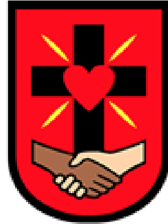

SACRED HEART
CATHOLIC PRIMARY
SCHOOL & NURSERY

FGM Statement

This is our school.

Together we worship; Together we learn; Together we belong.

With the love of God, our dreams and ambitions come true

September 2023

Policy Date: September 2023

Policy Status:

Approval by Governing

Body October 2023

Review Cycle: 18months or as required

Next Review Date: January 2025

At Sacred Heart Catholic Primary School & Nursery we are proud to provide a safe, stimulating and inclusive learning environment where every member of our community is valued and respected.

Mission Statement

'Together we worship, Together we learn,
Together we belong – with the love of God…
our dreams and ambitions come true.'

Our broad, balanced, creative curriculum and enrichment activities provide opportunities for everyone to achieve and succeed. Together we take pride in making a positive contribution to our school and the wider community.

This policy should be referred to in conjunction with the curriculum, assessment and teaching and learning policies.

SAFEGUARDING STATEMENT

"Sacred Heart Catholic Primary School is committed to safeguarding and promoting the welfare of children and young people and expects all staff and volunteers to share this commitment".

REVIEW DATE: Dec 2024 or sooner as required

This policy provides guidance to all adults working within the school whether paid or voluntary or directly employed by the school or by a third party.

FGM POLICY

At Sacred Heart Catholic Primary School and Nursery we respect and value all children and are committed to providing a caring, friendly and safe environment for all our pupils so they can learn, in a calm and secure atmosphere. We believe every pupil should be able to participate in all school activities in an enjoyable and safe environment and be protected from harm. This is the responsibility of every adult employed by, or invited to deliver services at our school. We recognise our responsibility to safeguard all who access school and promote the welfare of all our pupils by protecting them from all forms of harm.

1. Statement of Purpose

At Sacred Heart Catholic Primary School and Nursery, we are determined to ensure that all necessary steps are taken to protect children, young people and adults from harm. This includes safeguarding girls from Female Genital Mutilation (FGM). Following the mandatory FGM reporting requirements for education, health and social care professionals, the Governing Body have ratified this policy which has been written with the guidance from Liverpool Safeguarding Children's Board FGM Protocol and should be read in conjunction with school's Safeguarding and Child Protection policy.

2. Implementing FGM Duty

To implement FGM Duty Sacred Heart Catholic Primary School and Nursery will ensure all staff, governors and volunteers have access to training to ensure all have an understanding and build capability to deal with the risks identified. This includes:

- An understanding of what FGM means;
- An understanding of FGM types;
- An understanding of FGM risk factors;
- An understanding of FGM legislation;
- How to challenge FGM ideology;
- How to obtain support from the senior leadership team, the police, local authorities and multi-agency partnerships;
- How to share information to ensure a person at risk of FGM obtains appropriate support;
- How and when to make a direct FGM referral to the police;
- How to record and maintain records to comply with school's responsibilities.

3. What is FGM

FGM is a form of child abuse that can lead to extreme and lifelong physical and psychological suffering to women and girls. The term FGM comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for nonmedical reasons. In general, girls undergo female genital cutting (FGC) around the age of three years old, though the age may vary depending on the type of ritual and customs of the local village or region.

Communities supporting FGM justify the practice for a variety of reasons. These may be:

- Sexual control of men over women
- Preservation of virginity
- Custom and tradition
- Family honour
- Hygiene or cleanliness
- Mistaken belief that FGM is a religious requirement FGM is also known as Female Circumcision (FC) and Female Genital Cutting (FGC). The reason for these alternative definitions is that it is better received in the communities that practice it, who do not see themselves as engaging in mutilation.

FGM is included within the revised (2013) government definition of Domestic Violence and Abuse.

4. FGM is Classified into Four Major Types

1.'Clitoridectomy which is the partial or total removal of the clitoris and, in rare cases, the prepuce (the fold of skin surrounding the clitoris);

2.Excision which is the 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 1 and II account for 75% of all worldwide procedures;

3.Infibulation which is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, and sometimes outer, labia, with or without removal of the clitoris; Type III accounts for 25% of all worldwide procedure and is the most severe form of FGM;

All other types of harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

5. Local Terms for the Procedure

These include;

- tahara in Egypt;
- tahur in Sudan;
- bolokoli in Mali, which are words synonymous with purification.

Several countries refer to Type 1 FGM as sunna circumcision* (which means usual practise/tradition in Islam). It is also known as kakia, and in Sierra Leone as bundu, after the Bundu secret society.

Type III FGM (infibulation) is known as "pharaonic circumcision" in Sudan, and as "Sudanese circumcision" in Egypt.

TERMS USED FOR FGM IN OTHER LANGUAGES

Country	Term used for FGM	Language
CHAD – the Ngama Sara subgroup	Bagne	
	Gadja	
GAMBIA	Niaka	Mandinka
	Kuyungo	Mandinka
	Musolula Karoola	Mandinka
GUINEA-BISSAU	Fanadu di Mindjer	Kriolu
EGYPT	Thara	Arabic
	Khitan	Arabic
	Khifad	Arabic
ETHIOPIA	Megrez	Amharic
	Absum	Harrari
ERITREA	Mekhnishab	Tigregna
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

6. Who Practices It

FGM is practised around the world in various forms across all major faiths. Today it has been estimated that currently, about three million girls, most of them under 15 years of age, undergo the procedure every year. The majority of FGM takes place in 29 African and Middle Eastern countries, and also includes other parts of the world; Middle East, Asia, and in industrialised nations through migration which includes; Europe, North America, Australia and New Zealand.
Globally the WHO estimates that between 100 and 140 million girls and women worldwide have been subjected to one of the first three types of FGM.
There are substantial populations of people in the UK from countries where FGM is endemic; in London, Liverpool, Birmingham, Sheffield, Cardiff and Manchester (HM Government 2006). UK communities that are most at risk of FGM include Kenyans, Somalis, Sudanese, Sierra Leoneans, Egyptians, Nigerians, Eritreans and Ethiopians. However women from non-African communities that are at risk of FGM include Yemeni, Kurdish (Iraqi, Iranian and Turkish country of origin), Indonesian, Malaysian, Pakistani women and Indian women (Muslim Bohra Community).
It is important to recognise that the migrant populations may not practice FGM to the same level as their country of origin; a migrant's reason for being in the UK may well be avoidance of FGM and second and third generation migrant populations may have very different attitudes towards FGM than their parents. However that same second or third generation may often be the children or adults at greatest risk of having the procedure carried out.

7. Religion and FGM

Muslim scholars have condemned the practice and are clear that FGM is an act of violence against women. Furthermore, scholars and clerics have stressed that Islam forbids people from inflicting harm on others and therefore most will teach that the practice of FGM is counter to the teachings of Islam. However, many communities continue to justify FGM on religious grounds. This is evident in the use of religious terms such as "sunnah" that refer to some forms of FGM (usually Type I).

FGM is not practised amongst many Christian groups except for some Coptic Christians of Egypt, Sudan, Eritrea and Ethiopia. The Bible does not support this practice nor is there any suggestion that FGM is a requirement or condoned by Christian teaching and beliefs. FGM has also been practiced amongst some Bedouin Jews and Falashas (Ethiopian Jews) and again is not supported by Judaic teaching or custom.

8. Health Impact

FGM has NO health benefits, and it causes harm in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies.
Many women appear to be unaware of the relationship between FGM and its health consequences; in particular the complications affecting sexual intercourse and childbirth which can occur many years after the mutilation has taken place.

8.1 Health Impact Complications Are Common and Can Lead to Death

The highest maternal and infant mortality rates are in FGM-practicing regions. The actual number of girls who die as a result of FGM is not known. However, in areas of Sudan where antibiotics are not available, it is estimated that one-third of the girls undergoing FGM will die.

8.2 Immediate Physical Problems

- Intense pain and/or haemorrhage that can lead to shock during and after the procedure;
- Occasionally death;
- Haemorrhage that can also lead to anaemia;
- Wound infection, including tetanus. Tetanus is fatal in 50 to 60 percent of all cases;
- Urine retention from swelling and/or blockage of the urethra;
- Injury to adjacent tissues;
- Fracture or dislocation as a result of restraint;
- Damage to other organs.

8.3 Long-term Health Implications

In the UK, girls and women affected by FGM will manifest some of these long term health complications. They may range from mild to severe and can be chronic.

- Excessive damage to the reproductive system;
- Uterine, vaginal and pelvic infections;
- Infertility;
- Cysts;
- Complications with menstruation;
- Psychological damage; including a number of mental health and psychosexual problems,

e.g. depression, anxiety, post traumatic stress, fear of sex.

- Abscesses;
- Sexual dysfunction;
- Difficulty in passing urine;
- Increased risk of HIV transmission/Hepatitis B/C – using same instruments on several girls;
- Increased risk of maternal and child morbidity and mortality due to obstructed labour. Women who have undergone FGM are twice as likely to die during childbirth and are more likely to give birth to a stillborn child than other women. Obstructed labour can also cause brain damage to the infant and complications for the mother (including fistula formation, an abnormal opening between the vagina and the bladder or the vagina and the rectum, which can lead to incontinence).

9. FGM- Possible Indicators

9.1 Indicators of Risk

There are factors that may indicate a child may be at risk of FGM. As with all other aspects of safeguarding they may form part of a collective picture of concern. For example if:

- the family originates from a community known to practice FGM and / or information is shared of intention to travel to their country of origin;
- a parent requests permission for a child to travel oversees for an extended period during the academic year;
- a parent seeks to withdraw their child from learning about FGM in school;
- a child expresses anxiety about a special ceremony or traditional custom; another family member is known to have previously undergone FGM.

9.2 Indicators that FGM has taken place

- Difficulty walking, sitting or standing Prolonged absences from school/college

- Spending long periods away from the classroom/office with urinary or menstrual problems
- Reluctant to undergo medical examinations
- Noticeable changes in behaviour – FGM can result in post-traumatic stress
- Soreness, infection or unusual presentation when a nappy is changed
- Asking for help but not being explicit about the problem due to embarrassment or fear

10. Protective Legislation

FGM has been a criminal offence in the UK since The **Prohibition of Female Circumcision Act 1985.** The Act was repealed by **The FGM Act 2003** and closed a loophole which enabled victims to be taken outside of the jurisdiction for the purposes of FGM, without sanction. **The FGM Act 2003** made it unlawful for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where FGM is legal. The legislation was designed to prevent families and carers from taking girls abroad to undergo the procedure. The Act increased the maximum penalty for being found guilty of FGM from 5 to 14 years imprisonment. The **FGM Act 2003** also made it a criminal offence to re- infibulate following an FGM procedure.

There are new legislative measures being brought through the **Serious Crime Act 2015** which will strengthen the legislative framework around tackling FGM. The changes include introducing 'habitual UK resident' rather than 'permanent UK resident', and introducing FGM Protection Orders (similar to Forced Marriage Protection Orders).

FGM is considered to be a form of child abuse (it is categorised under the headings of both **Physical Abuse** and **Emotional Abuse**). A local authority may exercise its powers under **Section 47** of the Children Act 1989 if it has reason to believe that a child is likely to suffer or has suffered FGM. Under the Children Act 1989, local authorities can apply to the Courts for various Orders to prevent a child being taken abroad for mutilation.

FGM is also an abuse of female adults usually categorized under **Honour based violence** and **domestic abuse** definitions. Where a female adult is also defined as an **Adult at risk**, additional support mechanisms would be available through local social care teams and adult safeguarding processes.

Private law remedies can be used as a form of legal protection. For example a **Prohibited Steps Order** under Section 8 Children Act 1989 can be used to prevent a child being taken abroad or from having the procedure. A Non Molestation Order under Part IV of the Family Law Act 1996 may also be used as protection for the child or adult. The Domestic Violence Crime and Victims Act 2004 make the breach of a Non Molestation Order a criminal offence.

It may be possible for victims of FGM to claim compensation from the **Criminal Injuries Compensation Authority**. The injuries must be reported to the police.

The Police have **Police Protection** powers where there is reasonable cause to believe that a child or young person, under the age of 18 years, is at risk of **Significant Harm**. A police officer may (with or without the cooperation of social care) remove the child from the parent and use the powers for 'police protection' (section 46 of the Children Act 1989) for up to 72 hours.

The Local Authority has further powers under Section 44 of the Children Act 1989. Under this section, the Local Authority may apply for an **Emergency Protection Order** (EPO). The Order authorizes the applicant to remove the girl and keep her in safe accommodation for up to 8 days. This Order is often sought to ensure the short term safety of the child.

An EPO can be followed by an application from the Local Authority for a **Care Order**, **Supervision Order** or an Interim Order (sections 31 and 38 of the Children Act 1989). Without such an application, the EPO will lapse and the local authority will no longer have **Parental Responsibility** for the child.

There will be cases where a **Care Order** is not appropriate, possibly because of the age of the young person. A Local Authority may ask the Court to exercise its inherent jurisdiction to protect the young person.

Once a young person has left or been removed from the jurisdiction, the options available to police, Local Authority and other services become more limited. In such situations an application may be made to the High Court to make the young person a **Ward of Court** and have them returned to the UK.

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.

International legislation

There are two international conventions containing articles which can be applied to FGM. Signatory states, including the UK, have an obligation under these standards to take legal action against FGM. These include **The UN Convention on the Rights of the Child** and **The UN Convention on the Elimination of All Forms of Discrimination against Women**. FGM breaches several of these rights.

11. Safeguarding: Procedure for Safeguarding Children from FGM within

See also **Keeping Children Safe in Education** 2023

11.1 Teachers, other school staff, volunteers may become aware that a female is at risk of FGM) through a parent / other adult, a child or other children disclosing that:

- The procedure is being planned;
- An older child or adult in the family has already undergone FGM.
- A professional, volunteer or community group member who has information or suspicions that a female is at risk of FGM should consult with their agency or group's designated safeguarding adviser (if they have one) and should make an immediate referral via their local safeguarding procedures and notify the Police

The Referral should not be delayed in order to consult with the designated safeguarding adviser, a manager or group leader, as multi-agency safeguarding intervention needs to happen quickly.

Once concerns are raised about FGM there should also be consideration of possible risk to other females in the practicing community.

Regulated professionals i.e. teachers, social workers and healthcare professionals have a duty under the Serious Crime Act (2015) to report any cases of FGM identified in a female less than 18 years of age to the police via the non-emergency number: 101

11.2 FGM- Visually Identified Cases

The reporting duty for visually identified cases only applies to cases discovered in the usual course of a professional's work. If genital examinations are not undertaken in the course of delivering a role, then the duty does not change this.

Most professionals will visually identify FGM as a secondary result of undertaking another action.

There are no circumstances in which our staff should examine a girl. It is possible however that a teacher (applying the definition stated earlier) may see something which appears to show that FGM may have taken place e.g. changing a nappy, assisting toileting, SEN intimate care needs. In such circumstances, the teacher must make a report under the duty, but should not conduct any further examination of the child.

11.3 FGM- Verbal Disclosure

As with all safeguarding disclosures, it is not the duty of staff to interrogate or investigate whether FGM has been carried out. Staff should be aware that the girl may use alternative words or references rather than the specific term Female Genital Mutilation or FGM e.g. cut, cutting. To help enable the girl to share information staff should:

- Find a quiet place to talk;
- If asked not to tell anyone explain your safeguarding duty;
- Maintain a calm appearance and open posture;
- Allow time – let the girl talk freely without leading the conversation;
- Listen carefully and accurately;
- Wherever possible use the girl's description to clarify any disclosure e.g. 'you said "special ceremony"- what did you mean?
- Reassure telling was the right thing to do. The professional's responsibility to report to the Police only applies when the victim makes a **direct verbal disclosure**. If another person makes an indirect disclosure about a girl the mandatory duty to report to the police does not apply. Such disclosures will be handled in line with our usual processes for safeguarding concerns

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12. FGM- Making a Report to the Police

12.1 Reports under the mandatory duty will be made as soon as possible after a case is discovered, best practice being by the close of the next working day. The legislation requires the professional to report to the police force area within which the girl resides. Reports will usually be made orally by calling the single non-emergency number 101, although written reports are also permitted. The professional will be required to share the following information:

- An explanation of why they are making a report under FGM duty;
- Their details- name, place of work, role, contact details and availability;
- Contact details of the Headteacher – Mrs Joy McCallum and Designated Safeguarding Leads – Miss Jen Jordan and Mrs Jen Sim.
- The girl's details- name, age, date of birth and address.

The Police will issue a reference number which will be recorded in our safeguarding record. The record will include details of the discussion and any decisions made.

12.2 FGM- Action Following a Report to the Police

In line with safeguarding best practice the girl's parents or guardians will be informed that a report has been made to the Police **unless this action is deemed to put the girl or anyone else at risk**. This will be discussed with school's safeguarding lead. All further action taken will be in line with our general safeguarding responsibilities, which may involve participating in a multiagency response.

13. FGM- Failure to Comply with the Duty

Failure to comply with mandatory FGM reporting to the Police is dealt with by the performance measures in place for each profession and through staff disciplinary procedures. Should the school dismiss a teacher, or if a teacher resigns before dismissal occurs, the Governing Body may refer the matter to the National College of Teaching and Leadership (NCTL), as regulators of the teaching profession. The result of such referral may result in fitness to practice proceedings and affect teaching registration.

14. The Role of the Head Teacher

- It is the Head Teacher's role to implement the school's FGM Policy with the support of the Senior Leadership Team and Governing Body;
- It is the Head Teacher's role to ensure there is a collective responsibility for safeguarding and that all staff and volunteers are aware of the FGM policy and related policies, protocols and procedures;
- The Head Teacher will ensure staff members with named responsibility for child protection have a clear understanding of school's FGM policy and receive training in order to support staff and volunteers;
- The Head Teacher will promote FGM Duty when overseeing the development of the curriculum and all other aspects of school life;

15. The role of all staff: teaching and non-teaching

- All staff will be made aware of and have access to school's FGM Policy, protocols and procedures;
- All staff will attend annual safeguarding and FGM training which will include guidance on implementing FGM reporting duties;
- All staff will strive to safeguard pupils in all aspects of the FGM agenda;
- As with all aspects of safeguarding, teachers will support teaching assistants, support staff and volunteers working in their classrooms or on educational visits;
- All staff have a responsibility to monitor and, where necessary, guide the practice of volunteers, visitors or contractors working in school. Any concerns will be reported to the Head Teacher or Deputy Head Teacher.

16. Curriculum delivery

A wide range of safeguarding topics is delivered through school's core and enhanced curriculum. This includes Personal Social Health Education (PSHE) and pastoral support/intervention. Details of curriculum content are regularly shared with parents/guardians who are actively encouraged to support their child's learning. Where appropriate, multi-agency partners support this delivery.

17. Support for Girls and Women Affected by FGM

There are two main areas of support that should be offered to all women and girls affected by FGM
-,Counselling, and de-infibulation for type III.

Counselling

Girls and women suffering from anxiety, depression or who are traumatised as a result of FGM should be offered counselling and other forms of therapy. All girls and women who have been undergone FGM should be offered counselling to discuss how deinfibulation will affect them.
Parents, husbands boyfriends, partners can also be offered counselling.

De-Infibulation/Reversal

This is a small procedure to open the scar carried out in a specialist clinic usually under local anaesthetic. The skin will be stitched at either side of the scar to keep it from healing together again and will usually heal very quickly. This should enable normal intercourse and child birth and reduce the number of infections a girl/woman may suffer. It does not replace tissue that has been removed and more scar tissue may form but it can improve a female's quality of life. Please see

FGM SPECIALIST HEALTH SERVICES IN ENGLAND AND WALES

For an up to date list of FGM Clinics, please click the link below and then go to 'Download a list of all available clinics'.

http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Pages/fgm-health-services-for-women.aspx

In light of this information Sacred Heart have decided to take proactive action to protect and prevent our girls being forced to undertake FGM. The Headteacher and Governors do this in 4 ways:

1. A robust Attendance Policy that does not authorise holidays, extended or otherwise, unless in exceptional circumstances and with evidence of reason where possible.

2. FGM training for all staff at the front line dealing with the children (all our staff are Safeguard Trained)

3. Comprehensive PSHE and Relationship and Sex Education delivered to children around Keeping Safe at the appropriate age.

In order to protect our children it is important that key information is known by all of the school community.

Indications that FGM has taken place:

- Difficulty walking, sitting or standing.
- Prolonged absences from school.
- Spending long periods away from the classroom/office with urinary or menstrual problems.
- Reluctant to undergo medical examinations.
- Noticeable changes in behaviour – FGM can result in post-traumatic stress.
- Soreness, infection or unusual presentation when using the toilet.
- Asking for help but not being explicit about the problem due to embarrassment or fear.

Indications that a child is at risk of FGM:

- The family comes from a community known to practice FGM - especially if there are elderly women present.
- In conversation a child may talk about FGM.
- A child may express anxiety or excitement about a special ceremony.
- The child may talk or have anxieties about forthcoming holidays to their country of origin.
- Parent/Guardian requests permission for authorised absence for overseas travel or you are aware that absence is required for vaccinations.

If a woman has already undergone FGM – and it comes to the attention of any professional, consideration needs to be given to any Child Protection implications e.g. for younger siblings, extended family members and a referral made to Social Care or the Police.

Referring concerns to the Designated Safeguarding Team

Should you have any concerns that a child is at risk of or has been subject to FGM you must immediately refer it to the designated Safeguarding Lead Joy McCallum. In her absence speak to the Deputy Designated Leads Jen Jordan or Jen Sim.

Appendix 1: Guidance for Interviewing Parents/Children/Adult at risk

Ask

These questions and advice are guidance and each case should be dealt with sensitively and considered individually and independently.

If relevant ask children/Adult at risk to tell you about their holiday. Sensitively and informally ask the family about their planned extended holiday ask questions like;

Who is going on the holiday with the child/adult?

How long they plan to go for and is there a special celebration planned?

Where are they going?

Are they aware that the school cannot keep their child on roll if they are away for a long period?

Are they aware that FGM including Sunna is illegal in the U.K even if performed abroad? Use term that may be familiar with as FGM may not always be understood.

If you suspect that a child / adult is a victim of FGM you may ask them;

Your family is originally from a country where girls or women are circumcised – Do you think you have gone through this or at risk of this practice?

Has anything been done to you down there or on your bottom?

Would you like support in contacting other agencies for support, help or advice?

Inform them that you have to share information confidentially with relevant agencies if you are concerned that they or someone else is at risk of being harmed.

Record

All interventions should be accurately recorded by the persons involved in speaking with the child or adult. All recording should be dated and signed and give the full name and role of the person making the recording.

Refer

To Public Protection and Investigation Unit, Social Care or Health/Voluntary sector for medical follow up or support services.

Appendix 2: Useful Contacts

Third Sector Agencies Working With FGM

Foundation for Women's Research and Development (FORWARD)

Tel: 0208 960 4000

Email: **forward@forwarduk.org.uk**

The NSPCC 24hour helpline to protect children and young people affected by FGM

Tel: 0800 028 3550

Childline

24 hour helpline for children: 0800 1111

National 24 hour Domestic Violence Helpline

24-hour Helpline: 0808 2000 247

Home Office

https://www.gov.uk/government/collections/female-genital-mutilation

Statutory Agencies Working with FGM

Local Authority referral points for children across Merseyside

Merseyside Police

Refer to your local Police Force**FGM Clinics**

There are several specialist FGM clinics in many large UK cities. Some are linked to an antenatal clinic; others may be within a community clinic or GP surgery. All of these clinics are NHS clinics and therefore free of charge. Most clinics are run by specially trained doctors, nurses, or midwives.

A point to note is that some victims may not want to use local clinics due to fear of being recognised by local community.

How to access an FGM clinic

If you wish to go to refer to any of the clinics, you should check if a GP referral, is required as most clinics do not do not take self-referrals. If the woman is pregnant, a midwife may be able to refer.

Multi-Cultural Antenatal Clinic – Liverpool Women's Hospital

Crown Street

Liverpool L8 7SS

Tel: 0151 702 4180 or 0151 702 4178

Mobile: 07717 516134

Open: Monday-Friday 8.30am-4.30pm

Contact: Joanne Topping

Link Clinic held on a Monday between 9am and 1.30pm.

http://www.liverpoolwomens.nhs.uk/Our_Services/Maternity/Specialist_antenatal_clinics.aspx

St Mary's Hospital – Gynaecology & Midwifery Departments

Dr Fiona Reid MD MRCOG
Consultant Urologist
The Warrell Unit
St Mary's Hospital
Manchester

St Mary's Hospital Consultant Paediatric Gynaecologist

Dr Gail Busby
Tel 44 (0) 161 276 1234

Email: **Gail.busby@cmft.nhs.uk**

ORGANISATIONS WORKING ON ISSUES ON AROUND FGM

POLICE SERVICE

Metropolitan Police Service / Project Azure
020 7161 2888

UK GOVERNMENT

https://www.gov.uk/female-genital-mutilation

HELPLINES

National Society for the Prevention of Cruelty to Children (NSPCC) FGM Helpline
24 –hour Helpline. Free phone 0800 028 3550
www.nspcc.org.uk/fgm

Black Association of Women Step Out (BAWSO)
24-hour Helpline: 0800 731 8147
www.bawso.org.uk

ChildLine
24-hour Helpline for children: 0800 1111
www.childline.org.uk

National Domestic Violence Helpline
24-hour Helpline: 0808 2000 247
www.nationaldomesticviolencehelpline.org.uk

NSPCC British Sign Language Helpline for deaf or hard-of-hearing callers
ISDN videophone: 020 8463 1148
Webcam: nspcc.signvideo.tv (available Monday – Friday, 9am – 5pm, in English language only)
Text: 0800 056 0566

OTHER ORGANISATIONS

28 Too Many
http://28toomany.org/

Africans Unite Against Child Abuse (AFRUCA)
http://www.afruca.org/

Agency for Culture and Change Management UK (ACCM UK)
http://www.accmuk.com/

Birmingham & Solihull Women's Aid
http://bswaid.org/

Foundation for Women's Health Research & Development (FORWARD)
http://www.forwarduk.org.uk/

Halo Project
http://www.haloproject.org.uk/

Manor Gardens Health Advocacy Project
http://www.manorgardenscentre.org/

The Maya Centre
www.mayacentre.org.uk

For more organisations and local services, please visit
https://www.gov.uk/female-genital-mutilation

Black Association of Women Step Out (BAWSO)

Wrexham Office
33 Grosvenor Road
Wrexham
LL11 1BT

Tel: 01978 355 818
Fax: 01978 355 707

http://www.bawso.org.uk/contact-us/wrexham-2/

Appendix 3: Glossary

Angurya cuts: A form of FGM type 4 that involves the scraping of tissue around the vaginal opening.

The term "**closed**" refers to type 3 FGM where there is a long scar covering the vaginal opening. This term is particularly understood by the Somali and Sudanese communities

Infibulation is derived from the name given to the Roman practice of fastening a 'fibular' or 'clasp' through the large lips of a female genitalia (usually within marriage) in order to prevent illicit sexual intercourse.

Re-infibulation (sometimes known as or referred to as reinfibulation **or** re-suturing): The re-stitching of FGM type 3 to re-close the vagina again after childbirth (illegal in the UK as it constitutes FGM).

Sunna: the traditional name for a form of FGM that involves the removal of the prepuce of the clitoris only. The word 'sunna' refers to the 'ways or customs' of the prophet Muhammad considered to be religious obligations (wrongly in the case of FGM). Studies show, however, that the term 'sunna' is often used in FGM practicing communities to refer to all forms of FGM, not just FGM that involves only the removal of the hood of the clitoris

Adult at risk: The safeguarding Guidance within the Care Act 2014 (Chapter 14) replaces the 'No Secrets' Guidance (2000) regarding an adult at risk.

Under the Care Act 2014 safeguarding duties apply to an adult who:

- Has need for care and support (whether or not the local authority is meeting any of those needs) and
- Is experiencing, or at risk of , abuse or neglect; and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

Female Genital Mutilation (FGM) Safeguarding Risk Assessment Guidance

Introduction

The aim is to help make an initial assessment of risk, and then support the on-going assessment of women and children who come from FGM practising communities (using parts 1 to 3). For a list of communities where FGM is prevalent please see part 6.

INTRODUCTORY QUESTIONS:–

(1) Do you or your partner come from a community where cutting or circumcision is practiced? (See part 6 for map. Please remember you might need to consider that this relates to the patient's parent's country of origin; see part 7 for local terms).

(2) Have you been cut? It may be appropriate to use other terms or phrases.

If you answer YES to questions (1) or (2) please complete one of the risk templates.

PART ONE:– For an adult woman (18 years or over)

(a) PREGNANT WOMAN – ask the introductory questions.

If the answer is YES to either question, use part 1(a) to support your discussions.

(b) NON-PREGNANT WOMAN where you suspect FGM.
For example if a woman presents with physical symptoms or emotional behaviour that triggers a concern (e.g. frequent urinary tract infections, severe menstrual pain, infertility, symptoms of PTSD such as depression, anxiety, flashbacks or reluctance to have genital examination etc., see part 5); or if FGM is discovered through the standard delivery of healthcare (e.g. when placing a urinary catheter, carrying out a smear test etc.), ask the introduction questions.

If the answer is YES to either question, use part 1(b) to support your discussions.

PART TWO:– For a CHILD (under 18 years)

Ask the introductory questions (see above) to either the child directly or the parent or legal guardian depending upon the situation.

If the answer to either question is yes OR you suspect that the child might be at risk of FGM, use part 2 to support your discussions.

PART THREE:– For a CHILD (under 18 years)

Ask the introductory questions (see above) to either the child directly or the parent or legal guardian depending upon the situation.

If the answer to either question is yes OR you suspect that the child has had FGM (see part 5), use part 3 to support your discussions.

In all circumstances:

- The woman and family must be informed of the law in the UK and the health

consequences of practising FGM.

- Ensure all discussions are approached with due sensitivity and are non-judgmental.
- Any action must meet all statutory and professionals responsibilities in relation to safeguarding, and be in line with local processes and arrangements.
- Using this guidance does not replace the need for professional judgement in relation to the circumstances presented.

GUIDANCE

The framework is designed to support healthcare professionals to identify and consider risks relating to female genital mutilation, and to support the discussion with the patient and family members.

It should be used it to help assess whether the patient you are treating is either at risk of harm in relation to FGM or has had FGM, and whether your patient has children who are potentially at risk of FGM, or if there are other children in the family/close friends who might be at risk.

If when asking questions based on this guide, any answer gives you cause for concern, you should continue the discussion in this area, and consider asking other related questions to further explore this concern. Please remember either the assessment or the information obtained must be recorded within the patient's healthcare record. The templates also require that you record when and by whom it and at what point in the patient's pathway this has been completed.

Having used the guide, you will need to decide:

- Do I need to make a referral through my local safeguarding processes, and is that an urgent or standard referral?
- Do I need to seek help from my local safeguarding lead or other professional support before making my decision? Note, you may wish to consult with a colleague at a Multi- Agency Safeguarding Hub, Children's Social Services or the local Police Force for additional support.
- If I do not believe the risk has altered since my last contact with the family, or if the risk is not at the point where I need to refer to an external body, then you must ensure you record and share information about your decision accordingly.

An URGENT referral should be made, out of normal hours if necessary, if a child or young adult shows signs of very recently having undergone FGM. This may allow for the police to collect physical evidence.

An urgent referral should also be made if the healthcare professional believes that there are plans perhaps to travel abroad which present a risk that a child is imminently likely to undergo FGM if allowed to leave your care.

In urgent cases, Children's Social Services and the Police will consider what action to take. One option is to take out an Emergency Child Protection Order. If required, an EPO is an order made under Section 44 of the Children Act 1989 enabling a child to be removed to a place of safety where there is evidence that the child is in "imminent danger".

In many other situations if a child or young adult under 18 years of age is discovered to have had FGM, it should be reported to the Police via the 101 non –emergency number. The police will refer through local safeguarding processes for Children's Social Care and it is likely that this can be made during normal working hours and standard procedures, when the risk presented does not have an imminent or urgent element identified.

Part 2: CHILD/YOUNG ADULT (under 18 years old)

This is to help when considering whether a child is AT RISK of FGM, or whether there are other children in the family for whom a risk assessment may be required.

Indicator	Yes	No	Details
CONSIDER RISK			
Child's mother has undergone FGM			
Other female family members have had FGM			
Father comes from a community known to practice FGM			
A Family Elder such as Grandmother is very influential within the family and is/will be involved in the care of the girl			
Mother/Family have limited contact with people outside of her family			
Parents have poor access to information about FGM and do not know about the harmful effects of FGM or UK laww			
Parents say that they or a relative will be taking the girl abroad for a prolonged period – this may not only be to a country with high prevalence, but this would more likely lead to a concern			
Girl has spoken about a long holiday to her country of origin/another country where the practice is prevalent			
Girl has attended a travel clinic or equivalent for vaccinations/anti-			
FGM is referred to in conversation by the child, family or close friends of the child (see Appendix Three for traditional and local terms) – the context of the discussion will be important			
Sections missing from the Red book. Consider if the child has received immunisations, do they attend clinics etc			
Girl withdrawn from PHSE lessons or from learning about FGM - School			
Girls presents symptoms that could be related to FGM – continue with questions in part 3			
Family not engaging with professionals (health, school, or other)			

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Any other safeguarding alert already associated with the Always check whether family are already known to social care			

Indicator	Yes	No	Details
SIGNIFICANT OR IMMEDIATE RISK			
A child or sibling asks for help			
A parent or family member expresses concern that FGM may be carried out on the child			
Girl has confided in another that she is to have a 'special procedure' or to attend a 'special occasion'. Girl has talked about going away 'to become a woman' or 'to become like my mum and sister'			
Girl has a sister or other female child relative who has already undergone FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM should be reported to the police via 101 non-emergency number: The police will then refer to social services..

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Part 3: CHILD/YOUNG ADULT (under 18 years old)

This is to help when considering whether a child HAS HAD FGM.

Date: ____________ Completed by: _______________

Initial/On-going Assessment

Indicator	Yes	No	Details
CONSIDER RISK			
Girl is reluctant to undergo any medical examination			
Girl has difficulty walking, sitting or standing or looks uncomfortable			
Girl finds it hard to sit still for long periods of time, which was not a problem previously			
Girl presents to GP or A & E with frequent urine, menstrual or stomach problems			
Increased emotional and psychological needs eg withdrawal, depression, or significant change in behaviour			
Girl avoiding physical exercise or requiring to be excused from PE lessons without a GP's letter			
Girl has spoken about having been on a long holiday to her country of origin/another country where the practice is prevalent			
Girl spends a long time in the bathroom/toilet/long periods of time away from the classroom			
Girl talks about pain or discomfort between her legs			

SIGNIFICANT OR IMMEDIATE RISK			
Girl asks for help			
Girl confides in a professional that FGM has taken place			
Mother/family member discloses that female child has had FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM should be reported to the police via 101 non-emergency number. The police will then refer to social services.

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/Police/MASH, in accordance with your local safeguarding procedures.

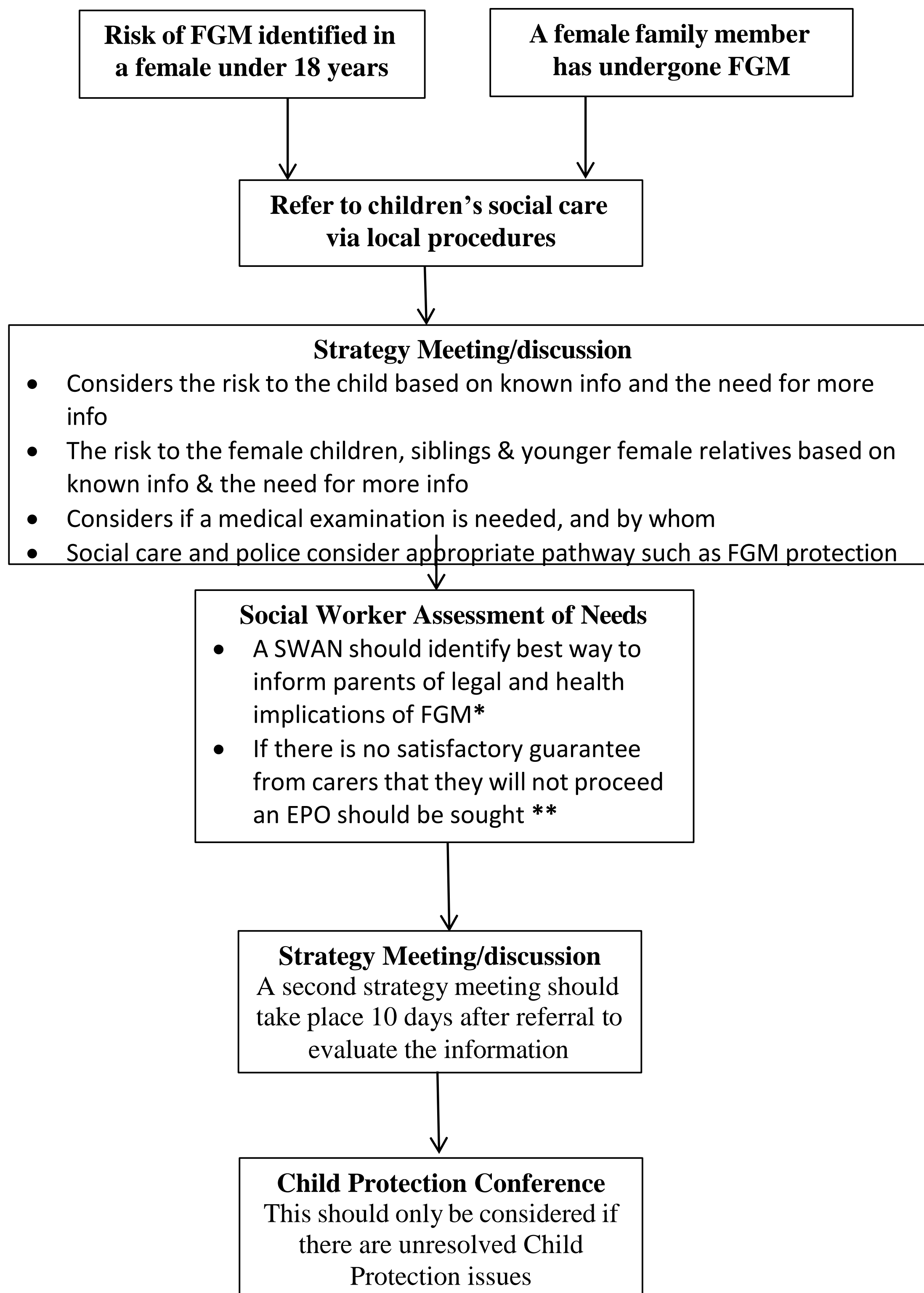
If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Appendix 5: Decision-making and Action Flowchart for Safeguarding Children

RISK OF FGM



* Assess the potential risk to any female children in the family

** If any legal action considered legal advice must be sought

Appendix 6: Decision-making and Action Flowchart for Safeguarding Children

ACTUAL FGM