



Honour Based Violence, Female Genital Mutilation and Forced Marriage

Multi-Agency Practice Guidance Updated 2017

Updated flowchart July 2017 to clarify reporting to ART or Police

National FGM updates 2015-2016:

In September 2016 the House of Commons Home Affairs Select Committee published [FGM: Abuse unchecked](#).

In June 2016 the DoH issued [Female Genital Mutilation Risk and Safeguarding Guidance](#).

In April 2016 the Government updated its [Multi-agency Statutory Guidance on Female Genital Mutilation](#).

In January 2016 the Government produced a [fact sheet on the New Duty for Health and Social Care Professionals and Teachers to Report Female Genital Mutilation](#) which clarifies the mandatory reporting process.

In September 2015 the DoH issued [Guidance on Understanding the Enhanced FGM Dataset](#) for mandatory reporting.

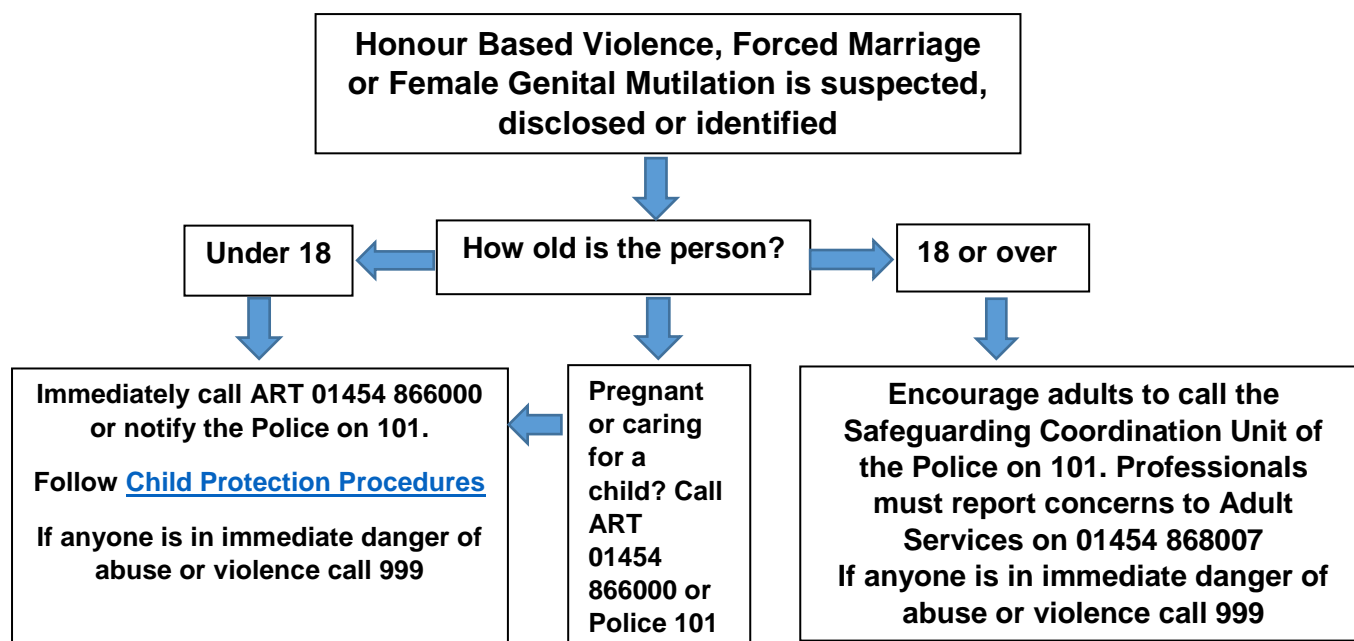
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INITIAL ACTIONS

- ▶ Reassure the victim, take the threats to their safety seriously and ensure confidentiality from family and community members
- ▶ DO NOT approach the victim's family or community
- ▶ NEVER send an individual back to their family, the Police will help find support
- ▶ If an interpreter is needed, use an official service, never family or community members
- ▶ Advise the victim to change mobile if relevant and turn off location services/GPRS capability within the phone settings
- ▶ Be wary of some services e.g. taxis as community or family may work in them
- ▶ Always assess the risk to any children in the family and make relevant referrals

RELATED SUPPORT SERVICES

Avon & Somerset Police, Safeguarding Coordination Unit Tel 101

Survive South Gloucestershire Support line Tel 0117 961 2999 (any domestic abuse)

Forced Marriage Unit Tel 020 7008 0151

Karma Nirvana helpline Tel 0800 5999 247 (honour-based abuse & forced marriage support)

Freephone 24-hour National Domestic Violence Helpline Tel 0808 2000 247

FORWARD UK www.forwarduk.org.uk Tel 020 8960 4000 (FGM support)

Integrate Bristol www.integratebristol.org.uk (FGM support)

Daughters of Eve www.dofeve.org (FGM support)

Scope

This guidance explains how South Gloucestershire agencies respond to incidents, (crime and non-crime) where Honour Based Violence (HBV), Forced Marriage (FM) and Female Genital Mutilation (FGM) may be a consideration.

It is imperative that all professionals are vigorously encouraged to take protective action where there are concerns that girls (from babies right up to adults) may be at risk or may be affected by FGM. In 2015 a statutory duty under the Serious Crime Bill was brought in for healthcare, social care and professionals in education settings to report any cases of FGM.

It should be noted that these three issues do not and should not stand alone. They are inexorably linked with domestic abuse and are part of the wider Government strategy to reduce [Violence against Women and Girls](#) (VAWG). This guidance should be used in conjunction with existing domestic abuse guidance, policy and procedures.

It should also be noted that this guidance is designed to maximise agencies' responses to cases, but it recognises that HBV, FGM and FM occur across a range of differing and diverse communities for a number of different reasons, and the information needs to be applied on a case by case basis.

This guidance is primarily directed at:

- South Gloucestershire Local Safeguarding Children Board partners
- South Gloucestershire Local Safeguarding Adults Board partners
- Health Service providers including Primary Care, Mental Health Services and Acute and Community Hospitals
- Voluntary and Community sector organisations
- Criminal Justice System (Police, CPS, Probation, Courts and Prison Service)
- Education sector, schools, colleges and universities.

The advice and guidance within the document enables South Gloucestershire agencies to provide an enhanced victim-centred response to incidents across the area, reflecting national guidance and best practice.

A victim-centred approach

Whatever someone's circumstances, they have rights that should always be respected such as personal safety and accurate information about their rights and choices.

Practitioners 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, practitioners should explain all the risks to the victim and take the necessary child or adult protection precautions. All conversations and actions taken or not taken should be noted on the written record.

Young people, especially those aged 16 and 17, can present specific challenges to agencies as there may be occasions when it is appropriate to use both child and

adult protection frameworks. For example, some 16 and 17 year olds may not wish to enter the care system but prefer to access refuge accommodation. Over 16s may be assessed under the MARAC Domestic Abuse arrangements if appropriate.

This document takes account of the following local and national guidance on FGM, Honour Based violence and Forced Marriage:

Female Genital Mutilation, Honour Based Violence and Forced Marriage Guidelines on the South West Child Protection Procedures

<http://www.proceduresonline.com/swcpp/>

South Gloucestershire [Multi-agency Best Practice Guidance on Identifying and Responding to Domestic Abuse 2016](#) Includes South Gloucestershire Multi-Agency Risk Assessment Conference (MARAC) Practitioner Guide

Bristol Safeguarding Board [FGM Multi-agency Guidance](#) 2011

Avon & Somerset Constabulary [Guidance on Threats, Assault and Hate Crime](#)

UK Government [FGM Multi-agency Practice Guidelines 2016](#)

UK Government [Forced Marriage Unit Guidelines](#)

Royal College of Midwives Tackling FGM in the UK: [Intercollegiate recommendations for identifying recording and reporting](#) 2013

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Training for Professionals

N.B. The Serious Crime Bill was amended in 2015 to include a duty for healthcare, social care and professionals in education settings to report FGM.

Multi-agency training on these and other related issues is available and recommended. See the relevant South Gloucestershire Council Children's Safeguarding training website pages.

Roles and Responsibilities

All Staff

It is the responsibility of all staff to comply with this guidance and ensure that they have undertaken related training referred to above. Front line supervisors in particular have a crucial role to play in ensuring that when staff respond to an Honour Based Violence, Female Genital Mutilation, Forced Marriage or related Domestic Abuse incident or disclosure:

- They do so promptly and in compliance with protocol, policy and procedure;
- Action is taken to protect the well-being and lives of victims and any children involved;
- Initial risk identification procedures are carried out using the DASH risk assessment checklist. Download the checklist at www.dashriskchecklist.co.uk;

- Perpetrators are held to account;
- Relevant assessment and referrals regarding children have been completed where applicable and account taken of other children in the family who are probably also at risk, now or in the future;
- Supervisors ensure cases are progressed expeditiously and this guidance is adhered to;
- Victims' wishes are sought, recorded and accommodated unless doing so would put the victim at greater risk of harm;
- Victims are updated regularly with the progress of their case.

2015 Mandatory Duty to Report

2015 saw an amendment to the Serious Crime Bill, following which front line professionals have a mandatory duty to report cases of Female Genital Mutilation (FGM).

The mandatory duty applies:

- In cases of 'known' FGM - i.e. instances which are disclosed by the victim and/or are visually confirmed
- To victims under 18
- To all regulated healthcare **and** social care professionals, **and** teachers
- Require reports to be made to the police within one month of initial disclosure/identification - depending on the circumstances of the case, this will not necessarily trigger automatic arrests; the police will then work with the relevant agencies to ensure an appropriate safeguarding response is put in place which places the interests of the child front and centre
- Failure to comply with the duty will be dealt with via existing disciplinary measures, which may include referral to the professional regulator and/or Disclosure and Barring Service as appropriate

The new duty is one strand of a wide range of measures the government has taken to help stop FGM including updating multi-agency guidelines, introducing an NHS prevention programme and providing training for NHS staff, prosecutors and police.

The government is also bringing forward legislation to highlight parents' and guardians' liability for failing to prevent their child being subject to FGM.

The Serious Crime Bill also includes provisions to extend the reach of the extra-territorial offences in the FGM Act 2003 to habitual as well as permanent UK residents.

The introduction of a new civil protection order will protect victims and potential victims, as it will for example enable the civil courts to stop girls being taken abroad for FGM by ordering their passport to be surrendered and a range of other measures will be available as deemed necessary. In addition, legislation is being brought forward to grant victims of FGM lifelong anonymity.

On 5 December 2014, the government launched a new specialist FGM Unit which works closely with affected communities and helps them to implement the new measures.

To get a clearer picture of the extent of FGM in the UK, all acute hospitals must now report about the prevalence of FGM each month, and the Home Office has part-funded a prevalence study to provide local areas with vital information needed to prioritise FGM. The first few months of recording these incidents has given strong indication of the scale of the issue (500 new cases per month have been recorded nationally). Data broken down to Local Authority area level is now available.

Recording

Reported incidents of Honour Based Violence, Female Genital Mutilation and Forced Marriage should always be recorded using your agency's formal procedures and be in line with the relevant South West Child Protection Procedures

<http://www.proceduresonline.com/swcpp/>

Monitoring and Evaluation

Individual agencies should regularly monitor compliance of their staff with this guidance and notify the South Gloucestershire Council Safeguarding Children Board of any issues arising. This Board also holds overall responsibility for the review and monitoring of this guidance.

Review

This guidance will be reviewed annually by the South Gloucestershire Council Safeguarding Board, taking into account latest Home Office and other Government policy and guidelines.

Definition of Terms

Honour Based Violence – Definition

The term 'Honour Based Violence' (HBV) is the internationally recognised term describing cultural justifications for violence and abuse. It justifies the use of certain types of violence and abuse against women, men and children. The Association of Chief Police Officers (ACPO) defines HBV as: 'A crime or incident, which has or may have been committed, to protect or defend the honour of the family and/or community'. **This may include Female Genital Mutilation and/or Forced Marriage.**

There is no specific offence of "honour based crime". It is an umbrella term to encompass various offences covered by existing legislation. Honour based violence can be described as a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. It is a violation of human rights and may be a form of domestic and/or sexual violence. There is no, and cannot be, honour or justification for abusing the human rights of others.

HBV is normally associated with cultures and communities from Asia, the Middle East and Africa as well as Gypsies and Travellers, but in reality, HBV cuts across all cultures, nationalities, faith groups and communities and transcends national and international boundaries. HBV is also a Domestic Abuse issue, a Child Abuse concern and a crime.

In terms of Domestic Abuse risk assessment, HBV is a significant risk factor for victims and must be regarded as a significant predictor of the likelihood of future harm or homicide.

Female Genital Mutilation (FGM) – Definition

The World Health Organisation has classified FGM as:

“all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organ for non-medical reasons” (WHO, 2010).

FGM and other terms (see glossary) has been classified by the WHO into four types:

- I. 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).
- II. 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).
- III. 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.
- IV. Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

FGM Legislation

Professional duties

Professionals and volunteers from all agencies have a statutory responsibility to safeguard children from being abused through FGM. Since 2015 professionals (in health, schools and social care) have a mandatory duty to report cases of FGM in under 18s.

Female Genital Mutilation Act 2003

In England, Wales and Northern Ireland all forms of FGM are illegal under the Female Genital Mutilation Act 2003. Scotland has its own FGM Act.

1. It is an offence if anyone aids, abets, counsels or procures any form of FGM for a girl or a woman for cultural or non-medical grounds;
2. This act makes it an offence to take a UK national or resident overseas for the purpose of or to aid and abet, procure or carry out FGM;
3. Any UK National or resident is protected;
4. A person is guilty of an offence if he/she aids a girl to carry out FGM on herself;
5. There are defences with regard to this Act. No offence is committed by an approved person (i.e. midwife or medical practitioner or person training to fulfil these roles) if they perform such a surgical procedure necessary for the girl's physical or mental health or in relation to a birth or labour;
6. The penalty for FGM is up to 14 years of imprisonment.

See the Government's [FGM Multi-agency Practice Guidelines 2016](#) for further details.

N.B. Female Genital Mutilation is not a religious requirement or obligation.

In communities where FGM is a common practice, it is practised by community members who are Muslims, Christians, animist and even non-believers. However, Muslims who practise FGM rationalise it as a Muslim religious obligation in spite of the fact that FGM, including a symbolic prick to the clitoris, has no link with Islam and is neither a requirement nor a 'Sunna' in Islam. Globally most Muslims do not practise FGM. FGM is not condoned by Christian or Jewish teachings, or the Bible or Torah. The [Muslim Council of Britain](#), the country's largest Muslim organisation, has condemned the practice of Female Genital Mutilation as "un-Islamic" and told its members that FGM risks bringing their religion into disrepute.

Forced Marriage – Definition

A Forced Marriage (FM) is a marriage in which one or both spouses do not (or, in the case of some adults with learning or physical disabilities, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure (UK Forced Marriage Unit, 2009).

There is a clear distinction between an arranged and forced marriage. An arranged marriage is entered into freely by both parties, although their families take a leading role in the choice of the partner. Forced marriage is a form of abuse and should be

treated as such. Cases should be tackled using existing structures, policies and procedures designed to safeguard children and victims of domestic abuse.

Forced Marriage is now a specific offence under s121 of the Anti-Social Behaviour, Crime and Policing Act 2014.

FGM generally affects girls, but Forced Marriage can affect both genders. It is also important to be aware that both practices are not linked to religion, but are a result of cultural influence.

Honour Based Violence Guidance

Women and girls are the most common victims of honour based violence however it can also affect men and boys. Crimes of 'honour' do not always include violence. Crimes committed in the name of 'honour' might include:

- domestic abuse
- threats of violence
- sexual or psychological abuse
- forced marriage
- being held against your will or taken somewhere you don't want to go
- assault

See Appendix 3 for further information on 'Honour'.

Honour Based Violence is a significant risk factor for Domestic Abuse.

If a child is at risk of harm contact Children's Services via ART: Tel 01454 866000

If an adult is at risk of harm contact Adult Services: Tel 01454 868007

Contact the Police Safeguarding Coordination Unit: Tel 101

The South Gloucestershire Partnership Against Domestic Abuse advocate the use of the ACPO DASH (2009) risk assessment checklist to determine the level of risk of a domestic abuse case. The risk assessment checklist can be downloaded from www.dashriskchecklist.co.uk

The ACPO DASH is an evidenced-based risk assessment tool, drawn from extensive research by leading academics in the field of domestic homicides, 'near misses' and lower level incidents. 'Risk' in these terms, is the risk of significant harm or death, by murder or suicide.

The checklist should be used whenever a professional identifies that someone **aged 16 or over** is experiencing domestic abuse. It is designed to be used for those suffering current rather than historic domestic abuse and, ideally, should be used as a rapid response to an incident of domestic abuse. If you are concerned about the risk to a child/children or a vulnerable adult you should make a referral to the appropriate department to ensure that a full assessment of their safety and welfare is made – this may be in addition to or instead of a MARAC referral.

The South Gloucestershire Domestic Abuse MARAC is the meeting where information is shared on the highest risk domestic abuse cases between

representatives of local police, probation, health, children and adults safeguarding, housing practitioners, substance misuse services, independent domestic violence advisers (IDVAs) and other specialists from statutory and voluntary sectors.

After sharing all relevant information that they have about an adult (aged **16 and over**) at risk, the representatives discuss options for increasing the safety of the adult at risk and form a coordinated action plan. The MARAC will also discuss the risks posed to children under 16 and how to manage the person alleged to be causing the harm.

Forced Marriage Guidance

See also the regularly [updated guidance](#) on the GOV.UK pages on Forced Marriage.

Forced marriage is a form of domestic violence and a way of exerting control over choices and autonomy. There are links between forced marriage and so-called 'honour' based violence whereby not consenting to the marriage results in violence due to the perceived 'dishonouring' by the victim of the family's will.

The difference between Forced and Arranged Marriage

There is a clear distinction between a forced marriage and an arranged marriage. In arranged marriages, the families of both spouses take a leading role in arranging the marriage, but the choice whether or not to accept the arrangement remains with the prospective spouses. In forced marriage, one or both spouses do not (or, in the case of some adults with disabilities, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, sexual, financial and emotional pressure.

Consent is essential to all marriages – only the spouses will know if they gave their consent freely.

Remember

If families have to resort to violence or emotional pressure to make someone marry, that person's consent has not been given freely and therefore it is a forced marriage.

There are several different motivations for forced marriage. For women, forced marriage is usually used to control their sexuality, including cases of unplanned pregnancy, but also encompassing 'unsuitable' boyfriends or the family's interpretation of her dress or behaviour as immodest. Similarly, for the 15% of forced marriage victims who are male, many are forced into marriage because their families know or suspect they are gay. Other reasons can include strengthening family links, interpretation of religious position, exchanging land/property or for the provision of care where one party has a disability.

'If families have to resort to violence or emotional pressure to make someone marry, that person's consent has not been given freely and therefore it is a forced marriage' ([Multiagency practice guidelines: Handling cases of Forced Marriage](#), Forced Marriage Unit)

Some forced marriages take place in the UK with no overseas element, while others involve a partner coming from overseas or a British national being sent abroad.

What to do if you suspect someone is at risk of or has been subject to Forced Marriage:

If a child is at risk of harm contact Children's Services via ART: Tel 01454 866000.

If an adult is at risk of harm contact Adult Customer Services: Tel 01454 868007.

Always contact the Police Safeguarding Coordination Unit: Tel 101.

If you are concerned that a child or young person may be (or may have been) forced to marry, you should discuss this with your safeguarding lead. You can also contact the Forced Marriage Unit (national helpline number 020 7008 0151) for advice and support, or visit the [FMU page](#) of the Foreign and Commonwealth Office website. Call 999 in an emergency.

The South Gloucestershire Partnership Against Domestic Abuse advocate the use of the ACPO DASH (2009) risk assessment checklist to determine the level of risk of a domestic abuse case. Download the checklist at www.dashriskchecklist.co.uk

See Appendix 1: *Forced Marriage Quick Reference Guide for All Agencies*

Prevalence

There are no reliable estimates on the extent of Forced Marriage in the UK. The Forced Marriage Unit website gives [statistics for 2015](#).

Missing People and Forced Marriage

Missing people, especially young women or girls, require further consideration when assessing their motivations for 'running off'. Documented cases have shown that girls and young women have, for instance, left a family home in order to escape both arranged and forced marriages.

Staff should be aware that family and community members may attempt to enlist the police and other agencies in their efforts to locate someone who has 'gone missing.' They may seek to embellish the report by exaggerating the subject's vulnerability, when in fact the person is actually trying to flee forced marriage.

Similarly, family and community may allege false crimes and name the missing person as the perpetrator, again, to enlist police resources into finding the subject.

Likewise, there have been cases in the UK where families and community members have attempted to thwart police investigations into missing people by withholding information or actively seeking to misdirect police enquiries.

Whatever the apparent circumstances, staff who deal with such incidents must consider the potential lethal consequences of simply returning a missing person to their family.

Female Genital Mutilation - Summary

- FGM is illegal in the UK
- FGM is cutting or mutilation 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 (see map at Appendix 2)
- FGM is 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.

From Home Office FGM [Multi-agency Practice Guidelines 2014](#)

Part 1 – Multi-agency FGM Guidance

Female Genital Mutilation Guidance

FGM is illegal and a form of child abuse; if you suspect a child may be at risk of this practice or has already undergone FGM you must take action immediately and discuss with your safeguarding lead. You should also contact South Gloucestershire Council Services via First Point: 01454 866000/01454 864380 and Police on 101.

Prevalence

FGM is a tradition practised in 28 African countries and parts of Asia and Latin America. The communities with the highest prevalence are generally from the Horn of Africa and include countries such as Somalia, Egypt, Mali, and Guinea. FGM has also been documented in communities in Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan.

Appendix 2 gives a map of countries that practise FGM.

Those who are affected by FGM may be British citizens born to parents from FGM practising communities, or girls resident in the UK who were born in countries that practise FGM. These may include immigrant, refugees, asylum seekers, overseas students or the wives of overseas students.

In the wider Bristol area, including South Gloucestershire, there are a number of affected communities that come from areas where FGM is practised, these include; Somalia, Sudan, South Sudan, Eritrea and Gambia. This is not an exhaustive list, and the collection of data about prevalence locally is a key challenge, but it highlights the affected communities that local organisations and agencies need to engage with.

Migration to England and Wales from countries where FGM is practised

Research by Macfarlane and Dorkenoo¹ in 2014 showed the overall numbers of women aged 15-49, who were permanently resident in England and Wales but born in FGM practising countries increased from 182,000 in 2001 to 283,000 in 2011. Numbers of women born in the countries in the Horn of Africa, where FGM is almost universal and where the most severe Type III form, infibulation, is commonly practised, increased by 34,000 from 22,000 in 2001 to 56,000 in 2011. The numbers of women from countries in East and West Africa, where FGM Types I and II, clitoridectomy with or without excision of the labia minora, are very common, also increased by 10,000 over the same period.

Estimated numbers of women and girls with FGM

An estimated 103,000 women aged 15-49 with FGM born in countries in which it is practised were living in England and Wales in 2011, compared with the estimated 66,000 in 2001. In addition there were an estimated 24,000 women aged 50 and over with FGM born in FGM practising countries and nearly 10,000 girls aged 0-14 born in FGM practising countries who have undergone or are likely to undergo FGM. Combining the figures for the three age groups, an estimated 137,000 women and girls with FGM, born in countries where FGM is practised, were permanently resident in England and Wales in 2011.

Over half of the women aged 15-49 with FGM, 53,000, were born in countries with almost universal Type III FGM, and a further 20,500 were born in countries with very high rates of Type I and II FGM. Women aged 50 and over with FGM are likely to continue to experience gynaecological and psychosomatic problems. These older women who have had FGM themselves are also likely to create pressure to continue the practice among their younger family members. Three fifths of these women were born in countries where FGM is almost universal.

Estimated numbers of women with FGM giving birth

All acute hospitals must now report about the prevalence of FGM each month.

It was estimated that, since 2008, women with FGM have made up about 1.5 per cent of all women delivering in England and Wales each year. About three fifths of them were born in the group of countries in the Horn of Africa where FGM is almost universal and Type III is commonly practised.

Girls born in England and Wales to mothers with FGM

From 1996 to 2010, 144,000 girls were born in England and Wales to mothers from FGM practising countries. It was estimated that 60,000 of these girls aged 0-14 in 2011 were born to mothers with FGM. In both cases, well over half of the mothers came from the countries in the Horn of Africa where FGM is almost universal and

¹ A. Macfarlane & E. Dorkenoo, 2014, *Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk. Interim report on provisional estimates*. City University London

Type III is practised and slightly under a fifth came from the countries in West and East Africa where Types I and II are highly prevalent.

These figures may be slight underestimates as they do not take account of migration since 2011.

Why the practice continues

The World Health Organisation (WHO) cites a number of reasons for the continuation of FGM, such as:

- Custom and tradition;
- A mistaken belief that FGM is a religious requirement;
- Preservation of virginity/chastity;
- Social acceptance, especially for marriage;
- Beliefs about hygiene and cleanliness;
- Increasing sexual pleasure for the male;
- Family honour;
- A sense of belonging to the group and conversely the fear of social exclusion;
- Beliefs about enhancing fertility

The WHO states that in every society where it is practised FGM is the manifestation of gender inequality that is entrenched in social, economic and political structures. FGM is a form of violence against women and girls

Religion and FGM

Muslim scholars have condemned the practice and are clear that FGM is an act of violence against women. Further, scholars and clerics have stressed that Islam forbids people from inflicting harm on others and therefore the practice of FGM is counter to the teachings of Islam.

FGM is practised amongst some Christian groups, particularly Coptic Christians in Egypt, Sudan, Eritrea and Ethiopia. The Bible does not support this practice nor is there any suggestion that FGM is a requirement or condoned by Christian teaching and beliefs. FGM may also take place amongst some Bedouin Jews and Falashas (Ethiopian Jews).

Forced Marriage and Female Genital Mutilation

There have been reports of cases where individuals have been subject to both practices.

One case reported to the British High Commission involved a 16 year old Somali girl who was rescued in Ethiopia. She had been taken to Somalia to have FGM and to be forced to marry. She managed to escape the marriage but had not avoided FGM. If you are concerned about an individual who may be at risk of both FGM and Forced Marriage you should notify your safeguarding lead and consult the Multi-agency Practice Guidelines on handling cases of forced marriage. These can be found at <https://www.gov.uk/forced-marriage>

Child protection and FGM

FGM is considered to be a form of child abuse (it is categorised under the headings of both physical abuse and emotional abuse). Working Together to Safeguard Children (HM Government, 2010), states that a local authority may exercise its powers under section 47 of the Children Act 1989 if it has reason to believe that a child is likely to suffer or has suffered FGM.

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

- Any information or concern that a child is at immediate risk of, or has undergone, FGM should result in a child protection referral to local authority children's social care;
- Every attempt should be made to work with parents on a voluntary basis to prevent the abuse;
- A local authority must exercise its duty under s47 of the Children Act 1989 if it has reason to believe that a child has suffered, or is likely to experience FGM.

Risk Factors, Signs & Symptoms

Below are some indications that FGM may be planned or a risk. These statements in isolation do not prove FGM will happen but they are indicators for further investigation to exclude the risks of FGM:

- **Any female child who has a sister who has already have undergone FGM must be considered to be at risk, as must other female children in the extended family.**
- Parents from practising communities state that they or a relative will take the child out of the country for a prolonged period;
- A child may talk about a long holiday to her country of origin or another country where the practice of FGM is prevalent, including African countries and the Middle East;
- A child may confide to a professional that she is to have a 'special procedure' or to attend a special occasion;
- A professional hears reference to FGM in conversation, for example a child may tell other children about it (be aware of the wide variety of descriptions);
- A child may request help from a teacher or another adult;
- Any female child born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family;

Indications that FGM may have already taken place include:

- A child may spend long periods of time away from the classroom during the day with bladder or menstrual problems;
- A child may have difficulty walking, sitting or standing;
- There may be prolonged absences from school;

- A prolonged absence from school with noticeable behaviour changes on the girl's return could be an indication that a girl has recently undergone FGM;
- Professionals also need to be vigilant to the emotional and psychological needs of children who may be/are suffering the adverse consequence of the practice, e.g. withdrawal, depression etc;
- The child may ask for help or confide in a professional;
- A child requiring to be excused from physical exercise lessons without the support of her GP;
- Recurrent Urinary Tract Infections (UTIs) or complaints of abdominal pain.

Health Consequences

Many women, men and professionals appear to be unaware of the major health issues associated with FGM. The physical and mental trauma usually causes long term complications for these women.

The short term consequences for children and women subjected to FGM may include:

- Severe pain and bleeding, which in some cases may result in anaemia;
- The pain and trauma can also produce a state of clinical shock;
- Infections are common, particularly as the procedure is generally carried out in unhygienic conditions and/or with instruments that are not sterilised;
- In some cases, potential fatal septicaemia and tetanus may occur.

Long term consequences of FGM may include:

- Discomfort and pain during/after sexual intercourse and recurrent infection may lead to infertility;
- Abscesses, painful cysts;
- Keloid scarring. This can cause problems during pregnancy and childbirth;
- Women may feel angry, depressed and suffer from post-traumatic stress disorder;
- Infections, HIV, Hepatitis B

Talking about FGM

The most important consideration regarding language is to establish what words the survivor of FGM or person at risk is most comfortable using. Research with local charities made up of affected communities is that they would like agencies to 'mirror' their language so if they say "cut", professionals should say "cut". It is highly unlikely that they would ever use the term 'female genital mutilation' unless they are activists in eradicating the practice. Some terms used to talk about FGM:

"Sunna" circumcision or cutting is used extensively to describe Type I FGM.

Egypt: "Thara" and in Sudan "Tahoor" are derived from the Arabic "Tahar" meaning to clean or purify.

Somalia: “Halalays”, derived from the Arabic “Halal”, ie sanctioned, implies purity.

Gambia: “Niaka” – “to cut /weed clean”; “Kuyango” – the name for the shed built for initiates; “Musolula” – “the women’s side” – that which concerns women.

Most countries also use the same word to describe both FGM and male circumcision
E.g.: “Gudiniin” in Somali.

Guide to asking about FGM

- Different terminology will be culturally appropriate to the different cultures. Alternative approaches are to ask a woman whether she has undergone FGM saying: ‘I’m aware that in some communities women undergo some traditional operation in their genital area. Have you had FGM or have you been cut/ Circumcised ?’
- To ask about infibulation professionals can use the question: “*are you closed or open?*” This may lead to the woman providing the terminology appropriate to her language / culture.
- Asking the right questions in a simple, straightforward and sensitive way is key to establishing the understanding, information exchange and relationship needed to plan for the girl or woman’s wellbeing and the welfare and wellbeing of any daughters she may have, or girl’s she may have access to.

Remember:

- They may wish to be interviewed by a practitioner of the same gender.
- They may not want to be seen by a practitioner from their own community.
- 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 such as Language Line.

Dos and don’ts

Think about engaging families and young people **before** concerns arise. This contact can educate these families about the Law, health risks and the statutory duties we all have to protect young people. This preventative work is essential.

If you are a trusted individual of the potential victim you may wish to talk to them further about your concerns. Alternatively, you may be approached by someone concerned about FGM.

When talking about FGM remember these points:

Do

- Create an opportunity for the individual to disclose, seeing the individual on their own;
- If an interpreter is required, they should be female, appropriately trained in relation to FGM and must not be a family member or known to the individual. You MUST also know their views on FGM to ensure they advocate for the safety of the girl at risk;
- 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';
- Be sensitive to the fact that the individual will be loyal to their parents;
- Give the individual time to talk, and make sure you take detailed notes;
- Get accurate information about the urgency of the situation if the individual is at risk of being subjected to the procedure;
- Give the message that the individual can come back to you again;
- Be sensitive to the intimate nature of the subject;
- Make no assumptions;
- Be willing to listen;
- Be non-judgemental (condemning the practice, but not blaming the girl/woman);
- Understand how she may feel in terms of language barriers, culture shock, that she, her partner, her family is being judged;
- 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.

Don't

- Promise complete confidentiality (blanket confidentiality cannot be given to the individual as this is a crime and child abuse and must be reported);
- Although 'mutilation' is the most appropriate term, it might not be understood or it may be offensive to a woman from a practising community who does not view FGM in that way
- Do not use a male interpreter when talking to women.

Interpreters

Never use family members, friends, neighbours or those with influence in the community as interpreters. People may feel embarrassed to discuss personal issues in front of them and sensitive information may be passed on to others and place the person at risk of FGM in further danger. Furthermore, such an interpreter may deliberately mislead practitioners and/or encourage the person to drop the complaint and submit to their family's wishes.

- Try to be aware of the cultural/Clan issues of the interpreter and the person who is at risk or had FGM. There can be tensions or power imbalances between people if this is not considered.

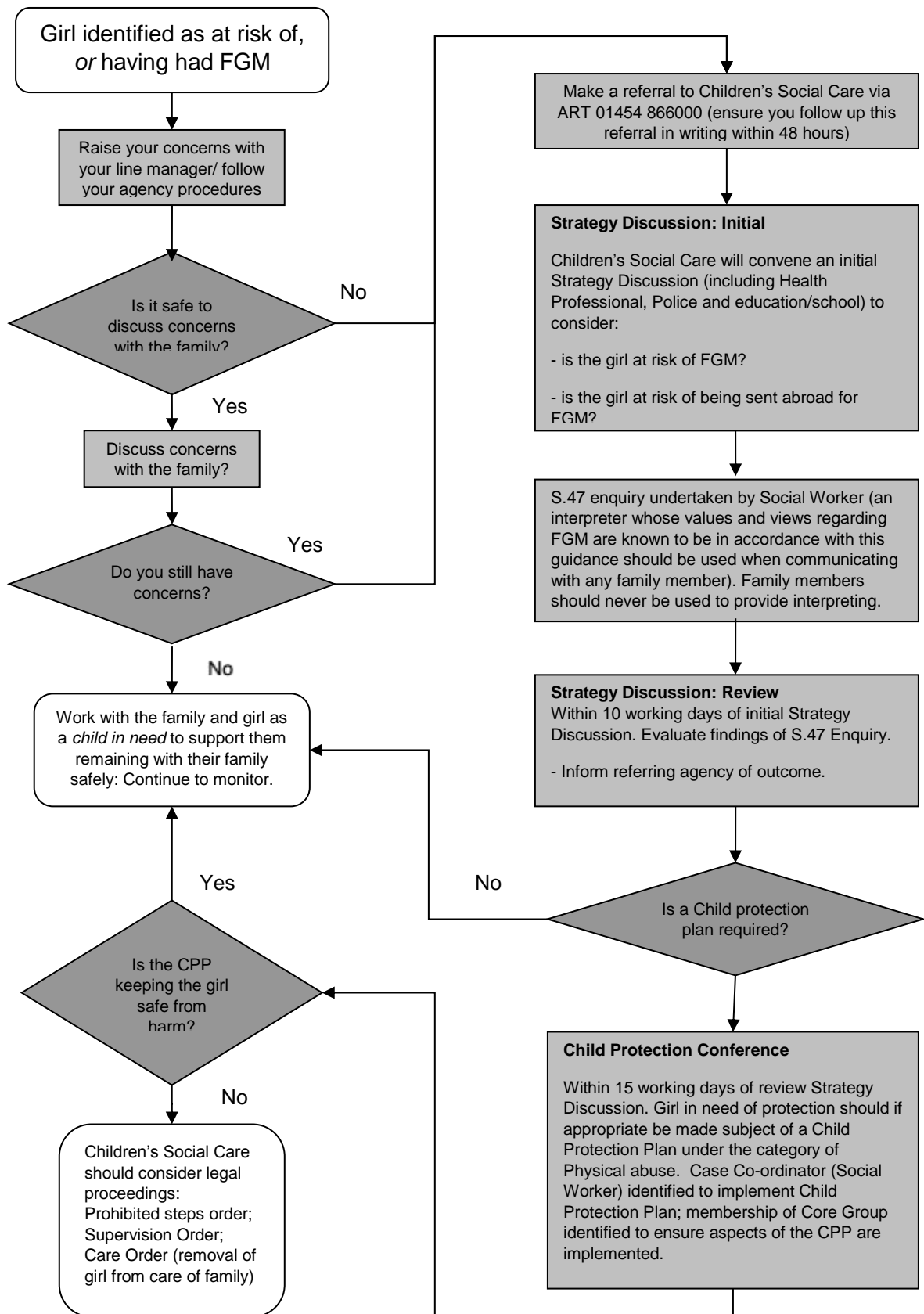
Safety procedures

For many people, prosecuting their family is something they simply will not consider;

- If the victim is from overseas, fleeing potential FGM and applying to remain in the UK, is an extremely complicated process and requires professional immigration advice.
- For many victims from overseas returning to their country of origin is not an option – they may be ostracised or subjected to violence if they do not agree to have FGM.
- These risks should be explained, even just to exclude this option.
- Many people, especially women, may be extremely frightened by contact with any statutory agency as they may have been told that the authorities will deport them and/or take their parents/children from them.
- Practitioners need to be extremely sensitive to these fears when dealing with a victim from overseas, even if they have indefinite leave to remain (ILR) or a right of abode as they may not be aware of their true immigration position. These circumstances make them particularly vulnerable.
- If it is discovered that they are in breach of immigration rules (for example if they are an overstayer), remember that they may also require medical treatment, or be the victim of a crime and be traumatised as a result.

Do not allow any investigation of their immigration status to impede police enquiries into an offence that may have been committed against the victim or their children.

**You should consider using an interpreter whose values on FGM are known, when talking to the family.
DO NOT use family members**



Part 2 – FGM Single Agency Practice Guidance

Professionals and volunteers in most agencies have little or no experience of dealing with female genital mutilation. Coming across FGM for the first time they can feel shocked, upset, helpless and unsure of how to respond appropriately to ensure that a child, and/or a mother, is protected from harm or further harm. The following agency-specific guidance may help support the professional.

Child protection: Actions to be taken by single and multi-agency workforce:

There are three circumstances relating to FGM which require identification and intervention:

1. Where a child (under 18) is at risk of FGM;
2. Where a child has been abused through FGM;
3. Where a prospective mother has undergone FGM.

If you suspect a child may be at risk of FGM or has already undergone FGM you must take action immediately and discuss with your safeguarding lead. You should also contact South Gloucestershire Council Children's Services and the Police, unless your agency has an alternative agreed process:

ART (Children's Services): Tel 01454 866000 or 01454 86438

Police Safeguarding Coordination Unit: Tel 101

Duty to report

The Government amended the Serious Crime Bill in 2015 to place a statutory duty on regulated health and social care staff, and teachers, to report cases of FGM in under 18s.

Children's Social Care

All referrals received by children's social care specifying a risk of FGM will be fully investigated.

Social Workers will refer to South West Child Protection Procedures guidance relating to 'Female Genital Mutilation' and 'Managing Individual Cases' in undertaking any investigations.

Key principles

FGM constitutes a significant risk of harm and should be fully and thoroughly investigated under s.47 Children Act 1989;

Every attempt should be made to work in partnership with the family;

The aim of any work with the child and family is to avoid the child undergoing any form of FGM not the removal of the child from the family.

All referrals to children's social care concerning FGM will be considered at a Strategy Discussion in order to plan the S.47 enquiry. Given the complexity of the issues

involved it is not appropriate to hold this discussion by telephone. A Strategy Discussion should be held at the earliest possible opportunity, undue delay may place the child at risk of harm. In cases of possible and actual FGM the Strategy discussion must be a meeting of the following:

- Children's social work team;
- Community Paediatrician and a Health specialist in FGM;
- Police Safeguarding Coordination Unit
- Education (early years or school setting attended by child/young person where appropriate);
- Voluntary Sector support services, where appropriate
- Legal advice (there may be a need to consider the use of specific legal orders to protect the child concerned);
- The referring agency (if appropriate).

The following issues should be part of the agenda in any strategy discussion regarding FGM:

- Use of an independently approved interpreter in all dealings with the family (see <http://www.proceduresonline.com/swcpp/>);
- Provision of appropriate advice and information to the family where this has not already occurred, regarding the law and harmful consequences of FGM;
- The provision of counselling and support services to the child/young person;
- Risk to siblings and other children in the community;
- Any intelligence on who has performed or is to perform the mutilation;
- The immediate health needs of the child;
- The possibility for prosecution.

Where FGM has already occurred the Strategy Discussion should discuss how, where and when the procedure was performed and the implications of this.

Where the S.47 Enquiry finds that the child is at risk of harm a Child Protection Conference may be appropriate in order to consider whether a Child Protection Plan is needed. Where the risk is considered to be more immediate it may be necessary to seek appropriate legal orders to protect the child.

Police

The Police response will largely be shaped by the nature of the referral. The referral will fall into one of two categories: concerns that the girl is at future risk of FGM or that a girl has already been subjected to FGM.

Future risk

In all cases, the welfare of the child will take priority and their views should be sought and acted upon where this is possible. It is recognised that in securing their physical and psychological integrity, it may not always be possible to act in accordance with a child's wishes but these should be sought and decisions to act otherwise than in accordance with these wishes should be explained to them and documented within the record of the incident.

In cases of immediate risk, the Duty Inspector should be informed and immediate action taken to protect the child. The use of Police Protection Powers under S.46 Children's Act 1989 should be considered.

In out of hour's cases, the Duty Inspector should be informed and they should consider the need to inform the On Call DI for the force.

If information is received that suggests a girl may be at [non urgent] risk of undergoing FGM, immediate referral should be made to the Safeguarding and Co-ordination Unit who will in turn make a referral to the relevant intake team within Children's Social Care.

All FGM referrals will generate a strategy discussion in accordance with S47 Children's Act 1989. This discussion will agree the action to be taken and will include Social Care, Police and any other relevant agencies. This must be held without delay and within 48 hours.

A detailed Guardian crime report must be completed at the earliest opportunity. Ensure the 'Honour Based' tab and drop down selection of 'Genital Mutilate' is completed on the soft pages of Guardian.

Officers should carry out and record the following actions:

- From start to finish, listen and respond to the needs and where appropriate wishes of the child who is likely to be distressed and confused by the involvement of police and other agencies
- Appropriate Police checks
- PND/International checks
- Obtain details of child's school/health visitor/midwife/GP
- Obtain details and consider intelligence/investigation in relation to other siblings/extended family
- Risk assessment/risk management plan
- A voluntary written agreement should be drawn up by CSC and signed by the girl's parents/carers. This should include an undertaking to protect the girl specifically from FGM and any other physical harm along with an agreement to allow medical examinations at future dates should concerns necessitate this.

The following where appropriate:

- Consider Interpreters. These should be accredited and unconnected with the family or local community and
- Medical examination: this should be carried out by a Paediatrician in line with safeguarding procedures

Where possible, parental co-operation is desirable. In most cases, unless information indicates it would increase the risk to the child or frustrate safeguarding activity, the next step should be to speak to the girl thought to be at risk. This will be achieved

either by a visit to school or other setting or during a joint visit to the home address. In all cases, the girl should be spoken to alone. Her parents or other carers/relatives should be informed of the law covering FGM and the consequences of the practice for the girl. A voluntary written agreement should be drawn up with parents/carers. While this visit will largely be undertaken by CSC and Police, assistance can be sought from other sources including community organisations where appropriate.

If there is any suggestion that the family still intend to subject the child to FGM then the child's safety and well-being is the absolute priority. Officers should consider the use of Police Protection Powers under S.46 Children's Act 1989 and remove the child to a place of safety.

Where it is felt by all agencies that the short term risk has been managed, it may nonetheless be appropriate to engage in further monitoring of the girl (e.g. her demeanour on her return from holiday). This monitoring should form part of the risk management plan and all agencies should be aware of and respond to their continuing safeguarding duties.

Existing FGM suspected – Police protocol

An FGM investigation should follow the principles of good investigation, be robust and enforce the law. The barriers to victim and witness co-operation are such that officers are likely to have to fully exhaust all identified lines of enquiry to establish a good evidential case. Specialist tactics including covert methods and financial investigation should be considered at the earliest stage and advice sought. In all circumstances, not only in dealing with FGM, officers should consider and respond to cultural beliefs and practices but this must not delay or prevent investigative or safeguarding activity. In the case of FGM, the position of law enforcement and statutory partners is clear: FGM is child abuse, an extreme example of gender based violence and is illegal. This stance is the non-negotiable bench mark for the police response to concerns and confirmed FGM cases.

The welfare of the relevant child and other children in the family should be the subject of ongoing review, particularly female siblings and other female relatives.

When available, reference should be made continuously to the Authorised Professional Practice for FGM produced by the College of Policing.

The investigation should be the subject of regular ongoing multi-agency reviews, in line with protocols developed with the relevant Local Children's Safeguarding Board.

Reference should be made to the guidance documents for conducting Achieving Best Evidence interviews and to the Victims Code, both of which are likely to be relevant for FGM investigations.

Specific considerations for Police FGM investigations

The officer in the case will liaise closely with the regional FGM SPOC throughout the investigation of the case and subsequent court proceedings.

Any interpreter should be accredited and appropriately trained (where possible) in relation to FGM. A family/community member should not be used because this increases the likelihood both of the child being influenced and feeling unable to speak freely.

There are further considerations regarding language in FGM investigations. 'Female Genital Mutilation' is not a term which is used within affected communities. Consultation with affected communities has shown that a good general rule is to 'mirror' the language used by the girl herself. This is most likely to put her at a level of ease in what clearly may be a difficult and inherently intimate conversation with her.

Corroborative evidence should be sought through a medical examination. This should be carried out by an appropriately qualified Forensic Physician, Forensic Nurse or Paediatrician. Where practicable the wishes of the victim will be taken into account and adhered to in terms of gender and/or ethnicity of the practitioner

Any medical examination should take place in a dedicated examination suite to ensure victim care and that the integrity of evidence is maximised.

Where an expert opinion is sought the officer in the case will, as soon as is reasonably practicable, provide the Forensic Physician with all prosecution evidence. The CPS will also include the Physician in any conference that takes place with the Prosecutor, officer in the case and Police SPOC.

If consent for a medical examination is refused by a parent/guardian, consideration should be given to working with Children's Social Care to apply for an Emergency Protection Order or Interim Care Order so that direction can be given by the court for a medical at the request of the local authority.

While not exclusive to FGM investigations, the information disclosed within parallel Family Court proceedings is likely to be of great significance to the criminal investigation. Early advice should be sought from Legal Services and the FGM SPOC to ensure that applications for disclosure are made systematically and at the earliest opportunity.

There may also be issues around immigration status. Police enquiries in to FGM must not be impeded by an immigration investigation and an agreement or protocol must be met with UKBA.

All Health Professionals

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

- The girl at risk;
- Any siblings;
- If it is a woman consideration for any daughters she may have now or in the future;
- Any extended family who may be at risk.

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

[Useful link: See the videos for health professionals at <http://www.fgmresource.com/> from the FGM National Clinical Group.]

The following organisations are required to have regard to the FGM Enhanced dataset standard from October 2015:

- General Practice
- Mental Health Trusts
- Acute Trusts (mandatory since 1 July 2015) Sexual health and GUM (Genito-Urinary Medicine) clinics, where patients do not have to provide their personal information, are out of scope, but these services are nonetheless reminded of their responsibilities to share information to ensure appropriate safeguarding responses are put in place every time this becomes necessary.

Midwives

Midwives now ask **all** pregnant women whether they have had any procedures carried out 'below' e.g. piercings.

Midwives should talk about FGM at initial booking to all women (be mindful if they are married to men from FGM-practising communities). Midwives should follow NMC and local guidance re documentation. They must also document that the woman has been told about the law and information is shared with appropriate health professionals (GP and Health Visitor).

Professionals should consult with their child protection adviser and the relevant Social Work Team (via ART 01454 866000). *Any female children of women who have been subject to FGM will be at high risk of being victims of FGM. This needs to be recorded and explored further.*

After childbirth a girl/woman who has been de-infibulated (opened) may request and continue to request re-infibulation (being sewn up again). This is against the law. This should be treated as a child protection concern, because whilst the request for

re-infibulation is not in itself a child protection issue, the fact that the girl or woman is apparently not wanting to comply with UK law and/or consider that the process is harmful raises concerns in relation to daughters she may already have or may have in the future. Professionals should consult with their child protection adviser and with the relevant Social Work Team or Hospital Social Work Department about making a referral to them.

Midwives have their own FGM Pathway and guideline which is available on the Intranet. Children's Services (Tel 01454 866000) should also be informed.

Health Visitors

Health Visitors are in a good position to reinforce information about the health consequences and the law relating to FGM. Health visitors should discuss the risks of FGM and document the parent's response and the advice and any leaflets given to explain the law relating to FGM. Any concerns about a parent's attitude towards FGM should be taken seriously and appropriate referrals made. Professionals should consult with their child protection adviser, the client's GP and the relevant Social Work Assessment Team about making a referral to them.

Any female children of women who have been subject to FGM will be at high risk of being victims of FGM. This needs to be recorded and explored further with Children's Social Care and the Police Safeguarding Coordination Unit.

Health visitors should remember that children may be at risk of FGM at any age, even before school age.

School Nurses

School Nurses are in a good position to reinforce information about the health consequences and the law relating to FGM. The school nurse should work closely with the child's school supporting them in any concerns. The school nurse should be vigilant to any health issue such as recurrent urinary tract infection that may indicate FGM has been done. If the school nurse has contact with any family who come from a country where FGM is practised they should discuss the risks of FGM and document the parent's response and any advice and leaflets given to explain the law relating to FGM. Any concerns about a parent's attitude towards FGM should be taken seriously and appropriate referrals made. Professionals should consult with their child protection adviser and Children's Services (Tel 01454 866000) and the Police Safeguarding coordination Unit (Tel 101) should be informed.

GPs

Treatment room and Practice Nurses should be vigilant to any health issue such as recurrent urinary tract infection that may indicate FGM has been done. They also need to consider families who are requesting foreign travel vaccinations. This can be an ideal opportunity to talk about FGM, the health risks and the law. Document any advice or leaflet given out. It is an ideal time to talk to women from FGM practising communities about the issues of FGM when they attend for their routine Cervical smears. Any concerns about a parent's attitude towards FGM should be taken

seriously and appropriate referrals made. Professionals should consult with their child protection adviser and with the relevant Social Work Assessment Team about making a referral to them.

Emergency departments and Walk in Centres need to consider the risks associated to FGM, e.g. if girls from FGM-practising countries attend with Urinary Tract Infections (UTI), menstrual pain, abdominal pain, or altered gait etc. then their assessment should include assessing the risks associated with FGM. This should be documented and professionals should consult with their child protection adviser and the relevant Social Work Team about making a referral to them.

Documents that guide health professionals include:

FGM: Caring for patients and child protection (BMA, July 2006)

Royal College of Nursing- FGM educational resource (2006)

Royal College of Obstetrics and Gynaecology FGM guidelines

Early Years Settings, Schools and Colleges

Girls of all ages, even as young as babies and toddlers, are at risk of FGM. If you have concerns that children in your community are at risk or victims of Female Genital Mutilation in addition to this guidance we refer you to the South West Child Protection Procedures Guidelines for FGM: <http://www.proceduresonline.com/swcpp/>

Ask

Ask children to tell you about their holiday plans. Sensitively and informally ask the family about their planned extended holiday. Ask questions like;

- Who is going on the holiday with the child?
- How long they plan to go for and is there a special celebration planned?
- Where are they going?
- Are they aware that the school cannot keep their child on roll if they are away for a long period?
- Are they aware that FGM including *Sunna* is illegal in the U.K even if performed abroad?

If you suspect that a child is a victim of FGM you may ask the child;

- Your family is originally from a country where girls or women are circumcised – do you think you have gone through this?
- Has anything been done to you down there or on your bottom?
- Do you want to talk to someone who will understand you better?
- Would you like support in contacting other agencies for support, help or advice?

These questions and advice are guidance and each case should be dealt with sensitively and considered individually and independently. Using this guidance is at the discretion of the Head Teacher.

Record

All interventions should be accurately recorded by the persons involved in speaking with the child or young person. All recording should be dated and signed and give the full name and role of the person making the recording.

Refer

Child protection lead or Head Teacher needs to seek advice about making referrals to the relevant Social Work Team and Police Safeguarding Coordination Unit and to follow South West Child Protection Procedure Guidelines on FGM and CP referrals.

Resources for Schools

Schools can create an 'open' and supportive environment by raising awareness through learning in sex and relationship education within PSHE. The majority of girls are cut before they turn 15 years old, so early awareness is crucial. Listed below are some helpful resources and information about FGM for teachers:

- [Keeping children safe in education: statutory guidance for schools and colleges](#)
- [Working Together to Safeguard Children 2015](#)
- The Home Office [Female Genital Mutilation Resource Pack](#) (updated 2016) includes a wide range of good practice examples and resources available
- A [DVD for secondary school staff on how to tackle FGM issues](#) is available from Integrate Bristol, a charity that works towards equality and integration
- [Key Stage 3 \(Y7\) lesson plan](#) produced by Islington Council to raise awareness of the practice of FGM and provide information on how and where young people can get help
- The [FGM Fact File - Interactive Teaching Resource](#) is a teaching resource by the Foundation for Women's Health Research and Development (FORWARD) - see 'Training' section below - for use in secondary schools (Y9-11) as part of personal, social and health education. It aims to raise young people's awareness of FGM, help them realise that it is a form of abuse, and make them aware of who and where they can go to for help. There is also a [teachers' pack](#) to support the resource.
- Infant and primary schools: effective sex and relationship education within PSHE can help pupils keep themselves safe from harm through building their confidence to ask for help, learning that their body belongs to them and giving

them the language to describe private parts of their body. The Sex Education Forum and [PSHE Association](#) have advice and guidance on effective teaching and learning in sex and relationship education and PSHE.

Voluntary sector

Any professional, volunteer or community group member who has information or suspicions that a child is at risk of FGM should consult with their agency or group's child protection adviser (if they have one) and should make an immediate referral to either the local duty social care team via ART T:01454 866000, or the Police Safeguarding Unit on Tel 101.

The referral should not be delayed in order to consult with your child protection adviser, a manager or group leader, as multi-agency safeguarding intervention needs to happen quickly.

If there is a concern about one child, be aware that siblings are at high risk.

It is expected that individuals that make a referral to the police or children's social care in their role with a voluntary sector organisation will not normally be able to remain anonymous. However, given the heightened sensitivity within communities that practise FGM and potential risk to those individuals, referrals made by members of the community who are working with a voluntary sector organisation can reasonably expect not to have this information passed to the family involved. They should still give their details and organisation contact information when making a referral but can request that they remain 'anonymous' with regard to the family or child who is the subject of the referral.

Protection of vulnerable adults

If you have suspicions or knowledge that a woman 18 or over is at risk of Female Genital Mutilation report your concerns to the Police and the Safeguarding Adults team.

If an adult is at risk of harm contact Adult Services: Tel 01454 868007.

Police Safeguarding Coordination Unit: Tel 101.

The South Gloucestershire Partnership Against Domestic Abuse advocate the use of the ACPO DASH (2009) risk assessment checklist to determine the level of risk of a domestic abuse case. Download the checklist at www.dashriskchecklist.co.uk

END OF SINGLE AGENCY GUIDANCE.

SEE APPENDICES BELOW.

Appendix 1

FORCED MARRIAGE Quick Reference Guide for All Agencies

Ideally, the information should be gathered by a police or social care trained specialist. However there may be occasions when an individual is going overseas imminently and as it is an emergency an education/ probation /health/social care staff may need to gather as much information as possible from the victim.

In these cases, the information should be passed on to Police, Children's Services or Adult Social Care and the Ministry of Justice Forced Marriage Unit. All information should be securely stored in accordance with Safeguarding policies and procedures.

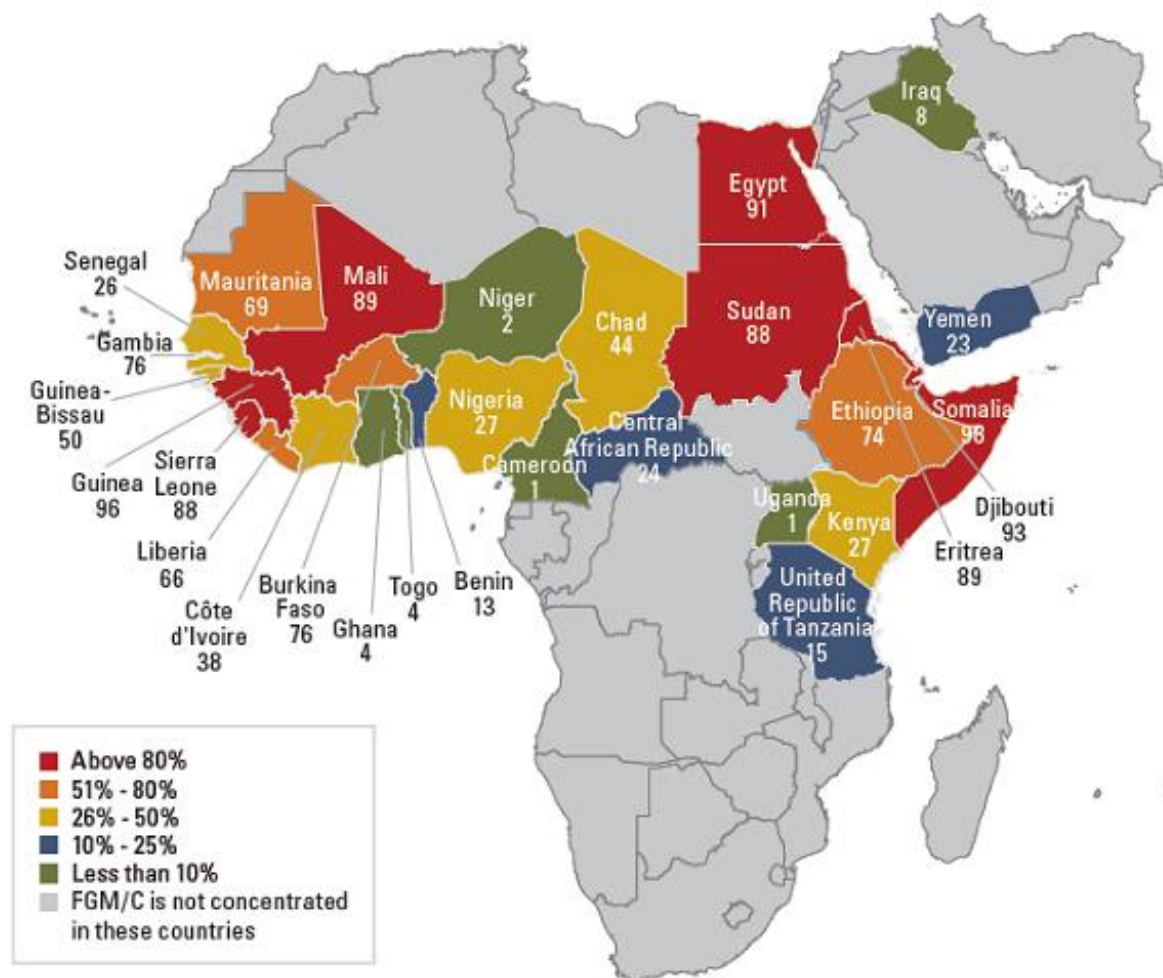
It is important to get as much information as possible when a case is first reported, as there may not be another opportunity for the person to make contact (the "one chance rule").

1. Obtain details of the person making the report, their contact details, and their relationship with the individual under threat.
2. Obtain details of the person under threat including:
 - Date of report
 - Name of person under threat
 - Nationality
 - Age
 - Date and place of birth
 - Alias names / 'known as' names
 - Passport details
 - School/ College details (if relevant)
 - Employment details
 - Full details of the allegation
 - Name and address of parents or those with parental responsibility
 - National Insurance number
 - Driving licence number (if relevant)
3. Obtain a list from the person under threat of all those friends and family who can be trusted and their contact details.
4. Establish a code word to ensure you are speaking to the right person.
5. Obtain any background information including education attended, involvement by adult or children's social care, doctors or other health services etc.
6. Record details about any threats, abuse or other hostile action against the person, whether reported by the victim or a third party.
7. Obtain a recent photograph and any other identifying documents.
8. Document any other distinguishing features such as birthmarks and tattoos etc.
9. Establish the nature and level of risk to the safety of the person (e.g. is she pregnant? Do they have a secret boyfriend or girlfriend? Are they already secretly married?)
10. Establish if there are any other family members at risk of forced marriage or if there is a family history of forced marriage and abuse.

Appendix 2

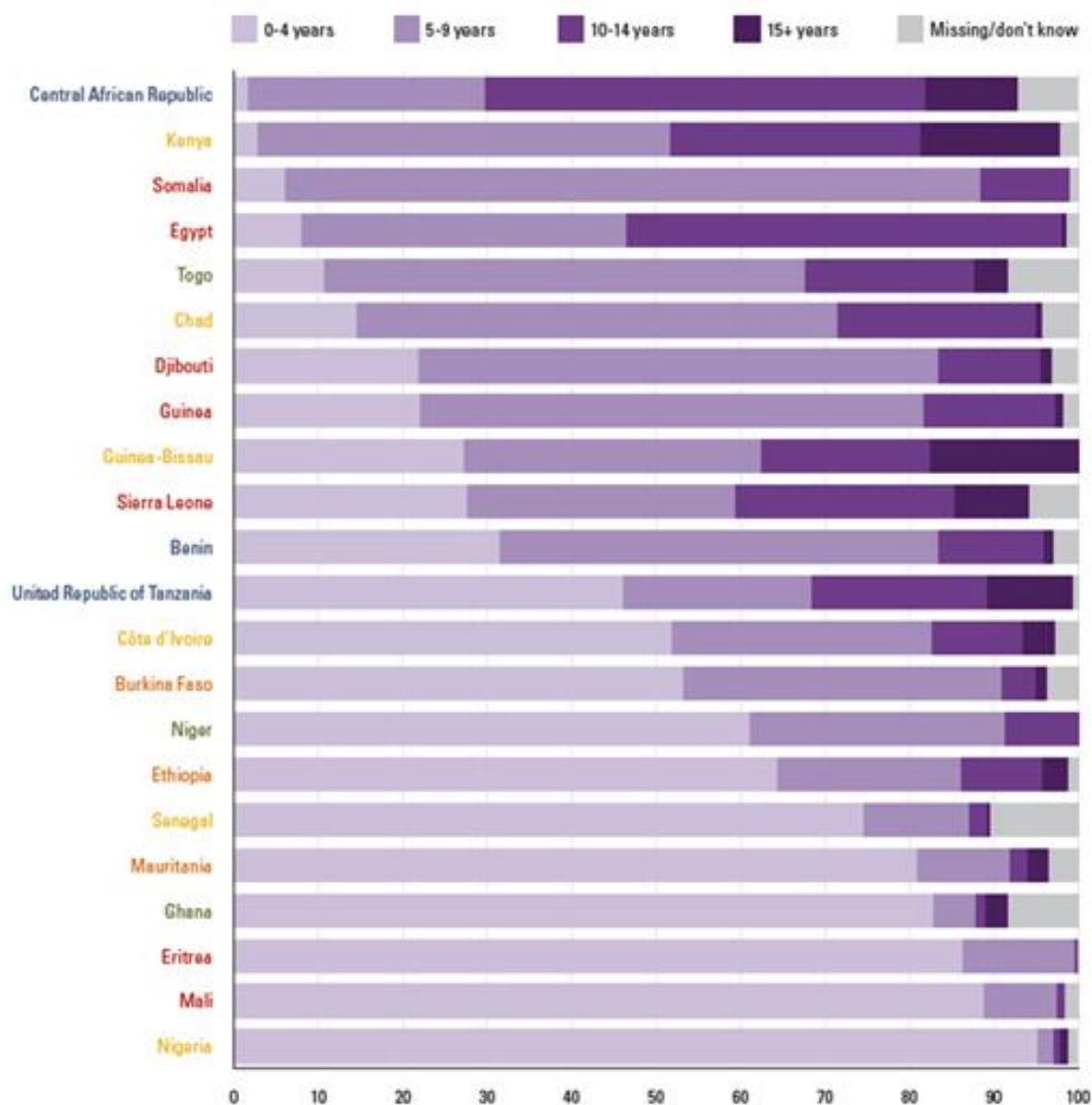
Prevalence of FGM among women aged 15-49 in Africa and the Middle East

Source: UNICEF (July 2013), global databases based on data from Multiple Indicator Cluster Survey, Demographic and Health Survey and other national surveys, 1997–2012.



Appendix 3

Percentage distribution of ages at which girls have undergone FGM (as reported by their mothers)



Appendix 4

Further detail on ‘Honour’

The term ‘honour’ has widely varying interpretations. For the purposes of this guidance however, honour relates to the concept that the reputation and social status of an individual, a family or community is based on the behaviour and morality of its members. Honour is a fluid and entrenched concept passed down through family generations. It is generally a non-verbal and subtle aspect through the socialisation of children and young people as they are growing up and implemented through the hierarchical structures within families and communities.

Honour rules and codes of behaviour are anchored within the hierarchical patriarchal framework where men have the overall power and control which ensures that women and girls behave as the culture considers appropriate and their physical and sexual integrity is controlled.

Any behaviour outside the boundaries of the behaviour codes and rules brings dishonour, disrespect, humiliation, disgrace and shame not only for the family and the community, ethnic or faith group but also impacts on the individual concerned.

Background to Honour

It is important to try and understand the part ‘honour’ plays in an individual’s life because this can help to understand a perpetrator/s’ mind-set, what might prompt someone to feel ‘shamed’ or ‘dishonoured’ and hence the lengths they might go to restore their reputation, honour and status.

The following are ways in which a person may perceive the importance of honour.

- **Self-awareness/pride**
Honour is important to people in all societies. However, there are some communities / societies where standards of behaviour are a significant part of an individual’s image, identity and status.
- **Increased security and prospects for offspring**
Families who are seen to have high standards of honour and moral behaviour enjoy respect and social status including increased marriage and career prospects within their community.
- **Improved contacts and business opportunities**
Families with high social status can gain material benefits such as increased income for the self-employed and greater trade for owners of shops and businesses.

Common ways in which honour can be damaged

Among some communities in the UK, where family and community honour and reputation is of great importance, there are many factors which are viewed as dishonourable and may be considered as bringing shame and dishonour on the individual, their family and their community.

For instance:

1. Defying parental authority

Where parents and extended family are expected to control and manage the behaviour of their children, and particularly girls and young women, and who are perceived to have publicly failed to do so may lose status in the community as a result.

2. Dress, behaviour and attitude

Changing patterns of dress, behaviour and attitude whilst living in the West can impact upon their relationships within the family and the community. Modesty is the code of dress generally.

3. Sexual relationships/ behaviour before marriage

Pre-marital or extra-marital relationships (even of a non-sexual kind) are not acceptable in many communities and from a faith and cultural perspective may be seen as a violation of the key principles and values of that family.

4. Use of drugs or alcohol

Drinking alcohol and abusing drugs or using illicit or illegal drugs which are prohibited by religion, culture or tradition and the law can bring shame on families. Their children are seen to be abandoning or rejecting the values of their parents, the family and the community and breaking the law of the land.

5. Gossip

Rumours and gossip, even if untrue, can damage the status and reputation of an individual and of course the family and community.

Dishonour

Specific behaviours, attitudes and actions that may constitute 'dishonour' are wide ranging and include:

- Reporting Domestic Abuse
- Smoking cigarettes or drugs
- Perceived inappropriate make-up or dress
- Running away from home
- Rape, sexual harassment or assault
- The existence of a boyfriend or other 'non-approved' relationship
- Pregnancy before or outside marriage
- Inter-faith, inter-caste, or inter-ethnic relationships
- Rejecting a forced or arranged marriage
- Leaving a spouse and/ or children
- Seeking divorce particularly where the dowry may be large
- Seeking child custody
- Bearing a female child/ children
- Kissing, holding hands or other intimacy in a public place
- Sexual relations, sexual integrity and behaviour prior to marriage, within marriage, post-divorce or concerning a widow
- Homosexuality – being 'outed' or 'coming out' to others

Abuse and violence as a consequence of dishonour and shame may include:

1. Self-harm, suicide or attempted suicide as a result of controls and abuse
2. Forced suicide/ attempted suicide as an inflicted act or punishment
3. Controlling sexual activity (e.g. forcing or withholding sexual activity)
4. Child abuse
5. Rape
6. Kidnapping or false imprisonment
7. Threats to kill
8. Assault
9. Harassment/ stalking
10. Bullying
11. Forced abortion
12. Being forced into marriage
13. Pressure to return home
14. Pressure to go abroad
15. House 'arrest' and restriction of movement within and outside the home.
16. Excessive restrictions on home life (not allowed a phone, to use internet or develop friendships outside of wider family / friends circle etc.)

This list is not exhaustive, but highlights abuses of human rights and/ or criminal offences over and above the disapproval by family/ community.

END OF GUIDANCE