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THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

City of Westminster

London Borough of Hammersmith and Fulham | The Royal Borough of Kensington and Chelsea | Westminster City Council

Responding to Female Genital Mutilation in Westminster

Report to Policy and Scrutiny Committee, March 2016

1. Prevalence of Female Genital Mutilation (FGM) in Westminster and the Tri-borough area

Female Genital Mutilation is a British problem, which urgently requires innovative solutions. Local data suggests that 12,850 residents in the Tri-borough come from countries where FGM is practiced and that as many as 770 school age girls could be at risk of FGM in Westminster. We are committed to safeguarding girls from FGM and to appropriately supporting those who have been identified as victims. This is being done through the following:

1. FGM Pilot at St Mary's and Queen Charlotte's Hospital Maternity Clinics: - a joint approach to identifying families where girls may be at risk of FGM in the future
2. Pilot clinic for Children and young people that have suffered FGM – a holistic offer for girls that have had FGM that meets the standard of a CP medical but also offers practical and emotional help
3. Appointment of a Tri-Borough FGM Lead Safeguarding and Community Worker – worker who leads the clinics and offers support and advice to front-line Social Workers
4. Designated Child Protection Advisors (CPA – a Social Worker specialising in Child Protection and chairs meetings about children at risk of harm) for harmful cultural practices.
5. Harmful Cultural Practices Pilot in partnership with MOPAC – a capacity building project that provides enhanced training for practitioners and on site "educator advocates" from the voluntary sector that provide advice on all forms of harmful cultural practices.
6. Community engagement events to inform local communities about the health and legal consequences of FGM.
7. FGM as a core component of all safeguarding training
8. LSCB community worker who is building links with Mosques, Madrassas to build their capacity to recognise and respond to all safeguarding issues
9. Awareness raising work in schools with staff and young people
10. Summer campaign to raise awareness of the increased risks to girls over the school holidays in the community and professional networks.

2. FGM Pilot

The thinking behind this project started with a review of practice in 2013 in relationship to safeguarding across faith and cultures. As a result it was agreed that Westminster would designate one of their existing Child Protection Advisors as a lead for safeguarding in this area, to build up expertise and to oversee the quality of work. Through tracking these cases more closely, it quickly became apparent that Children Services were not receiving any referrals in relation to FGM, despite having significant proportions of practising communities. A multi-agency working group was then formed to explore this in more depth which identified a lack of trust and understanding between Health and Social care as a core part of the problem. It was agreed that one agency could not lead on risk assessment in this complex area of work and that a new joined up approach should be tried.

The work led to the design of a proto-type model that first became operational in October 2014 at St Mary's hospital. It was first devised and piloted by Westminster City Council, but has since become a Tri-Borough project. The project is called "Team around the FGM clinic";

FGM maternity clinics already exist in most hospitals but the pilot builds on this so that women are jointly assessed by a mid-wife and social worker from both a health and social perspective. These clinics are run by midwives however the pilot introduced a multi-disciplinary team within the clinic. The clinic team now includes a specialist FGM midwife, an FGM Lead Social Work practitioner, community Health Advocates (survivors of FGM) a male worker and a trauma based therapist. The project is currently being implemented in two clinics in the tri-borough -St Mary's Hospital and Queen Charlotte's Hospital, potentially expanding to Westminster and Chelsea Hospital in the next few months.

The main aim of the FGM project is early identification of girls who might be at risk of FGM in order to work with their families to assess that risk and undertake preventative work. The premise is that children at greatest risk of FGM are the female children of FGM victims; therefore the FGM maternity clinic is an effective way of identifying women who have had FGM and are expecting or already have female children. When pregnant women book in for antenatal care at the hospital, they are asked whether they have been victims of FGM. Those who have had FGM are then referred to the FGM clinic and receive a joint assessment from the specialist team.

The critical aspect of the approach is that the specialist social worker is co-located and embedded within the services already available to and accessed by women with FGM-mainstream maternity care. This results in proactive information sharing between midwifery and social care resulting in timely and effective intervention with mothers who are FGM victims and their families. Referrals for a social work assessment are made when mothers attending the clinic have female children or give birth to a female child. Please see the attached framework and referral pathway for the pilot.

During this pilot, the Tri-borough has developed crucial relationships with our partners in Health and the community itself which has subsequently fostered a positive outcome for the FGM project. The stigma around social workers has been lessened through the work of the Health Advocates, whose main role is as a mediator between the Local Authority and the community; this has proved crucial for the success of the project. The Health Advocates try to bring all parties together by translating and moderating the cultural nuances of the issue.

The addition of the therapist to the team has brought in an invaluable element of support to victims of FGM, while the male worker is instrumental in having discussions with fathers/ husbands which might otherwise have been difficult to facilitate, given the sensitive nature of FGM.

What this holistic approach results in is the pregnant woman developing a trusting and comfortable relationship with the service – one in which she sees the FGM service, including a safeguarding assessment for her children, as a part of a larger package of support, rather than FGM being the only focus of the intervention. This relationship then forms the basis of an open and honest discussion about family history and beliefs surrounding FGM – one that will enable a realistic and accurate assessment of risk.

Where girls have been identified as already being subject to FGM, existing Child Protection procedures are followed. Additionally, a pilot Clinic for Children and Adolescents affected by FGM has been developed to offer specialised services to support these girls. This team consists of a Consultant Paediatrician, Consultant Gynaecologist, Health Advocate, Therapist

and specialist Social worker, and has been planned in conjunction with the Police to ensure the clinic meets medico-legal standards. So far 2 medicals have taken place in the clinic.

In addition to the clinics the workers function as a virtual team brought together in the 'Team around the FGM clinic' which meets on a monthly basis to discuss the cases and multiagency assessments. These meetings serve as a safety net to fully explore all risk and protective factors for each girl/unborn girl identified through the pilot.

Initially the project was funded by WCC but since then the project has attracted a DfE innovation grant. The is running in parallel with a MOPAC funded pilot known as the Harmful Cultural Practices pilot which builds capacity in the front-line to deal with all forms of harmful practices through additional training and specialist consultation on case work from the voluntary sector.

The FGM innovation has been successful in creating a referral pathway between Health, Maternity and Children's services and ensuring that there is protocol around information sharing so that all professionals share information when necessary to safeguard girls/unborn girls identified as being at risk. However, what we know about FGM is that a female child might be at risk of FGM occurring at any point in her childhood/teenage hood. Sharing information with the GP, health visitor and school nurse about FGM having been identified in a female member of a child's family ensures that professionals are aware and able to be pick up on signs of potential risk and/or have discussions with children and their families at different points in the child's life.

Another aspect of the project is community engagement and awareness raising around the health and legal implications of FGM, and there have been extensive community events held in Westminster. In October 2015 the government introduced a new legal requirement known as Mandatory Reporting which requires Teachers, Social Workers and Health staff to report known cases of FGM in children directly to the Police, and a number of events have been held to explain this change to local communities and professionals. Debbie Raymond, Joint Head of Safeguarding has addressed the community on two occasions regarding this.

As a part of the wider Violence against Women & Girls strategy, the Tri-borough Local Safeguarding Children's Board offers FGM training to a range of professional bodies that have contact with girls across different age groups. These courses address the issue of Mandatory reporting. We are also planning two 'Learning Events' to support the 150 schools in the Tri-borough with addressing FGM, and this will intensify in the run up to the summer break. There have also been a number of sessions with school pupils; most recently a number of sessions were completed with pupils at Marylebone boy's schools.

3. Impact of the Lead FGM Practitioner

The project has produced a substantial increase in the number of families where FGM has been identified to be an issue, enabling a proportionate response at an early help stage or through Child in Need or Child Protection services. In addition, the project has generated a number of "milestone" cases such as: self referrals by pregnant mothers that an older child has been cut; child protection investigations, including cases that have led to a Child

Protection plans. One case was also referred to the Crown Prosecution Service for potential criminal action; this case involved a British born child who was cut in infancy at a clinic in Malaysia during a trip abroad. The experience of working with these cases are enabling front-line practitioners, with the guidance of the lead worker, to build up more skill and experience in assessing risk in a way that will prevent FGM rather than just responding to it.

Whilst referral rates for FGM are still considered to be low in comparison to the local demographic, this has to be understood within the following context which means that FGM is a hidden problem that needs proactive solutions. The community and inter-agency work we have undertaken suggest the following factors as relevant:

- Most girls are cut at primary school age, in the context of another wise loving and caring family environment in a way that is normalized and therefore not perceived as abuse. There is also a "grooming" element to this with some girls recounting that they are given gifts to maintain secrecy. Therefore the likelihood of disclosure is low, which is why the introduction of mandatory reporting has not produced an increase in referrals because only known cases of FGM meet the threshold to be reported to the Police.
- Inter-agency awareness and understanding needs to be improved and we have offered an extensive schedule of training to address this.
- Referral rates for all forms of abuse with a sexual component are low because of issues of privacy and shame for victims, and the fear of prosecution for the families.
- In many of the cases we have identified, the FGM has been performed overseas prior to immigration to the UK.
- Although low, referral rates are significantly higher than they were at the outset of the project when we had not received any referrals at all.

4. Facts and Figures

FIGURES FROM PILOT – October 2014 – 2015	
Number of women seen at the FGM clinics (all cases receive early help offers)	68
Number of families referred to Children's Services for risk assessment by the pilot	21
Number of families still under assessment within the pilot process	34

FIGURES FROM CHILDREN SERVICES (referrals not from the hospital pilot, but overseen by the lead worker)		
Borough	Children in Need	Child Protection
WCC	14	2
RBKC	10	2
LBHF	3	8

- This project is subject to independent qualitative and quantitative evaluation that will be available in August 2016
- The project has also generated an increase in referrals for border boroughs – notably Brent and Ealing

5. Future Challenges

Apart from the increase in referrals which this project has produced one of it's major successes is the increased understanding about the complexity of FGM – this is enabling us a service to develop more effective methods of assessing future risk to children.

This learning from this innovation project was presented to a pan-London audience at a conference chaired by Stephen Greenhalgh, Deputy Mayor of London on 1st February 2016. The Deputy Mayor also intends to visit the project delivery team, and to meet a group of boys at St Marylebone School to discuss what they have learned about FGM during the awareness raising sessions that have been undertaken with them. The date for this is still being arranged.

The DfE funding will end in May 2016, and an application has been made to the innovation fund for a bridging grant to support the project to continue running while a sustainable source of funding is identified.

D. Raymond
Joint Head of Safeguarding, Review & Quality Assurance
March 2016

APPENDIX I.

Team Around of the FGM Project and its Pathways and procedures May 2015- May 2016