# LEICESTER CITY HEALTH AND WELLBEING BOARD
# DATE: 28th February 2019

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|---|---|
| **Subject:** | Addressing Female Genital Mutilation (FGM) in Leicester |
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## EXECUTIVE SUMMARY:

This report makes some proposals for future work to strengthen Leicester City Council and its partners' stance against FGM. Whilst the council condemns the practice in all its recognised forms, no dedicated work has been undertaken to formally publicise this stance, or indeed to invite partners to stand alongside us in this stance.
This paper provides some background information about the practice, sets out what we have addressed so far in terms of our approach to FGM and provides some options for further work, drawing on examples from nationally recognised good practice.
A group of officers from a range of partner agencies has been identified and approached with a view to forming a task and finish group, for which there has been strong support.

## RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Note the content of the report
- Support the approach to set up a multi-agency group tasked to:
    - Seek to understand the current prevalence of FGM and how it is affecting women and girls in Leicester
    - Review current procedures and ensure the support available is accessible and effective
- Support the development of a joint action plan focusing on community engagement to understand and educate about the issue within communities

# REPORT:

## 1. Background

### 1.1 What is FGM?

Female Genital Mutilation (FGM), also known as female circumcision or female genital cutting, is defined by the World Health Organisation (WHO) as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons". The WHO has classified FGM into 4 types. Further detail on definitions can be found in **Appendix A**.

### 1.2 Implications of FGM

There is evidence that there can be significant health implications arising from FGM, both immediately and long-term. Immediate complications can include severe pain, shock, haemorrhage, tetanus, gangrene or sepsis, urine retention, open sores in the genital region and injury to nearby genital tissue, wound infections, as well as blood-borne viruses such as HIV, hepatitis B and hepatitis C and in some cases death.

Long-term consequences can include recurrent bladder and urinary tract infections, abnormal periods, cysts, infertility, chronic vaginal and pelvic infections, kidney impairment and possible kidney failure and the need for later surgeries.

There can also be significant psychological and mental health implications that result from FGM including depression and anxiety, and flashbacks during pregnancy and childbirth.

As well as the physical and psychological impacts set out above, it is recognised that FGM results in an increased risk of childbirth complications and new-born deaths.

**Appendix B** contains a diagram setting out the effects of FGM throughout the life course for girls and women.

### 1.3 Cultural underpinnings / motives

Although FGM is practised by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. However, FGM predates Christianity, Islam and Judaism, and the Bible, Koran, Torah and other religious texts do not advocate or justify FGM. In most societies, FGM is considered a cultural tradition, which is often used as an argument for its continuation. Religious leaders take varying positions with regard to FGM: some promote it, some consider it irrelevant to religion, and others oppose it and contribute to its elimination. Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice.

It is useful to understand the some of the reasons parents and communities continue the practice of FGM as this may help us to plan future engagement around the issue. Parents may feel they are genuinely doing the best to protect their daughters. Some reasons given for practising FGM are that it:

- brings status and respect to the girl
- preserves a girl's virginity/chastity
- is a rite of passage
- gives a girl social acceptance, especially for marriage
- upholds the family honour
- cleanses and purifies the girl

- gives the girl and her family a sense of belonging to the community
- fulfils a religious requirement believed to exist
- perpetuates a custom/tradition
- helps girls and women to be clean and hygienic
- is cosmetically desirable
- is (mistakenly) believed to make childbirth safer for the infant

1.4 Prevalence

National

It is estimated that 137,000 women and girls are living with FGM in the UK and that 60,000 girls aged 13 and under are at risk of FGM.

A report by City University London and Equality Now (2015) found that:

- London as a whole has the highest prevalence rates, with 21 women per 1,000 affected by FGM. The 10 highest prevalence rates are located in local authorities within the capital.
- Manchester, Slough, Bristol, Leicester and Birmingham have high prevalence rates, ranging from 12 to 16 per 1,000,
- Milton Keynes, Cardiff, Coventry, Sheffield, Reading, Thurrock, Northampton and Oxford had rates of more than seven per 1,000.
- Rural areas show prevalence's of well below one per 1,000, but cases were found in all local authorities in England and Wales.

Local

Between April 2015 and March 2016 NHS Leicester City CCG Trust recorded 30 observations of FGM, 15 were pregnant women in midwifery services. This was the second highest number of recorded FGM in that year in the Midlands and East CCGs. During October 2016 to December 2016 University Hospitals of Leicester NHS trusts identified FGM in 10 pregnant women attending midwifery services.

It is likely that these figures are much lower than actual prevalence and issues around reporting and data sharing needs to be looked at as part of the future work to be planned. The FGM lead within Leicestershire Police has been contacted and is keen to work with us to help strengthen our understanding of local prevalence, as it is likely that they will have a record of FGM reports and referrals.

See **Appendix C** for further information on FGM prevalence locally, nationally and internationally.

1.5 Legal position

Current law

Under the Female Genital Mutilation Act 2003 it is an offence for any person in England, Wales or Northern Ireland (regardless of their nationality or residence status) to perform FGM (section 1); or to assist a girl to carry out FGM on herself (section 2).

It is also an offence to assist (from England, Wales or Northern Ireland) a non-UK national or resident to carry out FGM outside the UK on a UK national or permanent UK resident (section 3).

Section 4 extends sections 1 to 3 to extra-territorial acts so that it is also an offence for a UK national or permanent UK resident to: perform FGM abroad; assist a girl to perform FGM on

herself outside the UK; and assist (from outside the UK) a non-UK national or resident to carry out FGM outside the UK on a UK national or permanent UK resident.
Against that background, section 70(1) of the Serious Crime Act 2015 ("the 2015 Act") amends section 4 of the 2003 Act so that the extra-territorial jurisdiction extends to prohibited acts done outside the UK *by* a UK national or a person who is resident in the UK. Consistent with that change, section 70(1) also amends section 3 of the 2003 Act (offence of assisting a non-UK person to mutilate overseas a girl's genitalia) so it extends to acts of FGM done *to* a UK national or a person who is resident in the UK.

Other sections of the 2015 Act protect the identity of victims of FGM and make the failure to protect a girl from risk of FGM a criminal offence. There is also a legal duty for professionals (including all healthcare workers, teachers and social workers) to notify the police of FGM. See **Appendix D** for further information on the legal position.

Although the law is clear that FGM has been illegal in the UK since 1985, prosecutors have found it difficult to secure a conviction. There have been only three previous trials, all of which ended in acquittals. However, in a landmark case on 1 February 2019, a Ugandan woman from east London became the first person to be found guilty of performing (or allowing someone else to perform) FGM on her 3-year-old daughter in 2017. The National Police Chiefs' Council commented that while prosecutions alone will not stop this abuse, the guilty verdict sends a strong message and it is hoped will encourage other victims to report the crime. Sentencing will take place on 8 March 2019; carrying out FGM carries a maximum sentence of 14 years in custody.

Female Genital Mutilation Protection Orders (FGMPOs)
Section 73 of the 2015 Act provides for FGMPOs for the purposes of protecting a girl against the commission of a genital mutilation offence or protecting a girl against whom such an offence has been committed. Almost 300 FGMPOs have been granted since 2015. Breach of an FGMPO would be a criminal offence with a maximum penalty of five years' imprisonment, or as a civil breach punishable by up to two years' imprisonment. See **Appendix E** for further information about FGMPOs.

## 2. Work to date

### 2.1 Policy & Procedure

FGM is clearly referenced throughout the Leicester, Leicestershire & Rutland Safeguarding Children procedures manual, including links to national guidance and the Statement opposing FGM (often referred to as a health passport). These policies and procedures were developed by a Task and Finish Group that was led by Children's Safeguarding at the time.

Section 2.23 of the manual is entitled "Safeguarding Children at Risk of Abuse through Female Genital Mutilation" and sets out who is at risk and how professionals should respond, record and report FGM. There is a clear referral process and pathway for professionals to follow in cases where either a girl is at risk of FGM, has undergone FGM or where a girl or woman has given birth and has already undergone FGM. (The referral process is attached at **Appendix F**.)

In 2016 the Leicester Safeguarding Children Board (LSCB) published their findings from a multi-agency audit on a small number of FGM cases. This summary is attached at **Appendix G**.

## 2.2 Awareness raising campaign

Some awareness raising work was undertaken by the LSCB in 2017 prior to the school summer holidays, including the commissioning of a video narrated by a local GP, Dr Sethi, and the publishing of a leaflet. Copies of both can be found at http://www.lcitylscb.org/information-for-practitioners/safeguarding-topics/female-genital-mutilation/school-awareness-raising-for-summer-holidays/.

## 2.3 Strategic response

FGM has been referenced by Leicester City Council through its strategic partnerships over past years. Most recently Leicester's Children's Trust Board (LCTB) members identified it as an issue around which they wanted to hold a focus session, in terms of identification and safeguarding of children at risk through to the risk to babies born to mothers who have undergone FGM, and the physical and psychological impact that may have on the parent/child.

On 2 March 2017, a focus meeting of the LCTB was held. Experts from Public Health, local health providers and voluntary support organisations were invited to give presentations (Leicestershire Partnership Trust, Somali Development Service and Zinthiya Trust). These presentations were followed by small group work discussing the following questions:

- Do processes need to change in order to better support children who are at risk of, or have experienced FGM?
- How can we effectively increase awareness of FGM?
- What information do we collect and how is it used?
- What don't we know?

The key themes that emerged from the group discussions were:

- More community engagement is needed to increase awareness
- Communities need help to understand that FGM is not required by their religion (with the aid of religious leaders and other respected community figures)
- The importance of the use of positive language and a sensitive approach
- The need to share and effectively allocate resources
- The need to share and tap into information and good practice from other areas e.g. Bristol has developed a training pack for teachers and has champions from each agency or youth ambassadors to engage with schools and young people in order to increase awareness
- The need to support schools in increasing their involvement in raising awareness without segregating or causing conflict between pupils
- The need for local information about prevalence and trends to inform communication and sharing information to protect girls and women

This session was felt by members to be very useful; however, it was very clearly the beginning of a conversation about a complex issue about which many attendees were learning for the first time. The links made by members with community groups that support on issues around FGM were invaluable, but further developmental work would be needed to

strengthen awareness, knowledge and support for the council's condemnation of the practice.

## 3. Planning and identifying future work

Many of the points raised at the LCTB focus session will be addressed if it is decided to take up some of the opportunities set out below, providing an up-to-date and more detailed, integrated partnership response to the issue of FGM in Leicester.

### 3.1 Tackling FGM through Community Behaviour Change

The REPLACE Approach is a new way to tackle FGM and replaces the dominant methods used to end FGM in which the focus was previously on raising awareness of the health and human rights issues associated with the practice and then expecting individuals to change their behaviour concerning FGM.
Behaviour change theories combined with community engagement are central to the REPLACE Approach. The REPLACE Approach empowers FGM-affected communities through community leaders, influential people within the community and community peer group champions to challenge the social norm supporting FGM. The approach is based on encouraging behavioural change through engaging and working with communities and is supported by good evaluation throughout the process.

### 3.2 Task and Finish Group

A Task and Finish Group has been established and will hold an initial meeting in March 2019. The purpose is to gather knowledge and intelligence on the extent of FGM in Leicester, how it is being addressed by various partners and the barriers to dealing with FGM. Membership will include:

- Public Health
- Social Care & Education (Safeguarding (Children & Adults) & Education reps)
- Leicestershire Police
- Clinical Commissioning Group
- Leicestershire Partnership Trust (Health Visiting rep)
- University Hospitals Leicester (Midwifery rep)
- Specialist violence against women rep (Voluntary & Community Sector)
- University of Leicester
- Community representatives
- Community Safety (Domestic Violence/Sexual Violence Manager)

Further members will be identified as the work progresses.

The Task and Finish Group's purpose is to use the knowledge and intelligence gathered to form an action plan that addresses key priorities. These might include:

- Prevention through awareness raising and education
- Community-led initiatives to ensure appropriate messages, campaigns, etc.
- Training and empowerment through the implementation of training & education programmes across the City tailored to professionals and communities.
- Continued support to law enforcement officers safeguarding, reporting and recording

- Ensure that professionals access the LSCB multi-agency safeguarding training to include the issue of identifying girls at risk of FGM and referring them as part of child safeguarding.
- Take a life course approach to treatment, services and support
- Support University Hospitals Leicester NHS Trust in their work to offer women access to a specialist FGM midwife and increase access to psychological support
- Data collection and sharing - Agencies including health, social care, safeguarding, police and midwifery should collect and share data where appropriate

3.3 Community Engagement

Effective engagement with communities to develop local FGM priorities and initiatives is vital to ensure they are effective and appropriate to their audience.

Community engagement events to discuss FGM should be held in partnership with the voluntary & community sector. Events for women and children should be held separately, with a particular focus on engagement with men and older females.

Key stakeholders should all commit to fully engage and consult with communities on all FGM interventions.

## 4. Next steps

The Task and Finish Group will be convened in March 2019 and begin to plan actions that can be taken immediately (those surrounding data gathering and reviewing current processes and support available) and proposed future actions.

An action plan will be developed and will be brought back to the Health and Wellbeing Board for comment and sign off at a future date.
Some opportunities and ideas that will be considered include:

- A council motion and/or partnership pledge
- Preventative work through awareness raising, community engagement and training
- Support to law enforcement activity
- Review and update safeguarding processes
- Consideration of specialist services and clinics

## Appendix A – Further background detail

Definitions

The World Health Organisation (WHO) has classified Female Genital Mutilation into four types:

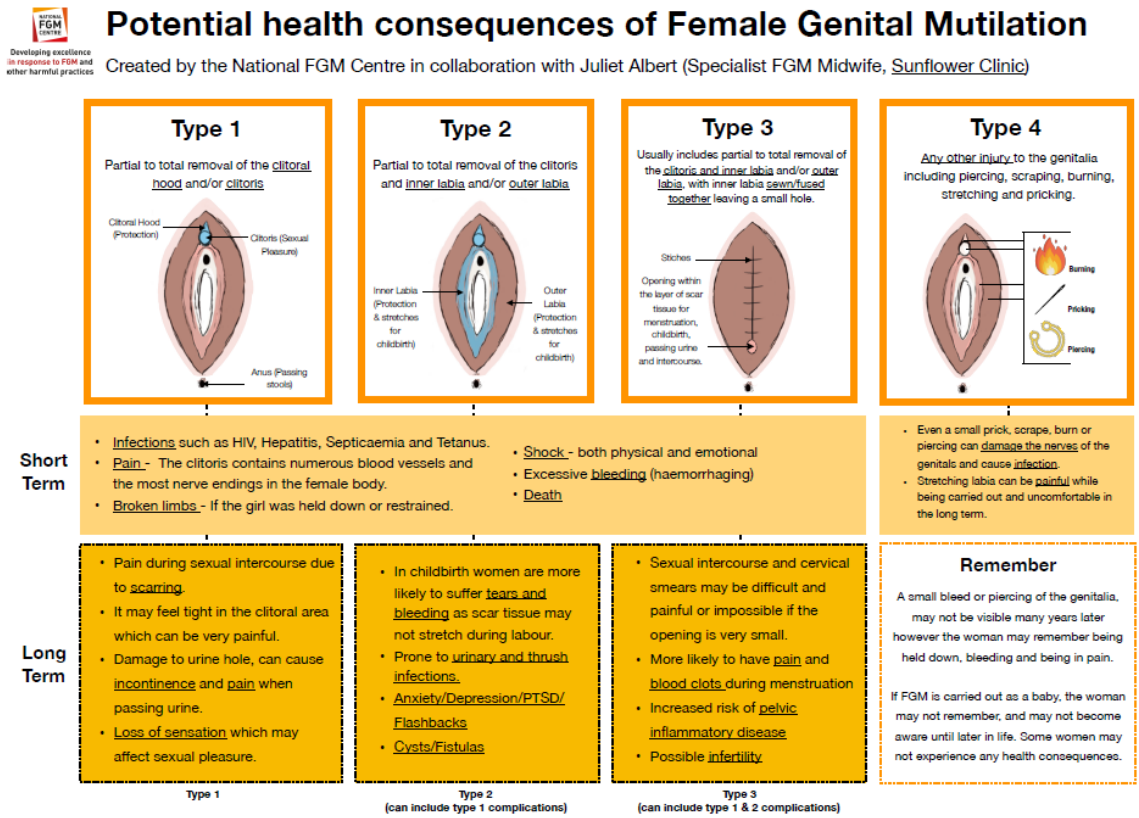
Type 1 - excision of the prepuce, with or without excision of part or all of the clitoris

Type 2 - excision (Clitoridectomy) 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 region;

Type 3 - Infibulation - This is the most severe 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 can be preserved during healing by insertion of a foreign body;

Type 4 - Unclassified - pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of 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 purpose of tightening or narrowing it; and any other procedure that falls under the definition given above.

The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. Procedures are mostly carried out on young girls sometime between infancy and aged 15, and occasionally on adult women.



**Appendix B – Life Course impacts of FGM**

**Appendix C – FGM Prevalence**

Global Prevalence

- It is estimated that 125 million women and girls worldwide have undergone FGM.
- It is estimated that 3 million girls are subjected to FGM every year.

Groupings of the 29 countries where FGM is concentrated, by FGM Prevalence amongst girls and women aged 15-49.

Groupings by FGM prevalence levels (15-49 year old females)

| Countries | | |
|---|---|---|
| Very high prevalence countries | Prevalence rates >80% | Somalia, Guinea, Djibouti, Egypt, Eritrea, Mali, Sierra Leone, Sudan |
| Moderately high prevalence countries | Prevalence rates 51-80% | Gambia, Burkina Faso, Ethiopia, Mauritania, Liberia |
| Moderately low prevalence countries | Prevalence rates 26-50% | Guinea-Bissau, Chad, Ivory Coast, Kenya, Nigeria, Senegal |
| Low prevalence countries | Prevalence rates 10-25% | Central African Republic, Yemen, Tanzania, Benin |
| Very low prevalence countries | Prevalence rates <10% | Iraq, Ghana, Togo, Niger, Cameroon, Uganda |

National Prevalence

It is estimated that 137,000 women and girls are living with FGM in the UK and that 60,000 girls aged 13 and under are at risk of FGM.2

A report by City University London and Equality Now (July 2015)[1] looked at prevalence of FGM in England and Wales and developed estimates of the numbers of women with FGM living in England and Wales, the numbers of women with FGM giving birth and the numbers of girls born to women with FGM. To derive these estimates the report used the results of household interview surveys in the countries in which FGM is practised, demographic data about women born in these countries and girls born to them was derived from the 2011 census and from birth registration.

The survey found that;

[1] City University London and Equality Now. Prevalence of Female Genital Mutilation in England and Wales: National and local estimates, July 2015

- London as a whole has the highest prevalence rates, with 21 women per 1,000 affected by FGM. The 10 highest prevalence rates are located in local authorities within the capital.
- Manchester, Slough, Bristol, Leicester and Birmingham have high prevalence rates, ranging from 12 to 16 per 1,000,
- Milton Keynes, Cardiff, Coventry, Sheffield, Reading, Thurrock, Northampton and Oxford had rates of more than seven per 1,000.
- Rural areas show prevalence's of well below one per 1,000, but cases were found in all local authorities in England and Wales.

Prevalence of FGM in Leicester

Since 2014 Acute NHS Trusts (Foundation and non-Foundation) must provide returns to the Department of Health on a monthly basis of the prevalence of FGM within their treated population.

Between April 2015 and March 2016 NHS Leicester City CCG Trust recorded 30 observations of FGM, 15 were pregnant women in midwifery services. This was the 2nd highest number of recorded FGM in that year in the midlands and east CCGs.

During October 2016 – December 2016 University Hospitals of Leicester NHS trusts identified FGM in 10 pregnant women attending midwifery services.

Evidence suggests that for these women there may be an increased risk of childbirth complications and new-born deaths. For those mothers who have undergone FGM there is also the potential risk that their female children will also undergo the procedure.

It would be beneficial to identify the FGM lead within Leicester City Police as it is likely that they will have a record of FGM reports and referrals.

## Estimating at risk females of Female Genital Mutilation

To estimate the population affected or at risk of female genital mutilation analysis has been carried out to identify the number of females in Leicester from countries where FGM prevalence is high. The 2011 Census and the 2018 Leicester School Census have been used to calculate estimates, both sources currently collect country of birth information.

To note: the pattern of migration increases the complexity of producing an estimate for females at risk of FGM. We are aware that some people from countries where FGM prevalence is high have migrated (possibly more than once) and had children in countries not traditionally associated with high rates of FGM. Females born in these countries therefore will not be included in the estimate but because of their ethnicity they would still be considered at risk of FGM. For example, some east African communities have settled in European countries before moving again to the United Kingdom.

In addition to this other ethnic groups may have been born in countries where FGM prevalence is high however do not share the practice of FGM. For example, Leicester has a sizable East African Asian population.

**Table 1. Census 2011 -** Numbers of females born in at risk countries by age.
*Source: ONS, Census 2011*

| Country of Birth | Age 0 to 15 | | Age 16 to 49 | |
|---|---|---|---|---|
| | Number | % | Number | % |
| **Women in Leicester** | 33828 | | 87520 | |
| **Africa: North Africa** | 73 | 0.2% | 298 | 0.3% |
| **Africa: Central and Western Africa** | 115 | 0.3% | 982 | 1.1% |
| **Africa: South and Eastern Africa** | 708 | 2.1% | 7252 | 8.3% |
| **Africa: Africa not otherwise specified** | 5 | 0.0% | 326 | 0.4% |
| **Middle East and Asia: Middle East** | 338 | 1.0% | 1034 | 1.2% |
| **Total born in region where FGM is prevalent** | 1239 | 3.7% | 9892 | 11.3% |

1,239 or 3.7% of Leicester females aged 0 to 15 were born in regions where FGM prevalence is high. These females are at risk of becoming a potential victim of FGM.

9892 or 11.3% of Leicester females aged 16 to 49 were born in regions where FGM prevalence is high. These females have potentially already been a victim of FGM.

**Table 2. School Census 2018** - Numbers of school aged (4-16) females currently attending Leicester schools who were born in countries where FGM prevalence is high. *Source: Leicester School Census 2018*

| Country of birth | Females aged 4-16 |
|---|---|
| Cameroon | 5 |
| Egypt | 12 |
| Eritrea | 11 |
| Ethiopia | 6 |
| Gambia, The | 4 |
| Ghana | 17 |
| Guinea | 4 |
| Iraq | 101 |
| Kenya | 22 |
| Mauritania | 0 |
| Nigeria | 49 |
| Senegal | 0 |
| Sierra Leone | 3 |
| Somalia | 56 |
| South Sudan | 1 |
| Sudan | 13 |
| Tanzania | 7 |
| Togo | 1 |
| Uganda | 5 |
| Yemen | 2 |

| | |
|---|---|
| **Total females born in country where FGM is prevalent** | **319** |
| Total females in Leicester schools | 27425 |

319 or 1.2% of Leicester females aged 4 to 16 were born in regions where FGM prevalence is high. These females are at risk of becoming a potential victim of FGM.

**Table 2.1 School Census 2018** - Numbers of school aged (4-16) females currently attending Leicester schools by ethnicity *Source: Leicester School Census 2018*

| Ethnic Group | Total | Percentage | |
|---|---|---|---|
| **African Asian** | 188 | 0.7% | |
| **Bangladeshi** | 618 | 2.3% | |
| **Indian** | 8300 | 30.3% | |
| **Other Asian** | 1526 | 5.6% | |
| **Any Oth Asian b'ground** | 23 | 0.1% | |
| **Pakistani** | 1077 | 3.9% | |
| **Sri Lankan Other** | 1 | 0.0% | |
| **Black African** | 19 | 0.1% | |
| **Other Black African** | 1062 | 3.9% | |
| **Black Caribbean** | 232 | 0.8% | |
| **Other Black** | 2 | 0.0% | |
| **Any Oth Black b'ground** | 409 | 1.5% | |
| **Black Somali** | 1015 | 3.7% | |
| **Chinese** | 75 | 0.3% | |
| **Asian and Black** | 1 | 0.0% | |
| **Asian & Any Oth Eth G'p** | 3 | 0.0% | |
| **Any Oth Mixed b'ground** | 560 | 2.0% | |
| **Other mixed background** | 2 | 0.0% | |
| **White and Asian** | 516 | 1.9% | |
| **White and Black African** | 244 | 0.9% | |
| **White & Black Caribbean** | 606 | 2.2% | |
| **Info not yet obtained** | 168 | 0.6% | |
| **Arab Other** | 3 | 0.0% | |
| **Iranian** | 1 | 0.0% | |
| **Kurdish** | 3 | 0.0% | |
| **Any other Ethnic Group** | 614 | 2.2% | |
| **Refused** | 113 | 0.4% | |
| **White British** | 7220 | 26.3% | |
| **White Eastern Euro'n** | 10 | 0.0% | |
| **White English** | 5 | 0.0% | |
| **White European** | 1648 | 6.0% | |
| **White Irish** | 25 | 0.1% | |
| **Traveller - Irish Heritage** | 40 | 0.1% | |
| **Any Oth White b'ground** | 2 | 0.0% | |
| **White Other** | 328 | 1.2% | |
| **Other white British** | 1 | 0.0% | |

| | | | |
|---|---|---|---|
| **Gypsy** | 3 | 0.0% | |
| **Gypsy/Roma** | 86 | 0.3% | |
| **Other Gypsy/Roma** | 7 | 0.0% | |
| **Roma** | 47 | 0.2% | |
| **White Western Euro'n** | 3 | 0.0% | |
| **No information recorded** | 621 | 2.3% | |
| | 27427 | | |

When considering ethnicity we have an at-risk population of 2,099 or 7.7% of the female Leicester school population

**Appendix D – Legal position**

Current law

Under the 2003 Act it is an offence for any person in England, Wales or Northern Ireland (regardless of their nationality or residence status) to perform FGM (section 1); or to assist a girl to carry out FGM on herself (section 2). It is also an offence to assist (from England, Wales or Northern Ireland) a non-UK national or resident to carry out FGM outside the UK on a UK national or permanent UK resident (section 3).

Section 4 extends sections 1 to 3 to extra-territorial acts so that it is also an offence for a UK national or permanent UK resident to: perform FGM abroad; assist a girl to perform FGM on herself outside the UK; and assist (from outside the UK) a non-UK national or resident to carry out FGM outside the UK on a UK national or permanent UK resident.

Extension of extra-territorial jurisdiction

Against that background, section 70(1) of the Serious Crime Act 2015 ("the 2015 Act") amends section 4 of the 2003 Act so that the extra-territorial jurisdiction extends to prohibited acts done outside the UK *by* a UK national or a person who is resident in the UK. Consistent with that change, section 70(1) also amends section 3 of the 2003 Act (offence of assisting a non-UK person to mutilate overseas a girl's genitalia) so it extends to acts of FGM done *to* a UK national or a person who is resident in the UK.

Anonymity of victims of FGM

Section 71 of the 2015 Act amends the 2003 Act to prohibit the publication of any information that would be likely to lead to the identification of a person against whom an FGM offence is alleged to have been committed. This is similar, although not identical, to the anonymity given to alleged victims of sexual offences by the Sexual Offences (Amendment) Act 1992. Anonymity will commence once an allegation has been made and will last for the duration of the victim's lifetime.

Offence of failing to protect a girl from risk of FGM

Section 72 of the 2015 Act inserts new section 3A into the 2003 Act; this creates a new offence of failing to protect a girl from FGM. This will mean that if an offence of FGM is committed against a girl under the age of 16, each person who is responsible for the girl at the time of FGM occurred will be liable under this new offence. The maximum penalty for the new offence is seven years' imprisonment or a fine or both.

Duty to notify police of female genital mutilation

Section 74 inserts new section 5B into the 2003 Act which creates a new mandatory reporting duty requiring specified regulated professionals in England and Wales to make a report to the police. The duty applies where, in the course of their professional duties, a professional discovers that FGM appears to have been carried out on a girl aged under 18 (at the time of the discovery). The duty applies where the professional either is informed by the girl that an act of FGM has been carried out on her, or observes physical signs which appear to show an act of FGM has carried out and has no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth. The duty applies to professionals working within healthcare or social care, and teachers. It therefore covers:

- Professionals regulated by a body overseen by the Professional Standards Authority

(with the exception of the Pharmaceutical Society of Northern Ireland). This includes doctors, nurses, midwives, and, in England, social workers,

- Teachers
- Social care workers in Wales.

The duty does not apply where a professional has reason to believe that another individual working in the same profession has previously made a report to the police in connection with the same act of FGM. For these purposes, professionals regulated by a body which belongs to the Professional Standards Authority are considered as belonging to the same profession.

## Appendix E – Female Genital Mutilation Protection Orders

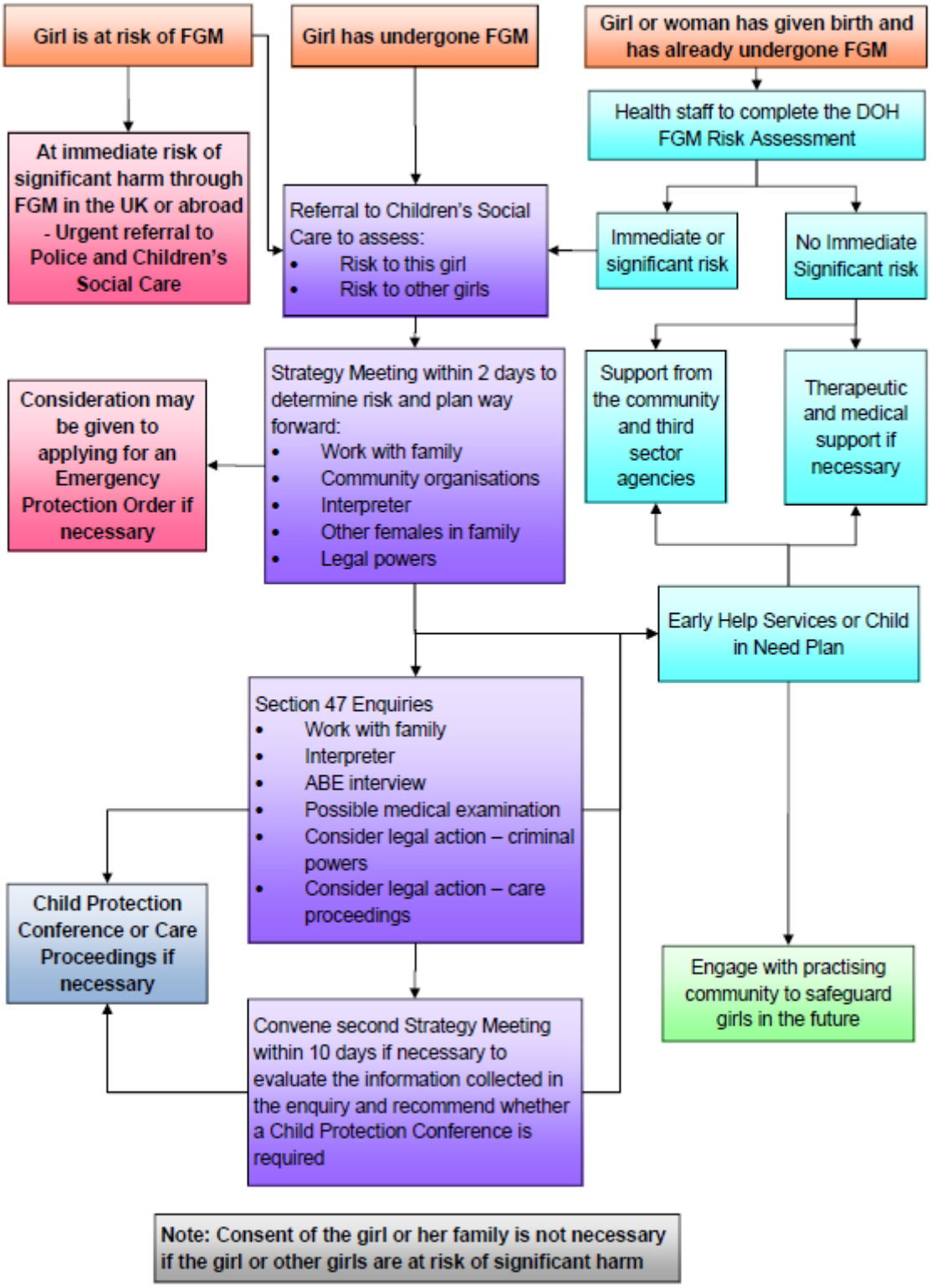
Section 73 of the 2015 Act provides for FGMPOs for the purposes of protecting a girl against the commission of a genital mutilation offence or protecting a girl against whom such an offence has been committed. Breach of an FGMPO would be a criminal offence with a maximum penalty of five years' imprisonment, or as a civil breach punishable by up to two years' imprisonment. The court may make a FGMPO on application by the girl who is to be protected or a third party. The court must consider all the circumstances including the need to secure the health, safety, and well-being of the girl.

https://www.gov.uk/government/consultations/female-genital-mutilation-proposal-to-introduce-acivil-protection-order

Under the new provisions an FGMPO might contain such prohibitions, restrictions or other requirements for the purposes of protecting a victim or potential victim of FGM. This could include, for example, provisions to surrender a person's passport or any other travel document; and not to enter into any arrangements, in the UK or abroad, for FGM to be performed on the person to be protected.

## Appendix F – Safeguarding Referral Processes

### Referral Process for Female Genital Mutilation (FGM) Flowchart



## Appendix G – LSCB Multi-agency audit summary

Leicester Safeguarding Children Board

**Leicester LSCB Multi-agency Audit: Female Genital (FGM) 2016 Summary**

This summary (briefing) is aimed at managers and practitioner working with children and families in Leicester. Key findings/conclusions from the audit and information about FGM is presented. Please share this summary (briefing) with colleagues.

**Background**

- Working Together to Safeguard Children (2015) requires Local safeguarding Children Boards to evaluate multi-agency working through joint audits of case files.
- Female Genital Mutilation (FGM) is a priority for the LSCB.
- Locally, there is a need to understand the scale and needs of children and young people vulnerable to FGM to safeguard them from the risk to FGM.
- A multi-agency LSCB audit on FGM was conducted in July 2016, to check compliance and seek assurance to the application of the LLR LSCB multi-agency safeguarding procedures; partner agency identification and response to cases where FGM is a theme; identify learning to improve practice in safeguarding children and young people vulnerable to FGM.
- The audit report will be presented to the LSCB Performance, Analysis and Assurance Group (PAAG).

**Methodology**

The audit process, sample and selection of cases, scope and audit tool was discussed and agreed by the LSCB Lead Audit Commissioners group representatives from the following agencies:

- Clinical Commissioning Group
- Leicestershire Police
- Children Social Care, Safeguarding Unit, Leicester City Council
- Leicestershire Partnership Trust (LPT)
- LSCB office

The audit included accuracy of case details, referrals and response and identification of FGM and underpinning this was the 'voice of the child' and compliance to procedures.

Seven cases were selected from a list supplied by Leicestershire Partnership Trust (LPT) to the LSCB office. Two of the cases were siblings. Not all 7 cases were known to the agencies (other than LPT), and although the sample was small the audit identified good practice and areas for improvement and learning.

The audit was completed by: Safeguarding Unit (Children Social Care); School (Learning Services); Leicestershire Partnership Trust (LPT), Clinical Commissioning Group (CCG), University Hospitals of Leicester (UHL), Leicestershire Police.

**Definition of FGM**

The World Health Organisation (WHO) defines female genital mutilation (FGM) as: *"all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons"* (WHO, 2014). FGM is physical abuse, and it is also a form of sexual violence.

Internationally FGM is recognised as a violation of the human right s of girls and women.

**Legislation**

The FGM Act introduced in 2003 came into force in 2004:

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

The FGM Act 2003 was amended by the Serious Crime Act 2015 and now includes:

- An offence for failing to protect a girl from the risk of FGM
- Extra-territorial jurisdiction over offences of FGM committed abroad by UK nationals and those habitually (as well as permanently) resident in the UK
- Lifelong anonymity for victims of FGM
- FGM Protection Order which can be used to protect girls at risk
- A mandatory reporting duty which requires specified professionals to report known cases of FGM in under 18s to the police.

**Conclusion**

Although a small number of FGM cases were audited, the audit evidenced variability in relation to the quality of practice.

- Case recording of demographic information remains an issue particularly in relation to recording accurate details and of language, ethnicity and religion.
- The voice of the child/lived experience was lacking within practice. It was unclear whether siblings, cousins and other female members of the family and extended family were spoken to, as there might have been female children within the family and/or community who might have been vulnerable to FGM.
- There was no evidence of contingency planning for children vulnerable to FGM in the future, and a need was identified for direction/guidance from the LSCB and partner agencies on the way forward in relation to this issue.

The audit found that the compliance to LLR LSCB procedures was variable:

- Where strategy discussions took place these were timely and the appropriate practitioners were invited, however, there is need for GPs to be informed and invited to strategy discussions.
- Where FGM was identified/known at GP practices, FGM was recorded on the mother's and child's case notes and alerts noted on the child's case notes.
- Interpreters were not used for all the cases where this was required. However, cultural perspectives were considered by social care in the cases audited by Children's Social Care.
- Within UHL and LPT there was compliance to the practice of routinely questioning women in relation to FGM, but there was a need identified to embed use of the FGM tool in clinical practice in UHL and training of practitioners in LPT to use the FGM tool.
- Children's Social Care did not always provide feedback on the outcome of their decision to the referrals made by partner agencies, and partner agencies did not follow up for feedback when non was received, which showed a lack of compliance to the LLR LSCB multiagency safeguarding procedures.

**Recommendations**

- Awareness of the LLR LSCB procedures including FGM (and the FGM assessment tool) should be raised by agencies. This should include awareness of the 'Whole family' approach to identify and speak to family and extended family members when undertaking assessments as there might be other female children within the family, extended family and community who might be vulnerable to FGM.
- Partner agencies have in place processes and management oversight to ensure that practitioners within their agencies are compliant with the LLR LSCB multi-agency safeguarding procedures.
- LSCB partner agencies should consider the issue of contingency planning (and guidance) for children where families where FGM has been identified to reduce the risk posed to these children and young people in the future.
- Future FGM audits should be conducted jointly with the LSAB.

**Further Information**

- LSCB Websites: http://www.lcitylscb.org/ and http://lrsb.org.uk/
- LLR LSCB Multi-agency Safeguarding Procedures: http://llrscb.proceduresonline.com/chapters/contents.html
- LLR LSCB Resolving Practitioner Disagreements and Escalation of Concerns: http://llrscb.proceduresonline.com/chapters/p_res_profdisag.html