the police, together with a statement showing that the respondents and/or any other persons directed by the court have been served with the order or informed of its terms. The order and statement should be delivered to the police station for the address of the person being protected by the order, unless the court specifies another police station.

3.4. FGM Mandatory Reporting Duty

Section 5B of the 2003 Act³³ introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report ‘known’³⁴ cases of FGM in under 18s which they identify in the course of their professional work to the police.

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 therefore covers:

- health and social care professionals regulated by a body which is overseen by the Professional Standards Authority for Health and Social Care (with the exception of the Pharmaceutical Society of Northern Ireland). This includes those regulated by the:
 - General Chiropractic Council
 - General Dental Council
 - General Medical Council
 - General Optical Council
 - General Osteopathic Council
 - General Pharmaceutical Council
 - Health and Care Professions Council (whose role includes the regulation of social workers in England)
 - Nursing and Midwifery Council
- teachers³⁵ - this includes qualified teachers or persons who are employed or engaged to carry out teaching work in schools and other institutions, and, in Wales, education practitioners regulated by the Education Workforce Council;
- social care workers in Wales³⁶.

³³ As inserted by section 74 of the Serious Crime Act 2015.

³⁴ “Known” cases are those where either a girl informs the person that an act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was, or was part of, a surgical operation within section 1(2)(a) or (b) of the FGM Act 2003.

³⁵ Section 5B(11) of the FGM Act 2003 (as inserted by section 74 of the Serious Crime Act 2015) provides the definition for the term ‘teacher’: “‘teacher’ means – (a) in relation to England, a person within section 141A(1) of the Education Act 2002 (persons employed or engaged to carry out teaching work at schools and other institutions in England); (b) in relation to Wales, a person who falls within a category listed in the table in paragraph 1 of Schedule 2 to the Education (Wales) Act 2014 (anaw 5) (categories of registration for purposes of Part 2 of that Act) or any other person employed or engaged as a teacher at a school (within the meaning of the Education Act 1996) in Wales”.

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.

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 made³⁷ applies for making reports. However, the expectation is that reports will be made much sooner than this.

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.

Cases of failure to comply with the duty will be dealt with in accordance with the existing performance procedures in place for each profession. **FGM is child abuse, and employers and the professional regulators are expected to pay due regard to the seriousness of breaches of the duty.**

³⁶ Section 5B(11) of the Female Genital Mutilation Act 2003 defines a "social care worker" as a person registered in a register maintained by the Care Council for Wales under section 56 of the Care Standards Act 2000.

³⁷ As required by section 5B (5)(c) of the 2003 Act (as amended by the Serious Crime Act 2015).

FGM Mandatory Reporting Duty: Additional Resources

Information for professionals subject the duty and their employers, including on how to make a report, is available at:

www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information

Additional information for health care professionals in England is available at:

www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare

3.4.1 Professionals Not Subject to the Mandatory Reporting Duty

While the duty is limited to the specified professionals described above, non-regulated practitioners still 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.

3.4.2 Safeguarding Duty in Wales

Professionals working within Wales should be aware that, once it is in force, section 130 of the Social Services and Well-being (Wales) Act 2014 will also apply to cases covered by the FGM mandatory reporting duty. The all-Wales child protection procedures, adopted by all safeguarding boards in Wales, provide a consistent framework for referral, consideration, and determining action by all safeguarding partners in Wales, including a dedicated protocol on FGM.

Chapter 4: Working Together to Tackle FGM

This chapter provides information for heads of organisations, third parties exercising public protection functions, and front-line professionals.

Key points

- **No single professional can have a full picture of an individual's needs and circumstances.** To ensure that women and girls affected by FGM receive the right help at the right time, everyone who comes into contact with them has a role to play.
- [Working Together to Safeguard Children](#) (2015) in England or [Safeguarding Children: Working Together under the Children Act 2004](#) (2007) in Wales set out the requirements and expectations on individual services and professionals to provide a multi-agency response to safeguard and promote the welfare of children. This document does not attempt to duplicate this guidance, and should be considered alongside other relevant guidance on safeguarding children and vulnerable adults.
- Wherever possible, professionals should actively seek and support ways to reduce the prevalence of FGM in practising communities in the UK. **Agencies should consider how preventative work, delivered by community organisations/community change advocates, can be embedded within their organisation's work on protection**, with a focus on involving community support for girls and families at risk.

4.1. Introduction

FGM is illegal. It is child abuse and a form of violence against women and girls and should therefore be treated as such. It should be addressed using existing structures, policies and procedures designed to safeguard children and vulnerable adults.

All bodies to which this guidance applies need to work effectively with one another, and with other relevant organisations to address FGM.

4.2. A Strategic Response / Actions for Heads of Organisations

Heads of relevant organisations should ensure that:

Roles and responsibilities

- their organisation has a **lead person whose role includes responsibility for FGM** (this will often be the designated safeguarding lead). This person should have relevant experience, expertise and knowledge. Their role should include ensuring that cases of FGM are **handled, monitored and recorded properly**;
- there is a **member of the organisation who has undertaken additional training** and can be approached to discuss and direct difficult cases (this may be the 'lead person' mentioned above);
- their staff **understand their role in protecting** those who have undergone or are at risk of abuse, including FGM;
- their staff **know to whom they should refer cases** within their organisation and when to refer cases to other agencies;
- their staff **understand the importance of timely information sharing** both internally and with other agencies;

Policies and procedures

- there are policies and procedures in place **to protect those who have undergone or are at risk of FGM**. The policies and procedures should be in line with existing statutory and non-statutory guidance on safeguarding children and vulnerable adults. These policies and procedures must reflect **multi-agency working arrangements**; and
- policies and procedures are **kept under review and updated** to reflect structural, departmental, legal and other relevant changes.

4.3. A Victim-Centred and Multi-Agency Approach

An effective local response to FGM should be underpinned by two key principles:

- **safeguarding is everyone's responsibility**: each professional and organisation should play their part; and
- **a victim-centred approach should be taken**: based on a clear understanding of the needs and views of girls and women affected by FGM.

4.4. Commissioning Services

It is likely that some women with FGM are living in every local authority area in England and Wales³⁸ (see [Section 2.4.1](#)).

It is important for commissioning leads to understand the data relating to their local communities so that their agency's response is appropriate to communities' needs. This includes ensuring that:

- services are provided to meet the **physical and mental health needs** of women and girls who have undergone FGM as appropriate;
- projects and services aimed at preventing FGM are developed in **consultation with FGM survivors and expert voluntary sector organisations**; and
- when commissioning services, considering whether there are **suitable local community organisations or individual peer educators** who have the experience to work with and support affected communities effectively.

When commissioning services, local authorities may wish to check whether community organisations are accredited. For example, the Imkaan Accredited Quality Standards³⁹ set out standards for community organisations working with black and minority ethnic (BME) women and girls on harmful practices including FGM and so called 'honour-based' violence.

Commissioning: Additional Resources

Information on commissioning health services for women and girls affected by FGM in England is set out in the Department of Health's *Commissioning Services to Support Women and Girls with Female Genital Mutilation (2015)*⁴⁰.

³⁸ Macfarlane A, Dorkenoo E. (2015) *Prevalence of Female Genital Mutilation in England and Wales: National and local estimates*. London: City University London and Equality Now <http://openaccess.city.ac.uk/12382/>

³⁹ www.imkaan.org.uk/iaqs

⁴⁰ www.gov.uk/government/publications/services-for-women-and-girls-with-fgm

4.5. Awareness and Training

Training should enable all staff to discharge their safeguarding duties with regard to FGM, as for any other form of abuse. Training on FGM could include the following:

- an overview of FGM (what it is, when and where it is performed);
- the UK law on FGM and child protection;
- the potential consequences of FGM;
- what to do when FGM is suspected or has been performed; and
- the role of different professionals and the importance of multi-agency working.

Local Safeguarding Children Boards (in England) and Safeguarding Children Boards (in Wales) are responsible for monitoring and evaluating the effectiveness of single agency and inter-agency training on safeguarding and promoting the welfare of children provided within their area⁴¹. This is in line with their function to develop policies and procedures in relation to training of those persons who work with children or in services affecting the safety and welfare of children⁴². Such policies and procedures may include specific training in relation to FGM.

*Safeguarding Children and Young people: roles and competences for health care staff*⁴³ provides a competence-based framework to set out the minimum training requirements for healthcare professionals in the UK to enable them to recognise child maltreatment and to take effective action as appropriate to their role. Knowledge of and the ability to recognise signs of FGM are included at all levels of competence.

In Wales, any training accessed must comply with the requirements of the forthcoming National Training Framework on violence against women, domestic abuse and sexual violence⁴⁴.

Awareness and Training: Additional Resources

E-learning for all professionals (including teachers, police, border force staff, and health visitors), developed by the Home Office, is available at www.fgmelearning.co.uk.

Health Education England offer e-learning, free to access by health and social care professionals, at www.e-lfh.org.uk/programmes/female-genital-mutilation/.

⁴¹ See Chapter 3 of Working Together to Safeguard Children 2015 for further information on the role of LSCBs in England.

⁴² Regulation 5(1)(a)(ii) of the Local Safeguarding Children Boards Regulations 2006 for LSCBs in Wales.

⁴³ www.rcpch.ac.uk/child-protection-publications

⁴⁴ <http://livefearfree.gov.wales/guidance-for-professionals/national-training-framework/?lang=en>.

4.6. Working with Communities and Community Groups

4.6.1 Working with Communities to End FGM

So-called cultural practices, such as FGM, can be deeply embedded in practising communities and working to end them requires both top down direction and a community-led approach.

Some of the ways organisations and professionals can help to end FGM include:

- involving individuals and families in discussions about how FGM can be ended within their family and wider community;
- talking to all groups, including men, boys and community leaders about FGM and its consequences;
- encouraging individuals to report suspected cases of FGM, and highlighting the anonymous means for doing this, such as the NSPCC helpline⁴⁵, for those unwilling to provide information to the authorities (see the FGM resource pack⁴⁶ for more information); and
- signposting to organisations that can provide support and advice to those who wish to end the practice within their family or community (for information on organisations working on FGM see the FGM resource pack⁴⁷).

Local authorities, Local Safeguarding Children Boards (in England), Safeguarding Children Boards (in Wales) and relevant professionals are encouraged to actively consider how best this could be done as part of existing work and engagement with practising communities, and how new initiatives could be established. Maintaining a continued dialogue with affected communities may help to ensure that prevention and support interventions are accepted.

⁴⁵ www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/female-genital-mutilation-fgm/

⁴⁶ www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack

⁴⁷ www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack

4.6.2 Community Groups

Community groups have a valuable role to play in responding to FGM. This may include:

- supporting women's access to specialist care;
- disseminating information in schools; and
- supporting and supplementing professional training programmes.

When developing services and projects, organisations should consider working with appropriate community groups and survivors to help make sure the services provided both meet the needs of service users, and that their staff understand the issues related to FGM.

Appropriately trained professionals can help to address fears and misconceptions that may deter those affected by FGM from engaging with statutory services. Professionals with specialist knowledge of FGM may also wish to consider how they can assist community groups, for example, by speaking at community-based events.

Information on local and national voluntary sector organisations working with communities on FGM, including a postcode search function which signposts local support services, is available at: www.gov.uk/female-genital-mutilation-help-advice.

4.6.3 Working with Survivors

It is important, where possible and with appropriate support provided, to involve survivors of FGM when developing services or policies that will affect them. In doing so, organisations should recognise that each individual survivor will have their own experiences and needs and should not be expected to represent all women and girls who have undergone FGM.

Survivors may also wish to act as change advocates to encourage communities to abandon FGM. Community groups working with those affected by FGM can help to facilitate engagement with survivors and can advise on the support they may need to speak out about their experience of FGM.

CASE STUDY: Working with community groups - North East FGM Forum

Crown Prosecution Service (CPS) North East wanted to improve criminal justice agencies' understanding of the issues faced by communities affected by FGM in the area, help communities to understand the criminal justice process and address any concerns there may be about engaging with criminal justice agencies.

CPS North East decided to set up a regional forum. Members of the forum include representatives of:

- the three Police and Crime Commissioners in the North East;
- the three police forces;
- community support services working with victims of FGM; and
- health services.

The aim of the forum is to provide opportunities for networking and dialogue between criminal justice agencies and organisations offering support to women affected by FGM to share information and best practice, and to identify areas for joint working.

The forum has resulted in the development of good practice in investigation of reports of FGM. Ongoing dialogue between the agencies, and their communities, is helping to ensure that local practice and policy across the North East are developed to take into account the needs of victims and communities, and that victims can be supported through the criminal justice system.

4.7. Information Sharing

When dealing with FGM, organisations and professionals should continue to have regard to their wider responsibilities in relation to the handling and sharing of information. To safeguard children and vulnerable adults in line with relevant statutory requirements and guidance, it may be necessary to share information with other agencies or departments.

To ensure effective safeguarding arrangements:

- all organisations should have arrangements in place which set out clearly the processes and the principles for sharing information between each other, with other professionals and with the LSCB; and
- no professional should assume that someone else will pass on information which they think may be critical to keeping a child or vulnerable adult safe. If a professional has concerns about an individual's welfare and believes they are suffering or likely to suffer harm, then they should share the information with the relevant local authority children's or adult's social care.

Chief executives and professionals working in healthcare in England should have due regard to the [FGM Enhanced Dataset Information Standard](#) (SCCI2026)⁴⁸ 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.

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 the Health and Social Care Information Centre (HSCIC). HSCIC collect and publish anonymised statistics on behalf of the Department of Health and NHS England. 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.

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 HSCIC. 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.

Guidance on the recording of FGM and the FGM Enhanced dataset standard is available at: www.hscic.gov.uk/fgm.

⁴⁸ www.hscic.gov.uk/fgm

Information Sharing: Additional Resources

*Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers (2015)*⁴⁹ gives guidance to front-line practitioners working in child or adult services who have to make decisions about sharing personal information.

⁴⁹ www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

Annex A: Background on FGM

A.1. Cultural Underpinnings and Motives of FGM

FGM is a complex issue, and individuals and families who support it give a variety of justifications and motivations for this. However, FGM is a crime and child abuse, and no explanation or motive can justify it. The justifications given 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;
- 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.

FGM is a traditional practice often carried out by a family who believe it is beneficial and is in a girl or woman's best interests. This may limit a girl's motivation to come forward to raise concerns or talk openly about FGM – reinforcing the need for all professionals to be aware of the issues and risks of FGM.

[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.

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, and the Bible, Koran, Torah and other religious texts do not advocate or justify FGM.

A.2. Medicalisation of FGM

Some who support the practice have sought to eliminate risks of infection (by, for example, carrying it out in a medical environment) in order 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.

A.3. Consequences of FGM

Men and women in practising communities may be unaware of the potential harmful health and welfare consequences of FGM, some of which are set out below.

A.3.1 Immediate/Short-Term Consequences of FGM

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

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

A.3.2 Long-Term Consequences of FGM

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 such as anxiety, flashbacks and post traumatic stress disorder;
- difficulties with menstruation (periods);
- complications in pregnancy or childbirth (including prolonged labour, bleeding or tears during childbirth, increased risk of caesarean section); and
- increased risk of stillbirth and death of child during or just after birth.

Further information on care and support for women and girls affected by FGM is provided at [Annex F](#).

Annex B: Risk

B.1. Risk Factors

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.

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.

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. Given this context, discussions about FGM should always be undertaken with appropriate care and sensitivity (see [Annex C](#)).

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

There are a number of factors in addition to a girl's or woman's community, country of origin and family history that could indicate she is at risk of being subjected to FGM. Potential risk factors may include:

- a female child is born to a woman who has undergone FGM;
- a female child has an older sibling or cousin who has undergone FGM;
- a female child's father comes from a community known to practise FGM;
- the family indicate that there are strong levels of influence held by elders and/or elders are involved in bringing up female children;
- a woman/family believe FGM is integral to cultural or religious identity;
- a girl/family has limited level of integration within UK 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 country of origin or another country where the practice is prevalent (see [Section 2.3](#) for the nationalities that traditionally practise 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 family is already known to social care in relation to other safeguarding issues;
- 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 G](#) for commonly used terms in different languages) – it is important to take into account the context of the discussion;
- 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.

Remember: 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 to when a girl reaches a particular age.

If any of these risk factors are identified professionals will need to consider what action to take. If unsure whether the level of risk requires referral at this point, professionals should discuss with their named/designated safeguarding lead.

If the risk of harm is imminent, emergency measures may be required.

See [Annex E](#) for information on legal interventions that can be used to protect girls/women at risk of FGM.

Professionals should not assume that all women and girls from a particular community are supportive of, or at risk of FGM. Women who recognise that their ongoing physical and/or psychological problems are a result of having had FGM and women who are involved or highly supportive of FGM advocacy work and eradication programmes may be less likely to support or carry out FGM on their own children. However, any woman may 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.

B.1.2 Indicators that FGM May Have Already Taken Place

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

- the girl or 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.

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

- a girl or woman asks for help;
- 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 family/child is already known to social services in relation to other safeguarding issues;
- 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 requires to be excused from physical education (PE) lessons without a GP's letter;
- there are prolonged or repeated absences from school or college (see 2015 guidance on children missing education⁵⁰);
- 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 be explicit about the problem; and/or
- a girl talks about pain or discomfort between her legs.

Remember: this is not an exhaustive list of indicators.

If any of these indicators are identified professionals will need to consider what action to take. If unsure what action to take, professionals should discuss with their named/designated safeguarding lead.

Professionals subject to the mandatory reporting duty are required to report 'known'⁵¹ cases of FGM in girls under 18 to the police (see [Section 3.4](#)).

⁵⁰ www.gov.uk/government/publications/children-missing-education

⁵¹ "Known" cases are those where either a girl informs the person that an act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was, or was part of, a surgical operation within section 1(2)(a) or (b) of the FGM Act 2003.

Annex C: Talking About FGM

Key points

- Supporting women and girls who have undergone FGM demands **sensitivity and compassion** on the part of the professional;
- Sometimes it will not be clear that FGM is the origin of the individual's problem/s;
- Professionals may experience strong emotions when dealing with FGM – **it is important they discuss this with a colleague or supervisor**;
- Important points to consider when talking to women or girls affected by FGM include: **ensuring that the conversation is not interrupted, giving the individual time to speak, only asking one question at a time, and remaining non-judgmental**;
- When developing written or visual materials for either individuals or the public, care must be taken to **ensure the materials are appropriate**, and developing them in **consultation with survivors and affected communities** is recommended.

C.1. Introduction to Talking About FGM

Good communication is essential when talking to individuals who have had FGM, may be at risk of FGM, or are affected by the practice.

Professionals should ensure that they enquire sensitively about FGM. The topic of FGM may arise in a variety of settings, including a GP's surgery as part of a medical consultation, a home environment during a health visitor's post-natal visit, or at school. Conversations may take place with the girl or woman who may be affected by FGM, a parent or other family member. 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.

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.

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. A lack of awareness may mean that a professional is unable to relate to the girl or woman/their family, which may lead to a failure to discuss the issue appropriately and result in distress for the girl or woman.

If, as a result of talking about FGM with an individual or family, a professional identifies that a girl is at risk of FGM or has undergone FGM, then appropriate action should be taken. See [Annex D](#) for guidance on safeguarding and [Annex F](#) for guidance on care and support.

Communicating About FGM: Additional Resources

Health and social care professionals in England can complete the e-learning session, 'Communication Skills for FGM consultations' at www.e-lfh.org.uk which provides advice and training to support these discussions.

Professionals in England can watch a video on NHS Choices where women who have had FGM discuss how they would like to see professionals hold sensitive conversations about FGM: www.nhs.uk/fgmguidelines

In Wales, NHS employees can speak to their FGM Safeguarding Lead to discuss any concerns and access necessary training. Information on online resources, data reporting arrangements and FGM Leads in Wales is available at: www.wales.nhs.uk/sitesplus/888/page/67421/

C.2. Preparing to Speak to Individuals and Families

Adhering to key standards will enable professionals to hold conversations in a sensitive and appropriate way. These include:

- making the care of women and girls affected by FGM the primary concern, treating them as individuals, listening and respecting their dignity;
- working with others to protect and promote the health and well-being of those in their care, their families and carers, and the wider community; and
- being open and honest, acting with integrity and upholding the reputation of the profession.

When initiating a conversation about FGM, professionals should:

- ensure that the conversation is opened sensitively;
- be aware of the specific circumstances of the individual when a discussion about FGM needs to take place; and
- be non-judgmental.

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. 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;
- 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 because of a lack of time 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 I](#) and [Annex H](#).

It is important that professionals understand the **appropriate language** to use and maintain a professional and non-judgmental approach to engage with the individual effectively in what may be a challenging and upsetting situation.

Professionals should:

- use culturally sensitive language;
- be aware that different communities may have different terms for FGM (see [Annex G](#));
- 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?”

Professionals have a responsibility to ensure women and families understand that FGM is illegal in the UK, and to explain the [harmful consequences](#) it can have. See [Annex I](#) for resources that can be used to support these conversations.

C.2.1 Using Translators

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

Care must be taken to ensure that an interpreter is available at services supporting women with FGM, as this is likely to be required for many appointments relating to FGM.

C.3. Communicating in Written and Public Formats

When issuing communication materials about FGM some specific considerations are required. Cultural sensitivities must not get in the way of tackling FGM, but communicating about it in the wrong way can undermine and damage efforts.

It is important to highlight that FGM is illegal, child abuse, a form of violence against women and girls, a human rights violation and a manifestation of gender inequality. However, communication on FGM also needs to be framed respectfully.

Campaigns that do not recognise this, risk doing inadvertent harm, including:

- pushing the practice underground;
- stigmatising women and girls who have already undergone FGM;
- fuelling racism/discrimination against affected communities;
- incorrectly suggesting that more minor forms of FGM, or FGM carried out in clinics under sanitary conditions, are acceptable.

To help ensure that communication activities are appropriate it is recommended that organisations consult with relevant community organisations and survivors.

Communication Activities: Additional Resources

Advice on developing communication activities on violence against women and girls, including FGM, is available in the [Violence against Women and Girls Communications Insight Pack](#)

Annex D: Safeguarding

Key points

- **FGM is illegal in England and Wales (see [Chapter 3](#) for more details).** Professionals should intervene to safeguard girls and protect women who may be at risk of FGM or have been affected by it.
- The level of safeguarding intervention needed will depend on how imminent the risk of harm is (see [Annex B](#) for risk factors). **An appropriate course of action should be decided on a case-by-case basis**, with expert input from all relevant agencies.
- **Working across agencies** as soon as a girl or woman is identified as being at risk of FGM is essential.

D.1. FGM: Part of Wider Safeguarding Responsibilities

FGM is not an issue where action or intervention can be determined by personal preference – it is an illegal, extremely harmful practice and a form of child abuse and violence against women and girls. Fears of being branded ‘racist’ or ‘discriminatory’ should not weaken the protection that professionals provide.

Organisations should have local safeguarding protocols and procedures for protecting children (see [Chapter 4](#)).

Managing risk throughout childhood

Being born to a mother who has undergone FGM may mean a female child is at greater risk of FGM (see [Annex B](#) for risk factors). This risk **can usually be identified at birth** as, through ante-natal care and delivery of the child, NHS professionals can and should have identified that the mother has had FGM.

Professionals should remember that FGM can be carried out at any age, so identifying that a girl is at risk of FGM at birth means that **safeguarding measures adopted may need to remain in place for a number of years over the course of her childhood.**

This differs from other forms of harm, and **this difference in approach should be recognised when putting in place policies and procedures to protect against FGM.**

Remember: If the only risk indicator is that a girl's mother has undergone FGM, referral to children's social care may not be appropriate, but other local multi-agency arrangements may be relevant. In such cases, monitoring is important to ensure that agencies respond appropriately if circumstances change and other risk factors arise. Where there is a specific risk, the case should be referred to social care.

Guidance for healthcare professionals on FGM risk and safeguarding is available at: www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm

D.2. Safeguarding Effectively

A girl at risk of FGM may need to be safeguarded over a significant proportion of her childhood, and it is therefore essential that agencies work together to determine the most appropriate safeguarding response. The importance of sharing information between practitioners and between agencies in relation to girls who may be at risk of FGM should not be underestimated (see [Section 4.7](#)). Potential signs of risk might be mentioned by a girl, her family or her friends to different professionals. For example, if a girl tells her teacher about an impending special ceremony, and in the following week the girl is taken to the GP surgery to receive travel vaccinations for planned departure, the knowledge of both of these details is critical to understanding the risk the girl faces. For this reason, professionals should:

- be aware and act upon the wide range of risk factors (see [Annex B](#)) in relation to FGM;
- have a consistent approach to sharing information with partner agencies and reviewing the individual situation; and
- put in place safeguarding actions which reflect the needs of the girl.

Equally, multi-agency working needs to be flexible and responsive to individual circumstances. For example, a policy to routinely refer all girls born to mothers who have FGM within seven days of birth to children's social care may not meet the needs of the girl. In this example, referral may be made at a stage where the risk has not fully developed and is not imminent which may result in the case being closed. Further action may not be appropriate at that time, but if circumstances change (for example, a relative moves into the family home, or the family's beliefs change), then safeguarding action may be required. Once a potential risk of FGM has been identified, this information should be shared between professionals and agencies to ensure that there is ongoing awareness of this risk.

If a risk of FGM is identified, the first steps when safeguarding girls and women will normally come in the form of discussions with the girl, her parents, and other family members. See [Annex C](#) for advice on how to have these conversations.

Having established that there are recognised signs of the risk of FGM, a professional should undertake a risk assessment.

Health professionals and relevant organisations in England, should have regard to the Department of Health guidance for professionals, *Female Genital Mutilation Risk and Safeguarding*⁵².

As part of the assessment, professionals should make sure that the girl and/or appropriate family members understand:

- that FGM is illegal;
- [the potential health consequences of FGM](#);
- any actions taken;
- that information will be shared about this with colleagues and partner organisations as appropriate.

When deciding what course of action to take, professionals may need to consult with their local/designated safeguarding lead and should always ensure that actions are consistent with local safeguarding policies. The course of action chosen should be based upon the needs of the girl or women identified as being at risk and will vary depending on the circumstances.

⁵² www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm

D.2.1 Girl (Under 18) who is Suspected to have Undergone FGM

If any professional suspects that a girl has undergone FGM their named/designated safeguarding lead must be made aware and **an immediate referral should be made to the relevant local authority's children's social care department.**

When a girl is **suspected** to have already undergone FGM, all professionals should:

- document this in their notes;
- complete relevant risk assessment; and
- follow local multi-agency safeguarding procedures.

D.2.2 Girl (Under 18) or Vulnerable Adult who is Suspected to be at Risk of FGM

All cases should be handled in accordance with local safeguarding procedures, and all relevant factors should be taken into account, as with all other forms of safeguarding risk to children or vulnerable adults. The initial referral should, in the case of a girl, be made to the relevant local authority's children's social care department (possibly via a Multi-Agency Safeguarding Hub if one is in place). In the case of a vulnerable adult, an initial referral should be made to adult social services.

Where there is an imminent or serious risk, an emergency response may be required, either an urgent referral to social services and/or potentially contacting the police. Where it is considered that there is an immediate risk to a girl or woman, the local authority⁵³ should consider whether to apply for an FGM Protection Order and/or an Emergency Protection Order (see [Chapter 3](#) and [Annex E](#)).

Where a girl or 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 child's or 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.

⁵³ Local authorities are 'relevant third parties' for the purposes of applying for an FGMPO, i.e. they can apply for such an order without seeking prior leave from the court to do so.

Local procedures should set out what to do in these circumstances. This is likely to include:

- **keeping a record of the discussion.** For healthcare professionals, this should be within the patient's record;
- **sharing this information** with the relevant local authority's children's social care department, via a Multi-Agency Safeguarding Hub if one is in place;
- if identified by a healthcare professional, **sharing this information with the girl's GP, health visitor or school nurse (dependent on age of child)** and potentially other professional delivering care to the child depending upon circumstances;
- in healthcare settings in England, making sure that the **FGM Risk Indication System** is used, and an indicator placed upon the girl's record as appropriate (see [Section D.2.9](#)).

In all cases, professionals should also consider risk to other children and women in the family.

Depending on the circumstances of the individual case, the professional's role and local procedures, a professional may need to make this referral personally. If the referral is made by another individual, all relevant information obtained from the child/family members should be shared with the referrer.

D.2.3 Girl (Under 18) or Vulnerable Adult who has Previously Been Identified as at Risk of FGM

With effective safeguarding and information sharing procedures in place, professionals will be able to see on a girl or woman's record that she has previously been identified as potentially at risk of FGM. Professionals treating or supporting the girl or woman should make themselves aware of any relevant information and take appropriate action, as for other forms of abuse.

Professionals should always take opportunities to discuss and understand changes to the girl's family circumstances, and look out for whether there is a change in relation to any of the known [risk factors](#). For example, if the professional becomes aware of new travel plans or the arrival of extended family members to live with the girl, this information should be shared with appropriate partner agencies. Local procedures should give advice of how to act in these circumstances.

D.2.4 FGM Disclosed by or Visually Identified in a Girl (Under 18)

Where a case of FGM is disclosed by or visually identified in a girl under the age of 18, regulated health or social care professionals and teachers are legally required to make a report to the police under the **FGM mandatory reporting duty**. See [Section 3.4](#) for further information.

Professionals who are not subject to the mandatory reporting duty should follow their local safeguarding procedures, and **discuss the case with their local safeguarding lead** to agree an appropriate a course of action.

D.2.5 Adult who has had FGM

There is no requirement for automatic referral of adult women with FGM to adult social services or the police. Professionals should be aware that any disclosure may be the first time that a woman has ever discussed her FGM with anyone. A referral to the police should not be an automatic response for all adult women who are identified as having had FGM; cases must individually assessed.

Professional should seek to support women by offering referral to community groups who can provide support, or other services as appropriate (see [Annex H](#)).

In all cases it is also important to consider whether the individual and/or her family are known to social services, and whether there are any existing safeguarding arrangements in place.

D.2.6 Professionals Working in Wales: Additional Considerations

In Wales, the duty to report to the local authority, as introduced by the Social Services and Well-being (Wales) Act 2014 will apply where there is reasonable cause to suspect that the girl is at risk of further abuse, has needs for care and support, and as a result of those needs is unable to protect herself against the abuse or the risk of it.

Section 130 of the Social Services and Well-being (Wales) Act 2014 is due to come into force on 6 April 2016. It will require “relevant partners” of the local authority (including the police, NHS Trust or Health Board) to inform the local authority where they have reasonable cause to suspect that a child within the local authority’s area is a child at risk (i.e. is experiencing or is at risk of abuse, neglect or other kinds of harm, and has needs for care and support).

D.2.7 Safeguarding Other Family Members

Whenever a woman is identified as having had, or being at risk of, FGM, consideration must be given not only to whether she is at risk of further harm, but also to whether there are other girls or women in her family or wider unit who may be at risk of FGM (see [Annex B](#)). Issues to consider may include the potential need to:

- share information about an adult related to or known to the child or vulnerable adult in relation to whom safeguarding action is being taken;
- share information about a girl or young woman who the professional does not have a direct relationship with, e.g. the elder daughter of a pregnant woman who a midwife is treating.

D.2.8 Women and Girls from Overseas

If the girl or woman is from overseas, and fleeing potential FGM, applying to remain in the UK as a refugee can be a complex process requiring professional immigration advice (see www.gov.uk/claim-asylum for more information about the asylum application process).

Many individuals, especially women, may be frightened by contact with any statutory agency, as they may have been told that the authorities will deport them and/or take their parents or children from them. Professionals need to be extremely sensitive to these fears when dealing with a victim or potential victim from overseas, whatever their immigration status, as they may not be aware of their true immigration position. These circumstances make them particularly vulnerable.

Professionals must not allow any investigation of immigration status to impede police enquiries into an offence that may have been committed against the victim or their children. Border Force officials and police officers may choose to establish an agreement or protocol about how any two simultaneous investigations may work.

D.2.9 NHS Staff in England: Additional Considerations

The FGM Risk Indication System in the NHS in England

The [Female Genital Mutilation Risk Indication System \(FGM RIS\)](#), is a national IT system for health that allows clinicians across England to note on a girl's record within the NHS Summary Care Record application (an existing part of a child's electronic record) that they are potentially at risk of FGM.

The FGM RIS allows the potential risk of FGM to be *shared confidentially* with health professionals across all care settings until a girl is 18 years old. The FGM RIS can be used at any appropriate time during the delivery of care to check whether the girl has been assessed as being potentially at risk of FGM.

If a girl is identified as being at potential risk of FGM, the FGM risk indicator should be added to the system following completion of an FGM risk assessment, as detailed in the Department of Health's guidance titled *Female Genital Mutilation Risk and Safeguarding Guidance for professionals (2015)*⁵⁴.

The FGM RIS is to be used in conjunction with local safeguarding frameworks and processes. Use of the FGM RIS will not change professional responsibilities in this regard.

The FGM RIS will hold the following information:

- an indicator that a girl is potentially at risk of FGM;
- the date that the FGM safeguarding risk assessment was carried out; and
- the date that the FGM risk indicator was added on to the system.

Who can access it?

Authorised health professionals with the relevant security permissions on their NHS Smartcard are able to access the FGM Risk Indication System. The main groups of health professionals who use the system to add or view information are those most likely to observe and identify the warning signs associated with the potential risk of FGM. These are usually GPs, practice nurses, midwives, school nurses, safeguarding specialists and health visitors.

It is also likely that information held within the system will be viewed by clinicians working in NHS travel centres, acute trusts, mental health trusts, and unscheduled care settings such as primary care out-of-hours services, minor injury units and A&E. If a professional working in social care or the police identifies a girl for whom it may be appropriate to have this indicator placed upon the girl's record, as part of the multi-agency response put in place to safeguarding the girl, they should discuss with the healthcare professional within the team how to make sure this is completed.

⁵⁴ www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm

Police: Additional Considerations

D.2.10 Police: Additional Considerations

[Section D.2.](#) provides guidance for all professionals on the considerations and actions for safeguarding women and girls who are at risk of, or who have undergone, FGM.

In addition, police should refer to the College of Policing's *Authorised Professional Practice on FGM*⁵⁵ which includes guidance on prevention, protection and evidence-gathering in FGM cases.

Officers must not let fears of being branded 'racist' or insensitive to cultural traditions weaken their investigative strategy or decision(s) to arrest suspects. Investigation must be robust and follow national and local guidance for safeguarding and child abuse investigations. In addition officers should be culturally aware and have an understanding of the people they are dealing with as part of any investigation.

Criminal investigations should follow national and local police guidance for safeguarding and child abuse investigations.

The procedures described apply in particular to officers and staff in the following roles:

- child abuse investigation teams;
- community safety units;
- public protection units;
- missing persons teams;
- specialist sexual offences investigation teams; and
- all police officers and police staff who in the course of their duty deal with or come into contact with children and young people.

⁵⁵

www.app.college.police.uk/app-content/major-investigation-and-public-protection/female-genital-mutilation/?s=female+genital+mutilation#prevention

Initial steps when a girl may be at risk of FGM

If an officer or a member of police staff believes 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 specialist team or similar. If this is outside their core hours, the duty inspector must ensure that effective protection measures are put in place to ensure the safety of the victim in addition to undertaking an effective primary investigation. The safety and welfare of the girl is of paramount importance. The specialist team will in turn make an immediate referral to the relevant local authority's children's social care team if this has not already been done by the first responders/ primary investigators.

If any officer believes that the girl could be at immediate risk of significant harm, and use of an [Emergency Protection Order](#) has already been considered, they should consider the use of police protection powers under section 46 of the Children Act 1989. Officers should carry out the following actions:

- complete appropriate checks, e.g. Police National Database (PND), Police National Computer (PNC), Children's Social Care;
- submit an appropriate intelligence log;
- complete relevant risk assessment and management plans (as per Force policy);
- complete a crime report, ensuring that the incident is flagged in accordance with force procedures;
- create a crime report/non-crime related occurrence to record the report/referral;
- inform their supervisor, who must be at least the rank of inspector (notify a superintendent if further strategic support is required and in accordance with local Force instructions);
- all officers and staff must consider whether this could be a critical incident and deal with the matter accordingly;
- consider 'Golden Hour' principles in relation to evidence gathering; and
- consider risk to other children and women in the family.

Next steps when a girl may be at risk of FGM

Depending on the circumstances of the case, FGM-related referrals may lead to a strategy meeting with the police, local authority children's social care, health professionals (school nurse, health visitor, or community/hospital paediatrician as appropriate) and the referrer (e.g. school). Such a meeting should take place as soon as practicable (and in any case within two working days).

Police: Additional Considerations

Officers 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 (see [Section E.1](#)). In addition, police and local authority children's social care should consider the use of an FGM Protection Order (see [Chapter 3.3](#)), and/or other protective order as appropriate. **The welfare of other children within the family, in particular (but not exclusively) female siblings, should be reviewed.** The investigation should be the subject of regular ongoing 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.

Officers must not let fears of being branded 'racist' or insensitive to cultural traditions weaken their investigative strategy or decision(s) to arrest suspects. Investigation must be robust and follow national and local guidance for safeguarding and child abuse investigations. In addition officers should be culturally aware and have an understanding of the people they are dealing with as part of any investigation.

Initial steps when a girl is thought/known to have had FGM

If any police officer or police staff is made aware that a girl has already undergone FGM, the duty inspector must be made aware and an immediate referral should be made to their local child abuse special team. If this is outside their core hours, the duty inspector (or on-call senior investigating officer) must manage the initial phase of the investigation and ensure that effective protection measures are put in place. The specialist team will in turn make an immediate referral to the relevant local authority's children's social care team.

Officers should carry out the following actions:

- complete appropriate checks, e.g. PND, PNC, Children's Social Care;
- submit an appropriate intelligence log;
- complete relevant risk assessment and management plans (as per Force Policy);
- refer to local authority children's social care (unless they were the referrer).
- complete a crime report, ensuring that the incident is flagged in accordance with force procedures;
- inform their supervisor, who must be at least the rank of inspector;
- ensure that the on-call superintendent is made aware of the referral;
- create a crime report/non-crime related occurrence to record the report/referral;

- if the report is made under the mandatory reporting duty (see [Section 3.4](#)) it must be recorded as a crime without delay or waiting for further investigation (unless there is immediately available credible evidence to show that a crime has not occurred). This includes cases where it is suspected that FGM occurred outside of England and Wales.
- all officers and staff must treat this crime as a critical incident and deal with the matter effectively;
- the investigative strategy should consider obtaining evidence or intelligence identifying the cutters (people who carry out FGM for payment or otherwise) and investigating these individuals with a view to identifying further victims and closing down such networks; and
- investigating officers must refer to the Police/Crown Prosecution Service (CPS) Protocol for the investigation and prosecution of FGM cases. The 43 English and Welsh police forces have signed this protocol.

Next steps when a girl is thought/known to have had FGM

If it is believed or known that a girl has undergone FGM, a multi-agency strategy meeting should be held as soon as practicable (and in any case within two working days) to discuss the implications for the child and the coordination of the criminal investigation.

There is a risk that the fear of prosecution will prevent those concerned from seeking help, resulting in possible health complications for the girl; thus police action will need to be in partnership with other agencies, affected communities and specialist non-government organisations. This should also be used as an opportunity to assess the need for specialist support services such as counselling and medical help as appropriate.

Police officers should refer to the CPS's guidance *Provision of Therapy for Child Witnesses Prior to a Criminal Trial*⁵⁶. As highlighted above, investigating officers must refer to the Police/CPS Protocol for the investigation and prosecution of FGM cases, which has been signed by the 43 police forces in England and Wales.

A second strategy meeting should take place within a reasonable as appropriate to support the operational response.

⁵⁶ www.cps.gov.uk/publications/prosecution/therapychild.html

Police: Additional Considerations

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*⁵⁷) 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. 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.

See [Annex C](#) for more information on talking about FGM with those affected.

Medical examinations

Corroborative evidence should be sought through a medical examination conducted by a qualified medical professional trained in identifying the different types of FGM.

In all cases involving children, an experienced paediatrician should be involved in setting up the medical examination. This is to ensure that a holistic assessment which explores any other medical, support and safeguarding needs of the girl or young woman is offered and that appropriate referrals are made as necessary.

Steps when an adult has had FGM

If any police officer or police staff is made aware that an adult woman has undergone FGM, a multi-agency disciplinary approach must be taken to consider the risks to the woman. This should consider any potential risk to any girls within the family (and extended family) and consider initial and core assessments of those girls. Consideration should also be given to providing supportive services for the woman, including counselling and medical assistance and signposting the FGM survivor to specialist non-governmental organisation support networks.

The investigative strategy should consider obtaining evidence or intelligence identifying the excisors (people who carry out FGM for payment or otherwise) and investigating these individuals with a view to identifying further victims and closing down such networks. Investigating officers must consult early with the CPS in all FGM cases - as per the police/CPS protocol so the most effective investigation and prosecution opportunities are identified. Further advice on progressing an investigation can be found online on the Authorised Professional Practice (APP) website (www.app.college.police.uk).

⁵⁷ www.cps.gov.uk/publications/prosecution/victims.html

D.2.11 School, Colleges and Universities: Additional Considerations

The statutory duties on schools and colleges are set out in *Working Together to Safeguard Children*⁵⁸ (for England) and *Safeguarding Children – Working Together under the Children’s Act 2004*⁵⁹ (for Wales) and *Keeping Children Safe in Education*⁶⁰ or *Keeping Learners Safe*⁶¹ in Wales. These apply to FGM as to any other form of abuse.

See [Annex B](#) for advice on how to identify girls who may have undergone FGM or may be at risk.

[Section D.2](#) provides guidance for all professionals on the considerations and actions around safeguarding of women and girls who are at risk of or who have undergone FGM.

As well as following relevant statutory guidance, schools, colleges and universities may also find it useful to:

- Raise awareness of FGM among staff and pupils/students by
 - displaying relevant materials;
 - providing staff training;
 - making materials such as books or DVDs available;
 - including FGM in relevant parts of the school curriculum: PSHE in England (PSE in Wales); sex and relationship education; science; citizenship.
- Resources, including examples of lesson plans, are available in the online resource pack⁶².

⁵⁸ www.gov.uk/government/publications/working-together-to-safeguard-children--2

⁵⁹ www.gov.wales/topics/health/publications/socialcare/circular/nafwc1207/?lang=en

⁶⁰ <https://www.gov.uk/government/publications/keeping-children-safe-in-education--2>

⁶¹ <http://gov.wales/topics/educationandskills/publications/guidance/keeping-learners-safe/?lang=en>

⁶² www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack

School, Colleges and Universities: Additional Considerations

What to do if a student stops attending school

Details of the steps that local authorities need to take to meet their duty to identify all children (of compulsory school age⁶³) not receiving a suitable education are described in (England) Children missing education – statutory guidance for local authorities (Nov 2013)⁶⁴ or Statutory Guidance to Help Prevent Children and Young People from Missing Education: Welsh Assembly Government Circular 006/2010.

If a teacher, lecturer or other member of staff suspects that a student has been removed from, or prevented from, attending education **as a result of FGM**, a referral should be made to the local authority children's or adult's social care and the police.

Staff may consider speaking to the student's friends to gather information – although they should not make clear that FGM is suspected as this may get back to the family who may hasten any plans to perform the procedure (as well as potentially breaching confidentiality).

Remember: schools and local authorities have specific duties in relation to attendance at school or removing pupils from the school register. Staff should not delete a pupil from the school's admission register, except in certain circumstances. These are prescribed in The Education (Pupil Registration) (England) Regulations 2006. In certain circumstances, schools are required to inform the relevant local authority of a pupil who is to be removed from the admission register;

⁶³ As defined in section 8 of the Education Act 1996

⁶⁴ www.gov.uk/government/publications/children-missing-education

CASE STUDY: Norbury School

Norbury School had a large population of pupils from countries known to practise FGM.

The head teacher decided that the school should raise awareness of FGM and identified two key colleagues, both who were well respected by pupils, parents and the wider community, to lead on this work.

They recognised that they needed to bring communities on board with the work rather than have a 'top down' approach. They also wanted to be open and honest about facts, based on an educational approach, rather than 'blame' and 'lecture'. They used the [NSPCC PANTS](#) programme as a basis for their FGM awareness programmes. The PANTS programme sets out a simple message for children that parts of their body covered by underwear are private, their body belongs to them and that no-one has the right to make them do anything that makes them feel uncomfortable.

The school had six months of regular meetings with stakeholders including health services, children's services, their parent group, the voluntary sector, the police, cluster schools and charities to understand the facts, the various educational approaches, training and engagement with communities.

Following these meetings the school created their own FGM lesson plans, resources and approaches which they were shared with their stakeholders and modified as required.

All Year 5 & 6 pupils' parents met the school and reviewed the resources before the lessons were piloted and INSETs were held for their staff, governors and parents.

The class groups for the lessons were not single-sexed groups until year 6, where they split the boys and the girls in order to see how the questions developed. This was a good step as they found that the boys were very curious and some very angry that this could be done to their sisters, cousins, friends. The school also created a playground display and made it clear that they were educating and not blaming, whilst remaining clear about the law in this county.

By the end of the summer term, they had delivered the FGM awareness lessons to all their year 4 – 6 pupils and have the PANTS programme under way across the school from Nursery to year 6.

To celebrate the voice of the child, the school have created a working party of Year 3- Year 6 children to raise awareness of FGM across their borough. The children have presented to both professionals and children and even take questions from the floor. The school has strong links with their cluster secondary schools and Year 10 students from those schools have supported the delivery of PANTS lessons to their Year 1 children.

Annex E: Legal Interventions

Key points

- **Where a girl or woman is at risk, legal interventions should be considered.**
- Interventions may include **police protection, an Emergency Protection Order, an FGM Protection Order (FGMPO) and/or other orders or applications.**
- The relevant agencies should consider what is appropriate on a **fact-specific basis**. In some cases it may be considered that an FGMPO is sufficient to protect a girl at risk. In other cases it may be more appropriate for a **combination of orders** to be sought, for example, an FGMPO and making a girl a ward of court.
- **Referral to an accredited family law practitioner** to deal with wider issues of private or public family law may be equally important to meet the girl's needs.
- Where an application has been made to the family court to protect a girl who may be at risk of harm (for example, for a care order) and it is subsequently recognised **that there is a risk of FGM but no application for an FGMPO has been made, the applicant can request the court to consider making such an order.** A court can also make an FGMPO of its own volition where it considers it necessary to protect a girl from FGM during the course of other court proceedings.

E.1. Police Protection

Local authority children's social care may approach the police and ask for their assistance in undertaking a joint investigation. The way in which this is to be handled should be covered in the procedures prepared by the Local Safeguarding Children Board and in accordance with *Working Together to Safeguard Children*⁶⁵ (for England) and *Safeguarding Children – Working Together under the Children's Act 2004*⁶⁶ (for Wales). A joint approach can be particularly effective where it is thought that a girl or young woman is at immediate risk of FGM.

Where there is reasonable cause to believe that a child would otherwise be likely to suffer significant harm, a police officer may (with or without the cooperation of social care) remove that child from the parent and use the powers for 'police protection' (section 46 of the Children Act 1989) for up to 72 hours. The police must inform children's social care who must assist in finding safe and secure accommodation for the girl or young woman if requested to do so. Children's social care must assist the police, by arranging a placement for the child or young person in a place of safety, taking into account risk management and safety planning – whether this is in local authority accommodation provided by children's social care, on their behalf, or in a refuge.

Local authority children's social care must commence child protection enquiries under section 47 of the Children Act 1989 when they are informed that a child who lives, or is found in their area, is in police protection⁶⁷. They must also do so if they are told that the child is the subject of an emergency protection order, or they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering or likely to suffer significant harm.

Children's social care may apply for an Emergency Protection Order (EPO) (see [Section E.3](#)) at any point within the 72 hours if there is reasonable cause to believe the child is likely to suffer significant harm if she is not removed to accommodation provided by or on behalf of the local authority or does not remain in the place in which she is then being accommodated. The police have the power to make their own application for an EPO on behalf of the relevant local authority, but as a matter of practice this is done by children's social care.

⁶⁵ www.gov.uk/government/publications/working-together-to-safeguard-children--2

⁶⁶ www.gov.wales/topics/health/publications/socialcare/circular/nafwc1207/?lang=en

⁶⁷ Section 47(1)(a)(ii) of the Children Act 1989.

Remember:

- police officers have powers, under section 17(1)(e) of the Police and Criminal Evidence Act 1984, to enter and search any premises in order to protect life or prevent injury;
- police officers can also prevent the removal of a child from a hospital or other safe place in which the child or young person is accommodated⁶⁸;
- the parents may ask for contact with the child under protection, but this does not have to be granted if it is not, in the opinion of the officer designated for the purposes of section 46, both reasonable and in the best interests of the child, i.e. if it would place the child or young person in danger;
- the local police child abuse investigation team must be informed of any child under police protection;
- a girl may wish to see a female police officer;
- the girl may, or may not, want to see a police officer from her own community – try to give the child the choice;
- in all cases, check whether or not the girl is subject of a Child Protection Plan; and
- the police do not have parental responsibility with respect to a child while that child is under police protection, but they must do what is reasonable in all the circumstances of the case for the purposes of safeguarding or promoting the child's welfare (having regard in particular to the length of the period during which the child will be protected).

E.2. FGM Protection Orders

Section 5A of and Part 1 of Schedule 2 to the 2003 Act⁶⁹ provide for the making of FGM Protection Orders (FGMPOs) in England and Wales⁷⁰. An FGMPO is a civil order which may be made for the purposes of protecting a girl at risk of FGM or protecting a girl against whom an FGM offence has been committed. Breach of an FGMPO is a criminal offence with a maximum penalty of up to 5 years' imprisonment. **More information on FGMPOs is available in [Section 3.3](#).**

⁶⁸ Section 47(1)(a)(ii) of the Children Act 1989.

⁶⁹ As inserted by section 73 of the Serious Crime Act 2015.

⁷⁰ Part 2 of Schedule 2 to the 2003 Act makes similar provision in Northern Ireland.

E.3. Emergency Protection Orders (EPO) Under Section 44 of the Children Act 1989

An application for an EPO can be made by anyone – including social workers, police, youth workers, advocates or friends of the girl or young woman – but in practice it is usually made by local authority children’s social care.

An EPO authorises the applicant to remove the girl and keep her in safe accommodation, but this power can only be exercised in order to safeguard the girl’s welfare. In addition, the EPO operates to require any person in a position to do so to comply with any request to produce the child to the applicant. An EPO may also include directions as to the medical examination of the child (or that such examinations should not take place), although if the child is of sufficient understanding to make an informed decision, she may refuse to submit to such an examination.

An EPO lasts for a period not exceeding eight days, but it may be renewed for up to a further seven days.

More information on EPOs is available at: www.cafcass.gov.uk/grown-ups/professionals/care.aspx

For further information on court orders, refer to The Children Act 1989: court orders (2014).

E.4. Care Orders and Supervision Orders

Sometimes an EPO is followed by an application from the local authority for a Care Order or Supervision Order (sections 31 and 38 of the Children Act 1989). Without either a Care Order or an Interim Care Order, once the EPO has lapsed, the local authority will no longer have parental responsibility.

No care or supervision order may be made with respect to a child who has reached the age of 17 (or 16 if the child is married).

When a Care Order or Supervision Order is not available due to the age of the child, children’s social care should be aware of the opportunities presented by an FGM Protection Order or by making a child a ward of court, under the inherent jurisdiction of the High Court. A Ward of Court Order is available up to 18 years old. A child who is the subject of a Care Order cannot be made a ward of court

More information on Care Orders and Supervision Orders is available at: www.cafcass.gov.uk/grown-ups/professionals/care.aspx

E.5. Inherent Jurisdiction

A children's social care department may ask the High Court to exercise its inherent jurisdiction to protect the child. Any person with a genuine interest in the child, including the child themselves, a private individual or the Children and Family Court Advisory Support Service (CAFCASS/CAFCASS CYMRU) legal services department can apply to have a child made a ward of court.

A local authority may only apply for an order under the High Court's inherent jurisdiction if it has permission from the court to do so (under section 100 of the Children Act 1989). Leave to apply may only be granted by the court if it is satisfied that the result the local authority wishes to achieve could not be achieved through the making of any order, other than one under the court's inherent jurisdiction. A local authority is entitled to apply for this where they have reasonable cause to believe that if the court's inherent jurisdiction is not exercised, the child is likely to suffer significant harm.

For the purposes of obtaining protection for a child or young person, there is little difference between wardship and the other orders made in the exercise of the inherent jurisdiction of the High Court⁷¹. All types of orders under the inherent jurisdiction are flexible and wide-ranging, and an order may be sought where there is a real risk of a child being subjected to FGM. Where there is a fear that a child may be taken overseas for the purpose of FGM, an order for the surrender of their passport may be made as well as an order that the child may not leave the jurisdiction without the court's permission.

Orders for the immediate return of the child or young person can be obtained. These orders can be enforced on family members or extended family members. The orders are in the form of injunctions with penal notices attached.

E.5.1 Applications for Wardship

Once a young person has left the country, there are fewer legal options open to police, social services, other agencies or another person to recover the young person and bring them back to the UK. One course of action is to seek the return of the young person to the jurisdiction of England and Wales by making them a ward of court. Making a child a ward of court falls within the inherent jurisdiction of the High Court.

⁷¹ See paragraph 1.3 of Practice Direction 12D of the Family Procedure Rules 2010 that provides guidance on the distinguishing characteristics of wardship.

An application for wardship is made to the High Court Family Division⁷², and may be made by a relative, friend close to the child or young person, or CAF/CASS/CAF/CASS CYMRU legal services department or any interested party. Where an urgent ward of court application is required, an application should be made where possible within court hours. It is key that in such situation, early liaison with the Clerk of the Rules occurs in order that they can attempt to accommodate such requests. When it is not possible to apply for urgent wardship order within court hours, contact should be made with the security office at the Royal Courts of Justice (020 7947 6000 or 020 7947 6260)⁷³ who will refer the matter to the urgent business officer. The urgent business officer can contact the duty judge. The judge may agree to hold a hearing, either convened at court or elsewhere, or by telephone⁷⁴.

Paragraph 16 of Schedule 2 to the 2003 Act makes it clear that there is no effect on:

- the inherent jurisdiction of the High Court;
- any criminal liability;
- any civil remedies under the Protection from Harassment Act 1997;
- any right to an occupation order or a non-molestation order under Part 4 of the Family Law Act 1996;
- any right to a forced marriage protection order under Part 4A of that Act;
- any protection or assistance under the Children Act 1989; or
- any claim in tort

if making an application for a FGM Protection Order.

⁷² Rule 12.36(1) of the Family procedure Rules 2010.

⁷³ www.justice.gov.uk/courts/procedure-rules/family/practice_directions/pd_part_12e

⁷⁴ Practice Direction 12E (Urgent business) www.justice.gov.uk/courts/procedure-rules/family/practice_directions/pd_part_12e

E.6. Repatriation

When a British national seeks assistance at a British Embassy or High Commission overseas and wishes to return to the UK, the Foreign and Commonwealth Office (FCO) will do what it can to assist or repatriate the individual. Sometimes the FCO may ask the police or social services for assistance when a British national is being repatriated to the UK from overseas.

In many cases a victim of FGM may be extremely vulnerable: because of their age, the country in which they are located or their personal circumstance. If the FCO is able to repatriate them, it may not be able to give the police or social services much, if any, notice of the person's arrival due to the urgency of the situation. Sometimes a person may have risked their life to escape and their family may go to considerable lengths to find them. She may be extremely traumatised and frightened. These factors can make individuals particularly vulnerable when they return to the UK and it is likely that urgent multi-agency consideration of the level of risk faced by a victim of FGM will be appropriate.

Many FGM cases involve children under the age of 16. In such cases, in order to assist the victim to return to the UK, the support and assistance of UK agencies (such as police and social services) will be essential and assistance from overseas authorities seized with safeguarding duties is also likely to be necessary. In some countries this could be the police, but in others it may be the Ministry for Children or even Health. Supporting repatriation of FGM victims under 16 without the support of at least one person with parental responsibility or the safeguarding authorities in-country may be very difficult and drawn out.

Remember:

- the FCO cannot pay for repatriation. They will normally ask the person or trusted friends to fund the cost of repatriation. In some cases, repatriation has been funded by schools or social services. However, this should never delay the process of getting the individual to safety;
- the FCO can facilitate a British national's return to the UK by providing emergency travel documents, in some exceptional circumstances helping to arrange flights and, where possible, by helping to find temporary safe accommodation while the victim is overseas; and
- the FCO or social services may ask the police to meet the person on arrival, in case family members try to abduct them, at the airport.

Annex F: Care and Support

F.1. 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.

In Wales, there is a published FGM Care Pathway and any queries should be directed through the health board FGM lead:
www.wales.nhs.uk/sitesplus/888/page/67421/

F.2. 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 anger⁷⁵. There is increasing awareness of the severe psychological consequences of FGM for girls and women, which can become evident in mental health problems.

⁷⁵ Haseena Lockhat (2004) *Female Genital Mutilation: Treating the Tears*, London: Middlesex University Press.

Local commissioners must consider the provision of mental health support and services, and that girls and women who have undergone FGM are able to access this treatment as required. The 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.

F.3. Safety of Service Users

When services are commissioned, 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.

F.4. 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 examinations⁷⁶. This guidance covers the considerations around obtaining consent (required), and what to do if consent is not given.

⁷⁶ www.gmc-uk.org/guidance/ethical_guidance/13430.asp

Annex G: Terms Used for FGM In Other Languages

| Country | Term used for FGM | Language |
|--------------------------------|---------------------------------------------|-----------|
| CHAD – the Ngama Sara subgroup | Bagne | |
| | Gadja | |
| EGYPT | Thara | Arabic |
| | Khitan | Arabic |
| | Khifad | Arabic |
| ETHIOPIA | Megrez | Amharic |
| | Absum | Harrari |
| ERITREA | Mekhnishab | Tigreigna |
| GAMBIA | Niaka | Mandinka |
| | Kuyango | Mandinka |
| | Musolula Karoola | Mandinka |
| GUINEA-BISSAU | Fanadu di Mindjer | Kriolu |
| IRAN | Xatna | Farsi |
| KENYA | Kutairi | Swahili |
| | Kutairi was ichana | Swahili |
| NIGERIA | Ibi/Ugwu | Igbo |
| | didabe fun omobirin / ila kiko fun omobirin | Yoruba |
| SIERRA LEONE | Sunna | Soussou |
| | Bondo | Temenee |
| | Bondo/Sonde | Mendee |
| | Bondo | Mandinka |
| | Bondo | Limba |
| SOMALIA | Gudiniin | Somali |
| | Halalays | Somali |
| | Qodiin | Somali |
| SUDAN | Khifad | Arabic |
| | Tahoor | Arabic |
| TURKEY | Kadin Sunneti | Turkish |

Annex H: Contact Information

HELPLINES

NSPCC FGM helpline: 0800 028 3550

www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/female-genital-mutilation-fgm

email: fgmhelp@nspcc.org.uk

National Domestic Violence Helpline: 0808 2000 247 (24-hour)

www.nationaldomesticviolencehelpline.org.uk/

ChildLine: 0800 1111

www.childline.org.uk

POLICE

Police forces

www.gov.uk/contact-police

Metropolitan Police Service

Project Azure Partnership Team: 020 7161 2888

GOVERNMENT

FGM Unit

The FGM Unit, based at the Home Office, co-ordinates work on FGM across government and offers outreach support to local areas. Please note the unit does not handle individual cases.

fgmenquiries@homeoffice.gsi.gov.uk

Forced Marriage Unit

The Government's Forced Marriage Unit can be contacted for advice on forced marriage issues on 020 7008 0151 (Monday – Friday, 9am – 5pm; call 020 7008 1500 and ask for the Global Response Centre in emergencies outside of these hours).

OTHER ORGANISATIONS

For a list of other organisations who can provide advice and support on FGM see the 'Contact, helplines and clinics' section of the FGM resource pack:

www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack#contacts-helplines-and-clinics

Enter a postcode to find local organisations www.gov.uk/female-genital-mutilation-help-advice

Annex I: Resources

Safeguarding guidance

HM Government (2015) *Working Together to Safeguard Children*
www.gov.uk/government/publications/working-together-to-safeguard-children--2

Welsh Government (2007) *Safeguarding Children: Working Together under the Children Act 2004*
www.gov.wales/topics/health/publications/socialcare/circular/nafwc1207/?lang=en

Welsh Government (2001) *Framework for the Assessment of Children in Need and their Families*
<http://gov.wales/topics/health/publications/socialcare/guidance1/assessing/?lang=en>

HM Government (2015) *What to do if you're worried a child is being abused*
www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2

Department of Health (2015) *Female Genital Mutilation: Risk and Safeguarding – Guidance for professionals*
www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf

Department for Education (2015) *Keeping Children Safe in Education*
www.gov.uk/government/publications/keeping-children-safe-in-education--2

Department for Education (2015) *Children Missing Education: Statutory guidance for local authorities* www.gov.uk/government/publications/children-missing-education

All Wales Child Protection Procedures Review Group (2011) *All Wales Protocol: Female Genital Mutilation* www.wales.nhs.uk/sitesplus/888/page/67421/

Prevalence data

UNICEF FGM international data <http://data.unicef.org/child-protection/fgmc.html>

Macfarlane A, Dorkenoo E. (2015) *Prevalence of Female Genital Mutilation in England and Wales: National and local estimates*. London: City University London and Equality Now <http://openaccess.city.ac.uk/12382/>

HSCIC, NHS England FGM data
www.hscic.gov.uk/searchcatalogue?q=%22female+genital+mutilation%22&area=&size=10&sort=Relevance

FGM Protection Orders (FGMPOs)

HM Courts Service Application forms for FGMPOs and information in different languages on how FGMPOs can protect people www.gov.uk/female-genital-mutilation-protection-order

Mandatory reporting

Home Office (2015) *Mandatory reporting procedural information* www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information

Department of Health (2015) Mandatory reporting resources for healthcare professionals www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare

Home Office (2016) *Fact sheet on mandatory reporting of female genital mutilation* www.gov.uk/government/publications/fact-sheet-on-mandatory-reporting-of-female-genital-mutilation

Commissioning services

Imkaan, Accredited Quality Standards for working with black and minority ethnic (BME) women and girls and harmful practices: Forced marriage (FM), Female genital mutilation (FGM) and 'Honour-based' violence (HBV) <http://imkaan.org.uk/iaqs>

Department of Health (2015) *Commissioning Services to Support Women and Girls with Female Genital Mutilation* www.gov.uk/government/publications/services-for-women-and-girls-with-fgm

Training and awareness for professionals

Home Office, e-learning module FGM: How to recognise and prevent it www.fgmelearning.co.uk

E-learning for healthcare, e-learning modules for healthcare professionals in England www.e-lfh.org.uk/programmes/female-genital-mutilation/

Welsh Government, Live Fear Free: Training on Domestic Abuse, Sexual Violence and Violence against Women <http://livefearfree.gov.wales/guidance-for-professionals/national-training-framework/?lang=en>

Home Office (2015), FGM resource pack (including case studies and links to organisations and resources to support local work to tackle FGM) www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack%20%20

Information sharing

Department for Education (2015) *Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers* www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

Resources for healthcare professionals

NHS Choices, FGM guidance for professionals www.nhs.uk/guidelines

Department of Health (2015) *Female Genital Mutilation: Risk and Safeguarding – Guidance for professionals* www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf

Health and Social Care Information Centre, Information on the Female Genital Mutilation Risk Indication System www.hscic.gov.uk/fgmris

Health and Social Care Information Centre, Information on the Female Genital Mutilation (FGM) Enhanced Dataset Information Standard (SCCI2026) www.hscic.gov.uk/fgm

Department of Health and Health and Social Care Information Centre (2015) *Understanding the FGM enhanced dataset* www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm

Royal College of Obstetricians and Gynaecologists (2015) *Female Genital Mutilation and its management (Green-top Guideline No. 53)* www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg53/

Royal College of Nursing (2015) *Female Genital Mutilation* www.rcn.org.uk/clinical-topics/female-genital-mutilation

General Medical Council, Guidance on child protection examinations www.gmc-uk.org/guidance/ethical_guidance/13430.asp

General Medical Council (2008) *Consent: Patients and Doctors Making Decisions Together* www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp%20

General Medical Council (2009) *Confidentiality* www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

General Medical Council (2013) *Intimate Examinations and Chaperones* www.gmc-uk.org/guidance/ethical_guidance/21168.asp

Resources for police

College of Policing (2015) *Authorised Professional Practice: Female Genital Mutilation* www.app.college.police.uk/app-content/major-investigation-and-public-protection/female-genital-mutilation/?s=female+genital+mutilation#prevention

Crown Prosecution Service, *Provision of Therapy for Child Witnesses Prior to a Criminal Trial* www.cps.gov.uk/publications/prosecution/therapychild.html

Ministry of Justice (2011) *Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures* www.cps.gov.uk/publications/prosecution/victims.html

Asylum

Information on claiming asylum in the UK www.gov.uk/claim-asylum

Legal interventions

Children and Family Court Advisory and Support Service, information on legal interventions to safeguard children www.cafcass.gov.uk/grown-ups/professionals/care.aspx

Forced marriage

HM Government (2014) *The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage* www.gov.uk/guidance/forced-marriage

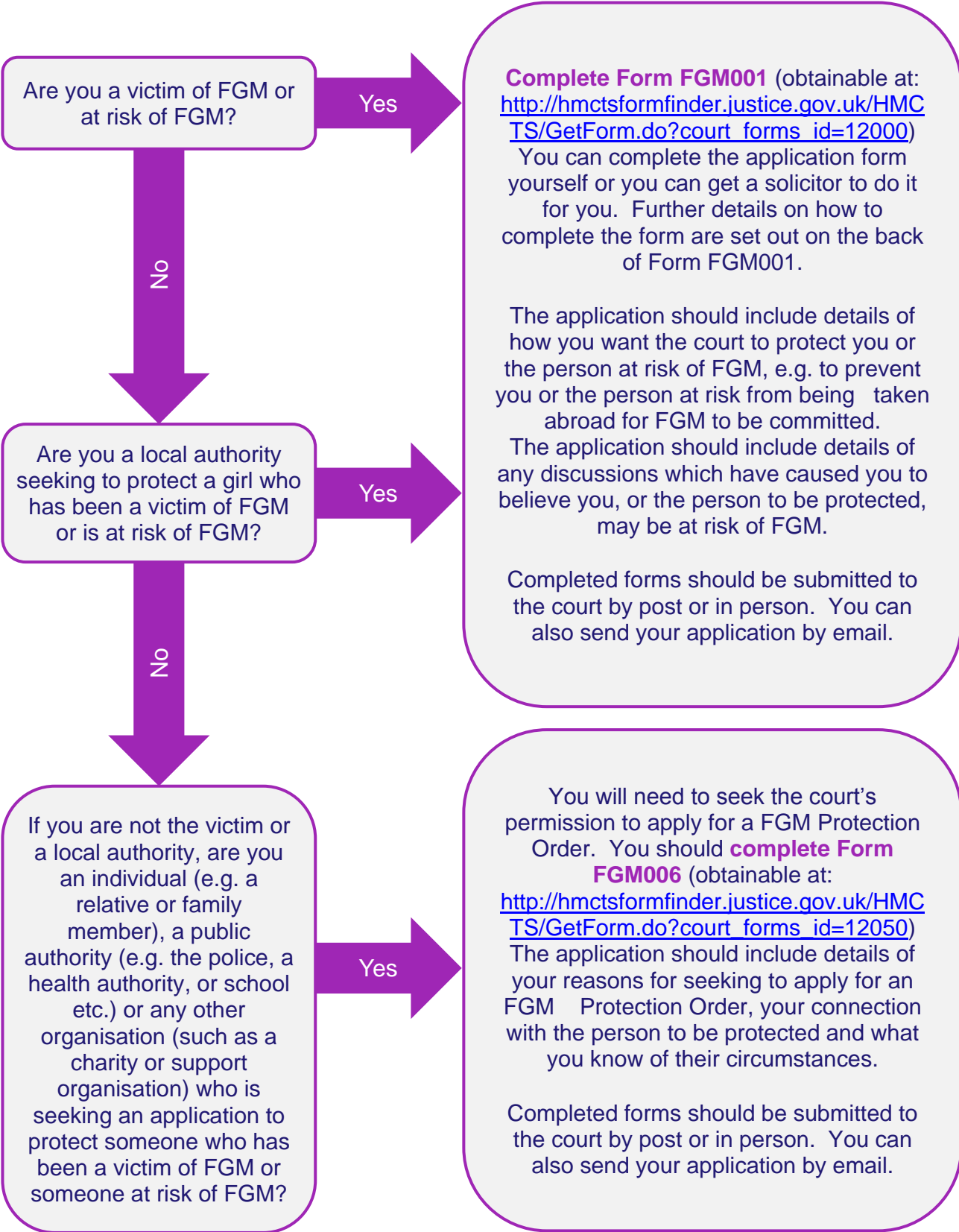
HM Government (2014) *Multi-agency practice guidance: handling cases of forced marriage* www.gov.uk/guidance/forced-marriage

Materials for public awareness-raising

To order hard copies of materials, email the FGM Unit: FGMenquiries@homeoffice.gsi.gov.uk

To order the [Statement Opposing FGM](#) (also known as the 'Health Passport') which sets out the law on FGM and the help and support available and is available in 11 languages, visit the Department of Health orderline website www.orderline.dh.gov.uk

Annex J: Making an Application for an FGM Protection Order (FGMPO)



Publication date: April 2016

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This publication is available for download at www.official-documents.gov.uk

ISBN: 978-1-78655-081-1