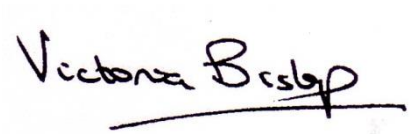
Title	**FGM Policy**
Reviewed	**September 2018**
Next Review	**September 2020** **Unless statutory guidance or advice changes**
Associated Policies	**Child Protection Policy** **Attendance Policy** **Children Missing from Education**
Originator	**V Bishop** **K Blackett**
Approved	

Contents

1. Background and statutory information

Hatton Academies Trust is charged under section 5C (1) of the Female Genital Mutilation Act 2003 to have regard for the statutory guidance stated in "Multi-agency statutory guidance on female genital mutilation" April 2016. All trust staff are charged to follow the guidance and procedures in the document. It also provides guidance and support for staff. Under the Serious Crime Act 2015, there is a mandatory duty to report known cases of FGM in under 18's to the police and an offence of **failing to protect a girl** from the risk of FGM. FGM protection orders can be used to protect girls at risk.

Section 5B of the 2003 Act introduces a **mandatory reporting duty (Appendix 1)** which required health and social care professional and **teachers** to report *known* cases of FGM in under 18's which they identify in the course of their professional work to the policy. The term teacher includes qualified teachers and those working as a teacher without QTS. This duty applied from 31st October 2015 onwards.

Failure to comply with this duty will result in a procedure under the Trust's disciplinary policy and referral to the National College of Teaching and Leadership (NCTL). "*Known*" cases are those where either a girl informs the person that an act of FGM has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out.

A copy of the document and the mandatory reporting information are available on the trust safeguarding hub. The mandatory reporting duty is highlighted in "Keeping Children Safe in Education" September 2018.

1.2 Principles

FGM is a criminal offence- it is child abuse and a form of violence against women and girls, and therefore should be treated as such. Cases should be dealt with as part of the trust and academy safeguarding policies and procedures.

There are, however, characteristics of FGM that staff should be aware of to ensure that they can provide appropriate protection and support to those affected. The following principles should be adopted:

- The safety and welfare of the child is paramount;
- All should act in the interests of the rights of the child, as stated in the United nations Convention on the Rights of the Child (1989);
- FGM is illegal in the UK;
- FGM is an extremely harmful practice- responding to it cannot be left to personal choice;
- Accessible, high quality and sensitive health, education, police, social care and voluntary sector services musty underpin all interventions;
- As FGM is often an embedded social norm, engagement with families and communities plays and important role in contributing to ending it; and

- All decisions or plans should be based on high quality assessments in accordance with "Working Together to Safeguard Children" (July 2018).

1.3. What is FGM (female genital mutilation)?

FGM is a collective term for all procedures involving partial or total removal of external female genitalia (see Appendix 2) for cultural or other non-therapeutic reasons. Typically it is performed on girls aged between 4 – 15 years of age or on older girls before marriage or pregnancy. It is illegal in the UK and it is also illegal to take a child abroad to under FGM. There is a maximum prison sentence of 14 years for anyone found to have aided this procedure in any way. It is considered to be child abuse as it causes physical, psychological and sexual harm.

FGM is more common than many people realise, both across the work and in the UK. It is practiced in 28 African countries and in parts of the Middle and Far East and increasingly in developed countries amongst the immigrant and refugee communities (Appendix 3)

In the UK it has been estimated that 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England & Wales are living with the consequences of FGE In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM.

FGM is a deeply embedded social norm, practiced by families for a variety of complex reasons. It is often thought to be essential for a girl to become a proper woman, and to be marriageable. The practice is not required by any religion.

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

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

FGM is known by a variety of names, including 'female genital cutting', 'circumcision' or 'initiation'.

2. Signs and Indicators to be aware of

2.1 Some indications that FGM may have taken place include:

- The family comes from a community that is known to practice FGM, especially if there are elderly women present in the extended family

- A girl/young woman may spend time out of the classroom or from other activities, with bladder or menstrual problems
- A long absence from school or in the school holidays could be an indication that a girl/young woman has recently undergone an FGM procedure, particularly if there are behavioural changes on her return – this may also be due to a forced marriage
- A girl/young woman requiring to be excused from physical exercise lessons without the support of her GP
- A girl/young woman may ask for help, either directly or indirectly
- A girl/young woman who is suffering emotional/psychological effects of undergoing FGM, for example withdrawal or depression
- Midwives and obstetricians may become aware that FGM has taken place when treating a pregnant woman/young woman.

2.2 Some indications that FGM may be about to take place include:

- A conversation with a girl/young woman where they may refer to FGM, either in relation to themselves or another female family member or friend;
- A girl/young woman requesting help to prevent it happening;
- A girl/young woman expressing anxiety about a 'special procedure' or a 'special occasion' which may include discussion of a holiday to their country of origin;
- A boy may also indicate some concern about his sister or other female relative.

3. Action to be taken if staff believe a child is at risk of FGM

3.1 You have a personal duty to report FGM concerns and information. The trust advises that you report to your academy's child protection Designated Senior Person, the Principal, or another senior member of staff. At the trust level, advice and guidance is available from the trust Safeguarding Directors.

3.2 If a girl/young woman is thought to be at risk of FGM, staff should be aware of the need to act quickly – before she is abused by undergoing FGM in the UK, or taken abroad to undergo the procedure. An interpreter must be used in all interviews with the family if their preferred language is not English. The interpreter must be female.

4. Making a report

The academy DSP or Principal will usually make the referral report.

This may be orally or in writing. Appendix 4 shows the FGM mandatory reporting process map.

The report is made to the police in the area in which the girl resides. The legislation requires that the girl is identified and the need to explain why the report is being made. A reference number should be given by the police and this should be recorded.

The advice is to call 101, the single non-emergency number. Further details of the procedure are given in Appendix 5. Reports should be made as soon as possible but usually by the close of the next working day.

5. Strategy Meeting/Discussion

5.1 Once a referral has been received for either a girl/young woman who is at risk or has undergone FGM, the DSP will immediately contact the relevant services from LCSB and MASH team.

It would be expected that a strategy meeting will be arranged.

This should involve representative from the police, Children's Social Care Services, and the academy. Relevant health care providers or voluntary/community/faith organisations with specific expertise (for example FGM, domestic violence and/or sexual abuse) should also be invited. Consideration should also be given to inviting a legal adviser.

5.2 The Strategy Meeting/Discussion must first establish if the parents and/or girl/young woman have had access to information about the harmful aspects of FGM. If not, the parents/girl/young woman should be offered the opportunity of educational/preventative programmes before any further action is considered.

5.3 Every attempt should be made to work with parents on a voluntary basis to prevent basis to prevent abuse of FGM occurring. The investigating team should ensure that parental co-operation is achieved wherever possible, including the use of community organisations and/or community leaders to facilitate the work with parents/family. However, if it is not possible to reach an agreement, the first priority is protection of the girl/young woman.

6. Girls/Young Women in Immediate Danger

6.1 If the parents cannot satisfactorily guarantee that they will not proceed with the mutilation and the Strategy Meeting/Discussion decides that as such the child/young woman is in immediate danger, then an Emergency Protection Order should be sought.

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

6.3 If the girl/young woman has already undergone FGM, the Strategy Meeting/Discussion will need to consider whether to continue enquiries or whether to assess the need for support services. Consideration should be given to establish, if there are any younger sisters, and an assessment may be needed to determine if there are any risks to younger siblings. If any legal action is being considered, legal advice must be sought.

7. Child Protection Conference

7.1 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. If a Girl/Young woman Has Already Undergone FGM

7.1 Where FGM has been practiced, a referral should be made to Children's Social Care. A Strategy Meeting/Discussion should consider how, where and when the procedure was performed and its implications for the girl/young woman. A girl/young woman who has undergone FGM should be seen as a Child in Need and offered services as appropriate. The Strategy Meeting should consider the need for medical assessment and/or therapeutic services for her.

7.2 The risk to other female children in the family and extended family must be considered at the Strategy Meeting and a referral made to Children's Social Care Services or Police as appropriate.

7.3 If the woman is the mother of a female child or has the care of female children, a multi-agency meeting needs to be held 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.

8. Cultural context

8.1 The issue of FGM is very complex. Despite the obvious harm and distress it can cause, many parents from communities who practice FGM believe it important in order to protect their cultural identity.

8.2 FGM is often practiced within a religious context. However, neither the Koran nor the Bible supports the practice of FGM. As well as religious reasons, parents may also say that undergoing FGM is in their daughter's best interests because it:

- Gives her status and respect within the community;
- Keeps her virginity/chastity;
- Is a rite of passage within the custom and tradition in their culture;
- Makes her socially acceptable to others, especially to men for the purposes of marriage;
- Ensures the family are seen as honourable;
- Helps girls and women to be clean and hygienic.

9. Consequences of FGM

9.1 Many people may not be aware 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.

9.2 Short term health implications include:

a. Severe pain and shock;
b. Infections;

c. Urine retention;
d. Injury to adjacent tissues;
e. Fracture or dislocation as a result of restraint;
f. Damage to other organs;
g. Death.

9.3 Depending on the degree of mutilation, it can cause severe haemorrhaging and result in the death of the girl/young woman through loss of blood.

9.4 Long term health implications include:

a. Excessive damage to the reproductive system;
b. Uterus, vaginal and pelvic infections;
c. Infertility;
d. Cysts;
e. Complications in pregnancy and childbirth;
f. Psychological damage;
g. Sexual dysfunction;
h. Difficulties in menstruation;
i. Difficulties in passing urine;
j. Increased risk of HIV transmission.

9.5 The Trust will take action to protect our students by ensuring that they are informed about FGM and are aware of what to do if they are concerned about themselves or someone else. These actions include female welfare assemblies.

9.6 This policy was produced to guide our staff and protect out pupils. It form part of the Hatton academies Trust child protection policies and a copy can be found on the trust safeguarding hub. The hub also includes further guidance and statutory documents.

Appendix 1: Home office FGM Fact Sheet

Home Office

New duty for health and social care professionals and teachers to report female genital mutilation (FGM) to the police

What is the new duty?

On 31 October 2015 a new duty was introduced that requires health and social care professionals and teachers to report 'known' cases of FGM in girls aged under 18 to the police.

For example, if a doctor sees that a girl aged under 18 has had FGM they will need to make a report to the police. Or, if a girl tells her teacher that she has had FGM, the teacher will need to report this to the police.

What will happen after the case has been reported to the police?

FGM is a serious crime and the police will need to investigate each reported case appropriately. The police will work with social care professionals to make sure that the girl is safe and her needs are put first.

Why is it being introduced?

When a girl has undergone FGM, a serious crime has taken place so it is very important that the police are involved as soon as possible. This will make sure that a proper investigation can take place.

The purpose of the new duty is to help make sure that professionals have the confidence to confront FGM and to help increase the number of referrals to the police so that cases can be investigated appropriately.

What the new duty won't do

It **doesn't mean** that police will take action without consulting appropriately with social care professionals and other relevant professionals.

It **won't require** professionals to report cases to the police where they suspect FGM may have been carried out or think a girl may be at risk. The duty also doesn't apply to women aged 18 or over. Professionals will follow existing safeguarding procedures in these cases.

Summary: Mandatory reporting of FGM*

Duty applies to regulated health and social care professionals and teachers in England and Wales.

Requires these professionals to make a report to the police if, in the course of their professional duties, they:

- are informed by a girl under 18 that an act of FGM has been carried out on her; or
- observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

*Introduced in Section 5B of the FGM Act 2003, as inserted by section 74 of the Serious Crime Act 2015

Appendix 2. Types of FGM

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

Type 1 – Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris)

Type 2 – Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the 'lips' that surround the vagina)

Type 3 – Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer lavia, with or without the removal of the clitoris

Type 4 – Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Appendix 3 International prevalence of FGM – Multi-Agency Statutory Guidance on Female Genital Mutilation

2.3. International Prevalence of FGM

FGM is a deeply rooted practice, widely carried out mainly among specific ethnic populations in Africa and parts of the Middle East and Asia. It serves as a complex form of social control of women's sexual and reproductive rights. The exact number of girls and women alive today who have undergone FGM is unknown, however, UNICEF estimates that over 200 million girls and women worldwide have undergone FGM[10].

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

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

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

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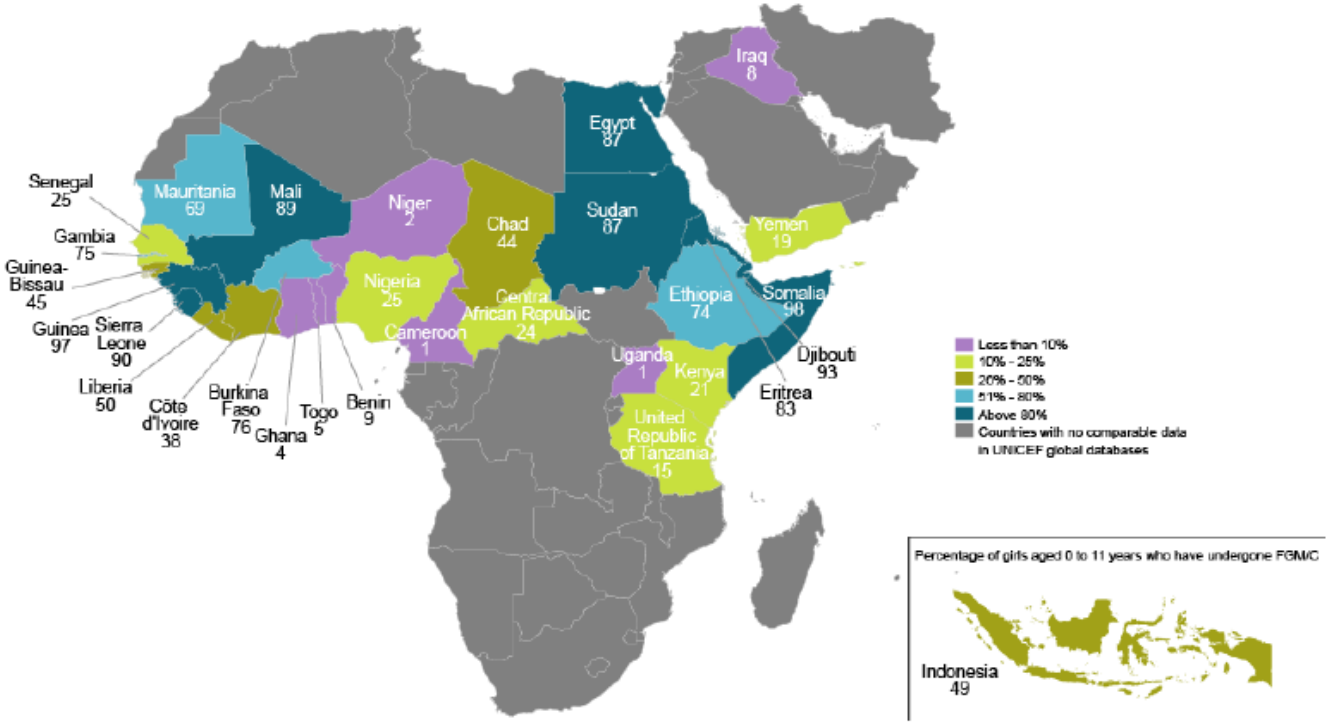
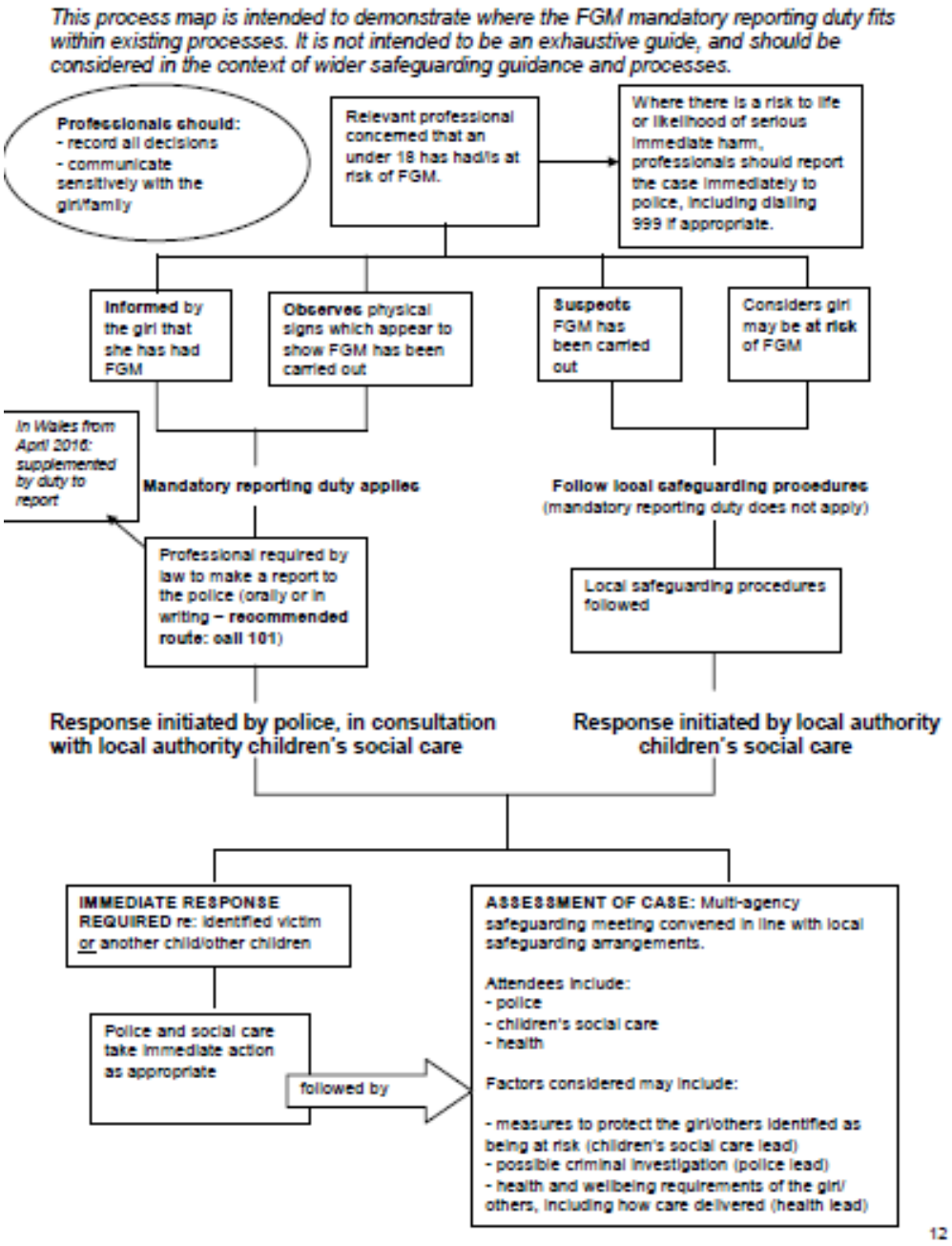
[10] UNICEF (2016) *Female Genital Mutilation/ Cutting: a Global Concern:* www.data.unicef.org/resources/female-genital-mutilation-cutting-a-global-concern.html

Figure 1: Percentage of girls and women aged 15-49 who have undergone FGM in Africa, the Middle East, and Indonesia



Notes: In Liberia, girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM since it is performed during initiation into the society. Data for Indonesia refer to girls aged 0 to 11 years since prevalence data on FGM among girls and women aged 15 to 49 years is not available. Sources: UNICEF global databases, 2016, based on DHS, MICS and other nationally representative surveys, 2004-2015. Map disclaimer

Appendix 4. FGM mandatory reporting process map. – Mandatory Reporting Female Genital Mutilation – procedural information



Appendix 5. Making a Report – Guidance on the process for Academy DSPs or Principals.

Timeframe for Reports

Where you become aware of a case, the legislation requires you to make a report to the police force area within which the girl resides. The legislation allows for reports to be made orally or in writing.

When you make a report to the police, the legislation requires you to identify the girl and explain why the report is being made. While the requirement to notify the police of this information is mandatory and overrides any restriction on disclosure which might otherwise apply, in handling and sharing information in all other contexts you should continue to have regard to relevant legislation and guidance, including the Data Protection Act 1998 and any guidance for your profession. The provisions of the Data Protection Act 1998 do not prevent a mandatory report to the police from being made.

While the legislation requires a report to be made to the police, it does not specify the process for making the report. If you have a formal agreement with the relevant team in the police that reports can be made to them directly, then reports may be made this way. In all cases you should ensure that you are given a reference number for the case and that you keep a record of it.

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It is recommended that you make a report orally by **calling 101**, the single non-emergency number.

When you call 101, the system will determine your location and connect you to the police force covering that area. You will hear a recorded message announcing the police force you are being connected to. You will then be given a choice of which force to be connected to – if you are calling with a report relating to an area outside the force area which you are calling from, you can ask to be directed to that force.

Calls to 101 are answered by trained police officers and staff in the control room of the local police force. The call handler will log the call and refer it to the relevant team within the force, who will call you back to ask for additional information and discuss the case in more detail.

You should be prepared to provide the call handler with the following information:

- explain that you are making a report under the FGM mandatory reporting duty
- your details:
  - name
  - contact details (work telephone number and e-mail address) and times when you will be available to be called back
  - role
  - place of work
- details of your organisation's designated safeguarding lead:
  - name
  - contact details (work telephone number and e-mail address)
  - place of work
- the girl's details:
  - name
  - age/date of birth
  - address
- if applicable, confirm that you have undertaken, or will undertake, safeguarding actions, as required by the English or Welsh version of Working Together to Safeguard Children as appropriate.

You will be given a reference number for the call and should ensure that you document this in your records (see section 2.3b).

Record Keeping

Throughout the process, you should ensure that you keep a comprehensive record of any discussions held and subsequent decisions made, in line with standard safeguarding practice. This will include the circumstances surrounding the initial identification or disclosure of FGM, details of any safeguarding actions which were taken, and when and how you reported the case to the police (including the case reference number). You should also ensure that your organisation's designated safeguarding lead is kept updated as appropriate.

Informing The Child's Family

In line with safeguarding best practice, you should contact the girl and/or her parents or guardians as appropriate to explain the report, why it is being made, and what it means. Wherever possible, you should have this discussion in advance of/in parallel to the report being made. Advice and support on how to talk to girls and parents/guardians about FGM is available in the multi-agency guidance on FGM.

However, if you believe that telling the child/parents about the report may result in a risk of serious harm to the child or anyone else, or of the family fleeing the country, you should not discuss it. For more information, please see information sharing advice for safeguarding practitioners. If you are unsure or have concerns, you should discuss these with your designated safeguarding lead.

Your Responsibilities After You Have Made a Report

In relation to any next steps, you should continue to have regard to your wider safeguarding and professional responsibilities, including any relevant standards issued by your regulatory body. For example, in a health context, your responsibilities include responding to the physical and psychological needs of the girl.

Depending on your role and the specific circumstances of the case, you may be required to contribute to the multi-agency response or other follow up to the case which will follow your report (see Section 3). If you are unsure, you should seek advice from your designated safeguarding lead.