Female Genital Mutilation: Safeguarding Girls and Women

Guidance and Procedure

Last updated: January 2017

RELATED POLICIES AND PROCEDURES

- What to do if you have a Concern about a Child in Buckinghamshire
- BSCB Information Sharing Code of Practice

1. Introduction

1.1. Female Genital Mutilation (FGM) is considered child abuse in the UK and is a grave violation of the human rights of girls and women. It has intolerable long-term physical and emotional consequences for the survivors and has been illegal in the UK for over 30 years. It is estimated that 137,000 girls and women in the UK are affected by this practice,[i] but this is likely to be an underestimation.[ii]

1.2. This multi-agency FGM guidance and procedure is relevant for agencies working with both children and adults. It has been produced to support agencies in Buckinghamshire to work effectively together to tackle FGM. **Agencies should continue to refer to relevant specialist professional guidance alongside this document.**

1.3. This document should also be read in conjunction with:

- Government Statutory Guidance on Female Genital Mutilation. This should be read and followed by all professionals who are working to safeguard and promote the welfare of children and vulnerable adults.
- BSCB Thresholds document and procedure for what to do if you are concerned about a child in Bucks
- The government's procedural information for professionals subject to the FGM mandatory reporting duty

2. Key Principles

2.1. All agencies/services should be alert to the possibility of FGM, and their approach should include a preventative strategy that focuses upon education, as well as the protection of girls / women at risk of significant harm.

2.2. The following principles should be adhered to:

- The safety and welfare of the girl / woman is paramount.
- All agencies/services and staff, including volunteers, should act in the interest of the rights of the girl / woman, as stated in the UN Convention on the Rights of the Child (1989)
- All decisions or plans for the girl / woman should be based on thorough assessments which have a sensitive approach to the issues of age, race, culture, gender, religion. Stigmatisation of the girl / woman or their specific community should be avoided.
- Buckinghamshire's agencies/services should work in partnership with members of affected local communities, to develop support networks and appropriate education programme.

3. Legal Status

3.1. The momentum to end FGM has grown significantly in the last four years due to various campaigners raising awareness of the issue and the government strengthening its stance on FGM.[iii] The UK government is committed to eradicating this harmful practice within a generation[iv] and has strengthened the legal framework to help achieve this.

Mandatory Reporting Duty (October 2015): Introduced under Section 5B of the 2003 Female Genital Mutilation Act, the duty requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s to the police which they identify in the course of their professional work. See Section 12 of this guidance for further details

Serious Crime Act (2015): This strengthened the 2003 Female Genital Mutilation Act with the following measures:
1) **Created a new offence** of failing to protect a girl from FGM. Anyone with parental responsibility for a girl under 16 who was mutilated will be potentially liable if they did not take steps to prevent it.
2) **Granted** life-long anonymity for persons against whom a female genital mutilation offence is alleged to have been committed.
3) **Enabled** a court to grant an "FGM protection order" for the purposes of:
   a) protecting a girl against the infliction of a genital mutilation offence, or
   b) protecting a girl against whom any such offence has been committed.

Female Genital Mutilation Act (2003): This replaced the 1985 Act in England, Wales and Northern Ireland.[1]

Made the following an offence:
1) To aid, abet, counsel or procure a person who is not a UK national or permanent UK resident to undertake a relevant act of FGM outside the UK.
2) To aid, abet, counsel or procure a girl to excise, infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris.
On conviction of indictment: a fine, or imprisonment for a term not exceeding 14 years, or both.

Prohibition of Female Circumcision Act (1985): It became an offence for any person:
a) to excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person.
b) to aid, abet, counsel or procure the performance by another person of any of those acts on that other person's own body.
On conviction or indictment: a fine or imprisonment for a term not exceeding 14 years or both.

4. Definition and Types of Female Genital Mutilation

4.1. The World Health Organisation (WHO) defines female genital mutilation as: "*all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons*".

4.2. FGM has been classified by the WHO into four types:

- **Type 1 - Clitoridectomy:** Partial or total removal of the clitoris and, rarely, the prepuce (the fold of skin surrounding the clitoris) as well.
- **Type 2 - Excision:** 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).
- **Type 3 - Infibulation:** 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. This is the most extreme form of FGM.
- **Type 4 - Other:** All other harmful procedures to the female genitalia for non-medical purposes for example, pricking, piercing, tattooing, incising, scraping and cauterising the genital area. Type 4 is noted by professionals to be common among practising communities. However, it is also the type that often goes unnoticed and therefore not recorded.

4.3. FGM is known by a number of names, including female genital cutting or circumcision. The names 'FGM' or 'cut' are increasingly used at the community level, although they are still not always understood by individuals in practicing communities, largely because they are English terms. Appendices B and C provide further information to help professionals talk about FGM with different communities, including the various names that may be used for FGM across different communities.

4.4. Those who are affected by FGM may be born to parents from FGM practising communities or women resident in the UK who were born in countries that practice FGM. These may include (but are not limited to) immigrants, refugees, asylum seekers, overseas students or the wives of overseas students.

4.5. The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out at any time, including when the girl is newborn, during childhood, adolescence, at marriage or during the first pregnancy. However, in the majority of cases FGM takes place between the ages of 5-8 and therefore girls within that age bracket are at a higher risk.

5. Prevalence

5.1. The Buckinghamshire Strategy for Tackling FGM contains more detailed information on the prevalence of FGM at an international, national and local level. A summary of key points is listed below.

5.2. The International Picture

- Globally 100 – 140 million women and girls have undergone FGM and a further 3 million girls undergo FGM every year in Africa. [v]
- Most of the females affected live in 28 African countries, with some also from parts of the Middle East and Asia. In Somalia, Sudan, Djibouti, Egypt, Guinea and Sierra Leone, FGM prevalence rates are over 90%.

5.3. The National Picture

5.3.1. The prevalence of FGM in the UK is difficult to estimate because of its hidden nature. However, a report published in July 2014[vi] estimated that as of 2011:

- Approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM;
- Approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM;
- Combining the figures for the three age groups, an estimated 137,000 women and girls with FGM, born in countries where FGM is practised, were permanently resident in England and Wales in 2011.

5.4. The Local Picture

5.4.1. There is an uneven distribution of cases of FGM around the country, with more occurring in those areas of the UK with larger communities from the practising countries. Whilst this would not make Buckinghamshire an area of high FGM prevalence, there are some areas close by that are likely to have far more cases such as Oxford, Reading, Slough and Milton Keynes.

5.4.2. The Buckinghamshire Joint Strategic Needs Assessment (JNSA) has used 2011 census data to estimate the number of women aged 15-49 years in Buckinghamshire and within each of the four Districts who may have undergone FGM.[vii]

- Approximately 792 (0.16% of the total population) Buckinghamshire resident women aged 15-49 years may have undergone FGM. In addition there will also be women aged 50 and over who have undergone FGM who are not included in these estimates.

- The highest number of women aged 15-49 estimated to have undergone FGM live in Wycombe District Council, although the proportion of the total population is slightly higher in South Bucks than in other Districts.
- In Wycombe District Council there are estimated to be 257 women (0.15% of total residents) who have had FGM, 238 (0.14% of total residents) in Aylesbury Vale District Council, 161 (0.24% of total residents) in South Bucks District Council, and 136 (0.15% of total residents) in Chiltern District Council.

5.4.3. Since the mandatory reporting duty was implemented in October 2015 (see section 12), no cases of FGM in Buckinghamshire have been reported to Thames Valley Police that could be recorded as a crime under Home Office Counting Rules.

5.4.4. Data on FGM prevalence can also be derived from The Female Genital Mutilation (FGM) Enhanced Dataset (see section 13). This is a repository for individual level data collected by healthcare providers in England. As of September 2016, all statistical releases relating to Buckinghamshire have data suppressed for statistical reasons, indicating between 0 and 4 reported cases for each reporting period.

5.4.5. **It is important professionals understand how to follow relevant reporting procedures so that we have an accurate picture of the prevalence of FGM in Buckinghamshire. Professionals should also be aware that as the demographics of our community shift over time, it is possible that we will see an increase in residents from those countries where FGM is prevalent.**

6. Cultural Context

6.1. The procedure is often carried out by an older woman in the community, who may see conducting FGM as a prestigious act.

6.2. The procedure can involve the girl / woman being held down on the floor by several women. It is often carried out without medical expertise, attention to hygiene or an anaesthetic. Instruments used have been known to include un-sterilised household knives, razor blades, broken glass and stones. The girl / woman may undergo the procedure unexpectedly, or it may be planned in advance.

6.3. The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. Increasingly, however, FGM is being performed by health care providers.[viii]

6.4. The WHO cites a number of reasons for the continuation of FGM, such as:

- Custom and tradition
- A mistaken belief that FGM is a religious requirement
- Preservation of virginity/chastity
- Social acceptance, especially for marriage
- A belief that it will increase marriageability
- Hygiene and cleanliness
- Increasing sexual pleasure for the male
- Family honour
- A sense of belonging to the group and conversely the fear of social exclusion
- Enhancing fertility

6.5. Religion and FGM

6.5.1. Muslim scholars and faith leaders, including the Muslim Council of Britain, have condemned the practice and are clear that FGM is an act of violence against women. Further, scholars and clerics have stressed that Islam forbids people from inflicting harm on others and therefore the practice of FGM is counter to the teachings of Islam.

6.5.2. The Bible does not support this practice nor is there any suggestion that FGM is a requirement or condoned by Christian teaching and beliefs.

7. Signs and Indicators

7.1. Specific factors that may heighten a child's risk of being subjected to FGM include:

- Girl's mother has undergone FGM
- Other family members have undergone FGM
- Father comes from a community known to practice FGM
- Mother / family have limited contact with people outside of her family
- Parents have poor access to information about FGM and do know about the harmful effects of FGM or UK law
- Girl/family has limited level of integration within UK community
- Girl/women repeated fail to attend or engage with health and welfare services
- A family elder such a grandmother is very influential within the family and is / will be involved in the care of the girl

7.2. Indications that FGM may be about to take place include:

- Parents say they or a relative will be taking the girl abroad for a prolonged period – this may not only be to a country with high prevalence, but this would be more likely to lead to a concern
- Girl has spoken about a long holiday to her country of origin / another country where the practice is prevalent

- Girl has attended a travel clinic or equivalent for vaccinations / anti-malarials
- FGM is referred to in conversation by the child, family or close friends of the family (see Appendix C for traditional and local terms) – the context of the discussion will be important
- Girl withdrawn from PHSE lessons or from learning about FGM at school
- Girl has confided in another that she is to have a 'special procedure' or to attend a 'special occasion'. Girls has talked about going away 'to become a woman' or to 'become like my mum and sister'
- The girl or a sibling may ask for help
- A parent or family member expresses concern that FGM may be carried out on a child

7.3. Indications that FGM may have already taken place include:

- Girl is reluctant to undergo any medical examination
- Girl spends long periods of time in the bathroom / toilet / away from the classroom
- Girl has spoken about having been on a long holiday to her country of origin / another country where the practice is prevalent
- Increased emotional and psychological needs such as withdrawal, depression or significant changes in behaviour
- Girl presents to GP or A&E with frequent urine, menstrual or stomach problems
- Girl talks about pain or discomfort between her legs
- Girl has difficulty walking, sitting or standing and looks uncomfortable
- Girl finds it hard to sit still for long periods of time, which was not a problem previously
- Girl is avoiding physical exercise or requiring to be excused from PE lessons without a GP letter
- A child may ask for help or confides in a professional that FGM has taken place
- Mother of family member discloses that FGM has taken place

8. Health Implications of FGM

8.1. Short term consequences of FGM may include:[ix]

- Severe pain during the procedure and healing
- Shock, which may be caused by pain and / or haemorrhage
- Excessive bleeding
- Difficulty in passing urine and faeces due to swelling and pain
- Infections or septic shock are common, particularly as the procedure can be carried out in unhygienic conditions and/or with instruments that are not sterilised.

- Psychological consequences due to the pain, shock and use of physical force by those performing the procedure
- Death can be caused by haemorrhage or infections
- Blood born viruses (for example Hepatitis B and C and HIV) and Tetanus are also a potential risk due to non-sterile equipment being used.

8.2. Long term consequences may include:

- Chronic pain
- Infections, particularly of the reproductive and urinary tracts
- Abscesses, painful cysts or keloids (excessive scar tissue formed at the site of the cutting)
- Menstrual problems
- Birth complications such as prolonged labour, recourse to caesarean section, postpartum haemorrhage and tearing
- Danger to the new-born, with high death rates and reduced Apgar scores
- Increased risk of HIV infection and transmission in adulthood due to an increased risk of bleeding during intercourse
- Psychological consequences such as fear of sexual intercourse, post-traumatic stress disorder, anxiety, depression and memory loss
- Loss of pleasure in sex and / or loss of ability to experience orgasm

8.3. Results from research in practicing African communities are that women who have undergone FGM have the same levels of Post-Traumatic stress Disorder as adults who have been subject to early childhood abuse. Research also indicates that the majority of the women (80%) suffer from affective (mood) or anxiety disorders.[x]

9. Procedure for responding to FGM

9.1. The following circumstances relating to FGM require identification and intervention:

- It is known that an adult woman has undergone FGM and there are no children or pregnant women in the household
- It is known that an adult woman has undergone FGM and there is an unborn child / female child(ren) in the family or household. However, FGM has not been identified in them and there are no signs that FGM is imminent
- It is known that an adult woman has undergone FGM, there is a female child / children in the family or household and there is suspicion FGM has occurred or may be imminent
- A female child / children have been subjected to FGM and this is confirmed by a disclosure or evident on examination.

9.2. Please refer to the following flow diagram to guide you through the procedure in Buckinghamshire for each of these circumstances.

Multi-Agency FGM Pathway

FGM / risk of FGM is identified or suspected, for example through

- Routine enquiry
- Disclosure
- Physical findings during examination
- Girl talks about attending 'special celebration' in high prevalence country of origin

See Section 7 of Multi-Agency FGM Guidance for further detail on potential signs and indicators of FGM

Explore consequences of FGM for the woman / girl (physical / psychological / legal) and any ongoing risk of FGM for any children / unborn children in the household. Avoid using a family member as an interpreter.

- Complete most relevant FGM screening tool (See Appendix A of Multi-Agency FGM Guidance)
- Provide information on the illegal status of FGM in the UK
- Inform that you will need to share information with the GP and any other relevant professional involved in the girl / woman's care (e.g. Health Visitor, midwife)
- Provide and discuss leaflet on FGM in appropriate language (see section 13 of the FGM Guidance for suggested leaflets) and advise on available support

Adult female identified as FGM victim and no female children or pregnant women in the family / household.

Treat as **LOW / FUTURE risk**

- Discuss with woman
- Ongoing preventative work with woman & family recommended
- Refer to services to manage psychological / physical / legal impact

- Inform GP with consent
- Flag internal records

Adult female identified as FGM victim and unborn child / female child(ren) in family / household. No FGM or signs of imminent FGM identified in them.

Treat as **LOW / FUTURE risk**

- Discuss with family **if safe to do so**
- Ongoing preventative work with woman & family recommended
- Refer to services to manage psychological / physical / legal impact

- Inform GP & other relevant services (eg midwife, social worker, health visitor). If consent is not given professionals may wish to reconsider risk level risk
- Flag internal records

Female childr(ren)/ vulnerable adult* in family/ household and:

- Suspicion FGM has occurred
- Signs of possible procedure suspected
- Signs procedure is planned / imminent

Treat as **HIGH / IMMEDIATE risk**

- Refer child to Children's Social Care using Multi-Agency Referral Form (MARF)
- Refer vulnerable adult to Adult Social Care
- Call Police on 999 if immediate action required

Female child(ren) / vulnerable adult* in family / household already subjected to FGM – confirmed by disclosure or evident upon examination.

Treat as **HIGH / IMMEDIATE risk**

- Refer child to Children's Social Care using MARF. Agencies subject to **Mandatory Reporting Duty** must also report to Police on 101
- Consider referring vulnerable adult to Adult Social Care
- Call Police on 999 if immediate action required

For child: Multi-agency strategy discussion led by Children's Social Care

- Legal advice may sought and action taken
- Consider if medical examination at SARC (Sexual Assault Referral Centre) is required
- Section 47 Enquiry which may lead to Child Protection Conference and Plan
- If Child Protection Plan is not keeping girl safe from harm, Children's Social Care will consider legal proceedings including FGM Prevention Order, Supervision Order or Care Order.

For vulnerable adult: Multi-agency response to be agreed in-line with local safeguarding procedures.

9.3. All professionals are encouraged to complete a risk screening tool for any case of FGM, whether it is known or suspected. This will help with the assessment of the situation, decision making and record keeping. A screening tool is provided at Appendix A.

9.4. **In all cases, professionals should consider dialling 999 if immediate Police action is needed.**

9.5. In cases where it is **known that a child has undergone FGM** (if a professional has seen evidence of it or heard about it directly from the child) professionals must make a referral to Children's Social Care using the Multi Agency Referral Form (MARF). Regulated professionals working within health or social care, and teacher, must also act in accordance with the FGM Mandatory Reporting Duty (see section 12) by reporting the case without delay to the police on 101.

9.6. If there are reasons to **suspect that a child has been abused through FGM**, (for example, see signs and symptoms listed in Section 7), the professional or the Safeguarding Lead from the organisation should make a referral to Children's Social Care using the MARF.

9.7. In cases where it is **known or suspected that a vulnerable adult has undergone FGM**, the professional should consider making a referral to Adult Social Care. Consideration should be given to how recently the FGM was undertaken and the impact on the individual. If there are any doubts about whether a referral should be made, the professional can ring the Multi-Agency Safeguarding Hub (MASH) for advice on 0800 137 915.
* In this content, a vulnerable adult is defined as someone who has care and support needs.[1]

9.8. If there is a perception that **a child may be at risk of FGM in the future** it is important to determine whether this risk is high and immediate, or low and future. All professionals should complete an FGM risk screening tool (see Appendix A) to help with the assessment of the situation, decision making and record keeping.

9.9. If there is concern that a **vulnerable adult may be at risk of FGM in the future** it is important to determine whether this risk is high and immediate, or low and future. All professionals should complete an FGM risk screening tool (see Appendix A) to help with the assessment of the situation, decision making and record keeping.
* In this content, a vulnerable adult is defined as someone who has care and support needs.[2]

[1] The Care Act 2014 sets out a minimum threshold in term of adult care and support needs: www.legislation.gov.uk/ukpga/2014/23/contents/enacted

9.10. An example of a high/immediate level of risk is if a girl is talking about a 'special' ceremony, going on a long holiday, or if a woman who has had FGM and gave birth to a girl admits to be supporting the practice.

9.11. An example of a low/future level of risk is when a woman who has had FGM and gave birth to a girl speaks against cutting her daughter.

9.12. Professionals should see to undertake a holistic assessment of the family given the pressure to undertake FGM can come from other members of the family such as female family elders.

9.13. In all cases the risk to other female children in the family and extended family must be considered, and all parents/carers should be given information on FGM explaining that it is illegal to carry it out in the UK or to take their child abroad and they have a statutory responsibility to protect their child from this practice.

9.14. If it has been determined that the risk is high/immediate it is important to act quickly – before the child is abused by being subjected to FGM in the UK, or taken abroad to undergo the procedure.

9.15. Every attempt should be made to work with parents to prevent abuse of FGM occurring. All professionals should ensure that parental co-operation is achieved wherever possible, including the use of community organisations and / or community leaders to facilitate the work with parents / family.

9.16. However, if it is not possible to reach an agreement and if the parents cannot guarantee that they will not proceed with the mutilation, the first priority is protection of the girl / woman and appropriate measures should be taken such as an Emergency Protection Order, Police Protection or an FGM Prevention Order should be sought.

9.17. There may be cases where the risk is determined as low at the time of the assessment, for example if a mother who has had FGM speaks against mutilating her daughter. However, as the child is growing up the risk might change from low to high and it is important that all agencies follow their internal procedures, and complete and attach an appropriate risk screening tool to the child's health records for future reference.

9.18. Regardless of the age of the girl or woman, or when the procedure took place, all professionals should make appropriate referrals to support those suffering from the physical or emotional consequences of FGM.

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[2] The Care Act 2014 sets out a minimum threshold in term of adult care and support needs: www.legislation.gov.uk/ukpga/2014/23/contents/enacted

9.19. There is no requirement for automatic referral of other adult women with FGM to adult social services or the police. Healthcare professionals should be aware that any disclosure may be the first time that a woman has ever discussed her FGM with anyone. Referral to the police must not be introduced as an automatic response when identifying adult women with FGM, and each case must continue to be individually assessed. Healthcare professionals should seek to support women by offering referral to specialist organisations that can provide support, and for possible clinical intervention or other services as appropriate. The wishes of the woman must be respected at all times.

10. Health professionals

10.1. Health professionals in GP surgeries, sexual health clinics and maternity services are the most likely to encounter a girl or woman who has been subjected to FGM. A question about FGM should be incorporated when the routine patient history is being taken and professionals should consider the advice provided in Section 13 about talking to a child or woman about FGM.

11. Information Sharing

11.1. As with any form of child abuse, when FGM / risk of FGM is identified it is important that information is shared appropriately with relevant professionals. This will help ensure the right measures are put in place to safeguard against the risk of FGM or to meet the physical and psychological needs of those who have undergone FGM.

11.2. You should discuss openly with the girl / woman and, where possible, with the parents of a girl, how, why and with whom information will be shared and seek their consent. **However, be aware that by alerting a girl's family, you may place her at increased risk of harm.** Professionals should take this into account and remember that consent for information sharing is not required where there is evidence the child is suffering or at risk of suffering significant harm, or in order to prevent a criminal offence from taking place.

11.3. The risk of FGM can change over time and if information has been shared then professionals who are in contact with a child in the future may be in a good position to spot signs of imminent or actual FGM. For example, if a midwife has shared information with a GP that a mother has had FGM, when her daughter attends the GP Practice with urine and stomach problems this may prompt early questioning about possible FGM.

11.4. Information should always be shared in line with the BSCB Information Sharing Code of Practice and the Government's information sharing advice for safeguarding practitioners.

11.5. The multi-agency pathway diagram provides further guidance on information sharing in relation to FGM. However, if you are unsure whether you can share information, then please refer to the BSCB Information Sharing Code of Practice and the government guidance. If you are in doubt, speak to your designated safeguarding lead as soon as possible.

11.6. For known cases of FGM, those agencies subject to the Mandatory Reporting Duty must share information in order to make a report (see below). Whilst it is good practice to discuss that you will need to share information to make a report, consent is not required. In cases where mandatory reporting has taken place, this does not negate the need to share information with other relevant professionals.

12. Mandatory Reporting

12.1. On the 31st October 2015 a new duty was introduced that requires all regulated professionals working within health or social care, and teachers, to report 'known' cases of FGM in girls aged under 18 to the police. This is an individual rather than a corporate duty.

12.2. 'Known' cases are those where either a girl discloses that FGM has been carried out on her, or where a professional observes physical signs on a girl appearing to show that FGM has been carried out. For example, if a doctor sees that a girl aged under 18 has had FGM they will need to make a report to the police. Similarly if a girl tells her teacher that she has had FGM, the teacher will need to report this to the police.

12.3. To make a report you should call the Police on 101 and state you wish to make a report under the FGM mandatory reporting duty. Reports should be made as soon as possible after the FGM is discovered, and best practice is to complete the report by the close of the next working day.

12.4. All agencies should ensure relevant frontline staff understand this duty and how to make a report. The professional consequences for failing to report a known case of FGM in a child are very serious.

12.5. Professionals subject the duty and their employers should refer to the government guidance on mandatory reporting. This includes a list of those professionals covered by the report and more detail on how to make a report.

12.6. The government has also published additional information on the mandatory duty for health care professionals in England

13. The FGM Enhanced Dataset

13.1. Some agencies will also need to submit data on FGM to the FGM Enhanced Dataset.

13.2. This dataset was set up to collect information on the prevalence of FGM from across the NHS in order to support a response to FGM that is based on an understanding of need. The Information Standard (SCC 12026 FGM Enhanced Dataset) requires clinicians across all NHS healthcare settings to record in clinical notes when patients with FGM are identified, and what type it is.

13.3. It became mandatory for all acute trusts to collect and submit the FGM Enhanced Dataset from 1st July 2015 and all mental health trusts and GPs from 1st October 2015. Community services within mental health trusts can participate. Sexual Health and GUM clinics do not need to submit FGM information but the legal obligation to appropriately share information for safeguarding purposes still applies.

13.4. All relevant agencies should ensure their staff are familiar with these requirements. Further information on the dataset can be found at www.digital.nhs.fgm.

14. Talking to women and children

14.1. Professionals discussing FGM with a child or woman suspected to be abused through FGM should tailor their response appropriately, including:

- Arranging for an interpreter if this is necessary and appropriate (avoid using a family member as an interpreter)
- Creating an opportunity for the child / woman to disclose, seeing the child / woman on their own
- Using simple language and asking straightforward questions
- Giving the opportunity to be accompanied by someone they know and trust
- Using terminology that the child / woman will understand, e.g. the child / woman may not view the procedure as abusive
- Being sensitive to the fact that the child / woman will be loyal to their parents
- Being willing to listen and giving the child / woman time to talk
- Getting accurate information about the urgency of the situation, if the child is at risk of being subjected to the procedure
- Giving the message that the child / woman can come back to you again
- Being sensitive to the intimate nature of the subject
- Making no assumptions

- Being non-judgemental (condemning the practice, but not blaming the girl/woman)
- Understanding how she may feel in terms of language barriers, culture shock, that she, her partner, her family are being judged
- 'Circumcised' is not medically correct and although 'mutilation' is the most appropriate term, it might not be understood or it may be offensive to a woman from a practising community who does not view FGM in that way. Different terminology will be appropriate to the different cultures (see Appendix C)
- Giving a clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM if / when they have daughters
- Carrying out Mental Capacity Assessment as necessary

14.2. Professionals can refer to 'Key questions for interviewing women with FGM' (Appendix B) to start a conversation on FGM. The following leaflets may also be useful for practitioners who are discussing FGM with women and children:

- FGM: The Facts (Home Office)
- More about FGM (Department of Health) – available in several different languages
- A guide on FGM for young people (Forward UK)

15. Requests for re-infibulation

15.1. After childbirth, a girl / woman who has been deinfibulated (a surgical procedure to open up the scar tissue to restore the normal vaginal opening, commonly called a 'reversal') may request re-infibulation. All girls / women who have undergone FGM (and their partners or husbands) must be told that re-infibulation is against the law and will not be done under any circumstances. Each woman should be offered counselling to address how things will be different for her afterwards.

15.2. If a woman continues to request re-infibulation this should be treated as a potential child protection concern, as the girl / woman's apparent reluctance to comply with UK law, may have implications for her own children if they are female. Professionals should consult with their agency's designated safeguarding lead and make a referral to Children's Social Care using the MARF.

16. Interpreters and Independent Mental Capacity Advocates

16.1. Wherever possible, a professional female interpreter should be used for a girl / woman known to have limited English. This will reduce misunderstanding, increase the likelihood of identification of FGM and any additional physical, psychological and social concerns. Use of family

members is not advised as they may influence decisions and inhibit true expression of the woman's feelings.

16.2. Always brief / debrief the interpreter, explain the purpose of the meeting, ensure they understand the issue and are happy to talk about FGM. We must remain aware that the interpreter may have experienced FGM, hence may have difficulty discussing it. Alternatively, they may view FGM as a valuable practice, hindering the interpretation process.

16.3. Always check that the girl / woman is happy to continue with the chosen interpreter, as communities affected by FGM are often small and therefore interpreters may be known socially by the girl / woman. The importance of confidentiality should be stressed to all parties involved.

16.4. In the case of an adult with care and support needs, it may be necessary to appoint an Independent Mental Capacity Advocate (IMCA) to support them with decision making. Further information, including how to book n IMCA can be found at: www.pohwer.net/buckinghamshire

Appendix A FGM Screening Tool / Risk Assessment

This section provides 4 short risk assessments that can be used by relevant professionals in the following scenarios:

1. **Child under 18 years old:** Use when considering whether a child has had FGM

2. **Child under 18 years old:** Use when considering whether a child may be at risk of FGM or whether there are other children in the family for whom a risk assessment may be required.

3. **Non-Pregnant woman over 18 years old:** Use when considering whether any female children are at risk of FGM, whether there are any other children in the family for whom a risk assessment may be required, or whether the woman herself is at risk of further harm in relation to FGM.

4. **Pregnant woman:** Use when considering whether the unborn child, or other female children in the family are at risk of FGM or whether the woman herself is at risk of further harm in relation to FGM.

NB, all of these assessments tools can also be used for adults with care and support needs.

FGM Risk Assessment Tool for Child or Young Adult (under 18)

Please use this tool when considering whether a child has had FGM.

Indicator	Yes	No	Details
CONSIDER RISK			
Girl is reluctant to undergo any medical examination			
Girl has difficulty walking, sitting or standing or looks uncomfortable			
Girl finds it hard to sit still for long periods of time, which was not a problem previously			
Girl presents to GP or A&E with frequent urine, menstrual or stomach problems			
Increased emotional and psychological needs eg. withdrawal, depression, or significant change in behaviour			
Girl avoiding physical exercise or requiring to be excused from PE Lessons without a GP's letter			
Girl has spoken about having been on a long holiday to her country of origin/another country where the practice is prevalent			
Gil spends a long time in the bathroom/toilet/long periods of time away from the classroom			
HIGH OR IMMEDIATE RISK			
Girl asks for help			
Girl confides in a professional that FGM has taken place			
Mother/family member discloses that female child has had FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM should be referred to Children's Social Care

Name _____
DOB _____
NHS number _____
Completed by _____
Initial/ On-going assessment

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

High or Immediate risk – if you identify one or more high or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should refer to Children's Social Care in line with the BSCB multi-agency FGM pathway

Any action taken should reflect the urgency of the situation. Where emergency measures are required consider calling the Police on 999.

Professionals subject to the mandatory reporting duty must report 'known' cases of FGM to the Police on 101.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

FGM Risk Assessment Tool for Child or Young Adult (under 18)

Please use this tool when considering whether a child is at risk of FGM, or whether there are other children in the family for whom a risk assessment may be required.

Indicator	Yes	No	Details
CONSIDER RISK			
Child's mother has undergone FGM			
Other female family members have had FGM			
Father comes from a community known to practice FGM			
A Family Elder such as Grandmother is very influential within the family and is/will be involved in the care of the girl			
Mother/Family have limited contact with people outside of her family			
Parents have poor access to information about FGM and do not know about the harmful effects of FGM or UK law			
Parents say that they or a relative will be taking the girl abroad for a prolonged period – this may not only be to a country with high prevalence, but this would more likely lead to a concern			
Girl has spoken about a long holiday to her country of origin/another country where the practice is prevalent			
Girl has attended a travel clinic or equivalent for vaccinations/anti-malarials			
FGM is referred to in conversation by the child, family or close friends of the child (see Appendix Three for traditional and local terms) – the context of the discussion will be important			
Sections missing from the Red book. Consider if the child has received immunisations, do they attend clinics etc			
Girl withdrawn from PHSE lessons or from learning about FGM - School Nurse should have conversation with child			
Girls presents symptoms that could be related to FGM – continue with questions in part 3			
Family not engaging with professionals (health, school, or other)			
Any other safeguarding alert already associated with the Always check whether family are already known to social care			

Name _____
DOB _____
NHS number _____
Completed by _____
Initial/ On-going assessment

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

High or immediate risk – if you identify one or more high or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should refer to Children's Social Care in line with the BSCB multi-agency FGM pathway

Any action taken should reflect the urgency of the situation. Where emergency measures are required consider calling the Police on 999.

Professionals subject to the mandatory reporting duty must report 'known' cases of FGM to the Police on 101.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Indicator	Yes	No	Details
HIGH OR IMMEDIATE RISK			
A child or sibling asks for help			
A parent or family member expresses concern that FGM may be carried out on the child			
Girl has confided in another that she is to have a 'special procedure' or to attend a 'special occasion'. Girl has talked about going away 'to become a woman' or 'to become like my mum and sister'			
Girl has a sister or other female child relative who has already undergone FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM should be referred to Children's Social Care.

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

High or immediate risk – if you identify one or more high or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should refer to Children's Social Care in line with the BSCB multi-agency FGM pathway

Any action taken should reflect the urgency of the situation. Where emergency measures are required consider calling the Police on 999.

Professionals subject to the mandatory reporting duty must report 'known' cases of FGM to the Police on 101.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

FGM Risk Assessment Tool for Non-Pregnant Women (over 18)

Please use this tool to help decide whether any female children are at risk of FGM, whether there are other children in the family for whom a risk assessment may be required or whether the woman herself is at risk of further harm in relation to her FGM.

Name _____
DOB _____
NHS number _____
Completed by _____
Initial/ On-going assessment

Indicator	Yes	No	Details
CONSIDER RISK			
Woman already has daughters who have undergone FGM – who are over 18 years of age			
Husband/partner comes from a community known to practice FGM			
Grandmother (maternal or paternal) is influential in family or female family elder is involved in care of children			
Woman and family have limited integration in UK community			
Woman's husband/partner/other family member may be very dominant in the family and have not been present during consultations with the woman			
Woman/family have limited/ no understanding of harm of FGM or UK law			
Woman's nieces (by sibling or in-laws) have undergone FGM Please note:– if they are under 18 years you have a professional duty of care to refer to social care			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment			
Family are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			
HIGH OR IMMEDIATE RISK			
Woman/family believe FGM is integral to cultural or religious identity			
Woman already has daughters who have undergone FGM – who are under 18 years of age			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be triggered if she is found to have FGM			

Please remember: any child under 18 who has undergone FGM should be referred to Children's Social Care.

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

High or Immediate risk – if you identify one or more high or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should refer to Children's Social Care in line with the BSCB multi-agency FGM pathway

Any action taken should reflect the urgency of the situation. Where emergency measures are required consider calling the Police on 999.

Professionals subject to the mandatory reporting duty must report 'known' cases of FGM to the Police on 101.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

FGM Risk Assessment Tool for Pregnant Women

Please use this tool to help you make a decision as to whether the unborn child (or other female children in the family) are at risk of FGM or whether the woman herself is at risk of further harm in relation to her FGM.

Indicator	Yes	No	Details
CONSIDER RISK			
Woman comes from a community known to practice FGM			
Woman has undergone FGM herself			
Husband/partner comes from a community known to practice FGM			
A female family elder is involved/will be involved in care of children/unborn child or is influential in the family			
Woman/family has limited integration in UK community			
Woman and/or husband/partner have limited/ no understanding of harm of FGM or UK law			
Woman's nieces of siblings and/or in-laws have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment.			
Woman's husband/partner/other family member are very dominant in the family and have not been present during consultations with the			
Woman is reluctant to undergo genital examination			
HIGH OR IMMEDIATE RISK			
Woman already has daughters have undergone FGM			
Woman requesting reinfibulation following childbirth			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have			
Woman says that FGM is integral to cultural or religious identity			
Family are already known to social care services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM should be referred to Children's Social Care

Name _____
DOB _____
NHS number _____
Completed by _____
Initial/ On-going assessment

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

High or Immediate risk – if you identify one or more high or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should refer to Children's Social Care in line with the BSCB multi-agency FGM pathway

Any action taken should reflect the urgency of the situation. Where emergency measures are required consider calling the Police on 999.

Professionals subject to the mandatory reporting duty must report 'known' cases of FGM to the Police on 101.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Appendix B: 3 Key Questions for discussing FGM with women

This is an amended version of the document developed by the Oxfordshire Safeguarding Children Board.

1. Known FGM women: Read any existing information you have relating to the woman and determine whether you need to go through screening tool again.

Start with a short discussion and introduction

As [health visitor/GPs/midwives] we are informed of a woman's medical history. I understand that you were cut/circumcised when you were a child. I understand that this is a sensitive subject/difficult for you. I know you have spoken about this previously to [health visitor/midwife/GP] but I would like to discuss this with you.

- *Is there anything I can help you with in this?*
- *Do you feel your daughter/s are at risk of being cut?*
- *Do you need any help or support for your own experience of being cut?*

Do FGM screening tool if this has not already been done by previous health professional. If not done and there is YES to any questions follow BSCB procedure

2. Not known if mother had FGM and her or partner from country/cultural background were FGM is significant risk.

Start with a short discussion and introduction

You / your partner are from [name country] where a high number of women are cut / circumcised when they are young girls. Women who have experienced this can find this traumatic. It affects their physical health, emotional health, childbirth and sexual relations. I would like to ask you a few questions. I appreciate this is a sensitive subject to talk about

- *Is this something that has happened to you? Have you been cut/circumcised when you were young?*
- *Has anyone in your family or partner's family been cut?*
- *Are there any influences/reasons why would you ever consider having your daughter cut/circumcised? (if yes, follow BSCB guidance)*
- *Do you feel that your daughter/s are at risk of being cut/circumcised by anyone in your family or in your circle of friends?*

If there is YES answered to any of the following, the FGM risk assessment tool should be done and BSCB procedure followed.

3. Universal

In some cultural backgrounds women are cut / circumcised when they are young girls. Women who have experienced this can find this traumatic. It affects their physical health, emotional health, childbirth and sexual relations.

- *Is this something you have knowledge or experience of?*
- *Do you need any further information?*
- *Do you need any further help or support?*

Appendix C Terms for FGM in different languages

Country	Term used for FGM	Language	Meaning
EGYPT	Thara	Arabic	Deriving from the Arabic word 'tahar' meaning to clean / purify
	Khitan	Arabic	Circumcision – used for both FGM and male circumcision
	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
ETHIOPIA	Megrez	Amharic	Circumcision / cutting
	Absum	Harrari	Name giving ritual
ERITREA	Mekhnishab	Tigregna	Circumcision / cutting
KENYA	Kutairi	Swahili	Circumcision – used for both FGM and male circumcision
	Kutairi was ichana	Swahili	Circumcision of girls
NIGERIA	Ibi / Ugwu	Igbo	The act of cutting – used for both FGM and male circumcision
	Sunna	Mandingo	Religious tradition / obligation – for Muslims
SIERRA LEONE	Sunna	Soussou	Religious tradition / obligation – for Muslims
	Bondo	Temenee	Integral part of an initiation rite into adulthood – for non Muslims
	Bondo / Sonde	Mendee	Integral part of an initiation rite into adulthood – for non Muslims
	Bondo	Mandingo	Integral part of an initiation rite into adulthood – for non Muslims
	Bondo	Limba	Integral part of an initiation rite into adulthood – for non Muslims
SOMALIA	Gudniin	Somali	Circumcision – used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word 'halal' i.e. 'sanctioned' – implies purity. Used by Northern & Arabic speaking Somalis
	Qodiin	Somali	Stitching / tightening / sewing refers to infibulation
SUDAN	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
	Tahoor	Arabic	Deriving from the Arabic word 'tahar' meaning to clean / purify
CHAD – the Ngama	Bagne		Used by the Sara Madjingaye
Sara subgroup	Gadja		Adapted from 'ganza' used in Central African Republic
GUINEA-BISSAU	Fanadu di Mindjer	Kriolu	Circumcision of girls

	Fanadu di Omi	Kriolu	Circumcision of boys
GAMBIA	Niaka	Mandinka	Literally to 'cut / weed clean'
	Kuyango	Mandinka	Meaning 'the affair' but also the name for the shed built for initiates
	Musolula Karoola	Mandinka	Meaning 'the womens side' / 'that which concerns women'

[i] http://www.nhs.uk/conditions/female-genital-mutilation/pages/introduction.aspx
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf
[ii] http://about-fgm.co.uk/about-fgm/world-prevalence/uk-prevalence/
http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/201/20105.htm
[iii] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/383075/Mandatory_Reporting_for_FGM_Consultation_Framework_v6.pdf
[iv] https://www.gov.uk/government/news/pm-hosts-girl-summit-2014-a-future-free-from-fgm-and-child-and-forced-marriage
[v] United Nations Children's Fund (2013). Female Genital Mutilation / Cutting: A Statistical overview and exploration of the dynamics of change. UNICEF, New York.
[vi] Equality Now and City University
[vii] Around 11,747 people (male and female, all ages) were recorded in the 2011 census as born in a country where FGM is practised. Approximately half of these residents were females and 61% of the population from the Black African/Caribbean ethnic group were in the 15-49 age group. Applying these proportions to the total residents who were born in a country where FGM is practised, the total number of females aged 15-49 were estimated by country of birth for Buckinghamshire and for each of the four Districts. The total number of women aged 15-49 years who may have had FGM was estimated by applying the FGM country specific prevalence to the above estimated number of women residents aged 15-49 who were born in a country where FGM is practised.
viii (World Health Organisation 2010)
ix Female genital mutilation fact sheet 2009
x (Behrendt A et al, 2005)

Buckinghamshire

BSCB

Safeguarding Children Board

Buckinghamshire Safeguarding Children Board
BSCB Procedure: Forced Marriage
August 2015

Version Control			
Version number	**Date**	**Author**	**Comments and nature of update**
V1.0	June 2011		Original Document
V2.0	August 2015		Revised by Policies and Procedures Sub Group
V3.0	October 2015	Sandra Parsons	Updated section 6.1 National Guidance and Advice

These procedures are based on 'Multi-Agency Practice Guidelines: **Handling Cases Of Forced Marriage'**, Foreign & Commonwealth Office 2009 and 'Forced Marriage and Learning Disabilities: **Multi-Agency Practice Guidelines'**, Foreign & Commonwealth Office 2010 and are focused on aspects of safeguarding children.

A 'forced' marriage (as distinct from a consensual 'arranged' marriage) is a marriage in which one or both spouses do not and/or cannot consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure. Duress cannot be justified on religious or cultural grounds.

Honour Based Violence (HBV) may be a feature of forced marriage and the BSCB has produced further guidance which is also available on the website.

1. POSSIBLE CONSEQUENCES OF FORCED MARRIAGE

1.1 Taking of dowry, forced repatriation, female genital mutilation, acid attacks, blood feuds, honour killings, abduction and homicide.

1.2 Many of these acts fall within the definition of domestic abuse.

1.3 Forced marriages of children may involve non-consensual and/or underage sex, emotional and possibly physical abuse and should be regarded as a child protection issue and referred to children's social care.

1.4 National guidance states that 85% of those seeking help concerning forced marriage are women and so this issue is primarily, but not exclusively, an issue of violence against girls and young women.

1.5 Whilst the majority of cases encountered in the UK involve South Asian families, partly reflecting the composition of the UK population, there have been cases involving families from East Asia, the Middle East, Europe, Norway and Africa. Some forced marriages take place in the UK with no overseas element, whilst others involve a partner coming from overseas or a British citizen being sent abroad.

2. FORCED MARRIAGE AND CHILDREN WITH LEARNING DISABILITIES

2.1 Research also indicates that the forced marriage of children and adults with learning disabilities is likely to be vastly underreported and can differ from the way in which forced marriage presents generally.

Person without a learning disability	**Person with a learning disability**
Duress always a factor	Duress may manifest itself differently, the person may even appear happy about the forthcoming marriage as they may not appreciate the consequences.
Person without a learning disability	**Person with a learning disability**

Victim often reports themselves that they may be or have been forced into marriage.	May report themselves or may need support to report. May be reliant on others to recognise what is happening and report or take action. By far the majority of cases come to the attention of statutory agencies through a third party.
More females than males reported to be forced into marriage. Most support services for forced marriage focused on meeting needs of females.	In the case studies identified through this research, proportions of males and females with learning disabilities being forced into marriage are similar. Services need to address needs of males and females.
Capacity to give or withhold informed consent to marriage.	May lack capacity to give consent to marriage. May not understand they are being forced into marriage. May be more easily coerced into marriage.
May be able to obtain support themselves if leave family or community (to find work, apply for benefits, housing, medical needs and so on), though they are often supported in accessing accommodation and other support services, particularly in the short term.	Often need ongoing support from a range of professionals in order that daily living needs are met (may include personal care, helping to eat, shopping, finances, social and leisure activities, work and so on). May need specific and specialist support if placed in a refuge. Males may find it difficult to obtain place of safety given limited availability of refuges to meet needs of males with or without a learning disability.

2.2 There are additional factors which may make someone with a learning disability more vulnerable. Some key motives for forcing people with learning disabilities to marry include:

- Obtaining a carer for the person with a learning disability.
- Obtaining physical assistance for ageing parents.
- Obtaining financial security for the person with a learning disability.
- Believing the marriage will somehow "cure" the disability.
- A belief that marriage is a "rite of passage" for all young people.
- Mistrust of the "system", mistrust of external (e.g. social care/health) carers.
- A fear that younger siblings may be seen as undesirable if older sons or daughters are not already married.
- The marriage being seen as the only option or the right option (or both) – no alternative.

3. LEGAL ASPECTS

3.1 **The Anti-social Behaviour, Crime and Policing Act (2014)** makes it a criminal offence to force someone to marry This includes:

- Taking someone overseas to force them to marry (whether or not the forced marriage takes place)
- Marrying someone who lacks the mental capacity to consent to the marriage (whether they're pressured to or not)
- Breaching a Forced Marriage Protection Order is also a criminal offence
- The civil remedy of obtaining a Forced Marriage Protection Order through the family courts will continue to exist alongside the new criminal offence, so victims can choose how they wish to be assisted

Forcing someone to marry can result in a sentence of up to 7 years in prison. Disobeying a Forced Marriage Protection Order can result in a sentence of up to 5 years in prison

3.2 In addition to the specific offences of forced marriage, there are still a number of other offences that may be committed. Perpetrators – usually parents or family members - may also be prosecuted for offences including threatening behaviour, assault, kidnap, abduction, theft (of passport), threats to kill, imprisonment and murder. For those under 16 other criminal offenses including cruelty to persons under 16 and child abduction may also be involved. The Crown Prosecution Service is responsible for making the decision for which offences(s) the perpetrator(s) should be prosecuted. Sexual intercourse without consent is rape, regardless of whether this occurs within a marriage or not. A woman who is forced into marriage is likely to be raped and may be raped until she becomes pregnant (WTSC 2010).

3.3 **The Forced Marriage Act (2007)** was brought in to protect those forced into marriage, whether children, teenagers or adults - and irrespective of background, gender, race or religion. The Act gives the courts a wide discretion to deal flexibly and sensitively with the circumstances of each individual case, employing civil remedies that will offer protection to victims without criminalising members of their family.

3.4 The Act gives victims the power to get Forced Marriage Protection Orders from the courts in whatever circumstances they find themselves. Under the Act, the court can order those forcing another into marriage to stop; or impose requirements upon them. If a person fails to comply with the court order they could be sent to prison for contempt of court.

3.5 Not all victims will be able to apply personally to the courts for protection. Some might not want to take court action against members of their own family. Where this happens the intention is that other people or organisations can step in on their behalf.

3.6 **The Mental Capacity Act 2005** aims to empower people to make decisions about their own lives where possible and protects those who lack capacity. If a person does not consent or lacks capacity to consent to a marriage, that marriage must be viewed as a forced marriage whatever the reason for the marriage taking place. www.legislation.gov.uk/ukpga/2005/9

4. RECOGNITION

4.1 Victims of existing or prospective forced marriages may be fearful of discussing their worries with friends and teachers; however they may come to the attention of professionals, those working in community groups or in a voluntary capacity due to various behaviours or circumstances consistent with distress. These may include factors relating to:

Education

- Absence and persistent absence
- Request for extended absence and failure to return from visits to country of origin
- Fear about forthcoming school holidays
- Surveillance by siblings or cousins at school
- Decline in behaviour, engagement, performance or punctuality
- Being withdrawn from school by those with parental responsibility
- Removal from a day centre of a person with a physical or learning disability
- Not allowed to attend extra curricular activities
- Sudden announcement of engagement to a stranger
- Prevented from going on to further/higher education

Health

- Accompanied to doctor's or clinics
- Self harm
- Attempted suicide
- Eating disorders
- Depression
- Isolation
- Substance misuse
- Early/unwanted pregnancy
- Female genital mutilation

Police

- Victim or other siblings within the family reported missing
- Reports of domestic abuse, harassment or breaches of the peace at the family home
- Female genital mutilation
- The victim reported for offences e.g. shoplifting or substance misuse
- Threats to kill and attempts to kill or harm
- Reports of other offences such as rape or kidnap
- Acid attacks

Family History

- Siblings forced to marry
- Early marriage of siblings
- Self harm or suicide of siblings
- Death of a parent
- Family disputes
- Running away from home
- Unreasonable restrictions e.g. kept at home by parents ("house arrest") & financial restrictions

5. RESPONSE

5.1 The "One Chance" Rule

You may only have one chance to speak to a potential victim and thus may only have one chance to save a life. This means that all practitioners working within statutory agencies, community workers and volunteers need to be aware of their responsibilities and obligations when they identify potential forced marriage cases. If the victim is allowed to walk out of the door without support being offered, that one chance might be wasted. Everyone working with victims of forced marriage and honour-based violence need to be aware of the "one chance" rule.

5.2 First Steps in all cases

- See them immediately in a secure and private place where the conversation cannot be overheard.
- See them on their own – even if they attend with others
- Recognise and respect their wishes

- Contact, as soon as possible, the Forced Marriage Unit based at the Foreign and Commonwealth Office fmu@fco.gov.uk, www.fco.gov.uk/forcedmarriage, 020 7008 0151, or 020 7008 1500 if out of hours. They produce useful information leaflets and posters which are available to download or order from the publications link on their website.
- If the young person is under 18 years of age, refer them to the designated person with responsibility for safeguarding children and activate local safeguarding procedures
- Reassure them about confidentiality i.e. practitioners will not inform their family
- Establish a way of contacting them discreetly in the future
- Consider the need for immediate protection and placement away from the family.

5.3 DO NOT:

- Send them away
- Approach members of their family or the community unless they expressly ask you to do so
- Share information with anyone without their express consent Breach confidentiality unless it is with the information sharing protocol
- Attempt to be a mediator

5.4 Additional Steps

- If necessary, record any injuries and arrange a medical examination
- Give them personal safety advice
- Develop a safety plan in case they are seen i.e. prepare another reason why you are meeting
- Establish if there is a family history of forced marriage, e.g. siblings forced to marry.
- Other indicators may include domestic violence, self-harm, family disputes, unreasonable restrictions (e.g. withdrawal from education or "house arrest") or missing persons within the family
- Advise them not to travel overseas. Discuss the difficulties they may face Identify any potential criminal offences and refer to the police if appropriate
- Give them advice on what service or support they should expect and from whom
- Ensure that they have the contact details for the trained specialist
- Maintain a full record of the decisions made and the reason for those decisions
- Information from case files and database files should be kept strictly confidential and preferably be restricted to named members of staff only
- Refer them, with their consent, to appropriate local and national support groups, counselling services and women's groups that have a history of working with survivors of domestic abuse and forced marriage.
- Anyone threatened with forced marriage or forced to marry against their will can apply for a Forced Marriage Protection Order. Third parties, such as relatives, friends, voluntary workers and police officers, can also apply for a protection order with the leave of the court. Fifteen county courts deal with applications and make orders to prevent forced marriages. Local authorities can now seek a protection order for vulnerable adults and children without leave of the court. Guidance published by the Ministry of Justice explains how local authorities can apply for protection orders and provides information for other agencies. www.justice.gov.uk/guidance/forced-marriage.htm
- Where a case of forced marriage has resulted in the serious harm of a child or young person, practitioners should also consider undertaking a Serious Case Review.

5.5 Remember

- Circumstances may be more complex if the young person is lesbian, gay, bisexual or transgender.
- British Embassies and High Commissions can only help British nationals or, in certain circumstances EU or Commonwealth nationals. This means that if a non-British national leaves the UK to be forced into marriage overseas, the British Embassy or High Commission will not be able to assist them.
- If in doubt, ask the Forced Marriage Unit for advice.

6. NATIONAL GUIDANCE & ADVICE

6.1 Professionals working in this field should be familiar with:

- **The Right to Choose:** Multi-agency statutory guidance for dealing with forced marriage (HM Government, 2014): www.gov.uk/government/uploads/system/uploads/attachment_data/file/322310/HMG_Statutory_Guidance_publication_180614_Final.pdf

- Multi-Agency Practice Guidelines: **Handling Cases Of Forced Marriage** (HM Government, 2014): www.gov.uk/government/uploads/system/uploads/attachment_data/file/322307/HMG_MULTI_AGENCY_PRACTICE_GUIDELINES_v1_180614_FINAL.pdf

- Forced Marriage And Learning Disabilities: **Multi-Agency Practice Guidelines** (HM Government, 2010) www.gov.uk/government/uploads/system/uploads/attachment_data/file/141824/Forced_Marriage_and_learning_disabilities_guidelines_FINAL.PDF

- The Forced Marriage Unit (FMU) is Government's central unit dealing with forced marriage casework, policy and projects. The FMU provides confidential information and assistance to potential victims and concerned professionals: www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/forced-marriage/

- The FMU guide for LGBT people: http://www.bucks-lscb.org.uk/wp-content/uploads/Professionals_Protocol_and_Guidance_Forced_Marriage/Leaflet_for_LGBT.pdf

- The FMU Survivors Handbook: http://www.bucks-lscb.org.uk/wp-content/uploads/Professionals_Protocol_and_Guidance_Forced_Marriage/Survivors_Handbook.pdf

- The FMU e-learning training package complements the multi-agency practice guidelines for professionals. You can access the course on the Forced marriage eLearning website

6.2 FMU staff can offer advice and assistance to individuals who:

- Fear they will be forced into a marriage (in UK or overseas)

- Fear for a friend or relative who may be forced into a marriage (in the UK or overseas)
- Have been forced into a marriage and do not want to support their spouse's visa application

Buckinghamshire
BSCB
Safeguarding
Children Board

Buckinghamshire Safeguarding Children Board
BSCB Procedure: Honour Based Violence
September 2013

Version Control			
Version number	**Date**	**Author**	**Comments and nature of update**
V1.0	May 2011		Original Document
V2.0	September 2013		Revised by Policies and Procedures Sub Group

1. Introduction

1.1 Honour based violence is the term used to describe murders in the name of so-called honour, sometimes called 'honour killings'. These are murders in which predominantly women are killed for perceived immoral behaviour, which is deemed to have breached the honour code of a family or community, causing shame.

1.2 The Police definition of so-called honour based violence is: 'a crime or incident, which has or may been committed to protect or defend the honour of the family and/or community'.

1.3 Professionals should respond in a similar way to cases of honour violence as with domestic violence and forced marriage (i.e. in facilitating disclosure, developing individual safety plans, ensuring the child's safety by according them confidentiality in relation to the rest of the family, completing individual risk assessments etc). See BSCB procedures for Domestic violence and Forced marriage.

1.4 Victims from black or ethnic minority groups, where the violence is perpetrated by extended family members or relate to forced marriage issues, may be more isolated due to religious and/or cultural pressures, language barriers, having no recourse to public funds or fear of bringing shame to their 'family honour'.

Procedures

These procedures should be read in conjunction with BSCB procedures for Domestic Violence, and where appropriate, BSCB procedures for Forced Marriage.

2. Recognition

2.1 A child who is at risk of honour based violence is at significant risk of physical harm (including being murdered) and/or neglect, and may also suffer significant emotional harm through the threat of violence or witnessing violence directed towards a sibling or other family member.

2.2 Honour based violence cuts across all cultures and communities, and cases encountered in the UK have involved families from Turkish, Kurdish, Afghani, South Asian, African, Middle Eastern, South and Eastern European communities. This is not an exhaustive list.

2.3 The perceived immoral behaviour which could precipitate a murder include:

- Inappropriate make-up or dress;
- The existence of a boyfriend;
- Kissing or intimacy in a public place;
- Rejecting a forced marriage;
- Pregnancy outside of marriage;
- Being a victim of rape;
- Inter-faith relationships;
- Leaving a spouse or seeking divorce.

2.4 Murders in the name of 'so-called honour' are often the culmination of a series of events over a period of time and are planned. There tends to be a degree of premeditation, family conspiracy and a belief that the victim deserved to die.

2.5 Incidents, in addition to those listed above, which may precede a murder include:

- Physical abuse;
- Emotional abuse, including:
  - house arrest and excessive restrictions
  - denial of access to the telephone, internet, passport and friends
  - threats to kill
- Pressure to go abroad. Victims are sometimes persuaded to return to their country of origin under false pretences, when in fact the intention could be to kill them.

2.6 Children sometimes truant from school to obtain relief from being controlled at home by relatives. They can feel isolated from their family and social networks and become depressed, which can on some occasions lead to self-harm or suicide.

2.7 Families may feel shame long after the incident that brought about dishonour occurred, and therefore the risk of harm to a child can persist. This means that the young person's new boy/girlfriend, baby (if pregnancy caused the family to feel 'shame'), associates or siblings may be at risk of harm.

3. Disclosure and response

3.1 When receiving a disclosure from a child, professionals should recognise the seriousness / immediacy of the risk of harm.

3.2 For a child to report to any agency that they have fears of honour based violence in respect of themselves or a family member requires a lot of courage, and trust that the professional / agency they disclose to will respond appropriately. Specifically, under no circumstances should the agency allow the child's family or social network to find out about the disclosure, so as not to put the child at further risk of harm.

3.3 Authorities in some countries may support the practice of honour-based violence, and the child may be concerned that other agencies share this view, or that they will be returned to their family. The child may be carrying guilt about their rejection of cultural / family expectations. Furthermore, their immigration status may be dependent on their family, which could be used to dissuade them from seeking assistance.

3.4 Where there is a disclosure of suspicion of honour based violence, staff in all agencies/organisations should respond immediately by referring to Social Care First Response Team, or where there is imminent risk, directly to the Police.

3.5 Referring agencies should make an assessment of risk of harm using a dedicated assessment tool e.g. DASH (http://www.caada.org.uk/)

3.6 The Social Care and Police response should include:

- Seeing the child immediately in a secure and private place;
- Seeing the child on their own;
- Explaining to the child the limits of confidentiality;
- Asking direct questions to gather enough information to make a referral to LA children's social care and the police, including recording the child's wishes;
- Encouraging and/or helping the child to complete a personal risk assessment

- Developing an emergency safety plan with the child;
- Agreeing a means of discreet future contact with the child;
- Explaining that a referral to children's social care and the police will be made (See Individual Case Management Procedures – Section 5)
- Record all discussions and decisions (including rationale if no decision is made to refer to children's social care).

3.7 Professionals should not approach the family or community leaders, share any information with them or attempt any form of mediation. In particular, members of the local community should not be used as interpreters.

3.8 All multi-agency discussions should recognise the police responsibility to initiate and undertake a criminal investigation as appropriate.

3.9 Multi-agency planning should consider the need for providing suitable safe accommodation for the child, as appropriate.

3.10 If a child is taken abroad, the Foreign and Commonwealth Office may assist in repatriating them to the UK.

https://www.gov.uk/government/organisations/foreign-commonwealth-office

Islamic Rules for Children Fasting in UK Primary and Secondary Schools

1. In Islamic law, children are not required to fast during Ramadan: they are only required to fast when they become adults.

2. a) The age of adulthood is disputed: some traditional views look at only biological factors, i.e. puberty. This usually equates to 12-15 years old for boys and 9-15 years old for girls (depending on when their periods start).

b) The stronger traditional view is that emotional and intellectual maturity is also required for adulthood, ie 15-20 years old for both sexes. [This view is found in all four of the main Sunni schools of law - cf. Sheikh Wahba Zuhayli's *Al-Fiqh al-Islami wa adillatuhu* (Islamic Jurisprudence and its Evidential Bases); the age of 18 or 19 was often mentioned classically as true adulthood.]

3. In Islamic tradition, children are often encouraged to fast, even though it is not a legal requirement, in order to prepare them for adulthood. The situation here is analogous to that of prayer (5 times a day), which is also expected of adults. For prayer, the ages of 7-10 are traditionally when they begin. Hence, many parents introduce their children to fasting at a similar age.

4. In Islamic law, the health of an individual is the first priority after their faith. This is why adults are exempt from fasting if they are sick or face other hardships that make fasting too difficult, eg travelling or unduly laborious or safety-critical work, e.g. medical surgeons or airline pilots.

5. In Islamic law, the decisions of relevant authorities in disputed matters are upheld and respected, eg court judgments or school policy.

6. Hence, if a school has a policy on fasting in the best interest of children, with input from Muslim parents, governors and leaders, parents are obliged by Islamic law to abide by that policy, even if it goes against their wishes.

7. Violation of such a policy by parents would entail going against their religion in two ways:

(i) by breaking their agreement with the school to abide by its policy and rules; and

(ii) by mistreating their child, since the school policy and Islamic law have the same purpose, ie to safeguard the health and education of the child.

8. a) Since social services have the same aim as Islamic law also, ie to safeguard children, a school's referral to them would also be in accordance with Islam.

b) Such a step is not ideal, of course, because of the status and importance of parents and the parent-child relationship in both Islam and UK society, and all attempts should be made to reach agreement such that a referral is not necessary.

Sheikh Dr. Usama Hasan – London, July 2013 (Ramadan 1434)

Breast Ironing

BSCB Guidance http://www.bucks-lscb.org.uk/professionals/breast-ironing/

What is breast ironing?

Breast ironing is practiced in all ten regions of Cameroon and has been reported in Benin, Ivory Coast, Chad, Guinea-Bissau, Kenya, Togo, Zimbabwe and Guinea-Conakry. The charity CAWODIGO – CAME Women and Girls (http://www.cawogido.co.uk/index.php) is concerned that African immigrants have brought breast ironing practice with them to the UK. In their efforts to reduce the number of affected girls and women, CAME provides training for Cameroonian organisations working to protect girls from being abused through breast ironing and supporting families and communities. Girls aged between 9 and 15 have hot pestles, stones or other implements rubbed on their developing breast to stop them growing further. In the vast majority of cases breast ironing is carried out by mothers or grandmothers and the men in the family are unaware. Estimates range between 25% and 50% of girls in Cameroon are affected by breast ironing, affecting up to 3.8 million women across Africa.

Why does breast ironing happen?

The practice of breast ironing is seen as a protection to girls by making them seem 'child-like' for longer and reduce the likelihood of pregnancy. Once girls' breasts have developed, they are at risk of sexual harassment, rape, forced marriage and kidnapping; consequently, breast ironing is more prevalent in cities. Cameroon has one of the highest rates of literacy in Africa and ensuring that girls remain in education is seen as an important outcome of breast ironing.

Breast ironing is physical abuse

Breast ironing is a form of physical abuse that has been condemned by the United Nations and identified as Gender-based Violence. Although, countries where breast ironing is prevalent have ratified the African Charter on Human Rights to prevent harmful traditional practices, it is not against the law.

Breast ironing does not stop the breasts from growing, but development can be slowed down. Damage caused by the 'ironing' can leave women with malformed breasts, difficulty breastfeeding or producing milk, severe chest pains, infections and abscesses. In some cases, it may be related to the onset of breast cancer.

Breast Ironing in the UK

Concerns have been raised that breast ironing is also to be found amongst African communities in the UK, with as many as a 1,000 girls at risk. Keeping Children Safe in Education (2016) mentions breast ironing on page 54, as part of the section on so-called 'Honour Violence'. Staff worried about the risk of breast ironing in their school should speak to the Designated Safeguarding Lead as soon as possible. Schools need to know the risk level within their communities and tackle the risk as appropriate.

Video https://youtu.be/lOqXWTwnEEE

Tri.x have issued a paper with further information and links regarding this practice http://www.trixonline.co.uk/website/news/pdf/policy_briefing_No-164.pdf

Buckinghamshire

BSCB

Safeguarding Children Board

Buckinghamshire Safeguarding Children Board
BSCB Guidance: Self-Harm
September 2013

Version Control			
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Contents

These guidelines are primarily intended for use by Professional carers/workers within Buckinghamshire and should be read in conjunction with the Buckinghamshire Safeguarding Children's Board (BSCB) procedures.

These guidelines are based on the Self Harm Guidelines for Staff within School and Residential Settings developed by the Oxfordshire Adolescent Self Harm Forum Steering Group (with representatives from OBMH, Oxfordshire PCT, Oxfordshire County Council, Oxfordshire PCAMHS, Oxfordshire Samaritans and Oxford University Centre for Suicide Research).

Self harm guidelines

These guidelines are intended to help carers and workers to support young people up to the age of 18 who harm themselves, and to access appropriate services where needed.

What is self harm and how common is it?

Self harm is any behaviour such as self-cutting, swallowing objects, taking an overdose, hanging or running in front of cars etc., where the intent is to deliberately cause self harm.

- Some people who self harm have a strong desire to kill themselves. However, there are other factors which motivate people to self harm including a desire to escape an unbearable situation or intolerable emotional pain, to reduce tension, to express hostility, to induce guilt or to increase caring from others. Even if the intent to die is not high, self harming behaviour may express a powerful sense of despair and needs to be taken seriously. Moreover, some people who do not intend to kill themselves may do so, because they do not realise the seriousness of the method they have chosen or because they do not get help in time.

- Over the last forty years there has been a large increase in the number of young people who deliberately harm themselves. A recent large community study in the UK found that in 15-16 year olds, approximately 6.9% of young people (3.2% males and 11.2% females) had self harmed in the last year. See Hawton et al. (2002) Deliberate self harm in adolescents: self report survey in schools in England. BMJ, 325, 1297-1211.

What causes self harm?

The following **risk factors,** particularly in combination, may make a young person vulnerable to self harm:

Individual Factors
- depression/anxiety
- poor communication skills
- low self esteem
- poor problem solving skills
- hopelessness
- impulsivity
- drug or alcohol abuse

Family factors
- unreasonable expectations
- abuse (physical, sexual, emotional or neglect)
- poor parental relationships and arguments
- depression, deliberate self harm, suicide or other mental health difficulties in the family
- drug/alcohol misuse in the family
- domestic violence

Social factors
- difficulty in making relationships/ loneliness
- persistent bullying or peer rejection
- easy availability of drugs, medication or other methods of self harm

The pressures for some groups of young people and in some specific settings may increase the risk of self harm:

- young people in residential settings (e.g. inpatient units, prison, sheltered housing or hostels or boarding schools)
- young people with mental health difficulties

A number of factors may **trigger** the self harm incident:

- family relationship difficulties **(the most common trigger for younger adolescents)**
- difficulties with peer relationships e.g. break up of relationship **(the most common trigger for older adolescents)**
- bullying
- significant trauma e.g. bereavement, abuse
- self harm behaviour in other students (contagion effect)
- identification with a peer group which promotes self harm
- self harm portrayed or reported in the media
- difficult times of the year (e.g. anniversaries)
- trouble in school or with the police
- feeling under pressure from families, school and peers to conform/achieve
- exam pressure
- times of change (e.g. parental separation/divorce)

Warning signs

There may be changes in the **behaviour** of the young person which are associated with self harm or other serious emotional difficulties:

- changes in eating/sleeping habits
- increased isolation from friends/family
- changes in activity and mood e.g. more aggressive than usual
- lowering of academic grades
- talking about self-harming or suicide
- abusing drugs or alcohol
- becoming socially withdrawn
- expressing feelings of failure, uselessness or loss of hope
- giving away possessions

N.B. Some young people get caught up in mild repetitive self harm such as scratching, which is often done in a peer group. In this case it may be helpful to take a low key approach, avoiding escalation, although at the same time being vigilant for signs of more serious self harm.

Examples of self harming behaviour

- cutting
- taking an overdose of tablets
- swallowing hazardous materials or substances
- burning – either physically or chemically
- over/under medicating e.g. misuse of insulin
- punching/hitting/bruising
- hair pulling/skin picking/head banging
- episodes of alcohol/drug/substance misuse or over/under eating can at times be acts of deliberate self harm

Self harm can be a transient behaviour in young people that is triggered by particular stresses and resolves fairly quickly, or it may be part of a longer term pattern of behaviour that is associated with more serious emotional/psychiatric difficulty. Where there are a number of underlying risk factors present, the risk of further self harm is greater.

What keeps self harm going?

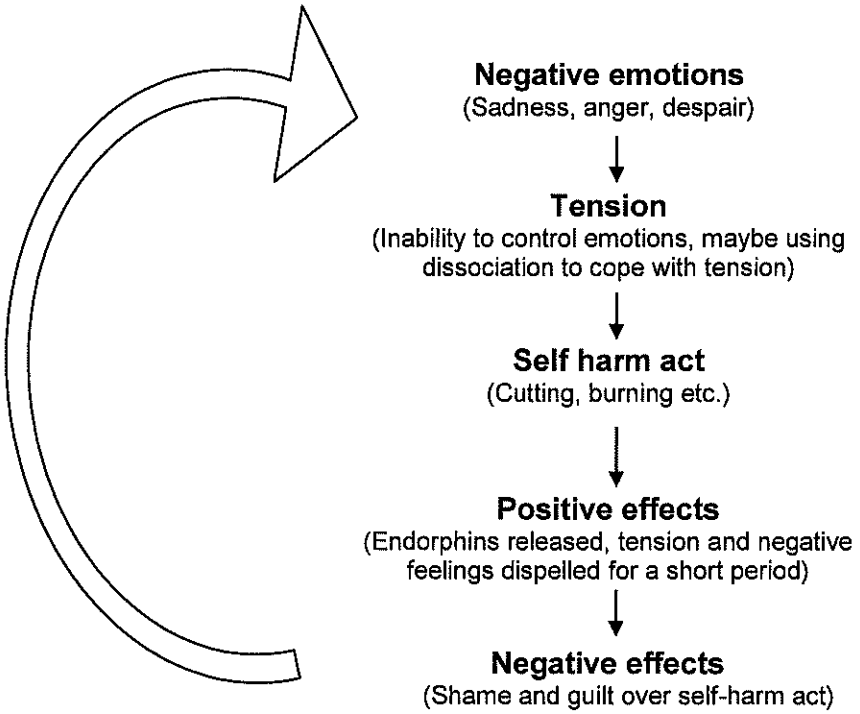
Once self harm (particularly cutting) is established, it may be difficult to stop. Self harm can have a number of functions for the student and it becomes a way of coping.

Examples of functions include

- Reduction in tension (safety valve)
- Distraction from problems
- Form of escape
- Outlet for anger and rage
- Opportunity to feel
- Way of punishing self or others
- Way of taking control
- Care-eliciting behaviour
- A means of getting identity with a peer group
- Non-verbal communication (e.g. of abusive situation)
- It can also be a suicidal act

The cycle of self harm/cutting

When a person inflicts pain upon himself or herself the body responds by producing endorphins, a natural pain reliever that gives temporary relief or a feeling of peace. The addictive nature of this feeling can make self harm difficult to stop.
Young people who self harm still feel pain, but some say the physical pain is easier to stand than the emotional/mental pain that led to the self harm initially.



Coping strategies

1. Using support networks

It is helpful to identify the support people in a young person's life and how to get in touch with them. Examples are friends, family, school teacher, counsellor. Knowing how to access a crisis line is also important.

2. Distraction activities

Replacing the cutting or other self harm with other safer activities can be a positive way of coping with the tension. What works depends on the reasons behind the self harm. Activities that involve the emotions intensely can be helpful.

Examples of distraction methods:

- Contacting a friend or family member
- Going for a walk/run or other forms of physical exercise
- Getting out of the house and going to a public place e.g. a cinema
- Reading a book
- Keeping a diary
- Looking after an animal
- Watching TV
- Listening to music

3. Coping with distress using self soothing

- Using stress management techniques such as relaxation
- Having a bubble bath
- Stroking a cat or other animal
- Going to the park and looking at the things around you (birds, flowers, trees)
- Listening to the sounds as you walk
- Listening to soothing music

4. Discharging unpleasant emotions in other ways

Sometimes it can be helpful to find other ways of discharging emotion which is less harmful than self harm:

- Clenching ice cubes in the hand until they melt – this can relieve some tension
- Writing, drawing and talking about feelings
- Writing a letter expressing feelings, which need not be sent
- Going into a field and screaming
- Hitting a pillow /soft object
- Listening to loud music
- Physical exercise can be a good way to discharge emotion

In the longer term a young person may need to develop ways of understanding and dealing with the underlying emotions and beliefs. Regular counselling/therapy may be helpful. Support from family members or carers is likely to be an important part of this. It may also help if the young person joins a group activity such as a youth club, a keep fit class or a school based club that will provide opportunities for them to develop friendships and feel better about themselves. Learning stress management techniques, ways to keep safe and how to relax may also be useful.

Reactions of staff

Staff may experience a range of feelings in response to self harm in a young person (e.g. anger, sadness, shock, disbelief, guilt, helplessness, disgust or rejection). It is important for all work colleagues to have an opportunity to discuss the impact that self harm has on them personally. The type and nature of the forums where these issues are discussed may vary between settings.

In *schools* young people may present with injuries to first aid or reception staff. It is important that these frontline staff are aware that an injury may be self inflicted, and that they pass on any concerns.
Within *residential settings*, young people may present to a range of staff, including key workers, domestic staff, admin staff or cooks.

The urge to escape difficulties

For some young people, self harm may express the strong desire to escape from a conflict or unhappiness at home and to live elsewhere. Injuring oneself can achieve a temporary respite if it entails a hospital admission or a short break at the home of a friend or relative. The young person may request admission to foster care or a residential home and parents may doubt their ability to cope at this stage. Entering care often carries with it many long-term disadvantages and increased vulnerability for the young person. It is acknowledged that for some young people being looked after is the best way forward but in most cases it is preferable to try to support the young person and family members in finding a resolution to their difficulties than to separate them further.

For those who are already in care, self harm may still be an expression of a desire to escape from their situation, for example, leaving the home. As before, it is important to support the young person, understand the nature of their difficulties and help them to find a way of resolving them.

If you believe that a young person would be at serious risk of abuse in returning home or in remaining in their residential setting, you should consult a Social Worker for advice.

If a child or young person goes missing from home or from a residential setting then the BSCB procedures should be initiated.

Thames Valley Missing Children Procedure: http://www.bucks-lscb.org.uk/bscb-procedures (Section 11)

How to help

If you are concerned that an episode of Self Harm was a serious attempt by the Young Person to end their life, please contact your local CAMHs Tier 3 team Duty Line (see appendix F) immediately.

1. First line help

When you recognise signs of distress try to talk with the young person about how they are feeling.

- Record and share with senior member of staff.
- When a young person has self harmed keep calm, give reassurance and follow the agreed first aid guidelines.
- In the case of an overdose of tablets advice must be obtained from a medical practitioner (GP or Accident and Emergency Department).
- If the young person is in a serious medical condition then an ambulance must be called.
- Try to work out together who you need to inform (see paragraph on confidentiality).
- Discuss the importance of letting parents know and address any concerns they have about this. For Children in Care discussion should include notifying the Social Worker (depending on the legal status of the Child).
- Contact parents to discuss concerns unless there are particular reasons why they should not be contacted. In these cases consult with designated safeguarding lead. Give the parents' fact sheet (Appendix D) when appropriate.
- For Children in Care contact their Social Worker in the first instance.
- Suggest to the parents and/or Social Worker a referral to CAMHS, or an appointment with the GP if there are serious medical issues. If young person is known to CAMHS contact Lead Professional / Care Co-ordinator or local teams duty line (Mon-Fri, 9-5).
- Ask for feedback from other agencies to support work with the young person.
- Work within Buckinghamshire Safeguarding Children Board policy/guidelines as appropriate (Child Protection Policies).
- Follow up contact with parents with a letter indicating your concern (Sample Appendix B).
- Have crisis telephone numbers available and easily accessible to young people.
- Follow agreed policy with regard to informing the senior management of your concerns.
- Record any incident (Sample Appendix C).
- Seek support for yourself if necessary.
- Advice can be obtained from the CAMHS telephone consultation service (see Appendix F).

2. Longer term support of a young person who self harms

It is important to understand the reasons behind the self harm and support the young person in keeping safe. Key workers/staff should work with the young person to build up self esteem, develop problem solving skills, and encourage strategies to cope with difficult feelings. If the young person is involved with CAMHS they should be supported to attend appointments and be encouraged to make use of the support offered.

Understanding and prevention of self harm

It may be helpful to explore with the young person what led to the self harm - the feelings, thoughts and behaviour involved. This can help the young person make sense of the self harm and develop alternative ways of coping.

An important part of prevention of self harm is having a supportive environment in the school or residential setting which is focused on building self esteem and encouraging healthy peer relationships. An effective anti-bullying policy and a means of identifying and supporting young people with emotional difficulties is an important aspect of this.

A check list of procedures and practices that can help schools manage and prevent self harm can be found in Appendix A.

Confidentiality

Confidentiality is a key concern for young people and they need to know that it may not be possible for their support member of staff or residential worker to offer complete confidentiality. If you consider that a young person is at serious risk of harming him/her self or others then confidentiality cannot be kept. It is important not to make promises of confidentiality that you cannot keep, even though the young person may put pressure on you to do so. If this is explained at the outset of any meeting the young person can make an informed decision as to how much information they wish to divulge.

Strategies to help in school or residential settings

- Arrange a mutually convenient time and place to meet.
- At the start of the meeting set a time limit.
- Make sure the young person understands the limits of your confidentiality.
- Encourage them to talk about what has led them to self harm.
- Remember that listening is a vital part of this process.
- Support the young person in beginning to take steps to keep him/herself safe and reduce the self-injury (if they wish to).e.g.
    - Washing implements used to cut.
    - Avoid alcohol if they feel they are likely to self-injure.
    - Take better care of injuries (the school health nurse or first aider may be helpful here).
- Help them to learn how to express their feelings in other ways e.g. talking, writing, drawing or using safer alternatives (as described earlier).
- Help them to build up self esteem
- Help them to find their own way of managing their problems. e.g.
    - If they say they dislike themselves, begin working on what they say they do like.
    - If life at home is impossible, begin working on how to talk to parents/carers.
- Help them identify their own support network.
- Offer information about support agencies; remember some internet sites may contain inappropriate information.

Further considerations

- Record any meeting with a young person; include an agreed action plan including dates, times and any concerns you have. Document who else has been informed of any information.
- It is important to encourage young people to let you know if one of their group is in trouble, upset or shows signs of harming. Friends can worry about betraying confidence, so they need to know self harm can be dangerous to life, and by seeking help and advice for their friend they are taking a responsible action.
- It can happen that two or more young people may self harm simultaneously. It is important that each case is looked at individually in terms of levels of risk and need

in the first instance. It is of course important at a later stage to consider what it was within the group dynamic that led to this situation and how best it could be managed in the future. (see Issues regarding contagion).

- The peer group of a young person who self harms may value the opportunity to talk to an adult, either individually or in a small group.

Response of supportive members of staff

For those who are supporting young people who self harm, it is important to be clear with each individual how often and for how long you are going to see them (i.e. the boundaries need to be clear). It can be easy to get caught up into providing too much, because of one's own anxiety. However, the young person needs to learn to take responsibility for their self harm.

If you find the self harm upsets you, it may be helpful to be honest with the young person. You need to be clear that you can deal with your own feelings and try to avoid the young person feeling blamed. They probably already feel low in mood and have a poor self-image; your anger/upset may add to their negative feelings. However, your feelings matter too. You will need the support of your colleagues and management, if you are to listen effectively to young peoples' difficulties.

Issues regarding contagion, multiple and copycat behaviours

When a young person is self harming it is important to be vigilant in case close contacts of this individual are also self harming.

Occasionally schools or residential settings may discover that a number of students in the same peer group are harming themselves. Self harm can become an acceptable way of dealing with stress within a peer group and may increase peer identity. This can cause considerable anxiety in school staff, parents and carers, as well as in other young people.

Each individual may have different reasons for self harming and should be given the opportunity for one to one support; however, it may also be helpful to discuss the matter openly with the group of young people involved. In general it is not advisable to offer regular group support for young people who self harm.

Where there appears to be linked behaviour or a local pattern emerging, a multi-agency strategy meeting should be convened.

Support/training aspects for staff

Staff giving support to young people who self harm may experience all sorts of reactions to this behaviour in young people (e.g. anger, helplessness, rejection); it is helpful for staff to have an opportunity to talk this through with work colleagues or senior management.

Staff taking this role should take the opportunity to attend training days on self harm or obtain relevant literature. Liaison with the local Child and Adolescent Mental Health Service may be helpful.

Consideration needs to be given to the impact the young person's self harming may have on their peer group.

Helping young people who self harm: Flow chart for young people. (universal)

If you are concerned that an episode of Self Harm was a serious attempt by the Young Person to end their life, please contact your local CAMHs Tier 3 team Duty Line (see appendix F) immediately.

Young person is self harming / is at risk of self harming

↓

Worker/carer informed/discovers a young person with problem.
Worker/carer to talk to young person
In an emergency, worker/carer to follow First Aid Guidelines

↓

Worker/carer to follow the organisation's policy regarding informing the senior management /leadership team (this allows the worker/carer to gain support of colleagues). Parents should be informed unless there are specific reasons not to.

↓

Discussion with relevant professionals involved with young person

↓

Ring CAMHS Consultation Line for advice **or** Social Care Contact Centre if there are safeguarding concerns

↓

IF APPROPRIATE:

- Meeting with parent(s) to inform and discuss concerns
- Follow up the meeting with a letter (Appendix B)
- Give crisis/help line details to parent and young person
- Give fact sheet for parents & carers (Appendix E)
- Refer to your organisations Safeguarding Lead / Guidelines and act accordingly (note confidentiality guidelines)

↓

Refer on to other agencies as appropriate

Appendix A

Self Harm Guidelines - Checklist for schools: Supporting the development of effective practice

The school has a policy or protocol approved by the governing body concerning self-harming	☐
ALL new members of staff receive an induction on self harm procedures and confidentiality	☐
ALL members of staff (teaching and non-teaching) receive regular training on child protection procedures	☐
The school has clear channels of communication that apply to this issue	☐
All members of staff know who to go to if they know a young person is self-harming	☐
Staff are supported throughout all processes concerned with this issue	☐
Staff know how to access support for themselves and students	☐
Students know who to go to for help	☐
The school has a culture that encourages young people to talk, adults to listen and believe	☐
Students are consulted on any curriculum provision (eg in PSHE) and pastoral support provided.	☐

Appendix B

Sample letter to parents following meeting about self harm

Date

Dear (Parent/Carer)

Thank you for coming to discuss.....

After our recent meeting I am writing to express concern about .....'s safety and welfare. The recent incident of self harm (or threat to self harm) by ..... suggests that he/she may need professional help.

I recommend that you visit your local GP for advice and help and /or as agreed, we have sent a referral to the Children and Adolescent Mental Health Service (CAMHS).

We will continue to provide support to ....., but would appreciate any information that you feel would help us to do this as effectively as possible.

If there is anything else we can do to help ..... please contact me.

Yours sincerely,

Title

Copies to:

Appendix C
Sample of an incident form to be used when a young person self harms

Young person's name		Date of report
Date of Birth		Gender
Professional's name		Job title
Agency		
School /College attended	Year	Special Needs

Incident

Date and time of occurrence

Action taken by professional

Decision made with respect to contacting parents
(and reasons for decision)

Recommendations

Follow up

Copies to:

Appendix D Fact sheet for parents/carers on self harm

It can be difficult to find out that someone you care about is harming him or her self. As a parent / carer you may feel angry, shocked, guilty and upset. These reactions are normal, but what the person you care about really needs, is support from you. They need you to stay calm and to listen to them. The reason someone self harms is to help them cope with very difficult feelings that build up and which they cannot express. They need to find a less harmful way of coping.

What is self harm?
Self harm is any behaviour such as self-cutting, swallowing objects, taking an overdose, hanging or running in front of cars etc. where the intent is to deliberately cause harm to self.

How common is self harm?
Over the last forty years there has been a large increase in the number of young people who harm themselves. A recent large community study found that in 15-16 year olds, approximately 6.9% of young people had self harmed in the previous year.

Is it just attention seeking?
Some people who self harm have a desire to kill themselves. However, there are many other factors which lead people to self harm, including a desire to escape, to reduce tension, to express hostility, to make someone feel guilty or to increase caring from others. Even if the young person does not intend to commit suicide, self harming behaviour may express a strong sense of despair and needs to be taken seriously. It is not just attention seeking behaviour.

Why do young people harm themselves?
All sorts of upsetting events can trigger self harm. Examples are: arguments with family, break up of a relationship, failure in exams or bullying at school. Sometimes several stresses occur over a short period of time and one more incident can be the final straw.

Young people who have emotional or behavioural problems or low self-esteem can be particularly at risk from self harm. Suffering a bereavement or serious rejection can also increase the risk. Sometimes young people try to escape their problems by taking drugs or alcohol. This only makes the situation worse. For some people self harm is a desperate attempt to show others that something is wrong in their lives.

What can you do to help?
Try to:

- Keep an open mind
- Make the time to listen
- Help them find different ways of coping
- Go with them to get the right kind of help as quickly as possible
- Some people you can contact for help, advice and support are:
- Your family doctor
- Young Minds Parents Information Service Tel: 0808 802 5544
- The Samaritans. Tel: 08457 90 90 90
- MIND Infoline. Tel: 0845 766 0163
- Youth Access. Tel: 0208 772 9900
- School Health Nurse/ Health Visitor

Appendix E Information sheet for young people on self harm

What is self harm?
Self harm is where someone does something to deliberately hurt him or herself. This may include: cutting parts of their body, burning, hitting or taking an overdose.

How many young people self harm?
A recent large study in the UK found that about 7% (i.e. 7 people out of every 100) of 15-16 year olds had self harmed in the last year.

Why do young people self harm?
Self harm is often a way of trying to cope with painful and confusing feelings. Difficult things that people who self harm talk about include:

- Feeling sad or feeling worried
- Not feeling very good or confident about themselves
- Being hurt by others: physically, sexually or emotionally
- Feeling under a lot of pressure at school or at home
- Losing someone close; this could include someone dying or leaving

When difficult or stressful things happen in someone's life, it can trigger self harm. Upsetting events that might lead to self harm include:

- Arguments with family or friends
- Break-up of a relationship
- Failing (or thinking you are going to fail) exams
- Being bullied

Often these things build up until the young person feels they cannot cope anymore. Self harm can be a way of trying to deal with or escaping from these difficult feelings. It can also be a way of showing other people that something is wrong in their lives.

How can you cope with self harm?
Replacing the self harm with other safer coping strategies can be a positive and more helpful way of dealing with difficult things in your life.

Helpful strategies can include:

- Finding someone to talk to about your feelings (this could be a friend or family member)
- Talking to someone on the phone (you might want to ring a help line)
- Sometimes it can be hard to talk about feelings; writing and drawing about your feelings may help.
- Scribbling on and/or ripping up paper
- Listening to music
- Going for a walk, run or other kinds of exercise
- Getting out of the house and going somewhere where there are other people
- Keeping a diary
- Having a bath/using relaxing oils e.g. lavender
- Hitting a pillow or other soft object
- Watching a favourite film

Getting help

In the longer term it is important that the young person can learn to understand and deal with the causes of the stress that they feel. The support of someone who understands and will listen to you can be very helpful in facing difficult feelings.

- **At home** - parents, brother/sister or another trusted family member
- **In school** - school counsellor, school nurse, teacher, teaching assistant or other member of staff
- **GP** – you can talk to your GP about your difficulties and he/she can make a referral for counselling
- **Help lines**:-

Young Minds	Tel: 0808 802 5544	youngminds@org.uk
The Samaritans	Tel: 08457 90 90 90	jo@samaritans.org.uk
MIND Infoline.	Tel: 0845 766 0163	
Youth Access.	Tel: 0208 772 9900	

National Self Harm Network
PO Box 16190
London NW1 3WW www.nshn.co.uk

My friend has a problem - How can I help?

- You can really help by just being there, listening and giving support.
- Be open and honest. If you are worried about your friend's safety, you should tell an adult. Let your friend know that you are going to do this and you are doing it because you care about him/her.
- Encourage your friend to get help. You can go with them or tell someone they want to know.
- Get information from telephone help lines, website, library etc. This can help you understand what your friend is experiencing.
- Your friendship may be changed by the problem. You may feel bad that you can't help your friend enough or guilty if you have had to tell other people. These feelings are common and don't mean that you have done something wrong/not done enough.
- Your friend may get angry with you or say you don't understand. It is important to try not to take this personally. Often when people are feeling bad about themselves they get angry with the people they are closest to.
- It can be difficult to look after someone who is having difficulties. It is important for you to find an adult to talk to, who can support you. You may not always be able to be there for your friend and that's OK.

Appendix F: Guidance for asking clients about internet and social media use (2017)

This document has been produced by Oxford Health NHS Foundation Trust and approved by the Oxfordshire Local Safeguarding Children Board. It is shared here as a resource that may also be helpful for professionals working in Buckinghamshire.

Guidance for asking clients about internet and social media us

- 91% of 16-24 year olds use the internet for social media[1]
- Social media use in relation to suicide and self-harm is an area of concern, particularly with young people [2]
- It is increasingly common for people to search the internet in the context of suicidality
- Social media and the internet generally can be protective as well as harmful[3]
- Assessments should incorporate internet and social media use in relation to self-harm/suicidality and clinicians/staff should engage clients in open dialogue around usage to try and reduce/minimise harmful use and promote helpful and protective resources[4]

The **internet** is predominantly used to search about methods of suicide, to purchase means e.g. prescription only medication and to look for support. Internet searching can also lead to social media platforms.

Social media includes:

- Suicide related chat rooms (pro suicide and preventative)
- Blogs
- Virtual bulletin boards and forums
- YouTube
- Social networking sites: Facebook, Twitter, MySpace, Google +
- Instant messaging (visual and text): Snapchat, Instagram, Tumblr
- Texting, email

In recent research[1] young people ranked **Instagram** and **Snapchat** as the social media networking sites that are most detrimental to mental wellbeing.

The same research identified potential negative and positive effects of social media on health:

	Potential positive effects of social media on health[1]
Anxiety & depression	Access to other people's health experiences and expert health information
Sleep	Emotional support and community building
Body image	Self-expression and self-identity
Cyberbullying	Making, maintaining and building upon relationships
Fear of missing out (FoMO)	

NB: both victims and perpetrators of cyberbullying have a higher risk of suicidality than the general population[2]

The risks associated with cyberbullying are the amplification of feelings of isolation, instability and hopelessness for those with pre-existing emotional, psychological or environmental stresses[2].

Additional concerns in relation to social media use:

- Cybersuicide pacts - these are generally made between strangers who have met through pro-suicide fora
- Introduction to new methods
- Influencing of decisions in relation to suicide e.g. peer pressure, idolisation
- Competition/challenges in relation to self-harm or suicide
- Contagion of self-harming or suicidal behaviour
- Suicide notes – increasing exposure of those reading them

Research has indicated that some clinicians/staff are unaware of clients' internet use and lack knowledge about chatrooms and social media[4]. It was noted that clinicians/staff can find themselves avoiding asking direct questions about internet and social media during suicide risk assessments for fear that it might 'put ideas into a patient's head'[3]. The same authors note that "*clinicians may be in a unique position to guide internet use, and knowing about internet activity could help to identify high risk clients and contribute to clinical decision making so that clients receive better support*".

Direct and curious questions are advised to elicit the extent of client's internet and social media use and to identify possible risks in relation to self-harm or suicide. By asking for names of sites/apps, potentially harmful platforms can be identified and passed on to managers and public health for consideration of preventative or safeguarding action.

Where suicidal ideation is disclosed and subsequent probing has identified that your client has thought about method, questions should seek to ascertain how research was carried out. For example:

- How did you decide on this method?
- Have you researched the method? How? Did you use the internet?
- Can you tell me what you looked at on the internet?
- What actions have you taken as a result of internet searching?
- Do you think you have seen anything online recently that may have influenced your decision around method?

Questions around social media use specific to self-harm might include:

- What social media sites are you using at the moment?
- Do you feel troubled by anything that takes place on your social media sites?
- Have you been involved in any discussions about self-harm (or suicide)
- Do you deliberately access social media that promotes self-harm or suicide?
- Do you deliberately seek out social media that promotes self-care and help seeking?

If potentially harmful self-harm /suicide related internet or social media use is elicited it is important for clinicians/staff to engage the patient in a dialogue to explore their motives for accessing such material and to try and support them in changing this behaviour. Possible questions might include:

- Why do you think you look at these internet sites/access this social media?
- How does it make you feel?
- Do you derive any benefit?
- What do you think the potential harms for you are?

Be curious as to why your client would choose to be exposed to potentially harmful internet/social media when there are supportive options easily accessible.

Focus on your client's ambivalence and encourage them to think of reasons for choosing more positive sites.

Sit with your patient and identify positive social media, apps and internet sites such as:

- Stay alive suicide prevention app
- Young Minds https://youngminds.org.uk/ https://www.facebook.com/youngmindsuk
- Student Minds http://www.studentminds.org.uk/ http://studentmindsorg.blogspot.co.uk/
- Mind https://www.mind.org.uk/ https://www.facebook.com/mindforbettermentalhealth
- Get Self Help https://www.getselfhelp.co.uk/
- Healthtalk http://www.healthtalk.org/young-peoples-experiences/depression-and-low-mood/depression-self-harm-suicidal-feelings

Incorporate positive internet and social media sites into safety planning.

AyeMind (ayemind.com) is a 'digital for youth wellbeing' site and has toolkits and resources for young people and professionals. If you are uncertain about navigating the internet or want to increase your knowledge this site is worth a visit.

References

1. Royal Society for Public Health (2017) Status of Mind: Social media and young people's mental health. London: Royal Society for Public health
2. Luxton, D. et al (2012). Social media and suicide: a public health perspective. American Journal of public health. 102(S2) S195-S200
3. Daine, K., Hawton, K., Singaravelu, V., Stewart, A., Simkin, S. and Montgomery, P., 2013. The power of the web: a systematic review of studies of the influence of the internet on self-harm and suicide in young people. *PloS one*, *8*(10), p.e77555.
4. Biddle, L. et al (2016). Priorities for suicide prevention: balancing the risks ad opportunities of internet use. Policy Report 7/2016, Bristol University.

Appendix G

Useful addresses and telephone help lines

CAMHS Consultation 9am – 5pm Mon – Fri:	01296 565365
Aylesbury CAMHs (duty line):	08442252414
High Wycombe CAMHs (duty line):	01296 564130
Amersham CAMHs (duty line):	01296 565250
Addaction	01296 331933
Young MINDS 102 – 108 Clerkenwell Road London ECIM 5SA E-mail youngminds@Ukonline.co.uk Mon and Fri. 10am – 1pm Tues, Weds, Thurs. 1pm – 4pm	020 7336 8445
Young MINDS Parents Information Service	0808 802 5544
Bristol Crisis Service for Women PO BOX 654 Bristol Avon BS99 IXH Fri. and Sat. 9pm– 2.30am Sun. 6pm-9pm	0117 925 1119
R-U-Safe? Young Women's Service The Centre Castlefield High Wycombe Buckinghamshire HP12 3LL	01494 534381
Samaritans 24 hour helpline	08457 90 90 90
Childline 24 hr helpline	0800 1111
CALM (Campaign Against Living Miserably) Helpline for 15 –24 year old males 7 days a week 5pm –3am	0800 58 58 58

Web sites

The Young People and Self-Harm Information Resource Website
www.ncb.org.uk/selfharm

Self-Injury and Related Issues (SIARI)
www.siari.co.uk

National Self-Harm Network
PO BOX 16190
London NW1 3WW
www.nshn.co.uk

Useful references

Hawton, K. (2006) By their own young hand. Deliberate self harm and suicidal ideas in adolescents. Jessica Kingsley Press

Schmidt, U and Davidson, K. (2000) Life after self harm: A guide to the future. Hove: Brunner-Routledge