Fairfield School

Female Genital Mutilation Policy

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Female Genital Mutilation Policy

Introduction

At Fairfield School, we are determined to ensure that all necessary steps are taken to protect our children, young people and adults from harm. This includes safeguarding girls from Female Genital Mutilation (FGM). This policy which should be read in conjunction with our Child Protection policy

To implement the FGM Duty Fairfield School will ensure all staff have access to training to ensure all have an understanding to deal with the risks identified.
This includes:

- an understanding of FGM
- an understanding of FGM types, including short and long term health effects and the risk factors
- an understanding of FGM legislation
- how to challenge FGM ideology
- how to share information to ensure a person at risk of FGM obtains appropriate support
- how and when to make a direct FGM referral
- how to record and maintain records to comply with school's responsibilities

What is Female Genital Mutilation (FGM)?

FGM is a form of child/abuse that can lead to extreme and lifelong physical and psychological suffering to women and girls. The term 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. In general, girls undergo female genital cutting (FGC) around the age of three years old, though the age may vary depending on the type of ritual and customs.
The World Health Organisation (WHO) estimates that between 100 – 140 million girls and women have experienced FGM. It is estimated that in 2014, 170,000 women in England and Wales were living with the consequences of FGM (Counter-Extremism Strategy- HM Government, 2015) with 1,036 newly recorded cases in England from April to June 2015.The origins of FGM are unclear but there is historical evidence of the practice in ancient Egypt, Tsarist Russia and by pre-Islamic Arabs and African tribes. It is predominately practiced in the African continent, Yemen and Iraq however, following migration, is also practiced amongst immigrant communities in Europe, North and South America, Canada, Australia and New Zealand. FGM is **not** an Islamic practice. It is a cross- cultural and cross-religious ritual.
Communities supporting FGM justify the practice for a variety of reasons.
These may be:

- sexual control of men over women
- preservation of virginity
- custom and tradition
- family honour
- hygiene or cleanliness
- mistaken belief that FGM is a religious requirement

Methods of FGM

There are four types of FGM categorised as:
1 Sunna Circumcision - removal of the prepuce with the excision of part or the entire clitoris. In this procedure the clitoris is pulled out and amputated. Bleeding is stopped by packing the wound or by stitching the clitoral artery.
2 Excision - a clitoridectomy which involves the partial or entire removal of the clitoris, as well as the scraping off of the labia majora and labia minora. Types I and II are thought to generally account for 80-85% of all female genital mutilation.
3 Infibulation - also known as 'Pharaonic Circumcision', this is the most extreme form of FGM which involves removal of the clitoris and the adjacent labia (majora and minora). The scraped sides of the vulva across the vagina

are then secured with thorns or sewn. The girl's legs are then tied together for between 2-6 weeks whilst fusion takes place. The scar creates skin that covers the urethra and most of the vagina to act as a physical barrier to intercourse. (A small opening is kept to allow passage of urine and menstrual blood). An infibulated woman must be dilated (a process that may take months) or recut (defibulation) to allow intercourse. Defibulation is traditionally undertaken by the husband or a female relative using a knife or piece of glass. The incision may be closed again (re-infibulation) after intercourse to secure fidelity to the husband. During childbirth defibulation is repeated to prevent an obstructed labour or perineal tears. Traditionally, re-infibulation is performed after the woman gives birth.
Because of the nature and extent of both the initial and repeated cutting and suturing, the physical, sexual and psychological effects of Type III infibulation are greater and longer- lasting than for other types of female genital mutilation.

4 Use of Angurya and Gishiri - The term "angurya cuts" describes the scraping of the tissue around the vaginal opening. 'Gishiri cuts' are posterior (or backward) cuts from the vagina into the perineum. These procedures often result in vesicovaginal fistulae and damage to the anal sphincter.

Possible Indicators of Risk of FGM

There are factors that may indicate a child may be at risk of FGM. As with all other aspects of safeguarding they may form part of a collective picture of concern.
For example if:

- the family originates from a community known to practice FGM and / or information is shared of intention to travel to their country of origin
- a parent requests permission for a child to travel oversees for an extended period
- a child expresses anxiety about a special ceremony or traditional custom
- another family member is known to have previously undergone FGM
- fatality as a result of shock, haemorrhage or septicaemia
- infection due to unsanitary conditions
- transmission of the HIV virus which can cause AIDS
- extreme levels of pain, fear, anxiety and discomfort

Immediate Health Consequences

FGM has many long-term physiological, sexual, and psychological effects some of which include:

- kidney and or recurrent urinary retention / infection
- genital malformation, cysts, keyloid scar formation
- delay of first menstrual cycle
- chronic pelvic complications
- sexual frigidity, pain during sex, lack of pleasurable sensation
- Post-Traumatic Stress Disorder
- mental health difficulties

Legislation

International legal frameworks such as the UN Convention on the Rights of the Child and UN Convention on the Elimination of all forms of discrimination contain general safeguarding measures, which may be applied to FGM.
The Prohibition of Female Circumcision Act (1985) made it a criminal offense in the UK to incise, infibulate or mutilate of the whole or any part of the labia majora, labia minora or clitoris of a person or to aid, abet, counsel or procure another person to carry out this procedure unless deemed a necessary surgical procedure carried out by a registered medical practitioner or midwife.

The 1985 Act was replaced by the **Female Genital Mutilation Act 2003.** Applying to England, Wales and Northern Ireland, the 2003 act extends offenses to also include:

- assisting a girl to carry out FGM on herself
- extra-territorial offences to deter people from taking girls abroad for mutilation.

The Serious Crime Act 2015 amends 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, it also amends section 3 of the 2003 Act (the offence of assisting a non-UK person to mutilate overseas a girl's genitalia) so that it extends to acts of FGM done to a UK national or a person who is resident in the UK.

These changes mean that the 2003 Act can capture offences of FGM committed abroad by or against those who are at the time habitually resident in the UK irrespective of whether they are subject to immigration restrictions. The term 'habitually resident' covers a person's ordinary residence as opposed to a short, temporary stay in a country. The courts determine whether an involved person is habitually resident in the UK, and therefore covered by the 2003 Act.

The Serious Crime Act (2015) also makes equivalent amendments to the Prohibition of Female Genital Mutilation (Scotland) Act 2005. The 2015 Act has also created a new offence- that of failing to protect a girl from FGM. This means 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. The term 'responsible' refers to those with parental responsibility who have frequent contact with the girl or where a person aged 18 or over have assumed responsibility for caring for the girl. The maximum penalty for the offence is seven years' imprisonment, or a fine or both.

Female Genital Mutilation Protection Orders (FGMPO)

The 2015 Act also introduces the provision of FGM protection orders, a civil law measure to protect a girl against the commission of a genital mutilation offence or protect a girl against whom such an offence has been committed.
Application for the court to make a FGMPO can be made:

- by the girl who is to be protected
- by a Relevant Third Party (RTP) appointed by the Lord Chancellor- currently only Local Authorities are classified as RTPs
- any other person with the permission of the court e.g. the police, a voluntary sector support service, a healthcare professional, a teacher, a friend or family member.

The court will consider all the circumstances including the need to secure, the health, safety, and well-being of the girl.
The FGMPO contains prohibitions, restrictions or other requirements to protect a victim or potential victim of FGM. This could include be an order to:

- surrender a person's passport or any other travel document
- protect a victim or potential victim from FGM from being taken abroad
- not enter into any arrangements, in the UK or abroad, for FGM to be performed on the person to be protected.

Breach of an FGMPO is a criminal offence with a maximum penalty of five years' imprisonment, or as a civil breach punishable by up to two years' imprisonment.

Public Protection Orders

There are other public protection orders that may also be used to protect girls less than 18 years deemed at risk,
Police Protection Order - this gives the Police power to remove a girl thought to be at risk of significant harm and place her under 'police protection' for up to 72 hours.
Emergency Protection Order - after 72 hours the Police or Social Care Services can apply for this further protection if a girl is still thought to be at risk.
Inherent Jurisdiction - of the court can be requested by Social Care Services where a care order is not deemed appropriate and issues concerning a girl cannot be resolved under the Children Act. Applications can also be made by any interested party to make a girl a ward of court.

Mandatory Reporting Duty

From October 2015 education, social care and health professionals in England and Wales have a **mandatory** duty to report to the **police** if they know a girl aged under 18 years of age has undergone FGM. The duty requires the individual professional who becomes aware of the case to make a report. Unlike other safeguarding concerns the reporting responsibility cannot be transferred e.g. to a designated named person for safeguarding.
This mandatory reporting duty applies to:

- Health and Social Care professionals regulated by a body which is overseen by the Professional Standards Authority for Health and Social Care
- Qualified teachers or persons who are employed or engaged to carry out teaching work in schools and other institutions
- Social Care Workers

Mandatory direct reporting to the police is required if the professional has:
visually confirmed FGM has taken place and there is no reason to believe the act was carried out in relation to physical or mental health purposes or connected to labour or birth or directly experienced a verbal disclosure that FGM has been carried out.

It's important to note that professionals are not required to report directly to the Police in relation to at risk or suspected cases or where the woman is over 18 years. In these cases we will follow our usual safeguarding procedures and reporting protocols. However, as with all aspects of Child Protection, where there is a risk to life or likelihood of serious immediate harm, we will report the case immediately to police.

Visually Identified Cases

The reporting duty for visually identified cases only applies to cases discovered in the usual course of a professional's work. If genital examinations are not undertaken in the course of delivering a role, then the duty does not change this. Most professionals will visually identify FGM as a secondary result of undertaking another action. Staff in school SHOULD NOT examine a girl. It is possible however that a member of staff may see something which appears to show that FGM may have taken place e.g. changing a pad, assisting in toileting, SEN intimate care needs. In such circumstances the incident must be reported but should not conduct any further examination of the young person.

Verbal Disclosure

As with all safeguarding disclosures, it is not the duty of staff to interrogate or investigate whether FGM has been carried out. Staff should be aware that the girl may use alternative words or references rather than the specific term Female Genital Mutilation or FGM e.g. cut, cutting. Where appropriate to help enable the girl to share information staff should:

- find a quiet place to talk maintaining a calm approach, let the girl talk freely without leading the conversation
- listen carefully and accurately
- if asked not to tell anyone explain your safeguarding duty
- wherever possible use the girl's description to clarify any disclosure e.g. 'you said "special ceremony"- what did you mean?
- reassure telling was the right thing to do

The professional's responsibility to report to the police only applies when the young person makes a direct verbal disclosure. If another person makes an indirect disclosure about a girl the mandatory duty to report to the police does not apply, such disclosures will be handled in line with our usual processes for safeguarding concerns.

Making a Report to the Police

Reports under the mandatory duty will be made as soon as possible after a case is discovered. Reports will usually be made orally by calling the single non-emergency number 101, although written reports are also permitted. The professional will be required to share the following information:

- an explanation of why they are making a report under FGM duty
- their details (name, place of work, role, contact details and availability)
- the girl's details (name, age, date of birth and address)

The Police will issue a reference number which will be recorded in our safeguarding record. The record will include details of the discussion and any decisions made.

Action Following a Report to the Police

In line with safeguarding best practice the girl's parents or guardians will be informed that a report has been made to the Police unless this action is deemed to put the girl or anyone else at risk. This will be discussed with the DSL. All further action taken will be in line with our general safeguarding responsibilities, which may involve participating in a multi-agency response.

Failure to Comply with the Duty

Failure to comply with mandatory FGM reporting to the Police is dealt with by the performance measures in place for each profession and through staff disciplinary procedures. Should the school dismiss a teacher, or if a teacher resigns before dismissal occurs, the Governing Body may refer the matter to the National College of Teaching and Leadership (NCTL), as regulators of the teaching profession.

The Role of the Governing Body

At Fairfield School we recognise that FGM Duty encompasses responsibilities for staff, in line with our safeguarding arrangements. All FGM duty concerns will be immediately reported to the Head teacher and named Safeguarding Governor. Together they will monitor ongoing liaison with the police and other multi-agency partners.

The Role of the DSL

• It is the DSL's role to implement the school's FGM Policy with the support of the Senior Leadership Team and Governing Body

• It is the DSL's role to ensure there is a collective responsibility for safeguarding and that all staff are aware of the FGM policy and related policies, protocols and procedures

• The DSL will promote FGM Duty when overseeing the development of the curriculum and other aspects of school life

• The DSL will inform the named Safeguarding Governor of all FGM Duty concerns/ referrals.

The Role of all Staff: teaching and non-teaching

• all staff will attend safeguarding and FGM training and have access to school's FGM Policy, protocols and procedures

• all staff will strive to safeguard pupils in all aspects of the FGM agenda

• all staff have a responsibility to monitor and, where necessary, any concerns will be reported to the DSL / Head teacher

Policies, Protocols and Procedures

Fairfield School has a range of supporting policies, protocols and procedures. All policies and protocols have been devised by the DSL and ratified by the school's Governing Body, and are regularly reviewed. These documents include our arrangements for the following areas:

• Safeguarding and Child Protection procedures

• Safe recruitment and selection processes including Disclosure and Barring Service (DBS), vetting checks and overseas vetting checks

• Delivery of safeguarding as part of the curriculum

• Students, volunteers, visitors in school

Procedures

• The pupils at Fairfield School may not always be able to make a disclosure, so staff are aware of activity such as holidays to a high risk country, family situation or cultural background

• If a child is suspected to be at risk from FGM, either by disclosure or by events around the child, staff are to report any concerns immediately to the DSL

• The DSL will then contact Kirklees Children with Disabilities Team, and the police to alert them of this risk

• Details will be kept on CPOMS

•Fairfield Safeguarding, Child protection and related policies are on the Fairfield School website

All students, volunteers, visitors are provided with information on our safeguarding procedures and will have a nominated point of contact in school to which any concerns should be reported. This includes any concerns regarding the practice of visitors.

We believe every pupil should be able to participate in school activities in an enjoyable and safe environment and be protected from harm. This is the responsibility of every member of staff at Fairfield School.