All Wales Child Protection Procedures Review Group

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ALL WALES ACPC

FEMALE GENITAL MUTILATION PROTOCOL

2005

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This Protocol is taken from the Cardiff ACPC protocol 2004.

The All Wales Child Protection Procedures Review Group wishes to acknowledge the work of Cardiff ACPC and express their thanks to them for allowing the use of their protocol.

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1. PROTOCOL FOR CHILDREN AND YOUNG PEOPLE

1.1 EQUAL OPPORTUNITY STATEMENT

This protocol affects a group of young people who are particularly vulnerable. Any decisions or plans for these children/young people, need to be based on good quality assessments and be sensitive to the issues of race, culture, gender, religion and sexuality, so far as not to stigmatise the child or the practising community.

2. PRINCIPLES

2.1.0 Female Genital Mutilation is illegal and is prohibited by the **Female Genital Mutilation Act 2003.**

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

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

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

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

3. LEGISLATION

3.1.1 Legislation against Female Genital Mutilation in the UK includes both international standards and national legislation.

3.1.2 There are two international conventions, which contain articles, which can be applied to Female Genital Mutilation.
Signatory states, including the UK, have an obligation under these standards to take legal action against Female Genital Mutilation.

3.1.3 The UN Convention on the Rights of the Child, ratified by the UK Government on 16th December 1991, was the first binding instrument explicitly addressing harmful traditional practices as a human rights violation. It specifically requires Governments to take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the

health of children.

3.1.4 The UN Convention on the Elimination of All Forms of Discrimination against Women, which came into force in 1981, recognises Female Genital Mutilation as a form of gender based violence against women. It calls on signatory Governments to take appropriate and effective measures with a view to eradicating the practice, including introducing appropriate health care and education strategies.

3.1.5 These conventions have been strengthened by two recent world conferences:

The International Conference on Population and Development (ICPD, Cairo, September 1994) mentioned and condemned Female Genital Mutilation specifically in several of its articles.

The World Conference on Women
(Beijing 1995) also condemned Female Genital Mutilation and called upon Governments to actively support programmes to stop it.

3.2 National Legislation

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

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

Saving for necessary operations by approved practitioners, a person is guilty of an offence if he, excises, infibulates or otherwise mutilates the whole or any part of a girl's labia, majora, labia minora or clitoris.

Other offences described in the Act are:

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

Female Genital Mutilation is an offence, which extends to acts performed outside of the United Kingdom.
Any person found guilty of an offence under the Act will be liable to a fine or imprisonment up to 14 years, or both.

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

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

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

4. DEFINITION

4.1.1 Female Genital Mutilation sometimes called Female Circumcision is a traditional practice, which takes three main forms:

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

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

Type 3 – Infibulation (also called Pharaonic Circumcision)
This is the severest form of Female Genital Mutilation. The term ‘infibulation’ is derived from the name given to the Roman practice of fastening a ‘fibular’ or ‘clasp’ through the large lips of their wives genitalia in order to prevent them from having illicit sexual intercourse.
In infibulation, the clitoris, the whole of the labia minora and the internal parts of the labia majora (the outer lips of the genitals, which lubricate the inside of the skin folds to prevent soreness) are removed. The two sides of the Vulva are then sown together with silk, catgut sutures, or thorns leaving only a very small opening to allow for the passage of urine and menstrual flow.

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

5. CONSEQUENCES OF FEMALE GENITAL MUTILATION

5.1.1 Many women appear to be unaware of the relation between Female Genital Mutilation and its health consequences; in particular the complications affecting sexual intercourse and childbirth which occur many years after the mutilation has taken place.

It is important to note that, depending on the degree of mutilation it may sometimes cause immediate fatal haemorrhaging.

5.1.2 Short-term health implications

a) severe pain and shock and occasionally fatality
b) infections
c) urinary retention
d) injury to adjacent tissues
e) fracture or dislocation as a result of restraint
f) damage to other organs

5.1.3 Long term health implications

a) excessive damage to the reproductive system
b) uterine, vaginal and pelvic infections
c) infertility
d) cysts
e) complications in pregnancy and childbirth
f) psychological damage; including a number of mental health and psychosexual problems e.g. depression, anxiety, frigidity (BMA 2001)
g) sexual dysfunction
h) difficulties in menstruation
i) difficulties in passing urine
j) increased risk of HIV transmission

6. SIGNALS AND INDICATORS

6.1.1 Professionals need to be aware of the possibility of Female Genital Mutilation. The following are some indicators of Female Genital Mutilation. However this is not an exhaustive list and professionals should be vigilant at all times:

- They come across a child who has undergone Female Genital Mutilation.
- They become aware that a child who may have undergone Female Genital Mutilation is suffering with a bladder or severe menstrual problems, which cause frequent absences from school.

* They hear reference to Female Genital Mutilation/Circumcision in conversation, for example a child may request help from a teacher or another adult.
* Midwives and Obstetricians will become aware when treating a pregnant woman who has been circumcised. This may trigger concern for any female child born and for any other girls in the family.
* The family comes from a community, which is known to practice Female Genital Mutilation. It may be possible that they will practice Female Genital Mutilation if female family elders are present.

6.1.2 Reasons Given for the continued Practice of Female Genital Mutilation

* Family honour;
* Custom and tradition;
* Hygiene and cleanliness;
* Preservation of virginity/chastity;
* Social acceptance especially for marriage;
* Religion in the mistaken belief that it is a religious requirement;
* A sense of belonging to the group and conversely the fear of social exclusion.

7. PROCEDURES AND PRACTICE GUIDELINES

7.1.1 The genital mutilation of female children and young women should be discouraged by appropriate educational and preventative programmes.

7.1.2 Staff who has responsibility for child protection work must be acquainted with child protection procedures and with any local preventative programmes, which exist.

7.1.3 Any information or concern that a child is at risk of, or has undergone Female Genital Mutilation should result in a child protection referral to social services and/or the police.

7.1.4 Female Genital Mutilation places a child at risk of significant harm and will therefore be investigated (initially) under Section 47 of the Children Act (1989) by Social Services and the police child protection team.

7.2 Strategy Meeting

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

7.2.2 The strategy meeting must first establish if either the parents or child have had access to information about the harmful aspects of Female Genital Mutilation.

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

7.2.4. An interpreter must be used in all interviews with the family if their first language is not English. The interpreter must not be a family relation.
The interpreter must be female.

7.2.5. Every attempt should be made to work with parents on a voluntary basis to prevent the abuse. It is the duty of the investigating team to look at every possible way that parental co-operation can be achieved. However, the child's interest is always paramount.

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

7.2.7 The primary focus is to prevent the child undergoing any form of Female Genital Mutilation, rather than removal from the family.

7.3 Children in immediate danger

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

7.4 If a child has already undergone Female Genital Mutilation

7.4.1 If a child has already undergone Female Genital Mutilation and this comes to the attention of any professional, a referral should be made to social services or police, and a strategy meeting convened to consider how, where and when the procedure was performed and its implication.

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

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

7.5 If a woman has already undergone Female Genital Mutilation

7.5.1 If a woman has already undergone Female Genital Mutilation and this comes to the attention of any professional, consideration needs to be given to any child protection implications e.g. for younger siblings, extended family members and a referral made to social services or police if appropriate.

7.5.2 If the woman is the mother of a female child or has the care of female children, a referral to Social Services under the Framework for the Assessment of Children in Need and their Families should be made. This will help to identify the most appropriate way of informing parents of the legal and health implications of Female Genital Mutilation and assessing the potential risk to female children in the family.

7.5.3 A child protection conference should only be considered necessary if there are unresolved child protection issues once the initial investigation and assessment have been completed.

8. INFORMATION SHARING

Lord Carlile in the Review of Safeguards for Children and Young People Treated in the NHS "Too Serious a Thing (2002)" stated that:

> *"There is nothing within the Caldicott Report, the Data Protection Act 1998 or the Human Rights Act 1998 which should prevent the justifiable and lawful exchange of information for the protection of children or the detection or prevention of Serious Crime"*

8.1.1 The Legal Framework

Professionals can only work together to safeguard children if there is an exchange of relevant information between them. Any disclosure of personal information to others must always, however, have regard to both common and statute law.

Normally, personal information should only be disclosed to third parties (including other agencies) with the consent of the subject of that information. Wherever possible, consent should be obtained before sharing personal information with third parties.

> **In some circumstances, consent may not be possible or desirable but the safety and welfare of a child dictates that the information should be shared.**

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

Health professionals may share information about a patient with another medical professional as part of providing care and treatment to that patient. This should be done in accordance with the common law duties of confidentiality, the Data Protection Act 1998 and the Human Rights Act 1998. Particular regard should be had to all the Data Protection Principles. Any disclosure should be considered on a case by case basis and limited to disclosing the information that it is necessary to disclose for the medical care and treatment of the child.
As a matter of practice seeking the consent of the parent on behalf of the child (where the child is not Fraser competent), should always be considered although where the safety of the child may be threatened by the disclosure such consent may not always be necessary.

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

8.1.2 The Common Law Duty of Confidence

Personal information about children and families held by professionals and agencies is subject to a legal duty of confidence, and should not normally be disclosed without the consent of the subject. However, the law permits the disclosure of confidential information necessary to safeguard a child or children in the public interest: that is, the public interest in child protection may override the public interest in maintaining confidentiality. Disclosure should be justifiable in each case, according to the particular facts of the case, and legal advice should be sought in cases of doubt.

Children are entitled to the same duty of confidence as adults, provided that, in the case of those under 16, they have the ability to understand the choices and the consequences relating to any treatment.
In exceptional circumstances, it may be believed that a child seeking advice, for example on sexual matters, is being exploited or abused. In such cases, confidentiality may be breached, following discussion with the child.

8.1.3 The Data Protection Act

The Data Protection Act 1998 requires that personal information is obtained and processed fairly and lawfully; only disclosed in appropriate circumstances; is accurate, relevant and not held longer than necessary; and is kept securely. The Act allows for disclosure without the consent of the subject in certain conditions, including for the purposes of the prevention or detection of crime, or the apprehension or prosecution of offenders, and where failure to disclose would be likely to prejudice those objectives in a particular case (for further guidance see *Data Protection Act 1998: protection and use of patient information* (Department of Health, 1998). Legal advice should be sought where appropriate or in cases of doubt.

8.1.4 The European Convention on Human Rights

Article 8 of the European Convention on Human Rights states that:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the

protection of the rights and freedoms of others.

Disclosure of information without consent might give rise to an issue under Article 8.
However this is not an absolute right and disclosure of information to safeguard children will usually be for the protection of health or morals, or the protection of the rights and freedoms of others, and for the prevention of disorder or crime, and information should therefore be shared.
Disclosure should be appropriate for the purpose and only to the extent necessary to achieve that purpose. Legal advice should be sought where appropriate, or in cases of doubt.

8.1.5 The Crime and Disorder Act 1998 Section 115
states:

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

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

8.2 Professional Guidance

8.2.1 Medical

The General Medical Council (GMC) has produced general guidance entitled *Confidentiality: Protecting and Providing Information (2000).* It emphasises the importance in most circumstances of obtaining a patient's consent to the disclosure of personal information, but makes clear that in their view information may be released to third parties – if necessary without consent – in certain circumstances. These circumstances include the following:

8.2.1.1 Children and other patients who may lack competence to give consent.

"Problems may arise if you consider that a patient is incapable of giving consent to treatment or disclosure because of immaturity, illness or mental incapacity. If such patients ask you not to disclose information to a third party, you should try to persuade them to allow an appropriate person to be involved in the consultation. If they refuse and you are convinced that it is essential, in their interests, you may disclose relevant information to an appropriate person or authority. In such cases you must tell the patient before disclosing any information, and, where appropriate, seek and carefully consider the views of an advocate or carer. You should document in the patient's record the steps you have taken to obtain consent and the reasons for

deciding to disclose information" (paragraph 38).

"If you believe a patient to be a victim of neglect or physical, or sexual or emotional abuse, and that the patient cannot give of withhold consent to disclosure, you should give information to an appropriate responsible person or statutory agency, where you believe disclosure is in the patient's best interests. You should usually inform the patient that you intend to disclose the information before doing so. Such circumstances may arise in relation to children where concerns about possible abuse may need to be shared with other agencies such as social services. Where appropriate you should inform those with parental responsibilities about the disclosure. If, for any reason, you believe the disclosure is not in the best interests of the abused or neglected patient, you must still be prepared to justify your decision".

8.2.1.2 Disclosure to protect the patient or others

"Disclosure of personal information without consent may be justified where failure to do so may expose the patient or others to risk of death or serious harm. Where third parties are exposed to a risk so serious that it outweighs the patient's privacy interest, you should seek consent to disclose where practicable. If it is not practicable, you should disclose the information promptly to an appropriate person or authority. You should generally inform the patient before disclosing the information" (paragraph 36).

The General Medical Council has confirmed that its guidance on the disclosure of information which may assist on the prevention or detection of abuse, applies both to information about third parties (for example adults who may pose a risk of harm to a child), and about children who may be the subject of abuse.

8.2.2 Nursing

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

- Disclosure should be with the consent of the patient

However disclosure can be made without consent where:

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

The NMC guidance also states that:

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

9 PROFESSIONAL GUIDANCE ON FEMALE GENITAL MUTILATION FOR HEALTH PROFESSIONALS.

In response to the growing need for health professionals in the UK to become aware of the issue of Female Genital Mutilation, the Royal College of Nursing issued guidance to nurses in March of 1994.

Female Genital Mutilation: The Unspoken Issue sought to raise nurses awareness of the subject and to give them a greater understanding of the issues involved. It hoped to stimulate discussion and to encourage nurses, midwives and health visitors to develop local responses to Female Genital Mutilation.

In January 1996 the British Medical Association (BMA) approved **Guidance for Doctors Approached by Victims of Female Genital Mutilation**. The guidance includes background information, the role of the doctor, guidance and recommendations for action.

In June 1997, **the Royal College of Obstetricians and Gynaecologists** issued a statement condemning all forms of Female Genital Mutilation, and clarifying the definition of infibulation and the obstetrician's position on repair of the vulva of a woman who has delivered a baby vaginally following a previous infibulation.

In June 1998, **The Royal College of Midwives** issued a position paper on Female Genital Mutilation, giving background information and clarifying the role of the midwife, both in the care of women and the protection of children.

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

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

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

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

Policy

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

Any information or concern that a child is at immediate risk of, or has undergone, Female Genital Mutilation should result in a child protection referral.
Female Genital Mutilation places a child at risk of significant harm and will, therefore be investigated (initially) under Section 47 of the Children Act (1989) by Social Services and the Police Child Protection Team.

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

There should also be consideration of other children from other families, once concerns are raised about the incidence or the perpetrator of Female Genital Mutilation.

Legal Position

Female Genital Mutilation is a criminal offence under the **Female Genital Mutilation Act 2003 (**replacing the Prohibition of Female Circumcision Act 1985. This offence carries a sentence of 5 years imprisonment on indictment for the person who conducted Female Genital Mutilation.
Defence may be submitted for medical reasons, if conducted by a medical practitioner, as the only exemption to the Act is on specific physical and mental health grounds. Cultural custom or rituals are not accepted as a defence.

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

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

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

11 GOOD PRACTICE GUIDANCE: THE ROLE OF THE POLICE

Policy

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

There should also be consideration of other children from other families, once concerns are raised about the incidence or the perpetrator of Female Genital Mutilation.

12 GOOD PRACTICE GUIDANCE: THE ROLE OF THE VOLUNTARY SECTOR

Support and advice can be obtained from specialist organisations such as:

* Foundation for Women's Health, Research and Development

which offers:

- Translation/Interpreting
- Counselling Support
- Educational Programmes
- Family Support Services

Once it is suspected that Female Genital Mutilation may have taken place or is about to take place the matter should be discussed with the person's Line Manager and Social Services.
A referral should then be made to Social Services for their investigation as per The All Wales ACPC Child Protection Procedures 2002 and updates.

Any need to seek advice should not be allowed to delay a child protection referral.

Training and education about Female Genital Mutilation should be available to all staff working with children and families.

13 GOOD PRACTICE GUIDELINES FOR STAFF WORKING IN EDUCATION AUTHORITIES

Policy

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

Any information or concern that a child is at immediate risk of, or has undergone, Female Genital Mutilation should result in a child protection referral.
Female Genital Mutilation places a child at risk of significant harm and will, therefore be investigated (initially) under Section 47 of the Children Act (1989) by Social Services and the Police Child Protection Team.

If there is concern about one child in a family consideration must be given to whether siblings are at similar risk.

There should also be consideration of other children from other families, once concerns are raised about the incidence or the perpetrator of Female Genital Mutilation.

Good Practice Guidelines

These guidelines should be considered in conjunction with All Wales ACPC Child Protection Procedures and the school's child protection handbooks.

Signals/ Indicators

All staff who come into contact with children at school may become aware of the practice of Female Genital Mutilation.
Some staff are particularly well placed to detect the risk of Female Genital Mutilation, particularly teachers in primary schools and school nurses.

All staff working in schools in areas where there are communities known to practice Female Genital Mutilation should be alerted to the possibility of the practice in the school population.

Indications that Female Genital Mutilation may be about to take place include:

- The family comes from a community that is known to practice Female Genital Mutilation. e.g. Somalian, Sudanese and other sub-Saharan countries.
- A child may talk about a long holiday to her country of origin and may confide to a teacher, school nurse or welfare officer, teachers aide or adult helper that she is to have a 'special procedure' or to attend a (special occasion).

* A conversation with a child may refer to Female Genital Mutilation/ circumcision.
* A parent may state that they or a relative are to take the child out of the country for a prolonged period of time.

Indications that Female Genital Mutilation may have already taken place include:

* A child may spend long periods of time away from the class during the day with bladder or menstrual problems.
* There may be prolonged absences from school because of bladder or menstrual problems.
* A prolonged absence from school with noticeable behaviour changes on the girl's return could be an indication that a girl has undergone Female Genital Mutilation.
* A referral to the school nurse that results in the seeking of further medical advice that suggests Female Genital Mutilation has taken place.

Once it is suspected that Female Genital Mutilation may have taken place or is about to take place, the matter should be referred to the Designated Member of Staff for Child Protection at the school. Advice at this stage can be sought from the Designated Officer for Child Protection (Schools Service), Education Welfare Officer, Social Services, Named / Designated Child Protection health professionals, School Nurse, Community Paediatrician or GP.

A referral should then be made to Social Services for their investigation as per The All Wales ACPC Child Protection Procedures 2002 and updates.

Any need to seek advice should not be allowed to delay a child protection referral.

14 REFERENCES

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