Argyll and Bute inter Agency Protocol for the Protection of Girls and Women at Risk of Female Genital Mutilation (FGM)

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Introduction

The Scottish Government has articulated its vision for Scotland's children in the publication of the refreshed National Guidance for Child Protection in Scotland (2014), setting out that all children and young people have the right to be cared for and protected from harm and abuse and to grow up in a safe environment, in which their rights are respected and their needs met. Children and young people should get the help they need, when they need it, and their welfare is always paramount.

This document reflects the child protection arrangements set out in both the National Guidance for Child Protection in Scotland and the National Guidance for responding to FGM in Scotland.

This document produced by the Argyll and Bute Child Protection Committee (CPC) provides the procedures and processes to be followed by all services in dealing with concerns about FGM across Argyll and Bute.

The procedures reflect the CPC's collective commitment to inter-agency collaboration and joint responsibility in this vitally important area of work. These procedures are mandatory for all staff from all agencies.

Local authorities, NHS boards and Police Scotland are responsible together for the protection of children and adults at risk in their area, and for the assessment and management of risk of harm posed by offenders. Chief executives and divisional police commanders ensure the discharge of these responsibilities through a variety of multi-agency arrangements, typically Child Protection Committees, Violence Against Women Partnerships, Adult Protection Committees, and Offender Management Committees reporting to the Chief Officers Group Public Protection in Argyll and Bute.

These procedures are for all front line practitioners and volunteers who work with children and young people aged 0-18 as well as those working with parents and carers of children. It is for all agencies within Argyll and Bute, Police, Social Work, NHS Highland, Education and the voluntary sector.

These procedures are primarily a child protection procedure for those under the age of 18 years; it provides information and directs individuals to appropriate guidance for adults who have been affected by FGM or may be at risk of FGM.

Female Genital Mutilation (FGM) is not an acceptable practice it is illegal in the UK and it is a form of child abuse under UK law.

Guiding Principles

This document is to guide those working with children and families as they:

- Approach and discuss this sensitive topic confidently
- Identify any girl who may be at risk of FGM
- Act appropriately in response to this concern
- Share information across and within agencies appropriately
- Initiate child protection procedures as indicated
- Gather, document and retain information meaningfully
- Contribute to education about and prevention of FGM within our communities

If you are concerned about the immediate safety of a child or adult call police on 999
If there is an acute health need such as bleeding, acute pain, fever or similar call 999 or go immediately to an Accident and Emergency department.

Female Genital Mutilation (FGM) is a collective term for all procedures which include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons or any other injury to the female genital organs for non-medical reasons. FGM is a harmful practice. It can cause long-term mental and physical harm, difficulty in child birth, infertility and even death.

FGM (FGM) is recognised internationally as a violation of human rights and a form of violence against women and girls. FGM is practised in over 28 African countries, parts of the Middle and Far East. The following countries have the highest incidence of FGM:

Djibouti (98%),
Egypt (97%),
Eritrea (95%),
Guinea (99%),
Mali (94%),
Sierra Leone (90%),
Somalia (98-100%).

There is very little data documenting prevalence in the UK and Scotland because of the lack of reporting, knowledge or training. In 2004, it was estimated that 74,000 women in the UK had undergone FGM and a further 7,000 under the age of 17 were at risk. (The Department of Health, CMO Update 37,2004**).**

International Standards

There are two international conventions, which contain articles, which apply to FGM. Signatory states, including the UK, have an obligation under these standards to take legal action against FGM. 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.

The UN Convention on the Elimination of All Forms of Discrimination against Women, which came into force in 1981, recognises FGM 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.

These conventions have been strengthened by two world conferences. The International Conference on Population and Development (ICPD, Cairo, September 1994) mentioned and condemned FGM specifically in several of its articles. The World Conference on Women (Beijing 1995) also condemned FGM and called upon Governments to actively support programmes to stop it.

Legislation in Scotland

The Prohibition of Female Genital Mutilation (Scotland) Act (2005) makes it unlawful to carry out any FGM procedures on a girl or a woman. The Legislation makes it an offence to aid, abet, counsel, procure or incite a person to:

- Commit FGM
- Assist a girl to commit FGM on herself
- For someone in the UK to arrange or assist FGM to be performed out with the UK by a person who is not a UK national or permanent UK resident

It is an offence under the act for UK nationals, or permanent UK residents, to carry out FGM abroad, even in countries where the practice is not banned by law. An amendment to the Prohibition of Female Genital Mutilation (Scotland) Act (2005) was passed by the UK Parliament within the UK Serious Crime Bill 2014. This change came into effect in 2015, and replaced the term “permanent resident” with “habitually resident”. This will ensure that a person who is not legally termed a ‘permanent UK resident’ will still be able to be tried in the Scottish Courts.

Home Office statistics indicate that FGM is much more common than people realise, both worldwide and in the UK. The Legislation also allows a convicting court to refer the victim and any child living in the same household as the victim, or person convicted of the offence, to the reporter to the Children’s Hearing. The reporter has grounds to refer such children to a children’s hearing, under section 67 of the Children’s Hearings (Scotland) Act 2011. These provisions also give the reporter grounds to refer to a children’s hearing any other children who are, or become, or are likely to become members of the same household as either the victim or the offender. Section 60 of the Children’s Hearings (Scotland) Act 2011 outlines the local authority’s duty to provide information to Principal Reporter:
(1) If a local authority considers that it is likely that subsection (2) applies in relation to a child in its area, it must make all necessary inquiries into the child’s circumstances.
(2) This subsection applies where the local authority considers:

(a) That the child is in need of protection, guidance treatment or control, And
*(b) That it might be necessary for a compulsory supervision order to be made in relation to the c*hild.

(3) Where subsection (2) applies in relation to a child the local authority must give any information that it has about the child to the Principal Reporter.The Police are subject to a similar duty under section 61 of the 2011 Act.

Information Sharing and Governance

Professionals in all agencies need to be confident and competent in sharing information appropriately, both to protect children from being abused through FGM and to enable children and women who have been abused through FGM to receive physical, emotional and psychological help.

Professionals in all agencies should share information in line with West of Scotland Child Protection Procedures https://www.argyll-bute.gov.uk/publications-practice-and-guidance

Further details on information sharing can be located within Getting it Right for Every Child and A Practitioner Guide to Information Sharing,

Confidentiality and Consent to Support Children and Young People's Wellbeing

Section 60 of the Children's Hearings (Scotland) Act 2011,outlines the local authority's duty to provide information to the Principal Reporter.
Section 61 of the Children's Hearings (Scotland) Act 2011 outlines a constable's duty to provide information to Principal Reporter.

Prevalence

An indication of FGM prevalence is attached as appendix A. FGM is a deeply rooted tradition, widely practiced mainly among specific ethnic populations in Africa, the Middle East and parts of Asia. The World Health Organisation (WHO) estimates that between 130-140 million girls and women have experienced FGM and up to two million girls per year undergo some form of the procedure each year.

FGM is practiced in more than 28 countries in Africa and in some countries in Asia and the Middle East, however in each of those countries the extent of the practice varies.

Women from non-African communities who are most likely to be affected by FGM include those from Yemeni, Iraqi, Kurdish communities, Malaysia and Pakistan.

There is an advisory position from the Information Commissioner for Scotland relating to information sharing for child protection which can be found at ico.org.

Cultural Underpinnings

Female genital mutilation is a complex issue; despite the harm it causes, many women from FGM practicing communities consider FGM normal and desirable. FGM is linked to concepts of 'purity', beauty and suitability for marriage.

Infibulation, where there is closing or some form of stitching over the vaginal opening is Strongly linked to concepts of virginity and chastity. It is used as a measure to prevent penetrative sexual intercourse outside marriage. In some cultures it is considered necessary at the time of marriage for the prospective husband and his family to see a woman 'closed'.

In some instances both mothers will then take the woman to be 'cut open' enough to be able to have penetrative sexual intercourse. Women may also require further procedures to 'open' the closing vagina in order to give birth. The consequences of this are pain, bleeding, varying degrees of incapacity and psychological trauma.

Following delivery of an infant, women may be subject to further FGM procedures to 'close' her again. If a woman requests such a procedure following delivery of an infant, this must be taken seriously by all professionals. It is illegal to play any part in this. The desire for this form of FGM, or 'reinfibulation' indicates a lack of understanding of the harmful effects of FGM, the legal aspects of FGM, and any daughter of a woman in these circumstances is regarded as being at high risk FGM.

Although FGM is practiced by secular communities, it may be claimed to be carried out in accordance with religious beliefs. However, neither the Bible nor the Koran justifies FGM. In 2006, senior Muslim clerics at an international conference on FGM in Egypt pronounced that FGM is 'not Islamic'.

Parents who support the practice of FGM may believe and say that they are acting in the child's best interests. The reasons they give include that it:

- Brings status and respect to the girl;
- Preserves a girl's virginity / chastity;
- Is part of being a woman;
- Is a rite of passage;
- Gives a girl social acceptance, especially for marriage;
- Upholds the family honour;
- Gives the girl and her family a sense of belonging to the community;
- Fulfils a religious requirement
- Perpetuates a custom/tradition;
- Helps girls and women to be clean and hygienic;
- Is cosmetically desirable; and makes childbirth safer for the infant.

There is no justification to subject any woman or girl to FGM.

Cultural Change in the UK

Communities where FGM is traditionally practiced may exert considerable pressure, control and sometimes coercion towards women and parents of girls regarding FGM. Affected families may be extremely vulnerable. For example they may have few English language skills, be financially insecure, fleeing persecution in their country of origin, and be socially isolated or dependent on a few families known to them. The practice of FGM is also associated with forced marriage and young age at marriage. The powerful effect of 'shame' relating to FGM should be acknowledged and understood by professionals. There are increasing instances where young men and women who have grown up in the UK (and assimilated British cultural beliefs and attitudes) are experiencing difficulties amongst their peer group, e.g. young men rejecting girlfriends when they discover that she had FGM as a girl or discovering that not all girls are subjected to FGM. Young people who resist FGM can also experience conflict within their family and community

Principles Supporting these Procedures

The following principles should be adopted by all agencies in relation to identifying and responding to children (and unborn children) at risk of or who have experienced female genital mutilation and their parent/s:

- The safety and welfare of the child is paramount;
- All agencies act in the interests of the rights of the chilas stated in the UN Convention (1989);
- FGM is illegal and is prohibited by the Female Genital Mutilation Act 2003 and Prohibition of Female Genital Mutilation (Scotland) Act 2005;

It is acknowledged that some families see FGM as an act of love rather than cruelty. However, FGM causes significant harm both in the short and long term and constitutes physical and emotional abuse to children; All decisions or plans for the child/ren should be

based on good quality assessments and be sensitive to the issues of race, culture, gender, religion and sexuality, and avoid stigmatising the child or the practicing community as far as possible;

Accessible, acceptable and sensitive Health, Education, Police, Children's Social Work and Voluntary Sector services must underpin this procedure; All agencies should work in partnership with members of local communities, to empower individuals and groups to develop support networks and education programmes.

Types of FGM

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

- Type 1 (Circumcision): Excision of the prepuce with or without excision of part of or the entire clitoris.
- Type 2: (Excision or Clitoridectomy): Excision of the clitoris with partial or total excision 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, scar tissue forms to cover the upper part of the vulva (external female genitalia) region.
- Type 3: (Infibulation or 'Pharaonic Circumcision'): This is the most extensive form of female genital mutilation .Infibulation often (but not always) involves the complete removal of the clitoris, together with the labia minora and at least the anterior two-thirds and often the whole of the medial part of the labia majora (the outer lips of the genitals). The two sides of the vulva are then sewn together with silk, catgut sutures, or thorns leaving only a very small opening to allow for the passage of urine and menstrual flow. This opening is often preserved during healing by insertion of a foreign body.
- Type 4 (Unclassified): This includes all other operations on the female genitalia including pricking, piercing or incising of the clitoris and or labia; stretching of the clitoris and or labia; cauterisation by burning of the clitoris and surrounding tissues; scraping of the tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above.

In practice it can be difficult to define the anatomy affected by FGM, and to allocate one of the WHO 'types'. A specialist examination by appropriately trained and experienced professionals is best practice.

Age and Procedure

The age at which girls are subjected to female genital mutilation varies greatly, from shortly after birth to any time up to and including adulthood. FGM is usually carried out by the older women in a practicing community, for whom it can be a way of gaining prestige and a source of income.

The arrangements for the procedure usually include the child being held down on the floor by several women and the procedure carried out without medical expertise, attention to hygiene and/ or anaesthesia. The instruments used include unsterilised household knives, razor blades, broken glass and stones. In addition, the child is subjected to the procedure unexpectedly. Increasingly some health professionals are performing FGM in the belief that it offers more protection from infection and pain. However, the medicalisation of FGM is condemned by all international groups, including the WHO.

Names for FGM

FGM is known by a number of names, including female genital cutting or circumcision. The term female circumcision is unfortunate because it is anatomically incorrect and gives a misleading analogy to male circumcision. The names ‘FGM’ or ‘cut’ are increasingly used at the community level, although they are still not always understood by individuals in practicing communities, largely because they are English terms.

For example, the Somali term for FGM is ‘Gudnin’ and the Sudanese word for FGM is ‘Tahur’. A list of some terms used by different communities is attached as Appendix B.

Consequences of FGM

The health implications of the FGM procedure are variable and can be severe to fatal for a child, depending on the type and circumstances of the FGM carried out (Appendix C).

As with all forms of child abuse or trauma, the impact of FGM on a child will depend upon such factors as:

- The severity and nature of the violence;
- The individual child’s innate resilience;
- The warmth and support the child receives in their relationship with their parent/s, siblings and other family members;
- The nature and length of the child’s wider relationship and social networks;
- Previous or subsequent traumas experienced by the child;
- Particular characteristics of the child’s gender, ethnic origin, age, (dis)ability, socio-economic and cultural background.

Short Term Implications for a Child’s Health and Welfare

Short term health implications can include:

- Severe pain;
- Emotional and psychological shock (exacerbated by having to reconcile being subjected to the trauma by loving parents, extended family and friends);
- Haemorrhage (bleeding);
- Wound infections including Tetanus and blood borne viruses (including HIV and Hepatitis B and C);
- Urinary retention;
- Injury to adjacent tissues;
- Fracture or dislocation as a result of restraint;
- Damage to other organs;
- Death

Long Term Implications for a Girl or Woman’s Health and Welfare

The longer term implications for women who have been subject to FGM Types 1 and 2 are likely to be related to the distress of the actual procedure and sexual function. Nevertheless, analysis of World Health Organisation data has shown that, as compared to women who have not undergone FGM, women who had been subject to any type of FGM showed an increase in complications in childbirth, worsening with Type 3. Therefore, although Type 3 creates most difficulties, professionals should respond proactively for all FGM types. The health problems caused by FGM Type 3 are significant –urinary problems, difficulty with menstruation, pain during

sex, lack of pleasurable sexual sensation, psychological problems, infertility, vaginal infections, specific problems during pregnancy and childbirth.
Women with FGM Type 3 require special care during pregnancy and childbirth.

The long term health implications of FGM include:

- Chronic vaginal and pelvic infections;
- Difficulties in menstruation;
- Difficulties in passing urine (takes a long time)and chronic urine infections;
- Renal impairment and possible renal failure;
- Damage to the reproductive system, including infertility;
- Infibulation cysts, neuromas and keloid scar formation;
- Complications in pregnancy and delay in the second stage of childbirth;
- Maternal or foetal death;
- Psychological damage; including a number of mental health and psychosexual problems including depression, anxiety, and sexual dysfunction;
- Increased risk of HIV and other sexually transmitted infections.
- Mental Health Problems

Case histories and personal accounts from women note that FGM is an extremely traumatic experience for girls and women that stay with them for the rest of their lives.

Young women receiving psychological counselling in the UK report feelings of betrayal by parents, incompleteness, regret and anger.It is possible that as young women become more informed about FGM this problem may be more frequently identified. There is increasing awareness of the severe psychological consequences of FGM for girls and women, which become evident in mental health problems.

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

The fact that FGM is ‘culturally embedded’ in a girl or woman’s community does not protect her against the development of Post -Traumatic Stress Disorder and other psychiatric disorders.

Professional Response

From the child protection perspective, there are three circumstances relating to FGM which require identification and intervention:

- Where a child is at risk of FGM
- Where a child has been abused through FGM
- Where a prospective mother (pregnant woman) has undergone FGM

Many professionals and volunteers in most agencies in Scotland have little or no experience of female genital mutilation. When 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.

Concern about being 'racist' can be a barrier to professionals reacting to or enquiring about FGM. This should not prevent the professionals from following child protection guidance and procedures.
The appropriate response to FGM is to follow the West of Scotland Inter-Agency Child Protection Procedures to ensure immediate protection and support for the child/ren.

The Inter-Agency Tripartite Referral Discussion will fully consider the most appropriate response to a child suspected of having undergone FGM as well as a child at risk of undergoing FGM, which may include:

- Arranging for an interpreter if this is necessary and appropriate; Note that this should not be a family member or originate from the same community network as the child or extended family.
- Creating an opportunity for the child to disclose, seeing the child on their own. Always consider a Joint Investigative Interview; Using simple language and asking straightforward questions; Using terminology that the child will understand, e.g. the child is unlikely to view the procedure as abusive;
- Being sensitive to the fact that the child will be loyal to their parents;
- Giving the child time to talk;
- Getting accurate information about the urgency of the situation, if the child is at risk of being subjected to the procedure;
- Giving the message that the child can come back to you again.
- Being sensitive to the intimate nature of the subject;
- Making no assumptions;
- Asking straightforward questions;
- Being willing to listen;
- Being non-judgemental (condemning the practice, but not blaming the girl/woman);
- Understanding how she may feel in terms of language barriers, culture shock, that she, her partner, her family are being judged;
- Giving a clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM if or when they have daughters.

Identifying a Child who has been Subject to FGM or who is at Risk of being Abused through FGM

Professionals in all agencies, and individuals and groups in the community, need to be alert to the possibility of a child being at risk of or having experienced female genital mutilation.

A child at risk of FGM; key risks
1. Family's country of origin has FGM practising communities
2. Mother (or other female relative, including sibling) has had FGM
3. Intention re FGM by child/ family member/ possible perpetrator/ non protective views
4. Upcoming trip to country of origin or out of UK
5. UK survivors of FGM have reported that individuals travel to the UK for the purposes of carrying out FGM or are already within the UK and carry out FGM.

'Intention' or 'non protective views' may be indicated by:

• FGM may be more likely if a female family elder with generally traditional views is part of the community or is visiting;
• 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;

• A child may request help from a teacher or another adult.

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 (taking a long time to pass urine) or menstrual problems;
• There may be prolonged absences from school. A time of increased risk is during school holiday periods, which allows healing to take place; therefore before and after school holidays are key for greater awareness by professionals who have regular contact with the child;
• 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/are suffering the adverse consequence of the practice, e.g. withdrawal, depression
• A child may confide in a professional;
• A child requiring to be excused from physical exercise lessons;
• A child may ask for help.

Professionals and Volunteers from all Agencies Responding to Concerns

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 agencies (Police Scotland, NHS Highland or Children and Families Social Work) as in the

Protection of Adults at Risk of Harm

Where there are any suspicions or knowledge that a woman aged 18 years or over is at risk of FGM, a referral to adult protection services may be appropriate if the person is unable to safeguard their own well-being, property, rights or other interests. In such instances and where the person is more vulnerable because of a disability, disorder, illness or infirmity, they may be deemed an 'adult at risk of harm consideration should be given to initiating an Adult Protection IRD as per the Adult Support and Protection (Scotland) Act,2007. Making a referral under this route does not detract from the need to contact Police Scotland.

Where the person is 18 and over and not known to services and you do not believe they are an adult at risk (as above) Police Scotland remain the sole referral route.

16 - 17 year olds

Young people, especially those aged 16 and 17, can present specific difficulties to agencies as there may be occasions when it is appropriate to use both child and adult protection frameworks. If there is any doubt, a child protection referral should be made. The age of the Individual concerned should not be a barrier to an Interagency Referral Tripartite Discussion taking place. A response proportionate to the level of risk being effected is the priority.

Use of Interpreters

Use of any interpreter or translator should only be through approved services such as the Interpretation and Translation Services. The girl or woman should be given the opportunity to express a preference for a male or female interpreter.

The interpreter should not be:

- A family member
- Known to the individual
- Someone with influence in the individual's community.

Other steps that should be taken when working with an interpreter include:

- Checking the dialect spoken before making arrangements
- Having a briefing meeting with the interpreter, prior to the discussion with the girl or woman
- If the interview is not a Joint Investigative or other forensic interview and the girl or woman wishes to be accompanied during the discussion, check that she understands the full extent of the discussion and the impact of having someone with her. If she insists, have a brief meeting with the accompanying person and establish the rules of confidentiality
- Explain the role of the interpreter at the beginning of the discussion
- Ensure that the interpreter does not add their own information or opinion.

Police Scotland

Reports that a girl or woman has been subject of FGM or concerns that a girl or woman may be at risk of FGM can come to the attention of officers and members of police staff from various sources, including direct reporting by a girl or woman; a named or anonymous member of the public; via statutory agencies such as education; health and local authority social work or 3rd sector advocacy and support services. FGM may also be identified incidentally as part of unrelated duties such as responding to other concerns or when conducting investigations into other crimes of offences

Children

Initial Action in Responding to Girls at risk of FGM including an unborn child:

- Details of any disclosure made to a first contact police officer or member of police staff should be carefully noted in the officer's personal notebook or other recording system STORM incident as soon as practicable.
- Such a disclosure and any initial interaction with a child should be regarded quite different from a Joint Investigative Interview.
- In such circumstances the child should be allowed to provide any voluntary account or information, however, should not be 'interviewed' or questioned in detail about the commission of or planned commission of FGM as this may undermine the reliability or admissibility of any information subsequent interview.
- The primary consideration must be the immediate safety of the child.
- The Prohibition of Female Genital Mutilation (Scotland) Act 2005 makes it illegal to perform or arrange to have FGM carried out in Scotland or abroad. A sentence of 14 years imprisonment can be imposed which highlights the gravity of the offence. FGM should always be seen as a cause of significant harm. As such, when there is information to suggest that a girl has been, is or is likely to be subject of FGM and may be at risk of significant harm, all officers or members of police staff must immediately signpost to their supervisor and Divisional Public Protection Unit, or if out with hours, the duty senior CID officer/ Duty Inspector, who will be responsible for assessing the level of risk to the child or any other children. This should not be interpreted to mean a child protection joint investigation will commence on every occasion.

What it will provide that our interface with partner agencies will reflect common standards of practice; shared language and understanding and provide a sensitive, proportionate response by specialist officers who are fully conversant with Police Scotland's Child

Protection - FGM Standard Operating Procedure, national guidance and local interagency child protection procedures to enable such procedures to be considered and implemented if necessary.

On all occasions information and intelligence databases must be researched in relation to the child and their family background. The minimum checks to be carried out by Police Scotland are:

- Police National Computer (PNC)
- Police National Database (PND)
- Criminal History System (CHS)
- Scottish Intelligence Database (SID)
- Violent and Sexual Offenders Register (ViSOR)
- Command and Control system
- Crime Management system
- Vulnerable Persons Database

The West of Scotland Inter-Agency Child Protection Procedures must be invoked for any child who has been subjected to FGM or where there is information that other risk factors are present.

On occasions where there is insufficient information to determine whether child protection procedures should be invoked, and more information is required to inform decision making the Divisional PPU or on duty senior CID officer should make an information sharing request to core partners (Social Work, Health and if appropriate Education) to share relevant information in relation to the child or any other child. This may result in an action for the most appropriate partner to engage with the child and her family in an attempt to gain further information. While PPU officers should be in a position to speak with parents/carers about the law and health implications and work collaboratively, the decision about which professional is best placed to engage with a child and their family about FGM needs to be carefully considered and should be agreed (and documented) between agencies.

The outcome of family engagement must be shared with Social Work, Health and Police Scotland. If necessary child protection procedures will be instigated and decisions around investigation (joint or single agency); joint investigative interview and type of medical examination will be made by Social Work and Police in consultation with Health during any subsequent IRTD.

Imminent Risk of Significant Harm

In most cases where there are concerns about FGM, these are not associated with imminent risk. However, if a child is about to leave the country; there is information about a fleeing family; clear intent for FGM to be carried out with the UK or any other abusive or negligent behaviour which places a child or unborn baby at immediate risk of significant harm, the Duty Inspector must ensure that effective protection measures are put in place immediately and primary investigation commences in liaison with the Divisional PPU or duty senior CID Officer. Child Protection Procedures will be immediately instigated, during which time consideration will be given to the application for a Child Protection Order or other relevant protection order.
On occasions where the risk is such that it is not practicable for a CPO or other relevant order to be applied for, Section of the Children's Hearing (Scotland) Act 2011 provides for emergency measures, specifically a constable's power to remove a child to a place of safety. Section 59 of the Children's Hearing (Scotland) Act 2011 relates to the obstruction

offence. A child may not be kept in a place of safety under this section for a period of more than 24 hours, therefore, as soon as practicable after a child is removed under this section, the Principal Reporter must be informed.

In addition, officers must inform their supervisor and Divisional PPU or on duty senior CID officer immediately powers under Section 59 of the Children's Hearing (Scotland) Act 2011 have been used to instigate child protection procedures.

Adult Victims of FGM or Adults at Risk of FGM

The overarching principles outlined above apply to adult victims of FGM or adults at risk of becoming the victim of FGM. First responding officers or members of police staff must immediately signpost to their supervisor and Divisional Public Protection Unit, or if out with hours, the duty senior CID officer, who will be responsible for assessing the level of risk to the adult. This will ensure a sensitive, proportionate response by specialist officers. While FGM is usually not undertaken for the sexual gratification of another, the circumstances of the act are such that when the victim or potential victim is an adult a Sexual Offences Liaison Officer will be deployed for the purposes of interview and act as a single point of contact.

Support from survivor advocacy services should always be considered prior to any interview taking place. Officers must consider whether the adult victim or potential victim may have additional needs, such as interpretation services; an appropriate adult if any mental disorder is suspected or if the adult may be an adult at risk as per the Adult Support and Protection (Scotland) Act 2007. Any such concerns must be immediately highlighted to the Divisional PPU so that all necessary support can be provided or Adult Support and Protection Procedures instigated. As above, the primary consideration must be the safety of the victim or potential victim.

Factors to Consider

During an investigation into FGM it will be important to establish the timing of the victim and individual family member's entry and exit of the UK. Securing passports; other travel documentation or payment receipts etc. which may
be of particular evidential value. All female members of the household and female relatives of the index case must be considered as being at risk of FGM and included in any risk assessment and safety planning. For children; families and communities affected by FGM their previous experience of 'authority' figures, including the police, whether abroad or within the UK and Scotland may have been negative or traumatic e.g. asylum seeking communities. This may add barriers to collaborative and meaning communication in addition to what is a sensitive subject.

If appropriate, a request may be made for an appropriately trained medical professional to conduct a medical examination. It may be in the child's or woman's best interest to have a medical examination for health and wellbeing purposes, without the need for forensic corroborative evidence a crime has not been committed within a country where unlawful. e.g. the FGM was carried out prior to entry into the UK. In all cases involving children, an experienced paediatrician should be involved in decision making and arranging medical examinations.

When a criminal investigation is raised, the interviewing of children and young people must be undertaken in line with the Scottish Government Guidance on the Joint Investigative Interviewing of Child Witnesses in Scotland 2011, in order to obtain best evidence.

If any legal action is being considered, early consultation with the Crown Office and Procurator Fiscal Service (COPFS) is important.

Police Procedures
On all occasions a restricted VPD Concern Form and SID should be submitted at the point of reporting/referral; updated as necessary and, on all occasions, at the conclusion of any investigation. To ensure the integrity and safety of those involved any STORM incident will also be restricted. A crime report must be raised as soon as there is information that a crime has taken place in line with the

Scottish Crime Recording Standards.

Officers should refer to the following documents on the force intranet:
Child Protection Standard Operating Procedures (SOP)
Honour Based Violence, Forced Marriage and Female
Genital Mutilation SOP
Scottish Government Guidance on the Joint
Investigative Interviewing of Child Witnesses in Scotland
(2011)
National Guidance for Child Protection in Scotland
(2014)
Adult Support and Protection SOP
Appropriate Adults SOP
Interpreting and Translating Services SOP

Note: the Victim and Witnesses (Scotland) Act 2014 provides for victims of specific crimes to specify a gender preference in relation to an interviewing officer and to gender preference for medical examiner. This does not specifically include FGM, but would be considered best practice.

Education: Guidelines for Teachers and Other Education Staff

The National Guidance for Child Protection in Scotland (2014) states that FGM should always be seen as a cause of significant harm and local child protection procedures should be invoked. Education staff should work closely with other agencies. The welfare of the child/ young person is always the primary concern.

Key points

The Children and Young People (Scotland) Act 2014 and the Getting It Right for Every Child approach require practitioners in all services for children and adults to meet children and young people's wellbeing needs, working together if necessary to ensure children and young people reach their full potential. When starting primary 1, key information about FGM risk assessment will be shared from a child's health visitor to the head teacher, to ensure that those in daily contact with a child are aware of the level of risk of FGM and any relevant related information. It is important to remember that risk assessment is a dynamic process, and a 'conversation' that continues through a girl's life. Education staff are most likely to become aware of factors that may bring about change to level of risk, such as a visit abroad, a visit from a family elder, or a special upcoming ceremony.

Education is a universal service. Children and young people spend up to six hours a day in the care of schools and early learning and childcare centres. These services build up strong relationships with children, young people and their parents by creating a positive ethos and culture based on mutual respect and trust. Children and young people may feel safe at school and that they can trust education staff. So they may be more likely to

confide in them. Education services can also monitor attendance and be sensitive to changes in physical and mental health. They may therefore notice children and young people at risk.

A child at risk of FGM; 4 key risks

- Family's country of origin has FGM practicing communities
- Mother (or other female relative, including sibling) has had FGM
- Intention re FGM by child/ family member/ possible perpetrator/ non protective views
- Upcoming trip to country of origin or out of UK

'Intention' or 'non protective views' may be indicated by;

- FGM may be more likely if a female family elder with generally traditional views is part of the community or is visiting;
- 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;
- A child may request help from a teacher or another adult.

Principles and general guidance

As with all child protection matters, staff should involve parents/carers unless the latter are the source of risk or harm.
Independent schools have child protection procedures in place. The response to suspected FGM should be the same as in a local authority school; child protection procedures should be followed. Education staff should know the risk factors and indicators of FGM, including children going on extended holidays to areas where FGM is practised and behaviour change on return.

If there are other child welfare or protection concerns, these should be part of the risk assessment process. Schools and early learning and childcare centres should include information on FGM within their annual child protection update. There is more information on the Education Scotland website at: www.education.gov.scot. Education Scotland working with partners and Education Authority staff have produced a short supported PowerPoint presentation, which authorities and head teachers can use to raise awareness of FGM in schools and early years settings.

Education staff should raise awareness of FGM and its legal implications with children and young people. For example, health and wellbeing (personal, social, health education) and RME courses could inform children and young people about FGM and the harm it causes. Education staff should also support children and young people to recognise and realise their rights within the United Nations Convention on the Rights of the Child (UNCRC).
Within Curriculum for Excellence, children and young people are entitled to personal support to enable them to: review their learning and plan for next steps gain access to learning activities which will meet their needs plan for opportunities for personal achievement prepare for changes and choices and be supported through changes and choices.
This is particularly significant for children and young people who have been affected by FGM. All children and young people should have frequent and regular opportunities to discuss their learning with an adult who knows them well and can act as a mentor, helping them to set appropriate goals for the next stages in learning. It is essential that support is provided to remove barriers that may have been caused by FGM or other issues that might

restrict their access to the curriculum because of their circumstances or short or longer term needs.

School Nurses

Please also refer to the NHS Highland Procedures for the
Protection of Girls and Women at Risk of Female Genital Mutilation (FGM).

Colleges and Universities

Where students are under 18 years of age, further educational establishments should follow their existing child protection policies when there is concern regarding a potential risk of FGM or if a student discloses that she has undergone FGM. Universities are less likely to encounter girls at risk of FGM but they may become aware that a student is concerned about a younger female relative, for example, or who discloses that she has undergone this herself when younger. They should consider how best to respond in such circumstances, seeking the guidance of appropriate agencies in drawing up their policies.

Students from countries with communities affected by FGM with children often attend Scottish universities for both undergraduate and post graduate degrees. Clear measures should be taken by University authorities to inform and support their students about this issue, preferably before they arrive in this country. They should offer clear information about the legal situation regarding FGM in Scotland, and information about who to go to for further information and support within health services, university pastoral services, social work, and voluntary organisations

Be aware that a woman or girl can be subject to FGM more than once. Staff responding to FGM should be aware that even apparently low-level concerns may point to more serious and significant harm. FGM is different from many other areas of child protection, because there are often no other child protection risk factors or indicators. It is not until FGM is discussed openly and directly that any indication of risk can be gained. Practitioners should consider all cases with an open mind and not make any assumptions about whether FGM has, has not, or is likely to occur. Staff need to be alert to the possibility of FGM; regarding both children they already know and in cases where concerns about children are not stated at the outset, including other females in the family or household.

Any information or concern that a girl is at immediate risk of, or has undergone FGM should result in a child protection referral to Children and Families Social Work or Police Scotland on the day the concern arises.
Where a concern does not require an immediate child protection response, it should be acknowledged quickly, indicating when a measured and proportionate response will be made.. Under GIRFEC arrangements, a child's planning meeting should be convened. Staff should, discuss and liaise with the child's Named Person. If a child protection response is required, the West of Scotland Inter-Agency Child Protection Procedures will be used to initiate an IRD.

Schools often have a relationship with the parents and are often best placed to discuss with parents their concerns. The Named Person may wish to ask the parents further questions: Ask straight forward questions using simple language: Give the reason as to why you are asking to meet such as

- 'I hear you are going (back) to Somalia, how long will you be visiting for?'
- Is it a holiday to visit family or friends?
- Is there a special occasion?

- I note that you come from a country where FGM/C or
  Cutting is practiced, tell me how do you feel about FGM/Cutting?
- Do the family you are going to visit believe in FGM/C or Cutting?
- Do you think you will be under pressure from family to
  have your daughter FGM/C/Cut?

Try to arrange the meeting for a time when you can speak to the woman her on her own. This is particularly important if you feel at any time that the woman is nervous or intimidated by her partner, Offer the opportunity to return to you at any time if they wish to speak further. Siblings as well as other girls in the family such as cousins, where known, should be considered as being part of this referral.

A Senior Education Manager should be informed. School, Early Years, Family and Community Centre staff and partner agencies will support the child /young person as relevant. A letter has been issued to schools from the Cabinet
Secretary for Education and Lifelong Learning and the Minister for Commonwealth Games and Sport around Female Genital Mutilation (FGM

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.
This information should be stored in the Child Protection folder

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 social work. Police Scotland can also be called on 101.The referral should not be delayed in order to consult with your child protection adviser, a manager or group leader, as multi-agency intervention needs to happen quickly.
If there is a concern about one child, siblings and household members must be referred at the same time.

Children and Families Social Work

All notifications of concern about children should be taken seriously. Children and families social work should investigate, initially, under Section 60 of the Children's Hearings (Scotland) Act 2011. Local authorities have a duty to promote, support and safeguard the wellbeing of all children in need in their area, and, insofar as is consistent with that duty, to promote the upbringing of children by their families by providing a range and level of services appropriate to children's wellbeing needs. When the local authority receives information which suggests a child may be in need of compulsory measures of supervision, social work services will make enquiries and give the Children's Reporter any information they have about the child. The Role of the Registered Social Worker in Statutory Interventions: Guidance for Local Authorities stipulates that, where children are in need of protection and/or in danger of serious exploitation or significant harm,a registered social worker will be accountable for:

- carrying out enquiries and making recommendations where necessary as to whether or not the child or young person should be the subject of compulsory protection measures;

- implementing the social work component of a risk management plan and taking appropriate action where there is concern that a the Child's Plan is not being actioned;
- making recommendations to a children's hearing or court as to whether the child should be accommodated away from home.

Children and family social workers also either directly provide, or facilitate access to, a wide range of services to support vulnerable children and families, increase parents' competence and confidence, improve children's day-today experiences and help them recover from the impact of abuse and neglect. For children in need of care and protection, social workers usually act as Lead Professional, co-ordinating services and support as agreed in the Child's Plan.

In fulfilling the local authorities' responsibilities to children in need of protection, social work services have a number of key roles. These include co-ordinating multiagency risk assessments, arranging Child Protection Case Conferences, maintaining the Child Protection Register and supervising children on behalf of the Children's Hearing.

Social work response to FGM

. Practitioners responding to FGM should be aware that even apparently low-level concerns may point to more serious and significant harm. Practitioners should consider all cases with an open mind and not make any assumptions about whether FGM has, has not, or is likely to occur. Practitioners need to be alert to the possibility of FGM; regarding both children they already know and in cases where concerns about children are not stated at the outset, including other females.

All concerns, including those that do not require an immediate child protection response should be acknowledged quickly, indicating when a measured and proportionate response will be made. Practitioners should, in all cases, discuss and liaise with the child's Named Person and other professionals involved with the family as part of the assessment process. Practitioners may find it helpful to develop a family tree, or genogram, to assess all familial links and influence.

Careful consideration should be given to the inclusion and communication with the child and their parents. The parents should be seen separately and there should be an assessment of whether their views differ. This should include consideration of the use of an interpreter, which professional should undertake this task and how best to do undertake it. Practitioners should find out if the parents and child have had information about FGM, its harmful effects and the law in Scotland. If not, practitioners should give 'A Statement Opposing Female Genital Mutilation' to the parents and, where appropriate, the child.
Additional information can be obtained from www.womenssupportproject.co.uk.
Practitioners should consult with the social work lead for FGM (Locality Manager for HSCP Children's Services Teams).
A decision will be made about whether concerns should be progressed under Child Protection procedures.
Consideration will also be given to how the child's wellbeing needs can be met, and whether or not a Child's Plan is required.
The need to gather information must always be balanced against the need to take any immediate protective action.
At this stage, information gathered may only be enough to inform an initial assessment of the risk to the child or children. On the basis of the assessment of risk, social work, health and police will need to decide whether any immediate action should be taken to protect the child and any others in the family or the wider community.

Children at Immediate Risk of Harm

If a child protection response is required, the West of Scotland Inter-Agency Child Protection Procedures will be used to initiate an IRD.
If these criteria are not met, but the referring professional still has a high level of concern about risk of FGM, then an IRD should be initiated regardless. It is critical that information-gathering involves all other key services as appropriate. Agency records should be checked and any previous agency involvement or any known relevant medical history, including that relating to parents/carers, should also be sought and considered.

The FGM risk assessment document should be used to discussions with family. The risk assessment should be clear on the antecedents to FGM,the type of FGM undertaken and the family background.

The assessment should give cognisance that a women or girl can be subjected to FGM more than once. The assessment should be used as a fluid tool and not a unique Check list. The risk assessment should then be recorded on the social work information management system (i.e.Carefirst) under the heading “FGM risk assessment summary”. Every attempt should be made to work with parents on a voluntary basis to prevent harm to any child. It is the duty of the investigating team to look at every possible way that parental co-operation can be achieved, including the use of community organisations to facilitate the work with parents/family. However, the child’s interests are always paramount.

If no agreement is reached, the first priority is the protection of the child and the least intrusive legal action should be taken to ensure the child’s safety. Where necessary, consideration should be given to referring the child to the Reporter to the Children’s Hearing. The primary focus is to prevent the child undergoing any form of FGM, rather than removal of the child from the family.
If agencies agree, as part of the IRD that a child is in immediate danger of FGM and the parents cannot satisfactorily guarantee that the child will not be subjected to FGM, then a Child Protection Order should be sought. Emergency police powers may also be used.

If a Girl has Already Undergone FGM

Be aware that a women or girl can be subjected to FGM more than once.
If a child has already undergone FGM, there must be an IRD to consider how, where and when the procedure was carried out and the implications of this. The IRD will need to decide whether to continue enquiries or assess the need for support services. This will include the risks of further FGM and the risk of FGM to other women and girls.

If legal action is being considered, practitioners must seek legal advice from local authority solicitors. A child protection case conference is not usually needed for a girl who has already undergone FGM, nor should her name be listed on the Child Protection Register unless she is still at risk of significant harm or neglect. However, in consultation with the child, parents and health colleagues, practitioners should consider referral for counselling and medical support suitable for the girl’s age.

A child protection case conference is only necessary if there are unresolved child protection issues after the initial investigation and assessment are complete.

More Information and Support

World Health Organisation (WHO) Fact Sheet on FGM

Scottish Legislation on FGM

National Training Resources website

A range of resources and recommended reading on FGM

DARF (Dignity Alert and Research Forum) - Scottish organisation providing information on

FGM and campaigning against the practice in the UK and in Africa

FORWARD - UK organisation raising awareness of FGM and campaigning against its practice. Also provides support

Daughters of Eve - provides support to those with experience of FGM

West of Scotland Inter-Agency Child Protection Procedures

National Guidance for Child Protection in Scotland (2014)
Getting it Right for Every Child A PRACTITIONER GUIDE TO INFORMATION SHARING, CONFIDENTIALITY AND CONSENT TO SUPPORT CHILDREN AND YOUNG PEOPLE'S WELLBEING

The Centre for Youth and Criminal Justice supports improvement in youth justice and aims to strengthen the creation, sharing and use of knowledge and expertise.

Framework for Risk Assessment Management and Evaluation (FRAME)

Visit the Argyll and Bute Child Protection Committee Website:

www.argyll-bute.gov.uk/abcpc