Our safeguarding arrangements will effectively prevent and respond to adult abuse

SAFEGUARDING ADULTS WORKBOOK

Module Five

Female Genital Mutilation

Teeswide Safeguarding Adults Board

Contents

Revision Number	Date Approved by the Board	Links to Other Policies	Review Date:
One	28 June 2016		June 2017
Two	May 2017		May 2018
Three	Sept 2018 (Business Unit)		Sept 2019

Introduction

This workbook has been developed for staff and volunteers who have completed Safeguarding Adults awareness training, which may have been through attending a tutor-led course, completing an e-learning course or the TSAB Safeguarding Adults Awareness workbook. This workbook will build on your prior learning and is module 5 of 8. The modules are as follows:

Module 1: Learning from Serious Instances of Adult Abuse
Module 2: The Mental Capacity Act & Deprivation of Liberty Safeguards
Module 3: Domestic Abuse
Module 4: Forced Marriage
Module 5: Female Genital Mutilation
Module 6: Prevent
Module 7: Modern Slavery
Module 8: Self-Neglect.

You must complete all sections of the workbooks and return them to your Manager for assessment. When you have successfully completed all of the modules, you will be issued with a certificate and your training records will be updated: the workbooks will be returned to you to be used as a reference tool.

In the appendices, you will find the current Teeswide Inter-Agency Safeguarding Adults Policy and Procedures for reference purposes.

The workbook has been checked for legal accuracy and is accurate as of Sept 2018. Suggested study time to be allocated to complete this module: 3 hours.

Once you have completed the workbooks please forward the ***Certificate of Completion*** page to the Teeswide Safeguarding Adults Board, Business Unit, using the contact details below, who will make a record of completion and issue a certificate.

Teeswide Safeguarding Adults Board Business Unit, Kingsway House, West Precinct, Billingham, TS23 2NX Email: tsab.businessunit@stockton.gov.uk

This workbook is aligned with nationally recognised competencies. It is based on the Bournemouth University National Competence Framework for Safeguarding Adults, reviewed in 2015, and mapped against the Safeguarding Adults: Roles and competences for health care staff- Intercollegiate Document issued August 2018.

On completing of this workbook, you will be able to:

Level 1 (Foundation)

1. Understand and demonstrate what Adult Safeguarding is
2. Recognise adults in need of Safeguarding and take appropriate action
3. Understand dignity and respect when working with individuals
4. Understand the procedures for raising a Safeguarding Concern
5. Have knowledge of policy, procedures and legislation that supports Safeguarding Adults activity
6. Ensuring effective administration and quality of safeguarding processes.

Target groups: **Alerters and NHS Level 1 & part of Level 2**

Including: All staff and volunteers in health and social care settings, all frontline staff in Fire and Rescue, Police and Neighbourhood Teams and Housing, Clerical and Administration staff, Domestic and Ancillary staff, Health and Safety Officers, staff working in Prisons and custodial settings, other support staff, Elected Members, Governing Boards and Safeguarding administrative support staff.

Although the word 'Alerter' is used here in conjunction with the national competency framework, the term 'Safeguarding Concern' was introduced in April 2015 to replace this.

Level 2 (Intermediate)

1. Demonstrate skills and knowledge to contribute effectively to the safeguarding process
2. Have awareness and application of legislation, local and national policy and procedural frameworks.

Target Groups: **Responders, Specialist Staff and NHS Level 2 & 3**

Including: Social Workers, Senior Practitioners, Social Work Team Managers, Voluntary and Independent Sector Managers, Heads of Nursing, Health and Social Care Provider Service Managers, Safeguarding Adult Co-ordinators, Police Officers, Probation Officers, Community Safety Managers, Prison Managers, MCA Lead, Best Interests assessors (including DoLS), Advocates, Therapists, Fire and Rescue Officers, staff working in Multi-Agency Safeguarding Hubs.

Female Genital Mutilation

FGM is a criminal offence; it is a form of violence against women and girls, therefore child abuse. FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life.

Principles

The following principles should be adopted by all agencies in relation to identifying and responding to girls (and unborn girls) and women at risk of, or who have experienced, FGM and their parent(s):

- The safety and welfare of the child is paramount
- All agencies act in the interests of the rights of the child as stated in the UN Convention (1989)
- FGM is illegal in the UK
- FGM is not a matter that can be left to be decided by personal preference – it is an extremely harmful practice. Professionals should not let fears of being branded 'racist' or 'discriminatory' weaken the protection required by vulnerable girls and women
- Accessible, acceptable and sensitive health, education, police, social care and voluntary sector services must underpin interventions
- It is acknowledged that some FGM practising families do not see it as an act of abuse; (however, FGM has severe significant physical and mental health consequences both in the short and long term and must not be excused, accepted or condoned)
- As an often embedded 'cultural practice', engagement with families and communities will be required to achieve a long-term abandonment and eradication of FGM
- All decisions or plans should be based on good quality assessments (using, for example, the common assessment framework) and be sensitive to the issues of race, culture, gender, religion and sexuality; and should avoid stigmatising the girl or woman affected, and the practising community, as far as possible given the other principles above.

What are the issues around FGM?

Summary:

- It is illegal in the UK to subject a girl or woman to, or to assist a non-UK person or UK resident to, carry out FGM overseas. For the purpose of the criminal law in England, Wales and Northern Ireland, FGM is mutilation, excision or infibulation of the labia majora, labia minora or clitoris.
- FGM is prevalent in 28 African countries as well as in parts of the Middle East and Asia.
- It has been estimated that over 20,000 girls under the age of 15 are at high risk of FGM in the UK each year and that 66,000 women in the UK are living with the consequences, although its true extent is unknown due to the hidden nature of the crime practised by families for a variety of complex reasons but often in the belief that it is beneficial for the girl or woman
- FGM constitutes a form of child abuse and violence against women and girls, and has severe short-term and long-term physical and psychological consequences.

Types of FGM

FGM has been classified by the World Health Organisation 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, labia, with or without removal of the clitoris
- Type 4 – other: all other harmful procedures to the female Genital for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

The age at which girls undergo FGM varies enormously according to the community. **The procedure may be carried out when the girl is new-born, during childhood or adolescence, just before marriage or during the first pregnancy.** However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 and therefore girls within that age bracket are at a higher risk.

UK Legislation

FGM is illegal in the UK
In England, Wales and Northern Ireland, the practice is illegal under the Female Genital Mutilation Act 2003 (this offence captures mutilation of a female's labia majora, labia minora or clitoris), and in Scotland it is illegal under the Prohibition of

Female Genital Mutilation (Scotland) Act 2005.

Under the 2003 Act, a person is guilty of an offence if they excise, infibulate or otherwise mutilate the whole or any part of a girl's or woman's labia majora, labia minora or clitoris.

Other than in excepted circumstances, it is an offence for any person to:
S1 Perform FGM in England and Wales
S2 Assist a girl to carry out FGM on herself in England and Wales
S3 Assist from England and Wales a none UK national or UK resident to carry out FGM outside the UK on a UK national or UK resident.

Any person found guilty of an offence under s 1, 2, or 3 of the Female Genital Mutilation Act 2003 will be liable to a maximum penalty of a fine or imprisonment of up to 14 years, or both.

The duty to protect
S3 A of the Act creates an offence of failing to protect a girl from risk of FGM.

S5B of the Act introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s to the police.

Read the guidance: **'Mandatory reporting of female genital mutilation: procedural information**'.

FGM Protection Orders
This is a civil order which may be made for the purposes of protecting a girl against the commission of an FGM offence – that is protecting a girl at risk of FGM or protecting a girl against whom an FGM offence has been committed.

Breach of a FGMPO is a criminal offence with a maximum penalty of up to five years imprisonment.

It is also an offence to assist a girl or woman to mutilate her own Genital. It is an offence for anyone (regardless of their nationality and residence status) to perform FGM in the UK or to assist a girl to perform FGM on herself in the UK. Provided that the mutilation takes place in the UK, the nationality or residence status of the victim is irrelevant.

Taking Place Overseas
It is an offence under the 2003 act for a UK national or permanent UK resident to perform FGM, or to assist a girl to perform FGM on herself, outside the UK. It is also an offence to assist FGM carried out abroad by anyone (including foreign nationals); although in some cases the offence is limited to the situation where the **victim** is a UK national or permanent UK resident. This would cover taking a girl abroad to be subjected to FGM.

Under the Children Act 1989, local authorities can apply to the courts for various orders to prevent a child from being taken abroad for mutilation.

''The girls knew from school that they shouldn't allow FGM to be done to them. They didn't want to be mutilated so they refused to go back to their family's country of origin... they went to the authorities and told them they were afraid to go back because of this. The authorities made the family guarantee that if they went back to their country on holiday, they would not do anything to the girls and monitored this.''

Any person found guilty of an offence under the Female Genital Mutilation Act 2003 will be liable to a maximum penalty of a fine or imprisonment of up to 14 years, or both.

International Prevalence of FGM

FGM is a deeply rooted tradition, widely practised mainly among specific ethnic populations in Africa and parts of the Middle East and Asia, which serves as a complex form of social control of women's sexual and reproductive rights. The World Health Organization estimates that between 100 and 140 million girls and women worldwide have experienced female genital mutilation and around 3 million girls undergo some form of the procedure each year in Africa alone. FGM has also been documented in communities in Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan.

Prevalence of FGM in the UK

- Over 1,700 victims of FGM were referred to specialist clinics in the last two years
- FGM is most commonly carried out when a girl is 5-8 years old
- 23,000 girls under 15 could be at risk of FGM in England and Wales
- NSPPC have responded to over 600 contacts about FGM since June 2013. More than a third of these contacts have resulted in a referral to the police or children's services
- Nearly 60,000 women could be living with the consequences of FGM

Source: NSPCC internal figures (as of 14 April 2015).

There is likely to be an uneven distribution of cases of FGM around the country, with more occurring in those areas of the UK with larger communities from the practising countries– found by the same study to be London, Cardiff, Manchester, Sheffield, Northampton, Birmingham, Oxford, Crawley, Reading, Slough and Milton Keynes. However, all areas, local authorities and professionals must be aware of and actively prevent and tackle FGM.

Names for FGM

FGM is known by a number of names, including 'female genital cutting', 'circumcision' or 'initiation'. The term 'female circumcision' is unfortunate because it is anatomically incorrect and gives a misleading analogy to male circumcision.

The names 'FGM' or 'cut' are increasingly used at the community level, although they are still not always understood by individuals in practising communities, largely because they are English terms.

Cultural Underpinnings and Motives of FGM

FGM is a complex issue, with a variety of explanations and motives given by individuals and families who support the practice (see box below).

Reasons given for practising FGM:

- It brings status and respect to the girl
- It preserves a girl's virginity/chastity
- It is part of being a woman
- It is a rite of passage
- It gives a girl social acceptance, especially for marriage
- It upholds the family honour
- It cleanses and purifies the girl
- It gives the girl and her family a sense of belonging to the community
- It fulfils a religious requirement believed to exist.
- It perpetuates a custom/tradition
- It helps girls and women to be clean and hygienic
- It is cosmetically desirable
- It is mistakenly believed to make childbirth safer for the infant

FGM is often seen as a natural and beneficial practice by a loving family who believe that it is in the girl's or woman's best interests. This also limits a girl's incentive to come forward to raise concerns or talk openly about FGM– reinforcing the need for all professionals to be aware of the issues and risks of FGM. It is because of these beliefs that girls and women who have not undergone FGM can be considered by practising communities to be unsuitable for marriage.

''People know of it as a tradition. They take it for granted as an operation that must be done to all girls.''

Despite the harm it causes, many women from FGM -practising communities consider FGM normal to protect their 'cultural identity'. As a result of the belief systems of the cultural groups who practise FGM, many women who have undergone FGM believe they appear more attractive than women who have not

undergone FGM. Women who have attempted to resist exposing their daughters to FGM, report that they and their families were ostracised by their community and told that nobody would want to marry their daughters.

''In our community the mother usually tells you that you have to protect yourself and your honour and not to bring the family shame.''

Infibulation (type 3) is strongly linked to virginity and chastity, and used to safeguard girls from sex outside marriage and from having sexual feelings. In some cultures, it is considered necessary at marriage for the husband and his family to see her 'closed' and, in some instances, both mothers will take the girl to be cut open enough to be able to have sex.

Although FGM is practised by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. However, FGM predates Christianity, Islam and Judaism, and the bible, Koran, Torah and other **religious texts do not advocate or justify FGM**.

Despite this, religion is sometimes given as a justification for FGM. For example, some people from Muslim communities argue that the Sunna (traditions or practices undertaken or approved by the prophet Mohammed) recommend that women undergo FGM, and some women have been told that having FGM will make them 'a better Muslim'.

However, senior Muslim clerics at an international conference on FGM in Egypt in 2006 pronounced that FGM is not Islamic, and the London central mosque has spoken out against FGM on the grounds that it constitutes doing harm to oneself or to others, which is forbidden by Islam.

Some views of people from FGM practising communities

"I cannot trust her if she is not circumcised"

"Female circumcision in our country has many beneficial aims like to keep the honour of the girl, but generally circumcision is not good because there is a difference between circumcised women and uncircumcised women"

"Yes I am happy to marry an uncircumcised woman"

"The right time to open my circumcision is at night-time of marriage"

FGM Procedure

It is believed that **FGM happens to British girls in the UK as well as overseas** (often in the family's country of origin). Girls of school age who are subjected to FGM overseas are thought to be taken abroad at the start of the school holidays, particularly in summer, in order for there to be sufficient time for her to recover before returning to her studies.

''Usually it is a gruesome ordeal with a lot of crying from the girl, and even with the child's screams no one does anything about it and her screams are ignored.''

FGM is usually carried out by the older women in a practising community, for whom it is a way of gaining prestige and can be a lucrative source of income. 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 or anaesthesia. The instruments used include unsterilised household knives, razor blades, broken glass and stones. The girl may often not be expecting the procedure, exacerbating the trauma that is experienced.

Consequences of FGM

Many men and women in practising communities can be unaware of the relationship between FGM and its harmful health and welfare consequences as set out below, in particular the longer-term complications affecting sexual intercourse and childbirth.

Immediate/short-term implications for a girl's health and welfare

The immediate/short-term consequences following a girl undergoing FGM 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.

Long-term implications for a girl or woman's health and welfare
The longer-term implications for women who have been subjected to FGM Types 1 and 2 are likely to be related to the trauma of the actual procedure, while health problems caused by FGM Type 3 are severe.

World Health Organisation research has shown that women who have undergone FGM of all types, but particularly Type 3, are more likely to have complications during childbirth.

Long-Term Consequences of FGM
The long-term consequences of FGM can include:

- Genital scarring
- Genital cysts and keloid scar formation
- Recurrent urinary tract infections and difficulties in passing urine
- Possible increased risk of blood infections such as hepatitis B and HIV
- Pain during sex, lack of pleasurable sensation and impaired sexual function
- Psychological concerns such as anxiety, flashbacks and post-traumatic stress disorder
- Difficulties with menstruation (periods)
- Complications in pregnancy or childbirth (including prolonged labour, bleeding or tears during childbirth, increased risk of caesarean section); and
- Increased risk of stillbirth and death of child during or just after birth.

Psychological and mental health problems
Case histories and personal accounts taken from women indicate that FGM is an extremely traumatic experience for girls and women, which stays with them for the rest of their lives. Young women receiving psychological counselling in the UK report feelings of betrayal by parents, incompleteness, regret and anger. There is increasing awareness of the severe psychological consequences of FGM for girls and women, which can become evident in mental health problems.

The results from research in practising African communities are that women who have undergone FGM have the same levels of Post-Traumatic Stress Disorder (PTSD) as adults who have been subjected to early childhood abuse, and that the majority of the women (80 per cent) suffer from affective (mood) or anxiety disorders.

The fact that FGM is 'culturally embedded' in a girl's or woman's community appears not to protect her against the development of PTSD and other psychiatric disorders. Professionals, particularly those in the health sector, should ensure that mental health support is made available to assist girls and women who have undergone FGM.

Identifying Young Women and Children at Risk

Professionals in all agencies, and individuals and groups in relevant communities, need to be alert to the possibility of a girl or woman being at risk of FGM, or already having undergone FGM.

There are a range of potential indicators that a child or young person may be at risk of FGM, which individually may not indicate risk but if there are two or more indicators present this could signal a risk to the child or young person.

Victims of FGM are likely to come from a community that is known to practice FGM.

Provided that the mutilation takes place in the UK, the nationality or residence status of the victim is irrelevant.

Professionals should also note that the girls and women at risk of FGM may not yet be aware of the practice or that it may be conducted on them, so sensitivity should always be shown when approaching the subject.

Specific factors that may heighten a girl's or woman's risk of being affected by FGM

There are a number of factors in addition to a girl's or woman's community that could increase the risk that she will be subjected to FGM:

- A female child is 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
- A female child has a sister or cousin who has already undergone FGM must be considered to be at risk, as must other female children in the extended family
- A female child's father comes from a community known to practice FGM
- The family indicate that there are strong levels of influence held by elders and/or elders are involved in bringing up female children
- A woman/family believe FGM is integral to cultural or religious identity
- A girl/family has limited levels of integration within the UK community
- Parents have limited access to information about FGM and do not know about the harmful effects of FGM or UK law
- Parents state that they or a relative will take the girl out of the country for a prolonged period
- A parent or family member expresses concern that FGM may be carried out on the girl
- A family is not engaging with professions, health, education or other
- A family is already known to Social Care in relation to other safeguarding issues
- A girl form a practicing community is withdrawn from Personal, Social, Health and Economic education

- A girl is unexpectedly absent from school
- A professional may hear reference to FGM in conversation, for example a girl may tell other children about it
- 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 undergone FGM must be considered to be at risk, as must other female children in the extended family
- Any girl withdrawn from Personal, Social and Health Education or Personal and Social Education may be at risk as a result of her parents wishing to keep her uninformed about her body and rights.

Indications that FGM may be about to take place soon

The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is new-born, during childhood or adolescence, at marriage or during the first pregnancy**.** However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 and therefore girls within that age bracket are at a higher risk.

There can be clear signs when FGM is imminent:

- It may be possible that families will practise FGM in the UK when a female family elder is around, particularly when she is visiting from a country of origin
- A professional may hear reference 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
- A girl may talk about a long holiday to her country of origin or another country where the practice is prevalent.

Indications that FGM may have already taken place:

It is important that professionals look out for signs that FGM has already taken place so that:

- the girl or woman affected can be offered help to deal with the consequences of FGM
- Enquiries can be made about other female family members who may need to be safeguarded from harm; criminal investigations into the perpetrators, including those who carry out the procedure, can be considered to prosecute those breaking the law and to protect others from harm.

There are a number of indications that a girl or woman has already been subjected to FGM:

- A girl or woman asks for help
- A mother/family member confides in a professional that FGM has taken place
- A girl or woman finds it hard to sit still for long periods of time, and this was not a problem previously
- A girl avoids physical exercise or requires to be excused from physical exercise without a GP letter
- Prolonged or repeated absences from school or college
- Increased emotional or psychological needs, for example withdrawal or depression, or significant change in behaviour
- A girl talks of pain or discomfort between her legs
- A girl or woman may have difficulty walking, sitting or standing
- A girl or woman may spend longer than normal in the bathroom or toilet due to difficulties urinating
- A girl may spend long periods of time away from a classroom during the day with bladder or menstrual problems
- A girl or woman may have frequent urinary or menstrual problems
- There may be prolonged or repeated absences from school or college
- A prolonged absence from school or college with noticeable behaviour changes (e.g. withdrawal or depression) on the girl's return could be an indication that a girl has recently undergone FGM
- A girl or woman may be particularly reluctant to undergo normal medical examinations
- A girl or woman may confide in a professional
- A girl or woman may ask for help, but may not be explicit about the problem due to embarrassment or fear.

Good Practice to Follow in all Cases

In all cases:

If you are worried about someone who is at risk of FGM or has had FGM, you must share this information with social care or the police. It is then their responsibility to investigate and safeguard and protect any girls or women involved. Other professionals should not attempt to investigate cases themselves. Please refer to your organisational procedures.

Duty to safeguard children and protect women at risk

Safeguarding girls and women at risk of harm through FGM poses specific challenges because the families involved may give no other cause for concern, for example with regard to their parenting responsibilities or relationships with their children. However, there remains **a duty for all professionals to act to safeguard girls and women at risk** – with four key issues to consider:

1. An illegal act being performed on a female, regardless of age
2. The need to safeguard girls and young women at risk of FGM
3. The risk to girls and young women where a relative has undergone FGM
4. Situations where a girl may be removed from the country to undergo FGM.

An illegal act being performed on a female, regardless of age

In addition to the legislation specifically criminalising FGM, professionals must abide by other relevant laws such as the Children Act 2004 (England and Wales) and the Children (Northern Ireland) Order 1995, the Human Rights Act 1998, and the European Convention on Human Rights, particularly Article 3 that no one will be "subjected to torture or to inhuman or degrading treatment or punishment".

The UN Convention on the Rights of the Child, which the UK has ratified, also applies and makes clear that any person below the age of 18 has the right to protection from activities or events that may cause them harm and that they need special safeguards and care, including appropriate legal protection.

> Professionals have a responsibility to ensure that families know that FGM is illegal, and should ensure that families know that the authorities are actively tackling the issue. This knowledge alone may deter families from having FGM performed on their children, and save girls and women from harm.

The need to safeguard girls and young women at risk of FGM

Under section 47 of the Children Act 1989, **anyone who has information that a child is potentially or actually at risk of significant harm is required to inform social care or the police**. Initially, the professional will refer the potential victim as a **child in need** and social services will assess the risk. This definition of harm has been extended in the Adoption and Children Act 2002, which includes where someone sees or hears of the ill treatment of another. Specifically, this relates to situations where there may not be direct disclosure of FGM being performed. See: **Safeguarding and Promoting the Welfare of Adults and Children at Risk Guidance** (signposted on page 22).

A local authority should exercise its powers to make enquiries to safeguard a girl's welfare under section 47 of the Children Act 1989 if it has reason to believe that a girl is likely to be subjected to or has been subjected to FGM. However, despite the very severe health consequences, parents and others who have FGM performed on their daughters do not intend it as an act of abuse – they believe that it is in the girl's best interests to conform with their prevailing custom.

Therefore, where a girl has been identified as being at risk of significant harm, it may not always be appropriate to remove the child from an otherwise loving family environment. Where a girl appears to be in immediate danger of FGM, consideration should be given to legal interventions.

It is an offence for a UK national or permanent resident to assist a non-UK person to perform a relevant act of FGM (as defined in section 3(2) of the Female Genital Mutilation Act 2003) abroad – this would cover taking a girl abroad to be subjected to FGM. However, there may be instances where the exact risk of this occurring is not known, but one parent – or a professional – may be concerned enough to alert professionals. In certain circumstances a Prohibitive Steps Order or Wardship Order can be used to prevent a girl being removed from the country – Chapter 5 describes legal interventions in more detail.

Talking about FGM

FGM is a complex and sensitive issue that requires professionals to approach the subject carefully.

An accredited female interpreter may be required. Any interpreter should be appropriately trained in relation to FGM and should not be a family member, not be known to the individual, and not be an individual with influence in the individual's community. This is because girls or women may feel embarrassed to discuss sensitive issues in front of such people and there is a risk that personal information may be passed on to others in their community and place them in danger.

Furthermore, there is a risk that interpreters who are from the family or who are from the individual's community may deliberately mislead professionals and/or encourage the individual to drop the complaint and submit to the wishes of their community or family.

When talking about FGM, professionals should:

- Ensure that a female professional is available to speak to if the girl or woman would prefer this
- Make no assumptions
- Give the individual time to talk and be willing to listen

- Create an opportunity for the individual to disclose, seeing the individual on their own in private
- Be sensitive to the intimate nature of the subject
- Be sensitive to the fact that the individual may be loyal to their parents
- Be non-judgemental (pointing out the illegality and health risks of the practice, but not blaming the girl or woman)
- Get accurate information about the urgency of the situation if the individual is at risk of being subjected to the procedure
- Take detailed notes
- Use simple language and ask straightforward questions
- Use terminology that the individual will understand, e.g. the individual is unlikely to view the procedure as 'abusive'
- Avoid loaded or offensive terminology such as 'mutilation'
- Use value-neutral terms understandable to the woman, such as:
  - "Have you been closed?"
  - "Were you circumcised?"
  - "Have you been cut down there?"

Be direct, as indirect questions can be confusing and may only serve to reveal any underlying embarrassment or discomfort that you or the patient may have. If any confusion remains, ask leading questions such as:

- "Do you experience any pains or difficulties during intercourse?"
- "Do you have any problems passing urine?"
- "How long does it take to pass urine?"
- "Do you have any pelvic pain or menstrual difficulties?"
- "Have you had any difficulties in childbirth?"

Give the message that the individual can come back to you if they wish. Give a clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM if/when they have daughters.

Women often recount feelings of great distress and humiliation due to the responses they receive from professionals when it is revealed that they have been subjected to FGM. They describe looks of horror, inappropriate and insulting questions, and feelings of shame from being made to feel 'abnormal'. Such negative reactions from professionals are caused by a lack of awareness or understanding of the issue, but can be devastating to a woman who has been subjected to FGM. These stories of negative experiences may reach the communities that practise FGM and could build barriers to the effective care and prevention of FGM, and deter women and girls from seeking treatment or support.

Asking the right questions in a straightforward and sensitive way is key to establishing the understanding, information exchange and relationship needed to ensure that the girl or woman, and her family members, are given the care, protection and safeguarding they need.

Individuals **Remember:**

- May wish to be interviewed by a professional of the same gender
- They may not want to be seen by a professional from their own community
- Alerting the girl's or woman's family to the fact that she is disclosing information about FGM may place her at risk of harm
- Develop a safety and support plan in case they are seen by someone 'hostile' at or near the department, venue or meeting place, e.g. prepare another reason why they are there
- If they insist on being accompanied during the interview, e.g. by a teacher or advocate, ensure that the accompanying person understands the full implications of confidentiality, especially with regard to the person's family
- For some, an interview may require an authorised accredited interpreter who speaks their dialect
- Do not assume that families from practising communities will want their girls and women to undergo FGM.

Person centered approach

Whatever an individual's circumstances, they have rights that should always be respected, such as the right to personal safety and to be given accurate information about their rights and choices. Professionals should listen to the victim and respect their wishes whenever possible.

However, there may be times when a victim wants to take a course of action that may put them at risk – on these occasions, professionals should explain all the outcomes and risks to the victim and take the necessary safeguarding precautions. Professionals should also be clear that FGM is a criminal offence in the UK and must not be permitted or condoned.

Forced marriage and FGM

There have been reports of cases where individuals have been subjected to both FGM and forced marriage. If you are concerned about an individual who may be at risk of both practices, you should consult the multi-agency practice guidelines on handling cases of forced marriage.

These can be found at: www.gov.uk/guidance/forced-marriage#guidance-for-professionals

Alternatively, you can contact the government's Forced Marriage Unit for advice on 020 70080151 (Monday – Friday, 9am – 5pm; call 020 70081500 and ask for the Global Response Centre in emergencies outside these hours).

Useful References and Websites

Care Act 2014 - Care and Support Statutory Guidance (Revised Feb 2017) https://www.tsab.org.uk/wp-content/uploads/2015/11/Revised-Care-Act-Guidance-Annotated-Chapter-14-20160311.pdf

FGM – Help and Advice: https://www.gov.uk/female-genital-mutilation-help-advice

MCA 2005 - Code of Practice
https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Multi-agency practice guidelines: Female Genital Mutilation, HM Government, 2011: https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

Teeswide Safeguarding Adults Board's Policies, Procedures and Guidance webpage including:

- Decision Support Guidance
- MCA and Deprivation of Liberty Safeguards Policy
- Safeguarding and Promoting the Welfare of Adults and Children at Risk Guidance

https://www.tsab.org.uk/key-information/policies-strategies/

Teeswide Safeguarding Adults Board - You Tube Channel (Playlist):
https://www.youtube.com/channel/UCMxNFNZsoxIc3YZEVXisx_w

Appendix 1

Teeswide Safeguarding Adults Concern Form

https://www.tsab.org.uk/report-abuse/

Appendix 2

Teeswide Safeguarding Adults Inter-Agency Procedure Summary

In accordance with the Care Act 2014, safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or at risk of abuse or neglect; and
- as a result of those care and support needs is unable to protect him/herself from either the risk, or the experience, of abuse or neglect

The adult experiencing, or at risk of abuse or neglect will be referred to the ***adult*** throughout this procedure.

		Stage of Procedure	Role	Responsibility	Maximum Timeframe
ENQUIRY PHASE	1	**Concern**	• Take immediate action to safeguard anyone at risk of abuse or neglect • Report and record concerns that an adult maybe at risk of abuse or neglect • Establish the ***adult's*** views, wishes if appropriate • Where an adult dies and abuse or neglect is suspected, a concern must be raised	Person raising concern	Immediate Inter-agency concern form completed within 1 day
	2	**Decision Making**	• Decision made as to whether the Inter-agency Safeguarding Procedure is appropriate to address the concern or whether more information is required as part of the enquiry • Decision support guidance used to inform the decision making process • Ensure that the views and wishes of the ***adult*** are taken into account • Determine who will undertake the initial enquiry if not the LA	Designated Officer	Within 3 days of receiving the concern

	Stage of Procedure	Role	Responsibility	Maximum Timeframe
		• Consider alternative action if safeguarding procedures are not appropriate • Consider providing feedback to the person raising the concern. • If the concern relates to a deceased adult, consideration to be given to raising a SAR notification • If the adult dies after the safeguarding concern has been raised, the enquiry will continue		
3	**Initial Enquiry**	• Further information gathered from identified sources in order to inform the decision as to whether to progress into safeguarding procedures • Seek or review the ***adult's*** views and wishes including their desired outcomes • Consider whether the ***adult*** requires an independent advocate to support them • Consider providing feedback to the person raising the concern *	Safeguarding partners; ***adult,*** their advocate, relative and carers	Within 3 days of receiving the concern
4	**Decision Making**	• Decision made as to whether the safeguarding procedures are appropriate to address the concern or whether more information is required as part of the enquiry • Decision support guidance used • Consider the ***adult's*** views and wishes including their desired outcomes • Consider whether the ***adult*** requires an	Designated Officer	Within 7 days of receiving the concern, if more time is required, the reason for the extended timescale must be recorded.

		Stage of Procedure	Role	Responsibility	Maximum Timeframe
			independent advocate to support them • Consider alternative action if safeguarding procedures are not appropriate • Consider providing feedback to the person raising the concern *		
ENQUIRY PHASE	**5**	**Strategy Meeting**	• Designated Officer co-ordinates the strategy discussion/meeting • Agencies invited to attend the strategy discussion to ensure they are prepared for the meeting and have the relevant information available to contribute to information sharing and decision • If the strategy discussion has taken place via telephone to ensure the adult is protected, then face-to-face strategy meeting will be convened at the earliest opportunity • Formulate a Inter-agency safeguarding plan if needed • Determine who will undertake the further enquiry if not the LA • Agree timescale for completion of enquiry • Involvement of the ***adult,*** their advocate, relative or carers to ensure that their views, wishes and desired outcomes are central to the process • Consider alternative action if safeguarding procedures are not appropriate	Designated Officer/all attendees	Within 7 days of receiving the concern, if more time is required, the reason for the extended timescale must be recorded.

	Stage of Procedure	Role	Responsibility	Maximum Timeframe
		• Consider providing feedback to the person raising the concern * • If a subsequent safeguarding concern is raised during an open safeguarding episode, this new concern must be explicitly considered and if necessary, a further face-to-face strategy meeting must be held		
6	**Further Enquiry**	• Agencies will provide an update on actions allocated at the previous strategy meeting • Co-ordination and collection of information about the safeguarding concern and the context in which it happened • On-going activity to address any protection needs • Involvement of the ***adult,*** their advocate, relative or carers to ensure their views, wishes and desired outcomes are central to the process • Identified lead investigator to report back to the Progress Strategy Discussion/Meeting every 28 days if the enquiry takes more than 28 days	Identified Lead Investigator	Within the timeframe agreed at the Strategy Discussion/Meeting
7	**Progress Strategy Discussion/Meeting**	• Review progress of enquiries, or if concluded evaluate the outcome • Review the views, wishes and desired outcomes of the ***adult*** • Review the interim safeguarding plan • Develop full safeguarding plan if needed	All attendees	Within 28 days of the initial Strategy Discussion/Meeting

	Stage of Procedure	Role	Responsibility	Maximum Timeframe
		• Set a date for the next Progress Strategy Discussion/Meeting if needed • Decision made to conclude Safeguarding Adults Procedures if appropriate and outcome recorded • Consider providing feedback to the person raising the concern *		
8	**Review**	• Review progress of enquiries • Review the views, wishes and desired outcomes of the ***adult*** • Set a date for the next Progress Strategy Discussion/Meeting if needed • Decision made to conclude Safeguarding Adults Procedures and outcome recorded and evaluated • Establish and record whether the ***adult's*** desired outcomes have been met and to what extent (MSP Survey) • Consider whether alternative action is required if safeguarding procedures have been concluded • Provide feedback to the person raising the concern *	All attendees, the adult, their advocate, relative and carers	Within 28 days of the Progress Strategy Discussion/Meeting

* Particularly when the person raising the concern has an ongoing relationship with the adult

Teeswide Safeguarding Adults Board
Safeguarding Adults Workbook
Module Five Assessment

Notice to Learners: You should complete the following questions without any help and submit answers to your line manager.

Question 1

List 4 Reasons given for practising FGM

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

Question 2

Write down 5 short-term consequences following a girl undergoing FGM

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

Question 3

Write down 5 long-term health implications of FGM

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

Question 4

Please answer True or False to the following questions:

a) FGM is illegal in the UK:

True / False

b) It has been estimated that over 20,000 girls under that age of 15 are at risk of FGM in the UK each year:

True / False

c) FGM constitutes a form of child abuse and violence against women:

True / False

d) Professionals should listen to the victim and respect their wishes whenever possible:

True / False

Name	
Job Role	

Appendix 4

Evaluation

Name:

Once completed please forward the workbook evaluation *(i.e. this page)* and the Certificate of Completion) to the Teeswide Safeguarding Adults Board, Business Unit, using the contact details below, who will make a record of completion and issue a certificate. Completion records may be shared with the training leads of your commissioning organisation to ensure that your staff development record remains up to date.

Teeswide Safeguarding Adults Board Business Unit, Kingsway House, West Precinct, Billingham, TS23 2NX Email: tsab.businessunit@stockton.gov.uk

Why did you complete this workbook? Module Five
Where did you do your training?
❍ Home ❍ Work ❍ Mixture
Overall, how satisfied were you that the workbook gave you the information that you needed to know?
❍ Very satisfied ❍ Satisfied ❍ Partly satisfied ❍ Dissatisfied
What is the most important thing you have learned from this workbook?
How will you use the information from this workbook in your day to day work?
Would you recommend this workbook to other people? Please explain.
Is there any aspects of the workbook you feel could be improved?

Manager / Supervisor: Please provide feedback on how the learner managed this learning experience.

Appendix 5

Adult Safeguarding Workbook
Certificate of Completion – Module Five

I have discussed the completion of the workbook with my manager / assessor.

Name *(please print)*: _____

Signature of employee: _____

Date: _____ / _____ / _____

Declaration:

I have seen the workbook completed by _____

(as it will appear on the certificate) and I can confirm that I am satisfied that they now have a good knowledge and understanding of Female Genital Mutilation.

Name *(please print)*: _____

Signature: _____

Date: _____ / _____ / _____

Details of Manager / Assessor:

Job Title: _____

Organisation: _____

E-mail Address: _____

Telephone Number: _____