Wakefield and District Safeguarding Children Board

Multi-Agency Protocol
For
Female Genital Mutilation (FGM).

1	Introduction – Guiding Principles
1.1	Female Genital Mutilation is child abuse and is a form of gender-based violence placing girls at risk of significant harm. FGM is Illegal in the UK and carries a maximum prison sentence of 14 years (Female Genital Mutilation Act 2003). No single agency or statutory body can meet the multiple needs of a girl or woman affected by FGM and therefore a multi-agency response is required. Central to effective safeguarding arrangements is the requirement to share information between agencies and given the need to potentially safeguard a child against FGM over a number of years there may be a number of different responses required. Decisions in relation to appropriate actions to be taken should be considered on a case by case basis with input from all agencies involved (Department of Health 2016). This Protocol has been agreed by all partner agencies of the Wakefield and District Safeguarding Children Board. The Protocol is relevant to any multi-agency staff member operating within the Wakefield district who may come into contact with girls and women who have undergone or are at risk of FGM. This Protocol relates to Wakefield district and describes local action to be taken. It is to be used in conjunction with the West Yorkshire Consortium of Local Safeguarding Children Boards Guidance WYSCB Guidance which is regularly updated every 6 months.
1.2	The Young people's Safeguarding Charter clearly outlines the expectation that all adults across the Wakefield community will help children to be safe and protected (Young People's Charter Wakefield). Listening to and responding sensitively to the child is essential to ensure that children are treated with care and respect and are clear about what needs to happen. It is important that professionals are aware that not all cultures associate FGM with the term mutilation, and words such as cutting may be more appropriate language. Professionals working directly with the child should ensure that they listen carefully to the child and use age-appropriate communication approaches to support the child and their family to understand what professionals are worried about.

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1.3	Female genital mutilation (FGM) is a collective term for all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM may also be referred to as female 'circumcision', 'cutting' or 'initiation' (NSPCC 2014). The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. The age at which FGM is carried out is most commonly before the girl reaches puberty, however In some cases the procedure may be carried out shortly after birth, or just before marriage. Where a pregnant woman who has previously been subjected to FGM is identified as carrying a female child, or there is a female child already in the family, the case must be referred to Children's Social Care in line with this Protocol. This may be in the antenatal period or at the point of birth once the gender of the child is confirmed.
1.4	FGM has been classified by the World Health Organization 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. Type 4 – Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. labial elongation, pricking, piercing, incising, scraping and cauterising the genital area. This includes genital tattoos and genital piercings for cosmetic rather than cultural reasons. NB it is illegal to carry out cosmetic procedures on a child under 18.
1.5	The prevalence of FGM is difficult to estimate because of the hidden nature of the crime.
1.6	In order to safeguard children and young women it is important that practitioners are able to: 1. Identify a girl (including an unborn female) or young woman who may be at risk of, or may have been a victim of FGM. 2. Initiate procedures to safeguard the child, ensuring that risks identified are appropriately managed. 3. Contribute, where appropriate, to preventative work ensuring the provision of support and advice to parents in relation to FGM.
2	**Where Risk Factors Are Identified But There Is Not A Suspicion That FGM Has Already Occurred**

2.1	Consider the full list of risk factors identified by the West Yorkshire Safeguarding Children Board WYSCB Guidance • The family belongs to a community in which FGM is practised, or they have limited levels of integration within UK community; • The family indicate that there are strong levels of influence held by elders and/or elders are involved in bringing up female children; • If a female family elder is present, particularly when she is visiting from a country of origin, and taking a more active / influential role in the family; • There are older girls or women in the family (e.g. older sister/s, mother) who have undergone FGM; • The child talks about a 'special procedure/ceremony' s going to take place or a long holiday to her country of origin or another country where the practice is prevalent; • Repeated failure to attend or engage with health and welfare services or the mother of a girl is very reluctant to undergo genital examination, including cervical smears; • Parents requesting permission for their girls to be taken out of school two weeks before or after the summer holidays (recovery period can be up to 8-10 weeks); • Where a girl from a practising community is withdrawn from Sex and Relationship Education they may be at risk from their parents wishing to keep them uninformed about their body and rights; • The child talks about 'becoming a woman' or 'rites of passage'; • The child talks about new clothing or special outfits; • The child becomes withdrawn or 'acting up' (out of character).
2.2	Organisations must ensure their staff follow their own organisational safeguarding procedures in relation to concerns about a child; this may include informing a designated safeguarding lead (DSL) about their concerns. FGM presents a lifelong risk to a child and any change in the family situation or any new information which raise a concern, must be reported immediately.

2.3	A referral to Children's Social Care **MUST** be made in all cases where risk factors have been identified : via **Social Care Direct 0345 8503503.** If the risk is immediate, ring Police on **999.** Social Care Direct is a service that deals with all requests for a children's social care service, including concerns related to child abuse and neglect.
3	**Referring The Child to Children's Social Care**
3.1	When making a referral, the professional must gather as much information as possible including basic demographic details such as name of the child, date of birth, names of significant family members including the parents, family address, contact telephone number etc. Any other relevant background information that is known at the time must also be shared with Social Care. Where a child is at immediate risk there must be **no delay** in making a referral to Children's Social Care via Social Care Direct and/ or the Police.
3.2	**Informing the Parents/Carers and Obtaining Consent** • It is best practice to inform parents/carers that a referral is being made, and what they can expect to happen. • It is best practice to obtain their consent to the referral. • Where parents/carers refuse to give consent, a referral should still be made in line with this Protocol. • If the professional has genuine concerns that informing the parents/carers of the referral will increase the risk of significant harm to the child, they should seek advice from their own agency safeguarding lead or Social Care Direct prior to the parents/carers being informed. In **all** cases, Children's Social Care must be advised if the parents or carers have been informed of the referral, and if consent has been obtained. If not, the referrer must explain why.
3.3	In addition to the Children's Social Care referral, multi-agency staff members must follow their own organisation's safeguarding procedures. For example, ensuring their Designated Safeguarding Lead is aware of the referral, ensuring appropriate information sharing, considering other professionals who may have relevant information.
4	**Action to be Taken by Children's Social Care**
4.1	Referrals made to Children's Social Care via Social Care Direct (0345 8503503) under this protocol will always be deemed to be **high priority** due to the potential vulnerability of the child. **All** referrals received by Children's Social Care must initiate a multi-agency Section 47 strategy discussion. This must as a minimum include Children's Social Care, Police, an appropriate Health Professional which, where possible, should be a Named Safeguarding Professional, and the referring agency.

	The outcome of this discussion will determine the management of the case based on the assessment of risk, which may include initiating a Section 47 investigation (The Children Act 1989). The multi-agency strategy discussion must also consider other females in the immediate or extended family who may be at risk. Consider involving Education (eg a Designated Safeguarding Lead) if the child or any other child in the household is of school age or in education. Consider gathering information from any other organisation or service involved with the family, including Third Sector organisations. **West Yorkshire procedures in relation to Strategy Discussions and Strategy Meetings can be found at:** WestYorksSCB Strategy Discussions
4.2	Children's Social Care will check records to ascertain if the family **is** in receipt of a service from the Children's and Young People's Directorate. Where known, the referral information will be recorded in detail on the Care Director system and treated as a **high priority** referral with regard to new information relating to FGM. Where the child or family are already known to services the Team Manager/Out of Hours duty Social Worker **must** initiate a new, **FGM focussed,** multiagency strategy discussion immediately (4.1). The allocated Social Worker for the child should be informed at the earliest opportunity; this should not delay initiation of the **new** multi-agency strategy discussion.
4.3	Consideration must be given to assessing risk and gathering information including the parents / carers views in relation to FGM and any potential influence of wider extended family members. Initial contacts with the family must include a discussion about the illegality of FGM and the impact on the health and rights of the child. Consider completing a risk assessment tool to guide decision-making FGM Govt Risk Assessment Tool • An independent interpreter **must** be used if the family are non-English speaking or have difficulty with legal or medical terminology. Where possible the interpreter must be female, in accordance with national guidance • Provide written Government guidance in appropriate language or direct parents to the Government website Govt Statement Opposing FGM (different languages) • Consider whether other girls are at risk in the immediate or extended family i.e. establish household/extended family composition • Contact any agency, including Third Sector organisations, who are working with the family and who may hold valuable information.
5	**Responding to A Disclosure That FGM Has Taken Place on a Child**
5.1	A referral to Children's Social Care must be made.

5.2	Professionals must be aware of the mandatory duty to report to the Police in accordance with The FGM Act 2003, amended by The Serious Crime Act 2015 This mandatory duty to report to the Police applies to all regulated Health, Education and Social Care professionals and was enacted in October 2015. The duty to report only applies:- • if the professional is informed by the girl (under 18 years) herself that an act of FGM has been performed on her or • the professional observes physical signs which show or appear to show that an act of FGM has been carried out on the girl for non medical reasons NB - this includes genital piercings and/or tattoos which are classified as type 4 FGM The duty to report does not apply to:- • Disclosures made by a third party e.g. parent/friend/family member • Children identified to be at risk NB - In these cases referrals to Children's Social Care must still be made in line with this Protocol The West Yorkshire Inter Agency Procedures Manual directs that professionals should complete the West Yorkshire Police FGM Reporting Form and email to cib@westyorkshire.pnn.police.uk. Following receipt the Police will create an incident log and a child protection report. The child protection report will be forwarded to the appropriate Safeguarding Unit to initiate Police and partner investigation. All staff must ensure that information is **only** transferred via their own agency **secure** email network. If this is not possible, reports must be made by calling 101. Additional guidance is available via - Mandatory Reporting of Female Genital Mutilation
5.3	All investigations should consider: • Where, when and by whom the FGM was performed • The type of FGM performed • Where the child has been subjected to FGM the case should be discussed with the Named Paediatrician. In **all** cases a referral to Children's Social Care should be made.
5.4	All children should be reviewed by a Paediatric Consultant to assess the type of FGM and any physical and/or mental health needs (Department of Health 2015). The multi -agency strategy discussion must consider any requirement for a medical examination and where indicated a formal child protection medical will be undertaken. Consent for the medical examination should be sought from the person with parental responsibility for the child and where consent is refused, legal advice should be sought.

	WYSCB guidance section 6.5 must be applied WYSCB Procedures
6	**Health Professionals**
6.1.	**Mandatory Recording of FGM Information for NHS funded providers** Health professionals have a duty to record FGM information on medical records and for central data collection when they become aware of it directly or for example via a Section 47 multi-agency strategy discussion. This applies to GPs, maternity services professionals, health visitors, school nurses, mental health professionals and others. Health staff should not assume that the FGM is historical and this should be established through sensitive but direct questioning. The Mandatory recording of FGM information when it is identified is intended to better support local and National processes in raising the awareness of the potential risks of FGM occurring to women and girls. The mandate covers the recording of information obtained through all activity undertaken in all clinical settings, and / or provided by NHS England commissioned services. The Mandate applies to the following organisations, which will be impacted by the implementation of this standard: - • NHS Acute Trusts (Foundation and Non-Foundation NHS Trusts) • NHS Mental Health Trusts • General Practitioners All NHS funded providers **MUST** pay regard to this information standard. Full details of these requirements can be found in the Requirements Specification: - (http://content.digital.nhs.uk/media/16781/2026122014spec/pdf/2026122014spec.pdf) NB. NHS organisations and new users **must register** to access CAP (Clinical Audit Platform) by completing the 'FGM Enhanced Dataset CAP user registration form: - **FGM Enhanced Dataset CAP User Registration Form [69kb]** This form contains important guidance about the dataset for Caldicott Guardians and CCGs and General Practices.
6.2	In the case of adult women where FGM is identified through the delivery of healthcare, the patient's rights to confidentiality must be respected if they choose not to pursue any further action i.e. no referral should be made to the Police or Children's Social Care – unless the woman is pregnant and carrying a female child, or a child within the immediate or extended family is considered to be at risk of or been subjected to FGM, when appropriate referrals must be made without delay.
7	**Decision Making**
7.1	This Protocol does not seek to remove or undermine professional judgement of any individual or

	organisation, but supports a consistent and multi-agency approach to undertaking risk assessments ensuring that decisions are **not** made by a single agency. In accordance with national multi-agency guidance (2016 Statutory Guidance) this document seeks to support the local delivery of a co-ordinated and consistent response in all cases.
7.2	If the appropriate Section 47 investigation threshold is met, the initial Multi Agency strategy meeting must be carried out with reference to Section 6.3 of the WYSCB guidance. A second strategy meeting must be held with 10 working days of the Initial Strategy Meeting to review all evidence gathered during the investigation (section 6.6 WYSCB Guidance) – as detailed below. A second strategy must be held with 10 working days of the Initial Strategy Meeting. The meeting should include the Police and relevant health practitioners and be chaired by the social work team manager. If possible, the Paediatrician who carried out the Child Protection Medical Examination should also attend. If this is not possible, they should provide their report on the outcome of the medical examination. Attendees will consider information collected during the Section 47 investigation and the Child Protection Medical Examination and decide on the outcome. • The child has suffered or is likely to suffer significant harm and an Initial Child Protection conference is required; • The child is not suffering or likely to suffer significant harm but requires services as a Child in Need. Children's Social Care Services will arrange a Child in Need Meeting; • Legal advice needs to be sought from the Local Authority Legal Services; or • No further action for Children's Social Care Services (consider referral to Early Intervention / CAF services).
7.3	Where there is professional disagreement the case should be referred to relevant managers or equivalent for escalation and resolution in line with West Yorkshire Consortium Safeguarding Children Procedures found at: West Yorkshire SCB Resolving Disagreements
7.4	The Safeguarding and Family Support Service must ensure that the outcomes of the Section 47 Enquiry are shared with the family (unless to do so would place the child at increased risk) and all relevant partners.
7.5	The outcome of the Section 47 strategy discussion must be recorded in detail by all agencies; if the threshold has been met for a Section 47 investigation this must be clearly stated. The outcome and actions identified at the strategy discussion must be circulated to all relevant agencies. All agency professionals must pay due regard to statutory guidance and ensure information is accurately recorded and shared appropriately and securely.

	Maintaining an accurate and contemporaneous record is particularly important where a decision is taken that no further action is required **at that time** to protect the child. In such cases additional consideration must be given to sharing information with appropriate agencies which may have a role in safeguarding the child **in the future**, e.g. GP, education, 0-19 service (health visiting, school nursing). This may include a record of the known family history of FGM. It is also appropriate to consider adding an alert or flag to the records of children identified as being at future risk of FGM. to add an alert or flag the records of children identified as at risk of FGM in the future.
7.6	Where an adult woman has made a disclosure in relation to FGM (and there are no risks to any children) health professionals must share information with all key health professionals including the GP to ensure that information is recorded within her health record in line with statutory guidance. If a disclosure is made to a professional from any other agency and there are no identified risks to any children, the worker to whom the disclosure is made should seek consent to share this information with the GP to facilitate access to other support services. The woman may wish to have her FGM status recorded however is not obliged to give her consent and her confidentiality must be maintained where consent is refused.
8	**Useful Links**
8.1	Multi agency Statutory Guidance , HM Government, 1 April 2016 Statutory Guidance
8.2	NSPCC NSPCC
8.3	NHS Choices NHS Choices FGM
8.3	Daughters of Eve Daughters of Eve