RELATED TOPICS

CONTENTS

- **Female Genital Mutilation**
- **Children of Alcohol Dependent Parents**

  This Guidance has been taken from the Newcastle Safeguarding Board Website.

  http://newcastlescb.proceduresonline.com/

- **Emergency Contact Numbers**

RELATED TOPICS

What is Female Genital Mutilation?

Female Genital Mutilation (FGM) is a fundamental violation of the rights of girls. It is discriminatory and violates the rights to equal opportunities, health, freedom from violence, injury, abuse, torture and cruel or inhuman and degrading treatment, protection from harmful traditional practices and to make decisions concerning reproduction. These rights are protected in international law.

FGM, which is often also referred to as 'female circumcision' or 'female cutting', comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons.

FGM is a long established and open social custom in parts of Northern and Central Africa but is also practiced in secrecy in the Middle East with evidence found in Jordan, Saudi Arabia, Syria, Iraq, Oman, United Arab Emirates and Iraqi Kurdistan.

The World Health Organisation has identified the following countries as having FGM prevalence rates of between 50 - 98%: Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Sierra Leone, Somalia, and Sudan. Chad and Cote d'Ivoire have prevalence rates of 45%.

FGM is considered Child Abuse in the UK and is illegal. It is a grave violation of the human rights of women and girls. In all circumstances where FGM is practised on a child it is a violation of the child's right to life, their right to their bodily integrity, as well as their right to health.

2. The Extent of the Problem in the UK

FGM is occasionally performed in the UK on girls from families who have emigrated from countries where FGM is practiced. However, there is limited evidence of the exact extent of the problem in the UK but, **The Foundation for Women's Health, Research and Development (FORWARD)** estimates that there are presently

86,000 first generation immigrant and refugee women and girls in the UK who have undergone FGM in their countries of origin, with more than 7,000 girls at risk.

As with forced marriage, there is to date no official collection of statistics of the extent of the problem in the UK. However, FGM is likely to occur with immigrant communities in Newcastle who have come from countries where the practice is common place.

3. Why is FGM Carried Out?

Parents who force their daughters to undergo FGM often justify their behaviour as protecting their children or preserving cultural or religious traditions. They typically do not see anything wrong with their actions. Many girls will have the expectation that they will experience FGM and may not be aware that they have a fundamental human right not to have this take place.

FGM is used as a means of controlling and de-sexualising women, repressing their sexual desire and to reduce the chance of their being sexual promiscuous. FGM is also carried out for reasons of aesthetics and hygiene and as a means of purification and ensuring that a woman is clean.

These motivations help us to understand why parents might force their daughters to undergo FMG but they cannot be used as a justification for subjecting women and girls to such harmful practices.

FGM is **not a religious practice**. It has been condemned by every major faith group, including Islam, Sikh, Hindu and Christian and no religious text requires it of women.

4. What are the Signs that a Girl may be At Risk of, or have Already Undergone, FGM?

RELATED TOPICS

These indicators are not exhaustive and whilst the factors detailed below may be an indication that a child is facing FGM, it should not be assumed that is the case simply on the basis of someone presenting with one or more of these warning signs. These warning signs may indicate other types of abuse such as forced marriage or sexual abuse that will also require a multi-agency response.

The following are some signs that the girl may be at risk of FGM:

- The family belongs to a community in which FGM is practised;
- The family makes preparations for the child to take a holiday, e.g. arranging vaccinations, planning an absence from school;
- The child talks about a 'special procedure/ceremony' that is going to take place;
- An awareness by a midwife or obstetrician that the procedure has already been carried out on a mother, prompting concern for any daughters, girls or young women in the family.

The following are some signs that FGM may already have taken place:

- Prolonged absence from school and noticeable behaviour change on return to school;
- Avoidance of specific classes or activities such as PE or sports, giving reasons of bladder, menstrual or abdominal problems;
- Girls finding it difficult to sit still in class or looking uncomfortable when sitting;
- Girls complaining of pain between their legs or talking about something someone did that they are not allowed to talk about.

Girls are at particular risk of FGM during school summer holidays. This is the time when families may take their children abroad for the procedure. Many girls may not be aware that they may be at risk of undergoing FGM.

RELATED TOPICS

If you suspect that someone you know is at risk of being subjected to any form of FGM you should take action to report it immediately. Time counts so please act as soon as you suspect that a girl may be at risk of FGM.

5. What are the Consequences of FGM?

There is generally limited data available on the effects of FGM, but for example it is estimated that in the Sudan one-third of girls who undergo FGM will die as a result. Where medical facilities are not easily accessible or are ill-equipped, emergencies arising from the practice cannot be treated. Thus, a girl who develops uncontrolled bleeding or infection after FGM may die within hours. It is important, for this reason, to remember that families in the UK will usually take their daughters abroad for the procedure.

Despite FGM being illegal there are doctors in the UK who have been willing to carry out the practice on young girls. There is evidence of doctors being struck off the medical register by the General Medical Council for carrying out FGM but to date there has been no prosecution in the UK. Even when the procedure is carried out by medical professionals who use surgical instruments and anaesthetics, this does not decrease the likely negative health consequences.

FGM is known to have potentially serious health consequences for women and girls, both psychological and physical. Although it has, so far, been difficult to document its psychological effects a number of immediate and long-term physical consequences have been identified.

5.1 Immediate Complications

- Severe pain and haemorrhaging:
- Shock and fever;
- Tetanus or sepsis;
- Urine retention and urinary infection;

RELATED TOPICS

- Ulceration and infection of the genital region;
- Injury to the adjacent tissue.

5.2 Long Term Consequences

- Anaemia;
- Cysts and abscesses;
- Scarring and hypersensitivity of the genital area;
- Damage to the urethra and other organs resulting in incontinence, recurring bladder and urinary tract infections;
- Painful sexual intercourse and sexual dysfunction;
- Infibulation can cause scar formation, difficulty in urinating and menstrual disorders;
- Infertility as a result of earlier infections;
- Prolonged and obstructed labour which can lead to fistulas, uterine rupture, brain damage to the infant and maternal and infant death;
- Women who have undergone FGM are twice as likely to die in childbirth and are more likely to give birth to a still born child than any other woman.

6. What can Professionals do?

Although in Newcastle the number of women and girls at risk of FMG is likely to be relatively small in number, there will still be some women and girls who have already undergone the procedure or could be under pressure to have it performed. It is therefore important for all professionals including members of the police, teachers, health care staff and social care staff who work with girls and young women throughout Newcastle to be aware of FGM.

NHS Actions

RELATED TOPICS

From April 2014 NHS hospitals will be required to record:

- If a patient has had Female Genital Mutilation;
- If there is a family history of Female Genital Mutilation;
- If an Female Genital Mutilation-related procedure has been carried out on a patient.

From September 2014 all acute hospitals must report this data centrally to the Department of Health on a monthly basis. This is the first stage of a wider ranging programme of work in development to improve the way in which the NHS will respond to the health needs of girls and women who have suffered Female Genital Mutilation and actively support prevention.

Labels of 'tradition', 'culture', 'religion' or a fear of being called a 'racist' should not stop action being taken to protect girls at risk of FGM. It is a form of child abuse and a violation of human rights.

In dealing with cases of FGM, it is important to take a victim centred approach. The role of professionals in providing care and support for women/girls who have experienced or are at risk of FGM include:

1. **Be aware, be informed.** Take steps to become aware of local minority ethnic communities which support FGM and of the special needs of the women and girls in those communities;
2. **Be sensitive.** Do not make assumptions about the woman's own views. Many women from communities which practise FGM oppose to it, but there are others who do not. It is important to be aware of the possible adverse psychosocial consequences for women and girls who have moved from a country where FGM is the norm, to one where it is illegal and generally abhorred;
3. **Assess individual needs.** Do not expect women to volunteer information about FGM or about any problems it has caused. Asking about circumcision

when providing antenatal care to women from the communities concerned will help identify the additional needs that women who have undergone FGM will have during their pregnancy, labour and delivery and for postnatal care. It is important that language used to describe FGM should be respectful and is not insulting to individuals, their culture or tradition;

4. **Inform and explain.** Professionals should work in a sensitive manner with families to explain the legal position around FGM in the UK. The families will need to understand that FGM and re-infibulation (the process of resealing the vagina after childbirth) is illegal in the UK and that if they are insistent upon carrying out the practice, the health visitor and Children's Social Care must be informed that any female child may be at risk. Interpretation services should be used if English is not spoken or well understood and the interpreter should not be an individual who is known to the family. Again it is important to be mindful of language used to describe and discuss FGM;

5. **Involve and inform other care professionals.** If a professional is concerned that FGM is going to be or has been performed on a child or young woman, they should follow the processes in their agency Child Protection Procedures to make a child protection referral, as well as alerting the health visitor and any social workers involved with the family. In such a situation, professionals should be mindful of other females in the family, including babies.

7. UK Legal framework and Prohibitions on FGM

In England, Wales and Northern Ireland, all forms of FGM are illegal under the Female Genital Mutilation Act 2003.

FGM is an offence which extends to acts performed outside of the UK and to any person who advises, helps or forces a girl to inflict FGM on herself. Any person found guilty of an offence under the Female Genital Mutilation Act 2003 will be liable to a fine or imprisonment of up to 14 years, or both.

RELATED TOPICS

FGM is considered to be a form of child abuse. Under the Children Act 1989 Local Authorities can exercise their powers under Section 47 and can apply to the Courts for various Orders to prevent a child being taken abroad for mutilation.

7.1 FGM and Asylum

The Home Office has publicly condemned FGM, stating that any woman or child fearing this violence should have grounds for asylum. However, only a very small number of women have been granted asylum in the UK and worldwide on the grounds of FGM. Many obstacles hinder the asylum process protecting of women fleeing FGM including concerns about cultural imperialism, credibility and a lack of firm evidence, together with a lack of knowledge and awareness of the complexity of the issues surrounding the practice.

CHILDREN OF ALCOHOL OR DRUG USING PARENTS

1. The Child

The effects on children of the misuse of alcohol and / or drugs by one or both parents or carers are complex and may vary in time, which is why a thorough assessment of needs and risk of harm is important. The Advisory Council on the Misuse of Drugs (ACMD) Report 'Hidden Harm - responding to the needs of children of problem drug users' estimated that there are between 200,000 - 300,000 children of problem drug users in England and Wales, i.e. 2-3% of all children under the age of 16. The report also concludes that parental drug misuse can and does cause serious harm to children at every age from conception to adulthood. The circumstances of children must be carefully assessed not only to consider immediate

risks but also the long term effects on the child of their parents' alcohol and / or drug misuse.

Parental substance misuse may be characterised by the use of multiple drugs, with or without alcohol, including by injection, and is strongly associated with economic deprivation and other factors that affect parenting capacity. The adverse consequences for the child are typically multiple and cumulative and will vary according to the child's age and development. In some cases the misuse of alcohol and / or drugs may be one factor which, when linked to domestic violence or mental illness, may increase the risks to the child..

An appropriate response to these children often require the close collaboration of a number of agencies including local Drug Action Teams, Health and Maternity services, Adults' Social Care and Children's Social Care, Adult Treatment Services, Courts, Prisons and Probation services.

The children of parents who misuse alcohol and / or drugs are at increased risk of developing drug or alcohol problems themselves and of being separated from their parents. Research demonstrates that children who themselves start drinking or taking drugs at an early age are at greater risk of unwanted sexual encounters and injuries through accidents and fighting.

2. Safeguards and Concerns

Drug or alcohol use in itself is not a reason for considering a child to be suffering or likely to suffer **Significant Harm**, although it may be a contributing factor. Professionals working with children need to understand the complexity of the lives of drug and alcohol users and gain confidence in working with people who misuse either of these substances. A thorough assessment by all relevant agencies is required to determine the extent of need and level of risk of harm in every case.

Where there is concern that a parent is involved in drug and/or alcohol use, the effect on the child needs to be considered, including:

- The child's physical safety while drug use or drinking is taking place;

RELATED TOPICS

- Possible trauma to the child resulting from changes in the parent's mood or behaviour;
- The impact of the parent's drug or alcohol use on the child's development, including the emotional and psychological wellbeing, education and friendships;
- The health and development of an unborn child;
- The impact on new born babies who may experience withdrawal symptoms, including interference with parent/child bonding;
- Babies may experience a lack of basic health care and poor stimulation;
- The extent to which the parent's drug or alcohol use disrupts the child's normal daily routines and prejudices the child's physical and emotional development;
- Older children may experience poor school attendance, anxiety about their parents' health and taking on a caring role for the parent or siblings;
- The impact on the child of being in a household where illegal activity is taking place, particularly if the home is used for drug dealing;
- How safely the parent's alcohol, drugs, and drug using equipment are stored;
- Dangerously inadequate supervision and other inappropriate parenting practices;
- Intermittent and permanent separation;
- Inadequate accommodation and frequent changes in residence.

The circumstances surrounding dependent, heavy or chaotic drug or alcohol use may inhibit responsible childcare, for example, poor physical health or mental health problems, financial problems and a breakdown in family support networks.

The parents' practical caring skills can be affected by misuse in the following ways:

- Lack of attention to basic physical needs;
- Lack of control of emotions;

RELATED TOPICS

- Impaired judgement.

3. Referrals

Any professionals, carers, volunteers, families and friends who are in contact with a child in a drug or alcohol misusing environment must ask themselves "What is it like for a child in this environment?" The **Common Assessment Framework** will assist in determining the level of vulnerability of the child and at what point a referral should be made to Children's Social Care under the **Making a Referral to Children's Social Care Procedure**.

Information gathered during the Common Assessment should form the basis for the referral. Where any agency encounters a substance user, who is pregnant and whose degree of substance misuse indicates that their parenting capacity is likely to be seriously impaired, they must make a referral to Children's Social Care, using the **Referral and Initial Information Record Form**.

The majority of pregnant substance misusing women will have been identified by maternity services and referred to the Substance Misuse Team. The Care Planning Approach /Care Co-ordination procedures will apply including input from the link midwives and a social worker from Children's Social Care, who will be invited to any meetings taking place in respect of the child(ren).

Where a newly born child is found to need treatment withdrawing from substances at birth, a pre-discharge discussion should take place and consideration should be given to holding a **Strategy Discussion/Meeting** before the child is discharged home.

4. Assessment and Initial Child Protection Conference

Change to: Children's Social Care will consider whether it is appropriate to undertake an **Statutory Assessment** in relation to all referrals where there is concern about parental drug or alcohol misuse. Children's Social Care will consider undertaking a Statutory Assessment of all pre-school children in a drug-misusing environment. In

the case of older children and young people the referral and assessment process must include any considerations that the child might themselves be misusing drugs or alcohol, with or without the parent's knowledge.

The Assessments will consider and take account of whether the parent is hiding or denying their alcohol misuse; whether they are engaged in any rehabilitation programme; whether they receive support from a partner, family or friends; the impact of their drug / alcohol misuse on the quality of care given to the child and the day-to-day environment of the child as well as the long term impact on the child.

Throughout the assessment process and where it is decided to call a Strategy Discussion / Meeting, undertake a **Section 47 Enquiry** and convene an **Initial Child Protection Conference**, those agencies who have worked with the parents in relation to their alcohol misuse must be asked to contribute and invited to participate in and attend relevant meetings.

5. Confidentiality

Confidentiality is important in developing trust between drug using parents and staff in agencies working with them in relation to their drug use.

Families with a drug-using parent need to be able to ask for advice from appropriate agencies and to work together with them to safeguard their children. Services need to be accessible and attractive to drug using parents and pregnant women who use drugs.

No agency can guarantee absolute confidentiality. All agencies, both statutory and non-statutory, should have written procedures on confidentiality which provide for the sharing of information where there is concern about the wellbeing of a child who may be suffering or at risk of suffering **Significant Harm**. When agencies start any

work with drug-using parents or with pregnant women who use drugs, these procedures must be explained to them.

6. Services for Pregnant Women

All maternity services should have procedures for pregnant women that encourage them to go to antenatal services and help them to stabilise, reduce or stop their drug or alcohol use.

When a woman with a drug or alcohol problem attends for antenatal care, she should be encouraged to contact the Substance Misuse Team for assessment and advice on the treatment options available to her.

Safeguarding Children: emergency contact numbers

If you're worried that?

A child in your church might be suffering from some kind of **ABUSE**

- **DO NOT -** try to diagnose, investigate or sort it out yourself
- **THINK HARD -** about what it is about the child's appearance or behaviour that is making you worried or suspicious
- **DO NOT -** promise confidentiality if someone talks to you about what might be abuse
- **DECIDE -** who you should TALK to and TALK TO THEM – within 24 hours. *This might be:* another leader or the minister

If the child is in the care of the Church you can contact Ruth Rogan, Diocesan Safeguarding Adviser to listen to your concerns and advise you on 07825 167 016.

You may think it necessary to contact

Children's Services			**Vulnerable Adults Services**	
Newcastle	Initial Response	0191 277 2500	Initial Response	0191 278 8377
Newcastle	Out of hours	0191 232 8520	Out of hours	0191 232 8520
Northumberland				
Alnwick		01665 626830	All Calls	01670 536400
Ashington		01670 815060		
Bedlington		01670 536800		
Berwick		01289 334000		
Blyth		01670 354316		
Cramlington		01670 712925		
Hexham		01434 603582		
Morpeth & Disabled Children's Team		01670 516131		
Out of Hours:				
North Tyneside		0191 643 7979	Initial Response	0191 643 2777
Out of Hours		0191 2006800	Out of hours	0191 200 6800
Cumbria		03332 401727		
Durham		**08458 505010**		
Or the NSPCC on 0808 800 5000				

In cases where the child is clearly in immediate danger you should contact the police by ringing 999.

Childline: 08001111