FGM Policy

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Farndon Primary Schoo

EQUALITY SCHEME
EQUALITY IMPACT ASSESSMENT FOR
FGM POLICY

Staff / Committee involved in development:	Health Safety Committee; Headteacher
For use by:	Staff, Governors and Parent/Carers
This policy relates to statutory guidance:	Keeping Children Safe in Education 2022 FGM Act 2003 Mandatory Reporting on FGM – procedural information
Key related Farndon Policies:	Safer Recruitment Whistle Blowing E-Safety Allegations of Abuse Against Staff Safeguarding Child Protection

Equality Impact Assessment: Does this document impact on any of the following groups? If YES, state positive or negative impact, and complete an Equality Impact Assessment Form or action plan, and attach.

Groups:	Yes/ No	Positive/Negative impact
Disability	No	
Race	No	
Gender	Yes	Positive way in supporting.
Age	No	
Sexual Orientation	No	
Religious and Belief	No	
Gender Reassignment	No	
Marriage & Civil Partnership	No	
Pregnancy & Maternity	No	
Other	No	

Reviewed by	Leadership and Management
Agreed by	Full Governors
Next Policy review date	Feb 2027

A copy of this form, and any related impact assessment form or action plan must be sent to the school office

Contents

1. Introduction

This policy provides information about female genital mutilation (FGM) and what action should taken to safeguard girls and young women who may be at risk of being, or have already been, harmed. FGM is extremely traumatic, can be fatal, and has significant short and long term medical and psychological implications. It is illegal in the United Kingdom, and therefore is a child protection issue. This policy adheres to the Rights of the child and article 37 where every child must not suffer cruel or degrading treatment and article 34 where children are protected from all forms of sexual abuse.

FGM has been a criminal offence in the UK since the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003 replaced the 1985 Act and made it an offence for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal. Further information about the Act can be found in **Home Office Circular 10/2004**. In 2015, THE Home Office released a report entitled Mandatory Reporting of Female Genital Mutilation – procedural information. Section 5B of the 2003 Act introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers to report known cases of FGM which they identify in their work to the police. **This took effect from 31st October 2015.**

2. Policy Statement

As a school we recognise that whilst there is no intent to harm a girl / young woman through FGM, the practice directly causes serious short and long term medical and psychological complications. Consequently, **it is a physically abusive act**.

It is our aim to prevent the practice of FGM in a way that is culturally sensitive and with the fullest consultations with community representatives and professional agencies.

All staff alerted to the possibility of FGM through the sharing of this policy in staff meetings and safeguarding training, and the policy should includes a preventative strategy that focuses upon education, as well as the protection of girls / young women at risk of significant harm. The following principles should be adhered to:

- The safety and welfare of the girl / young woman is paramount;
- All agencies and staff, including volunteers, will act in the interest of the rights of the girl / young woman, as stated in the UN Convention on the Rights of the Child (1989);

- All decisions or plans for the girl / young woman should be based on thorough assessments which are sensitive to the issues of age, race, culture, gender, religion. Stigmatisation of the girl / young woman or their specific community should be avoided;
- Cheshire agencies should work in partnership with members of affected local communities, to develop support networks and education appropriate programme's.

4. Female Genital Mutilation

4.1 Definition

The World Health Organisation (WHO) states that female genital mutilation (FGM) 'comprises 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, 2008). FGM is also known as female circumcision, but this is incorrect as circumcision means 'to cut' and 'around' (Latin), and it is quite dissimilar to the male procedure. It can also be known as female genital cutting. The Somali term is 'Gudnin' and in Sudanese it is 'Tahur'. FGM is not like male circumcision. It is very harmful and can cause long-term mental and physical suffering, menstrual and sexual problems, difficulty in giving birth, infertility and even death. The average age for FGM to be carried out is about 14 years old. However it can vary from soon after birth, up until adulthood.

4.2 Prevalence

FGM is much more common than most people realise. In 2004 it was estimated that there were approximately 80,000 girls and women in the UK who have undergone genital mutilation and a further 7,000 girls under 17 were at risk (Department of Health). Current figures are unknown as although there has been a rise in immigration to the UK during this period since 2004, educational programmes against FGM may have had an impact on reducing incidence.

FGM is traditionally practised in sub-Saharan Africa, but also in Asia or the Middle East. Those African countries were it is most likely to be practised include Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Mali, Sierra Leone, Somalia and Sudan. This does not mean that it is legal in these countries. There are a range of responses by individual nations: from still being legal, to being illegal but not upheld, to outright bans that are adhered to.

Girls and women from the Democratic Republic of Congo, Ghana, Niger, Tanzania, Togo, Uganda and Yemen are less likely to undergo FGM. But within these countries there are particular ethnic communities where

prevalence is higher. It should also be remembered that girls and young women who are British citizens but whose parents were born in countries that practiced FGM, may also be at risk.

4.3 Legal Position

FGM has been illegal in the UK since the Female Circumcision Prohibition Act 1985. This made it illegal for a person to excise, infibulate (sew together the labia majora) or otherwise mutilate the whole or any part of a girl / young woman's labia majora, labia minora or clitoris. It is also an offence for anyone to assist a girl / young woman to mutilate her own genitalia. The only exception is for operations for specific physical and mental health reasons, undertaken by registered medical or nursing practitioners.

The Female Genital Mutilation Act 2003 strengthened the 1985 Act, by making it an offence to take UK nationals and those with permanent UK residence, overseas for the purpose of circumcision, to aid and abet, counsel, or procure the carrying out of FGM. It also makes it illegal for anyone to circumcise girls or women for cultural or non-medical reasons. The 2003 Act increases the maximum penalty for committing or aiding the offence from 5 years to 14 years in prison.

Local authorities can apply to the courts for various orders, such as an Emergency Protection Order, under the Children Act 1989, to prevent a girl / young woman being taken abroad for the purposes of genital mutilation. In emergency situations consideration should also be given to the use of Police Protection. However these expire after 72 hours, so further provisions would have to be considered after this.

4.4 Cultural context

The issue of FGM is very complex. Despite the obvious harm and distress it can cause, many parents from communities who practice FGM believe it important in order to protect their cultural identity.

FGM is often practiced within a religious context. However, neither the Koran nor the Bible supports the practice of FGM. As well as religious reasons, parents may also say that undergoing FGM is in their daughter's best interests because it:

- Gives her status and respect within the community;
- Keeps her virginity / chastity;
- Is a rite of passage within the custom and tradition in their culture;
- Makes her socially acceptable to others, especially to men for the purposes of marriage;
- Ensures the family are seen as honourable;

- Helps girls and women to be clean and hygienic.

4.5 Main Forms of FGM

The World Health Organisation has classified four main types of FGM:

1. 'Clitoridectomy which is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, rarely, the prepuce (the fold of skin surrounding the clitoris) as well;
2. Excision which is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina);
3. Infibulation which is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, and sometimes outer, labia, with or without removal of the clitoris;
4. Other types which are all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area' (WHO FGM Fact Sheet, 2008).

4.7 Consequences of FGM

Many people may not be aware of the relation between FGM and its health consequences; in particular the complications affecting sexual intercourse and childbirth which occur many years after the mutilation has taken place.

Short term health implications include:

a. Severe pain and shock;
b. Infections;
c. Urine retention;
d. Injury to adjacent tissues;
e. Fracture or dislocation as a result of restraint;
f. Damage to other organs;
g. Death.

Depending on the degree of mutilation, it can cause severe haemorrhaging and result in the death of the girl / young woman through loss of blood.

Long term health implications include:

a. Excessive damage to the reproductive system;

b. Uterus, vaginal and pelvic infections;

c. Infertility;

d. Cysts;

e. Complications in pregnancy and childbirth;

f. Psychological damage;

g. Sexual dysfunction;

h. Difficulties in menstruation;

i. Difficulties in passing urine;

j. Increased risk of HIV transmission.

4.8 Signs and Indicators

Some indications that **FGM may have taken place** include:

- The family comes from a community that is known to practice FGM, especially if there are elderly women present in the extended family;
- A girl / young woman may spend time out of the classroom or from other activities, with bladder or menstrual problems;
- A long absence from school or in the school holidays could be an indication that a girl / young woman has recently undergone an FGM procedure, particularly if there are behavioural changes on her return (this may also be due to a forced marriage - (see **Safeguarding Children and Young People from Forced Marriage Procedure**);
- A girl / young woman requiring to be excused from physical exercise lessons without the support of her GP;

- A girl / young woman may ask for help, either directly or indirectly;
- A girl / young woman who is suffering emotional / psychological effects of undergoing FGM, for example withdrawal or depression;
- Midwives and obstetricians may become aware that FGM has taken place when treating a pregnant woman / young woman.

Support for a girl or young woman who may have undergone FGM can be obtained from the **Agency for Culture and Change Management** (Tel: 0114 272 8780).

Some indications that **FGM may be about to take place** include:

- A conversation with a girl / young woman where they may refer to FGM, either in relation to themselves or another female family member or friend;
- A girl / young woman requesting help to prevent it happening;
- A girl / young woman expressing anxiety about a 'special procedure' or a 'special occasion' which may include discussion of a holiday to their country of origin;
- A boy may also indicate some concern about his sister or other female relative.

5. Action to Take if Workers Believe a Child is at Risk of FGM

Any information or concern that a girl / young woman is at risk of, or has undergone FGM should result in an immediate referral to either Cheshire Police of Cheshire West Safeguarding Team.

5.1 When a report must be made

The FGM mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015). The legislation requires regulated health and social care professionals and teachers in England and Wales to make a report to the police where, in the course of their professional duties, they either:

- are informed by a girl under 18 that an act of FGM has been carried out on her; or
- observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have 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 is a personal duty which requires the individual professional who becomes aware of the case to make a report; the responsibility cannot be transferred. The only exception to this is if you know that another individual from your profession has already made a report; there is no requirement to make a second.

The duty does not apply in relation to at risk or suspected cases or in cases where the woman is over 18. In these cases, you should follow local safeguarding procedures. For more information, please see the English or Welsh version of Working Together to Safeguard Children as appropriate, and/or the multi-agency guidance on FGM.

Where there is a risk to life or likelihood of serious immediate harm, professionals should report the case immediately to police, including dialling 999 if appropriate.

5.1a Visually identified cases – when you might see FGM

The duty applies to cases you discover in the course of your professional work.
If you do not currently undertake genital examinations in the course of delivering your job, then the duty does not change this. Most professionals will only visually identify FGM as a secondary result of undertaking another action.

5.1b Verbally disclosed cases

If a girl discloses to you that she has had FGM (whether she uses the term 'female genital mutilation' or any other term or description, e.g. 'cut') then the duty applies. If, in the course of delivering safe and appropriate care to a girl you would usually ask if she has had FGM, you should continue to do so.
The duty applies to cases directly disclosed by the victim; if a parent, guardian, sibling or other individual discloses that a girl under 18 has had FGM, the duty does not apply and a report to the police is not mandatory. Any such disclosure should, however, be handled in line with school policy and the wider safeguarding responsibilities. It must be reported to the designated safeguarding lead who will then refer to children's social services.

5.2 Timeframe for reports

Reports under the duty should be made as soon as possible after a case is discovered, and best practice is for reports to be made by the close of the next working day, unless any of the factors described below are present. Staff should act with at least the same urgency as is required by our school safeguarding processes.
In order to allow for exceptional cases, a maximum timeframe of one month from when the discovery is made applies for making reports. However, the expectation is that reports will be made much sooner than this.

A longer timeframe than the next working day may be appropriate in exceptional cases where, for example, a professional has concerns that a report to the police is likely to result in an immediate safeguarding risk to the child (or another child, e.g. a sibling) and considers that consultation with colleagues or other agencies is necessary prior to the report being made. If you think you are dealing with such a case, you are strongly advised to consult colleagues, including your designated safeguarding lead, as soon as practicable, and to keep a record of any decisions made. It is important to remember that the safety of the girl is the priority.

5.3 Making a report

Where staff become aware of a case, the legislation requires that staff are to make a report to the police force area within which the girl resides. The legislation allows for reports to be made orally or in writing.
When staff make a report to the police, the legislation requires us to identify the girl and explain why the report is being made. While the requirement to notify the police of this information is mandatory and overrides any restriction on disclosure which might otherwise apply, in handling and sharing information in all other contexts

schools should continue to have regard to relevant legislation and guidance, including the Data Protection Act 1998 and any guidance for your profession. The provisions of the Data Protection Act 1998 do not prevent a mandatory report to the police from being made.

While the legislation requires a report to be made to the police, it does not specify the process for making the report. In all cases staff should ensure that they are given a reference number for the case and keep a record of it.

5.3a Making a report

It is recommended that staff make a report orally by **calling 101**, the single non-emergency number.
When you call 101, the system will determine your location and connect you to the police force covering that area. You will hear a recorded message announcing the police force you are being connected to. You will then be given a choice of which force to be connected to – if you are calling with a report relating to an area outside the force area which you are calling from, you can ask to be directed to that force.

Calls to 101 are answered by trained police officers and staff in the control room of the local police force. The call handler will log the call and refer it to the relevant team within the force, who will call you back to ask for additional information and discuss the case in more detail.

You should be prepared to provide the call handler with the following information:

• explain that you are making a report under the FGM mandatory reporting duty

• your details:
o name
o contact details (work telephone number and e-mail address)
o role
o place of work

• details of your organisation's designated safeguarding lead:
o name
o contact details (work telephone number and e-mail address)
o place of work

• the girl's details:
o name
o age/date of birth
o address

• if applicable, confirm that you have undertaken, or will undertake, safeguarding actions, as required.

You will be given a reference number for the call and should ensure that you document this in school records (see section 2.3b).

5.3b Record keeping

Throughout the process, staff should ensure that they keep a comprehensive record of any discussions held and subsequent decisions made, in line with standard safeguarding practice. This will include the circumstances surrounding the initial identification or disclosure of FGM, details of any safeguarding actions which were taken, and when and how staff reported the case to the police (including the case reference number). Staff should also ensure that the school's designated safeguarding lead is kept updated as appropriate.

5.3c Informing the child's family

In line with safeguarding best practice, staff should contact the girl and/or her parents or guardians as appropriate to explain the report, why it is being made, and what it means. Wherever possible, staff should have this discussion in advance of/in parallel to the report being made. Advice and support on how to talk to girls and parents/guardians about FGM is available in the multi-agency guidance on FGM.

However, if staff believe that telling the child/parents about the report may result in a risk of serious harm to the child or anyone else, or of the family fleeing the country, then staff should not discuss it. For more information, please see information sharing advice for safeguarding practitioners. If staff are unsure or have concerns, they should discuss these with the school's designated safeguarding lead.

5.4 Your responsibilities after you have made a report

In relation to any next steps, staff should continue to have regard to their wider safeguarding and professional responsibilities, including any relevant standards issued by the LCSB.
Depending on the role within school and the specific circumstances of the case, staff may be required to contribute to the multi-agency response or other follow up to the case which will follow the report. If staff are unsure, they should seek advice from the school's designated safeguarding lead.

6. Next steps following a report

Upon receipt of a report, the police will record the information and initiate the multi-agency response, in line with local safeguarding arrangements. If the police consider that emergency action is needed to protect the child, they may take action in advance of the multi-agency response.
While the multi-agency response will be initiated by the police, as they are the agency receiving the report, they will consult children's social care prior to taking action.

Factors considered may include:

- measures necessary to protect the girl/others identified as being at risk of harm (children's social care lead);
- possible criminal investigation (police lead);
- the health and wellbeing requirements of the girl/others, including how the care will be delivered (health lead).

The protection of the child must be paramount at all times. The multi-agency response will consider any wider health or emotional support that the child may need. In considering the case and next steps, local safeguarding processes should continue to be followed, in line with wider relevant guidance.

6.1 FGM Protection Orders

Depending on the circumstances of the case, the police or local authority may wish to consider applying for an FGM Protection Order (FGMPO) either to protect the girl or to protect other girls who may be at risk (e.g. siblings). An FGMPO is a civil order which may be made for the purposes of protecting a girl at risk of FGM or protecting a girl against whom an FGM offence has been committed.

7. Failure to comply with the duty

FGM is child abuse, and all staff are expected to pay due regard to the seriousness of breaches of the duty.

7.1 Teachers

For teachers, as a school we must handle any failure to comply with the duty in accordance with our staff disciplinary procedures.
If referred to the NCTL, they will consider referrals to determine whether the facts presented in respect of the individual's failure to comply with the duty are proven and whether they amount to unacceptable professional conduct or conduct likely to bring the profession into disrepute. If proven, the NCTL will consider whether it is appropriate to make a prohibition order which prevents the individual from carrying out teaching work in any school, children's home, sixth form college, and relevant youth accommodation in England.

Policy Agreed: February 2025

Signed:  Headteacher: A Walker