All Wales Child Protection Procedures

Review Group
Grwp Adolygu Canllawiau Amddiffyn Plant Cymru Gyfan

ALL WALES PROTOCOL

FEMALE GENITAL MUTILATION (FGM)

2011

Final Review:	**June 2011**
Author:	**Caroline Jones**
Consultation period	
Implementation:	**June 2011**
Review :	**2014**

This Protocol is taken from the Cardiff ACPC protocol 2004.

The All Wales Child Protection Procedures Review Group wishes to acknowledge the work of Cardiff ACPC and express their thanks to them for allowing the use of their protocol. The group also acknowledges the additional work undertaken by the pan – London LSCB

This procedure should be read in conjunction with the All Wales Child Protection Procedures (2008)

HM Government Multi-Agency Guidance: Female Genital Mutilation, Foreign & Commonwealth Office 2011, contains extensive information to assist practitioners in working with women and children.

Contents

1. PROTOCOL FOR CHILDREN AND YOUNG PEOPLE

1.1 Equal Opportunity 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 Female Genital Mutilation is illegal and is prohibited by the **Female Genital Mutilation Act 2003.**

2.2 It is acknowledged that some families see Female Genital Mutilation (FGM) as an act of love rather than cruelty, however, FGM causes significant harm both in short and long term and constitutes physical and emotional abuse to children.

2.3 The protocol must be underpinned by accessible, acceptable and sensitive Health, Education, Police, Social Services and Voluntary Sector Services.

2.4 All agencies should work in partnership with members of local communities, to empower individuals to develop support networks and education programmes.

2.5 The Rights of the Child as stated in the UN Convention (1989) will underpin this protocol.

2.6 The safety and welfare of the child is paramount.

3. LEGISLATION

3.1 Legislation against FGM in the UK includes both international standards and national legislation.

3.2 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.

3.3 **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.

3.4 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.

3.5 National Legislation

3.5.1 In the UK, all forms of FGM are illegal under the **Female Genital Mutilation Act 2003.**

This new Act replaced the previous Prohibition of Female Circumcision Act 1985. It introduced the new offence of taking a child out of the UK for the purpose of FGM.

Saving for necessary operations by approved practitioners, 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.

Other offences described in the Act are:

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

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.

3.5.2 FGM is child abuse. It is illegal. It is performed on a child who is unable to resist and who cannot be deemed to be giving any form of consent to what is an illegal act.

Working Together to Safeguard Children (2000) stated that if a Local Authority has reason to believe that a child is likely to suffer significant harm as a result of FGM, it should consider to what extent it should use its investigative powers under Section 47 of the Children Act 1989.

Subsequently, **Safeguarding Children: Working Together under the Children Act 2004 (Welsh Assembly Government 2006)** (Safeguarding Children) endorses the Home Office Guidance Circular 010/2004 The Female Genital Mutilation Act which states that offences of FGM should be investigated under the guidance set out in Safeguarding Children. The guidance further states that it should be bourne in mind that:

- Despite the very severe health consequences, parents and others who have this done to their children genuinely believe that it is in the child's best interest to conform with their prevailing custom. They believe it makes the child socially acceptable and do not intend it as an act of abuse; and
- There is no element of repetition – it is a one-off act of abuse (although younger female siblings of any child found to have been mutilated may be at risk).

Under the **Children Act 1989,** Local Authorities can apply to the Courts for various Orders to prevent a child being taken abroad for mutilation.

4. DEFINITION

4.1 The World Health Organisation (WHO) defines FGM as: all procedures (not operations) 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 FGM sometimes called Female Circumcision is a traditional practice, which takes three main forms:

Type 1 – Circumcision (Sunna)
This is the least severe form of FGM and involves the removal of the hood of the clitoris preserving the clitoris itself. This type of operation is also known as Sunna, which means 'tradition' in Arabic.

Type 2 – Excision (Clitoridectomy)
It involves the partial or total removal of the clitoris together with parts of the whole of the labia minora (small lips which cover and protect the opening of the vagina and the urinary opening). After the healing process has taken place, a large scar tissue forms to cover the upper part of the vulva region.

Type 3 – Infibulation (also called Pharaonic Circumcision)
This is the severest form of FGM. The term 'infibulation' is derived from the name given to the Roman practice of fastening a 'fibular' or 'clasp' through the large lips of their wives genitalia in order to prevent them from having illicit sexual intercourse.

In infibulation, the clitoris, the whole of the labia minora and the internal parts of the labia majora (the outer lips of the genitals, which lubricate the inside of the skin folds to prevent soreness) are removed. The two sides of the Vulva are then sown together with silk, catgut sutures, or thorns leaving only a very small opening to allow for the passage of urine and menstrual flow.

4.3 Type 4 – Unclassified
This includes all other operations on the female genitalia including pricking, piercing, and stretching of the vulva region, incision of the clitoris and/ or labia, cauterisation by burning the clitoris and surrounding tissues, incisions to the vaginal wall, scraping (anqurya cuts) or cutting (gishiri cuts) of the vagina and surrounding tissues.

5. AGE AND PROCEDURE

5.1 The age at which girls are subjected to FGM varies greatly, **from shortly after birth to any time up to adulthood**.

5.2 FGM is usually carried out by the older women in a practicing community, for whom it is a way of gaining prestige and can be a lucrative source of income in some communities.

5.3 The arrangements for the procedure usually include the child being held down on the floor by several women and the procedure carried out without medical expertise, attention to hygiene and anaesthesia. The instruments used include unsterilized household knives, razor blades, broken glass and sharpened stones. In addition the child is subjected to the procedure unexpectedly.

5.4 Increasingly some health professionals are performing FGM in the belief that it offers more protection from infection and pain. However, the medicalisation of FGM is condemned by all international groups including the WHO and is illegal.

6. CONSEQUENCES OF FEMALE GENITAL MUTILATION

6.1 Many women in practicing communities appear to be unaware of the relationship between FGM and its harmful health and welfare consequences, in particular the complications affecting sexual intercourse and childbirth, which occur many years after the mutilation has taken place.

6.2 The health implications for a child of the FGM procedure can be severe to fatal, depending on the type of FGM carried out.

6.3 As with all forms of child abuse or trauma, the impact of FGM on a child will depend upon such factors as:

- The severity and nature of the violence
- The individual child's innate resilience
- The warmth and support the child receives in their relationship with their parent/s, siblings and other family members
- The nature and length of the child's wider relationships and social networks
- Previous or subsequent traumas experienced by the child
- Particular characteristics of the child's gender, ethnic origin, age, (dis)ability, socio-economic and cultural background.

6.4 Short term implications for a child's health and welfare

6.4.1 Short term health implications can include:

- Severe pain
- Emotional and psychological shock (exacerbated by having to reconcile being subjected to the trauma by loving parents, extended family and friends)
- Haemorrhage
- Wound infections including Tetanus and blood borne viruses (including HIV and Hepatitis B and C)
- Urinary retention
- Injury to adjacent tissues

- Fracture or dislocation as a result of restraint
- Damage to other organs
- Death

6.5 Long term implications for a girl or woman's health and welfare

6.5.1 The longer term implications for women who have been subject to FGM Types 1 and 2 are likely to be related to the trauma of the actual procedure. Nevertheless, analysis of World Health Organisation data has shown that as compared to women who have not undergone FGM, women who had been subject to any type of FGM showed an increase in complications in childbirth, worsening with Type 3. Therefore, although Type 3 creates most difficulties, professionals should respond proactively for all FGM types.

6.5.2 The health problems caused by FGM Type 3 are severe – urinary problems, difficulty with menstruation, pain during sex, lack of pleasurable sensation, psychological problems, infertility, vaginal infections, specific problems during pregnancy and childbirth, including flashbacks.

6.5.3 Women with FGM Type 3 require special care during pregnancy and childbirth.

6.5.4 The long term health implications of FGM include:

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

7. SIGNALS AND INDICATORS

7.1 Professionals need to be aware of the possibility of FGM.

The following are some indicators of FGM. However this is not an exhaustive list and professionals should be vigilant at all times.

Further information is set out in HM Government Multi-Agency Practice Guidelines: Female Genital Mutilation (Foreign & Commonwealth Office 2011)

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124588.pdf

Indications that FGM may be about to take place include:

- The family comes from a community that is known to practice FGM e.g., Somalia, Sudan and other African countries. It may be possible that they will practice FGM if a female family elder is around. (See Appendix 1 for countries where FGM is prevalent)
- Parents state that they or a relative will take a girl out of the country for a prolonged period.
- A girl 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.
- A girl may confide to a professional that she is to have a 'special procedure' or to attend a special occasion.
- A professional hears reference to FGM in conversation, for example a girl may tell other children about it.
- A girl may request help from a teacher or another adult.
- Any girl 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.
- Any girl who has a sister who has already have undergone FGM must be considered to be at risk, as must other female children in the extended family.

Indications that FGM may have already taken place include:

- A girl may spend long periods of time away from the classroom during the day with bladder or menstrual problems if she has undergone Type 3 FGM
- There may be prolonged absences from school if she has undergone Type 3 FGM
- 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
- Professionals also need to be vigilant to the emotional and psychological needs of children who may/are suffering the adverse consequences of the practice e.g withdrawal, depression etc
- A girl requiring to be excused from physical exercise lessons without the support of her GP
- A girl may ask for help

7.2 Reasons given for the continued Practice of FGM

7.2.1 FGM is a complex issue, despite the harm it causes, many women from FGM practising communities consider FGM normal to protect their cultural identity.

7.2.2 As a result of the belief systems of the cultural groups who practice FGM, many women who have undergone FGM believe they appear more attractive than women who haven't been infibulated. Their perception is that normal female genitalia are both unattractive and unhygienic. In some cultures it is believed that a girl who has not undergone FGM, is unclean and not able to handle food or drink.

7.2.3 Infibulation is strongly linked to virginity and chastity. It is used to safeguard girls from sex outside marriage and from having sexual feelings. In more traditional cultures it is considered necessary at marriage for the husband and his family to see her closed.

In some instances both mothers will take the girl to be cut open enough to be able to have sex. Women also have to be cut open to give birth. The consequences of this are pain, bleeding, varying degrees of incapacity and psychological trauma.

7.2.4 Although FGM is practiced by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. However, neither the Bible, nor the Koran justify FGM. In 2006, top Muslim clerics at an international conference on FGM in Egypt pronounced that FGM is not Islamic.

7.2.5 Parents who support the practice of FGM say that they are acting in the child's best interests. The reasons they give include that it:

- Brings status and respect to the girl
- Preserves a girl's virginity/chastity
- Is part of being a woman
- Is a rite of passage
- Gives a girl social acceptance especially for marriage
- Upholds the family honour
- Gives the girl and her family a sense of belonging to the community
- Fulfils a religious requirement mistakenly believed to exist
- Perpetuates a custom/tradition
- Helps girls and women to be clean and hygienic
- Is cosmetically desirable, and
- Is mistakenly believed to make childbirth safer for the infant.

7.2.6 It is because of these beliefs that girls and women who have not undergone FGM are usually considered by practicing communities to be unsuitable for marriage. Women who have attempted to resist exposing their daughters to FGM report that they and families were ostracised by their community and told that nobody would want to marry their daughters.

8. PROCEDURES AND PRACTICE GUIDELINES

8.1 All agencies should work with the practicing communities to develop appropriate education and preventive programmes with a view to eradicating the practice of FGM.

8.2 **All** staff who have responsibility for child protection work must be acquainted with the All Wales Child Protection procedures and with any local preventative programmes, which exist.

8.3 Any information or concern that a child is at risk of, or has undergone FGM must result in a child protection referral to social services and/or the police.

8.4 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 protection team.

8.5 Strategy Meeting

8.5.1 On receipt of a referral a **strategy meeting** must be convened involving representatives from police, social services, health, education and voluntary services. Consideration also to be given to the involvement of appropriate linguistic, paediatric, specialist cultural and legal representation.

8.5.2 The strategy meeting must first establish if either the parents or child have had access to information about the harmful aspects of FGM.

8.5.3 If not, the parents/child should be offered the opportunity of educational / preventative programmes.

8.5.4 An interpreter must be used in all interviews with the family if their first language is not English. The interpreter must not be a family relation. The interpreter must be female and subject to appropriate recruitment processes and training in respect of safeguarding children.

8.5.5 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.

An agreement should be reached and recorded in the child's records to state how agencies will work with the parents to monitor the welfare of the child.

8.5.6 If no agreement is reached, the first priority is protection of the child and appropriate legal action should be taken to ensure the child's safety.

8.5.7 The primary focus is to prevent the child undergoing any form of FGM, rather than removal from the family.

8.5.8 Discussion about how the welfare of the child will be monitored in the future should take place and agreed measures should be recorded.

8.5.9 Consideration should be given to developing a safety and support plan for community members who fear hostility from family or community as a consequence of raising the issue of FGM.

8.6 Children in immediate danger

8.6.1 Where the child appears to be in immediate danger of mutilation and parents cannot satisfactorily guarantee that they will not proceed with it, and then an Emergency Protection Order should be sought.

8.7 If a child has already undergone FGM

8.7.1 If a child has already undergone FGM and this comes to the attention of any professional, a referral must be made to social services or police, in accordance with the

All Wales Child Protection Procedures, and a strategy meeting convened to consider how, where and when the procedure was performed and its implication.

8.7.2 A child who has undergone FGM should be seen as a child in need and offered services as appropriate. A holistic assessment including a physical examination of the child is very important. This assessment along with therapeutic services should be considered at the strategy meeting and offered in all cases.

8.7.3 The risk to other female children in the family must be considered at the strategy meeting. If a child's parents are intent on sending their daughter out of the country and it is considered mutilation is likely if she goes, legal advice should be sought.

8.8 If a woman has already undergone FGM

8.8.1 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, extended family members and a referral made to social services or police if appropriate.

8.8.2 If the woman is the mother of a female child or has the care of female children, a referral to Social Services under the Framework for the Assessment of Children in Need and their Families should be made. This will help to 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. If consent is not given for a Child in Need referral a Child Protection referral should be made.

8.8.3 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.

9 LEGAL POSITION

FGM is a criminal offence under the **Female Genital Mutilation Act 2003 (**replacing the Prohibition of Female Circumcision Act 1985). This offence carries a sentence of 5 years imprisonment on indictment for the person who conducted FGM.

Defence may be submitted for medical reasons, if conducted by a medical practitioner, as the only exemption to the Act is on specific physical and mental health grounds. Cultural custom or rituals are not accepted as a defence.

It is also an offence under the Act to arrange, procure, aid or abet FGM and upon indictment can carry a five-year custodial sentence.

It is also now an offence to take a child out of the UK for the purpose of FGM.

Parents/carers therefore too, may be liable for prosecution under the law.

10. INFORMATION SHARING

Lord Carlile 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"*

10.1 The Legal Framework

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.

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.

The best way of ensuring that information sharing is properly handled is to work within carefully worked out information sharing protocols between the agencies and professionals involved, and taking legal advice in individual cases where necessary.

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 may be threatened by the disclosure such consent may not always be necessary.

Where there is any doubt, legal advice about the particular circumstances should be sought.

10.2 The Common Law Duty of Confidence

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.

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.

10.3 The Data Protection Act

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.

10.4 The European Convention on Human Rights

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.

Disclosure of information without consent might give rise to an issue under Article 8. However this is not an absolute right and 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, and information should therefore be shared.

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.

10.5 The Crime and Disorder Act 1998 Section 115 states:

Any person who, apart from this subsection, would not have power to disclose information to relevant authority shall have power to do so where disclosure is necessary or expedient for purposes of any provision of this Act.

(The Act applies to statutory organisations and as FGM is a crime clearly states the ability to share information/ make a child protection referral without consent)

10.6 Professional Guidance

10.6.1 Medical

The General Medical Council (GMC) has produced general guidance entitled *Confidentiality: Protecting and Providing Information (2000).* 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:

10.6.1.1 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 of withhold consent to disclosure, you should give information to an appropriate responsible 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 must still be prepared to justify your decision".

10.6.1.2 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" (paragraph 36).

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.

10.6.2 Nursing

The **Nursing and Midwifery Council** states that:

- Disclosure should be with the consent of the patient

However disclosure can be made without consent where:

- In the public interest (usually where disclosure is essential to protect the patient, or someone else from the risk of significant harm).
- If required by law or order of a court

The NMC guidance also states that:

- *Where there is an issue of Child Protection you must act at all times in accordance with national and local policies*

11. PROFESSIONAL GUIDANCE ON FEMALE GENITAL MUTILATION FOR HEALTH PROFESSIONALS.

Concerns in relation to a mother who has undergone FGM

11.1 Health professionals encountering a girl or woman who has undergone FGM should be alert to the risk of FGM in relation to her:

- Younger siblings
- Daughters or daughters she may have in the future
- Extended family members

11.2 Health professionals in GP surgeries, sexual health clinics and maternity services are the most likely to encounter a girl or woman who has been subjected to FGM. All girls and women who have undergone FGM should be given information about the legal and health implications of practising FGM.

Health Visitors and Midwives and other health professionals are in a good position to reinforce information about the health consequences and the law relating to FGM.

11.3 If a girl or woman who has been de-infibulated requests re-infibulation after the birth of a child, where the child is female, or there are daughters in the family, health professionals should consult with their Designated Child Protection advisor and with LA Children's Social Care about making a referral to them.

11.4 After childbirth a girl/woman who has been de-infibulated may request and continue to request, re-infibulation. This should be treated as a child protection concern. This is because whilst the request for re-infibulation is not in itself a child protection issue, the fact that the girl or woman is apparently not wanting to comply with UK law and/or consider that the process is harmful, raises concerns in relation girl child/ren she may already have or may have in the future. Professionals should consult with the Designated Child Protection advisor and with LA Children's Social Care about making a referral to them.

11.5 If the girl or woman is a mother or prospective mother, her child/ren or unborn child should be considered at risk of significant harm. The health professional should consult with their Designated Child Protection advisor and should make a referral to LA Children's Social Care.

11.6 If the girl or woman has the care of female children, these children should be considered children at risk of significant harm, the Designated Child Protection advisor should be consulted and a referral made to LA Children's Social Care, as above.

11.7 Midwives, Health Visitors, School Nurses and GP's should ensure that information is shared in accordance with guidance to ensure the ongoing

monitoring of the health and development of child/young person who may be at risk of FGM.

11.8 See also the BMA Guidance: *FGM: Caring for patients and child protection*

It is important to note that when a Health Professional is concerned that FGM is likely to take place or has been performed, there is a duty to make a referral to social services.

http://www.bma.org.uk/images/FGMJuly06_tcm41-146715.pdf

Health Professionals must not investigate or deal with this issue alone.

Advice and support are available from the Health Board and Trust Named Doctors and Nurses and the Designated Doctors and Nurses Child Protection employed by the Public Health Wales NHS Trust.

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

In the event of there being suspicion of the incidence of FGM the child(ren) would be considered risk of significant harm.

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 Protection 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.

13. GOOD PRACTICE GUIDANCE: THE ROLE OF THE POLICE

Any information or concern that a child is at immediate risk of, or has undergone, FGM must 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 Protection Team.

If a referral is received concerning one child in a family consideration must be given to whether siblings are at similar risk.

There must also be consideration of other children from other families, once concerns are raised about the incidence or the perpetrator of FGM.

14. GOOD PRACTICE GUIDANCE: THE ROLE OF THE VOLUNTARY SECTOR

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 by LA Children's Social Care Services.

If a member of staff or a volunteer suspects that a child is at immediate risk of, or has undergone, FGM she should discuss this immediately with the organisation's designated person for Child Protection and their line manager.

A referral should then be made to Social Services for their investigation as per the All Wales Child Protection Procedures.

Any need to seek advice or guidance should NOT cause delay to the agencies Child Protection referral procedure.

All staff working with children and families should attend training in respect of FGM.

Further advice and support can be obtained from BAWSO Women's Aid a specialist organisation that supports women and children from BME communities affected by domestic violence. BAWSO also offer support, advice, guidance and training on cultural issues affecting BME communities.

For further information contact:

BAWSO
9 Cathedral Road
Cardiff
CF11 9HA
Tel: 029 20 644633
www.bawso.org.uk

National Organisation
FORWARD
www.forward.org.uk

15. GOOD PRACTICE GUIDELINES FOR STAFF WORKING IN EDUCATION AUTHORITIES

In the event of there being suspicion of the incidence of FGM the child(ren) would be considered at risk of significant harm.

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 Protection Team.

If there is concern about 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.

Good Practice Guidelines

These guidelines should be considered in conjunction with All Wales Child Protection Procedures (2008) and the School's Child Protection handbooks.

Section 175 of the Education Act 2002 requires Local Authorities and governing bodies of maintained Schools and Further Education Institutes to have arrangements for exercising their functions with a view to safeguarding and promoting the welfare of children. This document is one of the pieces of guidance issued by the Welsh Assembly Government to which Local Authorities and governing bodies must have regard for the purpose of Section 175 of the 2002 Act.

Safeguarding in Education 2008 outlines the role of Schools and the broad areas of responsibility for Local Authority Designated Lead Officers for Child Protection including specific circumstances of abuse such as FGM.

16. REFERENCES

1. Female Circumcision (Female Genital Mutilation) Royal College of Obstetricians and Gynaecologists, June 1997.

2. Female Genital Mutilation: Caring for patients and Child Protection. Guidance from the British Medical Association (2001)

3. Female Genital Mutilation: The Unspoken Issue, RCN 1994.

4. Guidance for Doctors Approached by Victims of Female Genital Mutilation, BMA, 1996.

5. Human Rights Act (1998)

6. Position Paper: Female Genital Mutilation (Female Circumcision). Royal College of Midwives, Number 21, June 1998.

7. Female Genital Mutilation Act 2003 (replaces Prohibition of Female Circumcision Act 1985).

8. The Children Act. (1989)

9. The Criminal Justice (Terrorism and Conspiracy) Act 1988.

10. Webb E., Hartley B. (1994) Female Genital Mutilation: a dilemma in child protection. Archives of the Diseases of Childhood 70: 441-444

11. Safeguarding Children: Working Together under the Children Act 2004 (WAG 2006)

12. UN Convention on the Rights of the Child (1989)

13. Safeguarding children at risk of abuse through female genital mutilation. London Safeguarding Children Board

14. BAWSO (2009). Female Genital Mutilation. Examining the practice in Wales.

15. All Wales Child Protection Procedures 2008.

16. HM Government Multi-Agency Practice Guidelines: Female Genital Mutilation. Foreign & Commonwealth Office 2011.

APPENDIX 1

PREVALENCE PROFILE AND LEGISLATION BANNING FGM IN AFRICA

These figures are offered only to give an indication of the scale the practice of FGM, they are figures for Africa, not for communities in the UK for which prevalence data is not available.

Country	Prevalence	Illegal / since
Benin	30%	Not yet
Burkino Faso	72%	1996
Cameroon	20%	None
Chad	60%	Went before parliament in 2001, not yet in place
Central African Republic	43%	1966
Djibouti	98%	1995
Egypt	97%	1959, there are grey areas, but in 1997 court upheld govt banning of FGM
Eritrea	90%	No specific banning law for fear of driving the practice underground
Ethiopia	90%	1994
Gambia	Approx 70%	None
Ghana	15%	1994
Guinea	99%	Late 1980's
Guinea Bissau	Approx 50%	1995 govt proposal to ban was defeated
Ivory Coast	45%	1998
Liberia	60%	None
Mali	93%	None, but draft legislation and govt campaigns against
Mauritania	25%	Not illegal, but banned in hospitals
Niger	5%	Not yet, draft legislation
Nigeria	%	In some areas since 1999
Senegal	20%	1999
Sierra Leonie	90%	None
Sudan	91%	1956, rescinded in 1983. Opposed by govt but not in law
Somalia	100%	In some areas since 1999
Kenya	38%	2001
Tanzania	18%	1998, however not enforced
Togo	12%	1998
Uganda	5%	Considering banning, children's legislation can be used
Yemen	23%	Not illegal, but banned in hospitals

Source: Female Genital Mutilation: Treating the Tears, Haseena Lockhat (2004)