Kent Safeguarding Children
multi-agency partnership

Medway
Safeguarding
Children Partnership
Safeguarding Medway's
children together

Safeguarding children at risk of abuse through female genital mutilation (FGM) procedures

November 2022

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Summary of Purpose	These procedures summarise the responsibility of professionals and volunteers to intervene effectively to prevent the genital mutilation of girls, and to identify, respond and support those who have been the victims of female genital mutilation (FGM).
Accessibility	This document can be made available in large print, or in electronic format. There are no copies currently available in other languages.
Equalities Impact Assessment	During the preparation of this policy and when considering the roles and responsibilities of all agencies, organisations and staff involved, care has been taken to promote fairness, equality, and diversity, in the services delivered regardless of disability, ethnic origin, race, gender, age, religious beliefs or sexual orientation.
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Policy Review Date	This document will be reviewed in November 2025.

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"I hope I'll be alive to see that day when we don't have FGM anymore…I broke the chain in my family, and I can't wait for the day when we see that chain break for good". (Hibo Wardere, anti-FGM campaigner)

1. Introduction

Female genital mutilation (FGM) is child abuse and a form of violence against women and girls and should be treated as such. Child protection procedures should be followed when there are concerns that a girl is at risk of, or is already the victim of, FGM.

These procedures summarise the responsibility of professionals and volunteers to intervene effectively to prevent the genital mutilation of girls, and to identify, respond and support those who have been the victims of FGM. For many professionals and volunteers this will mean being aware of which girls are at risk of, or may have already experienced, FGM and knowing how to report these concerns. For others who have more specific safeguarding responsibilities, it will involve complex work to safeguard girls, support victims and prosecute perpetrators. For everyone, it will involve questioning attitudes and beliefs that may get in the way of identifying girls who are at risk of FGM, and which may also get in the way of providing the consistent, determined support these girls need to keep them safe.

These guidelines should be read in conjunction with statutory guidance such as Working together to safeguard children 2018; Multi-agency statutory guidance on female genital mutilation; and Mandatory reporting of female genital mutilation – procedural information. They are also supported by the Kent Safeguarding Children Multi-Agency Partnership (KSCMP) and the Medway Safeguarding Children Partnership (MSCP).

Significant change is required as existing practice has identified very few victims and prosecutions despite the fact FGM has been illegal in the UK since 1985. Low rates of identification should not be taken to mean that the number of girls who've experienced FGM, or are at risk, is small.

2. Definition

The World Health Organisation (WHO) describes FGM as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons."

FGM has been classified by the WHO into four types:

Type 1 (Clitoridectomy) – partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals), and/or the prepuce/clitoral hood (the fold of skin surrounding the clitoral glans).

Type 2 (Excision) – partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva).

Type 3 (Infibulation) – narrowing of the vaginal opening through the creating of a covering seal. The seal is formed by cutting and repositioning the labia minora, or prepuce/clitoral hood and glans.

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

FGM is a deeply rooted practice, widely carried out 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 age at which FGM is carried out varies enormously according to the community. The procedures may be carried out on new-born infants, during childhood or adolescence or just before marriage or during a women's first pregnancy. There is no biblical or koranic justification for FGM and religious leaders from all faiths have spoken out against the practice. 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.

3. Justifications for FGM

FGM is a complex issue and individuals and families who support it give a variety of justifications and motivations for this. However, FGM is a crime and child abuse, and no explanation or motive can justify it. The justifications given may be based on a belief that it:

- brings status and response 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';
- cleanses and purifies the girl;
- gives the girl and her family a sense of belonging to the community;
- fulfils a religious requirement believed to exist;
- perpetuates a custom/tradition;
- helps girls and women to be clean and hygienic;
- is aesthetically desirable;
- makes childbirth safer for the infant; and
- rids the family of bad luck or evil spirits.

FGM is a traditional practice often carried out by a family who believe it is beneficial and is in a girl or woman's best interests. This may limit a girl's motivation to come forward to

raise concerns or talk openly about FGM – reinforcing the need for all practitioners to be aware of the issues and risks of FGM and the need to ask questions about FGM when there are concerns. In addition, women and girls who have undergone FGM may not fully understand what FGM is, what the consequences are, or that they themselves have had FGM.

FGM is a complex and sensitive issue that requires professionals to approach the subject carefully. Good communication is essential when talking to individuals who have had FGM, may be at risk of FGM, or who are affected by the practice. When speaking to families, the care of women and girls affected by FGM should be the primary concern, treating them as individuals, listening and respecting their dignity. Sensitive language should be used and the girl's wishes, culture and values are recognised and respected.

An accredited female interpreter may be required. Any interpreter should ideally be appropriately trained in relation to FGM, and should not be a family member, or someone known to the individual or who has influence in the individual's community.

4. What are the signs that a child is at risk / FGM has occurred?

Signs that a child may be a risk of FGM:

- a girl is born to a woman who has undergone FGM
- mother has requested re-infibulation following childbirth
- a girl has older sibling/s or family members who have undergone FGM
- one or both parents or elder family members consider FGM integral to their cultural or religious identity
- the family indicate that there are strong levels of influence held by pro-FGM elders who are involved in bringing up female children
- a girl from a practicing community who is withdrawn from PSHE and/or sex and relationship education or its equivalent may be at risk as a result of her parents wishing to keep her uniformed about her body, FGM and her rights
- if there are references to FGM in conversation, for example a girl may tell other children about it
- a girl may confide that she is to have a 'special procedure' or to attend a special occasion to 'become a woman'
- a girl may request help from a teacher or another adult if she is aware or suspects that she is at immediate risk
- parents state that they or a relative will take the child out of the country for a prolonged period and are evasive about why
- a girl is taken abroad to a country with high prevalence of FGM, especially during the summer holidays which is known as the 'cutting season'

Signs that FGM has occurred:

- prolonged absence from schools

- frequent need to go to the toilet
- long break to urinate
- urinary tract infections
- noticeable behaviour change
- talk of something somebody did to them that they are not allowed to talk about
- change of dress from tight to loose fitting clothing
- menstrual problems
- difficulty in sitting down comfortably
- complain about pain between their legs

Professionals should not be afraid to ask about FGM, using appropriate and sensitive language. If professionals do not give a girl the opportunity to talk about FGM, it can be very difficult for her to bring this up herself.

5. Consequences of FGM

Female genital mutilation (FGM) has no health benefits, and it harms girls and women in many ways. The practice involves removing and injuring healthy and normal female genital tissue, interfering with the natural functions of girl's and women's bodies. It can lead to immediate health risks, as well as a variety of long-term complications affecting physical, mental and sexual health and well-being throughout the life-course.

All forms of FGM are associated with increased health risks in the short-and-long-term. It is a harmful practice and is unacceptable from a human right as well as a public health perspective, regardless of who performs it.

Short-term health risks include:

- severe pain
- haemorrhage (excessive bleeding)
- shock
- genital tissue swelling and infections
- human immunodeficiency virus (HIV)
- urination problems
- impaired wound healing
- death
- mental health problems (the pain, shock and the use of physical force during the event, as well as a sense of betrayal when family members condone and/or organise the practice, are reasons why many women describe FGM as a traumatic event)

Long-term health risks (occurring at any time) include:

- pain
- infections - including chronic genital infections, chronic reproductive tract infections, and urinary tract infections
- painful urination

- vaginal problems
- menstrual problems
- excessive scar tissue (keloids)
- human immunodeficiency virus (HIV)
- sexual health problems
- childbirth complications (obstetric complications)
- obstetric fistula
- perinatal risks
- mental health problems

Even though FGM may be normative and considered to be of cultural significance in some settings, the practice is always a violation of human rights, with the risk of causing trauma and leading to problems related to girl's and women's mental health and well-being[1].

6. The law

In England, Wales and Northern Ireland, criminal and civil legislation on FGM is contained in the Female Genital Mutilation Act 2003. The act:

- makes it illegal to practice FGM in the UK;
- makes it illegal to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in that country;
- makes it illegal to aid, abet, counsel or procure the carrying out of FGM abroad;
- has a penalty of up to 14 years in prison and/or a fine.

As amended by the Serious Crime Act 2015, the Female Genital Mutilation Act 2003 also includes:

- an offence of failing to protect a girl from the risk of FGM – a person is liable if they are 'responsible' for a girl at the time when an offence is committed. This covers both someone who has 'parental responsibility' for the girl and has 'frequent contact' with her, as well as any adult who has assumed responsibility for caring for the girl in the 'manner of a parent'. This could be for example family members, with whom she was staying during the school holidays;
- Female Genital Mutilation Protection Orders (FGMPO). An FGMPO is a civil order which may be made for the purposes of protecting a girl against the commission of an FGM offence or protecting a girl against whom an FGM offence has taken place. Breaching an order carries a penalty of up to 5 years in prison. The terms of the order can be flexible and the court can include whatever terms it considers necessary and appropriate to protect the girl or woman including to protect a girl from being taken abroad or to order the surrender of passports. Click here to find out more about FGMPOs;

[1] Sexual and Reproductive Health and Research (SRH) (who.int)

- Allowing for the lifelong anonymity of victims of FGM – prohibiting the publication of any information that could lead to the identification of the victim. Publication covers all aspects of media including social media;
- Extra-territorial jurisdiction over offences of FGM committed abroad by UK nationals and those habitually (as well as permanently) resident in the UK;
- Mandatory reporting which requires specified professionals to report known cases of FGM in under 18's to the Police.

7. Mandatory reporting

Regulated health and social care professionals and teachers have a duty to report to the police 'known' cases of FGM in under 18's which they identify in the course of their professional work. Reports should be made using the non-emergency 101 telephone number.

'Known' cases are those where either a girl informs the person that an act of FGM, however described, 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 and the person has 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.

Reports under the duty should be made as soon as possible after a case is discovered, and best practice is for reports to be made by the close of the next working day. A longer timeframe than the next working day may be appropriate in exceptional cases where, for example, a professional has concerns that a report to the police is likely to result in an immediate safeguarding risk to the child (or another child e.g. sibling) and considers that consultation with colleagues or other agencies is necessary prior to the report being made.

Cases of failure to comply with the duty will be dealt with in accordance with the existing performance procedures in place for each profession.

It is important to remember that mandatory reporting does not replace safeguarding children actions. If a professional has concerns that FGM has taken place, they should share this information with their safeguarding lead and make a referral/request for support to the Kent Integrated Children's Services Front Door/Medway Children's Social Care.

For further information please refer to the Home Office Mandatory reporting of female genital mutilation – procedural information.

8. NHS data sharing

NHS Digital collects data on FGM within the NHS in England on behalf of the Department for Health and Social Care.

Data on the following is collected from NHS acute trusts, mental health trusts and GP practices:

- If a patient has had FGM;
- If there is a family history of FGM; and
- If a FGM related procedures has been carried out on a patient.

Aggregate information on the data collected is available online, see NHS Digital website.

Female Genital Mutilation Information Sharing (FGM-IS)

FGIS is a national IT system for healthcare professionals and administrative staff to record that a girl has a family history of FGM. For further information please see NHS Digital-FGM website.

9. Multi-agency approach to safeguarding and making a referral/request for support

Agencies across Kent and Medway should work together to effectively safeguard girls at risk from FGM. Practitioners must follow the HM Government Multi-agency statutory guidance on female genital mutilation in addition to these guidelines and Kent and Medway safeguarding children procedures.

Mandatory data recording and collection regarding FGM cases for acute hospital trusts has been in place since September 2014 and was extended to mental health trusts and GP surgeries from October 2015.

Information sharing is key to identifying, assessing, supporting and protecting victims and those at risk.

With regard to children at risk, where practitioners believe a child at risk has signs or symptoms of FGM, or there is good reason to suspect they are at risk of FGM then the practitioner must make a safeguarding referral/request for support in line with the Kent and Medway safeguarding children procedures.

Professionals should be aware of the possibility of FGM and vigilant to the following potential indicators that FGM may take place/have taken place, and if present must clarify their concerns and consider seeking advice and/or implement child protection procedures.

There is no statutory requirement to refer pregnant women who have undergone FGM routinely to children's social care. Professionals must consider the risk on a case-by-case basis, discuss with their safeguarding lead and decide the level of support that may be required e.g. early help referral/request for support.

Practitioners need to consider the potential increased risk to girls of honour-based violence from with the family or community when supporting the prevention of FGM.

10. Health services

Health professionals in universal services, GP surgeries, sexual health clinics, accident and emergency (A&E) departments, and maternity services are most likely to encounter a child or young person who has been subjected to FGM. Those who have undergone FGM should be given information about the legal and health implications of practicing FGM.

Health professionals have responsibilities to ensure appropriate questions are asked and information documented. Parents/carers should be given information about the legal and health implications of practicing FGM in a respectful and sensitive manner.

All conversations must be fully documented and stated the following:

- If the child or young person has undergone FGM;
- What type of FGM; and/or
- If there is a family history of FGM.

Health professionals/agencies must fulfil the mandatory reporting requirements as outlined by the mandatory reporting of female genital mutilation guidance.

Health professionals working with those who have undergone FGM and who have female children are required to document the type of FGM in their child/ren's Personal Child Health Record (PCHR) red book. See appendix 3 for guidance.

11. Midwifery services

Midwives should discuss FGM at the initial booking visit with those who come from countries that practice FGM or if they are married to, or in a relationship with someone from FGM practicing communities. Midwifery services should also report any identified FGM on the Female Genital Information Sharing System.

Data recording is mandatory for those identified as having FGM. All FGM diagnosis should be documented in the patients' medical records, even if FGM is not the reason for presentation. If a genital examination is performed and the type of FGM is identified, professionals should record the FGM type, using the WHO classification. Maternal history of FGM should be documented in the child/ren's PCHR red book. All further details in accordance with the HSCIC FGM Enhanced Dataset should also be recorded. Midwives should also explain to the patient that their personal data will be transmitted to the HSCIC for the purpose of FGM prevalence monitoring and that the data will not be anonymised.

Midwives must document that the patient has been informed about the health risks and the law and has been provided with a leaflet in an appropriate language (if available) that explains the health risks of FGM, the law and support services. They should also determine the view of FGM from the patient and their family.

Midwives/obstetricians must develop and document a plan for delivery in partnership with the patient and share information with relevant professionals i.e. safeguarding lead, GP, social worker, health visitor.

Midwives should be aware that some patients may be traumatised from their experience and have already resolved not to allow their daughters to undergo this procedure. Any concerns about a parent's attitude towards FGM should be taken seriously and appropriate referrals made.

If an unborn child, or any other child in the family, is at risk of FGM then reporting to social services or the police must occur.

Patients under the age of 18-years must be reviewed using FGM-IS via the CP-IS icon which accesses the Summary Care Record. The FGM tab is present and active for all those who have currently identified as having FGM within their family.

At birth, if the baby is a girl, contact your safeguarding team. They can support/ensure that the FGM tab is added to the child's records.

If a girl who has been de-infibulated requests re-infibulation/re-suturing after the birth of a child, they must be referred to Children's Social Care. Re-infibulation is illegal in the UK.

Whilst the request for re-infibulation is not in itself a safeguarding issue, the fact that the girl is apparently not wanting/able to comply with UK law due to family pressure and/or does not consider that the procedure is harmful raises concerns in relation to female children they may already have or may have in the future.

Risk can only be considered at a particular moment in time. Healthcare professionals should take the opportunity to continue discussions around FGM throughout the standard delivery of healthcare. If for example, a health visitor or GP has been passed information from a midwife about potential risk of FGM, at the next appointment with the patient, the health visitor/GP should discuss this.

12. Primary care, acute hospital trusts and community health services

Professionals should be vigilant to any health issues such as recurrent urinary tract infections or vaginal infections that may indicate FGM has been carried out.

Those attending health checks or travel vaccinations from high-risk countries provides an opportunity for health professionals to ask about FGM and advice about its health impacts and offer referral to additional support for those as having FGM. A referral/request for support must be made to children's social care for children identified as having had FGM or at risk of FGM.

Practitioners must document any advice or leaflets provided. Any concerns about a parent's attitude towards FGM should be taken seriously and appropriate referrals made.

Professionals should consult with their safeguarding lead and with the relevant social work assessment team about making a referral/request for support to them[2].

A question about FGM should be asked by practitioners at routine new patient contacts with girls from communities that practice FGM, and information must be documented in records/PCHR and a FGM leaflet/FGM passport should be provided.

Health visitors/school nurses are in a good position to reinforce information about the health consequences and the law relating to FGM and work in partnership with families and partner agencies to inform, educate and support individuals and communities, thereby protecting girls from abuse. Maternal history of FGM should be documented in the personal child health record (red book). A mandatory reporting duty for FGM requires regulated health professionals to report known cases of FGM in under 18-year-olds to the police.

Health services for asylum seekers and refugees must also be vigilant in discussing FGM and following the Kent and Medway safeguarding children procedures where appropriate.

13. Education (including Early Years Settings)

Statutory guidance and inspections frameworks for education settings recognise the important role education settings have to play in identifying and responding to FGM, including but not limited to:

- Keeping Children Safe in Education (KCSIE)
- Early Years Foundation Stage (EYFS)
- Ofsted: Inspecting safeguarding in early years, education and skills
- Relationships Education, Relationships and Sex Education (RSE) and Health Education

Children or young people who may be at risk of, or fear they may be at risks of, FGM may come to the attention of or seek support from education staff. It is important that early years providers, schools and colleagues create an open and supportive environment for children, young people and their families by raising awareness amongst staff and ensuring all members of their community are aware of the support available to them. Education setting should be addressing FGM with children as part of an age-appropriate curriculum in accordance with the relevant guidance, for example KCSIE and EYFS, and as part of Relationships and Sex Education (RSE), PHSE, citizenship and/or the science curriculum, and as inspected by Ofsted/Independent Schools Inspectorate (ISI).

Whilst all staff in education settings will be expected to seek advice from their designated safeguarding lead (or a deputy) and/or children's social care with regards to any concerns about a child exhibiting some of the signs of FGM, or reporting they have had FGM performed, there is an additional legal duty on teachers to report concerns directly to the police. Section 5B of the Female Genital Mutilation Act 2003 (as inserted by section 74 of the Serious Crime Act 2015) places a statutory duty upon teachers in England and Wales, to report to the police where they discover (either through disclosure by the victim or visual

[2] http://www.fgmnationalgroup.org/documents/literature_bma.pdf

evidence) that FGM appears to have been carried out on a girl under 18. Those failing to report such cases may face disciplinary sanctions. It will be rare for teachers to see visual evidence of FGM, and they should not be examining children, however the definition of what is meant by "to discover that an act of FGM appears to have been carried out" is used for all professionals to whom this mandatory reporting duty applies. Information on when and how to make a report can be found at: Mandatory reporting of female genital mutilation procedural information.

14. Police

There is a risk that the fear of prosecution of family members may prevent those concerned from seeking help and support from relevant agencies and in particular medical help as a result of long-term complications caused by FGM.

In many communities where the practice of FGM is prevalent, children who may have undergone/be due to undergo FGM may accept it as part of their religious/cultural upbringing due to a lack of understanding of the potential criminal offence being committed and future health complications that may prevail.

If a girl is at risk of undergoing or has already undergone FGM, the duty Detective Inspector must be made aware, and support should be sought from the Vulnerability Investigation Team (VIT) where the victim resides. Relevant safeguards should be put in place immediately in order to prevent any risk of harm to the chid. Consideration should be given to:

- risk to any other children should be acted upon immediately; and/or
- honour-based violence issues/forced marriage.

If any officer believes that a child could be at immediate risk of significant harm, they should consider the use of FGMPOs/police protection powers.

The Front Door/MASH should commence a strategy meeting with children's social care and relevant agencies.

If it is believed or known that a girl has undergone FGM, an initial strategy meeting must be held within the agreed timeframe, to enable full consideration to be given to the implications for the child and the coordination of the criminal investigation.

A second strategy meeting should take place within the agreed timeframe of the initial request for support/referral.

Children and young people should be interviewed under the relevant procedures (e.g. Achieving Best Evidence) to obtain the best possible evidence for use in any prosecution.

A medical examination should be conducted by a qualified doctor (or nurse) trained in identifying FGM.

15. Medway Children's Social Care / Kent Integrated Children's Services

When information is received by the Integrated Children's Services (Kent)/Children's Social Care (Medway) at the Front Door (Kent)/MASH (Medway), the team manager on duty will ensure that appropriate Children's Social Work Team district duty manager is informed in line with local policies and procedures. In all cases professionals should not discuss the referral/request for support with the parents/carers/family until a multi-agency action plan has been agreed.

On receipt of referral/request for support a strategy discussion meeting must be held within 24 hours or sooner as directed by the Front Door/MASH duty manager and include a designated lead health professional to contribute to discussion and inform decision making.

If a referral/request for support is received concerning one female in a family, consideration during the strategy discussions must be given to whether other females in the family are also at risk and there should be consideration of other females from other associated families if concerns are raised regarding an incident of, or the perpetrator of FGM.

A team manager (or their appointed deputy) from social care will convene and chair a strategy discussion meeting. It will be the senior social care representative's responsibility to access relevant information on the practice, and identify specialist help to assist in the sensitive planning of enquiries. Sourcing specialists should not stop or delay any initial intervention from taking place.

In addition to the team manager (or their appointed deputy) from social care chairing and coordinating the meeting, the strategy discussion meeting should include representation from:

- the allocated social worker responsible for the enquiry
- a senior member of the Kent Police Vulnerable Investigation Team (VIT)
- appropriate health services i.e. community paediatrician/safeguarding children named nurse
- statutory or voluntary sector i.e. FGM specialist/lead
- the lead agency or professional currently working with the child or young person
- any other professionals deemed appropriate by the Social Care Manager

The strategy discussion meeting must discuss whether parents of the child or young person have had access to information about the harmful aspects of FGM< and the law in the UK. If not, this information should be made available to them throughout any proceeding section 47 enquiry.

The strategy discussion meeting should consider the need for a medical assessment and/or therapeutic services for the female.

An FGM strategy discussion meeting should cover, at a minimum, the following issues:

- family history and background information including any other female relatives in the family

- scope of the investigation, what needs to be addressed and who is best placed to do this
- roles and responsibilities of individuals and organisations within the investigations, with particular reference to the role of the police
- whether a medical examination/treatment is required and if so, who will carry out what actions, by when and for what purpose?
- What action may be required if attempts are made to remove the child/adult from the country (i.e. Local Authority to make an application to court seeking a FGMPO)
- Identify key outcomes for the child and their family and the implications and impacts on the wider community
- Identify immediate next steps to safeguard the child (Section 47 Investigation, seek further Legal Advice, complete a Child and Family Assessment).

An interpreter must be used during all interviews with the family, and more importantly the affected female, if their first language is not English. The interpreter must not be a family relation and must not be known to the family. The interpreter should be female.

In cases where an interpreter is not used, and English is not the child's first language, the reasons for not using an interpreter must be recorded. Appropriate communication aids must be offered for affected females who have difficulties communicating due to disability/illness and this should be documented within their record. All interviews should be undertaken in a sensitive manner, and a Section 24 interview should ideally only be carried out once.

The child's agreement to being interviewed should always be sought prior to the interview. With regards to children, parental consent should be sought before a child's interview takes place, unless to do so would increase the likelihood of harm to the child.

All attempts must be made to work in partnership with parents, and to endeavour for parents to retain full parental rights in these circumstances. Where consent is not given, legal advice should be sought.

An outcome strategy discussion meeting should be held within timescales to discuss the outcomes and recommendations from the investigation and continue to plan the protection of the child. At all times the primary focus is to prevent the child undergoing any form of FGM by working in partnership with parents, carers and the wider community to address risk factors. However, where the assessment identifies a continuing risk of FGM then the first priority is protection, and the local authority should consider the need for:

- Legal action
- Criminal prosecution
- An Initial Child Protection Conference

Where a child has been identified as at risk or has been mutilated, it may not be appropriate to take steps to remove the child or an adult at risk from an otherwise loving family environment. Experience has shown that often the parents themselves can experience pressure to agree to FGM and see it as the best thing they can do for their daughter's future

marriage prospects. It is also important to recognise that those seeking to arrange the mutilation are unlikely to perceive it to be harmful and, on the contrary, believe it to be legitimate due to longstanding traditions.

Therefore, it is essential that when first approaching a family about the issues of FGM, a thorough assessment should be undertaken, with particular focus on:

- Parental/carer attitudes and understanding about the practice
- Child or young person's knowledge, understanding and views on the issue
- Whether the child or young person meets the criteria for ongoing services as a Child in Need
- Some thought and consideration should be given to where the assessment is undertaken. For example, it may be beneficial to talk to the family / victim outside the home environment to encourage them to talk freely and acknowledge the impact FGM would have.

Every attempt should be made to work with parents/carers on a voluntary basis to prevent abuse. It is the duty of social care to look at every possible way that parental/family cooperation can be formulated, the category of harm should be recorded as physical abuse.

Following all enquiries into FGM, regardless of the outcome, consideration must be given to the therapeutic/counselling needs of the child and their family.

Arranging a medical examination

A medical examination, if necessary, must only be undertaken with the child's consent (if considered to be Gillick competent) or the parent's consent (if the child is under 13 years-old or under 16 years-old and not Gillick competent). Where parents do not consent, legal advice should be sought.

In most cases there should only be one medical examination of the child or young person. In the cases of a child or young person known to have had FGM performed/or where professionals believe they have experienced FGM, there must be discussion with a Consultant Community Paediatrician to decide whether it is in the child's best interests to be seen locally or if a referral is to be made to the Specialist Paediatric FGM Clinic at the University College London Hospital to access expert advice and support.

In cases where subsequent medicals are required, clear reasons for this decision should be recorded as part of the assessment. Strategy discussions must involve health representatives with the appropriate competencies in managing FGM e.g. Local Community Paediatrician / Sexual Assault Referral Centre (SARC) professional / Specialist FGM Paediatrician.

If a medical/surgical procedure is required, and parents/carers refuse consent, legal advice must be sought immediately.

In the event of a suspicion about possible child sexual abuse, professionals must refer to the KSCMP/MSCP safeguarding procedures, including the Kent and Medway pathway for child sexual abuse medicals.

Children/young people in immediate danger

Where a child or young person appears to be in immediate danger of FGM and parents cannot satisfactorily guarantee that they will not proceed with it, an appropriate legal order should be sought.

If there is no evidence of risk

If the safeguarding enquiry concludes that there is no clear evidence of risk to the female then Integrated Children's Services (Kent) / Children's Social Care (Medway) will:

- Consult the child's GP, health visitor or school nurse about this conclusion and invite them to notify social care if any further information challenges it
- Notify appropriate professionals involved with the family of the enquiry and the stage at which it was concluded
- Inform the family and the referrer that the enquiry has been concluded
- Consider whether any child may be a Child in Need, and if so, offer appropriate services and to the child and their family

If it appears that no other children are at risk

- Integrated Children's Services/Children's Social Care will take no further action other than to liaise with health services to review any health concerns for the child who has undergone the procedure
- If the FGM seems to have been performed in the UK, the Police will seek information for the possible prosecution of the perpetrator
- The Integrated Children's Services/Children's Social Care will notify the child's GP, health visitor or school nurse and invite them to notify them if any changes in the situation arise e.g. the mother giving birth to further girls
- If there are concerns about younger girls in the family, Integrated Children's Services/Children's Social Care must convene a strategy meeting as soon as possible to discuss whether any protective action needs to be taken.

16. Frameworks, resources and useful links

Frameworks

These procedures have been developed by the KSCMP and MSCP and should be used in conjunction with the Kent and Medway Safeguarding Children Procedures. In addition, these procedures consider the following legislative frameworks:

- Multi-agency statutory guidance on female genital mutilation
- Mandatory reporting for female genital mutilation – procedural information

- Female genital mutilation risk and safeguarding – guidance for professionals
- FGM safeguarding and risk assessment – quick guide for health professionals
- Female genital mutilation: caring for patients and safeguarding children
- Female Genital Mutilation Act 2003

Resources

These local and national resources can be used to help raise professional's awareness and understanding as well as assist in safeguarding those at risk of FGM:

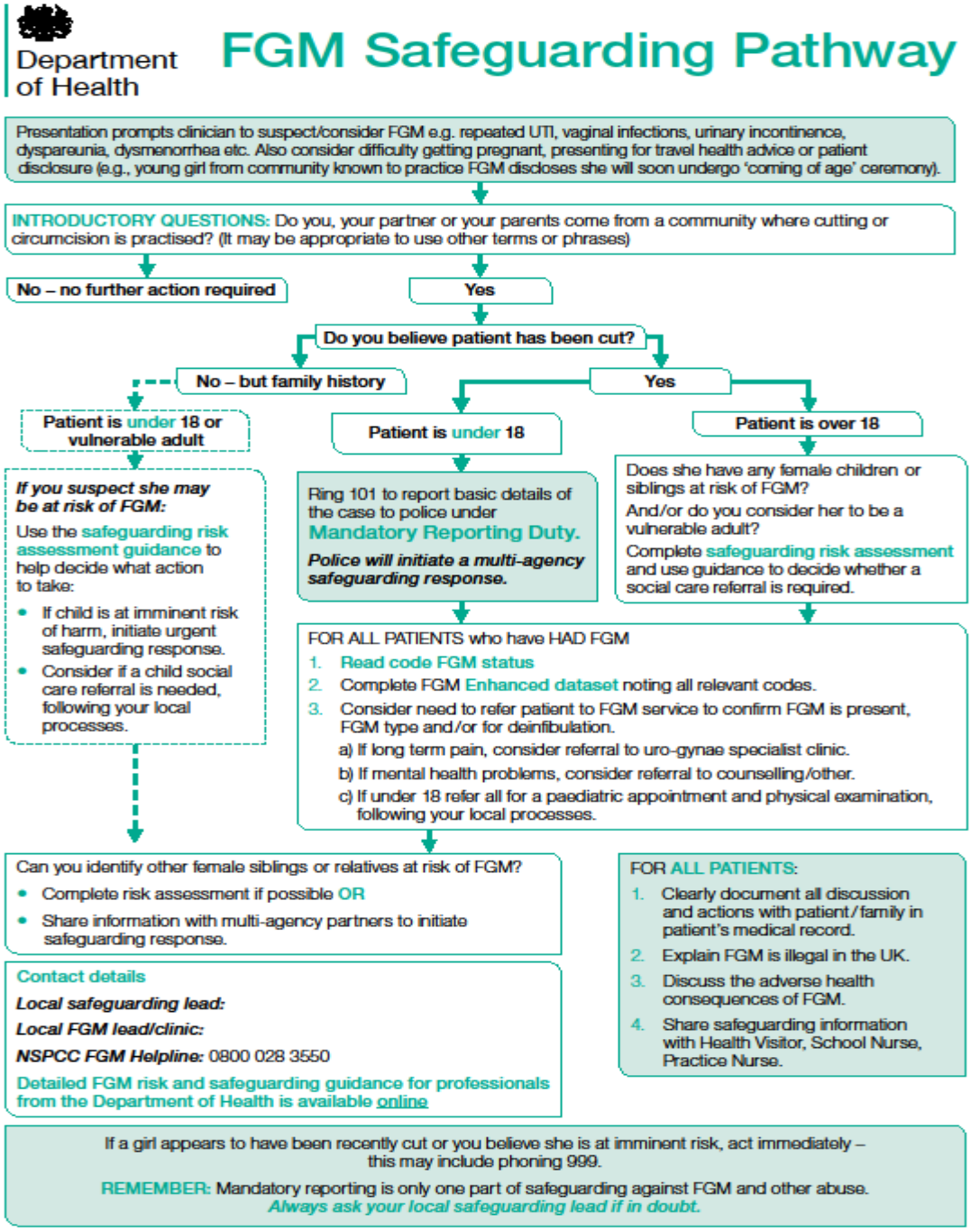
- Female genital mutilation resource pack (Home Office)
- FGM assessment tool for social workers (National FGM Centre)
- Safeguarding women and girls at risk of FGM (Department of Health and Social Care)
- FGM protection orders factsheet
- FGM safeguarding pathway

Useful links

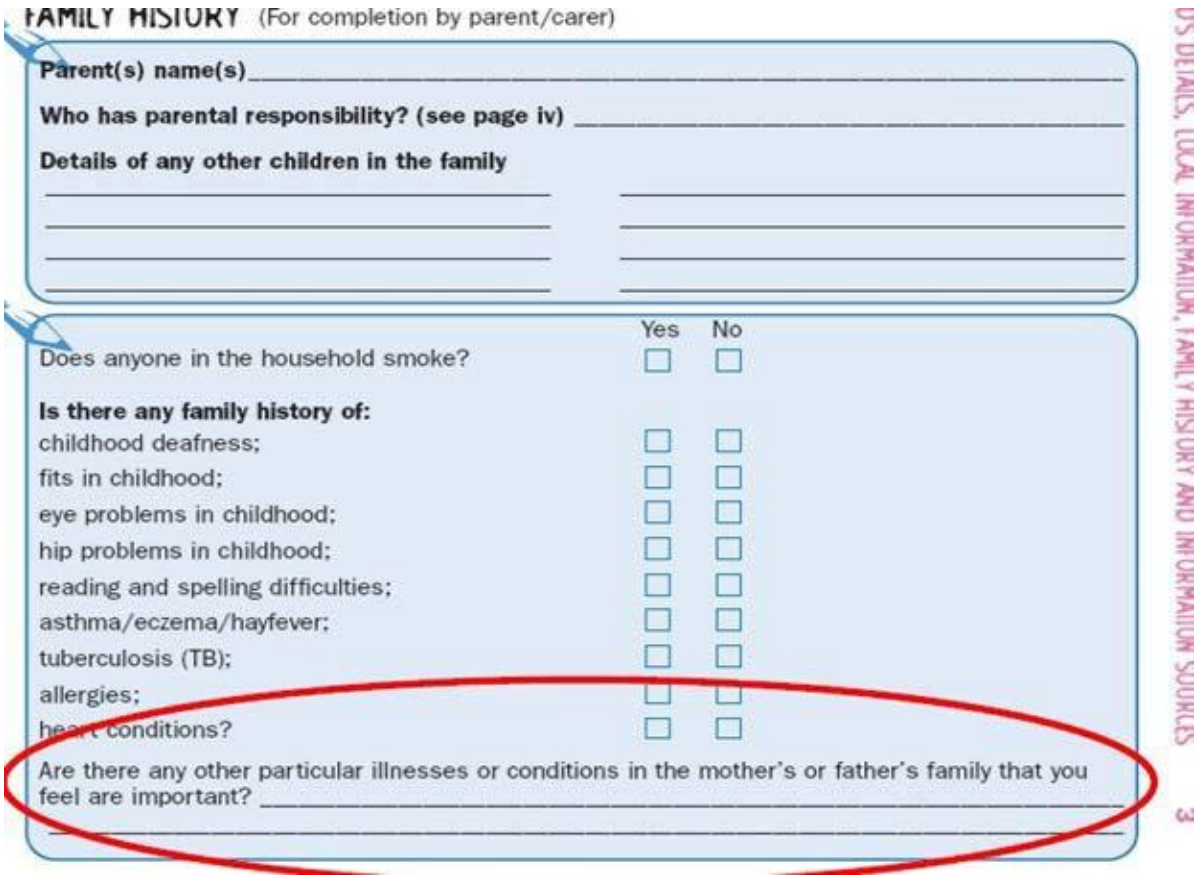
A variety of websites are available to seek further support and advice regarding FGM. These include:

- NHS – FGM
- World Health Organisation (WHO)
- National FGM Centre
- NSPCC
- Kent Safeguarding Children Multi-Agency Partnership
- Medway Safeguarding Children Multi-Agency Partnership

Appendix 1 – FGM Safeguarding Pathway



Appendix 2 – Recoding FGM in the Personal Child Health Record (red book)



FAMILY HISTORY (For completion by parent/carer)

Parent(s) name(s) _____

Who has parental responsibility? (see page iv) _____

Details of any other children in the family

_____ _____

_____ _____

_____ _____

_____ _____

	Yes	No
Does anyone in the household smoke?	☐	☐
Is there any family history of:		
childhood deafness;	☐	☐
fits in childhood;	☐	☐
eye problems in childhood;	☐	☐
hip problems in childhood;	☐	☐
reading and spelling difficulties;	☐	☐
asthma/eczema/hayfever;	☐	☐
tuberculosis (TB);	☐	☐
allergies;	☐	☐
heart conditions?	☐	☐

Are there any other particular illnesses or conditions in the mother's or father's family that you feel are important? _____

_____

DS DETAILS, LOCAL INFORMATION, FAMILY HISTORY AND INFORMATION SOURCES 3