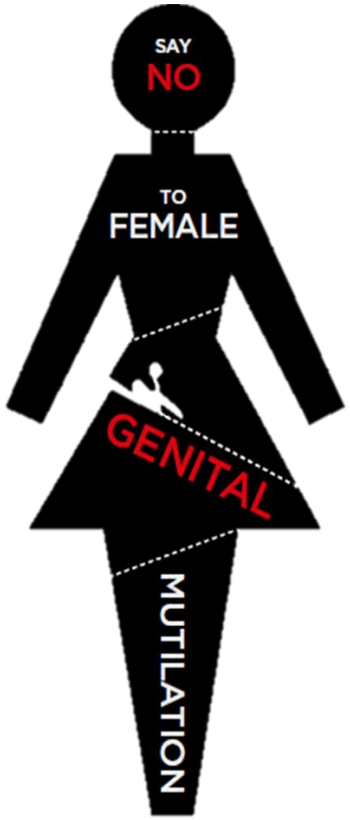


A working guide for Educational professionals to prevent and respond to Female Genital Mutilation

Contents

Safeguarding Procedures for education settings

1. Context

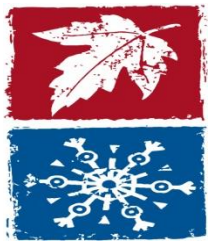
It has been illegal to practice Female Genital Mutilation (FGM) in the UK since 1985. Under the Female Genital Mutilation Act 2003 it also became a criminal offence for a habitually resident child in the UK to be taken abroad to undergo the procedure of FGM. It wasn't until 2015 that there was a stronger response to FGM from the government which placed a mandatory reporting duty on professionals of known cases of FGM as amended by the Serious Crimes Act 2015.

Concurrent to this there was a campaign in 2015 by a Bristol young person Fahma Mohamed to request that the then acting Education Secretary Michael Gove to write to all schools in England about FGM. This has prompted a more dedicated and robust approach to tackling FGM not just locally but also on a national level.

This document is intended to bring together information from briefings, newsletters and updates from

the Bristol City Council Safeguarding in Education Team centrally. It has been written in accordance to the Local Safeguarding Childrens Board policies and procedures, national guidance and legislation. The guidance would be suitable for all educational professionals who work with children – this includes early year's settings, maintained settings, academies, independent schools, alternative learning providers and post 16 providers.

In Bristol, the FGM working group of the BSCB (Bristol Safeguarding Childrens Board) have written annually to head teachers reminding them of the heightened risk of FGM to girls during the summer holiday period. This has traditionally been referred to the 'Summer Campaign Letter' as it was thought that schools need to be vigilant of families who request extended leave might travel back to their country of origin to practice FGM on their girl(s) – the six week summer holiday allowing for appropriate healing time from this practice.



Historically campaigns have focused on the summer holiday period as a heightened risk for girls to be cut. This tends to respond to identify Type 3 cases (infibulation), often ignoring emerging trends in practice from risk affected communities. This potentially could result in current safeguarding arrangements leaving girls at risk of the other forms of FGM. For schools, the Safeguarding in Education Team have developed an FGM safeguarding checklist to ensure that professionals are vigilant all year round. (Appendix 5)

Points to consider:

- Research published in July 2015 identifies that Bristol is one of the cities with the highest prevalence of women affected by FGM outside of London.[1] This highlights the importance of all schools in the city to maintain the attitude, 'it could happen here'. By taking action, Bristol schools contribute towards the clear city message 'Zero Tolerance Bristol', an initiative to make Bristol a city free from gender based violence.

- Recent data of newly recorded cases in the NHS (2016), where the FGM Type is known, **Types 1 and 2 have the highest incidence** (35 and 31 per cent respectively). [2] The data set also indicates that 18 women/girls presenting in a Health Setting for the first time with an FGM related complaint reported that the procedure **had been carried out in the UK**.

- Anecdotally, time for healing from Type 1 can be as fast as a week; the healing period for Type 3 is believed to be around 6 weeks.

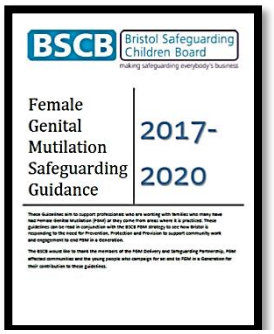
- Creighton SM, Dear J, de Campos C, et al. (2016) have identified Type 4 as the most common confirmed type in their study[3]. Healing time again can be as fast as a week depending on the procedure.

- Of 200 Million girls and women worldwide who have been subjected to the practice more than half live in just three countries: Indonesia, Egypt and Ethiopia (Unicef, 2016).[4]

References:

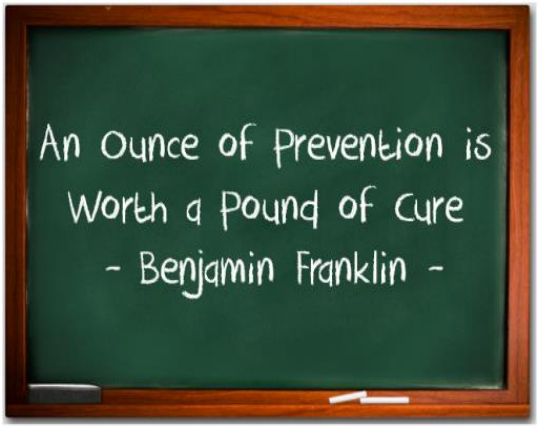
1. http://www.trustforlondon.org.uk/wp-content/uploads/2015/07/FGM-statistics-final-report-21-07-15-released-text.pdf
2. NHS (2016).Female Genital Mutilation (FGM) - April 2015 to March 2016, Experimental Statistics
3. Creighton SM, Dear J, de Campos C, et al.(2016). Multidisciplinary approach to the management of children with female genital mutilation (FGM) or suspected FGM: service description and case series. BMJ Open 2016;6: e010311.
4. https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf

2. Local Safeguarding Children Board Policies and Procedures



There has been an updated multi-agency guidance and strategy from the BSCB which is available from the website for 2017-2020. It is important to recognise that policies and procedures need to reflect the ever changing trends in practices as well as learning from practice and case reviews.

3. Prevention



The majority of the work in safeguarding girls is done at the preventative level. For example following a referral to social care assessments and interventions such as obtaining an FGM protection order are all safeguards to **prevent** FGM being performed on a girl.

Although it might appear that reporting concerns to First Response might be a disproportionate response, it is really important to recognise that the procedure of FGM involves physical and emotional harm to a girl. This should be considered a child protection concern and identified as significantly harmful.

If you have a concern that a girl might be travelling for the purposes of FGM, or that they have had a spell of sickness and absence where you have concern that the girl has been subjected to the practice, please see suspected cases for more information. **You must take further action – see suspected cases for more information**.

3.1 School Policies

Your setting needs to develop a robust and consistent **culture of safeguarding** that is understood and reflected in all areas of practice. In the context of FGM, this means having an explicit and clear statement that you oppose the practice and that you will take proactive steps to address this and safeguard children from significant harm.

In your Safeguarding and Child protection Policy you could include a statement similar to the next section:

FGM comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It is illegal in the UK and a form of child abuse with long-lasting harmful consequences.

Professionals in all agencies, individuals and groups from the wider communities, need to be alert to the possibility of a girl being at risk of FGM, or already having suffered FGM. There are a range of potential risk indicators which may indicate that a girl is a potential risk of FGM or have suffered FGM.

Safeguarding in Education Team.

There are further details in the Multi-agency statutory guidance on female genital mutilation issued by the home office.

It is important to recognise that FGM is a form of child abuse and can cause long term harm to a child. The school needs to follow the Local Safeguarding Children Board's policies and practice in assessing all potential cases. This assessment will require a robust multi-agency approach, details of this can be found on the Bristol Safeguarding Children Board website.

Procedures School should have in place:
(Insert name of establishment) has taken a proactive approach to protect and prevent girls in being forced to undertake FGM. The senior leadership team and governing body manage this in 5 ways:

1. There is a robust attendance policy that does not authorise holidays, extended or otherwise. The Designated Safeguarding Lead should be made aware of any requests.
2. FGM training for the safeguarding team and disseminated training for all members of staff.
3. FGM discussions by the Designated Safeguarding Lead with parents of children from practising communities who are at risk.
4. Comprehensive PSHE and Relationship and Sex Education throughout the school with specific work on safeguarding and a discussion about FGM.
5. Strong multi-agency working for suspected cases of FGM.

Mandatory Reporting Duty:
Section 5B of the Female Genital Mutilation Act 2003 (as inserted by section 74 of the Serious Crime Act 2015) places a statutory duty upon teachers along with regulated health and social care professionals in England and Wales, to report to the police where they discover (either through disclosure by the victim or visual evidence) that FGM appears to have been carried out on a girl under 18. Those failing to report such cases will face disciplinary sanctions.

Attendance/Extended holiday requests:
The school is proactive in encouraging all parents to put in writing any requests for extended leave in good time.

If there is a suspicion that a girl may be travelling for the purposes of FGM, or that they have had a spell of sickness and absence where there are signs that the girl has been subjected to the practice, the school will follow their safeguarding processes.

Practice tips

- Include information about request for extended leave as part of the home school agreement
- Promote this in newsletters at the beginning of the academic year.
- Use social media such as Twitter to reminder leading up to holidays.
- Having a signs and leaflets displayed in the school reception area.
- It is important that the Designated Safeguarding Lead over sees the requests for them to consider any safeguarding concerns including FGM.

3.2 Training on FGM awareness

Training for Designated Safeguarding Leads and deputy safeguarding leads should attend the multiagency FGM awareness and/or the FGM Developing Knowledge training via the BSCB and updates via the Safeguarding in Education Team's DSL networks. Please be aware that the Safeguarding in Education Team also deliver single agency 'FGM train the trainer' to support Designated Safeguarding Leads to deliver this robustly in their own settings.

It is important that your attendance lead is aware of the concerns of FGM. Different types of FGM require different healing times. Continuous absence due to illness or sickness may indicate that Type 1 or Type 4 (anecdotally a week's healing time) has been performed, or that the child might have reoccurring infections due to poor healing. It is important that the Designated Safeguarding Lead is notified of this.

All staff should have a basic awareness of what FGM is, the risks and the signs too look out for and know what to do if they have a worry or have identified a known case of FGM.

This could be done via:

- Online free Home office training.
- Development of a FGM awareness lead to train staff via getting them to attend the FGM awareness – train the trainer course from the Safeguarding in Education Team
- Commission Forward UK/ Integrate UK to deliver training to staff, parent groups and pupils.

3.3 Safeguarding on the Curriculum

Personal Social Health Economic (PSHE) Education and Sex and Relationship Education (SRE):

This is an important way for children and young people to safeguard them against FGM. Schools who have a robust PSHE and SRE curriculum have reported children have come forward and identified themselves as survivors of FGM.

Keeping Children Safe in Education 2016 places a duty on the governing body of a school setting to ensure that safeguarding is on the curriculum.

The Children and Social Care Act 2017 has set out expectations for the above to become compulsory however to date there has yet to be any guidance issued from the Department for Education around how this should be implemented.

Despite this Bristol Mayor, Marvin Rees, and Avon and Somerset Police Crime Commissioner, Sue Mountstevens have written to all school head teachers to raise the importance of PSHE in schools curriculum offer. Jointly both would like to achieve a 'Bristol Guarantee on PSHE education' for all schools and education settings.

Practice tips

- Ensure that you have an active PSHE lead within your setting and that they are engaged and regularly attending the PSHE networks.
- Consider engaging with the Mayors Award in partnership with the Bristol Healthy Schools programme.
- Ensure that you review a programme of PSHE and SRE regularly on a strategic level with the Designated Safeguarding Lead and an allocated Safeguarding member of the governing body.
- Ensure that you hold consultations with the community about PSHE/ SRE (see working in partnership with your communities)
- Ensure that there is an 'opt out' consideration for parents. Parents who do opt out should be invited for a meeting with the designated safeguarding lead to discuss the parent's worries (see taking action).

3.4 Work in partnership with your communities

When discussing issues around FGM, extended holiday requests, faith on the curriculum, PSHE and SRE, it is important to involve and engage **with** the community with consultations to develop positive practices.

This is really replicating the Bristol Model of combatting FGM. It is a multi-professional/ multi-agency model which underpins the working together. More importantly it encourages the children and young people, survivors of FGM as well as their communities in which they belong **as partners** in developing practices and policies. The following principles underpin this:

- **Respect:** Although as professionals we have to have a clear stance of recognising the process as unlawful and as a child protection issue, there needs to be sensitivity and respect exercised when working with risk affected communities. Values and beliefs around the practiced are deeply embedded. Recognise that openly discussing FGM, Genitals and sexual practices can be taboo for some communities. It is important to do this respectfully and safely.

- **Empowerment:** Recognising that FGM can often be embedded in socio-political-economic factors which may reinforce the vulnerability of risk affected communities. Interventions with the community need to be done in partnership and for change to be beneficial rather than draconian. More holistic support may be needed to be provided to the family around finances, accommodation, status and social isolation.

Practice tips

- **Establish a parenting support group** and target isolated members of the community to engage in activities.
- **Establish a parent rep group** which is able to have consultation with the Designated Safeguarding Lead/Senior Leadership team.
- **Consider using online social media forums** for consultations.
- **Have representation on your governing body** from the community.
- **Consult with specialist groups** e.g. Forward UK who has supported schools with holding FGM discussions.
- **Ensure that you have a robust, transparent feedback/ complaints process** – if a parent/ community is not happy with the outcome of interventions/ process, then this should be escalated proportionally through to the SLT and governing body rather than to go straight to OFSTED or the media.
- **Work collaboratively with other local schools** – share resources and good practice (if a parent is not happy with your school, they may wish to admit their child to the next closest school).

4. Taking action

These are cases where there is suspicion that FGM may be performed, or has been performed but does not fall under the mandatory reporting duty. **You must still take action.**

If you have a disclosure from a parent that child has already been cut and has not had any social care involvement, then you will need to refer this in on the basis that the child may need medical/emotional intervention, or there is additional risk to other female relatives who have yet been cut.

4.1 Risk

Each case will present with its own factors please see **Appendix 1** for a more comprehensive guide and examples of risk**.**

Referral risk assessment – This is not a safeguarding assessment.

The BSCB have published a referral risk assessment BSCB have designed the FGM Referral Risk Assessment (Appendix 2 of the multiagency guidance). This is designed to support you in assessing the risk of when to make a referral. This is only a pilot document however some school settings have found it helpful to use. Please include any supplementary information to any safeguarding referral to First Response.

Static Risk –

These tend to be something that the family have limited control over. Referrals should not be made on **just** the following static risk factors, however should be considered when looking at other risk factors.

Additional risk factors – A safeguarding assessment may be required.

These may be cause for concern and be identified via a number of different routes. Any combination of these with additional static risk factors should **trigger action** where the Designated Safeguarding Lead would progress to speaking with parents to get more information.

Agencies are likely to be proactive in seeing protective measures to prevent the girl form being cut. The outcome of the safeguarding assessment could range from a written agreement being drawn up with the parents to confirm their stance to not practice FGM to a FGM protection order being sought from the family courts, which will provide the statutory agencies powers to protect the girl(s) from FGM.

High risk factors – A safeguarding assessment may be required.

These are signs that a girl may have **already** survived FGM. **You will need to exercise caution around speaking to the parents**. You are likely to need to make a safeguarding referral. If you are unsure, please seek a second opinion from another involved professional.

Professionals should aim to take proactive preventive action, however some parents may continue to practice FGM despite the law. It is likely that if you identify any of the risks and that a referral has already been made to the local authority that you will need to make a **re-referral** for a multi-agency safeguarding assessment to be undertaken.

Do not do nothing. There are times where you feel that risk is small; it advised that you take a cautionary approach. However if as practitioner that you do not feel a referral is required, then use the referral risk assessment to document the reasons for not taking further action and providing the reasons for doing so. This should be kept in the child's safeguarding file.

You should seek to engage with and involve the family unless the following conditions are met:

- When you feel talking to the parents would put the child at greater risk of harm
- If there is the risk that information related to criminal activity may be lost or destroyed or you feel your life or that of others may be put at risk
- If talking to the parents may encourage them to avoid professional contact or abscond with the child

Practice tips

- **Do not assume you know the family well enough to say with certainty that they will not practice FGM–** schools may not have all the information to assess robustly whether the child is at risk of harm from FGM, e.g., records of parental or siblings having had FGM, this may be documented by a health practitioner.
- **FGM is significantly harmful and is a child protection concern** – FGM should be treated as any other referral for significant harm. It is important that the school refers cases to the Local Authority where you believe there is identified additional risk. A multi-agency safeguarding assessment is then conducted by qualified social workers. The school may contribute towards this assessment but should not take the decision not to refer.
- **Schools should not conduct written agreements or partnership agreements with families –** This process is done as part of a safeguarding assessment by the statutory agencies. These are not effective if other agencies do not share this information.
- **Take a universal approach -** Although certain communities are more likely to practice FGM, conversations should be had with all parents/carers who you believe to show additional risk factors. This is to avoid targeting and discriminating communities and assists in raising awareness of FGM as a form of gender based violence.

- **Seek a second opinion from a safeguarding supervisor.** You can anonymise the case so you do not break confidentiality.
- **Challenge professionally –** There are times when you may not agree with the action taken by another agency. It is important that you follow and exercise the BSCB escalation policy if you experience this.

4.2 Suspected cases of FGM

These are cases where you have additional risk factors as well as the static risk factors. This can also include the possibility that the child may have already been cut, but does not meet the conditions met under the mandatory reporting duty. This might be where you do not have a strong suspicion that FGM has been carried out, but you have not seen this directly or you have not received a direct disclosure from the girl. Please review Appendix 1 for identifying risk, but also look at practice tips to consider being robust in your approach in identifying whether these risks have been evidenced.

4.3 Holidays to country of origin (or to another country) where FGM is prevalent:

Historically the most common event whereby a referral is needed is when a family from a risk affected community is travelling back to a country where FGM is prevalent. **However we need to be mindful that there needs to be additional risk factors around the circumstances which lead you to believe that the child is at risk of being cut – rather than just referring because the family are going on holiday**. Some of these are identified in Appendix 1.

For a list of countries where FGM is prevalent please consult the Female Genital Mutilation/cutting: a global concern (UNICEF, 2016).

When a child has been identified to be going on a holiday (extended leave requested/disclosure by the child), the designated safeguarding lead should invite the parents in for a conversation to get more information for a potential assessment about FGM. You must be explicit in stating that FGM is illegal in the UK and that it is considered significantly harmful. You can use leaflets in different languages from the Bristol Against Violence and Abuse (BAVA) website.

For referral information please see the section 4.4 Referring to social care – this includes what questions to ask families (Appendix 2). The process will trigger a process which is outlined in the FGM Multi-agency guidance. For reference there is a flow chart for practitioners (Appendix 3).

Do not refer to social care a family every time they go on holiday (unless there are additional risk factors identified)

You may want to still have the interview with the parents to discuss taking holiday during term time and record this in your safeguarding file.

Written agreements should last until the child's 18th Birthday and may cover younger siblings within the family.

If a child transfers to a different phase settings, a copy of the written agreement should be transferred in the child's safeguarding file. For more information and guidance see the BSCB Guidance on the Transfer of a Child Protection Safeguarding File to another Educational Setting.

Following safeguarding guidance will help reduce unnecessary duplication and actions. This will also reduce anxiety and disruption to families.

Non returning students:

'*A child going missing from education is a potential indicator of abuse or neglect and such children are at risk of being victims of harm, exploitation or radicalisation*.' DfE, 2016.

There are circumstances where girls may not return back to school (or even the UK) after travelling to their country of origin. It would be prudent to consider that this might be due to FGM. Although there may be other safeguarding considerations you might need to consider (Honour Based violence / Forced marriages).

It is really important that you follow statutory guidance for children missing from education from Keeping Children Safe in Education 2016 under Annex A: Further information and Children Missing Education 2016.

The Local Authority has a duty to try and track children who appear to be missing from education. A referral to the Educational Welfare Service should be made after the 10th consecutive school day of the child is being missing. Reasonable enquiries should be made prior to this. However you can speak to the Educational Welfare Service for advice and guidance prior to this. A referral can be made online where you are looking to report a missing child. The Local Authority has issued its own guidance which can be found here.

Depending on the circumstances a joint plan and agreement between the school and the Educational Welfare Service will be made to contact social care following this – a referral should not be made, in relation to FGM, until the child presents back to school. This process of sharing information is important. If the child presents in another local authority or another school, it is important that the enquiries around FGM are followed up.

Practice Tips:

- **Notify parents of putting in extended holiday requests as early as possible.** This should be done in a planned way, parents should be encouraged to give as much notice for travel before they leave. A visit by the social worker and police can be extremely stressful in the best of circumstances. This is made worse if families are preparing to go on a long holiday –if possible do this in good time.
- **The interview does not have to be 'severe'**; a lot of the questions (Appendix 2) could be asked as a matter of interest in their holiday.
- **Do not to use family or another member of the community to interpret** as this is often a confidential matter. The Bristol City Council has in house translation services.
- **Speak to other educational settings you know children to be attending.** Have they had the same information as you?
- **If the family are leaving immanently don't wait.** If the family are leaving in less than a week then you need to have the conversation over the phone – do not create delay by waiting a day to get the parents into the setting for a face to face interview.
- **There will be incidents where parents do not notify the school before they leave**. Unless you can contact them before and make a referral, an interview should be conducted when they return.
- **Ensure that the attendance officer/administrator is aware of guidelines around non returning**

children – this is so they can monitor the attendance and admissions register in line with statutory guidance.

- **Keep records up to date** –it is important that you robustly report concerns on the child's safeguarding file in case the child presents at another setting.
- **For new students do a welfare check** - contact their former school/setting to see if any safeguarding concerns have been raised including FGM.

4.4 Mandatory Reporting Duty

This statutory duty applies to all **regulated professionals** who become directly aware of **known** cases of FGM. This includes teachers who either have:

1. seen evidence of FGM directly (through changing in early years or specialist settings)
or
2. Received a direct disclosure from the girl herself that she has been cut.

This applies to any girl under the age of 18.

The duty applies to the teacher themselves and cannot be delegated to the designated safeguarding lead. They will need to phone the police via 101 and obtain a crime reference number to discharge this duty. They do not need to notify the parents that they are doing this, however they should notify the designated safeguarding lead and safeguarding records should be updated. If they fail to comply with the mandatory reporting duty, they may face disciplinary sanctions.

As good practice, the designated safeguarding lead will need to notify social care that they have made a referral through the mandatory reporting duty.

If a professional is made aware of known cases of FGM and they are **not** a regulated professional then they should follow their normal safeguarding procedures.

4.5 Referring to social care:

You will need to speak to the family unless the exceptional conditions have been met, even in this situation, you may still need to engage with the family to gather enough information to support a safeguarding assessment. If you are unsure what to do double check with a colleague, e.g., Safeguarding in Education Team.

Conversations with parents should be in line with obtaining information from the table of questions in **Appendix 2**. The fields have been written in conjunction with other agencies to gather sufficient information for a safeguarding referral.

As the vast majority of cases are referred due to the extended holiday requests, these questions are on the first page of the table. You may want to print this off and use it during the interview. Information should be copied and pasted into a web form, if less than 2 working days provided over the phone to a First Response advisor. **Any inconsistencies need to be highlighted and noted in a referral.**

N.B, if there are other children in other settings speak to the designated safeguarding lead from that setting before you refer and agree who will make the joint referral. Do not duplicate, but share information – you should have obtained this information from the interview with the parents if you haven't already had a record of this.

Safeguarding in Education Team.

The less time you give partner agencies, the less planned and robust the response to protect the girl from harm. Before the family leaves a safeguarding assessment needs to be carried out (within 45 working days – which depending on risk could include strategies with partner agencies). In worrying circumstances a FGM Protection Order maybe sought from the courts. Ultimately a family could be prevented from leaving the country if the concerns are high.

Practice Tips:

- **Do not work in isolation.** Ensure that you seek advice or further information from another colleague or agency that has been identified from the family.
- **Seek consent at all times to share and obtain information from other settings**.
- **Seek consent at all times to share with social care (unless it meets conditions referenced earlier) -** although if the parents refuse, you should still refer the case citing that it is your professional duty. Please record the reasons why the family would not consent – this is an assessment of their attitudes towards FGM or professional engagement.
- **Explain the role of social care and the police to families –** parents may not share information because they are worried of having their children taken away from them or being arrested.
- **Use the First Response web form** - this is reviewed every day. If the family has given you two days or less notice – phone it through as a telephone referral. This means you can print a copy of your referral for your own records and to be shared with other educational settings for their records.

4.6 What happens next?

For a full explanation of what happens next please consult to the FGM Multi-agency statutory guidance 2017. This includes the use of writing agreements and FGM protection orders.

Safeguarding Assessments:

A multi-agency strategy meeting/ discussion is held between Social Care, the Police and a Community Paediatrician to further assess and come up with a plan to protect the children. If the case is complex, the school maybe invited to contribute and attend a sit down strategy meeting. A social worker would normally complete a safeguarding assessment to determine risk of FGM.

Interventions:

In the vast majority of cases of suspected cases of FGM, the parents are visited by a social worker and a non-uniformed police officer who will ask them to fill out a written undertaking not to carry out, or allow anyone to perform FGM on their children. Schools should receive a copy of this written agreement to ensure that robust monitoring of the children can happen on their return back to school. Often the case is closed to social care at this point.

If concerns are upheld then the Local Authority my consider using Child Protection measures and seek a legal remedy depending on the family's circumstances.
Monitoring cases.

Safeguarding in Education Team.

It is important that all staff are vigilant to the signs that a girl might have survived FGM. The school will need to take action to re-refer. These risk indicators are identified in the 'high risk' section of the risk indicators (Appendix 1).

If this is a case that has previously been referred, depending on whether there are any presenting symptoms, the child should be referred as soon as possible. Do not speak to the parents if you believe the child to be at further risk of harm or if doing so would compromise a potential criminal investigation.

To illustrate a potential case and its journey, please see **Appendix 4** for a case study.

5. Advice and support

Contacts for professionals you can contact for advice and support

Organisation	Contact	Telephone 	Email/website 
Police		101/999	
First Response		0117 9036444	First Response Webform
Safeguarding in Education Team	Henry Chan – FGM Portfolio holder.	0117 9224282/ 0117 9222710	Henry.chan@bristol.gov.uk Safeguardingineducationteam@bristol.gov.uk
Bristol Ideal	Donna Seeley	0117 9222621	bristolideal@bristol.gov.uk http://www.bristolideal.org.uk/
PSHE Lead	Julie Coulthard		healthy.schools@bristol.gov.uk *www.bristolhealthyschools.org.uk*
Refugee Women of Bristol	Layla Ismail	0117 9415867	info@refugeewomenofbristol.org.uk
Integrate UK	Sami Ullah – Outreach lead	0117 954 2808	info@integrateuk.org http://integrateuk.org/
Bristol Safeguarding Childrens Board training	Donald Gloag	0117 922 4626	bscb.safeguarding.training@bristol.gov.uk BSCB Training site
NSPCC FGM helpline		0800 028 3550	fgmhelp@nspcc.org.uk
Bristol Against Violence and Abuse (leaflets and resources)			www.bava.org.uk

Appendix 1

Static Risk These tend to be something that the family have limited control over. Referrals should not be made on **just** the following static risk factors, however should be considered when looking at other risk factors listed below.	
The girl has a parent from a practicing community	The family's attitude towards FGM would need to be considered as part of an interview if there are other risk indicators. There needs to be consideration of the attitudes of the wider family members.
The mother has had FGM herself	It is not appropriate for school practitioners to ask intimate questions of whether parents have had FGM –however if this is voluntarily disclosed should be documented on a referral.
Additional risk factors These may be cause for concern and identified via a number of different routes. Any combination of these, with additional static risk factors should **trigger action** where the Designated Safeguarding Lead would progress to speaking with parents to get more information. Agencies are likely to be proactive in seeing protective measures to prevent the girl form being cut. The outcome of the safeguarding assessment could range from a written agreement being drawn up with the parents to confirm their stance to not practice FGM to a FGM protection order being sought from the family courts, which will provide the statutory agencies powers to protect the girl(s) from FGM.	
A holiday to country of origin (or to another country) where FGM is prevalent: • **via extended holiday requests** • **a child discussing a holiday to their country of origin** • **A failure to return back to school when expected.**	Historically this is strongest indicator that schools will have that would raise concerns. Multi-agency practice has been developed around this and still continues to be an effective way to assess other areas of risk. **N.B this is not exclusive to the Summer Holidays.** Anecdotally, time for healing from Type 1 can be as fast as a week; the healing period for Type 3 is believed to be around 6 weeks.
A girl may confide that she is to have a 'special procedure' or to attend a special occasion to 'become a woman'.	Children and young people will enjoy talking about their holidays. It is important that all staff are aware of the signs of be aware of and that they record this and report to their Designated Safeguarding Lead. This information needs to be cross referenced when they speak to parents.
Withdrawal from PSHE or SRE sessions.	Parents may feel more uncomfortable with the content of the curriculum as the topics maybe taboo. There might be a concern as to the content of what is being taught. In certain cases, it might be that the parents do not want their children to learn about FGM as this might lead to their child potentially identifying themselves as a survivor of the practice.
The child or parents may express views which	This does not necessarily mean that their children have been subject to the practice, however there would be concerns about the parents

sympathise or justify the practice.	more likely to advocate for the practice. There might be a strong possibility that the parents are unaware of the law and guidance around FGM. This might be due to a reinforced cultural belief which has not yet been challenged. **N.B, you might be the first person who will explain the law to them.**
Other family members are known to have had the procedure done.	If the family have newly migrated to the UK from their country of origin, it might have been that older siblings have already been subject to the practice. If a younger girl has been born in the country it might have been that there has been effective intervention that has prevented them from being cut.
High risk factors The following are signs that a girl may have **already** had FGM. **You will need to exercise caution around speaking to the parents**. You are likely to need to make a safeguarding referral. If you are unsure, please seek a second opinion from another involved professional. Professionals should aim to take proactive preventive action, however some parents may continue to practice FGM despite the law. It is likely that if you identify any of the below risks and that a referral has already been made to the local authority that you will need to make a re-referral for a multi-agency safeguarding assessment to be undertaken.	
A girl may have difficulty walking, sitting or standing.	These are likely to occur as a result of a recent injury or trauma. This may not be indicative of FGM on its own, but
Longer times spent than normal in the toilet.	If a girl has had type 3 FGM then it is likely that she might struggle to urinate and either spends longer in the toilet, or visit the toilet more regularly.
Poor school attendance or illness due to reoccurring or frequent urinary, menstrual or stomach problems.	These might not indicate FGM, however, the girl could require medical intervention. It is important that the designated safeguarding lead takes appropriate action in advising parents to seek medical intervention. It could be that a referral is made to the school nurse or the family seeks advice from their general practitioner.
A reluctance to seek medical attention or poor engagement with health professionals with there is an identified health need.	If there is a perceived need and advice given to parents to seek medical advice and this is not sought then this could indicate that the family are concealing FGM.
A reluctance to get changed for or engage in physical education	There might be an indication that the child or young person will struggle with physical education if they have been subjected to FGM. Equally they might struggle to change in front of others if they have just been subjected to FGM as they would not want to draw attention to themselves.
Changes in emotional/ behavioural presentation - eg, withdrawal, depression.	It is important that the emotional impact of being cut is understood. Often the practice is done without anaesthetic and will be with the full knowledge of a carer. This will likely leave the child with unsupported physical and emotional trauma which will often spill out into their everyday lives.

Appendix 2

FGM Travel questions

Questions & Prompts	Response from family/child
Has there been any extended leave requested?	
Has the child disclosed anything about their holiday? If so, what is this?	
Who is going on the holiday? Be aware of the only female members of the family going.	
Who are they going to visit? Who are they staying with?	
Where are they going? Country and city/ town/ village	
What is the purpose of the visit? Is this consistent with other accounts?	
When are they coming back to the UK? Date to be expected. What date are they planning on the child being back?	
Specific information re: Travel details – When are they leaving? Which airport are they likely to use?	

Please complete the family/ child information on the next page. You will be asked this information when making a safeguarding referral.

Please retain this in the child's safeguarding file.

Family / Child information

Questions and Prompts	Response from family/child
Child's developmental needs Does the child have any emotional/ behavioural changes? Are there any additional needs such as Special educational needs? What is the child's relationship like with care givers?	
Family composition Who is in the immediate family? Are there other children in the family that attend other settings? Are there other wider family relatives that we need to be considerate of?	
Specific ethnicity What is the family's ethnicity? Do they identify with a community/tribe? Are they engaged with community (what part of the country are they from /visiting).	
Family integration **-** How well do they engage with professionals and the school? What is the attendance like? Have there been any missed meetings with staff? Do they attend any parenting groups? Would you consider the family to be isolated? Have the parents withdrawn their children from PSHE lessons?	
FGM in the family (it is not appropriate for schools to ask intimate details about parent's genitals – but should provide the information in the referral if this was volunteered by the family).	
Attitudes towards FGM Have you explained the law to them? What are the parent's attitudes to FGM? What are the wider family member's attitudes towards FGM? What did they say about it? Have they commented on their thoughts about the practice being illegal? Are they aware of the different types of FGM?	
Consent 'Do you give consent for me to share this information for a safeguarding assessment by the local authority?' **Y/N (if no, why not?)** **'A social worker may come out and visit you to confirm what has been discussed.'** You may need to explain the roll of the social worker at this point.	**If the family say 'no', please ensure that you notify them that it is your professional duty to share information in line with the Local Children's safeguarding duties.**

Risk Identified

Suspected FGM

Request for extended leave

Invite parents/carer in for dicussion

Other risks identified (see guidance)

Have conversation with parents, unless it puts children at further risk of harm

Child/ YP <18 confirms FGM (seen/disclosed)

Phone 101 to discharge duty

Child at immediate risk

Phone police via 999

Good practice to also refer to First Response. Police will share information anyway.

Have explicit conversation with the parents, explaining FGM is illegal & child abuse

Get information:
-who is going?
- where are they going?
- who are they visiting?
- purpose of the visit?
- when are they coming back?

Depending on response, consider making a referral

Consent - seek consent to refer; however, inform that you have a duty to share information if they refuse.

Online referral form unless child at immediate risk of harm - then phone

First Response and Social Care do a safeguarding assessment which may result in joint visit with police to sign a written agreement with parents

School monitors.

If written agreement breached, then re-refer

- Police: **101 / 999.**
- First Response: **0117 9036444.**
- NSPCC FGM helpline: **0800 028 3550,**
- Safeguarding in Education Team **0117 9222701**
- FGM Portfolio holder, Henry Chan: **0117 9224282**

Appendix 3

Appendix 4

Case Study - Education		Additional Comments
Initial Presentation:	The family is comprised of 5 children, all girls under the age of 16, and the parents. One of the primary schools had a verbal request from mother for extended holiday in September. Information about the holiday was recorded on their safeguarding system, and the family were notified explicitly that FGM is illegal and that they would pass the information on to First Response in accordance to the Bristol Safeguarding Children's Boards guidance. The reason for the extended holiday was due to ill health of an extended family member. Mother has stated that no members of her family or herself have been cut.	It is important that all educational settings promote that extended holiday requests are to be made in writing and copied into the Designated Safeguarding Lead. This could be incorporated into the home school agreement. All families who submit extended holiday requests should have the conversation about FGM. This is to avoid targeting communities. Safeguarding procedures should be reflected in the school's Safeguarding/ Child Protection Policy and the setting's Attendance Policy which should make it explicit that FGM is illegal and is a child protection issue.
Considerations taken:	There were two other education settings which the other children in the immediate family attend. One secondary and one specialist provision. These did not receive any requests for extended leave verbally or in writing at the time of the first request. The specialist setting received a written notification a number of months following the first request. The secondary setting did not receive a request for additional leave. The two youngest children are autistic with one child assessed as being non-verbal. There were significant concerns identified by the specialist setting about this child's additional vulnerability. Supervision and advice was sought from the Safeguarding in education team when the concerns did not appear to initially trigger action from social care.	Good practice would be to speak to the other settings prior to making a safeguarding referral as this can assist in the safeguarding assessment. This can save time Learning from serious case reviews and child protection incident reviews, if the referrer does not receive feedback of the outcome of their referral from social care, it is important to follow up and find out. If necessary, 'challenge those who appear not to be taking action' – Keeping Children Safe in Education 2016. It is also important to seek supervision or a second opinion if you are unsure or not in agreement with the outcome of a referral.
Agencies involved:	- Three different school settings; primary, secondary and specialist. - The 0-25 service – Social workers from the specialist Disabled Children's Team had been involved for the two children with autism. They had been providing support around respite and direct payments for short breaks. - Previous Early Help support including workers from Action for Children and Shelter. - Health visitor for youngest child. - Community Paediatrician for the two children diagnosed with autism.	Obtaining information and identifying who else is involved with the family is important in being able to support a social worker to do a safeguarding assessment. The accounts of parental engagement from the different agencies had been influential in terms of the outcomes of the assessment.

Referral and presenting risk:	There were concerns as to different times and notifications to the three different settings with regard to the extended leave requests. The family were also visiting their country of origin which has been identified as a risk affected community. Two of the girls are diagnosed with autism with one of the children being non-verbal. There were concerns that they would be more vulnerable as there would be additional factors which would place them at further risk of harm. Details of who was going, where they were going, who they were staying with, the purpose of the visit and details of travel were obtained by the school.	The summer holiday has traditionally been a higher risk of girls being cut as this gives longer for a potential healing time. NB, this is on the assumption that Type 3 FGM is being practiced. There is anecdotal evidence as well as data from the NHS data sets that certain communities are today more inclined to practice Type 1 over Type 3.
First Response initial assessment:	As the case was open to a social worker in the Local Authority from the 0-25 service, the referral was passed on to the team to undertake a safeguarding assessment as FGM is considered significantly harmful. The case had identified many static risks and highlighted that the parents had good engagement as well as recognising verbally that FGM is wrong and that they do not support the practice. The social work manager of the 0-25 service had reviewed historical records there were additional risks that became apparent: - a discrepancy between mother having had FGM previously despite stating to the school that she and no one else in the family had not had it done. - Different times and methods of notifying the schools of the extended holiday requests. - The reason for the holiday request citing ill health of a relative which is not consistent with the dates of travel. 'Why leave a couple of months later if the relative is ill now?'	The concerns identified are now undertaken by **Static risk:** risks that the family have no control over. For example their ethnicity, coming from a FGM risk affected community, a mother having had FGM themselves. However this does not included views, values and opinions expressed around the practice of FGM, and engagement with professionals.
Strategy:	The team manager progresses the assessment to a strategy discussion with the police and the community paediatrician due to heightened risks. As there were static risk factors/ indicators it was decided that the following actions were taken to progress the assessment: - A joint visit to parents with the social worker and police to discuss attitudes and reinforce messages that FGM is illegal (this was done with an interpreter). - Consider a written agreement to encapsulate this. - Convene a multi-agency meeting to further the assessment.	Where information gathered during an assessment results in the social worker suspecting that the child is suffering or likely to suffer significant harm, the local authority should hold a strategy discussion to enable it to decide, with other agencies, whether to initiate enquiries under section 47 of the Children Act 1989. A strategy discussion would normally involve a social work manager, a sergeant from the police or a community paediatrician.

	- Re-strategy to review the evidence.	This normally initiated as a telephone strategy, however if the case is complex, a sit down strategy can be convened.
Assessment:	**Joint visit to the family** This was done with the social worker and the police with an interpreter. - The family stated that they did not want to practice FGM on their children. - Only mother had signed the agreement as father had taken the two older children to a health appointment. - The mother had asked whether she would be criminally responsible if the older children chose to have the practice done when they were over the age of 18. There was a concern what prompted this question considering that she had indicated previously that she was against the practice. - Mother had confirmed that she had been cut by a family member when she was younger. ---------- - **Multi-agency meeting** This had been convened with education and social care to share information and discuss what steps should be taken to further protect the children. - The parents appeared to be compliant in that they would not wish their children to be cut. - There was a challenge from a school setting that they often found that the father would be 'too agreeable' to avoid further discussions. All the settings were asked to fill out the BSCB referral risk assessment tool to enable a holistic perspective on parental engagement. - Intervention to be offered to the children. The schools will further support the assessment by asking the parents if they would be happy for personal, social, health and economic education (PSHE) support to be offered to the children about keeping safe and being able to speak to adults if they are worried. - There was a professional disagreement with the outcome that the case would be closed at this point due to there being an over reliance on the parent's accounts despite there being discrepancies. - There were concerns that the signing of the written agreement was not a robust intervention to keep the children with additional learning needs from being cut. - The case was escalated to the team manger using	During the assessment period, it is important to act proportionally to the risk whilst accounting for the probability for the child being cut. The parents and most families may verbally disagree with practicing FGM. This may be true and at the same time be respected at the time of this; however there is a risk of disguised compliance. Often actions and interventions further assess the parent's attitudes by asking to engage with activities such as: - Signing a written undertaking. - Agreeing to medicals if further concerns are identified. - Agreeing for their children to engage with PSHE. The BSCB Escalation process is a way to challenge differences in opinion in terms of interventions and professional decisions. The escalation promoted for the re-strategy to include all agencies to share information and assess the presenting risks. The sit down strategy allowed for in depth conversation and all involved professionals to engage with the formation of a safety plan. The Use of FGM protection orders: - These can be used as an assessment of parental attitude towards the practice. - The legal order should be perceived as protective and preventative. - Although the majority of orders are sought after by the police and local authority, anyone can apply for one if they are concerned for the safety and wellbeing of the girl(s). Including the parents themselves, schools or health professionals.

	the BSCB escalation policy. --- **Re-strategy meeting** A sit down strategy was convened to conduct a multi-agency assessment of next steps. This was coordinated by social care but involved the Police, health, legal representation and the attendees at the multi-agency meeting. - Further professional views from health colleagues had been obtained. There was a record from the GP practice nurse which stated that mother was surprised that the practice was illegal in the UK despite being told previous times before by the midwife. - Consideration of the parent's attitude towards the practice should be respected as they had agreed to interventions and support. - Concerns about the parent's capacity to manage the two children with autism whilst travelling and on holiday may mean that they will rely on extended family members to provide child care. There are was a concern that the wider family may be pro-FGM considering it was a family member who had cut the mother. - The outcome of the meeting was to consider a FGM protection order with the family. On balance this would not to obstruct the family from travelling, but to reinforce the written agreement under a legal framework and support the parents to resist any potential family pressures.	- The order shall include any actions need to secure the safety of the children. These need to be proportionate to the risks identified. N.B, it is important to consider the impact of the worry for parents of the process to going to court. Despite the FGM protection order being a legal document, it would not mean that the children would be removed for their care. This might be a significant worry for a lot of parents. Additional support with use of an interpreter and supporting finding independent legal advice might be required. If the parents is openly saying that they oppose FGM, however there are additional risk factors (such as risk posed by extended family members or their community), a FGM protection order should empower and endorse the parent's stance.
Interventions and outcomes:	- The parents supported the FGM protection order. This was made in respect of all the children until their 18th birthdays. This was considered as proportionate protection and they have travelled to back to their country of origin. - The children will have on-going access to PSHE as a part of a general curriculum. This will give them an opportunity to develop an understanding of potential risks but also provides an opportunity for them to know what to do if they feel that they have been subject to the FGM. - On-going support from universal services and enhanced services from the 0-25 service for the children with diagnosed disabilities.	It is important to recognise that a court order does not fully eradicate risk. The court will need to grant permission for the applicant to share it with other professionals. Ongoing monitoring of the children would still need to occur from universal services. If there are signs of harm or additional concerns that arise that this is re-referred into social care to investigate and assess.

Appendix 5

Annual FGM Safeguarding checklist			
Month	**Event**	**School activity**	☑
January	Returning back from the Christmas holiday.	Review absences and check in with students **(and with other school holidays).**	
	Plan PSHE curriculum	Liaise with PSHE lead in preparation for International Day of Zero Tolerance for FGM (Feb) and for the rest of the year.	
February	6th February International Day of Zero Tolerance for FGM	Assemblies/ PSHE	
		Consider hosting a community Events /Parenting group.	
	BSCB Shadow Board Safeguarding Survey	Support Bristol students to have their say about what safeguarding issues affect them.	
March	8th March International Women's Day	Assemblies/ PSHE	
	Review attendance and Safeguarding policy with governing body.	Remind parents and carers about notifying schools or the extended holiday request.	
April	Check leaflets/Posters in school.	Download material from the **BAVA website.**	
	Is material visible and accessible?	Do safeguarding walk/tour	
	Annual Safeguarding audit submission	Completion with safeguarding governor.	
May	Review training and CPD for staff	See upcoming training in training table	
	Cascade learning through training for all staff.	Consider use of staff briefing, assemblies and PSHE updates.	
June	Review extended holiday requests and refer on if necessary (on going throughout the 6 terms)	Manage requests in accordance to the BSCB FGM Safeguarding Guidance 2017. **Refer early to allow time for a Multiagency assessment to be conducted.**	
July	Use of PSHE	Focus on year groups transitioning to another school (PSHE might lead to disclosures).	
	Review transitions for different schools	Prepare safeguarding files for transfer (this can happen throughout the year)	
August	**Summer Holidays.** Ensure if you are referring in the last week of the holidays you provide an out of office contact for someone who is able to answer questions for social care/police.		
September	Return to school.	Check in with returning students you may have referred.	
	Consider non-returning students or if a child has not arrived despite being a new starter.	Liaise with previous educational setting and your attendance officer. Follow up any absences in accordance with KCSIE (2016) and the Local Authority guidance.	
October	Engage with parents and the community about safeguarding/ PSHE.	Use parenting groups/ social networking. Advice PSHE content with parents.	
	Addressing worries in the community about social workers and the police	Consider inviting guest speakers – social care/ police/ early help to discuss the roll of services.	
November	November 25th – International Day for the Eradication of Violence Against Women.	Hold a White Ribbon Campaign event – Men working to end violence against women.	
December	Review and plan events for the next calendar year about developing FGM strategies.	Appoint a staff FGM champion and a student FGM champion to promote student inclusion.	
Please contact the Safeguarding in Education Team if you are requiring advice and guidance.			