



West Midlands Police and Crime Panel

Tackling Female Genital Mutilation in the West Midlands

A report by the West Midlands Police and Crime Panel







FGM
Champions from
Ark St Alban's
Academy,
Birmingham

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Preface



David Jamieson, left; Cllr Cooper, right

Cllr Darren Cooper, Chair West Midlands Police and Crime Panel and Leader Sandwell Metropolitan Borough Council

First, can I thank Stephen Rimmer, West Midlands Strategic Lead for Preventing Violence Against Vulnerable People who is employed by the seven West Midlands local authorities and the West Midlands Police and Crime Commissioner. Prior to starting this inquiry Stephen reported to both the West Midlands Police and Crime Panel and the West Midlands Joint Committee on progress being made by the Preventing Violence Against Vulnerable People Board. It was clear that he was making much progress, but that the Panel could also contribute to this work. We chose to investigate female genital mutilation (FGM) as we recognised that very little work on this had been undertaken at a regional level.

The evidence we received at our evidence gathering sessions was powerful and we are grateful for this. Can I thank practitioners and members of FGM practising communities who are already doing their best to eradicate the practice, as there is much good work already being undertaken by councils, West Midlands Police, schools, health professionals, the voluntary sector and community members.

I am sure that everyone reading this report will agree that FGM is a truly horrible act to inflict on another human being, especially a young girl you love. FGM is largely concentrated in a swathe of African countries, plus some Asian and Middle

Eastern countries. Many people from these countries have settled in the West Midlands. We want to celebrate the best of their traditions and cultures, but ensure this criminal act is firmly left behind.

I hope that the evidence received and the recommendations that come out of this intensive piece of work will start to address this desperate issue and ensure that no girls from the West Midlands are cut. Through this work we have identified where the weaknesses are in the system and the variability of knowledge and action being taken across the region. We need to reach the hearts and minds of FGM practising communities so they work with us to condemn this practice in order to protect all girls in the region.

David Jamieson, West Midlands Police and Crime Commissioner

I am grateful to the Panel for the time and effort that members have put into this important piece of work. The report is a helpful contribution to our approach in this area and the recommendations assist in developing our response. As set out in my Police and Crime Plan, I hold the Force to account for its work in this area, looking to see more reporting and a focus on enforcement and effective interventions. I have also already commissioned services to support victims of FGM.

The report is right to emphasise that a range of partners can contribute to building a wider community response to FGM, and ensuring that schools play their part too. I see the role of the PCC as playing a part among a number of partner agencies, organisations and stakeholders, such as local authorities, councillors, NHS organisations, and third sector groups, many of which are better placed to address the wider issues the report raises. Only by working together can we more quickly eradicate FGM.

Victims of FGM require short and long term holistic support from the statutory and voluntary sectors. To provide appropriate and sensitive support for women, professionals must develop their understanding of the enduring impact that FGM has on family relationships between the victim and her partner, her children and

particularly with her own mother. Victims suffer mentally and physically and appropriate support should be available for survivors who make the life changing decision to leave their community to protect themselves and their daughters. Through the work of the Victims Commission, we are exploring what this support could look like and we are working with communities to develop services that respond to the needs of victims of this crime.

Police and Crime Panel Statement

“The West Midlands Police and Crime Panel condemns the practice of Female Genital Mutilation (FGM) and supports the national campaigns to ensure its eradication. FGM is child abuse and illegal and should be treated as such; cultural sensitivities should not cloud judgement. All organisations in the West Midlands dealing with children need to understand that girls from FGM practising communities may be at risk and practitioners need to be empowered to ask parents questions and to work together in children’s best interests on a case by case basis.

We call upon all relevant authorities, including those involved in law enforcement, the justice system and public health, to do everything in their power to protect young girls from this life endangering, health threatening crime. We also call for appropriate support for women and girls who are victims of FGM.

The Police and Crime Commissioner needs to hold West Midlands Police to account for its contribution to prevention and securing prosecutions and to fund victims’ services for survivors of FGM in the region.”

Panel Recommendations

Moving Forward Together in the West Midlands

Recommendation 1: To ensure consistency in dealing with female genital mutilation (FGM), the Preventing Violence Against Vulnerable People Board should consider establishing a time limited West Midlands Task Force on FGM to:

- develop procedures, such as a clear and consistent common FGM risk assessment;
- build understanding and data on prevalence of FGM;
- develop clarity about information sharing;
- develop guidelines to ensure that when a girl is born to a mother who has undergone FGM that appropriate steps are taken to ensure the family are made aware that it is both illegal to perform FGM and causes unnecessary pain and suffering;
- explore potential for civil remedies (such as FGM protection orders); and
- develop any other key issues identified within this report, which require collective drive and consistency across the West Midlands.

Police and Crime Commissioner (PCC)

Recommendation 2: The Police and Crime Plan seeks to increase public reporting of hidden crime such as FGM; improve awareness within the police force and continue to do more with partners to prevent and detect hidden crimes. We expect the PCC to demonstrate leadership to progress these issues for FGM.

Recommendation 3: The PCC should encourage West Midlands Police to take all steps to work with the Crown Prosecution Service (CPS) to maximise the opportunity for a suitable West Midlands prosecution.

Partners

Recommendation 4: Councils, schools and health organisations (including NHS Trusts) need to ensure FGM is recognised as a priority by their boards and executives – and activity is not just led by determined individuals – to ensure prevention and referral is embedded in “how we do things round here”.

Recommendation 5: The PCC (as a commissioner for victims’ services), the Victims’ Commission, Health and Well-being Boards and Clinical Commissioning Groups should recognise the need for support and therapy for children and women who have undergone FGM and commission appropriately to meet that need. Where possible, opportunities for collaborative commissioning should be sought.

Recommendation 6: Given the importance of understanding the risks and effects of FGM in preventing the continuation of the practice, practitioners need access to training. All Safeguarding Children Boards should co-ordinate training and organisations should ensure that front-line staff are trained to spot the signs / risks of FGM and understand referral pathways.

Recommendation 7: The PCC should work with West Midlands Police, local authorities, health organisations, and the third sector to ensure that pro-active community empowerment work is being undertaken with communities from FGM practising countries (whilst recognising the value of broader engagement with such communities too), including appropriate men and women’s groups.

Recommendation 8: The PCC and local authorities recognise the crucial role that schools can play in engaging with parents, and therefore, encourage schools, where there are children from FGM practising countries, to play an active role in educating, preventing and referring. FGM should be included within school safeguarding policies and all staff and governing bodies should receive training. Further education colleges and universities also provide opportunities to engage with young people and staff should be able to spot the signs / risks of FGM and have knowledge of referral pathways.

Tracking Progress

Recommendation 9: The PCC and the Strategic Lead of the Preventing Violence Against Vulnerable People Board report to the West Midlands Police and Crime Panel on outcomes in six months' time, and thereafter to be agreed, on progress implementing these recommendations.

1 Introduction

1.1 Setting the Scene

To set the scene a range of views on female genital mutilation (FGM) are presented below.

Lynne Featherstone, Former Minister of State for Crime Prevention

"It can end within a generation. I absolutely think it's possible."

Video, September 2013

Keith Vaz, Chair Home Affairs Select Committee

"This is barbarism – brutality – and it needs to be dealt with. There is no community, religious or political justification for what is going on, which is why it needs to be stopped."

House of Commons, January 2015

Ban Ki-Moon, Secretary General of the United Nations

"We should strive to preserve the best in any culture, and leave harm behind."

"There is no developmental, religious or health reason to cut or mutilate any girl or woman. Although some would argue that this is a 'tradition', we must recall that slavery, so called honour killings and other inhumane practices have been defended with the same weak argument. Just because a harmful practice has long existed does not justify its continuation. All 'traditions' that demean, dehumanize and injure are human rights violations that must be actively opposed until they are ended."

New York, 2014

Hibo Wardere, FGM Campaigner

"FGM is totally, utterly designed to control women's sexuality. It's designed to make you feel incomplete. It's a horrendous act against girls."

"As a young girl you suffer silently, you cry silently. ..You are mentally tortured by flash backs you have of FGM."

"FGM has no colour, race or religion or culture. It's just child abuse that needs to be eradicated completely. We have to work harder than before."

Twitter. Februarv 2015

David Jamieson, West Midlands Police and Crime Commissioner

"FGM is a horrible, nasty practice that has no place in modern Britain."

Statement for End FGM Day 2015

Personal stories from the West Midlands

Sarata Jabbi, Chief Executive Officer, Care for Women and Girls (CAWAG)¹

"My name is Sarata Jabbi; I'm a Gambian, from a tribe called Mandingo. This is the tribe that mainly practice FGM in my country, because of their deeply-rooted culture and they believe it's religious. I underwent FGM at the age of seven. I could remember this when I and my siblings were told that we were going to attend a party at one of our relatives' house, we all got excited dressed in our new clothes and made our way to that house with some family friends. Upon our arrival, we were seated in the living room whilst the cutter was at the backyard waiting.

While waiting for the party to start, one of the old women came in and took the youngest of us to the backyard. All of a sudden I heard her screaming; in less than ten minutes the same woman came for the second youngest. As the third youngest a fear begins to build in me, my heart starts beating because mum and daddy weren't around to save me from whatever was there waiting for me.

Now that my turn came up, the same old woman comes into the house approaching me. I started running, but unfortunately there was neither nowhere nor no one to run to. As soon as I got in the backyard I found my two siblings lying on the floor bleeding excessively whilst the cutter covered her face with a scarf. I was looking around and in all the women's faces to see if I would see mummy's face by chance. One of them held me down on the floor, others tied my eyes, covered my mouth and stretched my legs apart, and then I felt a sharp cut in between my legs, I screamed for help, but to no avail.

As soon as the cutter finished the cutting, women start celebrating by singing and dancing, but ours was a different case. There was neither singing nor dancing because one of my sisters fainted due to heavy bleeding and was rushed to the hospital.

The pain of FGM is unbearable and unimaginable, it's the worst pain I have endured in life, and the pain was all over my body. It took me months to recover. Being a survivor of FGM, you live with it for the rest of your life, because of the psychological impact it leaves you with. For 24 years now since I was cut, it's as if it happened to me yesterday, because I can still remember the pain I went through.

I'm a mum of three, and had three natural births. Each of them was a horrific moment, as I got cut every time I gave birth, which keeps reminding me of FGM. FGM is bad, it's against human rights, it's a child abuse, its violence against women, it's unhealthy, and above all it's unreligious.

FGM is a cultural belief, but is seen by many as a religious credence, and our parents performed it on us for various reasons, and these are: to keep our virginities, for family honour, to make us fit in our society, to have less desire for sex, etc. FGM has done more harm than good, and is still costing lives. It should be everyone's business to end FGM in our generation and that of our young ones."

Nasser Mockbill, Community Liaison Co-ordinator, Ark St Albans Academy²

"Safeguarding and protecting children, from all dangers and harm wherever in the world they happen to be, is everyone's responsibility. To emphasise that FGM is everyone's business, the following needs to be said:

You have the option of walking out if the horror of FGM becomes too much for you. My advice to you is please do not walk away (or stop reading). The girls who have FGM done to them do not have that option and unless you stay and find out about the suffering they endure, you are not in a position to help them.

FGM is everyone's business! I am making it my business. Because, had I been born a girl (and this is for all men to contemplate), I would have been standing here as a survivor of FGM and all the horrors that entails.

FGM is everyone's business—the world is evolving and changing faster than we think. It is racing towards becoming one community.

This wonderful country of ours is the most generous and welcoming host in the world. The varied social make up of today's Britain, is a fair reflection of any place on this planet. Throughout our British history, we have welcomed and became enriched with wonderful and, vibrant cultures, foods and exotic delicacies, arts and music; and the unfamiliar, became a familiar part of everyday life for the receiving generation.

We, here in Britain, have also over the years, received from all corners of the world and benefited from elements vital to our existence, such as

doctors, nurses, scientists and engineers. Those arrivals may have seemed unfamiliar to the receiving generation at first glance, but they quickly became familiar; and their children, grandchildren and great grandchildren became subsequent generations of our beloved nation.

Every generation is blighted by danger and harm. Occasionally the danger may, at first, seem unfamiliar; and burying our heads in the sand is not an option. FGM may seem unfamiliar to some of us, but it's been the scourge of girls, for thousands of years.

FGM is a crime, FGM is a grave injustice, FGM is a subjugation of women. It is the responsibility, of every single one of us, to eradicate this horrific and inhumane practice from the whole world:

- We must eradicate FGM by law and campaign for it to be illegal everywhere in the world;
- We must eradicate FGM through raising awareness; and
- We must eradicate FGM through empowerment and education.

However, we must remember that the purpose of education is to get rid of your own ignorance first before educating others.

It is common knowledge that in some countries in the developing world, the welfare of the citizens is not a priority for the government. The citizens of those countries are children of their time and environment. It is common for them to starve to death and there is nothing that they can do about it. It is common for them to be so poor that they can't afford to buy an aspirin and there is nothing they can do about it. It is common for them to be deprived of basic education. It is common to be forced to marry; it is common to be a child bride; it is common to be oppressed, humiliated and subjugated; and it is common for a little girl to be dragged behind a bush and have her genitalia mutilated for no valid reason and there is nothing she can do about it because she happens to be a child of an environment that does not have an NSPCC helpline. There is nothing they can do about what is common practice in their environment.

But we can. We are in a privileged position, because we, by a stroke of luck are the citizens of the most civilized country in the world; and a leader in the world on human rights, equality, fairness and justice. A country that puts the welfare of its citizens at the very top. FGM is a nasty, vile practice that is ruining the lives of women. We all need to muck in and dispose of it.

1.2 Role of the Panel

The West Midlands Police and Crime Panel was established in November 2012 as part of the new governance arrangements for policing to provide the checks and balances in relation to the performance of the West Midlands Police and Crime Commissioner (PCC). The Panel consists of 12 councillors representing the 7 districts across the West Midlands (Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall and Wolverhampton) and two independent members. Named substitutes have also been appointed for each councillor member. Membership of the Panel in 2014/15 when this inquiry was undertaken is shown on page 2.

The Police and Social Responsibility Act 2011 sets out the responsibilities of the West Midlands Police and Crime Panel. It has a statutory duty to scrutinise and support the West Midlands Police and Crime Commissioner (PCC). In its latter role the Panel has carried out mini-scrutiny inquiries. This inquiry into female genital mutilation (FGM) is its third such report. The aim of this inquiry was to consider:

What can the Police and Crime Commissioner do to facilitate integrated working between agencies to prevent and respond to Female Genital Mutilation in the West Midlands?

The Panel is pleased to have had this opportunity to consider FGM and the picture across the West Midlands region. One witness suggested that "FGM is hidden and has not (until now) been discussed regionally." As a response the Panel has chosen to address its recommendations more broadly than just to the PCC. We feel able to do so under our statutory requirement to support the PCC.

1.3 Why this Inquiry?

In March 2014 the Regional Lead for Preventing Violence Against Vulnerable People (PVVP), Stephen Rimmer provided the Panel with an update on his work. He outlined key strands of the PVVP Board:

- Prevention - engaging communities through awareness raising, prevention and culture change;
- Protection - safeguarding those at risk, supporting those affected; and
- Justice - dealing with offenders and preventing reoffending.

One of the aims of the PVVP Board is to achieve “integration, not partnership” to transform the delivery of core public services and ensure coherent, efficient and effective services. The Panel subsequently agreed to undertake an inquiry into the preventing violence against vulnerable people agenda using female genital mutilation as the case study for this.

Stephen Rimmer presented his annual report to the Panel in January 2015. One of the priority workstreams for the current year is to put in place a:

“...consistent approach ...across the region to respond to threats of trafficking, FGM, forced marriage and so called honour based violence.” ³

Other workstreams also support this, such as statutory bodies working directly with communities to address a range of difficult issues.

1.4 How was the Inquiry Carried Out?

The Panel invited a range of organisations to evidence gathering sessions on 24 November 2014 and 19 January 2015. The witnesses are listed in Appendix 1. We extend our thanks to them for both giving up the time to talk to us and also taking a lead on tackling FGM in the region.

In just two sessions we could not speak to all agencies working on this topic. Our aim instead was to get a flavour of the wide range of activity, to understand how to embed best practice and identify gaps.

We also sent a ‘Call for Evidence’ to all seven Community Safety Partnerships and Directors of Public Health and all ten Clinical Commissioning Groups (CCGs) seeking written responses and developed an online questionnaire for the CCGs to send to their general practitioners (GPs). In spite of this, there are gaps in the

information we received which may reflect the distribution of FGM practising communities, the lack of work going on, or just a lack of responsiveness. Details of the evidence we received is included in the evidence pack.

In addition, officers supporting the Panel had further conversations with key speakers, practitioners and community activists attending:

- the conference *Preventing Female Genital Mutilation: A safeguarding issue for professionals working in health, education, social care and the police* (see evidence pack);
- the Muslim Women's Network UK FGM Summit; and
- FGM safeguarding training.

What has been striking at such events and on social media has been the strength of survivors in telling their own personal, and often horrifying, stories in order to ensure that practitioners and communities come together to ensure that FGM can be stopped in a generation. We thank survivors across the whole country who are working tirelessly to prevent FGM happening to other girls.

Notable absences from the evidence gathering were the Local Safeguarding Children's Boards (LSCB) which are key to multi-agency working locally. However, in Birmingham the Birmingham Against FGM multi-agency group has been made a sub-committee of the Local Safeguarding Children's Board and we heard from them.

Finally, our recommendations were shared widely such as with NHS Trusts, CCGs, Local Safeguarding Children Boards (LSCBs) and Directors of Children's Services and Public Health prior to publication.

1.5 What is FGM?

The World Health Organisation (WHO) defines FGM as:

"All procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons".⁴

It has many different names for the communities living in the West Midlands, but is often referred to as cutting. There are four different levels of FGM which are set out in Appendix 2.

The procedure is typically carried out by traditional practitioners without medical training, without anaesthetics and with crude cutting instruments. Typically, it happens when girls are under nine,⁵ but is also performed on babies, teenagers and adult women, for example, re-infibulation following child birth.⁶ FGM can lead to lifelong health and psychological problems for women and girls (see Appendix 3). Many members of FGM practising communities believe that male and female circumcision has the same effect. They clearly do not.

Internationally, FGM is practised in up to 28 African countries and parts of Asia and the Middle East (see Appendix 4). Rates of prevalence in these countries, however, varies considerably from 98% in Somalia to just 1% in Cameroon and Uganda.

The rationale for the practice differs from one country to another and even different tribes or groups. In some societies it is embedded in coming of age rituals. FGM is often linked to marriageability of girls, to preserve virginity, reduce sexual desire, and for hygiene reasons. It is believed to be a religious requirement by some, although it is not mentioned in the Qur'an or Bible.

The lesson for the West Midlands region is that we need to understand the communities who are living here through conversations. The message we heard from practitioners is that being judgemental does not enable us to understand motivations and then to be able to challenge myths with facts.

It is notable that in some countries steps are being taken to develop new coming of age celebrations to replace FGM and it may be that further conversations could be undertaken with local FGM practising communities to see if there is anything that could be done to support this in the UK too.⁷ Also, as cutters in FGM practising countries may make their living from this practice, so work is ongoing to develop other less harmful livelihoods for them. In the Gambia this includes being facilitators of new coming of age ceremonies.⁸

1.6 Child Protection

We heard that:

“FGM is child abuse – a violence issue, a child protection issue, a human rights violation.”⁹

FGM is a safeguarding issue for girls, but is complicated that in many communities it is seen as a cause for celebration and ceremony, unlike any other safeguarding issue. FGM also differs from other forms of child abuse in that it is a one-off event in the child’s life that usually takes place in an otherwise loving environment. As such, it is not usually accompanied by a pattern of behaviour and indicators that would normally alert authorities that a child was at risk.

One witness highlighted this complexity:

“The intention of it is not to abuse. The benefits that derive from it such as to become more marriageable, be seen as part of the clan, a rite of passage to womanhood are good intentions; it’s not on the whole that they wish to abuse their children.”

Like other hidden crimes, FGM can be a taboo topic which girls have been warned not to speak of it. We heard of one 49 year old woman, for example, who has not spoken with anyone about her FGM that had been performed at age seven.

We heard another woman’s story of health professionals never discussing her FGM despite giving birth five times. Her conclusion is that “professionals need to ask questions”.

We were also told of a school girl who had had been sent home from school for numerous urinary tract infections, but because none of the school staff had noticed a pattern or asked a question they were unaware of the trauma she was facing.

The cases highlighted to us show there are instances where professionals have come into contact with women and girls and, if they had been adequately trained to understand the risks of FGM and apply this knowledge and had sensitively

raised the issue of FGM, it could have resulted in earlier support to women and possibly prevention to girls. The box below shows other possible signs of FGM or a girl could be at risk.

If a woman has been cut then girls in their family (children, nieces etc.) are felt to be more at risk of undergoing the procedure. However, it cannot be assumed that all women who have been cut will cut their daughters. We were told that once the cycle of FGM has been broken within a single family then it is broken for ever.

Spotting the risks¹⁰

A girl or woman who has had FGM may:

- have difficulty walking, sitting or standing;
- spend longer than normal in the bathroom or toilet;
- have unusual behaviour after an absence from school or college;
- be particularly reluctant to undergo normal medical examinations; and
- ask for help, but may not be explicit about the problem

A girl at immediate risk of FGM may not know what's going to happen, but she might talk about:

- being taken 'home' to visit family;
- a special occasion to 'become a woman'; and
- an older female relative visiting the UK.

She may ask a teacher or another adult for help if she suspects FGM is going to happen or she may run away from home or miss school.

It is clear that FGM is not a matter to be culturally sensitive and permissive about.

Views include:

“It is child abuse and it is illegal, and should be addressed as such.”¹¹

“Don’t get confused or paralysed by culture, fear of racism, colonialism, family.”¹²

“[Police] Officers have a duty to safeguard everyone, including women and girls, which means that tackling FGM is an integral part of their role. They must take effective action to do so, without allowing themselves to be inhibited by fear of doing or saying the wrong thing or being accused of being racist. Officers should be culturally and faith aware in their dealings with victims of FGM, but should never hesitate to take appropriate and effective action to enforce the law and/or safeguard children. FGM is a crime in the UK.”¹³

2 National Context

2.1 Legislation and Policy

The Law

FGM has been illegal in this country since 1985 when the Female Circumcision Act was introduced. The Act was passed into law on 16 July 1985 and came into force on 16 September 1985. As the 30 year anniversaries of these dates are imminent, consideration should be given by partners in the region as to how to use this anniversary to reinforce the message of FGM being illegal.

FGM and the Law

It is an offence for any person to perform FGM in England, Wales or Northern Ireland, assist a girl to carry out FGM on herself or assist a non-UK person to carry out FGM outside the UK on a UK citizen or permanent resident. The provisions in the 1985 Act were strengthened in 2003 with the Female Genital Mutilation Act, which made it a criminal offence to take a UK national or permanent UK resident out of the country in order to have FGM carried out abroad. The revised Act increased the length of possible imprisonment to up to 14 years, or a fine or both, following prosecution and conviction.

The Serious Crime Act 2015 strengthens the Female Genital Mutilation Act 2003 by extending the provisions in the Act to habitual residents as well as citizens and permanent residents.

Recent Government Action

The Government in 2013 pledged to eradicate FGM in a generation.¹⁴ Its *Call to End Violence Against Women and Girls: Action Plan* included a series of commitments, including a toolkit for practitioners, funding for community engagement initiatives, a national prevalence study, and producing new guidance for the police.¹⁵ The Department of Health subsequently published *FGM: Multi-*

agency practice guidelines with information and best practice to follow to assist frontline professionals such as teachers, health and police officers. Many of our witnesses have referred to these guidelines.

In July 2014 the Home Affairs Select Committee report on *Female Genital Mutilation: the case for a national action plan* was published.¹⁶ This had a number of recommendations, including a call for a national action plan to increase the number of prosecutions, safeguard children and work with communities to abandon the practice.

From April 2014 all NHS healthcare professionals were required to record within a patient's clinical record if they identify that a woman or girl has had FGM. Since September 2014, all acute trusts must report monthly to the Department of Health on the number of patients who have had FGM. This anonymous data will be used to more accurately assess the prevalence of FGM.

In March 2015 the Serious Crime Act brought in new provisions to tackle FGM, making it illegal to encourage FGM, applying the FGM Act 2003 to habitual as well as permanent UK residents, granting lifelong anonymity to victims, bringing in a civil order ('FGM protection orders') to protect potential victims and introducing a duty on healthcare professionals, teachers and social care workers, to notify the police of known cases of FGM carried out on a girl under 18.

Justice System

Although FGM has been illegal since 1985 there have been no successful UK prosecutions. There has been just one attempted prosecution, but the doctor was found not guilty.

The Crown Prosecution Service (CPS) launched an action plan in 2012 and updated this in 2013. The police work closely with the CPS regarding alleged incidents of FGM. The Director of Public Prosecutions wrote to the former West Midlands PCC to underline the importance of inter-agency working:

“FGM has been a crime for almost 30 years but there has been no prosecution. Indeed there have not been any referrals to the Crown Prosecution Service for advice until relatively recently.

Prosecutors are not unwilling to prosecute. We are not going to get a prosecution for this offence if we just wait. We are not going to get a young girl coming forward to report an allegation against her parents for the abuse that she has suffered. We therefore need to do things differently. Awareness raising is important. We have appointed CPS Area FGM specialists to be proactive. A Protocol has also been signed in all police force areas. We think there is more to do by us, but also health and education professionals.”¹⁷

An alternative to criminal proceedings are civil orders (or injunctions). Generally, these are restrictions or positive requirements which can be imposed on individuals by the Civil Courts if the Court has enough evidence to believe that they are participating in some form of criminal activity. The focus of Civil Orders is on the prevention of crime and protecting communities through imposing restrictions with which they must comply or face prosecution. This may include restrictions on movement, and banning from certain areas or residences and travelling abroad. The sentences given for breaches are often prison sentences. The maximum sentence for breaching a Civil Order is two years imprisonment or an unlimited fine.

The advantages can be that the burden of proof is different in the civil court compared to the criminal court. The former requires guilt to be proven on the “balance of probability”. In addition, hearsay evidence may be used, the atmosphere is less formal, which may encourage witnesses to agree to be involved, it does not criminalise those involved, and the local authorities can bring forward cases.¹⁸

2.2 What is the Scale of FGM Nationally?

Data on prevalence in the UK is incomplete and so this is an issue which requires further work. Our witnesses told us that is generally considered that girls born to mothers who have been cut are the children most at risk. However, practitioners

need to remember that many families will choose not to continue the practice. It is likely that different communities hold to the practice or reject it in the UK to different extents and it would be interesting to know if this is being researched.¹⁹

Researchers have concluded that 127,000 women and girls over 15 years old from practising countries who had undergone FGM have migrated to England and Wales.²⁰ There were 24,000 girls (0-14 years old) living in England and Wales who have migrated from FGM practising countries. Based on prevalence of FGM in their home countries researchers estimate that almost 10,000 of these are at risk of FGM (i.e. they "have undergone or will undergo FGM".)²¹ Crucially, this does not include the risk of girls born in the UK.

It is estimated that over 71,000 of girls aged 0-16 born in England and Wales had mothers who had been cut.²² There are around 690,000 live births a year.²³ As 1.5% of mothers giving birth are estimated to have undergone FGM themselves²⁴ then this amounts to over 5,000 girls born each year who could be at risk of FGM.

As noted above, NHS clinical staff must record in patient healthcare records when it is identified that a patient has undergone FGM. The requirement to submit the FGM prevalence data is only mandatory for all acute NHS trusts, including accident and emergency departments. Between September 2014 and March 2015 the NHS recorded almost 4,000 newly identified cases of FGM nationally.²⁵ It is important to remember that these are not necessarily new cases of FGM, but women who will have been cut when young, whom the health service are now recognising as having undergone FGM, perhaps because they are presenting with other health issues, such as pregnancy.

However, 60 of these newly identified cases were girls under 18. Further work needs to be undertaken to understand the number of girls who have undergone FGM whilst British citizens or habitually resident in the UK, compared to those who were cut in their lands of birth and have since moved to the UK.

3 Regional Prevalence and Activity

3.1 Prevalence

FGM is a concern in the West Midlands, but the extent of this is unclear. This data is difficult to ascertain as FGM is a hidden crime. One Community Safety Partnership admitted what is probably the case across the whole region:

“There is no doubt amongst partners that our collective intelligence gap is significant.”²⁶

Time after time, when telling stories about their experiences, women have said they had never spoken about it. Data, therefore, is limited, but data collection and sharing is vital to target scarce resources to where the risk is greatest.

Risks and prevalence varies across the region, reflecting the location of FGM practicing communities. During our evidence gathering we learned of efforts to collate local data and work on this seems to be at different stages across the region.

Different sets of data can help build a picture of the scale of FGM in the region.

Numbers of Adults from FGM Practising Countries

It would be helpful to know the number of people living in each local authority area from FGM practising countries. However, this information does not appear to be comprehensively available. It is important to note the different prevalence rates for countries and different prevalence rates for communities from within these countries (See Appendix 4). What is also not known is the extent to which each practising community would wish to continue the practice in the UK or agrees that the cycle should be broken.

Number of Girls from FGM Practising Communities

School census data can be a useful source of information and at least two London boroughs (Westminster and Islington²⁷) have used this to get a better

understanding of local risks. Westminster City Council has ascertained how many girls are at risk in that local authority by using the information provided on the annual school census of all girls in education (except those in independent schools).²⁸ A report by the Wonder Foundation used the information provided about languages and found over 700 girls being educated in that London borough were at risk of FGM.²⁹ More locally, Sandwell Metropolitan Borough Council has also assessed and mapped data from the school census identifying over 260 girls from FGM practising countries.

For this report Birmingham City Council agreed to see what data locally can be ascertained in this way. An initial examination of the data by the Panel's secretariat would indicate that in Birmingham upwards of 5,000 girls enrolled in school between the ages of 5 and 18 come from FGM practising countries.

There are numerous caveats with this figure and at this stage it should be used with care. It comprises of counting girls who have named their ethnicity as being an FGM practising country (including Somalia, Yemen, Nigeria, Ghana, Iraq, Egypt, Ethiopia, Sudan and Sierra Leone). It also includes girls where the country was not named, but a language provides this identifier, such as Arabic (Yemen), Arabic (Iraq), Igbo (the language of a Nigerian community which practices FGM³⁰) and Tigrinya and Tigre, both Eritrean languages. Over half of these 5,000 girls are Somali (in either or both language and ethnicity identifiers). Clearly, noting Appendix 4, prevalence rates differ in these countries and, therefore, within the communities living in the West Midlands region. Many of these 5,000 girls will not, therefore, be at risk.

The second caveat is that there are many girls for whom the data does not make it clear if they or their family are from an FGM practising country – classifications, for example, of "Black-African", "Any Other Black Background" and "Other Black", unless there is a language identifier. Consequently, these have not been included in the tally, so the 5,000 may be an underestimate. Finally, there are many mixed heritage girls (such as "White and Black African" and "Black and Any Other Ethnic Group"). These have only been included in the tally when there was a clear

language marker (a small number), but it raises a question about what is known about the risks to mixed heritage girls as nothing was presented as evidence.

Although the school data set did not provide as clear as evidence as was hoped, it clearly identifies that there is a cohort of girls in the Birmingham who may be at risk of FGM. Similar data from each local authority in the region could be collated and further expertise applied to it to better understand patterns and risks. Also, working with the data teams and schools could help strengthen the data. The regional task force might want to explore these issues to identify the areas where there are risks.

Numbers of Women and Girls in the Region Who Have Been Cut

As noted above there is now mandatory reporting by health services of the number of women they have seen with FGM. To repeat the earlier caveats, this only records women who have been treated by a health practitioner and the issue has come up, or there has been a medical examination; it is not the number of women cut in that time period. Official statistics from acute hospitals in the seven districts show that between September 2014 and March 2015 there were 632 newly identified cases of women and girls in the West Midlands who have undergone FGM. This is not broken down by age. Earlier estimates (2007) were that 2% of births in Birmingham were to mothers with FGM.³¹

Overall, no information is available on the numbers of West Midlands girls who have been cut.

Information on Cutters in the Region

There have been no reports to West Midlands Police (WMP) of cutters in the West Midlands. However, there has been some intelligence to suggest that girls are brought to Birmingham (as well as other cities) to be cut.

Moving Forward in the West Midlands

There is obviously a high level of risk, but not enough is known and understood about who is at risk. Without data on FGM we cannot build a picture on local need

for FGM services, including the potential demand for a helpline and therapeutic support, or the funds needed to provide them.

We believe a region-wide discussion is needed and agreement should be reached on how prevalence and risk data can be collected. Mapping this distribution can help to target scarce resources where the risk is greatest. Although the health data would suggest that the risk of is greater in some parts of the region than others, movement around the region and inward migration means that no local authority area can afford to be complacent about the risks.

As a taboo subject, we were told that women will not often raise their FGM but will generally say if asked. To get better prevalence data, asking the question has to become routine for all agencies. This needs to become part of “how we do things around here” for a wide range of front line practitioners. Alongside data collection practitioners from all agencies need to have straightforward conversations with parents about their intentions for their female children.

There is inadequate evidence about whether the practice is performed in the UK. Further work needs to be undertaken to ascertain whether or not there are cutters based or working in the West Midlands. Building positive relationships with residents from FGM practising communities is key to this.

3.2 Multi-Agency Working

Benefits and Challenges

Tackling FGM is complex with many agencies holding part of the jigsaw. We feel that the PCC has to show leadership as FGM is an illegal practice, but all agencies have to play their role. We feel that multi-agency working with co-operation between all those that come into contact with children, policy makers and community based organisations can better safeguard girls at risk of FGM, change mind-sets, support survivors and deter perpetrators.

We heard about lots of work going on throughout the region to tackle FGM, but it was unclear how joined up this was and if different approaches reflect different

needs or just organisations being at different stages of the journey. Our evidence pack contains a summary of activity going on. We also heard about confusion, lack of awareness and of cases potentially falling between agencies.

The benefits of multi-agency working seem positive and we are supportive of steps already being taken to develop this within the local authority areas. One long standing example of this is Birmingham Against FGM (BAFGM) which was established in 2005 to coordinate multi-agency action to prevent FGM. It has representation from the Police, Birmingham City Council, Birmingham Community Safety Partnership, Primary Care and Hospital Trusts, Birmingham and Solihull Women's Aid and other third sector groups. It reports into Birmingham Violence Against Women Board and Birmingham Safeguarding Children's Board.

We also heard about Coventry City Council's work on FGM (overleaf). It should be noted that whilst much is seen as good practice, we understand some practitioners feel that each case needs to be dealt with on its own merits and risk assessed to make the best use of resources.

Multi-agency working will work best when there is consistency across all agencies. Austerity and increases on demands on local services has an impact on what organisations can deliver. At the same time we recognise that the recommendations of this report will require funding in order to effectively safeguard girls. The cuts in budgets to local authorities and the police mean that meeting priorities will require partnership working to be focused, effective and avoid duplication. Some common approaches can help – such as a common risk assessment. We suggest the PVVP Board is best placed to map what is required and co-ordinate this work.

One witness suggested it was now time for health services to stand at the forefront of tackling FGM. Another witness highlighted the sensitivities that agencies need to consider when working together to protect those at risk:

“Schools worry if they pass on suspicions the Police would come in with heavy boots.”

Case Study of Multi-Agency Work – Coventry City Council

The Local Safeguarding Children's Board (LSCB) has been working in partnership to address FGM locally since 2009. It has developed a safeguarding procedure and a website and offers training. The issue was taken to City Council in December 2013 and full support was given to the motion to eradicate FGM in Coventry (see Appendix 5). Responsibility sits with the acting Deputy Leader to demonstrate that it is important and needs to be taken seriously.

An FGM Task & Finish Group has been established (led by Public Health) to gather knowledge and intelligence on the extent of the problem in Coventry, how it is being addressed by various partners and the barriers in dealing with FGM. The group has made recommendations for multi-agency working on FGM across Coventry, endorsed by scrutiny and the Health and Wellbeing Board including:

- Prevention - awareness raising training aimed at anyone working with children and also parents and carers from FGM practising communities;
- Prosecution - continued support for WMP to enforce the law on FGM;
- Safeguarding, reporting & recording;
- Health services for women who have been cut;
- Improving data collection and sharing; and
- Developing educational approaches for schools.

In November 2014 the Health and Wellbeing Board organised a conference on FGM attended by around 300 professionals and community members. If a woman is affected by FGM and gives birth to a girl there is a referral to children's social care. This results in a joint visit by children's social care and WMP where they inform her that FGM is illegal and find out if the woman is under pressure from family or community to have FGM performed on her daughter. As a result 57% of WMP referrals of FGM are from Coventry, demonstrating that there is a very active referral policy.

Other work underway in Coventry to tackle FGM includes a local GP practice, primarily servicing asylum seekers and refugees, routinely asking new registrations about FGM. The City Council is also working with Coventry University on the REPLACE 2 project which aims to implement and evaluate community-based behaviour change intervention frameworks to tackle female genital mutilation in the EU. They are putting a volunteer manager into the voluntary sector to campaign with those communities.

In conclusion, one witness was emphatic that good practice was being undertaken in the region and that this should be celebrated. The Panel certainly heard evidence of some organisations leading the way (such as the partnership work in Coventry and the community-based work by Birmingham and Solihull Women's Aid) and some individuals working within their organisations to make a difference. There were also examples of early steps being taken in some local authorities to develop this work.

Information Sharing

Sharing data can help assess the level of risk and the resources required to tackle that. That alone, however, does not protect girls. That requires organisations proactively sharing data and, flagging risks to each other within the boundaries of client confidentiality and legislation and then taking appropriate action.

The Department for Education has published advice for front-line practitioners and senior managers providing services to children, young people, parents and carers on how and when to share personal information legally and professionally.³² However, this provides no specific advice about FGM. We were also told that, even within the health service, records are not joined up and further work needs to be undertaken to share information better between, for example, maternity hospitals and acute providers.

Overcoming Barriers to Reporting FGM

We asked agencies about perceived barriers to reporting and heard a variety of views including:

- Lack of information-sharing by health services
- Hidden problem in communities – there is reluctance to talk about FGM or report it;
- Confusion amongst health professional about patient confidentiality, which has been an impediment to sharing data with the police;
- The absence of robust data sharing agreements between agencies;

- Lack of awareness amongst health professionals about the risk factors and signs and how to respond. One respondent said they were seeking to address this issue by rolling out the “Spotting the signs” document with their sexual health services, in particular;
- Some women could be missed as there is not a requirement to ask every women or girl whether they have been subjected to FGM. Professionals are reminded to be aware of risk factors, including country of birth origin, and to use their professional judgement to decide when to ask the patient if they have had FGM;
- Some clinicians/staff may not ask or probe for fear of offending patients or meeting resistance; and
- Time constraints as staff are desperately overworked dealing with hundreds of other just-as-important issues.

3.3 Police and Crime Commissioner

The Police and Crime Commissioner has a number of key roles to play in this agenda:

- a) Setting priorities for WMP through the Police and Crime Plan;
- b) Holding WMP to account;
- c) Being responsible for funding local victims services; and
- d) Ensuring improved partnership working within the Criminal Justice System.

Priorities

The West Midlands Police and Crime Plan was updated in March 2015 and FGM is included under preventing and detecting hidden crimes. An excerpt is shown overleaf.

Extract From West Midlands Police and Crime Plan

Preventing and Detecting “Hidden Crimes”

“In addition to encouraging more reporting, we will continue to do more with partners to prevent and detect “hidden crimes”, by which we mean Domestic Violence, Child Abuse, Vulnerable Adult Abuse, Child Sexual Exploitation, Female Genital Mutilation, Forced Marriage, Honour Based Violence, Modern Slavery, Human Trafficking, Hate Crimes and Gender Selective Abortion. It is clear that public expectations of the role of the police in the regulation of private spaces and individuals’ intimate relationships are increasing, and we will work to understand the implications of new legislation in this area. We will expect our knowledge of these “hidden crimes” to further improve, and that the police and partners will use all the available powers to intervene to protect victims.

We have made a huge investment in the Force’s Public Protection Unit, with officer numbers rising from just over 300 to nearly 800 in 2014. “Sentinel” is the Force’s flagship policy to improve awareness and training for officers and staff, as well as encourage victims to come forward, and we will maintain close scrutiny of the Preventing Violence Against Vulnerable People programme to ensure it delivers on its promise.

There is more to do. We will:

- Agree with partners standard approaches to intelligence data collection, sharing and analysis, including a common “Indicator of Need” to identify those at risk;
- Agree with partners common protocols and responses based on best practice, such as where children who go missing or are recorded as absent;
- Look for opportunities to work with the private sector and other agencies, such as licensing committees, to support our safeguarding work;
- Increase further our emphasis on identifying, targeting and catching perpetrators, while strengthening our offender management; and
- Ensure there is effective support for victims.

More broadly, we will look to ensure that identifying and responding to “hidden crimes” becomes a mainstream policing function, with safeguarding part of everyone’s everyday business.”

The PCC's statement to support the 2015 Day Against FGM again highlighted his priorities:

"Let me be clear it is illegal to practice FGM in the UK and illegal to take British nationals or permanent residents of the UK abroad for FGM whether it is lawful in that country or not. West Midlands Police and I take this abuse very seriously and making sure that more women have the confidence to come forward is a top priority. As well supporting victims of this horrible crime we will focus on education and prevention. People should be in no doubt how seriously we take FGM and that together we will bring the perpetrators of these horrible crimes to justice. As well as training officers in how best to help with this horrible crime, supporting the victims of FGM is a top priority of the Victims Commission I have recently set-up."

Activity

In February 2014 an FGM study-day, organised by the former PCC, WMP's Public Protection Unit (PPU) and Birmingham Against FGM Group (BAFGM), sought to highlight how crucial education and information-sharing between agencies and strengthen further joint working and reporting. The PCC told the Panel that:

"The hard work is not turning into referrals and prosecutions. It is that symbolic act [of a successful prosecution] that will move the debate onwards."

Victims Commissioning

In October 2014 the PCC took responsibility for commissioning local victims services. The PCC told the Panel:

“I am setting up a Victims Commission. This [FGM] is on their agenda. I will bring to their attention and make sure they do consider it.”

In January 2015 the PCC established the Victims Commission, made up of experts from the community and voluntary sector to ensure that services to victims of crime are both victim led and fit for purpose. In April 2015 the PCC launched a new Victim Service (informed by the Victims Commission), to provide support and information to victims and make sure specialist help is provided when needed. There needs to be clarity about what support this will be able to give to survivors of FGM. However, the PCC has assured the Panel that FGM is a priority for WMP and so will be included in the work of the Victims Commission.³³

3.4 West Midlands Police

The PCC told the Panel that:

“One of the roles of the police is to protect individuals’ right to enjoy their own culture. However, that protection should never extend to crime.”

The Police have a role, both in prevention, and in investigating cases of suspected FGM. The Association of Chief Police Officers (ACPO) Lead on FGM has said:

“West Midlands Police have had FGM firmly on their agenda for many years, with training on dealing with FGM on the syllabus for detectives and child abuse specialists for five years. They have supported anti-FGM conferences, distributed posters to schools, surgeries and community centres, conducted web-chats on the topic, offered training to school representatives and are continuously working to improve their working practices in partnership with outside organisations, communities and the CPS, as well as sharing good practice with other forces. They are

also an active member of the Birmingham Against FGM group, and have been for many years.”³⁴

The Panel met Detective Superintendent Tim Bacon (the Force lead for safeguarding children) and Detective Constable Gillian Squires (the Force’s subject matter expert) from the PPU. We heard how FGM cases referred to WMP have increased from no reports between 2001 and 2003 to 25 reports in 2012, 41 reports in 2013 and 118 reports between January and November 2014. Officers attributed the difference to increased awareness of FGM giving professionals the confidence to report concerns about girls they fear could be at risk of being cut.

As noted, the West Midlands reflects the national landscape and, despite the increase of referrals, WMP has yet to secure a prosecution for FGM. We heard that, in 2012, a dentist and a doctor were arrested³⁵, but the case did not reach court, although we understand that they have both been struck off their professional registers. We were reassured, however, that every case in the West Midlands is investigated and some child protection orders have been issued as a result, thereby protecting a number of girls from being cut.

Whilst the police’s primary role in tackling FGM is to investigate suspected cases, we heard of the importance of police efforts in preventative activities to stop FGM happening in the first place. WMP launched Operation Sentinel in July 2013 which is a force-wide initiative aimed to enhance the service provided by the police and partner organisation to protect the most vulnerable, particularly those who are victims or are at risk of child sexual exploitation, honour-based violence, human trafficking, FGM and domestic abuse.

Operation Sentinel work on FGM has included:

- A poster and information campaign with specific messages for various audiences, including looking for signs of FGM and reporting routes;
- Delivering training sessions to community members and professionals including teachers, midwives, GPs and other professionals to identify the signs and how to report concerns;
- Training all WMP officers;

- Writing to all schools and GP practices;
- A schools conference looking at model lesson plans;
- Participation in a number of FGM workshops and conferences with partners; and
- Supporting the development of a community network to take forward changes from within local FGM practicing communities. The Force's PPU advocates Home Office advice to focus on changing the mind-set of mothers.

Local officers took part in Operation Limelight, a national operation at airports tackling people travelling to and from FGM practicing countries, to ascertain if any children were at risk. This operation had led to some referrals.

We note the importance of robust evidence collection and maintaining the ongoing co-operation of the FGM survivor in securing a conviction and heard that WMP has developed a protocol with the CPS for the best chance to secure a successful prosecution.

We were pleased to learn that during 2014 resources increased for the PPU to deal with serious sexual cases, child abuse and FGM. Numbers of officers increased in 2014 from just over 300 to 800 and now one in ten officers work in that team.

In the summer of 2014 the College of Policing carried out a consultation on their new training material to raise awareness amongst investigators and equip them to tackle to practice. The reference document is now available.³⁶

3.5 Local Authorities

Leadership

Although some councils have made a high profile statement to eliminate FGM, the Local Government Association (LGA) councillor's guide to FGM says:

“Councils have yet to feature in a significant way in the debates about what needs to be done to reduce instances of FGM. This is surprising because local authorities have a clear and important

role to play. They are the lead agency when it comes to safeguarding children and protecting them from harm. They provide or commission services that FGM survivors need. They can engage with communities where FGM has traditionally been practised and work with them to challenge views.”³⁷

The importance of raising the profile and awareness of FGM was recognised. It was noted that Coventry City Council had passed a resolution condemning FGM and West Midlands Police and Crime Panel Members were encouraged to persuade their Council to take a similar approach and ensure that action follows from it. Following this, debates have been held in Solihull and Walsall council meetings. But paper statements alone do not solve this challenge. We also need to have appropriate data sharing, respectful dealings with parents and procedures that work, clear referral processes and care pathways, everyone being clear about responsibilities, plus the provision of appropriate services.

Child Protection

Government guidelines make clear that:

“Anyone who has concerns about a child’s welfare should make a referral to local authority children’s social care; anybody can make a referral. Initially, the professional will refer the potential victim as a child in need and social care will assess the risk.”³⁸

A clear process is needed so that practitioners know when and how to refer and ensure that multi-agency safeguarding procedures are followed. We were concerned to hear, therefore, of the lack of clarity in one case when a school had referred a girl to children’s social care due to urgent concerns and after three days a strategy meeting had not been held and the school was told they should deal with it themselves.

Consideration should also be given as to how FGM data is recorded by, for example, children’s social care. One local authority told us that any intelligence on FGM will be contained within the detail of a child’s assessments and observations

and so cannot be extracted easily from a database. This may mean that opportunities are lost to look at patterns and trends.

Public Health

Public Health Departments have a range of responsibilities for commissioning services, such as school nurses, health visitors and sexual health services. Safeguarding issues, including FGM, need to be considered within this. Further work could be carried out across the region to consider approaches currently being taken in commissioning and how to achieve best outcomes in tackling FGM. There is inconsistency across the region. In Birmingham, for example, FGM is included in safeguarding training for school nurses and health visitors, but we understand that nothing specific to FGM has been included in the public health contracts for those services. Walsall has developed care pathways to address FGM to support sexual health services.³⁹ We understand that Dudley and Sandwell, for example, have not specified FGM pathways within their main sexual health contracts. However, a recent review of health services to support safeguarding in Sandwell did note good practice:

“School Nurses are encouraged to join fortnightly Twitter discussion through a professional Twitter school nursing community to discuss topics such as ... female genital mutilation ... This provides discussion and support at a national level that is disseminated locally ensuring advice and support is up to date and services are accessible to children and young people.”⁴⁰

Local authorities are required to produce a Joint Strategic Needs Assessment (JSNA) of the health and wellbeing of the local community. FGM data included in the JSNAs across the region appears to differ.⁴¹ Without data on FGM, these needs assessments cannot build a picture of the local need for FGM-related services and the funding required. This is another area where further work could be undertaken.

Councillors' Roles

Councillors should bear in mind the actions they can take. There are three ways that councillors in each of the seven districts can play a role in tackling FGM:

- as decision-makers, giving a high profile to policy interventions and making the issue a political priority for action;
- as ward councillors and community leaders, engaging with local people and holding discussions to work to end the practice; and
- as scrutineers, investigating the work that the council and its partners are doing and suggesting improvements.⁴²

Moving Local Authority Activity Forward in the West Midlands

An Esmée Fairbairn Foundation evaluation of FGM projects⁴³ concluded that:

“Although there are examples of promising practice (e.g. Bristol), local statutory responses to FGM prevention are largely patchy and inadequate, and do not reflect local levels of need. Although most project areas had policies in place, they were not always translated into concrete actions, e.g. training social care/health professionals in issues relating to FGM.”

This would suggest that a unified local authority approach across the region would be beneficial and there needs to be clear reporting and accountability mechanisms to ensure that concrete action follows all paper policies.

3.6 Schools, Nurseries and Children’s Centres

We heard schools potentially have a dual role in tackling FGM, firstly by identifying potential or actual victims, and secondly by raising awareness about the practice among pupils. Organisations have also found schools to be a safe environment for family education sessions. Children’s Centres, too, often reach many young children and provide crucial support to parents in the early years.

As with all practitioners, teachers need to be trained about FGM. Research by the National Society for the Prevention of Cruelty to Children (NSPCC) in 2013 found, astonishingly, that four out of five teachers had never had child protection training on girls at risk, and only one in six were aware that FGM is illegal.⁴⁴ All school staff should receive training regarding FGM. The Foundation for Women's Health Research and Development (FORWARD) gave a strong rationale as to why this should be all staff not just safeguarding leads. In one school, it was the cleaner who noticed blood in the girls' toilets after the holidays, and as she was from an FGM practising community, understood what this might signify, and alerted the appropriate person.⁴⁵

FGM is now meant to be considered in an Ofsted (Office for Standards in Education, Children's Services and Skills) safeguarding inspection and should, therefore, be something that teachers have awareness of.⁴⁶ All schools should have a policy regarding FGM and it should be considered in attendance, safeguarding and sex education policies. Each LSCB requires schools to complete a safeguarding audit. The LSCB design these as they wish, but clearly at a regional level they should be sharing good practice to ensure that FGM is picked up.

Educating young people and empowering them to question the practice is an important aspect of preventative work, although we heard this can be challenging to achieve in all schools. Teachers may say it is difficult to find space on the timetable for this issue. Additionally, this is a sensitive topic to discuss. We were told of one schools workshop where a number of the children walked out and others put their fingers in their ears. There was a call not to leave discussions with girls too late. One organisation found that Years 6 and 7 are more chatty and by Year 11 pupils are more circumspect, partly, because they have more understanding that a parent could be arrested. We understand that some schools just run sessions on FGM by picking out those girls from communities they feel most at risk. It was felt that this is unhelpful and just stigmatises those groups.

School and Nursery Examples from Birmingham

A) Nursery School Leading on Community Empowerment

Bloomsbury Nursery has worked with parents to raise awareness of FGM and why it needs to stop. Sally Davies, the Deputy Head, explained that the tireless work they have undertaken came from an unexpected visit from a father one day who said "we need to talk about FGM".⁴⁷ Working with the father, a Parents Forum was held to talk about the issue and many of those parents have continued to be involved in this issue. Not only is this approach making a difference to families, but is also recognised by Ofsted:

"At Bloomsbury Children's Centre, members of the parents' forum actively campaign to raise awareness of the risks associated with FGM. Their concerted lobbying and sensitive opposition to FGM is gathering support within the reach, and in the region, and importantly they are helping to safeguard children. 'Saving the next child' is the campaign's dedicated approach to end this form of child harm."⁴⁸

B) Safeguarding children through conversations with parents

Hazel Pulley, both the Head Teacher of Parkfield Community School and the Chair of Birmingham Against FGM, emphasised the importance of asking parents questions, even it is as simple as: "Are you taking your child away for cutting?" In Parkfield Community School the focus is on Year 3-6 children. The school works with mothers and a school nurse and accepts that a key challenge is to make sure no one feel discriminated against. "It can be done", we were told. Good practice at Parkfield includes training staff, asking parents directly if they have intentions to cut, telling the children they should "talk to your mums to make sure the area between your legs doesn't get changed," and referring if there are concerns.

C) Developing Youth FGM Champions

Muslim Women's Network UK has been working with Ark St Alban's Academy in Birmingham (a Church of England school under the Ark Trust). As well as dealing with FGM in class in a number of year groups they have also developed FGM champions in the 6th Form; girls as well as boys. Advocacy workshops have helped build their capacity. The group's first task was to launch a school wide competition to design a logo for Muslim Women's Network UK FGM Summit in 2015, which they subsequently ably helped to host. The school has championed the eradication of FGM in other ways, such as by putting advice about FGM on the front page of their regular newsletter and training staff to be able to deal with it.

In addition, we were warned that the very complex educational landscape (maintained schools, academies, supplementary schools, independent schools, studio schools and faith schools) is challenging. Also, parents have a right to opt out of personal, social, health and economic education (PSHE) which means not all children might receive this education.

Examples of how FGM is being proactively tackled in three Birmingham educational institutions are described in the box above. We look forward to sharing other examples from across the region.

3.7 Health

The Department of Health has produced guidelines for health professionals in dealing with FGM.⁴⁹ The role of health practitioners was in the public domain during 2014-15 as the only attempted prosecution for FGM was against a London doctor who had restitched a woman who had given birth. The doctor was found not guilty, but the case showed the importance of asking and understanding FGM. It would appear from the press that professionals who had examined the woman knew she had undergone FGM, but that she had not been put on the FGM pathway.⁵⁰ Thus, when she presented in hospital to give birth practitioners did not know this complication and it became an emergency situation. Further, the doctor in charge had not previously dealt with a case of FGM and said he had received no training on FGM.

All health professionals must collate data on women who have been cut, but midwives are in a unique position to address this directly. The Panel was informed by one midwife that “women have given us permission to inspect their genitals.”

Ideally, practitioners need to identify a woman who is cut on booking into antenatal services so all concerned know what needs to be done to ensure she can deliver safely. Additionally, the Panel were told that if a woman has been cut in the most extreme way it can be traumatising for her to only find that out when in hospital to give birth.

It is important, however, that any intelligence about women being cut whilst resident in the UK is shared appropriately. NHS England states that it remains best practice to share information between healthcare professionals to support the ongoing provision of care and efforts to safeguard women and girls against FGM.⁵¹

Health practitioners need to understand the referral pathways. In Walsall, for example, GPs were sent advisory letters giving them information on signs of FGM and were told where to refer cases to.⁵² We heard a range of FGM related activities developed by the local health sector which are noted below.

Heartlands / Heart of Birmingham NHS Trust

The Heart of Birmingham Trust (incorporating Heartlands, Good Hope and Solihull Hospitals) African Well Women's Clinic provides services to support pregnant and non-pregnant women who have undergone FGM. It is a long established proactive approach, and one of 16 specialised FGM maternity services in the country, the majority being in London.

At the clinic patients are assessed and the type of FGM is identified. A care plan is then developed according to her needs. Safeguarding issues and the law are also discussed with the patient. Patients may not know the severity of their condition and can be traumatised by the knowledge that this was done to them by their families. However, access to physiological support services is limited.

Wolverhampton Royal Hospital NHS Trust

Work to support patients with FGM is in its infancy. Around two years ago Wolverhampton Domestic Violence (Forum) undertook an awareness training session with around 50 community midwives. In September 2014 the lead practitioner organised a multi-agency forum to discuss how key agencies could work together to tackle FGM.

A matron-led FGM task and finish group has been established. Clinician guidelines have been updated and an FGM safeguarding policy is in development. Since the beginning of 2014 the maternity department has incorporated FGM awareness training into the monthly mandatory sessions for midwifery and obstetrics teams.

Birmingham South Central CCG

The CCG is focussing on FGM as a key safeguarding issue. They are ensuring partner organisations know how to refer (such as into multi-agency safeguarding hub (MASH) arrangements) and are gaining assurances that FGM is being added to training, plus they have delivered training to GPs and others.

A key challenge identified was frontline professionals having a lack of understanding of safeguarding needs of children from black and minority ethnic backgrounds. Work has begun to implement the recommendations from a research project and develop a training toolkit with Birmingham Safeguarding Children Board to raise awareness, develop communication skills and embed good practice.

One group of GPs at the Capehill Medical Centre issue information on FGM, and the fact it is illegal, at patient travel clinic appointments. The CCG intend to share this example of good practice with other groups.

Once again, the importance of training cannot be understated. It needs to be part of the “way we do things around here.” Although one CCG told us that FGM is included in level 3 safeguarding children training for GPs, we found responses from GPs in another CCG area showed huge differences in availability and take up. During our discussions we discovered an example of FGM work which was being led just by an individual health practitioner. We congratulate their efforts and dedication, but urge all local Executive Health Trust Boards to make FGM a priority as a key safeguarding and health issue, so it is not left to individual champions.

3.8 Third Sector – Voluntary, Community and Faith

Third sector organisations have been at the forefront in tackling FGM. The Panel met two organisations committed to raising awareness, training professionals and working with affected communities. They told us that education and awareness raising is one of the most effective ways of eradicating the practice and that their work has to be scaled up across the region:

“We need to change attitudes. We need a massive community development campaign.”

“The more we get the word out there the easier it is to end it.”

We acknowledge this is not a straightforward process as cultural practices, such as FGM, have been ingrained for many generations and require extensive work to change attitudes. We heard that messages have to be clear, but there were discussions at our meetings about the appropriateness of terms used and images used in promotional material. In particular, some images were felt to be inappropriate as they may be stressful to women and girls who have undergone FGM.

The Panel recognises that the whole community must be involved in ending FGM, including women, men and young people. There needs to be work with men as they can be agents of change. Working with young people is also important as education can empower them to stop it happening to themselves or their contemporaries and as the next generation of parents.

Awareness raising cannot just be undertaken with community leaders. One danger flagged was that although a community leader might say they are against FGM, they might not mean all types of FGM. The lesson was that if community and faith leaders are being asked to speak out against FGM that clarity is sought that they are against all forms of FGM.

We heard how community education and engagement was most effective when information about the health implications of FGM is discussed. Communities have felt stigmatised if they are just seen in terms of FGM alone and it should be acknowledged they have housing, benefits, immigration, health and employment and other needs to discuss as part of a wider community development approach. We heard one perspective that at one stage WMP would only engage with black and minority communities on the Prevent agenda, whereas those communities wanted to address local community safety issues, stop and search and so on. There is a danger, it was suggested, that some communities may perceive that the

same is now true for FGM, that WMP and other public agencies might only seek engagement with FGM practising communities on the issue of FGM.

Birmingham and Solihull Women's Aid (BSWA)

Since 2010 BSWA has run an FGM Community Development Project, recruited community champions (women who are passionate about FGM who want to address the issue in their community), established women and youth groups across the city, provided outreach support for women affected and shared learning through leaflets and training sessions.

In 2010 BSWA and Options UK recruited and trained 15 local women from FGM practising communities to be researchers into community views on FGM. This learning has been disseminated through several conferences and a range of multi-agency training.⁵³

A young women's group they have set up produced an animation "*Unstitch*" to highlight the issues. This can be seen at: https://www.youtube.com/watch?v=0D-ge_D8LhA.

BSWA has received Violence Against Women and Children government funding to act as the local expert and train other organisations to develop preventative initiatives and local community champions.

BSWA's "ABCD" approach to addressing FGM:

Change **A**ttitudes - Women may be ignorant of health problems as result of FGM or of the type of FGM done and communities are not aware of FGM as child abuse. There is a need for major community education campaigns.

Tackle **B**arriers - Professional training of how to work with communities is necessary. There is failure to see FGM as safeguarding; few services; poor professional responses; difficult to identify indicators & FGM dynamic cultural practice.

Apply **C**oercion - There is slow level of reporting; victims withdraw; and insufficient evidence. Social pressure aids silence on deeply embedded cultural practice.

Understand **D**iaspora - Many different communities practice FGM in myriad of ways - one size does not fit all. Communities are not aware of others' practices; may feel a stigma of being viewed only through prism of FGM and made to feel ashamed.

Muslim Women's Network UK (MWNUK)

MWNUK, a national charity based in Birmingham, has been undertaking a range of activities to tackle FGM. MWNUK is undertaking a research project on FGM in Birmingham which includes going into schools to talk to pupils and parents. Its research will be published later in the year. We were told that their work has encouraged a number of women to talk about their personal experiences for the first time, and also identifying girls at risk or believed to have been cut.

Researchers found inconsistencies in frontline professional's knowledge of FGM referral processes and appropriate follow up of disclosures and concerns.

Research has identified the need for local specialist psychological support for women and girls and outreach work.

Further debate is needed on how to create an environment that enables girls to access help they need which does not require the consent of their parents.

MWNUK is keen to develop a local information video and leaflets. They also organised a very successful community and multi-agency FGM summit in March 2015 in conjunction with Ark St Alban's Academy.

We discussed the role of religion in FGM. Although it is practiced in some Muslim communities it is not a religious practice, it is a cultural one and in some countries it is practiced more in Muslim communities and in others more in Christian ones.⁵⁴ However, the Esmee Fairbairn Foundation says that:

"Periodic re-engagement with religious leaders will be required to ensure the important messages that they have communicated remain relevant and fresh."⁵⁵

In order to do this, partners should agree how to work appropriately with local faith organisations in their areas.

4 Conclusions and Recommendations

4.1 Police and Crime Panel Statement

Clearly, there is much that is going on to tackle FGM that is positive across the region. Different areas and organisations are at different places in the journey: some just setting out, with others having long established multi-agency working. Below, the Panel sets out its position on FGM and priorities for further work:

“The West Midlands Police and Crime Panel condemns the practise of Female Genital Mutilation and supports the national campaigns to ensure its eradication. FGM is child abuse and illegal and should be treated as such; cultural sensitivities should not cloud judgements. All organisations in the West Midlands dealing with children need to understand that girls from FGM practising communities may be at risk and practitioners need to be empowered to ask parents questions and to work together in children’s best interests on a case by case basis.

We call upon all relevant authorities, including those involved in law enforcement, the justice system and public health, to do everything in their power to protect young girls from this life endangering, health threatening crime. We also call for appropriate support for women and girls who are victims of FGM.

The Police and Crime Commissioner needs to hold West Midlands Police to account for its contribution to prevention and securing prosecutions and to fund victims’ services for survivors of FGM in the region.”

4.2 Priorities for Tackling FGM

The Panel firmly believes that FGM is child abuse and that it needs to be eradicated. Prosecution and prevention have to go hand in hand. In talking to witnesses it became clear that a regional approach that places prosecution as the primary aim will compromise and conflict girls as they see those who care for them being dealt with by the police, or even a fear that they would have to give evidence against their family members. There was a fear that tackling this insensitively will just drive this further underground. The focus has to be in working with communities to prevent it occurring and in supporting those who have been cut.

There needs to be a shift in public understanding and social norms and investment in evidence based research and in key stakeholders and community based organisations.

In Bloomsbury, Birmingham, it took just one father to say to a member of staff at the nursery “we must talk about this” to start robust, community focused activity. It has been said before in a safeguarding context “it is everyone’s business.” We believe it only takes one person to ask ‘have you been cut?’, “do you intend to cut your daughter?”, “who will work with me to stop FGM?”, “how can my organisation be more resilient?” and through multiple individual actions each and every day, we believe FGM can be stopped in a generation.

We now set out our nine recommendations to tackle FGM in the region. They fall into five general areas of work:

- Working together with consistency across the region;
- Educating and empowering communities;
- Educating and empowering practitioners;
- Prosecution; and
- Providing support and therapy.

4.3 Integrated Working

It is suggested that:

“Despite commendable work, existing UK FGM programmes lack the rigour, multi-agency coherence and funding needed to address asylum seekers’ and refugees’ needs satisfactorily. What is required is an integrated policy agenda capable of meeting these girls’ and women’s needs. This agenda should cover the training of professionals, research, community education and the development of culturally sensitive health services.”⁵⁶

In his 2014 Annual Report, Stephen Rimmer set out an intention to develop an integrated operating model for PVVP which has real collective commitment.

Integration means working across a range of partners with different, perhaps incompatible structures, cultures and incentives for transformation. Learning from several case studies the Panel found the following are needed to drive forward successful integration:

- Strong political and managerial leadership;
- Shared vision and understanding of the outcomes and benefits between partners;
- Clear and regular communication with staff and users;
- Developing clear processes and local data sharing agreements; and
- Openness of senior leadership to potential difficulties and a clear process for managing risk and failure.

We asked agencies about the benefits greater integrated working between agencies might bring to tackling FGM, and we heard:

- Sharing information would enable prevalence to be mapped, risks to be identified and increase the oversight of safeguarding female children;

- Raise awareness of the issue with professionals across the West Midlands and how to appropriately signpost cases or refer concerns;
- Shared agendas would enable targeted, joined-up and collective preventative work and a better response to those who have already undergone FGM;
- Working together can help meet the demand and discharge responsibly more effectively; and
- Raise public awareness of FGM and improve communication with the public.

Further steps should be taken to ensure that more integrated working between agencies is developed to ensure limited resources are used most effectively, that data is shared appropriately with intent and that the actions of any single agency contributes to the shared priorities.

It appears that progress has been different across the region and moving toward a baseline should be agreed. This should include collective ways of assessing risk and clarity on what practitioners need to do and what early help is available. Where there is an existing MASH this team can provide a base to build on for integrated working.

The Panel's view is that greater co-ordination and collaboration between statutory bodies and community groups is also required to ensure a joined-up and consistent approach to ending FGM, to develop the right services and focus resources on both preventative work and to supporting those living with the consequences.

The PCC has a key role in facilitating integrated working in this area and his Police and Crime Plan for 2015 set out some intentions for tackling hidden crimes. If applied to FGM it sets out the priorities well:

- There is further regional work to be done on agreeing with partners across the region a standard approach to collecting, sharing and analysing data and agreeing how to best flag girls at risk;
- There is further work to agree with partners common protocols and responses based on best practice;

- There is a need for the Police to work in an intelligently joined up way with other organisations, especially health and educational to support each other's safeguarding work;
- To build on intelligence to target and catch perpetrators, especially cutters themselves; and
- The PCC in conjunction with partners needs to ensure there is effective support for victims.

The Panel believes the PVVP Board, the PCC and existing multi-agency working groups in local authorities are best placed to drive the integrated working agenda forward. We recommend that a regional task force on FGM is established. It was suggested to us that that this should include community representatives and NHS Trust Chairs to facilitate progress on some of the recommendations. It was also suggested that the task force should develop a long term regional FGM Reduction Strategy along with an FGM Delivery Plan for 2015/16 onwards, focusing on multi-agency activity.

See Recommendations 1 and 2 (See Pages 7–9)

4.4 Prevention

Leadership and Champions

Organisations need leadership from the top (such as full Council or Cabinet, and organisations' Executives or Boards) and also champions able to make this reality. As noted previously, some councils have made a high profile statement to eliminate FGM, which needs to be followed through by officers and councillors themselves understanding how this will be implemented and the role they need to play.

Change may need to come from the PCC and political and managerial leadership. Commissioners of services need also to be aware of FGM.

See Recommendation 4

Procedures

FGM is child abuse and needs to be treated accordingly through consistent child protection and safeguarding procedures. Child protection is paramount and it is important to have transparent policies and risk assessments in place. Across the region more can be done to:

- Develop data to ensure an understanding of the number of girls at risk and where they live (using school census data could be a starting point);
- Increase disclosures;
- Establish data sharing agreements, outlining what data can be shared locally, whilst respecting women and girls' rights and privacies;
- Ensure appropriate FGM training and reporting is written into relevant commissioned services;
- Develop clear processes and joint training of staff to overcome barriers and allay fears about information sharing; and
- Develop consistent and clear pathways with clear responsibilities, roles and time-scales.

See Recommendation 1

Awareness and Knowledge of Frontline Practitioners

One witness said:

“There are few services for women. GPs are overwhelmingly ignorant and may not even ask the right questions. Professionals can be ignorant. We need training for professionals. If we trained every police officer, teacher, GP and nurse, they can help identify those who need [to be protected] and where it takes place, which we need for successful prosecution.”

There is an on-going need to build professional awareness and capability.

Furthermore, leaders and managers within organisations need to build FGM into

safeguarding policies to ensure prevention and referral is embedded into everyday practices. There clearly needs to be work carried out to clarify procedures and sources of support across the region, as one practitioner pointed out she was:

“Unclear what pathways currently exist and what support services are available.”

As the Serious Crime Act 2015 introduces mandatory reporting of FGM by healthcare professionals and teachers, it is vital all practitioners in the West Midlands have the right information to identify those at risk of FGM, spot the signs and risks and understand reporting obligations and referral pathways.

Another witness reiterated the importance of training:

“Training appears to be essential, yet problematic. When asked, some key personnel within agencies are still unaware of the issues of safeguarding and FGM e.g. GPs within Clinical Commissioning Groups. There is a matter of urgency for all ‘first hand professionals’ to receive training as soon as possible to ensure children are safeguarded.”

Across the region there needs to be a co-ordinated and comprehensive training and information programme for frontline practitioners which should include:

- Clear referral pathways (for safeguarding and support), understood by front-line health professionals and school staff;
- Training for professionals to identify those at risk or living with the consequences of FGM. This should cover the law, safeguarding, the risk indicators and lifelong impact of FGM to give front line staff the knowledge and skills to address it; and
- Support to develop professional inquisitiveness to get over any reluctance or awkwardness of professionals to raise FGM and to talk about it sensitively in routine conversations with patients or parents at school.

We feel the LSCBs are in the best position to take a lead on ensuring multi-agency training is provided, in conjunction with the third sector, campaigners and other

statutory bodies. It was suggested to us, during the consultation on the report, that Safeguarding Adults Boards also have a role to play in offering and co-ordinating training. This should be explored further.

See Recommendations 6 and 8

Community Awareness

Working with affected communities is key to eradicating FGM. It is important to educate children, women and men of the dangers and health risks of FGM and the fact that the practice is illegal in the UK.

As noted, it is felt that girls whose mothers have been cut are most at risk and it is with those families where engagement is particularly required. One approach we heard of was in Coventry where a joint home visit is undertaken by children's social care and WMP. Other practitioners, suggest a case by case approach is required and that health professionals can be in an ideal position to have such conversations.

Attitudes are changing and community champions are speaking out against FGM. We need to support those community champions and recognise their bravery and the unique links to communities that they can provide. However, cultural change will not happen straightaway, and we believe proactive community engagement work is essential to change mind-sets and deter perpetrators. This requires:

- Celebrating, publishing and sharing best practice for local community engagement initiatives, information for men and boys and school based workshops for parents and children;
- Working with young people in affected communities to empower them to question the practice, to break the cycle of FGM;
- Engaging with community leaders, religious leaders, community and voluntary groups and holding discussions about the practice;
- Ensuring imagery and terms used are appropriate;

- Developing more detailed understanding of each of the FGM practising communities settled in the region; and
- Developing guidelines for working with families where there are girls and a mother who has, herself, been cut.

We believe the PCC is best placed to facilitate this community empowerment work with WMP, local authorities, health organisations and the third sector.

[See Recommendations 1 and 7](#)

4.5 Prosecution

Many people have talked about how there is a race on to be the first police force to secure a prosecution. We accept that a successful prosecution can send out a powerful positive message and help to change mind-sets. However, it is important to note that every act of FGM that could lead to prosecution represents a failure to protect a girl.

We heard about the difficulties securing a prosecution, such as obtaining evidence, and survivors' understandable reluctance to testify against family members. In addition, until recently, there was the legal loophole that women and girls had to be permanent UK citizens for a case to be taken. The burden of evidence appears high as there is a need to prove beyond all reasonable doubt that at one point in time the girl was not cut and at a later point in time she was, plus being able to name the cutter and any accomplices. None of this excuses FGM or accepts its inevitability, but it explains some of the difficulties in achieving a successful prosecution.

There is a need to pool intelligence to bear down on anyone who is cutting in the region or the wider UK.

We encourage close working between the CPS and WMP to ascertain if any cases in the region have a likelihood of success and to see how the girls themselves can be protected from having to give evidence in court against a close family member.

We also support the use of civil orders to protect girls. The Serious Crime Act 2015 has introduced FGM protection orders, although no commencement date has yet been set. An FGM protection order may contain prohibitions, restrictions or requirements as a court considers appropriate for the purposes of preventing FGM. As these are civil orders, the burden of proof is different to criminal convictions and require the balance of probability. We would encourage sharing of good practice across the region as experience of using these develops. A business case is being built to support local authority collaboration on a broad range of civil orders across the West Midlands. We support the exploration of using civil orders (injunctions) to tackle and disrupt the practice of FGM wherever possible and appropriate.

[See Recommendations 1 and 3](#)

4.6 Support Services for Survivors of FGM

Women can suffer from poor health after FGM and health services need to be able to meet the health needs, particularly around childbirth. Women may need to be opened to enable a natural birth and scar tissue can impede delivery too.

We heard about the long term health and psychological damage FGM causes. MWNUK said that flashbacks at least twice a week were common in the women they had been talking to.

It was apparent that there are inadequate counselling and other support mechanisms available. There needs to be more in place to support survivors of FGM. We were told, for example, of a third sector organisation struggling to find a counsellor for a 13 year old who had recently disclosed FGM. In London a specialist clinic for girls opened last year which includes psychotherapists and play specialists. It has dealt with girls aged between 3 and 17. The lead health professional has stressed the need for specialist services for children.⁵⁷ In this region an environment needs to be created to help girls access help.

The PCC, as commissioner for local victims' services, local authorities and CCGs need to work together to ensure that appropriate FGM counselling and support

services for both the health and psychological impacts available for women and girls who have undergone FGM. It was suggested in a time of budget pressures that a ring fenced budget should be made available to provide a counselling service and single point of contact. There is a challenge in ensuring the provision of therapeutic services reflects the prevalence of FGM, given the current lack of comprehensive data about needs.

It should be noted that the Criminal Injuries Compensation Authority (CICA) Scheme can compensate women and girls for the damage inflicted by FGM. There does not need to be a conviction, in fact the assailant does not need to be identified, but the applicant must co-operate as far as possible in bringing a known assailant to justice. However, an award will be withheld unless the incident is reported to the police as soon as reasonably practicable.⁵⁸

If the incident is reported to the police whilst the applicant is a minor, an application must be made to CICA by the time the applicant is aged 20. If reported to the police after age 18 years of age, within two years of that reporting. There is additional guidance around timescales and the eligibility to apply to the Scheme at the on line guide.

The Criminal Injuries Compensation Authority Scheme can compensate blameless victims of violent crime who were injured in Great Britain or another relevant place. The Scheme sets out what is considered to be a relevant place.

[See Recommendation 5](#)

4.7 Moving Forward

We wish to consider progress reports on the implementation of our recommendations over the next year and would reiterate the comment of the Chairman of the Home Affairs Select Committee, Keith Vaz, on the Government's response to the Committee's FGM report that:

“The worst possible thing that we could do for those who suffer every day is to produce a report [and] let it lie on a shelf.”⁵⁹

[See Recommendation 9](#)

Appendix 1: Witnesses

The Panel is very grateful to the following who contributed to our Inquiry sessions:

David Jamieson, West Midlands Police and Crime Commissioner

Stephen Rimmer, Strategic Lead for Preventing Violence Against Vulnerable People

DSI Tim Bacon, West Midlands Police

DC Gillian Squires, West Midlands Police

Emma Danks, Midwife, Royal Wolverhampton Hospitals NHS Trust

Etain McDermott, Public Health Programme Officer, Coventry City Council

Dr Tanya Richardson, Public Health Consultant, Coventry City Council

Nasheima Sheikh, Deputy Chief Executive, Birmingham & Solihull Women's Aid

Fiona Allen, Deputy Designated Nurse, Birmingham South/Central CCG

Shahin Ashraf MBE, Muslim Women's Network UK

Shaista Gohir MBE, Chair Muslim Women's Network UK

Hazel Pulley, Head Teacher Parkfield Community School /Chair Birmingham
Against FGM

We also received written submissions from a number of organisations (See our Evidence Pack).

The draft report was sent to all witnesses and the draft recommendations were also sent to key contacts in the majority of organisations being asked to implement them:

- All West Midland NHS Trust Chairs and Chief Officers
- All West Midlands Clinical Commissioning Group Chairs
- Directors of Children Services
- Directors of Public Health
- Community Safety Partnerships
- Local Safeguarding Children Board Chairs and Lead Officers

We are grateful for all those who took the time to comment.

Appendix 2: FGM Definition

FGM has been classified by the World Health Organisation into four types:

Type	Type	Description
Type I	Clitoridectomy	Partial or total removal of the clitoris and/or the prepuce
Type II	Excision	Partial or total removal of the clitoris and the labia minora, with or without removal of the labia majora
Type III	Infibulation	Narrowing of the vaginal opening through the creation of a covering seal by cutting and repositioning the labia minora and/or the labia majora, with, or without removal of the clitoris
Type IV		All other harmful procedures to female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping and cauterisation.

REINFIBULATION OR RE-SUTURING

Reinfibulation is when the raw edges of the FGM wound are sutured again following childbirth, recreating a small vaginal opening similar to the original FGM Type III appearance.

SOURCE: Multi-Agency Practice Guidelines: Female Genital Mutilation HM Government 2014 www.gov.uk

Appendix 3: Health and FGM

There are both short and long term health consequences of FGM for women and girls. The short-term consequences following a girl undergoing FGM can include:

- severe pain
- emotional and psychological shock
- haemorrhage.
- wound infections, including tetanus and blood borne viruses (including HIV and Hepatitis B & C).
- urinary retention.
- injury to adjacent tissues.
- fracture or dislocation as a result of restraint.
- damage to other organs.
- death.

The long-term health implications of FGM can include:

- chronic vaginal and pelvic infections.
- difficulties with menstruation.
- difficulties in passing urine and chronic urine infections.
- renal impairment and possible renal failure.
- damage to the reproductive system, including infertility.
- infibulation cysts, neuromas and keloid scar formation.
- obstetric fistula.
- complications in pregnancy and childbirth.
- pain during sex and lack of pleasurable sensation.
- psychological damage, including a number of mental health and psychosexual problems such as low libido, depression, anxiety and sexual dysfunction; flashbacks during pregnancy and childbirth; substance misuse and/or self-harm.
- increased risk of HIV and other sexually transmitted infections.
- death of mother and child during childbirth.

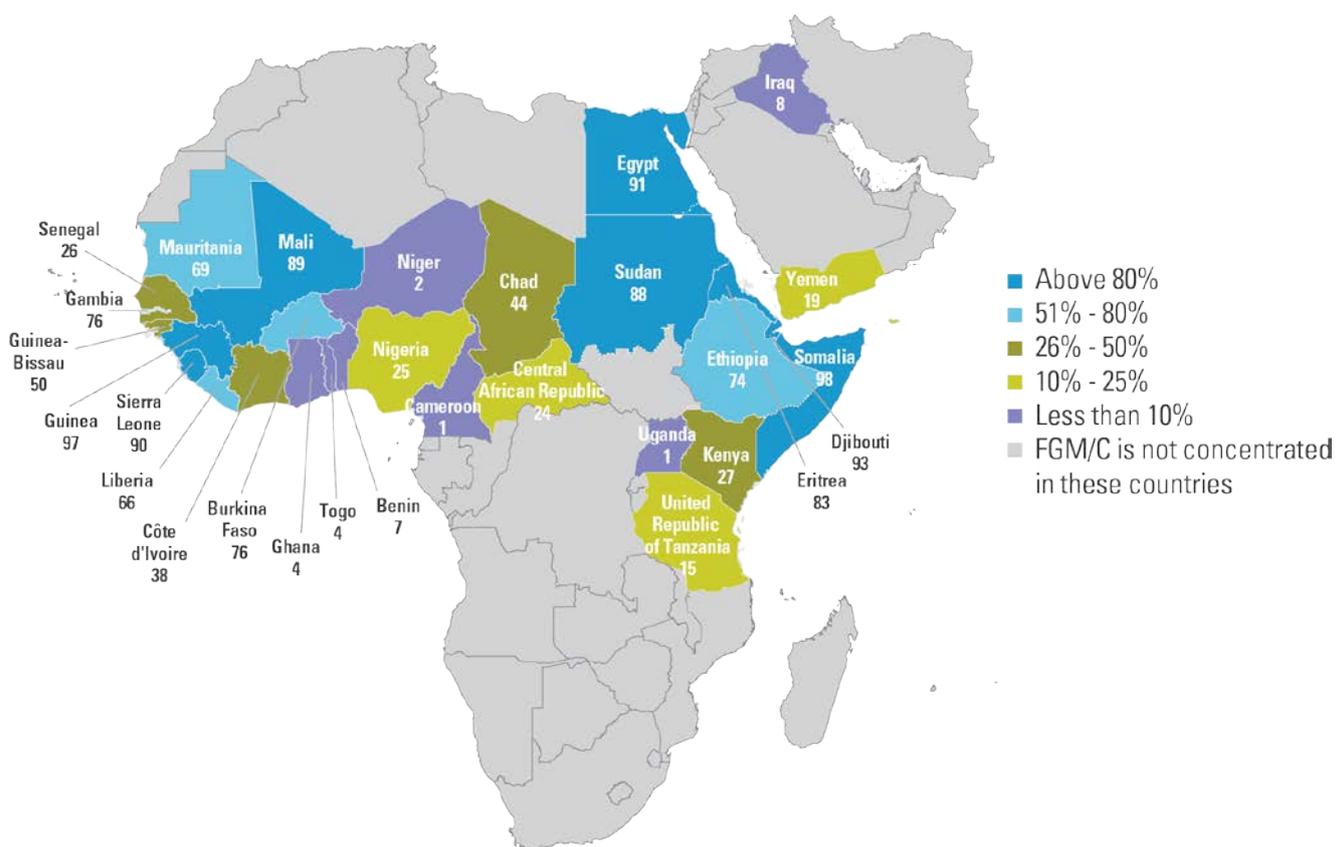
SOURCE: Multi-Agency Practice Guidelines: Female Genital Mutilation HM Government 2014 www.gov.uk

Appendix 4: Where is FGM From?

According to the World Health Organisation (WHO), FGM is practiced in up to 28 African countries plus some countries in Asia and the Middle East and among migrants from these areas.

The map below details the prevalence of FGM in women aged 15-49 in these African countries plus Iraq and Yemen. FGM is also reported to be practised in parts of Indonesia, Malaysia and in Kurdistan (which is split between Iraq, Iran, Syria and Turkey), but there is no data as to the extent.

Percentage of girls and women aged 15 to 49 years who have undergone FGM



Note: In Liberia, girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM since it is performed during initiation into the society.

Source: UNICEF global databases, 2014, based on DHS, MICS and other nationally representative surveys, 2004-2013; <http://www.data.unicef.org/child-protection/fgmc>

Appendix 5: Coventry City Council Motion

“This Council condemns the hideous practise of Female Genital Mutilation (FGM) and supports the national campaigns including that of the British Arab Federation (BAF) in its campaign to ensure its eradication.

We support:

1. Enforcement of the law so that British girls and girls resident in Britain are protected from being taken to different legal jurisdictions with the intention of carrying out FGM.
2. Better enforcement of the law including against parents and guardians who organise FGM and practioners who conduct FGM procedures
3. Better education to support young girls in resisting FGM, to educate boys to oppose it and to empower communities to confront it

We call upon all relevant authorities, including those involved in law enforcement, the justice system and public health, to do everything in their power to protect young girls from this life endangering, health threatening crime”

Source: Coventry City Council Meeting 3rd December 2013

Appendix 6: Useful Contacts and Further Information

POLICE

West Midlands Police FGM Advice:

<http://www.west-midlands.police.uk/advice-centre/help-and-advice/honour-abuse/female-genital-mutilation/>

Contact West Midlands Police on 101, or call Crimestoppers anonymously on 0800 555 111. In an emergency ring the West Midlands Police on 999.

UK GOVERNMENT

National Multi-Agency FGM Guidelines - Download the current government guidance providing advice and support to frontline professionals who have responsibilities to safeguard children and protect and support adults affected by FGM from:

<https://www.gov.uk/government/publications/female-genital-mutilation-guidelines>

HELPLINES

National Society for the Prevention of Cruelty to Children (NSPCC) FGM Helpline

24 –hour Helpline. Free phone 0800 028 3550

www.nspcc.org.uk/fgm

ChildLine

24-hour Helpline for children: 0800 1111

www.childline.org.uk

Muslim Women’s Network UK Helpline

Monday, Wednesday and Friday (10am to 1pm) and Saturday (7pm to 9pm)

0800 999 5786 (free from landlines)
0303 999 586 (to call from mobiles)
07415 206 936 (text us)
info@mwnhelpline.co.uk

Birmingham and Solihull Women's Aid Helpline

Monday to Friday, 9:15 a.m. to 5.15 p.m. Free phone 0808 800 0028

OTHER ORGANISATIONS

Foundation for Women's Health Research & Development (FORWARD)

<http://www.forwarduk.org.uk/>

Daughters of Eve

<http://www.dofeve.org/>

NHS Choices – FGM Health Services

<http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Pages/fgm-health-services-for-women.aspx>.

WEST MIDLANDS REGION – SAFEGUARDING REFERRALS

The details below are from local authority and Safeguarding Children Board websites. Generally professionals are asked to complete inter-agency referral forms available on the web sites.

Children's social care teams may not accept referrals about FGM if they regard the risk to the girl as low. In such cases a referring agency may be asked to work with the family to reduce risks (referred to in some authorities as "early help". This will be dependent on agreed thresholds and local advice should be sought.

Birmingham

If you have any concerns about the safety and/or welfare of a child or young person telephone the Multi-Agency Safeguarding HUB (MASH) on 0121 303 1888 or email MASH@birmingham.gov.uk

Out of office hours call the Emergency Duty Team on 0121 675 4806
<http://www.lscbbirmingham.org.uk/>

Coventry

If there is no immediate danger or you need advice or information call the Referral and Assessment Service on 024 7678 8555
Out of office hours in an emergency call 024 7683 2222
http://www.coventrylscb.org.uk/reporting_concerns_summary.html

Dudley

Call the appropriate office:
Brierley Hill Area Office: 01384 813000
Dudley, Sedgley and Coseley Area Office: 01384 813200
Halesowen and Stourbridge Area Office: 01384 815902
Out of office hours contact the Emergency Duty Team on 0300 555 8574
<http://safeguarding.dudley.gov.uk/report-it/>

Sandwell

In an emergency contact Sandwell's Contact Centre on 0845 351 0131
Or complete a multi-agency referral form available at:
http://www.sandwellscb.org.uk/site/reporting_concerns_home.html

Solihull

To report suspected abuse please call 0121 788 4333
Outside office hours in an emergency call 0121 605 6060
<http://www.solihull.gov.uk/Resident/socialservicesandhealth/childrenfamilies/safeguardingchildren/safeguardingchildrenyoungpeople>

Walsall

The Multi Agency Screening Team (MAST) is on 01922 658195
Out of office hours call the Emergency Response Team on 0845 111 2922 or 0845 111 2923
<http://wlscb.org.uk/concerned-about-a-child/>

Wolverhampton

For non-emergencies call the Central Referral Team on 01902 555392
Out of office hours in an emergency call 01902 552999
http://www.wolvesscb.org.uk/home_reporting_concerns.html

Glossary

ACPO	Association of Chief Police Officers	ACPO was wound up in April 2015 and is replaced by the newly-created National Police Chiefs' Council (NPCC) to coordinate operational policing and collaboration amongst forces at the national level.
BAFGM	Birmingham Against FGM	Established in 2005 to coordinate multi-agency action to prevent FGM (Members include West Midlands Police, Birmingham City Council and Primary Care and Hospital Trusts) and is now a sub-group of the Birmingham Safeguarding Children Board.
BSWA	Birmingham and Solihull Women's Aid	Birmingham and Solihull Women's Aid supports women and children affected by domestic violence, rape and sexual assault.
CCG	Clinical Commissioning Groups	Plan and design local health services and commission the majority of health services, including emergency care, elective hospital care, maternity services, and community and mental health services. CCGs are overseen by NHS England.
CPS	Crown Prosecution Service	Prosecutes criminal cases investigated by the police in England and Wales.
FGM	Female Genital Mutilation	All procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.
FORWARD	Foundation for Women's Health Research and Development	An African women's campaign and support organisation founded in 1983. Working through partnerships in Europe and Africa focusing on FGM, Child Marriage and Obstetric Fistula.
GP	General practitioner	GPS look after the health of people in their local community
JSNA	Joint Strategic Needs Assessment	Local authorities are required to produce a JSNA of the health and wellbeing of the local community.
LGA	Local Government Association	The national voice of local government. Works with councils to support, promote and improve local government

LSCB	Local Safeguarding Children Board	Each locality has a statutory responsibility (under the Children Act, 2004) to have these partnerships in place. The purpose is to hold partners to account and to ensure safeguarding children remains high on the agenda.
MASH	Multi-Agency Safeguarding Hub	A multi-agency team which co-locates key safeguarding agencies with a view to better identifying risks to children, and improving decision-making, interventions, and outcomes. They exist in some, not all of the West Midlands local authorities.
MWNUK	Muslim Women's Network UK	A national Muslim women's organisation that works to improve the social justice and equality for Muslim women and girls.
NSPCC	National Society for the Prevention of Cruelty to Children	A charity campaigning and working in child protection.
OFSTED	Office for Standards in Education, Children's Services and Skills	Inspects and regulates services that care for children and young people, and services providing education and skills for learners of all ages.
PCC	Police and Crime Commissioner	An elected official in England and Wales charged with securing efficient and effective policing of a police area.
PCP	Police and Crime Panel	Scrutinises and supports the Police and Crime Commissioner (PCC).
PPU	Public Protection Unit	A Unit within West Midlands Police
PVVP Board	Preventing Violence Against Vulnerable People Board	Consists of Council Leaders, senior police, health, safeguarding and children's services leaders. Developed the West Midlands PVVP Delivery Plan and provides oversight, support and challenge of key outcomes
	Victims' Commission	The advisory body to the West Midlands PCC in respect of specialist services. Members of the Victims Commission bring expertise, knowledge and experience to the development of policy related to victims of crime.
WMP	West Midlands Police	The second largest police force in the country, covering an area of 348 square miles and serving a population of almost 2.8 million.
WHO	World Health Organisation	The directing and coordinating authority on international health within the United Nations.

Endnotes

- Setting the scene:** <https://twitter.com/HiboWardere> (Edited from original twitter); bit.ly/1dVV62f; bit.ly/1EqG3E4 ;bit.ly/1PAq6k5; bit.ly/1CsVn69
- 1 By email
 - 2 Abridged from speech at Muslim Women's Network UK FGM Summit, March 2015
 - 3 <http://westmidlandspcp.co.uk/wp-content/uploads/2015/01/Item-06-PVVP-Annual-Report-2014-WMPCP-19-JAN-15.pdf>
 - 4 <http://www.who.int/mediacentre/factsheets/fs241/en/>
 - 5 LGA (2014) *Female Genital Mutilation: A councillor's guide*. At: bit.ly/11uN77A
 - 6 In some communities, the raw edges of the wound are sutured again after childbirth, recreating a small vaginal opening. - See more at:
<http://www.unfpa.org/resources/promoting-gender-equality#sthash.pZXQA9bq.dpuf>
 - 7 E.g. Kenya -
<http://www.irinnews.org/indepthmain.aspx?InDepthId=15&ReportId=62470>;
<http://www.globalfundforwomen.org/impact/success-stories/62-general/2105-what-it-takes-to-end-fgm>
 - 8 http://www.path.org/publications/files/CP_fgm_combnd_rpt.pdf
 - 9 Adowa Kwateng-Klavitse, FORWARD, speaking at the Preventing Female Genital Mutilation conference, 9 December 2014
 - 10 <http://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/female-genital-mutilation-fgm/signs-symptoms-and-effects/>
 - 11 Local Government Association (2014) FGM: A councillor's guide At: bit.ly/11uN77A
 - 12 Adowa Kwateng-Klavitse, FORWARD speaking at the Preventing Female Genital Mutilation conference
 - 13 <https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/female-genital-mutilation/#the-reasons-why-fgm-is-practised>
 - 14 <https://www.gov.uk/government/policies/improving-the-lives-of-girls-and-women-in-the-worlds-poorest-countries/supporting-pages/helping-to-end-female-genital-mutilation-for-girls-and-women-in-africa>
 - 15 <https://www.gov.uk/government/publications/call-to-end-violence-against-women-and-girls-action-plan>
 - 16 <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/201/201.pdf>
 - 17 <http://www.westmidlands-pcc.gov.uk/media/280303/24-02-2014-letter-to-bob-jones.pdf>
 - 18 West Midlands Civil Orders Project Business Case
 - 19 E.g. Behrendt, A (2010) *Listening to African Voices* at <http://www.planusa.org/docs/ListeningtoAfricanVoices.pdf> is an in-depth study of views from men and women from different countries living in one German city which has led to a greater understanding of attitudes, risks and priorities.
 - 20 Macfarlane A and Dorkenoo E (2014) Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk. Interim report on provisional estimates. At: <http://www.equalitynow.org/sites/default/files/FGM%20EN%20City%20Estimates.pdf>
 - 21 Macfarlane A and Dorkenoo E (2014) It is possible that is an overestimate if prevalence in the UK were less here than in their home countries
 - 22 Macfarlane A and Dorkenoo E (2014) 60,000 0-14 year olds estimated in 2011 and a further 11,700 born in 2011 and 2012

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- 23 England and Wales - http://www.ons.gov.uk/ons/dcp171778_384394.pdf
- 24 Macfarlane A and Dorkenoo E (2014)
- 25 3963 cases - <http://www.hscic.gov.uk/catalogue/PUB17463/fgm-mar-2015-exp-rep.pdf>
- 26 WMPCP Summary of Regional Activity
- 27 <http://bit.ly/1F3FvK>
- 28 <https://www.gov.uk/school-census>
- 29 <http://bit.ly/1bTZoph>
- 30 <http://www.ncbi.nlm.nih.gov/pubmed/15512221>
- 31 <http://bit.ly/1Ksq3bV>
- 32 <https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice>
- 33 Letter from PCC, 6th February 2015
- 34 <http://www.acpo.police.uk/ThePoliceChiefsBlog/EndFGM.aspx>
- 35 <http://www.telegraph.co.uk/news/uknews/crime/9246130/Pair-held-by-police-investigating-female-genital-mutilation-in-UK.html>
- 36 <https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/female-genital-mutilation/?s=female+genital+mutilation>
- 37 Local Government Association (2014) *Female Genital Mutilation: A councillor's guide*
At: bit.ly/1IuN77A
- 38 HM Government (2014) *Multi-Agency Practice Guidelines: Female Genital Mutilation*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf
- 39 WMPCP Summary of regional activity
- 40 bit.ly/1F6QBHU
- 41 WMPCP Summary of regional activity
- 42 bit.ly/1IuN77A
- 43 Esmee Fairbairn Foundation, ROSA, Options UK and Trust for London (2013) *Tackling Female Genital Mutilation in the UK: What works in community-based prevention work*
- 44 <http://www.sec-ed.co.uk/news/teacher-training-failure-leaves-girls-23000-at-risk-of-female-genital-mutilation>
- 45 Vanessa Diakides, Muslim Women's Network UK FGM Summit, March 2005
- 46 <http://bit.ly/1EueSHO>
- 47 Muslim Women's Network UK FGM Summit, March 2015
- 48 Ofsted 2015 *Children Centre Inspection, Birmingham - Aston/Nechells Group 2*
- 49 <http://bit.ly/1cTNNrG>
- 50 <http://www.theguardian.com/society/2015/feb/04/first-female-genital-mutilation-prosecution-dhanuson-dharmasena-fgm>;
<http://www.theguardian.com/commentisfree/2015/feb/05/guardian-view-failed-fgm-prosecution-right-idea-wrong-case>
- 51 <http://www.england.nhs.uk/2014/12/08/fgm-prevention/>
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- 53 bit.ly/1HHcJge
- 54 <http://bit.ly/1bTZoph>
- 55 <http://esmeefairbairn.org.uk/news-and-learning/publications/fgm-initiative-evaluation-of-the-first-phase>
- 56 Powell, R, Lawrence, A, Mwangi-Powell, F and Morison, L (no date) *Female Genital Mutilation, Asylum Seekers and Refugees: the need for an integrated UK policy agenda*.
At <http://www.fmreview.org/en/FMRpdfs/FMR14/fmr14.14.pdf>
- 57 Evening Standard "FGM clinic sees its youngest patient yet – a 3 year old girl" 27/11/14
- 58 <http://www.cica-criminalinjuries.com/>
- 59 <http://www.theyworkforyou.com/whall/?id=2015-01-29a.335.0>





West Midlands Police and Crime Panel

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Twitter: [@Westmidspcp](https://twitter.com/Westmidspcp)

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