

Waltham Forest

Local Safeguarding Children Board

Female Genital Mutilation Protocol For Children and Young People

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Waltham Forest Primary Care Trust have worked collaboratively with Waltham Forest Local Safeguarding Children Board (LSCB) to develop practice guidelines to aid professional work to safeguard children who may be subject to or suffering the effects of Female Genital Mutilation.

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FEMALE GENITAL MUTILATION.

1 INTRODUCTION

Female Genital Mutilation (FGM) is much more common than most people realise, both worldwide, and in the UK. With migration to Western countries from areas where FGM is practised, it is increasingly found in immigrant communities in the United States, Canada, Europe, and Australia (World Health Organisation 1997).

The World Health Organisation estimated that between 130-140,000,000 girls and women have experienced FGM and up to three million girls per year undergo some form of the procedure each year (UNICEF 2005).

It is practised in over 28 African countries, parts of the Middle and Far East. There are substantial populations from countries where FGM is endemic in London, Liverpool, Birmingham, Sheffield and Cardiff but it is likely that communities in which FGM is practised reside throughout the UK.

The following countries have the highest incidence of FGM: Djibouti (98%), Egypt (97%), Eritrea (95%), Guinea (99%), Mali (94%), Sierra Leone (90%), and Somalia (98-100%) (WHO 2001).

To respond to increasing diversity within the Borough, Waltham Forest Local Safeguarding Children Board has produced this protocol to aid professional decision making in order to safeguard and promote the welfare of children.

1.1 EQUALITY AND DIVERSITY STATEMENT

This protocol affects a group of young people who are particularly vulnerable. Any decisions or plans for these children/young people need to be based on good quality assessments and be sensitive to the issues of race, culture, gender, religion and sexuality, so far as not to stigmatise the child or the practising community.

2 PRINCIPLES

- 2.1.1 Female Genital Mutilation is illegal and is prohibited by the **Female Genital Mutilation Act 2003**.
- 2.1.2 It is acknowledged that some families see FGM as an act of love rather than cruelty, however, FGM causes significant harm both in the short and long term and constitutes physical and emotional abuse to children
- 2.1.3 Accessible, acceptable and sensitive Health, Education, Police, Social Services and Voluntary Sector services must underpin the protocol.
- 2.1.4 All agencies should work in partnership with members of local communities, to empower individuals to develop support networks and education programmes.
- 2.1.5 The Rights of the Child as stated in the UN Convention (1989) will underpin this protocol.

3 LEGISLATION

3.1 International Standards

- 3.1.1 Legislation against FGM in the UK includes both international standards and national legislation.
- 3.1.2 There are two international conventions, which contain articles, which can be applied to FGM. Signatory states, including the UK, have an obligation under these standards to take legal action against FGM.
- 3.1.3 **The UN Convention on the Rights of the Child**, ratified by the UK Government on 16th December 1991, was the first binding instrument explicitly addressing harmful traditional practices as a human rights violation. It specifically requires Governments to take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
- 3.1.4 **The UN Convention on the Elimination of All Forms of Discrimination against Women**, which came into force in 1981, recognises FGM as a form of gender based violence against women. It calls on signatory Governments to take appropriate and effective measures with a view to eradicating the practice, including introducing appropriate health care and education strategies.
- 3.1.5 These conventions have been strengthened by two world conferences. **The International Conference on Population and Development** (ICPD, Cairo, September 1994) mentioned and condemned FGM specifically in several of its articles. **The World Conference on Women** (Beijing 1995) also condemned FGM and called upon Governments to actively support programmes to stop it.

3.2 United Kingdom Legislation

- 3.2.1 In the UK, all forms of FGM are illegal under the **Female Genital Mutilation Act 2003**. A person is guilty of an offence if he, excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris except for operations performed on specific physical and mental health grounds by registered medical or nursing practitioners. Other offences described in the Act (see Appendix 1) are:

- Assisting a girl to mutilate her own genitalia
- Assisting a non-UK person to mutilate a girl's genitalia overseas

FGM is an offence, which extends to acts performed outside of the United Kingdom. Any person found guilty of an offence under the Act will be liable to a fine or imprisonment up to 14 years, or both.

- 3.2.2. FGM is considered to be a form of child abuse as it is illegal and is performed on a child who is unable to resist or give informed consent. **Working Together to Safeguard Children (HM Government 2006)**, states that 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.

This protocol reflects information available in **London Child Protection Procedures** (Edition 2, 2003 pp 150 - 152).

4 DEFINITION

- 4.1 “FGM constitutes all procedures which involve partial or total removal of the external female genitalia or injury to the female genital organs whether for cultural or other non-therapeutic reasons” (WHO, 1996)
- 4.2 The specific form that FGM takes varies from one country to another and there are difficulties associated with any classification. There is significant variation in the extent of the cutting because of the poor conditions in which it is carried out. **Girls and women may not know the type they have experienced.**
- 4.3 FGM (see glossary for other terms) is a traditional practice. The World Health Organisation (WHO) is currently reviewing the 1997 classification in collaboration with UNICEF, UNFPA and UNIFEM (see glossary of terms). The new version identifies 5 types of FGM. (UNICEF 2005):
- a) **Type i**
Refers to excision of the prepuce with partial or total excision of the clitoris (clitoridectomy).
 - b) **Type ii**
Refers to partial or total excision of the labia minora (small lips which cover and protect the opening of the vagina and the urinary opening), including the stitching or sealing of it, with or without the excision of part or all of the clitoris.
 - c) **Type iii (Infibulation)**
Indicates excision of part or most of the external genitalia and stitching/narrowing or sealing of the labia majora- often referred to as “infibulation”. The two sides of the vulva are sewn together with silk, catgut sutures, or thorns leaving only a very small opening to allow for the passage of urine and menstrual flow. This opening is often preserved during healing by insertion of a foreign body.
 - d) **Type vi**
Makes specific reference to a range of miscellaneous or unclassified practices, including stretching of the clitoris and or labia, cauterisation by burning of the clitoris and surrounding tissues, scraping of the tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts), and the introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of FGM given above.
 - e) **Type v**
Refers to the symbolic practices that involve the nicking or pricking of the clitoris to release a few drops of blood

5 CONSEQUENCES OF FEMALE GENITAL MUTILATION

- 5.1.1 Many women appear to be unaware of the relation between FGM and its health consequences; in particular the complications affecting sexual intercourse and childbirth which occur many years after the mutilation has taken place.
- 5.1.2 **Short-term health implications**
- a) Severe pain and shock
 - b) Haemorrhage

- c) Wound infections including Tetanus and blood borne viruses (including HIV, Hepatitis B and C);
- d) Urinary retention;
- e) Injury to adjacent tissues;
- f) Fracture or dislocation as a result of restraint;
- g) Damage to other organs
- h) Death

5.1.3 Long term health implications

- a) Chronic vaginal and pelvic infections;
- b) Difficulties in menstruation;
- c) Difficulties in passing urine and chronic urine infections
- d) Renal impairment and possible renal failure
- e) Damage to the reproductive system including infertility;
- f) Infibulation cysts, neuromas and keloid scar formation;
- g) Complications in pregnancy and delay in the second stage of childbirth;
- h) Maternal or fetal death
- i) Psychological damage; including a number of mental health and psychosexual problems including depression, anxiety, and sexual dysfunction
- j) Increased risk of HIV and other sexually transmitted infections.

6 THRESHOLDS FOR REFERRAL AND RISK ASSESSMENT

6.1 Professionals need to be aware of the possibility of FGM. The following are potential indicators that FGM may take place. Professionals should be vigilant at all times to the following:

- The family comes from a community that is known to practise FGM. E.g. Somalia, Sudan and other African countries. (See introduction). It may be possible that they will practice FGM if a female family elder is present in the family network.
- Any female child born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family
- Parents state that they or a relative will take the child out of the country for a prolonged period.
- A child may talk about a long holiday to her country of origin or another country where the practice is prevalent, including African countries and the Middle East.
- The child may confide to a professional that she is to have a 'special procedure' or to attend a special occasion.
- Reference to FGM/Circumcision is heard in conversation, for example a child may request help from a teacher or another adult.
- Individually these thresholds may not indicate risk but if there are two or more present this could signal risk to the child.

6.2 Indications that Female Genital Mutilation may have already taken place include:

- A child may spend long periods of time away from the classroom during the day with bladder or menstrual problems.
- There may be prolonged absences from school.
- A prolonged absence from school with noticeable behaviour changes on the girl's return could be an indication that a girl has recently undergone FGM.
- At antenatal booking the holistic assessment may identify women who have undergone FGM. Midwives and Obstetricians should then plan appropriate care for pregnancy and delivery (RCOG 2003, RCM 1998)
- Professionals also need to be vigilant to the needs of children who may/are suffering the adverse consequence of the practice;

6.3 Reasons given for continued Practice of Female Genital Mutilation

- Family honour;
- Custom and tradition;
- Hygiene and cleanliness;
- Preservation of virginity/chastity;
- Social acceptance especially for marriage;
- A mistaken belief that it is a religious requirement;
- A sense of group belonging.

7 PROCEDURES AND PRACTICE GUIDELINES

7.1 General

- 7.1.1 Educational and preventative programmes should seek to ensure that the genital mutilation of female children and young women does not occur. Professionals working in a diverse community must always consider the issue of FGM in their work with service users and their families.
- 7.1.2 Staff who have responsibility for child protection work must be acquainted with child protection procedures and existing local preventative programmes relating to FGM.
- 7.1.3 At the first contact professionals must consider the cultural background of the girl/woman (see Introduction and Section 6).
- 7.1.4 If the service user is a woman who is circumcised, but at the contact has no children, educational and preventative advice and support must be given.
- 7.1.5 Consideration must also be given to any existing or future female children (see Section 6)
- 7.1.6 If FGM is suspected the child(ren) should be considered at risk of significant harm.
- 7.1.7 Any information or concern that a child is at immediate risk of, or has undergone, FGM should result in a child protection referral. FGM places a child at risk of significant harm and should result in a child protection referral to social services. Social Services will investigate (initially) under Section 47 of the Children Act (1989).
- 7.1.8 Professionals must work together to safeguard children and be aware of their obligations relating to the exchange of relevant information (see section 8).

- 7.1.9 If a referral is received concerning one child, consideration must be given to whether siblings are at similar risk. Once concerns are raised about FGM there should also be consideration of possible risk to other children in the practicing community.

7.2 Strategy Meeting

- 7.2.1 On receipt of a referral a strategy meeting must be convened within two working days, and should involve representatives from police, social services, education, health and voluntary services. Health providers or voluntary organisations with specific expertise must be invited; this must include a Community Health Advisor/Specialist Nurse from Waltham Forest Primary Care Trust African Well Women's Service. Consideration may also be given to inviting a legal advisor (LCPC Edition 2).
- 7.2.2 The strategy meeting must first establish if either parents or child has had access to information about the harmful aspects of FGM and the law in the UK. If not, the parents/child should be given appropriate information regarding the law and harmful consequences of FGM.
- 7.2.3 Every attempt should be made to work with parents on a voluntary basis to prevent the abuse. It is the duty of the investigating team to look at every possible way that parental co-operation can be achieved. However, the child's interest is always paramount.
- 7.2.4 Where there is no information to suggest that significant harm is imminent, the initial strategy meeting must make a decision to clarify all of the information about the family and the risk of harm, before taking any decision to continue with the formal child protection investigation. The information gathered during this initial assessment must then be considered at the review strategy meeting within 5 working days.
- 7.2.5 An interpreter/community advocate appropriately trained in all aspects of Female Genital Mutilation must be used in all interviews with the family, subject to their agreement. (Where agreement cannot be obtained, further legal advice should be sought) A female interpreter should be used and must not be a family relation (See Good Practice Guidelines for Social Work Staff).
- 7.2.6 If no agreement with the family is reached, the first priority is protection of the child and the least intrusive legal action should be taken to ensure the child's safety.
- 7.2.7 The primary focus is to prevent the child undergoing any form of FGM rather than removal from the family.

7.3 Children in immediate danger

- 7.3.1 Where there is good information that the child is being taken from the UK imminently (within 2 days), legal advice should be sought in order to consider taking action to prevent the child moving before the s47 enquiries have been carried out.
- 7.3.2 If the strategy meeting decides that the child is in immediate danger of mutilation and parents cannot satisfactorily guarantee that they will not proceed with it, then an emergency protection order should be sought.

7.4 If a child has already undergone FGM

- 7.4.1 If a child has already undergone FGM and this comes to the attention of any professional, a referral should be made to social services. A strategy meeting must be convened within two days. The strategy meeting will consider how, where and when the procedure was performed and the implication of this.

- 7.4.2 If the child has already undergone FGM the strategy meeting will need to consider carefully whether to continue enquiries or whether to assess the need for support services. Particular attention should be given to assessing the needs of any other girls in the family. If any legal action is being considered, legal advice must be sought.
- 7.4.3 A second strategy meeting should take place within ten working days of the referral, with the same chair. This meeting must evaluate the information collected in the enquiry and recommend whether a child protection conference is necessary. (LCPC 2003).
- 7.4.4 A girl who has already undergone FGM should not normally be subject to a child protection conference or registered unless additional child protection concerns exist. However, she should be offered counselling and medical help. Consideration must be given to any other female siblings at risk (see good practice guidelines for social services).
- 7.4.5 A child protection conference should only be considered necessary if there are unresolved child protection issues once the initial investigation and assessment have been completed.

7.5 If a woman has already undergone Female Genital Mutilation

- 7.5.1 If a woman has already undergone FGM and this comes to the attention of any professional, consideration needs to be given to any child protection implications e.g. for younger siblings, daughters or extended family members and a referral made to social services. These children should be considered children in need.
- 7.5.2 If the woman is the mother of a female child or has the care of female children, these children should be considered children in need. Subsequent initial and core assessments should identify the most appropriate way of informing parents of the legal and health implications of FGM and assessing the potential risk to female children in the family.

8 INFORMATION SHARING

Lord Carlisle in the Review of Safeguards for Children and Young People Treated in the NHS "Too Serious a Thing (2002)" stated that "There is nothing within the Caldicott Report, the Data Protection Act 1998 or the Human Rights Act 1998 which should prevent the justifiable and lawful exchange of information for the protection of children or the detection or prevention of Serious Crime"

8.1 The Legal Framework

- 8.1.1 Professionals can only work together to safeguard children if there is an exchange of relevant information between them. Any disclosure of personal information to others must always, however, have regard to both common and statute law.
- 8.1.2 Normally, personal information should only be disclosed to third parties (including other agencies) with the consent of the subject of that information. Wherever possible, consent should be obtained before sharing personal information with third parties. **In some circumstances, consent may not be possible or desirable but the safety and welfare of a child dictates that the information should be shared.**
- 8.1.3 The best way of ensuring that information sharing is properly handled is to work carefully within worked out information sharing protocols between the agencies and professionals involved, and taking legal advice in individual cases where necessary.
- 8.1.4 Health professionals may share information about a patient with another medical professional as part of providing care and treatment to that patient. This should be done in accordance with the common law duties of confidentiality, the Data Protection Act 1998 and

the Human Rights Act 1998. Particular regard should be had to all the Data Protection Principles. Any disclosure should be considered on a case-by-case basis and limited to disclosing the information that it is necessary to disclose for the medical care and treatment of the child. As a matter of practice seeking the consent of the parent on behalf of the child (where the child is not Fraser competent), should always be considered although where the safety of the child might be threatened by the disclosure such consent is not always necessary. Where there is any doubt legal advice about the particular circumstances should be sought.

8.2 The Common Law Duty of Confidence

- 8.2.2 Personal information about children and families held by professionals and agencies is subject to a legal duty of confidence, and should not normally be disclosed without the consent of the subject. However, the law permits the disclosure of confidential information necessary to safeguard a child or children in the public interest: that is, the public interest in child protection may override the public interest in maintaining confidentiality. Disclosure should be justifiable in each case, according to the particular facts of the case, and legal advice should be sought in cases of doubt.
- 8.2.3 Children are entitled to the same duty of confidence as adults, provided that, in the case of those under 16, they have the ability to understand the choices and the consequences relating to any treatment. In exceptional circumstances, it may be believed that a child seeking advice, for example on sexual matters, is being exploited or abused. In such cases, confidentiality may be breached, following discussion with the child.

8.3 The Data Protection Act

- 8.3.1 The Data Protection Act 1998 requires that personal information is obtained and processed fairly and lawfully; only disclosed in appropriate circumstances; is accurate, relevant and not held longer than necessary; and is kept securely. The Act allows for disclosure without the consent of the subject in certain conditions, including for the purposes of the prevention or detection of crime, or the apprehension or prosecution of offenders, and where failure to disclose would be likely to prejudice those objectives in a particular case (for further guidance see Data Protection Act 1998: protection and use of patient information (Department of Health, 1998). Legal advice should be sought where appropriate or in cases of doubt.

8.4 The European Convention on Human Rights

- 8.4.1 Article 8 of the European Convention on Human Rights states that:
1. Everyone has the right to respect for his private and family life, his home and his correspondence.
 2. There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.
- 8.4.2 Disclosure of information without consent might give rise to an issue under Article 8. Disclosure of information to safeguard children will usually be for the protection of health or morals, or the protection of the rights and freedoms of others, and for the prevention of disorder or crime. Disclosure should be appropriate for the purpose and only to the extent necessary to achieve that purpose. Legal advice should be sought where appropriate, or in cases of doubt.

8.5 Professional Guidance

8.5.1 **Medical:** The General Medical Council (GMC) has produced general guidance entitled Confidentiality: Protecting and Providing Information (2004). It emphasises the importance in most circumstances of obtaining a patient's consent to the disclosure of personal information, but makes clear that in their view information may be released to third parties – if necessary without consent – in certain circumstances. These circumstances include the following:

8.5.2 Children and other patients who may lack competence to give consent.

“Problems may arise if you consider that a patient is incapable of giving consent to treatment or disclosure because of immaturity, illness or mental incapacity. If such patients ask you not to disclose information to a third party, you should try to persuade them to allow an appropriate person to be involved in the consultation. If they refuse and you are convinced that it is essential, in their interests, you may disclose relevant information to an appropriate person or authority. In such cases you must tell the patient before disclosing any information, and, where appropriate, seek and carefully consider the views of an advocate or carer. You should document in the patient's record the steps you have taken to obtain consent and the reasons for deciding to disclose information” (paragraph 38).

“If you believe a patient to be a victim of neglect or physical, or sexual or emotional abuse, and that the patient cannot give or withhold consent to disclosure, you must give information promptly to an appropriate person or statutory agency, where you believe disclosure is in the patient's best interests. You should usually inform the patient that you intend to disclose the information before doing so. Such circumstances may arise in relation to children where concerns about possible abuse may need to be shared with other agencies such as social services. Where appropriate you should inform those with parental responsibilities about the disclosure. If, for any reason, you believe the disclosure is not in the best interests of the abused or neglected patient, you should discuss the issues with an experienced colleague. If you decide not to disclose information you must be prepared to justify your action”.

8.5.3 Disclosure to protect the patient or others

“Disclosure of personal information without consent may be justified where failure to do so may expose the patient or others to risk of death or serious harm. Where third parties are exposed to a risk so serious that it outweighs the patient's privacy interest, you should seek consent to disclose where practicable. If it is not practicable, you should disclose the information promptly to an appropriate person or authority. You should generally inform the patient before disclosing the information”.

8.5.4 The General Medical Council has confirmed that its guidance on the disclosure of information which may assist on the prevention or detection of abuse, applies both to information about third parties (for example adults who may pose a risk of harm to a child), and about children who may be the subject of abuse.

8.6 Nursing

8.6.1 The Nursing and Midwifery Council (NMC) produced **Guidelines for professional practice (1996)** which contained the following advice on providing information:

8.6.2 Disclosure of information occurs:

- With the consent of the patient or client;
- Without the consent of the patient or client when the disclosure is required by law or by order of a court; and

- Without the consent of the patient or client when disclosure is considered to be necessary in the public interest.

8.6.3 The public interest means the interest of an individual or groups of individuals or of society as a whole and would, for example, cover matters such as serious crime, child abuse, drug trafficking or other activities, which place other at serious risk (paragraph 55 – 56).

9 GATHERING INFORMATION, AND ASKING THE QUESTIONS

1. At the first contact, all health professionals must consider the cultural background of the girl/woman (see Introduction and Section 6).
2. If the girl/woman is from a community who traditionally practices FGM, a sensitive approach to information gathering must be used. Firstly the health professional must establish if the girl/woman has been circumcised. This will include the use of female interpreters. Consideration must be given to using appropriately trained female interpreters. This must not be a family member.

Women from practising communities will not be offended if they are asked sensitively whether they have been circumcised. It is important for the health and well being of the girl/woman to establish her status. Appropriate services can then be planned.

You may say:

“I understand that you are from a community that may practice Female Circumcision”

Then ask any of the list below:

Have you been cut?

Have you been circumcised?

Are you closed?

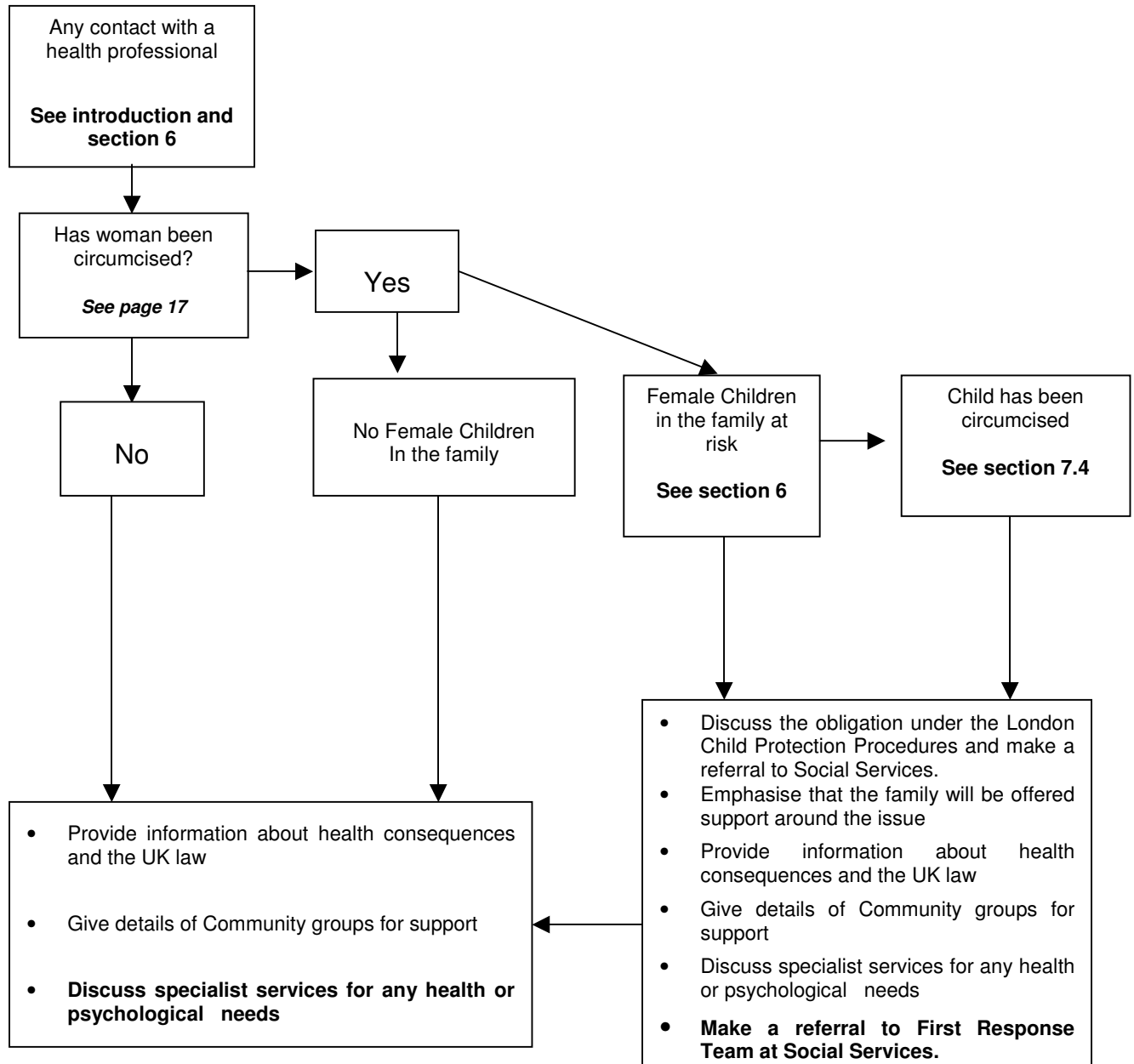
If the answer to these questions is **Yes** then you must refer to the main document for guidance.

APPENDICES

PROFESSIONAL GUIDANCE

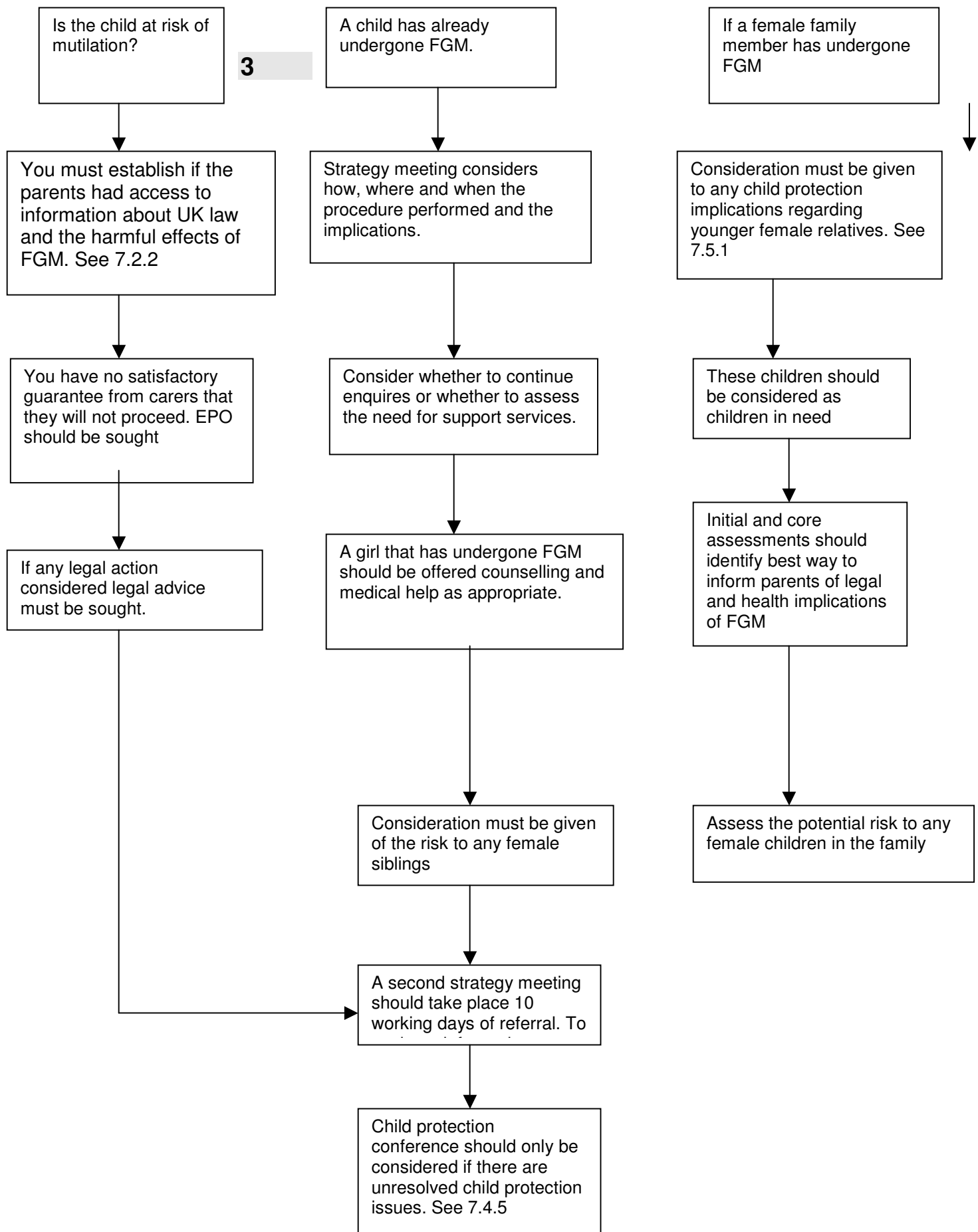
1 HEALTH PROFESSIONALS.

1.1 Working with Women from Practicing Communities



2 GOOD PRACTICE GUIDELINES FOR STAFF WORKING IN SOCIAL SERVICES DEPARTMENTS.

- 2.1 If FGM is suspected the child should be considered a child in need of protection. Any information or concern that a child is at immediate or long-term risk of or has undergone FGM should result in a child protection referral. The aim is to prevent a child undergoing any form of FGM, rather than removal from family, and every attempt should be made to work with parent on a voluntary basis.
- 2.2 FGM referrals will initially be dealt with as Section 47 enquiries. A Strategy meeting should be convened within two working days. The Chair must be trained in FGM or be a CP Advisor.
- 2.3 You must invite the professionals that usually attend. However, you must also include health or voluntary organisations with specific expertise in FGM, i.e. the community health advisor or specialist nurse from Waltham Forest Primary Care Trust African Well Women's Service.
- 2.4 A trained female interpreter or community advocate must be used in all interviews with the family. See 7.2.4
- 2.5 Community Advocates can play an important role in helping to gain parental agreement for work to take place on a voluntary basis, without the need to continue a formal child protection investigation. They can be used to gather further information clarifying issues and family attitudes.



3

PRACTICE GUIDANCE: THE ROLE OF THE POLICE

Policy

Any information or concern that a child is at immediate risk of, or has undergone, FGM should result in a child protection referral. FGM places a child at risk of significant harm and will, therefore be investigated (initially) under Section 47 of the Children Act (1989) by Social Services and the Police Child Abuse Investigation Team.

If a referral is received concerning one child in a family, consideration must be given to whether siblings are at similar risk. **There should also be consideration of other children from other families, once concerns are raised about the incidence or the perpetrator of FGM.**

The Child Abuse Investigation Team will follow their own Standard Operating Procedures in relation to a referral of FGM and investigate whether an offence has been committed. Information sharing from the outset will enable Police to effectively investigate whether FGM is being practised in the UK and ensure that this is stopped.

4 GOOD PRACTICE GUIDANCE: THE ROLE OF THE VOLUNTARY SECTOR

Support and advice must be obtained from organisations such as:

London Borough of Waltham Forest Social Services

Waltham Forest Primary Care Trust

The Police Child Abuse Investigation Team

Waltham Forest African Well Women's Service

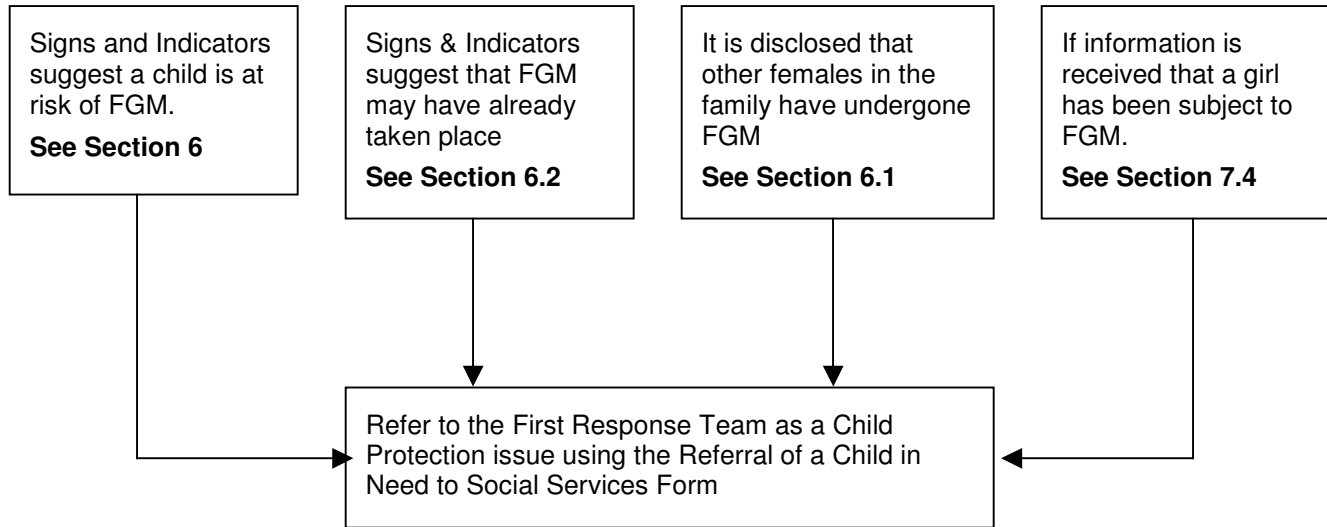
Once it is suspected that FGM may have taken place or is about to take place the matter must be discussed with the voluntary worker's Line Manager and Social Services.

A referral should then be made to the First Response Team, Social Services for their investigation as per London Child Protection Committee Procedures.

The referrer should keep written records of:

- Discussions with child
- Discussions with parent
- Discussions with managers
- Information provided to Social Services
- Decisions taken (clearly timed, dated and signed)
- The referrer should confirm verbal and telephone referrals in writing, within 48 hours, using an interagency referral form.
- Further guidance regarding recording is available in LCPC procedures, Edition 2, pp 105.

5 GOOD PRACTICE GUIDELINES FOR STAFF WORKING IN EDUCATION AUTHORITIES



6 REFERENCES

1. Confidentiality: Protecting and Providing Information. General Medical Council (2004).
2. Female Circumcision (Female Genital Mutilation) Royal College of Obstetricians and Gynaecologists, June 1997.
3. British Medical Association (2004), Female Genital Mutilation: Caring for Patients and Child Protection. Guidance from the BMA Ethics Department
4. Female Genital Mutilation: The Unspoken Issue, RCN 1994.
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7 GLOSSARY OF TERMS

1. Female Genital Mutilation is sometimes called Female Circumcision or Female Cutting
2. Type i, Female Genital Mutilation may be known to some communities as Sunna. Sunna is an Islamic word used to describe an action by the Prophet Mohammed.
3. The term '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.
4. The term "Closed" refers to type iii female genital mutilation where there is a long scar covering the vaginal opening. This term is particularly understood by the Somali and Sudanese communities
5. LCPC. London Child Protection Committee.
6. UNICEF- The United Nations Children's Fund
7. UNFPA-United Nations Population Fund
8. UNIFEM- United Nations Development Fund for Women