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Partnership and Place Overview and Scrutiny Committee

Thursday 20 March 2014 at 7.00 pm
Board Room 7&8 - Brent Civic Centre, Engineers Way, Wembley HA9 0FJ

Membership:

Members Councillors:	**first alternates** Councillors:	**second alternates** Councillors:
Van Kalwala (Chair)	Daly	Ogunro
Green (Vice-Chair)	Lorber	Leaman
Arnold	Al-Ebadi	Jones
Cheese	Matthews	Hopkins
Harrison	Oladapo	Ketan Sheth
HB Patel	Colwill	Kansagra
RS Patel	Chohan	S Choudhary
Krupa Sheth	Aden	Long

For further information contact: Peter Goss, Democratic Services Manager
020 8937 1353 peter.goss@brent.gov.uk

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democracy.brent.gov.uk

The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members

Item Page

1 Declarations of personal and prejudicial interests

Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on the agenda.

2 Deputations

3 Minutes of the previous meeting held on 1 - 8

The minutes are attached.

4 Matters arising

5 Brent Council's new Apprenticeship Programme 9 - 14

The Council's new Apprenticeship Programme was set up in September 2013. The aim of the programme is to recruit 100 apprentices to the council over 3 years. The first of the new cohorts started in January 2014. This paper provides an update on the progress with implementing the programme and future developments.

Ward Affected: All Wards

***Contact Officer**:* Cara Davani, Director, HR

Tel: 020 8937 1909

cara.davani@brent.gov.uk

6 Brent Housing Partnership (BHP) performance update 15 - 20

This presentation by Folake Olufeko, BHP interim Head of Finance, will provide an overview of Brent Housing Partnership's (BHP) performance and provides an analysis of BHP compared with performance from last year. BHP is regulated by the Homes and Communities Agency which sets framework outlining the standards required from all social housing operators. BHP has laid out key performance objectives to show how they are meeting these standards.

Ward Affected: All Wards

***Contact Officer**:* Jon Lloyd-Owen,

Operational Director, Housing and Employment

Tel: 020 8937 5199

jon.lloyd-owen@brent.gov.uk

7 Registered Social Landlords update 21 - 44

This report provides an overview on the relationships with Social Landlords and the Council. The report focuses on the main Registered Providers (RPs) operating in Brent, and looks at work that has taken place over the last twelve months and how to move forward with this work.

Ward Affected: All Wards

Contact Officer*:* Tony Hirsch, Policy and Performance

Tel: 020 8937 2336

tony.hirsch@brent.gov.uk

8 Tackling violence against women and girls in Brent 45 - 198

The report is a review of the harmful practices of Female Genital Mutilation (FGM), Forced Marriage (FM) and Honour Based Violence (HBV) on Women and Girls in Brent. The report makes twelve recommendations and the task group asks the committee to consider the recommendations, especial the recommendations that have a direct impact on services safeguarding residents.

Councillor John, Chair of the Task Group, will be present for this item.

Ward Affected: All Wards

Contact Officer*:* Ben Spinks, Assistant Chief Executive

Tel: 020 8937 6677

ben.spinks@brent.gov.uk

9 Date of next meeting

The next meeting of the Partnership and Place Overview and Scrutiny Committee will be subject to the Council's agreed annual programme of meetings for 2014/15.

10 Any other urgent business

Notice of items raised under this heading must be given in writing to the Democratic Services Manager or his representative before the meeting in accordance with Standing Order 64.

Please remember to ***SWITCH OFF*** your mobile phone during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public.

MINUTES OF THE PARTNERSHIP AND PLACE OVERVIEW AND SCRUTINY COMMITTEE
Tuesday 21 January 2014 at 7.00 pm

PRESENT: Councillor Van Kalwala (Chair), Councillor Green (Vice-Chair) and Councillors Arnold, Harrison, HB Patel, RS Patel and Krupa Sheth

Also present: Councillor Hirani

Apologies for absence were received from: Councillors Cheese

1. **Declarations of personal and prejudicial interests**

   None declared.

2. **Deputations**

   None.

3. **Minutes of the previous meeting held on**

   RESOLVED:

   That the minutes of the meeting held on 20 November 2013 be approved as an accurate record of proceedings.

4. **Matters arising**

   Members sought clarification regarding whether the borough employment strategy had been finalised. Members also stated that they were still waiting for a breakdown of labour demand and skills in the borough, by ward. Jacqueline Casson informed members that she would ensure that the information was disseminated to them.

   Members also queried what was currently happening to the Employment and Enterprise Team, as the Navigator Pilot had concluded in December 2013 and an external review of the service was due to take place at the end of February 2014. The Chair surmised that the team were probably conducting a review of the pilot at this time.

5. **Children's Social Care**

   Neil MacDonald, Head of Children’s Commissioning, introduced the presentation and informed members that Graham Genoni, Operational Director Social Care, sent his apologies. Members were presented with an overview of Child social care. It was explained that Children’s services were governed by the Children Act 1989 and subsequent legislation in the Children Act 2004.

One of the main concerns for Children Social Care at the moment, due to its high public profile, was child exploitation and missing children. This had been brought to the public's attention through a number of cases relating to children in residential care homes. It was explained that residential care homes were graded in the same way schools were by Ofsted, and Brent only used homes that had been graded as good or outstanding. Members were informed that Brent currently had 24 children in residential care. It was more expensive for the Council to have a child in residential care than it was to place them in a specialist fostering placement. Therefore the service was trying to work with children at a younger age so that they could avoid needing to place them in residential care. They were also working with families through the family intervention and support team to try and prevent family breakdowns. He explained that there were also having to undertake an increasing number of homelessness applications and that they were working closely with housing on these applications.

Neil MacDonald informed members that the Munro Review contained a number of recommendations for Children's social services. The main focus of the review was to ensure that the child's journey was placed back at the heart of social work. He outlined the different categories of children that the department had a statutory responsibility towards, including children with disabilities, care leavers and Children in Need. Members were informed that per 10,000 Brent's figure was 48.5 which was lower than both Brent's comparative neighbour, Newham, and the national average which was 59. In terms of the structure of Children's Social Services in Brent, it was explained that there were 5 locality teams in the Borough, 4 looked after teams as well the Fostering and adoption teams and Contracts and Commissioning. The Contracts and Commissioning team accounted for £18m of the services £32m budget.

Neil MacDonald explained that in the last Ofsted expectation Brent were deemed to 'need improvement' which was the same as 60% of all Local Authorities. He added that it was believed that the next Ofsted inspection would be tougher. It was explained that the Local Safeguarding Children's Board would also be inspected. Therefore it was very important that the service continued to improve. This included up skilling current social workers and reducing the length of time that an assessment takes before an outcome was determined for the child.

Members sought further clarification as to how the Children's social services and the housing department worked closely together. They also queried why there was not much comparative information in the presentation; for example what was the caseload per social worker in Brent and the number of permanent social workers and how did these figures compare with other boroughs. Members also questioned what work the department were planning to do to ensure that they were improving and received a better grading from Ofsted. They also questioned what the threshold was for a child being removed from their family as there was still, sometimes, a negative perception of Social Services. The Committee concluded their questions by asking how the department supported children leaving care at 18 and how there were taking on the recommendations of the Munro report and putting the child at the heart of social work.

In response to the questions raised by the Committee, Neil MacDonald, explained that some families that were offered housing outside of the borough by the housing department attempted to gain a different offer of accommodation from social

services due to having children in the borough. However social services worked with housing to ensure that they both come to the same offer of housing based on the families' legal rights. Neil MacDonald stated that around 60% of the staff in children's social service were permanent members of staff which was more than neighbouring borough Ealing. He added that he was aware that having a permanent workforce was vital to improving the service which would in turn improve their Ofsted rating. He added that there was a determination in the service to drive through improvements.

In regards to families being fearful of disciplining their children, Neil MacDonald stated that he understood this was a perception of social services. However the reality was that there were fewer children in care and that the main aim of social services was to keep the child within their families.

The Committee were informed that under the Leaving Care Act 2000 the authority had a legal responsibility to provide support for young people leaving care. There was also an initiative called 'staying put' to help children stay in foster care placements after the age of 18. In regards to ensuring that the child's views were at taken in to consideration, it was explained, that all cases were audited to make sure this was happening. They also sought the views of other young people and children via different groups and forums.

Members thanked Neil MacDonald and noted the presentation.

6. **Multi-Agency Safeguarding Hub (MASH)**

Grace Fagan, Principal Officer for Brent Family Front Door (BFFD), began by introducing Nicky Case from Family Solutions and Jacinth Jeffers from Health Economy as well colleagues from the Metropolitan Police and advised the Committee that they may also ask questions of these officers as well as herself in regards to MASH (Multi Agency Safeguarding Hub).

Members were informed that MASH went live in July 2013 and it provided an aligned service so that families could access the support services they needed promptly and efficiently. MASH allowed the different agencies involved to be better at matching services with the needs of the community. Grace Fagan detailed the five core elements of MASH, explaining that these elements were not specific to Brent and had been agreed by all London Stakeholders. All partners involved with MASH were located on the same floor in the Civic Centre, although not all of them were there 5 days a week, they could be reached immediately which helped with information sharing between the different partners. This was detailed as one of the benefits of MASH as joined up working meant they could intervene earlier and ensure that people were quickly signposted to a wide range of services within the community.

Members were advised that Brent had been part of research carried out by Greenwich along with five other boroughs. Greenwich had compared pre and post MASH data from all of the boroughs. In Brent, within a couple of months of MASH being introduced the number referrals had fallen by six. It was explained that once MASH had collated all the relevant intelligence from the different agencies regarding an individual or a family, they were only allowed to hold that information

for six months. Grace Fagan concluded stating that MASH had been set up as a new service with One Council funding for one year and therefore the service would be reviewed in June 2014.

Members enquired why MASH was only able to keep the information for six months. They also enquired how many gangs MASH had identified as being operational in Brent and what action MASH could take against the gangs that had been identified. Members welcomed agencies within in Brent working together and asked if they also worked with other boroughs. They concluded their questions by asking how the financial benefits of the service would be calculated.

Grace Fagan responded by informing members that although they were only able to hold on to the collated information in regards to a referral for 6 months, the individual agencies still had the intelligence they held themselves. Therefore the intelligence gathered on a family or individual was not lost after 6 months. Also Brent did work with other MASHs in other boroughs when needed. In regards to the number of gangs operational in Brent, it was stated that MASH had identified 33 gangs. It was explained that this may be a higher number than the committee were aware of as MASH processed all gang activity even small gangs that only contained a few people. Grace Fagan added that MASH was limited by what they could do by law in regards to gangs. However they were able to identify people who were at risk and work with other agencies to safeguard them.

In conclusion Nicky Case from Family solutions stated that they had a cross benefit calculator that they used to help determine how much intervention cost per person or family and then how much each family was costing them post intervention. Grace Fagan stated that they were hoping that the long term benefits of the service outweighed the financial costs.

Members noted the presentation and thanked Grace Fagan and the other attendees for their time.

7. **Housing and Safeguarding**

Laurence Coaker, Head of Housing Needs, began by stating that although his team did not sit with the MASH team, they did have a single point of contact within their team that MASH could contact. Members were then informed that the cap on benefits had not yet had as big of an impact on the service as predicted. However rent arrears were now starting to accrue in the Borough. He stated that there were a number of families that Brent had assumed a duty too that were in temporary accommodation that would have to be relocated outside of the Borough. He stated that before they made a decision to move a family with children they did contact Children's Social Services to ensure that there were no safeguarding issues. They had also set up a system to track children to make sure that they appeared back on the radar in the area that they had been moved too. He added that Chris Spencer had interviewed him to identify the gaps in safeguarding in housing. It was identified that more training was needed for front line staff to recognise abuse and what to do with that information.

Members questioned how many families had been moved outside of the borough and they also queried how the 'Safe and Secure' initiative was working in Brent.

Laurence Coaker explained to members that the families that were in temporary accommodation were the families that Brent had accepted that it had homeless duty too. Since October 2012, 7 of these families had chosen to leave the borough voluntarily. Since the change in legislation in September 2012 the authority could discharge its duty to house to the private sector. He stated that they received around 100 applications a week for housing and they accepted a duty to around 900 a year. He added that they were hoping that they would be able to discharge at least 50% of those applications to the private sector. Currently they were discharging 26 a month to the private sector.

In regards to Safe and Secure, Laurence Coaker explained that its success was inconsistent in Brent. This was primarily due to most of the London Boroughs not having suitable 2 or more bedroom properties for people to move into. He stated that they received no more 12 applications a year as it was initiative that was designed to only support a small number of people.

Members thanked Laurence Coaker and noted the presentation.

8. Adult Safeguarding

Phil Porter introduced the presentation explaining that safeguarding adults did not have the same legislative framework as children social services did. The assumption was that those over the age of 18 were able to make decisions for themselves. Therefore the Council worked to safeguard all vulnerable adults against significant harm or exploitation.

Members were then informed that although safeguarding adults was everyone's responsibility, Brent Safeguarding Adults Board and the Adult Safeguarding operational team had specific responsibility for safeguarding adults. The operational team were focussed on outcomes and like Children's Social Services they tried to ensure that the person was at the centre of the process and the team's first priority was to ensure that the person was safe. The team consisted of a range of professionals including social workers, a previous police officer and a nurse. Adult Safeguarding did not have a legislative framework but was framed by 'No Secrets' guidance and Pan London Safeguarding Procedures.

Phil Porter detailed the different types of Safeguarding Adults investigations including Office of the Public Guardian Matters which took place when a vulnerable adult, whose money was managed by a friend of relative through a Power of Attorney, was financially abused. In regards to investigations against an individual person who were not employed to provide services, the Safeguarding Adults Operational Team were able to investigate and determine their outcome on a balance of probabilities which was a less stringent burden of proof than the police needed to investigate.

In regards to the investigations that Safeguarding Adults Operation Team carried out they did take, on average, longer to complete than the 25 days target. However Brent was getting better at ensuring that all investigations had a conclusive outcome rather than being deemed 'Not Determined /Inconclusive'. Alerts to the team had almost doubled since 2010 yet the number of referrals had stayed the

same. This was encouraging as it meant that more people were aware of vulnerable adults and were reporting instances.

Phil Porter concluded his presentation by informing members that Adult Safeguarding had two priorities for 2014. The first was to reduce financial abuse, as a significant proportion of it could be avoided. The second was to reduce the number of pressure ulcer incidents as again, in a number of instances, they were avoidable.

Members discussed the presentation and raised a number of queries. They questioned what the budget was for delivering the Adult Social Services safeguarding adults priorities and how they would quantify the savings they made by achieving these priorities. Members also sought clarification as to who regulated private care homes and ensured they were safeguarding their residents. Details were also requested as to why vulnerable adults did not feel safe in the Borough. The Committee asked what the main issues were facing Adult Social Services and concluded their questioning by asking how officers got the message out to the diverse community in Brent.

Responding to the queries raised, Phil Porter informed members that it would be hard to quantify the financial benefits. However the work would be deemed as core business and therefore they would not have to make savings to deliver the work. In regards to how private care homes were licensed, Councillor Hirani explained that CQC checked all homes and accredited them. It was added that the council did not assess the quality of individual care homes themselves as this would result in a duplication of work. However they did carry out contract monitoring visits, social and feed information to the CQC. Therefore were checks and balances in place. Phil Porter clarified that the Council had a responsibility to all vulnerable adults whether their care was self-funded or publicly funded.

Phil Porter stated that it was a trend within the borough that people who received care did not feel as safe as people who received care in other boroughs. Therefore a wider council approach was needed to tackle this to ensure that people did feel safe. In regards to the risks that the work programme faced, Phil Porter stated that the main risk was under reporting of incidents. To ensure that this message was delivered to the diverse community Phil Porter was visiting the multi faith forum and added that more could be done to get the message out.

Councillor Hirani concluded by stating that they wanted to continue to raise the profile of abuse to vulnerable adults. They also wanted to change the culture so that people did not hide concern and instead there was an environment of openness.

The Committee thanked Phil Porter and Councillor Hirani and noted the presentation.

9. **Police - Adult Safeguarding**

The Committee noted that these issues had been discussed in previous items.

10. **Fire Services - Adult Safeguarding**

Terry Harrington, Borough Commander Brent, London Fire Brigade gave a presentation on how the fire brigade in Brent were currently safeguarding adults in the borough. Members were informed that the key performance indicators (KPIs) on the monthly statistical bulletin were colour coded green, amber and red depending on how well the fire brigade were achieving each indicator. Terry Harrington highlighted to members that there were four indicators that were red.

Members were informed that based on the number of dwelling fires that had already occurred, the brigade were on target to meet there end of year targets for dwelling fires. It was explained that a number of the fires had occurred in multiple occupancy, rented properties due to a number of reasons including substandard conditions and overuse of the property. In light of this, the Fire Brigade, were in support of Brent Council's potential initiative to ensure that all private landlords were licensed.

It was explained that the reason they had not met their KPI for outdoor rubbish fires was due to an on-going issue regarding the amount of rubbish on the streets in Brent. It was hoped that having a more effective reporting mechanism between the fire brigade and the council would help ensure that rubbish was being dealt with promptly. Once this mechanism was put in place, Terry Harrington hoped to roll out a volunteer cycle scheme which had proved successful in other boroughs. They had also not met their KPI for outbreaks of fires in residential homes and sheltered housing. It was explained that this was primarily due to people who had been assessed to be able to live independently having some difficulties with certain tasks. Terry Harrington stated that he believed that because of this it would be a good idea for the fire brigade to be involved in the case management of these vulnerable adults to ensure that fire safety risk assessments were conducted. Phil Porter, Head of Adult Social Care stated that he would be happy to work with the fire brigade on this. Terry Harrington stated that they had already exceeded their KPI target for all non-domestic fires in PRO properties. He added that this was due to Brent having the largest industrial estate in Europe as well as a high density of industrial units elsewhere. Therefore they were seeking an evaluation of this KPI target in Brent. It was added that a number of these industrial units had been converted illegally to domestic dwellings and that more was needed to deter people from doing this.

In regards to people being stuck in lifts in Brent, it was explained that London Fire Brigade had developed a strategy with Brent Housing Partnership (BHP) to ensure that if people called 999 the control room would divert the calls to Brent lift engineers as opposed to the fire brigade. This was because a lot of the calls that the Fire Brigade were responding too were non-emergency calls. It was concluded that this arrangement was working well but that there were a number of lifts outside of this agreement that still meant the fire brigade were responding to non-emergency calls.

Members questioned whether the fire brigade had been able to prosecute any offending landlords. They also questioned whether the Fire Brigade passed on the information when they discovered an illegal over development of a property. Members also sought clarification as to whether the fire brigade and the Council could protect people being exploited by landlords through adult safeguarding.

In response to the questions raised Terry Harrington explained that when the fire brigade were able to prosecute landlords and that they were currently prosecuting some landlords. However these prosecutions could take years. He added that they did liaise with the planning department at the council but that currently there were strict guidelines for properties that actually needed a license and most private rented properties did not fall within these guidelines. It was explained that there was an information sharing protocol but that the fire brigade were not eligible to view some of the information.

Phil Porter explained that there was a nationally agreed definition of what constituted a vulnerable adult and if an adult fell within this definition then the Safeguarding Adults Team could act. However, it was agreed that there were a number adults who would not fit into these categories but who may be at high risk of being exploited by their landlords. Terry Harrington stated that in Camden they were developing a strategy to protect vulnerable adults who were deemed to be at risk for different reasons. DCI Tariq informed the committee that a similar meeting was taking place at Brent Civic Centre on 26 February and invited the fire brigade to that meeting. Phil Porter highlighted that adult social care also provided support to people where self-neglect was putting their health at risk.

Members noted the presentation and thanked Terry Harrington for his time and commented that they also had similar evidence of over loading of private rented accommodation and welcomed the suggestion to license private landlords.

11. **Work Programme 2013/14**

Members noted the work programme.

12. **Date of next meeting**

The next meeting of the Partnership and Place Overview and Scrutiny Committee has been scheduled to take place on 20 March 2014.

13. **Any other urgent business**

None.

The meeting closed at 10.15 pm

Z VAN KALWALA
Chair

Partnership and Place Overview and Scrutiny Committee

20 March 2014

Report by Human Resources Director

Brent Council's New Apprenticeship Programme

1.0 Summary

1.1 The Council's new Apprenticeship Programme was set up in September 2013. The aim of the programme is to recruit 100 apprentices to the council over 3 years. The first of the new cohorts started in January 2014. This paper provides an update on progress implementing the programme and future developments.

2.0 Recommendation

2.1 The Committee is asked to note the progress against the agreed apprenticeship programme targets.

3.0 Background

3.1 A report was presented at the meeting of this Committee on the 20th November 2013. The report set the scene for introducing an apprenticeship programme. The government through the National Apprenticeship Service (NAS) is committed to increasing the number of young people participating in apprenticeships as part of their strategy to get young people into work. NAS has a target of 1 in 5 16-19 year olds undertaking an apprenticeship by the year 2019/20.

3.2 Unemployment among 16-24 year olds in London is above the national average – 24.7% of young people are unemployed in London, while the national average is 20.9%. The London Borough Apprenticeship project run by the London Councils and funded by NAS has created 614 additional apprenticeship places – exceeding its original target of 550 – and over 340 young people have started work.

3.3 The council is committed to being part of this initiative to get young people into work. Equally important to the council is that it is seen as a leader and role model amongst local employers championing the interests of young people to improve their employability and economic wellbeing. The table below provides information on those claiming job seekers allowance in Brent.

Age Group	National %	London %	Brent %
18-24	5.1	4.0	4.3
16-65	3.0	3.0	3.6

Brent's profile is better than the national average and comparable with the London profile for the 18-24 year age group. Looking at the broader employment group the national and London averages are 3% and Brent is 3.6%. In this particular group there is evidence to show the gap is closing. Previously 4.2 % were claiming job seekers allowance in Brent. It is not possible to show a comparison in the 18-24 age group. Although this presents a positive trend for Brent in terms of employment levels amongst young people, the council is committed to ensuring all young people are afforded the opportunity to enter employment and progress their careers.

3.4 Children and young people generally perform well in the education system in Brent and leave school and go on to further education. However, many young people are now exploring different ways to pursue their chosen career as a genuine alternative to going to university. The financial responsibility associated with university can be prohibitive for many young people and their families. The apprenticeship programme provides a vocational and practical pathway for young people to fulfil their career aspirations.

4.0 Apprenticeship Programme in Brent

4.1 The council established it's refreshed apprenticeship programme last year in keeping with the national and London initiative. It provides a young person with an alternative vocational route into work whilst continuing their education. The design of the programme is geared toward raising skill levels and offers a range of career paths that will enable young people to build interesting and rewarding careers in local government.

4.2 It is aligned with the council's priority to promote jobs, growth and fair play to achieve the outcome of more local people in more local jobs; more local people supported into work, and Brent's Children and Young People's Plan which seeks to ensure young people have the skills they need to achieve economic wellbeing in adulthood. The council is keen to encourage applications from young people in the local community which is consistent with it's workforce strategy.

4.3 The programme enables the council to nurture talent in house and address recruitment difficulties in the market where there are skill shortages. The objectives for the council's apprenticeship programme are to:

- raise the quality and number of apprenticeships. The aim is to ensure that apprentices are better skilled and competent.
- work with departments to create apprenticeship offers in areas of skills shortages (e.g. social care) and areas that are attractive to young people (e.g. leisure sector).
- improve the range of apprenticeship opportunities on offer across departments.

- work strategically with Regeneration and Growth Department to target apprenticeship opportunities in wards where youth unemployment is highest; thereby reducing unemployment, worklessness and improving income levels. The programme co-ordinator will work collaboratively with the Head of Employment and Enterprise to ensure there is a commitment by contractors to recruit apprentices.

- provide looked after children, who have disproportionally poorer educational outcomes and weaker job prospects than other young people, with the opportunity to gain an apprenticeship place by working with stakeholders in Children and Young People to promote the benefits of apprenticeships to young people leaving care.

4.4 The new apprentice programme is an ambitious initiative aimed at improving the employment prospects for young people through a major expansion of apprenticeship jobs offered within the council. It is a 3 year (2013-2016) programme with a target of employing 100 apprentices in a variety of roles across the council.

In summary the features of the programme are:

- apprenticeships are offered in a diverse range of occupations across the council.

- the apprenticeship co-ordinator works with departments to identify entry level positions that can be converted into apprenticeships.

- a two stage programme. Apprentices are offered a 12-month fixed-term contract as a minimum during which they will learn on-the-job and complete a number of vocational qualifications including an NVQ level 2 as well a Functional Skills qualification in maths, english and ICT.

- on successful completion of year 1 an apprentice may be offered an advanced apprenticeship (18 month fixed term contract) linked to NVQ level 3.

- a starting salary of £8,500 for 16-18 age group and £9,500 for the 19-23 age group. In addition 3 increments of £500 are paid on completion of each NVQ qualification. Salary costs are funded from departmental budgets.

- extensive five day corporate induction programme to provide apprentices with an in-depth understanding of Brent's culture and values as well as providing training in areas such as communication and team working. Following the corporate induction apprentices receive more specific job related induction.

- apprentices are able to access the range of training offered as part of the corporate learning and development offer.

- recruitment and training of workplace mentors to provide additional support. A buddy system has also been introduced to provide apprentices with basic support and guidance on office processes and protocols.

- development programme for managers aimed at providing effective support for apprentices.

- celebration event to raise the profile across the council and the wider community.

4.5 The recruitment and selection of apprentices is undertaken through the council's normal recruitment and selection procedures and appointments are made on merit. The programme offers high quality learning and development to a wide cross section of the community, enabling the council and the community to benefit from a more skilled, motivated and flexible workforce.

4.6 The table below shows the annual recruitment targets for the programme.

Year	No of Apprentices
2014	35
2015	35
2016	30

5.0 The Apprenticeship Programme - Progress

5.1 Since November 2013, twenty one of the first cohort of apprentices for 2014 have been recruited. Some commenced employment on 27th January and others on 3rd March 2014. Further rounds of advertising to recruit to the remaining positions in 2014 will take place in March and June/July. There will be two intakes, one in April and the other in September. Research undertaken suggests that June/July is likely to be the best time to engage with the widest group of young people, particularly school leavers. It is therefore anticipated that a greater number of the posts will be advertised in June/July. It is intended to work with the Employment and Enterprise Team to engage with local partners, Job Centre Plus, local schools and Connexions to raise awareness of the opportunities amongst young people in the community and encourage them to apply.

5.2 To promote the councils apprenticeships amongst local young people a number of information days will be held at the Civic Centre to promote apprenticeships at Brent. Existing apprentices will be involved in the design and delivery of these events to engage their peer groups. An apprenticeship website is also being developed to make information about the opportunities more accessible to young people. Digital and e-communication methods are also being explored.

5.3 The positions available so far cover a more diverse range of work disciplines than previously - accounting and finance, housing, health and social care, planning, ICT as well as customer service and business administration.

5.4 The apprentices in post have completed the induction programme. Since induction peer meetings have been held with the apprentices to review their progress as well as to reinforce messages about workplace behaviours. Apprentices and their line managers have met with training providers to plan the work programme required to meet the qualification criteria. Generally the

feedback from managers has been positive and most are established in their roles and making a real contribution in their service area.

5.5 There is a commitment in the programme to target looked after children who have disproportionally poorer educational outcomes and weaker job prospects. The programme is working closely with stakeholders in the Children and Young People Department to promote the benefits of apprenticeships to young people leaving care. It has also been arranged through BACES to run a programme targeting young looked after people to improve their opportunity to gain an apprenticeship. This is scheduled to start April 2014.The programme will be over a two month period and will focus on preparing young people for work including workplace etiquette, literacy and numeracy skills and work experience. The council would like to see 20% of the apprenticeships being offered to young people in this group. It is also recognised that there will be a need to provide greater support to those who secure an apprenticeship to remain engaged and motivated to succeed. This will be achieved partly through the assigned social worker and partly through specialist support and mentoring. The arrangements are currently being developed and will be in place by April 2014.

5.6 Provision has also been made through the Employment and Enterprise Team for young people in Brent to be able to access workshops and one to one support designed to get people ready for work and to give them the best opportunity to secure one of the apprenticeship positions. The support provided includes completing application forms, interview skills and work place etiquette training.

5.7 Arrangements have also been put in place to support managers. These include monthly round table discussions where managers can discuss issues and share learning about the apprenticeship scheme. Training and briefings are also provided to support managers for example with engaging with training providers and undertaking workplace assessments.

5.8 A career development module has been developed which is an integral part of the programme. It has been designed to enable the apprentices to maximise the learning and experience gained from being an apprentice and secure permanent employment with the council or another employer. The council has set a 10% target for the retention of apprentices. The module covers how to search for job opportunities within the council and externally and preparing and presenting at interviews. It is also planned for apprentices to receive IT training for word and excel at basic and intermediate levels. IT skills are considered to be essential for the apprentices to be productive in the workplace and to progress their careers. They will also be encouraged to access other training offered in the council's corporate training offer.

5.9 It is early days to be able to report on the progress of the first cohort of apprentices. Implementation of the programme will be closely monitored to ensure the apprentices receive the necessary support to achieve a successful outcome for the individual and the council. The current cohort of apprentices will be involved in a three month review of the programme to identify ways in which the programme can be enhanced to attract and retain young people to successfully complete the programme.

6.0 Financial Implications

6.1 The cost of an apprentice varies according to the age of the individual. The apprentices' starting salary of £8500 (aged 16-18) £9500 (aged 19-23) and will be funded from departmental budgets. The maximum salary cost (including employer on costs) for up to 35 apprentices ranges from £392,700 to £498,900. The training provider who delivers the vocational qualifications will draw government funding for the cost of the qualification for each apprentice. Where an apprentice is 19 and over there is a requirement for the council to make a contribution towards the training cost. The calculation for determining the actual cost will depend on the number of 16-18 year olds on the programme compared to the number of 19 to 23 year olds. The greater the number of 16-18 year olds the lower the cost for the council.

7.0 Legal Implications

7.1 The council is committed to providing further employment opportunities to local people given unemployment rates and the council is legally able to encourage local residents to apply for vacancies however final recruitment decisions must be based on merit.

8.0 Diversity Implications

8.1 The council demonstrates its commitment to diversity by permitting entry-level posts to be converted to apprenticeship opportunities thereby increasing the profile of its younger workforce. The council has improved its diversity of apprenticeships by offering a wider range of disciplines including finance, social care, planning and leisure. Support will also be given to apprentices to identify suitable employment opportunities in advance of their apprenticeship being completed. The apprenticeship programme lead will work closely with the recruitment service to facilitate the smooth transition of apprentices into permanent employment.

8.2 It is important that young people who experience greater disadvantage in the labour market gain access to the council's apprenticeship programme. To ensure access is offered to 'hard to reach' young people, the delivery team will work with various partners to promote and engage young people. Additional support provided by trained mentors will help with the retention of apprentices.

Background Papers

Report to Corporate Management Team September 2013
Report to Partnership and Place overview and Scrutiny Committee 20 November 2013

Contact Officer

Cara Davani, HR Director
cara.davani@brent.gov.uk
020 8937 1909

Key Performance Information Comparison

December 2012 - December 2013

Brent Housing Partnership is regulated by the Homes and Communities Agency which sets framework outlining the standards required from all social housing operators. We have laid out our key performance objectives to show how we are meeting these standards.

Key		Comparing performance	
We are happy with our performance in this area as we are either meeting or above our target	☺	Better	↑
We are within the 5% tolerance level and close to meeting our target	😐	No change	⇔
Our performance has been disappointing in this area and we are not meeting target, we are exploring ways to improve in this area	☹	Worse	↓

Tenant Involvement and Empowerment	2012/13	2013/14			Better or Worse	Target	Performance against target
	Q4	Q1	Q2	Q3			
We aim to respond to 96% of correspondence within 10 calendar days	95%	88%	92%	93%	↓	96%	😐
Notes on correspondence: The drop in cumulative performance is mainly due to poor performance in April 2013 (78%). In 6 subsequent months performance met or exceeded the 95% target and in Quarter 3 of 2013/14 performance was 95.5%, exceeding the 95% target.							
We aim to answer 87% of phone calls within 15 seconds	89%	88%	Not available	Not available		87%	
Notes on telephone performance: Statistics on telephone handling for most of BHP and council services are currently unavailable since the change in phone systems last year. Data is still available for the Repairs Contact Centre which continues to use a specialist Automated Call Distribution (ACD) system software. The Council have a project to improve customer contact and will be including BHP in this project which will consider improved hunt group management and more use of ACD software where appropriate.							
We aim to resolve 95% of 48 hour enquiries within 48 hours	93%	100%	97%	93%	↓	95%	😐
We aim to respond to 93% of stage one complaints within 20 days	91%	80%	88%	88%	↓	93%	😐
We aim to have less than 3% of stage one complaints escalated to stage two	New for 2013/14	3%	3.5%	2.8%		3%	☺
We aim to respond to all members enquiries within 10 days	88%	85%	91%	90%	↑	100%	☹
Notes on complaints performance: After achieving the target of 90% in 2012/13, a target of 93% was set for 2013/14. BHP sets a high standard in complaints reporting compared to other council sections and London peers. On average BHP receive 35 stage 1 complaints monthly and unfortunately in 2013/14 have only responded to an average of 31 within the target time of 20 days. Complaints officers are working with managers to ensure that internal response times are met and that work loads are managed effectively.							

Home	2012/13	2013/14			Better or Worse	Target	Performance against target
	Q4	Q1	Q2	Q3			
We aim to make and keep 99% of standard repairs appointments	99.8%	99.8%	99.9%	99.8%	⇔	99%	☺
We aim to complete 95% of repairs on the first visit	97%	99%	98%	98%	↑	95%	☺
We aim to have 96% satisfaction upon post inspection	98%	100%	99.7%	99.2%	↑	96%	☺
We aim for 96% of customers to be satisfied with the quality of repairs work	98%	99%	99%	98%	⇔	96%	☺
We aim to complete all repairs within 6 working days	5.06	6.59	5.99	5.35	↓	6 days	☺
We aim for all of our properties to have a valid gas safety certificate at all times	99.9%	100%	100%	100%	⇔	100%	☺
We aim to complete all major adaptations within 60 days	38	38	40	42	↓	60	☺
We aim to complete all minor adaptations within 4 days	4	4	4	4	⇔	4	☺
Average length of time to complete major capital works under £5k (referrals)	New for 2013-14	Not available	7.4	14.3		30 days	☺
Average length of time to complete major project works over £5k (planned)	New for 2013-14	Not available	25.5	26.0		40 days	☺
Tenancy	2012/13	2013/14			Better or Worse	Target	Performance against target
	Q4	Q1	Q2	Q3			
We aim to let empty homes within 26 days	28	26.6	26.2	24.3	↑	26 days	☺
We aim for 95% of new tenants to be satisfied with our property	90%	93%	90%	92%	↑	95%	😐
Comment on new tenant satisfaction: New tenant satisfaction cards were reintroduced in November 2012 and performance has improved overall since then. BHP let an average of 20 properties per month and as the survey relies on tenants taking the time to reply, the data we are able to collect is small. BHP receives an average of 17 responses per month and of those responses, on average, 15 new tenants are satisfied with their homes. Cases where direct offers have been forced on tenants or decoration is not to tenants standard have resulted in negative responses to these surveys.							
We aim to issue all section 20 notices to leaseholders within 14 days	New for 2013-14	100%	100%	100%		100%	☺
We aim to serve all Right to Buy 2 notices within the 4 weeks legislation time	New for 2013-14	100%	100%	100%		100%	☺

Neighbourhood and Community	2012/13	2013/14			Better or Worse	Target	Performance against target
	Q4	Q1	Q2	Q3			
We aim for 88% of our residents to be satisfied with the standard of grass cutting and shrub maintenance	87%	84%	91%	92%	↑	88%	☺
We aim to inspect all playgrounds weekly	99%	100%	100%	100%	↑	100%	☺
We aim to inspect all communal areas in buildings twice monthly (except high-rise buildings)	100%	100%	95%	96%	↓	100%	😐
We aim to inspect all communal areas in high-rise buildings monthly	100%	100%	100%	100%	⇔	100%	☺
We aim for 96% of all residents to be satisfied with the standard of internal cleaning	94%	93%	83%	84%	↓	96%	☹
We aim for 91% of all residents to be satisfied with the standard of external cleaning	90%	87%	86%	88%	↓	91%	😐
We aim for 96% of communal areas in buildings inspected to be clear of obstructions	98%	99%	Not Available	99%	↑	96%	☺

Notes on neighbourhood satisfaction: BHP have seen a significant improvement in resident satisfaction with neighbourhood services in the last 3 months. BHP hope that through continued monitoring standards will improve further and performance targets will be met.

Neighbourhood and Community	2012/13 Q4	2013/14 Q1	2013/14 Q2	2013/14 Q3	Better or Worse	Target	Performance against target
We aim to have 93% of our building cleaning assessed with a gold standard	91%	95%	Not Available	91%	↓	93%	😐
We aim to have 99% of our grounds maintenance work assessed with a gold standard	94%	100%	Not Available	98%	↓	99%	😐
We aim to have 80% of our LEQ gradings assessed as gold	76%	84%	Not Available	77%	⇔	80%	😐

Notes on LEQ grading: Due to IT issues, reporting has not been available on LEQ inspections until recently. BHP are working with contractors and tenants to improve the standards of sites and financial defaults will be issued if standards are not adhered to.

Value for Money	2012/13	2013/14			Better or Worse	Target	Performance against target
	Q4	Q1	Q2	Q3			
We aim to collect 98% of all net rent and arrears	97.9%	95%	96.8%	97.6%	↑	98%	Annual
We aim to collect 98.5% of current gross rent	99%	98%	98.5%	98.3%	↓	98.5%	😐

Notes on rent collection: Although there has been a small dip in the collection % in quarter 3 of 0.2%, the monthly collection rate has increased each month between October – December. The Income Managers have identified arrears cases which we are sending out calling cards, text messages and making phone contact in order to maximise income. If the present monthly trend continues during quarter 4 with a steady increase in the monthly collection figures, we should meet our target at year end.

Value for Money	2012/13 Q4	2013/14 Q1	2013/14 Q2	2013/14 Q3	Better or Worse	Target	Performance against target
We aim to collect 111% of leasehold service charge owed	104%	21%	63.8%	86.4%	↑	111%	Annual
We aim to support employees in a healthy work environment so that an average of less than 6 working days is lost per staff member in the year	6.5	6.3	5.9	6	↑	6 days	☺

Performance Comparison Report

Key Performance Indicators December 2012 - December 2013

Brent Housing Partnership is regulated by the Homes and Communities Agency which sets framework outlining the standards required from all social housing operators. We have laid out our key performance objectives to show how we are meeting these standards.

Overview

BHP has improved performance in almost all areas from December 2012 to December 2013. Ambitious goals were set for 2013/14 performance and the targets set reflect this. BHP used trends in our data, HouseMark benchmarking data and analysis on the current social housing climate to inform the target setting and have taken steps to ensure that BHP performance equals or betters our peers in the next 3 years.
Over half of all indicators are currently meeting target and performance is expected to meet or exceed target at year end. There are many areas where performance has not met standard and, as seen in the comments, managers are monitoring services in these areas and taking action where necessary. Please see in the comments by area below comparison between performance in 2012/13 and 2013/14 and the constraints faced in certain areas.

Highlights		Quarter 3 2012/13	Quarter 3 2013/14	Performance comparison
Tenancy	We aim to let empty homes within 26 days	29	24.3	↑
Notes on Lettings: After recommendation from the board BHP has proposed a performance improvement plan to reduce the average re-let time to 24 days. This will help align performance with similar organisations benchmarked on HouseMark. The current median on HouseMark is 23.34 days. The improvement plan specifies staged targets as follows: 2013/14: 26; 2014/15: 25; 2015/16: 24. BHP is currently on track to meet the first stage of these targets in 2013/14. An increasing number of properties are being returned in a poor state resulting in an increase in the amount and value of Major void works required. As Major works voids are excluded from the calculation, this has helped improve the reported figure compared to the the previous year. BHP is also looking at implementing the four week notice period (Pre-Voids) and adding 4 weeks on from receipt of keys, apart from Evictions and Deceased cases.				
Home	We aim to complete all repairs within 6 working days	5.64	5.33	↑
Notes on repairs: After good performance in 2012/13 the target repairs end to end time was reduced from 10 days to 6 days. BHP has maintained the service at this standard in 2013/14 despite an increase in repairs jobs.				
Value for Money	We aim to support employees in a healthy work environment so that an average of less than 6 working days is lost per staff member in the year	7.8	6	↑

Exceptions		Quarter 3 2012/13	Quarter 3 2013/14	Performance comparison
Tenant Involvement & Empowerment	We aim to respond to 96% of correspondence within 10 calendar days	96%	**93%**	↓
Notes on correspondence: The drop in cumulative performance is mainly due to poor performance in April 2013 (78%). In 6 subsequent months performance met or exceeded the 95% target and in Quarter 3 of 2013/14 performance was 95.5%, exceeding the 95% target.				
Tenant Involvement & Empowerment	We aim to respond to 93% of stage one complaints within 20 days	95%	**88%**	↓
Notes on complaints responses: After achieving the target of 90% in 2012/13, a target of 93% was set for 2013/14. BHP sets a high standard in complaints reporting compared to other council sections and London peers. On average BHP receive 35 stage 1 complaints monthly and unfortunately in 2013/14 have only responded to an average of 31 within the target time of 20 days. Complaints officers are working with managers to ensure that internal response times are met and that work loads are managed effectively.				
Value for Money	We aim to collect 98.5% of current gross rent	98.4%	**98.3%**	↓

Notes on rent collection: BHP is on track to meet the target of 98.5% gross rent collection at year end. This target was set as a realistic goal for BHP in the current economic climate. The implementation of the government's welfare reform measures are the biggest challenge for the income collection team. Rent officers are employing new ways of working to help maximise rent collection. A welfare reform team was set up to support residents directly affected by the under-occupation charges; rent officers are working flexible hours outside of 9-5 to enable more direct contact to be made with tenants; officers are utilizing the Citizens Advice Bureau and other agencies to offer support to tenants; and officers are provided with more in depth rent collection reporting to track progress in their areas.

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Partnership with Registered Providers

20th March 2014

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Background

The Housing Strategy 2014-19

Borough	Population change between 2001 and 2011
Kensington and Chelsea	-200
City of London	200
Sutton	10,300
Merton	11,800
Kingston upon Thames	12,800
Havering	13,000
Bexley	13,700
Bromley	13,900
Richmond upon Thames	14,700
Hammersmith and Fulham	17,300
Barking and Dagenham	22,000
Camden	22,300
Lewisham	27,000
Islington	30,300
Hillingdon	30,900
Harrow	32,300
Croydon	32,800
Lambeth	36,900
Ealing	37,500
Westminster	38,100
Haringey	38,400
Enfield	38,900
Waltham Forest	39,900
Greenwich	40,200
Redbridge	40,400
Hounslow	41,700
Barnet	41,800
Southwark	43,400
Hackney	43,500
Wandsworth	46,600
Brent	47,700
Tower Hamlets	58,000
Newham	64,100

Y-axis: -300, 19,700, 39,700, 59,700, 79,700, 99,700

■ Population change between 2001 and 2011

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Birth Rate – Per 1000 Female Population

100.00
95.00
90.00
85.00
80.00
75.00
70.00
65.00
60.00
55.00
50.00

2006 2007 2008 2009 2010

95.28
76.33
71.30
72.11
69.32
70.77
65.82
66.62
62.37

Brent
London
NW London

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Household size and housing demand

- National average household size is 2.4 persons (and fell between 2001 and 2011)
- Brent average household size is 2.8
- Only Newham has a larger average at 3.0
- Only Newham has a larger number of five person+ households at 21,106 compared to 17,488 in Brent
- Household size drives demand, especially for larger homes, but is also influenced by supply – for example because adult children cannot leave home

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Tenure Change 2001 - 2011

120
100
80
60
40
20
0
Brent
Ealing
H&F
Harrow
Hillingdon
Hounslow
K&C
Outer London
Inner London
2001
2001
2001

120
100
80
60
40
20
0
Brent
Ealing
H&F
Harrow
Hillingdon
Hounslow
K&C
Outer London
Inner London
2011
20011
2011

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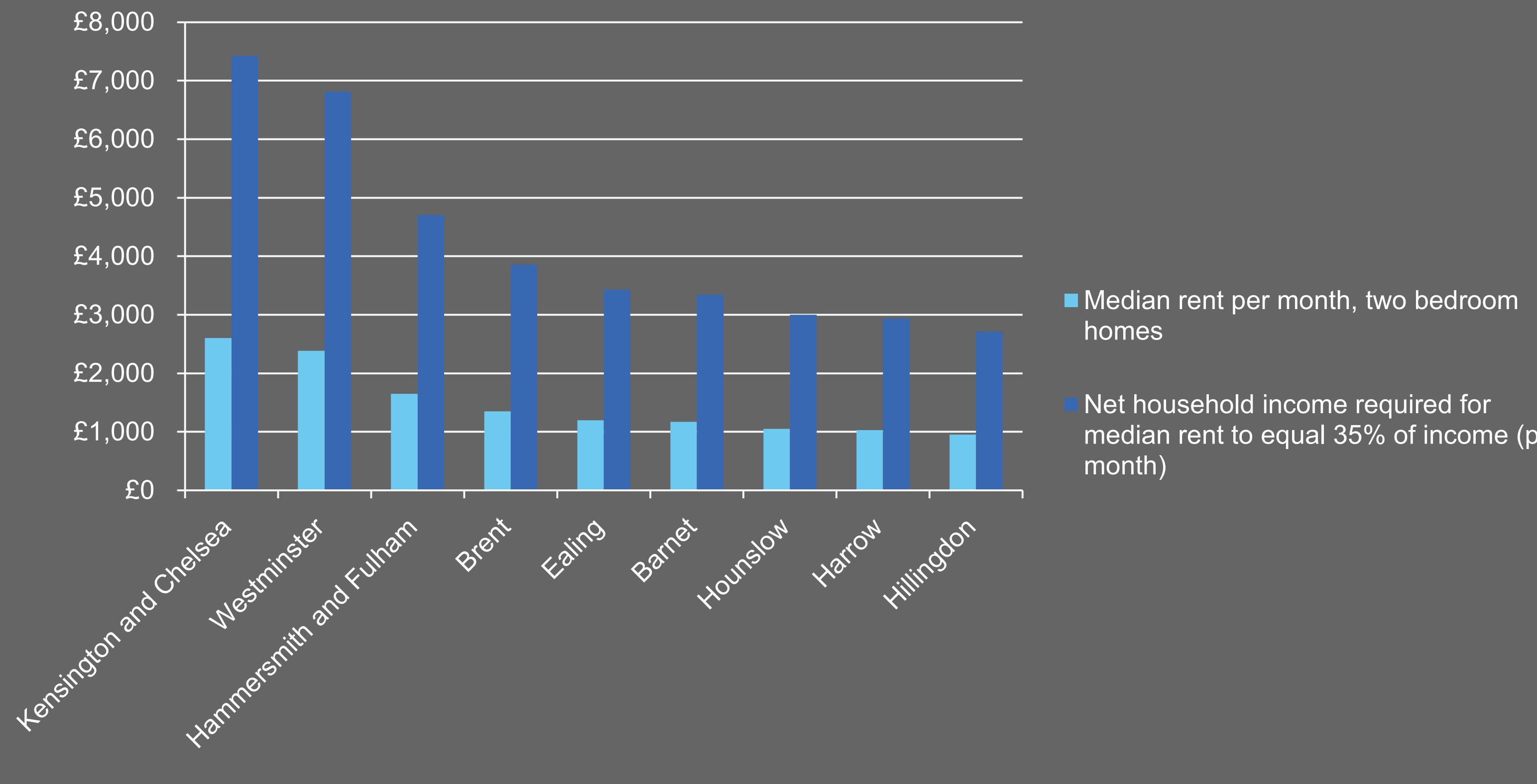
Comparative Affordability



(Shelter Rent Watch 2013)

Median Weekly Earnings – All Employees

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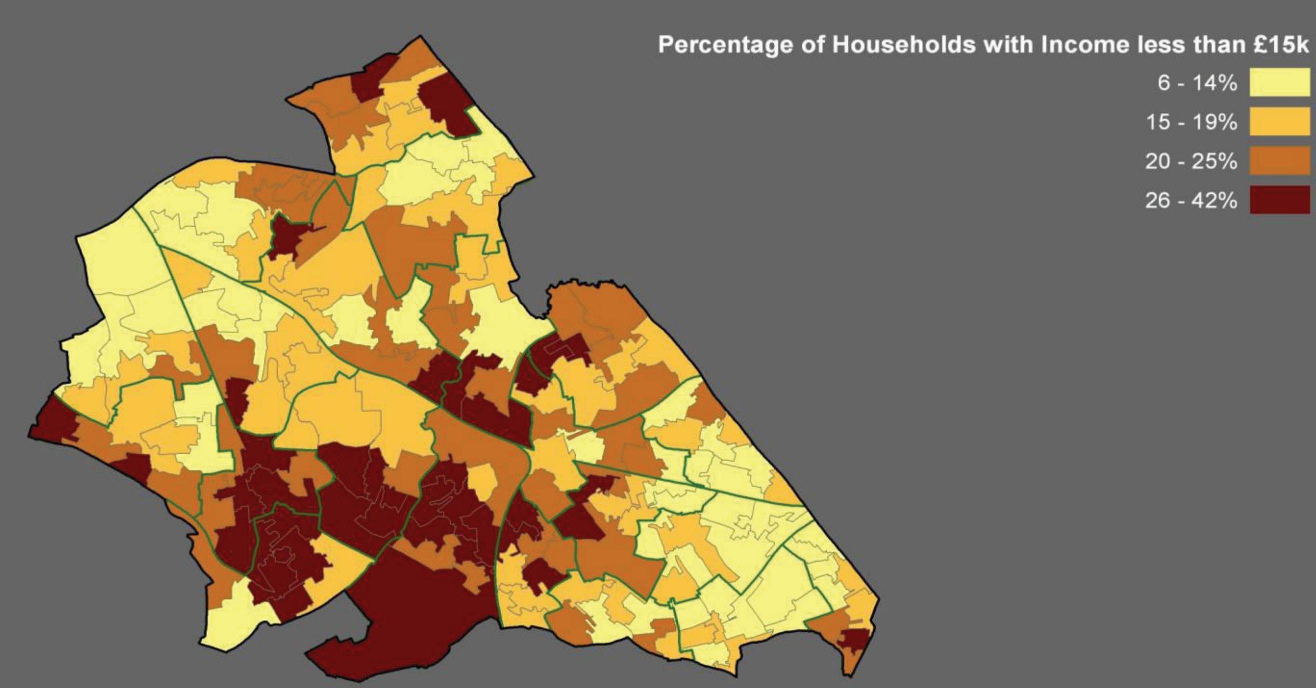
Distribution of Incomes Below £15,000



Distribution of social rented housing

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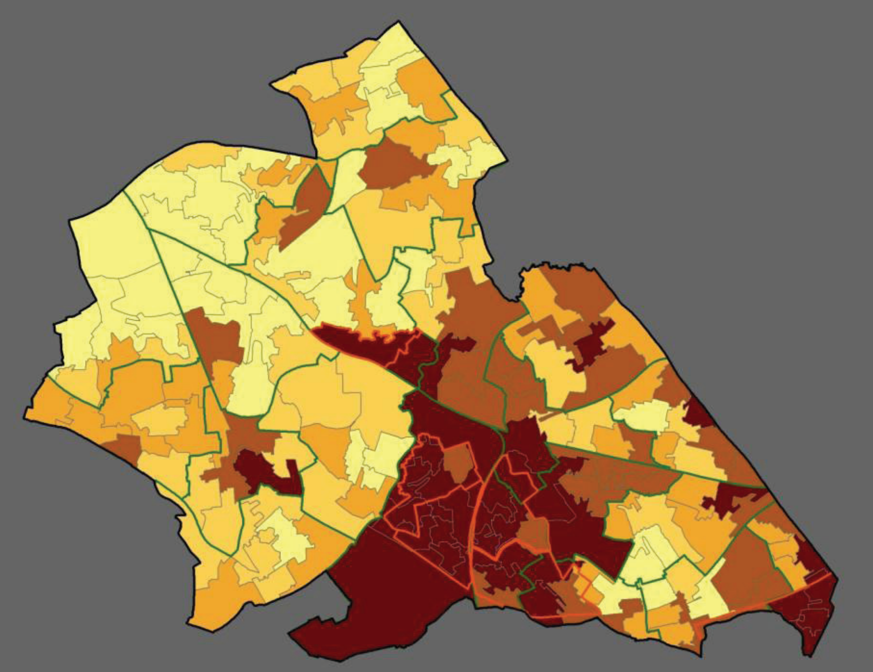
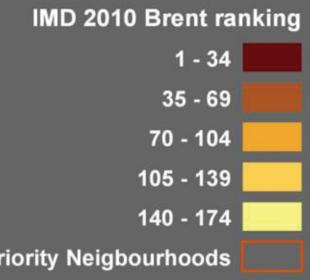
Index of Multiple Deprivation





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Percentage of unemployed (JSA claimants)

25
20
15
10
5
0

Mar-92 Nov-92 Jul-93 Mar-94 Nov-94 Jul-95 Mar-96 Nov-96 Jul-97 Mar-98 Nov-98 Jul-99 Mar-00 Nov-00 Jul-01 Mar-02 Nov-02 Jul-03 Mar-04 Nov-04 Jul-05 Mar-06 Nov-06 Jul-07 Mar-08 Nov-08 Jul-09 Mar-10 Nov-10 Jul-11 Mar-12 Nov-12

Brent %
London %
GB %

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Unemployment by Ward

10
9
8
7
6
5
4
3
2
1
0

Alperton
Barnhill
Brondesbury Park
Dollis Hill
Dudden Hill
Fryent
Harlesden
Kensal Green
Kenton
Kilburn
Mapesbury
Northwick Park
Preston
Queens Park
Queensbury
Stonebridge
Sudbury
Tokyngton
Welsh Harp
Wembley Central
Willesden Green

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Welfare Reform & Homelessness

- Local Housing Allowance – move to 30th percentile in 2012
- Overall Benefit Cap - currently 1,500 households affected
  - 460 of these in temporary accommodation and 8-900 in PRS
- Homelessness driven by welfare changes.
- Evidence / perception that significant number of landlords have withdrawn from providing housing for those on benefits
- Brent has among largest TA populations in London/UK

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Housing Strategy – The Challenges

- Rising population not matched by increase in housing provision
- Growth
- Huge growth in private rented sector – now a third of the market
- Rents increasing in Brent and London driven by housing shortage
- House prices – a high multiple of incomes – market returning…
- Rents unaffordable for many on average and lower incomes
- Low incomes and poverty concentrated in social housing and parts of private rented
- Welfare Reform sharply limiting access to private rented for many households
- Housing supply inadequate and uncertain prospects

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Challenges: Demand

Response: Demand Management

Response: Supply

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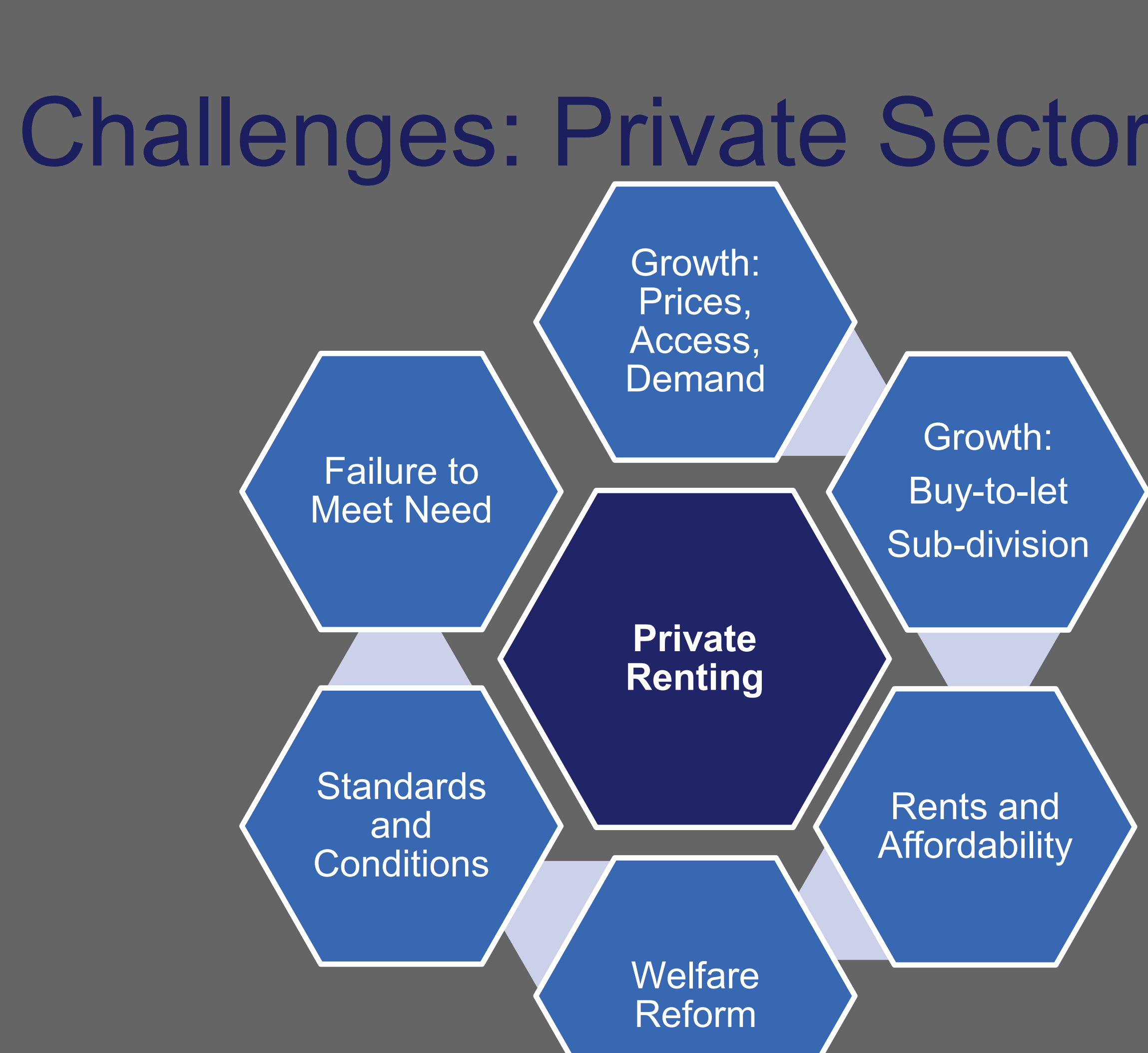
Challenges: Private Sector



What do we need from our partners?

- New supply of affordable housing
- New supply of market and sub-market products
- Focus on employment
- Focus on effective use of stock
- Focus on health and well-being

The Landscape for Registered Providers

- Mayor's Housing Strategy
- Mayor's Covenant Programme from 2015
- New products – Capped and Discounted Rents
- Private sector provision
- Asset management and stock improvement
- Tenure and prioritisation

Response to Change

- Dual track – long-term and short-term provision?
- Increased focus on employment as a route into and out of affordable housing
- Risk aversion?
- Concern over threats to income?
- Imposition of unwelcome conditions?
- Stock rebalancing?
- Impact on affrodability?

Next Steps

- 10,000 new homes by 2019
- Local Framework Agreement
  - Social housing affordable within the Overall Benefit Cap,
  - Private' rented housing that is affordable to those on HB
  - Low-cost home ownership products for those on middle incomes in the borough
- Develop partnership working through the Employment and Enterprise Strategy

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Partnership and Place Overview and Scrutiny Committee
20 March 2014

Report from the Assistant Chief Executive

For Action

Wards Affected: ALL

Task Group Report on Tackling Violence against Women and Girls in Brent

1.0 Summary

1.1 Members of the Health Partnership Overview and Scrutiny Committee (HPOVS) on a number of occasions, expressed an interest in forming a task group to tackle violence against women and girls in Brent; focusing on Female Genital Mutilation (FGM), Honour Based Violence (HBV) and Forced Marriages (FM).

The task group was agreed by HPOVS in March 2013 and has used this time to conduct an in-depth review into harmful practices. The task group report is attached as appendix A. The findings of the tasks groups review is wide reaching, effects many pubic services and has a direct impact on the lives of women, children and young people.

2.0 Recommendations

2.1 The Partnership and Place Overview and Scrutiny Committee consider the contents of the report;

2.2 The Partnership and Place Overview and Scrutiny Committee agree (where appropriate for partnership and safeguarding services) the 12 recommendations made by the task group.

3.0 Detail

The task group's key findings are as follows:

3.1 The scale and nature of Harmful Practices in Brent

The task group wanted to establish the prevalence of harmful practices in Brent. We found that there was very little data held and the data that was held by the organisations we contacted was not shared between partners. We met with a number of community groups to gather anecdotal evidence based on their experiences and talked to national and local charities with expertise in this area. While we can't be certain about the extent of these practices within Brent we believe that they are significant enough to recommend that a mapping exercise is undertaken to establish the number of women and girls at risk and that this work should be coordinated with partners and specialist charities.

3.2 Awareness, Knowledge and Criminality

The task group believes that there is a worrying lack of knowledge and understanding in Brent about harmful practices, the impact they have and the legislation relating to them. All of the women's groups we met with agreed that raising awareness within affected communities was key to tackling harmful practices. The task group recognises the important role that schools have in raising awareness and safeguarding. We undertook some research with school governors and whilst 64% of our respondents were aware of all three offences, only 21% said that they were covered as part of existing safeguarding training.

The task group has therefore made recommendations focussed on community engagement, awareness raising, obtaining resources, involvement in local and national media campaigns and highlighting harmful practices as criminal offences.

3.3 Partnership working including referral processes and pathways

The task group found that while there are many organisations currently working with women and girls affected by harmful practices, there was frequently a lack of coordination between partners and a lack of clarity about referral pathways. This contributed to the negative experience of many of the women we talked to. The task group is therefore recommending that a harmful practices strategy is developed within the wider Violence against Women and Girls Strategy which will provide a clear framework for partners to work within. We also recommend that all key staff from relevant agencies undertake training to ensure a better understanding of the issues, identification of those at risk and establishing referral pathways.

3.4 Services and accessing available funding

It is clear that for better more coordinated services to be available voluntary and statutory agencies need to work together. This will not only enable organisations within Brent to pursue all avenues of available funding but

ensure that services that are commissioned will have a real and lasting impact.

3.5 **Task Group Recommendations**

1. **That tackling harmful practices becomes a high partnership priority within Brent and that a clear partnership strategy is developed within the context of the wider Violence against Women and Girls Strategy. The harmful practices strategy should include:**

    1.1. Developing services to protect women and girls at risk

    1.2. Developing services to support women and girls subjected to harmful practices

    1.3. Robust recording and better quality of data and sharing of data from all partners

    1.4. Clear and consistent guidance for reporting risk, pathways for referrals and services

    1.5. Provide clear guidance to all key staff and the public on how to report a crime against a women affected by these issues.

    1.6. A single point of contact is established for those affected

    1.7. The adoption of good practice from elsewhere, health service, local authorities, voluntary sector organisations and educational institutions.

2. **That work in relation to the implementation of the Harmful Practices Strategy is the responsibility of:**

    - **The Children's Safeguarding Board**
    - **The Health and Wellbeing Board**
    - **Safer Brent Partnership**
    - **The Assistant Chief Executive Department will take the overall lead responsibility**

3. **That mapping of practising communities is undertaken to establish the number of women and girls at risk and should be undertaken as part of the Safer Brent strategic assessment process. This work should be completed using tested methodologies, such as those used by Forward and in coordination with Brent's partners and specialist charities such**

as Forward, the Asian Women's Resource Centre, the Jan Trust and the Iranian and Kurdish Women's Rights Organisation (IKWRO).

4. **That a programme of community engagement about violence against women focussing on harmful practices is developed which ensures that members of affected communities play a lead role. Awareness raising events should be aimed at all sections of the local community, partners, relevant staff and Council Members.**

5. **That awareness raising resources, leaflets and posters are clearly displayed in medical and educational establishments particularly GP surgeries, clinics. Hospitals, schools and colleges. These should include a single point of contact for those affected by harmful practices.**

6. **That Brent Council and its partners work with local and national media, including community radio and television stations, to raise awareness and educate the public on harmful practices and the negative effect it has on women and girls in our society.**

7. **That a programme of training is developed for all key staff from all relevant agencies who are likely to have contact with affected women and girls that will ensure a better understanding of the issues, identification of those at risk and referral pathways. Funding is available to the voluntary sector to assist Brent in delivering this training programme.**

8. **That all awareness raising and training activities highlight the changes in the law which make these harmful practices criminal offences.**

9. **That joint working is undertaken with schools to ensure that all head teachers, school governors and those responsible for safeguarding receive training and that all year seven children receive information as part of Personal Social and Health Education (PSHE).**

10. **That Brent Council in conjunction with its partners, particularly Council for Voluntary Services (CVS) Brent, pursue all avenues for available funding and support specialist charities and local voluntary organisations to bid for money from government agencies such as the Forced Marriage unit and the European Union fund.**

11. **That Brent Council along with its partners annually take part in the International UN sponsored awareness day that takes place 6th February each year. Zero Tolerance of Female Genital Mutilation day is set up to make the world aware of Female Genital Mutilation and to promote its eradication.**

12. **That Brent Clinical Commissioning Group (CCG) should commission services for women and girls affected by the harmful practices of Female Genital Mutilation, Honour Based Violence and Forced Marriages.**

4.0 Financial Implications

4.1 None

5.0 Legal Implications

5.1 None

6.0 Diversity Implications

6.1 None

Background Papers

Task Group Report – Tackling Violence against Women and Girls in Brent

Contact Officers

Kisi Smith-Charlemagne
Scrutiny Officer
020 8937 2129
kisi.smith-charlemagne@brent.gov.uk

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Tacking Violence against Women & Girls in Brent

An Overview & Scrutiny Task Group Report

March 2014

Membership

Councillor Ann John (OBE) Chair
Councillor Patricia Harrison
Councillor Ann Hunter
Councillor Sandra Kabir

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1. Chair's Foreword

The United Nations describes violence against women and girls across the world as a global epidemic. Gender inequality gives rise to many traditional and cultural harmful practices. These include Female Genital Mutilation (FGM), Forced Marriage (FM) and Honour Based Violence (HBV) which are all closely connected along with Domestic Violence. The task group examined all three of these harmful practices and how they impact on women and girls in the London Borough of Brent

The task group's work has been conducted at a time when greater media coverage is shining a long overdue light on these horrifying harmful practices. We have been particularly impressed with the very effective and continuing campaign against FGM conducted by the Evening Standard. We are also aware that there has been an increasing and extensive coverage of these issues on television and radio through specialist investigative and current affairs programmes and the national news networks. As these practices are so hidden and little discussed this is a very welcome development. The Forced Marriage Unit and the FGM helpline set up by the government and the commitment to end FGM within a generation is vital in ending these practices. There are also a number of Parliamentary Select Committees working on different aspects of these issues.

This coverage gives confidence to all those brave women who speak out and the expert organisations that openly campaign against these harmful practices. During our research we met with a large number of truly inspiring women who have, in many cases, harrowing stories to tell. We recognise that it is these women who will play the biggest role in bringing about change within communities affected by these issues, but they need our support.

We are well aware that this report is only one small but important contribution to the huge effort required to tackle violence against women and girls in all its forms. We urge the council and all partners to ensure that the recommendations contained in this report are implemented in full. The individual members of the task group are passionate about these issues and will continue to campaign on them at every possible opportunity.

First of all I would like to thank all of the organisations and individuals who we have met with or visited. They have all made a massive contribution to the work of this task group and the formulation of our recommendations.

I would like to thank my task group colleague Councillors and Officers Councillor Sandra Kabir, Councillor Pat Harrison, Councillor Ann Hunter, Kisi Smith-Charlemagne, Jacqueline Casson and Mala Maru. Their commitment, knowledge and diligence have ensured the success of this piece of work and I am grateful for their support throughout what at times has been an emotional experience.

2. Executive Summary

Violence against women is an illegal, intolerable act and is a human rights violation. It is fundamentally wrong, impacts on the health and wellbeing of women and has wider effects in preventing them from fully contributing to society. It impacts on the wider society through lack of economic development, cost to public services, Health, Social and Police and a lack of societal well being. It is both a barrier to equality and a result of inequality. Female Genital Mutilation Honour Base Violence and Forced Marriages are all illegal and harmful and can never be justified in the name of freedom of religion or belief.

Brent is recognised as one of the most ethnically diverse population in the country and a significant proportion of these communities have religious and cultural ties to areas of the world where the harmful practices of Female Genital Mutilation, Honour Base Violence and Forced Marriages are prevalent. All of these offences are considerably under reported nationally and locally. The task group believes that it is imperative that the council and our partners raise awareness, provide advice and support our communities, and prosecute those who participate in these illegal harmful practices.

The task group's key findings are as follows:

The scale and nature of Harmful Practices in Brent
The task group wanted to establish the prevalence of harmful practices in Brent. We found that there was very little data held and the data that was held by the organisations we contacted was not shared between partners. We met with a number of community groups to gather anecdotal evidence based on their experiences and talked to national and local charities with expertise in this area. While we can't be certain about the extent of these practices within Brent we believe that they are significant enough to recommend that a mapping exercise is undertaken to establish the number of women and girls at risk and that this work should be coordinated with partners and specialist charities.

Awareness, Knowledge and Criminality
The task group believes that there is a worrying lack of knowledge and understanding in Brent about harmful practices, the impact they have and the legislation relating to them. All of the women's groups we met with agreed that raising awareness within affected communities was key to tackling harmful practices. The task group recognises the important role that schools have in raising awareness and safeguarding. We undertook some research with school governors and whilst 64% of our respondents were aware of all three offences, only 21% said that they were covered as part of existing safeguarding training.

The task group has therefore made recommendations focussed on community engagement, awareness raising, obtaining resources, involvement in local and national media campaigns and highlighting harmful practices as criminal offences.

Partnership working including referral processes and pathways
The task group found that while there are many organisations currently working with women and girls affected by harmful practices, there was frequently a lack of coordination between partners and a lack of clarity about referral pathways. This contributed to the negative experience of many of the women we talked to. The task group is therefore recommending

that a harmful practices strategy is developed within the wider Violence against Women and Girls Strategy which will provide a clear framework for partners to work within. We also recommend that all key staff from relevant agencies undertake training to ensure a better understanding of the issues, identification of those at risk and establishing referral pathways.

Services and accessing available funding

It is clear that for better more coordinated services to be available voluntary and statutory agencies need to work together. This will not only enable organisations within Brent to pursue all avenues of available funding but ensure that services that are commissioned will have a real and lasting impact.

3. Recommendations

1. **That tackling harmful practices becomes a high partnership priority within Brent and that a clear partnership strategy is developed within the context of the wider Violence against Women and Girls Strategy. The harmful practices strategy should include:**

    1.1. Developing services to protect women and girls at risk

    1.2. Developing services to support women and girls subjected to harmful practices

    1.3. Robust recording and better quality of data and sharing of data from all partners

    1.4. Clear and consistent guidance for reporting risk, pathways for referrals and services

    1.5. Provide clear guidance to all key staff and the public on how to report a crime against a women affected by these issues.

    1.6. A single point of contact is established for those affected

    1.7. The adoption of good practice from elsewhere, health service, local authorities, voluntary sector organisations and educational institutions.

2. **That work in relation to the implementation of the Harmful Practices Strategy is the responsibility of:**

    - **The Children's Safeguarding Board**
    - **The Health and Wellbeing Board**
    - **Safer Brent Partnership**
    - **The Assistant Chief Executive Department will take the overall lead responsibility**

3. That mapping of practising communities is undertaken to establish the number of women and girls at risk and should be undertaken as part of the Safer Brent strategic assessment process. This work should be completed using tested methodologies, such as those used by Forward and in coordination with Brent's partners and specialist charities such as Forward, the Asian Women's Resource Centre, the Jan Trust and the Iranian and Kurdish Women's Rights Organisation (IKWRO).

4. That a programme of community engagement about violence against women focussing on harmful practices is developed which ensures that members of affected communities play a lead role. Awareness raising events should be aimed at all sections of the local community, partners, relevant staff and Council Members.

5. That awareness raising resources, leaflets and posters are clearly displayed in medical and educational establishments particularly GP surgeries, clinics. Hospitals, schools and colleges. These should include a single point of contact for those affected by harmful practices.

6. That Brent Council and its partners work with local and national media, including community radio and television stations, to raise awareness and educate the public on harmful practices and the negative effect it has on women and girls in our society.

7. That a programme of training is developed for all key staff from all relevant agencies who are likely to have contact with affected women and girls that will ensure a better understanding of the issues, identification of those at risk and referral pathways. Funding is available to the voluntary sector to assist Brent in delivering this training programme.

8. That all awareness raising and training activities highlight the changes in the law which make these harmful practices criminal offences.

9. That joint working is undertaken with schools to ensure that all head teachers, school governors and those responsible for safeguarding receive training and that all year seven children receive information as part of Personal Social and Health Education (PSHE).

10. That Brent Council in conjunction with its partners, particularly Council for Voluntary Services (CVS) Brent, pursue all avenues for available funding and support specialist charities and local voluntary organisations to bid for money from government agencies such as the Forced Marriage unit and the European Union fund.

11. That Brent Council along with its partners annually take part in the International UN sponsored awareness day that takes place 6th February each year. Zero Tolerance of Female Genital Mutilation day is set up to make the world aware of Female Genital Mutilation and to promote its eradication.

12. **That Brent Clinical Commissioning Group (CCG) should commission services for women and girls affected by the harmful practices of Female Genital Mutilation, Honour Based Violence and Forced Marriages.**

***Please note that the order of recommendations throughout the body of the report appear in order of importance and not necessarily in the order listed above.**

4. Introduction – Scope of the task groups work

This task group was set up by the Health Partnerships Overview and Scrutiny Committee to investigate ways of tackling the prevalence and impact of Female Genital Mutilation, Honour Based Violence and Forced Marriages.

Female Genital Mutilation and Honour Based Violence are criminal offences which carry jail sentences. In June 2012 the Prime Minister announced that forcing someone to marry will become a criminal offence in England and Wales and this was included in the Anti-Social Behaviour, Crime and Policing Bill which is currently going through Parliament. The new law will be accompanied by a range of measures to increase protection and support for victims with a continuing focus on prevention and will come into force later this year.

A new definition of domestic violence was implemented by the Home Office in March 2013. It includes: “Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: Psychological, Physical, Sexual, Financial and Emotional”.

The Home office goes on to say that “Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. “Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim”. * This definition of controlling behaviour, which is not a legal definition, includes so called **'honour' based violence, Female Genital Mutilation** and **Forced Marriage**, and it is clear that victims are not confined to one gender or ethnic group.

Female Genital Mutilation has been deemed an offence by the Human Rights Council of the United Nations since 1985, and made a criminal offence in the UK in the same year. This was amended in 2003 to cover UK nationals taken abroad. However to date no prosecutions have ever been brought in the UK. In November 2012 The Crown Prosecution Service (CPS) announced a new 10 point action plan for improving detection rates and prosecution. This includes:

- Gathering more robust data on allegations – looking at the reporting duties and mechanisms for medical professionals, social care professionals and teachers.
- Identifying what issues have hindered investigations and prosecutions.
- Exploring how other jurisdictions prosecute crime.

- Ensuring that police and prosecutors work together closely from the start of the investigation.

The CPS will also explore whether it is possible to prosecute offences under other legislation. For instance, it may be easier to support a prosecution under section 5 Domestic Violence, Crime and Victims Act (DVCVA) 2004, as amended by DVCVA 2012, which creates an offence of causing or allowing a child or vulnerable adult to die or suffer serious physical harm.

The definitions that the task group worked to are as follows:

Female Genital Mutilation/cutting – involves the complete or partial removal or alteration of external genitalia for non-medical reasons. It is mostly carried out on young girls at some time between infancy and the age of 15; and its extensive harmful health consequences are widely recognised[1].

Honour Based Violence – violence committed to protect or defend the 'honour' of a family and/or community. Women, especially young women, are the most common targets, often where they have acted outside community boundaries of perceived acceptable feminine/sexual behaviour. In extreme cases the woman may be killed[2].

Forced Marriage – One or both people do not (or in cases of people with learning or physical disabilities, cannot) consent to the marriage and pressure or abuse is used. This also includes child marriages as children are below the age to give informed consent. The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel like they're bringing shame on their family)[3].

The task group's key findings are focused on:

1. ***The scale and nature of harmful Practices in Brent and Impact of recent legislative changes***

2. ***Awareness, knowledge and criminality***

3. ***Partnership working including referral pathways and processes***

4. ***Services and accessing available funding***

5. Task Group Membership

Councillor Ann John OBE (Chair)
Councillor Patricia Harrison
Councillor Ann Hunter
Councillor Sandra Kabir

[1] The World Health Organisation (WHO)
[2] The Crown Prosecution Service (CPS)
[3] The Forced Marriage Unit (FMU)

6. Methodology

In order to complete the work identified in the scope, and produce a set of recommendations that would start to tackle some of the issues related to the harmful practices of FGM, FM and HBV in Brent, the task group gathered research and evidence from a wide range of sources. This included:

- The Team from FORWARD (Kekeli Kpognon, Maria Aden Naima Ibrahim and Rita Buhanda)
- The Jan Trust (Sana Malik and Sajda Moghul)
- Somali Advice and Information Forum - SAFFI (Rhoda Ibrahim & Yasmin Ali)
- Help Somalia Foundation (Harbi Farah)
- Brent Police/Azure Project (Nicola Butler and Louise Caveen)
- Birmingham City Council (Monika Bindal)
- Bristol City Council (Jude Williams)
- Brent Education Welfare (Stephen McMullan)
- Brent Public Health (Melanie Smith and Imran Choudhury)
- Brent Children's Social Services (Jo Moses)
- Brent Adult Safeguarding (Colin Boughen)
- Brent Local Children Safeguarding Board (Sue Matthews)
- Brent Ward Working (Carol Allen)
- Brent Community Safety (Chris Williams and Mala Maru)
- Northwick Park Hospital/NHS (Florence Acquah & Gloria Rowland)
- Asian Women's Resource Centre (Sarbjit Ganger)
- Iranian and Kurdish Women's Rights Organisation (Nezahat Cihan and Diana Niammi)
- Ashiana Network (Zuleyha Toprak)
- Brent Schools Head (Allyson Moss)

- Brent School Governors (Samira Mohamed)
- Home Office - Forced Marriage Unit & Sexual Violence (Joint Director-Chaz Akoshile)
- Home Office - Sexual Violence Unit (Sean Mcgarry)
- IMKAAN (Sumanta Roy)
- All Parliamentary Party Group (Baroness Jenny Tonge)
- The World Health Organisation – WHO (Glenn Raymond Thomas)
- BTEG Research (Tebussum Rashid)
- G Light Development & Somalian TV (Amran Mohammed)

Members of the task group also attended:

- Capita Conference on Tackling Forced Marriage and Honour Based Violence
- Jazari Community Centre (Abdi Ahmed) to talk to Somali women about FGM
- London Councils European Funding conference
- Brent FGM awareness training
- Jan Trust Forced Marriage awareness training
- Members Development Training on Harmful Practices - Delivered by FORWARD and the Asians Women's Resource Centre
- Brent White Ribbon Seminar
- A visit to Northwick Park Maternity Unit and Well Woman Clinic
- Brent School Governors Annual Conference
- Brent Children's Safeguarding Board Steering Group on FGM
- Iranian and Kurdish Women's Rights Organisation to talk to survivors of forced marriage.
- The launch of All Party Parliamentary Group's report on forced marriage

The task group formed a professional discussion group which consisted of Individuals from the above named organisations, departments and groups. The task group held two meeting where pre-designed questions (Appendix 1 & 2) were used to lead a round table discussion on

FGM, FM and HBV. Members of the task group also reviewed a great deal of literature and academic research in relation to this subject areas and a list of references is set out at the end of this report. Ultimately though, the task group was keen to ensure that this report focused on Brent and produced locally implementable recommendations.

The task group designed questionnaires which were used to gather information and evidence used to support this report at events attended, these included:

- Members Development Training on Harmful Practices - Delivered by FORWARD and the Asians Women's Resource Centre (Appendix 3)

- Brent School Governors Annual Conference (Appendix 4)

7. Policy Context

Local

Traditionally the main focus of the work that has taken place in Brent in relation to violence against women and girls has been on domestic violence and rape. However since 2010 Female Genital Mutilation, Forced Marriage and Honour Based Violence has been gaining prominence and FGM in particular is now one of the priorities of the Safer Brent Partnership. The council and its partners are aware that these harmful practices are taking place in some areas of the borough. However the very nature of these offences and the fact that they are often dismissed as religious or cultural traditions means that they are not discussed openly, are shrouded in secrecy and there is a fear of speaking out against them and reporting them.

National press, the London Evening Standard, BBC Radio 4, television and social media networks have recently been highlighting issues relating to FGM, Forced Marriage and Honour Based Violence. This has included using cases of women and girls in Brent who have become victims.

The charity FORWARD (Foundation for Women's Health Research and Development), The Asians Women's Resource Centre and Northwick Park's African Well Women's Clinic, have undertaken work in Brent to provide services to women who had been subject to harmful practices. Research conducted by the charity FORWARD in 2007 (Appendix 5), showed that second to LB Southwark, Brent had the next highest number of women with FGM that had given birth to children in England and Wales. ASCENT[4] also provided statistics in October 2013 (Appendix 6) on the number of domestic and sexual violence calls placed to their help lines. This showed Brent had the 6th highest number of calls placed in London.

London, National & International

In April 2009 the Mayor of London launched *The Way Forward: A call for action to end violence against women* a consultation on proposed set of actions for dealing with all forms of

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[4] Ascent is a project undertaken by the London VAWG Consortium, delivering a range of services for survivors of domestic and sexual violence, under six themes, funded by London Councils.

violence against women in London. This includes the harmful practices of FGM, Forced Marriage and Honour Based Violence. The British government is taking Violence Against Women and Girls very seriously and there is further legislation in the pipeline. Further detailed work is being done by Select Committees.

The existing legislative framework that relates to Tackling Violence against Women and Girls and Harmful Practices includes:

- Prohibition of Female Circumcision Act 1985
- Nationality, Immigration and Asylum Act 2002
- Female Genital Mutilation Act 2003
- Sexual Offences Act 2003
- Asylum and Immigration Act 2004
- Forced Marriage (Civil Protection Act) 2007
- Impending – Forced Marriage (Criminal Act) 2014

There is evidence that nationally awareness about the prevalence and impact of Female Genital Mutilation, Forced Marriage and Honour Based Violence is increasing amongst politicians and policy makers. For instance:

Female Genital Mutilation
In November 2012 the UK government launched a 1 year pilot of the Statement Opposing Female Genital Mutilation. The Statement Opposing FGM, which is currently used in Holland and is known as the 'Health Passport', is pocket-sized and states the law and the potential criminal penalties that can be used against those allowing FGM to happen. In Holland, it is primarily used by families who have migrated to Holland and do not want their children to be subjected to FGM, but still feel compelled by cultural and social norms when visiting family abroad.

The British government has also pledged up to £35m international development aid to help eliminate FGM in a generation. A portion of the new money expected to be around £8m would be spent on research into the best ways of ending the practice. The rest will be used to fund community programmes, with money channelled through the UN programme on FGM, and to support the Home Office in targeting the diaspora, who take children from the UK overseas to be cut.

Forced Marriage
The Anti-social Behaviour Crime and Policing Bill, currently going through Parliament will criminalise both Forced Marriage and breach of a Forced Marriage Protection Order.

Honour Based Violence
The Home Office released its reviewed 2013 action plan *A Call to End Violence against Women and Girls.* The action plan commits to engage with communities who practice 'honour' based violence such as FGM and Forced Marriage to change attitudes and behaviours, with following specific HBV actions:

- Work on the development of guidance and learning programmes for the Police on sexual and domestic violence, including FGM, Forced Marriage, Honour Based Violence and stalking.
- Review the findings from the ‘honour’ based violence local mapping exercise and identify models of effective practice to share with local areas, particularly those where awareness and activity to tackle forms of Honour Based Violence is low.

In November the London Violence against Women and Girls Consortium sponsored by the Mayor of London launched the Ending Harmful Practices project Women Against Harmful Practices (WAHP). The project which forms part of ASCENT is delivered by a partnership of 8 specialist organisations working across different Black Minority Ethnic and Refugee (BMER) communities in London with women experiencing Female Genital Mutilation, Honour Based Violence, Forced Marriage and other harmful practices. Support includes one to one advice and information on rights, entitlements, intensive casework and advocacy support, therapeutic support groups and counselling. The project also works to raise awareness amongst voluntary and statutory agencies and runs workshops and peer mentoring support for young women.

8. Key Findings and Recommendations

8.1. The scale and nature of Harmful Practices in Brent

The task group were keen to find out about the scale of Female Genital Mutilation, Forced Marriage and Honour Based Violence in Brent. However we soon realised for a variety of reasons, particularly the secrecy and taboos that exist around discussing these issues and the under or incorrect reporting of incidences, there was not an easy way to get this information.

We therefore started at looking at the information that existed nationally and for London. This included:

Violence against women

London has the highest rate of female victimisation in England and Wales.[5] Compared to the rest of the country, London has the lowest percentage of successful outcomes (measured as convictions of prosecuted cases) for violence against women offences (only 62 per cent were successful last year compared to 72 per cent nationally).[6]

Female Genital Mutilation (FGM)

An estimated 6.3 per cent of pregnancies in inner London [7] and 4.6 per cent in outer London are to women with FGM[8]. FGM was outlawed in 1985 by the Human Rights Council of the United Nations, and made a criminal offence in the UK in the same year. This was amended in 2003 to cover UK nationals taken abroad. There have been no convictions in the UK compared to 100 in France. FGM is prevalent in 28 African countries as well as in parts of the Middle East and Asia. FORWARD[9] estimated that over 20,000 girls under the age

[5] Home Office, 2004-8, British Crime Survey. Analysis of data comparing London rates with overall findings
[6] Crown Prosecution Service, 2009, Violence against women Crime Report 2008-2009, p.70
[7] These figures come from the only study in the UK that seeks to estimate prevalence. The research was funded by the Department of Health and undertaken by the Foundation of Women’s Health
[8] Forward, 2007, A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales

on 15 are at risk of FGM and 66,000 women in the UK are living with the consequences.

Research was funded from Public Health Brent to the Help Somalia Foundation in September 2013 for a study of the Somalian population in Brent. It shows that there are over five thousand women and children, many of whom have either been cut or are at risk (Appendix 7).

Honour Based Violence (HBV)

Nationally, there are around 12 so-called 'honour' murders a year. The Metropolitan Police recorded 256 incidents linked to 'honour' in the year 2008/09, of which 132 were criminal offences. This is a 60 per cent rise for the year to April 2009. These are the most recent figures available at this time and were collected by a Freedom of information request made by IKWRO. IKWRO have recently produced a report called the *"Postcode Lottery"* which details the UK Police forces failings to correctly recording Honour Based Violence cases (Appendix 8).

Forced Marriage (FM)

January to May 2012[10] - 594 cases where the FMU has given advice or support related to a possible Forced Marriage. 14% of calls involved victims below 15 years old, 87% involved female victims and 13% involved male victims. Countries of Origin: Pakistan (46%), Bangladesh (9.2%), UK (8.7%), India (7.2%), Afghanistan (2.7%), Within the UK the geographical distribution of instances was as follows: London (20.9%), West Midlands (16.7%), South East (10.4%), North West (5.1%), 25 instances involving those with disabilities (23 with learning disabilities, two with physical disabilities and two with both) were brought to the FMU's attention. Seven instances involved victims who identified as lesbian, gay, bisexual, and transgender (LGBT).

Linked to forced marriage, many cultures have a tradition of marrying daughters at a young age. Female children, already malnourished and undervalued, are often married to much older men. In such marriages, females have little power and sense of self-determination. Those who marry early cannot stay in school and often have little motivation or ability to plan their families. Some cultures believe early marriage guarantees a long period of fertility; very young brides may need a smaller dowry. The age of female marriage is slowly rising in most of Africa; but in East Africa and Nigeria, it is dropping as young virgins, considered less likely to be infected with HIV/AIDS are sought as brides. Early marriage is most prevalent in Sub-Saharan Africa and in South Asia. In Bangladesh, 47 percent of women, ages 20 to 24, are married by age 15. In Guatemala, India, and Niger, the rates are 12, 18, and 50%, respectively.

Early marriage and childbearing are closely linked to low educational attainment. In Cameroon, 27% of married women, under age 20, finished seven years of school, compared to 77% of unmarried women. In Guatemala, teenage mothers are five times less likely to finish

[10]The Foreign and Commonwealth Office's Forced Marriage Unit (FMU) May 2012

secondary education than women whose first birth occurs later. Early marriage usually results in early childbearing, with severe consequences for the health of young mothers and their babies. Infants born to teenage mothers are up to 80% more likely to die within their first year than are infants born to mothers aged 20 to 29. Maternal mortality rates are twice as high for women aged 15 to 19 as for women aged 20 to 29. The task group supports the discussions in parliament to legislate for a minimum age of 18 years for marriage and does not support marriage at 16 years with parental consent.

Data for Brent

The task group requested data from the following sources about harmful practices in Brent. Not all of the organisations we contacted were able to provide data, please see all responses in Table 1. Table 2 shows the available data held by sources. There is very little data held anywhere on the local prevalence levels of harmful practices in Brent; and the data that has been recorded, has not previously been readily shared between Brent partners. We are still unsure of the extent of FGM, Forced Marriages and Honour Based Violence incidents in Brent and more work needs to be done. The tables below bear out the strong view expressed frequently that these practices are under-reported.

Table 1 – Written responses to request for Harmful Practice Statistics for LB Brent

Source	Response
FORWARD	No specific Brent data, however FORWARD provided a summary of Brent Community reached this year: • 63 women in total were reached through the work of our outreach worker in different community settings and women attending Coffee morning support and all women were given FGM awareness and information • We worked with 5 one to one support cases from the Brent area. Cases involved referral to Acton African Women's Well Clinic, and educational support • 4 men from the Borough of Brent attend FORWARD Men Advisory Committee • Most of Brent clients we have worked with this year are Muslims, Somali; between the ages of 25 to 60. The marital statuses of most clients are either single and/or lone parents.
TAWRC	Please note that we had considerably reduced staff capacity and these figures are based on two members of staff providing services. We have since expanded and we have 4 members of staff providing services.
Northwick Park/Brent NHS	A database has now been in existence since 2009, the data is used for Freedom of information requests and service planning. The FGM status is recorded in the patients Discharge notes so that Health Visitors and GPs are aware. There is currently no formal procedure for reporting this anywhere else. We undertook 10 reversals this year and 97% of the women who visited the clinic were of Somalian origin.
Brent Police	The criteria for flagging is purposefully vague so that even if there

	is only a perception from the officer that this might be happening, then the flag goes in, to ensure the most appropriate unit deal with the case.
Home Office: FMU	It is not of any significance to collect the name of the borough where forced marriage victims live, it makes no difference to the case or action that the FMU would take.
Home Office: SVU	We do not hold this information.
IKWRO	We keep detailed records of our clients and have provided the figures for Brent clients. Further to our 2010 FOI study of HBV cases across England, we are carrying out a similar study and will have new data to report in the spring on 2014.
IMKAAN	We are unable to provide this information for Brent or any borough as we do not hold this information. It is difficult to collect this data as it is often not recoded and goes unreported.
LB Brent	We started capturing data on FGM, forced marriages and honour bases violence in 2013, no data is available prior to that date.

Table 2 - Shows the amount of harmful practices in March 2012 – April 2013

Source	FGM	FM	HBV
Brent Children's Social Services	0	6	3
FORWARD	-	-	-
TAWRC	-	13	80
Northwick Park/Brent NHS	236	-	-
Brent Police	5	11	18
IKWRO	-	8	4

The task group also met with a number of community groups such as the Somalian Advice and Forum for Information (SAFFI) and the Jazari community group. The discussion group at SAFFI consisted of 13 women and the discussion group at Jazari Community Centre consisted of 31 women. All of the women that attended these groups said that they had been subjected to one of the three types of FGM. Please see case studies of harmful practices within Brent (Appendix 8).

The task group is concerned that a large majority of organisations and charities are still working from the prevalence figures released by FORWARD in October 2007 and that there is currently no coordinated effort by a central body to collect Brent specific data. While we were conducting the task group work we were pleased to hear that FORWARD have been commissioned to undertake a new prevalence study and that there is to be a report released in 2014.

In April 2013 LB Islington conducted a study;[11] the purpose of this study is to establish a more detailed picture of Female Genital Mutilation in Islington. The study adapted the method used by the Foundation for Women's Health, Research and Development (FORWARD; 2007) which used UK census data and national and regional FGM prevalence data to estimate the number

[11] Female Genital Mutilation (FGM) in Islington: A Statistical Study

of women and girls in the UK who were likely to have undergone FGM. The Islington study combined FGM prevalence data with language and ethnicity data for Islington to produce a similar estimate (Appendix 9).

We believe that anecdotal evidence points to much higher incidences of these harmful practices happening in Brent. The under reporting and reluctance of partners to share data means that more work needs to be undertaken to map out the true picture of prevalence using similar methodologies as outlined above.

Recommendation 3

- **That mapping of practising communities is undertaken to establish the number of women and girls at risk and should be undertaken as part of the Safer Brent strategic assessment process. This work should be completed using tested methodologies, such as those used by Forward and in coordination with Brent's partners and specialist charities such as Forward, the Asian Women's Resource Centre, the Jan Trust and the Iranian and Kurdish Women's Rights Organisation (IKWRO).**

8.2. Awareness, knowledge and criminality

Prior to the release of FORWARD's data in 2007, the awareness and knowledge of harmful practices in Brent was limited. Individuals and some services who had dealt with incidents of harmful practices had some awareness of the issues, most of which had came from encountering cases on a day to day basis, however they had not received any formal training and guidance. The release of FORWARD's *'Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales'* in 2007 has provided the platform for those working to eradicate FGM and has highlighted the use of other violent harmful cultural customs. However awareness and knowledge of harmful practices is still not at an adequate enough level to have a significant impact reducing prevalence and improving service provision.

The task group found that there was a serious lack of knowledge within practising communities. Of the women that the task group consulted with, those not born in the UK said that they were unaware of their human rights in regards to FGM and unaware of the physical and mental health complications that it may cause prior to coming here. With Forced Marriages and FGM women were under the impression that it was part of the Qur'an, was Halal and a religious requirement that they could not say no to. The women revealed that various degrees of honour based fear and violence were applied as a form of pressure for them to adhere to their cultural traditions. These women were also unaware of UK laws and criminals charges regarding FGM, Forced Marriages and Honour Based Violence prior to coming here and for a while after arriving.

The women and girls, who were born in the UK, had a better awareness and knowledge about their human rights, UK laws and how/or where to seek help if they are at risk. However these stronger more empowered young women or girls often became the victim of Honour Based Violence, as they are seen as too westernised, too unruly and could not be easily controlled so ultimately may bring shame on their family. Iranian and Kurdish Women's Rights Organisation (IKWRO) and the Jan Trust told us that it was important that professionals

supporting these young women are fully trained and can identify the warning signs, are aware of the correct procedures of engagement and do not put their lives at risk by trying to mediate with parents or family members. FMU guidance states that NO MEDIATION should take place, ONE CHANCE or these young women face abduction, violence and often death. Untrained and poorly trained professionals are putting the lives of these young women at risk. We believe that more support needs to be provided to girls and women who are brave enough to challenge cultural and religious norms.

Prior to starting this review members of the task group had varying degrees of knowledge about harmful practices. The task group wanted to assess the knowledge of other councillors and school governors. Members of the task group proposed the following a strongly worded motion to Council.

- This Council commends the work of the members' task group on Tackling Violence against Women and Girls in Brent. This task group is committed to ending harmful practices by raising public awareness of issues such as Female Genital Mutilation Forced Marriages and Honour Based Violence. These practices, and all instances of violence against women, constitute illegal, intolerable acts and human rights violations.

- This Council notes the positive influence members can wield within communities by encouraging individuals and groups to speak out against harmful practices, which impact on the wellbeing of women and girls in Brent. To ensure that members are fully informed on all these harmful practices and how to deal with them effectively, there will be a member development event held on Thursday 21 November 2013. Sessions will be led by the expert organisations FORWARD and the Asian Women's Resource Centre.

- Members also note the work of the White Ribbon Campaign day- a charitable organisation started by men which seeks to end violence against women. Members whole-heartedly support this cause and will sign the White Ribbon pledge to affirm that they will never condone or remain silent about violent acts against women. A Brent Council event marking White Ribbon Day – the internationally recognised day for the Elimination of Violence Against Women – will be held in the Civic Centre on November 25.

- We call on all members to unite in the fight against these harmful practices, and resolve to end all practices which cause physical or emotional distress to women and girls in Brent within the 5-year target set by the Government earlier this year.

This was passed unanimously. The Member Development training session, delivered by FORWARD and the Asian Women's Resource Centre, on harmful practices was well attended by councillors.

We recognised early in our work the importance of engaging with schools and those who make decisions about teachers and student training. The charities we talked to had informed us that it was quite difficult to get their training programmes into schools. We decided that it would be beneficial to talk to school governors at the Annual Brent School Governors Conference to find out their views. A questionnaire was circulated to all governors who attended the conference and 34 Governors responded. A summary of the responses is as follows:

Q1: Awareness of the offences FGM, FM and HBV

- 64% of school governors are aware of all three offences and
- 70% were aware of at least one or more of the offences.

Q2: Are any of the above covered in your safeguarding training?

- Only 21% said the above offences were covered by existing safeguarding training.
- 36% said they didn't know or were unsure if the topics were covered by existing safeguarding training.

Q3: Are Personal Social Health and Education (PSHE) lessons in school's curriculum?

- 70% of schools governors said that PSHE lessons form part of the school's curriculum.

Q4: If yes, would you like to see these topics included in the PSHE lessons?

- 61% would like to see these topics included in PSHE lessons (but age-appropriate).

Q5: How do you ensure pupils receive information about sensitive subjects, particularly with regard to the dangers and existence of these offences?

- 30% of school governors said they were either unaware of or didn't know what the schools did to inform pupils of sensitive information.
- Some school governors (15%) suggested that they already utilise the PSHE or other curricula to ensure pupils had the information they needed.
- Other school governors suggested that information could be conveyed to parents and carers through various meetings and literature.

Q6: What kind of training and materials would your school need in order to cover the topics?

- 42% of school governors left this question blank – the highest on the survey.
- Many of the comments on what type materials would be required involved some type of workshop or training material such as literature and videos for staff, parents and pupils. Some suggested people share experiences or have a re-enactment of the crimes.

Q7: To your knowledge, is there any work currently being done at your school to tackle these problems?

- Only 6 (18%) of school governors said their school was currently working to tackle one or more of these offences.
- Most (70%) either reported that their school was not currently working to tackle these offences or they did not know if work was being undertaken on these topics.

Q8: Does your school currently employ a nurse?

- Nearly half (48%) of school governors reported that there was either no school nurse employed at the school or they were unsure if there was one.

Q9: In your opinion, what would you like to see schools do to protect females against the above?

- When asked what they would like to see in their schools to address these issues, most (24%) school governors suggested some type of training for staff and education for parents and pupils.
- Other suggestions included raising awareness and creating safe spaces for pupils to talk about such issues.
- One governor suggested that schools need to address children being taken out of school to travel abroad for long periods.

Q10: Would you know what outside (the school) bodies to contact, either to get information you need to cover these topics or to get direct support if needed?

- When asked if they knew what outside body to contact (if needed), most 73% of school governors responded by saying either no or that they were not sure who to contact.

We found some good examples of educational establishments within Brent who have made positive encouraging steps to deal with harmful practices and safeguarding. For instance the College of Northwest London who currently runs a programme called *"Feel Safe, Be Safe"*, which offers advice and support to students who do not feel safe or have safeguarding concerns. The college advertises this service on the student intranet and has published and distributed booklets to students. Students can contact the service by text, e-mail or a single phone number which is constantly manned. So far the college has been able to support a number of students including helping girls who were being forced into marriage. Evidence from colleges elsewhere in London confirms this. The task group strongly supports the establishing of a single point of contact for women and girls affected by these issues and we are keen that the example of a single point of contact is used by partners when developing services in Brent. We would also like to highlight the Stonebridge School Safeguarding Policy agreed in January 2014 (Appendix 10), which specifically includes FGM and sets out the signs that children may exhibit. A copy of this is attached to this report.

We believe that there is a real opportunity to work with schools and to ensure that all head teachers and school governors receive training on harmful practices and that an appropriate level of information focussed on respect and equality between the sexes is offered to all year seven pupils.

The Impact of recent legislative changes

Domestic Violence Legislation now covers controlling behaviour, which includes so called 'honour' based violence, female genital mutilation and Forced Marriage. As mentioned earlier the UK government introduced clauses in the Anti-social Behaviour Crime and Policing Bill which will criminalise both forced marriage and breach of a Forced Marriage Protection Order.

Prior to introducing this the Home Office conducted a survey on criminalising Forced Marriage and received 297 responses to the consultation,

Of the total number of 297 responses:

- 54% of respondents were in favour of the creation of a new offence;
- 37% were against the creation of a new offence;
- 9% of respondents were undecided;
- 80% felt that current civil remedies and criminal sanctions are not being use effectively.

A few of the women and professionals that the task group engaged with expressed some concern that recent legislative changes would result in harmful practices being driven underground. Discussions are currently taking place in parliament, about raising the age of consent for marriage from 16 years to 18 years.

The Task group supports raising the age for consent to marriage and the criminalisation of Forced Marriages and welcomes the roll out of the legislation later this year.

Recommendation 4

- **That a programme of community engagement about violence against women focussing on harmful practices is developed which ensures that members of affected communities play a lead role. Awareness raising events should be aimed at all sections of the local community, partners, relevant staff and Members.**

Recommendation 5

That awareness raising resources, leaflets and posters are clearly displayed in medical and educational establishments, particularly GP surgeries, clinics, Hospitals, schools and colleges. These should include a single point of contact for those affected by harmful practices.

Recommendation 6

That Brent Council and its partners work with local and national media, including community radio and television stations, to raise awareness and educate the public on harmful practices and the negative effect it has on women and girls in our society.

Recommendation 7

That a programme of training is developed for all key staff from all relevant agencies who are likely to have contact with affected women and girls that will ensure a better understanding of the issues, identification of those at risk and referral pathways. Funding is available to the voluntary sector to assist Brent in delivering this training programme.

Recommendation 8

That all awareness raising and training activities highlight the changes in the law make these harmful practices criminal offences.

Recommendation 9

That joint working is undertaken with schools to ensure that all head teachers, school governors and those responsible for safeguarding receive training and that all year seven children receive information as part of Personal Social and Health Education.

Recommendation 11

That Brent Council along with its partners annually take part in the International UN sponsored awareness day that takes place 6th February each year. Zero Tolerance of Female Genital Mutilation day is set up to make the world aware of Female Genital Mutilation and to promote its eradication.

8.3. Partnership working including referral processes and pathways

Throughout the task group's work it was noted that a large proportion of the professionals and stakeholders who were doing work to tackle harmful practices were working independently. This is especially evident in relation to the data. The data was captured using inconsistent methods, was not shared with other partners, and was not used to benchmark incidences or plan for provision and service needs.

The task group found evidence that since 2010 there has been a more noticeable effort in partnership working, however women and girls are still experiencing poor treatment and support and this is often because of a lack of partnership working. Pathways and referral processes differ from organisation to organisation and often professionals were unaware of the next step in the referral process. For example one medical professional stated that once she made the referral to social services, it was unclear what would happen next and she did not know what to tell her patient. Some services we talked to were following safeguarding guidance from the Forced Marriage Unit and the Home Offices Multi agency guide; some services adopted a combination of their own processes with parts of the Home Office guidance and Pan London Child protection guidance.

Where no clear agreement between partners has been established, confusion still occurs about where an incident should be signposted to, what services clients may be entitled to and the best course of action to take. Local authorities and GPs are often the first point of contact and many of the women we talked to have had a negative experience and are not referred or sign-posted to relevant services and partners.

A number of the women shared examples of poor practice amongst statutory agencies (health professionals, police, the courts, job centres and council staff) which left them feeling dismissed, disbelieved, vulnerable and not informed about where to access support. Barriers encountered included lack of understanding about the issues affecting them, for example most of the women we talked to had no understanding of the concept of safeguarding. Other barriers included a lack of practical assistance and a few felt that they were being discriminated against. Some of the women were concerned about being stigmatized and having their children taken away from them. They felt that the barriers and attitudes they encountered had made them less likely they would report incidents and make it more likely that they remained in dangerous situations

Access to on-going face-to-face training on different forms of VAWG from the specialist VAWG sector would go some way to ensuring responses were more consistent and of a high quality. For women with immigration/asylum issues, access to support services including refuge accommodation is particularly difficult, and women face a higher risk of destitution. Therefore there is a need for more joint work with UK Boarder Agency and other partners to improve referral to specialist VAWG services and review existing practice and policies on VAWG.

IMKAAN[12]recently produced a report *Beyond the Labels* which explores the views and opinions of Women and girls who have been subjected to harmful practices. The report also examines the barriers preventing access to support and summarises recommendations made by these women and girls and how local authorities and other professionals can improve their response to harmful practices. Some of the recommendations include:

Local Authorities

- Local authority staff particularly to have a more consistent and better understanding and knowledge on how to respond to VAWG.

Health

- For GPs to be more informed and proactive about the appropriate care and referral pathways specifically where women require access to support from the VAWG sector.
- Professionals in the health sector e.g. GPs, health visitors etc. to be trained to ensure that they are able to respond better to women after they disclose violence.
- GPs to have a better understanding of their need for confidentiality when seeking support. For example, women and girls wanted more opportunities to be alone with the GP to disclose safely.

UK Border Agency (UKBA)

- The UKBA (Home Office) to implement a working culture which is more sensitive and appropriate on VAWG and one which starts from the premise of belief.

Criminal Justice System

- For the police to have a better and more consistent awareness and training on VAWG to prevent women from feeling that their experiences have been minimised or dismissed because of an emphasis on physical violence rather than psychological violence and coercive control.
- For the police to be more informed and provide better quality and more consistent advice and information to enable effective referral to specialist VAWG services.
- Regular communication between the police and women/girls so they feel more informed once they have made a formal report. This included being regularly updated on any actions taken against the perpetrator(s) as well as information on location which would impact on their safety.
- More consistent forms of protection to support women and girls to feel informed, equipped and safe before, during and after court proceedings.
- Improved knowledge and training on VAWG across all parts of the Criminal Justice System (CJS) and more specialist VAWG courts.

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[12] Imkaan is a UK-based, black feminist organisation dedicated to addressing violence against women and girls.

“A call to end violence against women and girls (action plan 2013)” the Home Offices Commitment to tackling Violence against Women and girls identifies working in partnership as one if its main priorities. Partnership working - Guiding principle*: Work in partnership to obtain the best outcomes for victims and their families*. The action plan sets out the outcomes it hopes to achieve by 2015:

- Better support available for victims and their families with statutory, voluntary and community sectors working together to share information and agree practical action

- Improved the life chances of victims of violence against women and girls overseas, with this issue an international priority for the UK.

- Promote effective partnership working between police and schools where children are at risk of domestic violence (e.g. Operation Encompass on going to 2015).

- Continue to work in partnership across Government and with the third sector to ensure that the impact of Government reforms are fully understood and managed

- Provide clear information on violence against women and girls to commissioners in the changing commissioning landscape

- Support statutory and voluntary services in sharing information about the women and girls most at risk and agreeing clear referral and needs assessment arrangements

- Continue to demonstrate leadership internationally to address violence against women and girls, and ensure that the links are made between the women whom the UK is helping overseas and those who arrive in the UK seeking protection.

Key activity since 2012 on partnership working in England and Wales:

- Provided £100,000 to determine gaps in service provision at a local level, help local authorities better understand what services will best assist victims, and assist the voluntary sector in professionalising their dealings with statutory agencies;

- In response to the consultation “Getting it Right for Victims and Witnesses”, set out the move to a new model for the provision of support services for victims of crime where the majority of services will be commissioned locally by Police and Crime Commissioners (while rape support services will continue to be funded centrally);

- Funded Against Violence & Abuse (AVA) and the Aya Project (managed by Women’s Aid and IMKAAN) to build capacity within the women’s sector and help them better understand Local Authority commissioning processes; and help Local Authority commissioners better understand the needs of violence against women and girls victims and measures to tackle perpetrators in their areas

The task group would like to ensure that a partnership strategy on harmful practices is developed within the context of the Violence against Women and Girls Strategy that would

facilitate a more coordinated approach between partners working on this issue and provide clear guidelines to key staff on referrals and services available. We would also recommend that all key staff undertake training to build a better understanding of the issues, enable them to identify those at risk and make referrals.

Recommendation 1
That tackling harmful practices becomes a high partnership priority within Brent and that a clear partnership strategy is developed within the context of the wider Violence against Women and Girls Strategy. The harmful practices strategy should include:

1.1. Developing services to protect women and girls at risk

1.2. Developing services to support women and girls subjected to harmful practices

1.3. Robust recording and better quality of data and sharing of data from all partners

1.4. Clear and consistent guidance for reporting risk, pathways for referrals and services

1.5. Provide clear guidance to all key staff and the public on how to report a crime against a women affected by these issues.

1.6. A single point of contact is established for those affected

1.7. The adoption of good practice from elsewhere, health service, local authorities, voluntary sector organisations and educational institutions.

Recommendation 2
That work in relation to the implementation of the Harmful Practices Strategy is the responsibility of:

- **The Children's Safeguarding Board**
- **The Health and Wellbeing Board**
- **Safer Brent Partnership**
- **The Assistant Chief Executive Department will take the overall lead responsibility**

8.4. Services and accessing available funding
To establish the extent of existing services available to those affected by harmful practices the task group met with key staff from within the council and its partners to discuss the current provision. Most council departments told us that for cases where there are children or vulnerable adults safeguarding concerns there was social services provision. All other cases, especially where there is no recourse to public funds, are referred to charities and the voluntary sector.

In the course of our work, members of the task group visited various charities and community groups to ask them what improvements they would like to see to current service provision. We also looked at the recommendations set out in the IMKAAN Report "*Beyond the Labels".*

The recommendations set out in the report mirrored the views of the Brent residents consulted. These were:

On future services for women and girls

- For refuge provision to be more accessible across London in order to prevent women from being housed in generic homelessness provision.

- Consistent and longer term investment in women-led women-only spaces and services that women and girl's value, and that make them feel safer, protected and understood.

- More consistent and longer term investment in BME women-led services which provide effective responses to differences in social identity and support women and girls to experience higher levels of social inclusion and belonging.

- To improve the availability of local women-only services which are specialist in their approach and respond to women and girls' individuality of experience and identity.

- More accessible services that offer different forms of expertise including responses to Female Genital Mutilation, Forced Marriage, sexual violence and exploitation, domestic violence, support in exiting prostitution.

- More accessible services to address additional vulnerabilities and support needs including drug and alcohol, disabilities, chronic health issues and mental health needs.

- Improved access to refuge provision for women with immigration/asylum related issues particularly where women lack the relevant documentation or access to any other means of financial or housing support.

- Increased investment in projects that provide longer term support e.g. life skills, training, employment, and programmes that support women and girls to recover and reduce isolation after they have left the violence.

- Increased access to longer term, flexible and specialist key-work support at points of crisis and where women are rebuilding lives after leaving violence. This was specifically important to women who experience a range of complexities and where there are gaps in existing service provision e.g. exiting prostitution, young women within a gang/group-based context and/or peer-based abuse, Female Genital Mutilation and Forced Marriage.

- Improved access to holistic support services that are young-women centred and tailored to address the specific needs and experiences of young women.

- Improved access to long-term VAWG counselling and therapeutic support services which are rooted in a VAWG approach, including BME specific provision.

Overall it is important for public sector commissioners to recognise the need for more consistent and longer term investment in a diverse range of women-only VAWG service models and approaches which respond to different forms of VAWG and social identity. Women affected by FGM spoke about the barriers around disclosure and the complexities of reporting family and community members, hence the importance of on-going case-work support through community-based support workers. There are also inadequate levels of targeted provision for young women in the context of different forms of VAWG. Equally significant is improving access to services that provide longer term and flexible arrangements for emotional support through counselling, group work, peer-learning programmes and activities for adults and children. These were considered as significant as access to safe housing.

The recent London Council funded ASCENT project which launched in November 2013 is a partnership within the London Violence against Women and Girls Consortium, delivering a range of services for survivors of domestic and sexual violence and abuse under six themes funded by London Councils. ASCENT improves service provision for those affected by sexual and domestic violence and abuse in London through the provision of front-line services as well as support to voluntary and statutory organisations. The London VAWG Consortium is made up of 22 organisations working in partnership to deliver comprehensive, cost effective, high quality services to all communities across London. This innovative partnership strengthens referral pathways across organisations and identifies trends and emerging need.

We would also like to highlight the work at Northwick Park Maternity Unit, particularly the African Well Women's Clinic as an example of good practice. They keep records and collect data of all women subjected to FGM, provide counselling and perform reversal surgery prior to birth.

In October members of the task group visited London Councils to discuss the new funding programmes for 2014-2020. The rights and Citizenship Programme 2014-2020 which holds a budget of €439 Million, has the general objective of contributing to the creation of an area where the rights of the person are promoted and protected. The programme will be centrally managed and funding will be allocated on a competitive basis. Transnational projects and multi-agency and multi-sector partnerships will be favoured. Call for proposals will happen in the second quarter of 2014 (early autumn).

Specific related Objectives include:

- Enhancing the exercise of rights deriving from citizenship of the European Union
- Implementing the principle of non-discrimination
- Enhancing the respect of the right of the child

Type of actions that will be funded:

- Raising awareness of harmful practices within practising communities
- Identifying good practice in running specialist support services for victims of Violence
- Training professionals who work with vulnerable children (e.g. children in residential care, in detention or separated children)

- Improving EU citizens' understanding of their rights and help them realise when these have been violated
- Developing mechanisms to collect and report hate crime or xenophobic incidences
- Encouraging the private sector to improve gender balance
- Exchanging good practice in promoting good pay

All public and private organisations, including international organisations legally established in one of the 28 EU members states are able to apply to the rights and Citizenship Programme 2014-2020 Fund.

The task group would urge partners to work together to access this funding.

Recommendation 10
That Brent Council in conjunction with its partners, particularly Council for Voluntary Services (CVS) Brent, pursue all avenues for available funding and support specialist charities and local voluntary organisations to bid for money from government agencies such as the Forced Marriage unit and the European Union fund.

Recommendation 12
That Brent Clinical Commissioning Group (CCG) should commission services for women and girls affected by the harmful practices of Female Genital Mutilation, Honour Based Violence and Forced Marriages.

9. Conclusion

The task group believes that this report provides a range of important recommendations which, when implemented, will lead to improved outcomes for the women and girls in Brent who have been, or are likely to be affected by FGM, Forced Marriage and Honour Based Violence. All of the women we talked to from affected communities were adamant that they did not want their daughters to suffer like they had. We hope that we can help them, by working with our local communities, the voluntary and community sector, specialist agencies and partners. We can raise awareness about these criminal activities and ensure that preventative interventions and services are in place to reduce the negative impacts that these harmful practices have. The individual members of the task group are passionate about these issues and will continue to highlight them at every possible opportunity.

Stakeholders:

1.	LB Brent	Council Officers: – Councillors (Members) Brent Community Safety Brent LSCB & Children Services Brent Education Welfare Brent Adult Safeguarding Brent Multiagency Safeguarding Hub Public Health Scrutiny Committees (Health, Partnership & Place and Children & Young People) Policy Teachers School Governors
2.	NHS & Clinical Commissioning Group (CCG)	Hospitals – Northwick Park and Central Middlesex School Nurses Midwives Health Visitors GPs Doctors/Surgeons
3.	Charities, Community Groups and Voluntary Sector	Parents & Parent Groups Young People and Youth Groups Charity Groups:- Forward Jan Trust Asian Women's Resource Centre Ashiana Network Iranian & Kurdish Women's Rights Organisation Somali Advice and Forum of Information Help Somalia Foundation Jazari Community Centre Women's Refugee's Daughters of Eve One Billion and Rising White Ribbon Charities Men's Charities
4.	Partners for Brent /Multi Agency Safeguarding Hub/Safer Brent Partnership	Police CVS
5.	Religious Groups	Multi Faith Forum Group Priests, Vicars, Imams and Clerics from all denominations in the borough
6.	Community	Residents and Resident Groups
7.	Government Agencies	Mayor of London VAWAG Dept.

		The Home Office The Forced Marriage Unit All Party Parliamentary Dept.
8.	Other Local Government Authorities	Bristol Islington Lambeth Southwark Harrow Ealing Birmingham City Council
9.	Other Interested Parties	Members of Parliament (MPs) Media

References:

The task group referred to a number of reports in the course of its work. Key documents include:

- Home Office, 2004-8, British Crime Survey Analysis of data comparing London rates with overall findings
- Crown Prosecution Service, 2009, Violence against women Crime Report 2008-2009
- Forward, 2007, A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales
- The Foreign and Commonwealth Office's Forced Marriage Unit (FMU) May 2012
- Female Genital Mutilation (FGM) in Islington: A Statistical Study 2012
- IMKAAN recently produced a *Beyond the Labels* report 2013
- The Home Office *A call to end violence against women and girls (action plan 2013)*
- Mayor of London's Violence against Women and Girls strategy "The Way Forward", (2009)
- "A Childhood Lost" A report on Child Marriage in the UK and Developing World from the UK All-Party Parliamentary Group on Population, Development and Reproductive Health (2012)
- "Postcode lottery" A report on research undertaken by the Iranian and Kurdish Women's Rights Organisation (IKWRO) on police records of 'honour' based violence (January 2014)

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Tackling Violence Against Women And Girls in Brent Task Group
Professional Discussion Group

Meeting 1 – Female Genital Mutilation (FGM)

Meeting:

Tackling VAWAG in Brent Task Group – Professional Discussion Group
Friday 8th November 2013,
Brent Civic Centre Room – 5M 003
10.00am – 12.00pm

Questions:

1. In your professional opinion and in your area of work, what methods:
   A) Have been successful?
   B) Have been unsuccessful?
   C) Would you recommend for good practice?

2. What has made the biggest impact on improving the work you do, tackling FGM?

3. Other than funding, what could we recommend to the Council and its partners that would help your work?

4. How has funding cuts impacted on your work? And how have you managed to maintain your services?

5. What do you feel we should say about the issues that affect you?

6. Where do you think best practice is taking place e.g. other boroughs, cities, countries?

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Tackling Violence Against Women And Girls in Brent Task Group
Professional Discussion Group

Meeting 2 – Forced Marriage & Honour Based Violence

Meeting:

Tackling VAWAG in Brent Task Group – Professional Discussion Group
Friday 6th December 2013,
Brent Civic Centre Room – 7M 003
10.00am – 13.00pm

Questions:

Discussion 1, Forced Marriage - FM

What is your opinion on the criminalisation of Forced Marriage?
(Continue with Q. 1-6)

Discussion 2, Honour Based Violence - HBV

Where is the notion of honour coming from and how do we begin to change mind set?
What are the sign leading up to HBV being inflected on an individual?
(Continue with Q. 1-6)

1. In your professional opinion and in your area of work, what methods:
   A) Have been successful?
   B) Have been unsuccessful?
   C) Would you recommend for good practice?

2. What has made the biggest impact on improving the work you do?

3. Other than funding, what could we recommend to the Council and its partners that would help your work?

4. How has funding cuts impacted on your work? And how have you managed to maintain your services?

5. What do you feel we should say about the issues that affect you?

6. Where do you think best practice is taking place e.g. other boroughs, cities, countries?

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Members Training, 21st November 2013

Tackling Violence against Women & Girls in Brent

Questionnaire

This Council Members Task Group was set up to review Violence against Women and Girls in Brent and will focus on:

Female Genital Mutilation (FGM)
Forced Marriages
Honour Based Violence

With the aim of bringing these highly illegal and violent crimes against women to the forefront of public awareness, the task group will be collecting and reviewing evidence from victims, partners and other professionals, in order to improve services and protect Women and Girls in Brent. The task group would like to you know your thoughts and ask if you could please complete this short questionnaire; part 1 before the start of the training, and part two once the sessions has finished.

Thank you in advance for your cooperation

Name of your Ward ……………………………………………………………………………………

Part 1

(To be completed before training session)

Please circle your answers

1. Are you aware of the particular offences that this task group is tackling?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

2. Are you aware of the law regarding these offences?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

3. Are you aware of the council's responsibility in protecting women and girls in Brent?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

4. Would you know what outside bodies to contact, either to get the information you need to cover these topics, or get direct support if needed? **Yes/No**
   (Please list outside bodies)……………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   …

Part 2

(To be completed after training session)

Please circle your answers

1. Are you aware of the particular offences that this task group is tackling?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

2. Are you aware of the law regarding these offences?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

3. Are you aware of the council's responsibility in protecting women and girls in Brent?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

4. Would you know what outside bodies to contact, either to get the information you need to cover these topics, or get direct support if needed? **Yes/No**
   (Please list outside bodies)…………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

5. How do you ensure that vulnerable women and girls in your wards receive information about such sensitive subjects, particularly with regard to the dangers and existence of the offences previously mentioned?
   (Please Write in) ………………………………………………………………………………

6. What kind of training and materials would you need in order to cover these topics in your wards?
   (Please write in)…………………………………………………………………………………

7. To your knowledge, is there any work currently being done in your wards to tackle the above offences? **Yes/No**

8. In your opinion, what would you like to see members do to protect women and girls against the above offences?
   (Please write in)…………………………………………………………………………………

9. What one thing have you learnt here today that you will take away and discuss with others?
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ……………………………………………………………………………………………………...

Annual Brent Governors Conference 2013

Tackling Violence against Women & Girls in Brent

Questionnaire

This Council Members Task Group was set up to review Violence against Women and Girls in Brent and will focus on:

Female Genital Mutilation (FGM)
Forced Marriages
Honour Based Violence

With the aim of bringing these highly illegal and violent crimes against women to the forefront of public awareness, the task group will be collecting and reviewing evidence from victims, partners and other professionals, in order to improve services and protect Women and Girls in Brent. The task group would like you know your thoughts and ask if you could complete this short questionnaire and return it to the Tackling Violence against Women & Girls in Brent display stall today.

Thank you in advance for your cooperation

Name of your school (Optional)……………………………… …......... **Please circle your answers**

1. Are you aware of the particular offences that this task group is tackling?
   Female Genital Mutilation (FGM) **Yes/No**
   Forced Marriages **Yes/No**
   Honour based Violence **Yes/No**

2. Are any of the above listed offences covered in your safeguarding training? **Yes/No**

3. Are Personal Health Sex Education (PSHE) lessons on your school's curriculum? **Yes/No**

4. If you answered yes to Q3, would you like to see these topics included in the PSHE lessons? **Yes/No**

5. How do you ensure that pupils in your school receive information about such sensitive subjects, particularly with regard to the dangers and existence of the offences previously mentioned?

   (Please Write in) ………………………………………………………………………………

6. What kind of training and materials would your school need in order to cover these topics?

   (Please write in)………………………………………………………………………………

7. To your knowledge, is there any work currently being done in your school to tackle the above offences? **Yes/No**

8. Does your school currently employ a school nurse? **Yes/No**

9. In your opinion, what would you like to see schools do to protect females against the above offences?

   (Please write in)………………………………………………………………………………

10. Would you know what outside bodies to contact, either to get the information you need to cover these topics, or get direct support if needed? **Yes/No**
    (Please list outside bodies)…………………………………………………………………………

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A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales

Summary Report

Principal Investigators
Efua Dorkenoo BSc MSc RGN RSCN OBE
Linda Morison BSc MA CStat
Alison Macfarlane BA Dip Stat CStat FFPH

Foundation for Women's Health, Research and Development (FORWARD)
In collaboration with
The London School of Hygiene and Tropical Medicine and
The Department of Midwifery, City University

Funded by
Department of Health, England

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PRINCIPAL INVESTIGATORS

Efua Dorkenoo OBE BSc MSc RGN RSCN

Linda Morison BSc MA CStat

Alison Macfarlane BA Dip Stat CStat FFPH

MAPS

Chris Grundy

FOREWORD

Female genital mutilation (FGM) is a grave human rights violation which is perpetuated by families in the name of culture, tradition and religion. The World Health Organisation estimates that globally from 100 to 140 million girls and women have undergone some type of FGM. It has been estimated that currently, about three million girls, most of them under 15 years of age, undergo the procedure every year. The majority of FGM takes place in 28 African countries but many immigrant communities continue the practice in Europe, North America, Australia and New Zealand.

The practice of FGM is an international problem. Numerous international human rights laws and conferences have highlighted the need to eliminate this practice. FGM violates the human rights of women and girls, causing them physical and psychological harm. It also denies them the enjoyment of the highest attainable level of sexual and reproductive health. Steps have been taken by the UK parliament to discourage FGM, for example, the government introduced a new Law on FGM in 2003 to demonstrate its commitment to preventing the occurrence of FGM in the UK, but to date there have been no convictions under this law.

More needs to be done to tackle FGM. The lack of data on FGM makes it difficult for policy makers and professionals to respond effectively to the needs of affected women and to protect girls from undergoing FGM. Within the UK, data used to support policy decisions have been at best estimates.

FORWARD's new collaborative work with the London School of Hygiene and Tropical Medicine and the City University is a welcome attempt to address this gap. "A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales: Summary Report", provides reliable data to inform and plan better maternity and gynaecological care and related support services for girls and women affected by FGM. This study suggests that over 20,000 girls under the age of 15 are potentially at risk of FGM in England and Wales. It also suggests that the practice is on the increase. It is hoped that the results of the study will support the planning and implementation of a comprehensive national strategy in the UK that will help to expedite efforts to end FGM within one generation.

Many sectors need to work collaboratively, including health, social, education, community and the police to integrate a better understanding of FGM into its policies and services to meet the needs of those affected and to eliminate this human rights violation. It is hoped that this study and its recommendations will provide the impetus to change.

Baroness Joyce Gould - FORWARD Patron

A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales: Summary Report

Foundation for Women's Health, Research and Development (FORWARD)
In collaboration with
London School of Hygiene and Tropical Medicine
Department of Midwifery, City University

FORWARD is an African Diaspora led non-profit organisation dedicated to improving the health and human rights of African girls and women in the UK and Africa. We focus on tackling harmful gender based discriminatory practices such as female genital mutilation and child and forced marriage through enabling our partners and key stakeholders including women and young people to help shape the health and rights of African girls and women. Through advocacy, training and advice, research and resource development we seek to influence government and other statutory bodies in the area of policy development and implementation. FORWARD is one of the leading advocates in the UK fighting to eliminate female genital mutilation.

FORWARD
765-767 Harrow Road
London NWI0 5NY
Tel: 0208 960 4000
Fax: 0208 960 4014
Email: forward@forwarduk.org.uk
www.forwarduk.org.uk

UK Registered Charity No: 292403

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1. Introduction

The United Nations has recognised female genital mutilation (FGM) as a human rights violation. In the UK the practice is included in the UK Children Act and other legislation. There is recognition that it is practised in some minority communities in the UK. It has also been the focus of two and half decades of educational campaigns by voluntary groups in the communities concerned.

Despite this, there are no reliable data on the extent of FGM in the United Kingdom. Lack of data on FGM marginalises the issue. An urgent need for these data has been expressed at all levels, from grassroots organisations to parliament.

Data are needed for the planning and implementation of a comprehensive national strategy for the prevention and the elimination of FGM in the United Kingdom, to act as a baseline against which to measure the success of programmes to combat FGM and for targeted advocacy. Reliable data on FGM are also needed to inform maternity and gynaecological care as well as other support services that are needed for girls and women with complications of FGM.

These are the first systematic estimates for England and Wales. Although, as the report describes, there are some limitations in the methods used, they give some insight into the scale and the spread of FGM in England and Wales and support the view that action is needed to prevent FGM being passed on to the younger generation.

2. Background

Female genital mutilation (FGM) constitutes partial or total removal of the external female genitalia or injury to the external female genitals for non therapeutic reasons.[1] It is estimated that 100-140 million girls and women in Africa and Yemen have undergone FGM and that 3 million young girls undergo FGM every year.[2] FGM also occurs in some parts of the Middle and the Far East. Mainly due to migration, women with FGM are increasingly found in Europe, the United States, Canada, New Zealand and Australia.

Table 1: WHO 1995 classification of FGM types

Type	Description
I	Excision of the prepuce, with or without excision of part of the clitoris
II	Excision of the clitoris with partial or total removal of the labia minora
III	Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)
IV	Practices including piercing, pricking and incising of the clitoris and/or labia, cauterisation by burning of the clitoris and surrounding vaginal orifice (angurya cuts) or cutting of the vagina to cause bleeding or for the purposes of tightening or narrowing it.

Source: WHO, 1995[1]

The World Health Organisation has classified FGM into the four types shown in Table 1. FGM Type III accounts for approximately 15 per cent of all women with FGM in Africa, whilst FGM Type I and II account for approximately 80 per cent. Little is known about Type IV FGM, including types of FGM practised outside Africa.

2.1. Reasons given for practising FGM

The practice of FGM is embedded in ancient beliefs surrounding women's fertility and control of their sexual and reproductive capacity. The reasons given by communities who practise FGM vary widely but a common reason given for the practice is that it reduces the sexual desire of girls and women, promotes virginity and chastity, maintains fidelity in married women and is done for aesthetic reasons. FGM is practiced to enhance girls' marriage ability and to please their husbands. In some groups, FGM is central to girls' rite of passage into adulthood and is an integral part of society's definition of womanhood.

2.2. FGM as a human rights issue

FGM is a human rights violation in the absence of any perceived medical necessity. Among those rights that are violated are the right to the integrity of the person and the highest attainable level of physical and mental health.[3] FGM is recognised by the United Nations to be part of discrimination as well as a form of violence against girls and women.

Article 1 of the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) defines discrimination as "any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social cultural, civil or any other field, CEDAW art. 1, United Nations General Assembly Resolution 34/180 of 18 December, 1979.

Article 24 of the Convention on the Rights of the Child (1989) states:" States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health … " (Para 1) and "States Parties shall take all effective and appropriate measures with a view to abolishing traditional with a view to abolishing traditional practices prejudicial to the health of children … "(Para 3), UN General Assembly resolution 34/180 of 18 December 1979

The Declaration on the Elimination of Violence against Women expressly states in its article 2: "Violence against women shall be understood to encompass, but not limited to, the following:

(a) Physical, sexual and psychological violence occurring in the family, including … dowry related violence … female genital mutilation and other traditional practices harmful to women …" .UN General Assembly,A/RES/48/ 104, 85th plenary meeting, 20 December 1993.

The 2002 UN Special Session on Children, endorsed by 69 heads of states and governments, which include the United Kingdom, set a goal to end female genital mutilation by the year 2010.[4]

2.3. Health risks

The health risks associated with FGM are wide and some are severely disabling.[5] Despite this, there are few large series of case reports or quantitative community-based reports of the frequency and patterns of the consequences of FGM. Girls and women undergoing FGM Type III are particularly likely to suffer serious and long-term complications as the stitching of the labia majora to create a flap of skin covering the vaginal opening causes a direct mechanical barrier to urination, menstruation, sexual intercourse and to delivery.

A recent large scale WHO collaborative study in six African countries showed that women with FGM were at higher risk of caesarean section, post-partum haemorrhage, prolonged maternal hospitalisation, infant resuscitation and perinatal death among women with FGM than those without FGM; and that the risk increased with the severity of FGM.[6] Another study in the Gambia, where Type II FGM is commonly practised, found that women with FGM were more likely to have Bacterial Vaginosis and to have been infected with Herpes Simplex Virus-2. Both of these could have implications for increasing risk of HIV infection.[7]

There is little documentation on the psychosexual and the mental health consequences of FGM. One controlled study which was undertaken in Senegal, found that women who had been subjected to FGM were significantly more likely to suffer from post-traumatic stress disorder (PTSD) and other psychiatric syndromes when compared to women who had not been subjected to FGM.[8]

2.4. FGM practitioners

FGM is largely performed by traditional practitioners without anaesthetics but in urban centres and amongst the elite it may be performed by western trained health professionals with anaesthetics.

2.5. Age when FGM is performed

Amongst ethnic groups for whom FGM is a traditional practice, it is generally performed on young girls who are below the legal age of majority. The age at which the procedure is performed varies from one community to another. It can be carried out during infancy, on girls under ten years old or on adolescent girls and occasionally on adult women including pregnant women. Most experts agree that the age at which genital mutilation is performed is decreasing.

2.6. Evidence that FGM is a concern in the UK

The United Kingdom has had a long history of migration from its former colonies. FGM is known to be commonplace in some of these countries. More recently, increasing numbers of refugees from the Horn of Africa fleeing from civil unrest and war have sought asylum in the UK. A study involving case studies of 50 women attending an African well-woman clinic in London described 14 primigravid women with FGM Type III who required episiotomy for sustained perineal tears at the time of delivery.[9] Small scale academic studies and local authority casework interventions on girls deemed at risk of undergoing FGM, also show that FGM is a continued traditional practice in specific African communities in the UK.[10-13]

Because of the concern about FGM, the UK Prohibition of "Female Circumcision" Act came into force in 1985. The Act made it an offence to carry out or to aid, abet or procure the performance by another person, of any form of female genital mutilation, except for specific medical purposes. FGM was further recognised as a denial of the girl child's fundamental human rights to her physical integrity and natural sexuality and has been incorporated as a case for concern into 'Working Together to Safeguard Children', a guide to arrangements for inter-agency co-operation in the UK to protect children from abuse.[14]

Further legislation, the 'Female Genital Mutilation Act 2003', came into force in March 2004. It introduces the issue of extraterritoriality, which makes it an offence for FGM to be performed anywhere on UK nationals or UK permanent residents. This closes the loophole in the 1985 Act, which gave room for parents to get around the law by taking their girls abroad for FGM and then returning them to the UK. The 2003 legislation also increases the penalty for aiding, abetting or counselling to procure FGM to 14 years imprisonment or a fine or both. FGM is a hidden practice which is difficult to detect. To date, no prosecutions on FGM have been made under the UK legislation although two doctors have been found guilty of serious professional misconduct before the General Medical Council.[15] Although FGM is incorporated into child protection, at present no data are collected on the number or type of social work cases involving FGM in the UK.

In 2005, Scotland amended its legislation on female genital mutilation in line with the 'Female Genital Mutilation Act 2003' that applies to England, Wales and Northern Ireland. Although female genital mutilation is already illegal in Scotland, the amended Bill extends the provisions of the current legislation by giving them extra-territorial effect and increases the maximum penalty from 5 to 14 years imprisonment.

There are at least ten specialist clinics in the NHS which treat women and girls who have been mutilated. These clinics all have trained and culturally sensitive staff who offer a range of healthcare services for women and girls including reversal surgery. Services are confidential and in many instances interpreters are available. These clinics are open to women to attend without referral from their own doctor.

The Department of Health has also recently funded a well-received DVD for health professionals, which provides factual and clinical information on this subject. Female genital mutilation is also recognised as a form of domestic abuse highlighted in Responding to domestic abuse: A handbook for health professionals, published by the Department in January 2006.

3. Statement of the problem

3.1. Previous estimates of the prevalence of FGM in the UK

It has been estimated that there are from 3,000 to 4,000 new cases each year in the United Kingdom but no indication was given of the methods used to derive these figures.15 Other estimates suggest that 22,000 girls under the age of 16 years are at

risk of FGM and 279,500 women already resident in the UK have undergone FGM.[16] These estimates were derived by applying the WHO estimates of the prevalence of FGM figures in practising countries17 to estimates of numbers of women reporting six of these countries of origin in the 1999 Labour Force Survey.

In the United States, the Centers for Disease Control and Prevention derived estimates using 1990 census data and estimates of the prevalence of FGM in women's countries of origin.[18] The Population Reference Bureau updated these analyses using 2000 census data and more recent prevalence survey data. It concluded that the numbers of women with or at risk of FGM had risen by 35 per cent over the decade.[19] Similar methods have been used to derive estimates for Belgium and Spain.[20]

3.2. Limitations of previous estimates for the UK

Although the methods used so far to derive estimates of the number of women and girls affected by FGM in the UK have led to the best estimates available to date, there are obvious limitations with the reliability of these figures.

- The UK Labour Force Survey sample used to derive the estimates of females affected by FGM was not large enough to produce estimates about the size of the country of birth groups which were estimated to be fewer than 6,000 in number and the estimates were subject to sampling variability.
- It omitted the second generation of women, who were born in the UK but who may have undergone FGM.
- It assumed that the prevalence of FGM in practising migrant or refugee populations in the UK was the same as in their countries of origin. This assumption may not be valid but there are very few data on the effect of migration on the practice. One study suggested a lower prevalence of FGM among young Somalis in London than the population average in Somalia.11

In this report, we present estimates which overcome the first of these limitations by deriving numbers of women born in practising countries from the 2001 Census of Population. We have extended the number of countries of origin practising FGM from six to twenty nine. The improved estimates are still subject to limitations 2 and 3 so a survey will be needed to produce estimates which include second generation women and to allow for possible differences between the prevalence of FGM in women living in the UK and in their countries of origin. The process of producing the estimates presented here will provide the groundwork for designing such a survey as well as furthering future community based research.

4. Study objectives

To estimate for women and girls resident in England and Wales:

- The prevalence of FGM among women aged 15 and over.
- The number of registered maternities, that is, pregnancies ending in a registrable live or stillbirth, to women who have undergone FGM.
- The estimated numbers of girls aged below 15 at risk of FGM and the type of FGM.

The study was restricted to England and Wales. Although the proportions of births in Scotland and Northern Ireland to women born outside the UK in general and women from FGM practising countries has increased over the years since 2001 as a consequence of inward migration, the numbers of births to women from FGM practising countries were still relatively low.

5. Methods

The overall approach was to identify countries in which FGM is practised and from which there is significant migration to England and Wales, identify published data about the prevalence of FGM in those countries and apply them to Census and birth registration data for England and Wales obtained from the Office for National Statistics.

5.1. Identifying published data about the prevalence of FGM

Demographic and Health Surveys (DHS) implemented by Macro International for USAID (http://www.measuredhs.com) or the Multiple Cluster Indicator Surveys (MICS) implemented by national governments with technical assistance from UNICEF or other UN agencies. For countries where such estimates were not available published, bibliographic databases and reports from national and international bodies were searched.

5.2. Estimation of the number of women born in FGM practising countries and the number likely to have undergone FGM.

The method used for the calculation of prevalence was adapted and refined from FGM prevalence studies in the USA, Belgium and Spain.18,20 These also used census data.

The data items of relevance are women's ages, countries of birth, ethnicity and local authority of residence on census night. In discussion with the Office for National Statistics (ONS) Census Customer Services staff, tabulations using these variables already undertaken either as part of ONS own programme of publications or commissioned by others were reviewed. We obtained a table for England and Wales as a whole, M1000, which tabulated the numbers of women born in each of the countries in which FGM is practised, by age-group.

The number of women with FGM was estimated by multiplying the number of women in each age-group from each FGM practising country by the age-specific FGM prevalence for that country and then summing these numbers over all the FGM practising countries. The age-specific FGM prevalence in each country of origin was assumed to represent the probability that a woman from that country in that age group would have FGM.

It was planned to do further work that will repeat the above tabulation by ethnicity so that women with Asian and white ethnicity can be excluded from the figures and also to include tabulations by region in order to examine geographical spread, but this was not possible within the time and resources available.

5.3. Updating the 2001 estimates

Since the estimates calculated using methods described in 5.2 are now five years out of date, migration data were requested from ONS with the aim of updating estimates of numbers of women from practising countries. Because of disclosure control these were requested for groups of countries, according to the categorisation described in Table 2, rather than for all individual countries.

5.4. Estimating the number of maternities to women born in FGM practising countries by local authority.

Because of the emphasis on affected women, the analysis of birth registration data was conducted in terms of maternities, defined as pregnancies leading to one or more registrable live or stillbirths. In order to satisfy disclosure control procedures, tabulations of numbers of maternities by age and mother's country of birth for mothers born in the FGM practising countries for each year from 2001 to 2004 were held within ONS and not released to us. The study team provided age-specific FGM prevalences for each of the countries. Estimates of numbers of maternities to women with FGM in each local authority were calculated by ONS by multiplying the number of women delivering in each local authority area in each age-group and in each country where FGM is practised by the age-specific FGM prevalence estimate for that country. These numbers were then summed over all the countries where FGM is practised to estimate the total number of women with FGM overall in England and Wales and for each region.

5.5. Estimates of numbers of females younger than 15 years with FGM or at risk of FGM

Numbers of girls aged below 15 who had been born in FGM practising countries, were derived from the 2001 census. An additional tabulation of the birth registration data provided us with births of females to mothers from countries which practice FGM between 1993 and 2004. This gave a minimum estimate of numbers of girls under 15 residents in England and Wales at risk or having undergone FGM. To assess the magnitude of these risks, the FGM practising countries were categorised by level of risk of FGM.

5.6. Mapping

Two maps were created by Chris Grundy of the Public and Environmental Health Research Unit at the London School of Hygiene and Tropical Medicine.

5.7. Ethics

This study involved secondary analysis using FGM rates derived from publicly available survey data DHS and MICS as well as other published research data not requiring prior permission before use. Following an application to ONS' Microdata Release Panel, the birth registration statistics for England and Wales were made available as aggregated counts, not as individual records, to comply with ONS' disclosure control rules. According to the ONS, secondary analyses of census material which we will be working with can be used for research without prior permission. All analyses of ONS data in this report were checked by ONS to ensure that disclosure did not occur.

FORWARD was the institutional base for the study with collaboration from the London School of Hygiene and Tropical Medicine and City University.

6. Results

6.1 Prevalence of FGM in countries of birth

Countries in which FGM is reported to be a traditional practice were identified as:

North Africa and Yemen	Sub-Saharan Africa
Djibouti	Benin
Egypt	Burkina Faso
Eritrea	Cameroon
Ethiopia	Central African Republic
Somalia	Chad
Sudan	Cote D'Ivoire
Yemen	Democratic Republic of the Congo
	Gambia
	Ghana
	Guinea
	Guinea Bissau
	Kenya
	Liberia
	Mali
	Mauritania
	Niger
	Nigeria
	Senegal
	Sierra Leone
	Togo
	Uganda
	Tanzania

FGM has been reported in other countries or groups but little is known of the extent or type of practice. A form of FGM, probably Type I or IV, has been described in Muslim women in Malaysia[21] and Indonesia.[22] FGM has also been reported among some Kurdish groups, the Dowdi Bohra in India21 and Ethiopian Jews now resettled in Israel, although little information is available.

For 20 of the 29 countries in the above list, estimates of FGM prevalence by country among 15-49 year olds overall and for five year age-groups were obtained from rigorous national surveys notably the Demographic and Health Surveys (DHS) implemented by Macro International for USAID (http://www.measuredhs.com) or the Multiple Cluster Indicator Surveys (MICS) implemented by national governments with technical assistance from UNICEF or other UN agencies. For the nine countries where such estimates were not available published, bibliographic databases and reports from national and international bodies were searched for data on FGM prevalence.

International and national organisations with a possible interest in FGM known to work in these countries were also approached by the principal investigator for any information they could provide on FGM prevalence. Best estimates were then derived by pooling any published data found with local information. The results of this are shown in Table 2.

Countries were then classified according to the prevalence of FGM and the types of FGM found there, using the WHO 1995 classification of types of FGM. This method of grouping countries, shown in Table 2 is modified by us from that of UNICEF which was based only on prevalence.[2] The results of this are shown in Table 3, which shows the prevalences. These categories were then used in plotting Figure 1. FGM practices usually vary by ethnic group so the overall prevalence for a particular country tends to reflect the number and size of practising ethnic groups within it.

Table 2 Grouping of countries according to prevalence and type of FGM

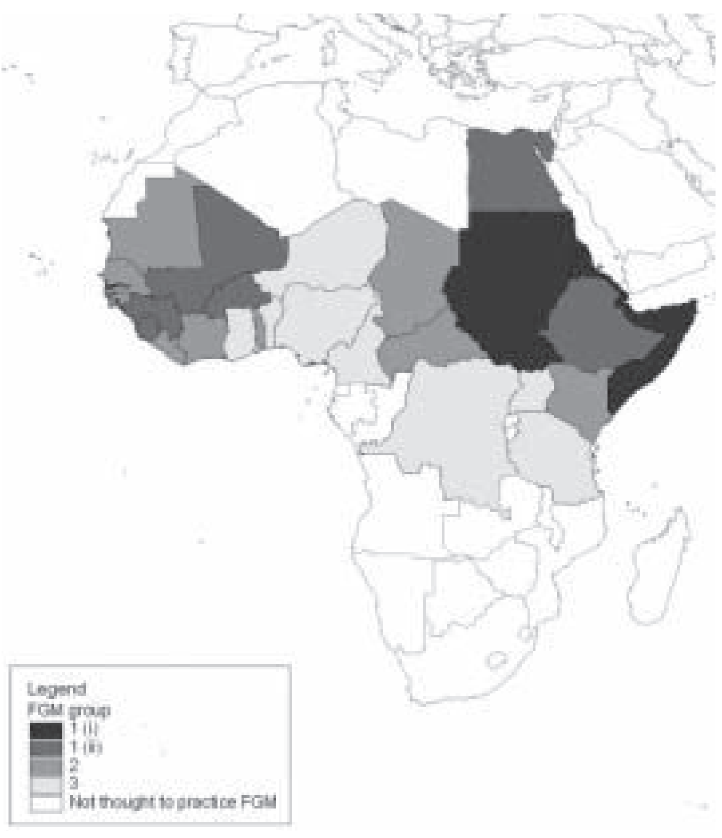
FGM category	Descriptive title of category	Definition
1(i)	Almost universal FGM and substantial WHO FGM Type III	Prevalence 85 per cent or higher and over 30 per cent of operations are type III
1(ii)	High prevalence WHO FGM Types I and II	Over 75 per cent prevalence and predominantly Types I and II
2	Moderate prevalence WHO FGM Types I and II	25 -74 per cent prevalence and predominantly Types I and II
3	Low prevalence WHO FGM Types I and II	Under 25 per cent prevalence and predominantly Types I and II

Adapted from UNICEF[2]

Table 3 shows FGM prevalence estimates overall and by age-group for the 29 practising countries identified. Because prevalence rates differed by age, being lower in younger age groups for some countries such as Kenya and Nigeria, we decided to use age-specific prevalences in the calculations for England and Wales, where available. The overall and age-specific prevalences were assumed to be probabilities that a woman from that country would have FGM. Table 3 also shows which countries were in each of the four risk groups specified in Table 2. These groupings were used where disclosure control did not allow categories as small as country to be used or where we had no information on probability of FGM, as was the case for females under 15 years old.

6.2. Estimates of the number of women likely to have FGM in England or Wales

Table 4 shows that 174,528 women resident in England or Wales in 2001 had been born in an FGM practising country. This figure seems likely to be an underestimate. Firstly, they did not include the 9,030 women who said they were born in Africa but did not state which country. Of these, 3,626 said they were born in East Africa, 276 in North Africa and 896 in West Africa. The second problem was low response to the census in inner city areas, particularly in Inner London. ONS took steps to compensate for this by imputing missing data, but this may not have fully compensated for any non-response by women born in the 29 countries considered here.



Countries in each FGM group shown in Table 2

1(i)	Almost universal FGM, over 30% FGM Type III	Sudan (north), Somalia, Eritrea, Djibouti.
1(ii)	High national prevalence FGM WHO Type I and II	Egypt, Ethiopia, Mali, Burkina Faso, Gambia, Guinea, Sierra Leone
2	*Moderate national prevalence of FGM WHO Type I and II	Central African Republic, Chad, Cote D'Ivoire, Guinea Bissau, Kenya, Liberia, Mauritania, , Senegal, Togo
3	*Low national prevalence of FGM WHO Type FGM I and II	Benin, Cameroon, Ghana ,Niger, Nigeria, Democratic Republic of Congo, United Republic of Tanzania, Uganda

*FGM prevalence is tied to ethnicity in these countries. Although national FGM prevalence's in these countries are moderate to low, FGM prevalence could be high amongst the specific ethnic groups who practice it.

Table 3 FGM prevalence by age group and grouping of country according to FGM risk

Country	Source of data	Year of survey	Overall	Age group 15–19	20–24	25–29	30–34	35–39	40–44	45–49	Group1
Benin	DHS	2001	16.8	12.1	13.4	16.9	18.4	18.3	25.1	23.7	3
Burkina Faso	DHS	2003	76.6	65.0	76.2	79.2	79.4	81.6	83.1	83.6	1(ii)
Cameroon	DHS	2004	1.4	0.4	2.5	1.6	1.1	1.2	1.8	2.4	3
Central African Republic	MICS	2000	35.9	27.2	33.8	35.6	39.9	43.3	41.5	41.9	2
Chad	MICS	2000	44.9	41.6	43.9	44.4	46.5	45.0	45.2	51.5	2
Côte d'Ivoire	DHS	1998–99	44.5	41.2	42.7	42.4	49.0	44.5	51.4	51.0	2
Democratic Republic of the Congo	WHO	1998	5.0								3
Djibouti	Union National des Femmes de Djibouti3	1991	98.0								1(i)
Egypt	DHS	2003	97.0	96.8	97.4	97.3	96.5	96.4	96.5	98.0	1(ii)
Eritrea	DHS	2001–02	88.7	78.3	87.9	90.8	93.4	92.6	94.1	95.0	1(i)
Ethiopia	DHS	2000	79.9	70.7	78.3	81.4	86.1	83.6	85.8	86.8	1(ii)
Gambia	Singhateh SK4	1985	79.0								1(ii)
Ghana	DHS	2003	5.4	3.3	3.8	6.4	6.3	6.7	5.5	7.9	3
Guinea	DHS	1999	98.6	96.6	98.5	99.1	99.1	99.1	99.3	99.5	1(ii)
Guinea Bissau	WHO	1998	50.0								2
Kenya	DHS	2003	32.2	20.3	24.8	33.0	38.1	39.7	47.5	47.7	2
Liberia	Marshall R5	1984	60.0								2
Mali	DHS	2001	91.6	91.2	91.3	91.9	92.1	92.3	91.2	91.0	1(ii)
Mauritania	DHS	2000–01	71.3	65.9	71.1	73.4	74.2	71.7	76.5	68.5	2
Niger	DHS	1998	4.5	5.0	4.8	4.3	5.3	3.8	3.3	3.3	3
Nigeria	DHS	2003	19.0	12.9	17.0	20.8	19.4	22.2	22.2	28.4	3
Senegal	DHS2	2005	28.2	24.8	28.0	28.4	30.1	30.5	30.3	30.6	2
Sierra Leone	Koso Thomas O6	1987	90.0								1(ii)
Somalia			97.0								1(i)
Sudan (north)	MICS	2000	90.0	85.5	88.6	89.3	89.8	91.5	91.6	92.9	1(I)
Togo	National Committee on Harmful Practices7	1993	50.0								2
Uganda	WHO8	1998	5.0								3
United Republic of Tanzania	DHS	1996	17.7	13.2	15.7	19.3	20.6	18.3	21.3	21.9	3
Yemen	DHS	1997	22.6	19.3	22.2	21.3	22.9	23.6	25.1	25.0	3

Footnotes

1. See Table 2 for definitions of groups
2. Data for Senegal (2005) are from preliminary report.
3. Anecdotal report from Union National des Femmes de Djibouti. Unpublished report. In Warzazi A. Report of the Working Group on Traditional Practices Affecting the Health of Women and Children. New York,NY United Nations,ECOSOC, Commision on Human Rights,1991
4. Singhateh SK. Female Circumcision, the Gambian experien ce: a study on the social,economic and health complications.Banjul, The Gambia Women's Bureau,1985.Unpublished report
5. Marshall R et al.Traditional Practices Affecting the Health of Women and Children in Liberia, Seminar on Teaditional Practices, Dakar, IAC, 1984
6. Koso Thomas O. The circumcision of women: a strategy for eradication.London,Zed Press,1982
7. The National Committee on Harmful Traditional Practices,Togo, Unpublished Report
8. IAC. Female Genital Mutilation in Uganda. Geneva,Inter-African Committee on Traditional Practices Affecting the Health of Women and Children,1993(IAC)
9. Other reports on FGM not reflected in the table above

a. Israel: Asali A et al. Ritual female genital surgery among the Bedouin in Israel.Archives of sexual behaviour,1995,24:573-577.
b. Israel: Grisaru N, Lezer S,Belmaker RH. Ritual female genital mutilation among Ethiopian Jews. Archives of sexual behaviour,1997,26(2):211-215
c. India: Ghadially R. All for Izat: the practice of female circumcision among Bohra Muslims'Manushi,No.66,New Delhi,India,1991,Unpublished paper
d Iraqi Kurdistan: A study by WADI showed that 60 per cent of women (out of 1,544 women and girls interviwed) in the rural area of Germain had undergone FGM, United Nations Office of Humanitarian Affairs, Jan 2005 Unpublished study.
e. Indonesia: Pratiknya AW. Female circumcision in Indonesia:a synthesis profile for cultural,religious and health values. In: Female circumcision:strategies to bring about change Proceedings of the International Seminar on Female Circumcision,Mogadishu,Somali,13-16 June 1988.Rome,Somali Women's Democratic Organization/Italian Association for Women in Development,1989.Unpublished paper.

The largest population groups from practising countries were from Ghana, Kenya, Nigeria, Somalia and Uganda. Table 4 also shows estimated numbers with FGM. The estimated number of women resident in England and Wales in 2001 who had been subjected to FGM was 65,790. The highest estimated numbers of women with FGM were from Kenya and Somalia.

Table 4 Number of women born in FGM practising countries and estimated number of women with FGM, residents in England and Wales enumerated in 2001 census

Country of birth	Enumerated number of women aged 15-49	Estimated number aged 15-49 with FGM
Benin	99	18
Burkina Faso	33	26
Cameroon	1,353	21
Central African Republic	163	64
Chad	44	20
Côte d'Ivoire	1,082	489
Democratic Republic of the Congo	1,199	60
Djibouti	93	91
Egypt	3,698	3,592
Eritrea	2,804	2,545
Ethiopia	3,421	2,807
Gambia	1,387	1,096
Ghana	22,116	1,340
Guinea	101	100
Guinea Bissau	155	78
Kenya	45,396	18,516
Liberia	555	333
Mali	41	38
Mauritania	13	9
Niger	39	2
Nigeria	33,485	6,925
Senegal	264	77
Sierra Leone	6,625	5,963
Somalia	15,744	15,272
Sudan	3,200	2,879
Togo	174	87
Uganda	19,640	982
United Republic of Tanzania	10,512	2,102
Yemen	1,092	262
Africa - East (not otherwise stated)	3,626	
Africa - North (not otherwise stated)	276	
Africa - West (not otherwise stated)	896	
Africa (not otherwise stated)	4,232	
Total ignoring not stated	**174,528**	**65,790**

ONS' Migration Statistics Unit provided data about inward and outward migration to update these estimates over the years 2001 to 2005. It was unable to subdivide estimated numbers of migrants by age as these estimates are based first on the International Passenger Survey, which has a relatively small sample and does not record informants' ages. In addition, asylum seeking statistics are not disaggregated by sex. The data provided do imply a net inflow of women migrants from countries practising FGM, however. Although the largest numbers came from the countries with low prevalence, it was estimated that there was a net inflow of about 3,000 women from the high prevalence countries.

6.3. Estimated number of maternities in England and Wales in women with FGM

Table 5 shows the number of maternities in England and Wales to women born in FGM practising countries, the estimated number of maternities to women with FGM and the total number of maternities for each of the four years 2001 to 2004. Over the four years, the estimated number of maternities to women with FGM increased by 44 per cent from 6,256 in 2001 to 9,032 in 2004. Figure 2 and Table 6 show the geographical spread of the maternities to women likely to have undergone FGM in 2001 and 2004. As expected, the geographical distribution was extremely uneven with the highest estimated percentages in London, but with prevalences of over two per cent in the cities of Cardiff in Wales and Manchester, Sheffield, Northampton, Birmingham, Oxford, Crawley, Reading, Slough, Milton Keynes and many London boroughs. In 2004, the prevalence was 6.3 per cent in Inner London and 4.6 per cent in Outer London.

Table 5 Maternities to women from FGM practising countries and estimated number and percentage of maternities to women with FGM, England and Wales, 2001 to 2004

Year of birth	Number of maternities to			Percentage of maternities to women with FGM
	Women born in FGM practising countries	Women with FGM	All women	
2001	13,328	6,256	588,868	1.06
2002	14,666	7,109	590,453	1.20
2003	16,890	8,090	615,787	1.31
2004	19,356	9,032	633,651	1.43

Table 6 Estimated number of maternities to women with FGM and percentage of all maternities to women with FGM by region for local authorities where percentage exceeds one per cent, England and Wales, 2001-2004

Local authority	2001		2002		2003		2004		Total
or region of residence	Number	%	Number	%	Number	%	Number	%	Number
Non-residents	5	1.84	6	2.93	5	2.25	6	2.73	22
Cardiff / Caerdydd	70	1.97	96	2.72	90	2.45	103	2.81	360
Rest of Wales	18	0.07	18	0.07	29	0.11	28	0.10	95
Wales	88	0.29	114	0.38	119	0.38	131	0.41	455
NORTH EAST	31	0.12	40	0.15	36	0.13	39	0.14	152
Manchester	150	2.74	176	3.13	216	3.66	252	3.84	794
Liverpool	44	0.90	65	1.33	61	1.20	67	1.34	237
Rest of North West	62	0.10	63	0.10	87	0.13	120	0.17	338
NORTH WEST	256	0.34	304	0.41	364	0.47	439	0.55	1,369
Sheffield	69	1.22	105	1.92	126	2.15	130	2.14	430
Rest of Yorkshire and the Humber	55	0.11	86	0.17	97	0.19	158	0.29	396
YORKSHIRE AND THE HUMBER	124	0.22	191	0.35	223	0.39	288	0.48	826
Northampton	44	1.79	57	2.37	62	2.37	81	3.18	243
Leicester UA	116	2.92	181	4.41	212	4.85	226	4.98	735
Rest of East Midlands	61	0.16	69	0.18	81	0.20	93	0.23	307
EAST MIDLANDS	221	0.50	307	0.69	355	0.76	400	0.84	1,285
Birmingham	185	1.29	236	1.63	365	2.39	500	3.20	1,286
Coventry	23	0.64	27	0.76	50	1.33	63	1.60	164
Rest of West Midlands	61	0.14	80	0.19	86	0.19	135	0.30	366
WEST MIDLANDS	269	0.45	343	0.57	501	0.79	698	1.07	1,816
Watford	11	0.99	11	1.05	16	1.46	22	1.92	60
Luton UA	32	1.13	36	1.16	43	1.40	34	1.07	143
Rest of East	138	0.25	124	0.22	156	0.27	170	0.29	591
EAST	181	0.30	171	0.29	215	0.35	226	0.36	794
City of London	3	5.77	2	3.57	1	1.64	2	3.45	8
Camden	175	6.34	234	8.35	240	8.20	235	7.81	883
Hackney	209	5.15	233	5.77	249	5.87	231	5.32	921
Hammersmith and Fulham	144	6.19	181	7.10	192	7.60	194	7.48	711
Haringey	253	6.66	216	5.82	238	6.18	241	6.06	948
Islington	130	5.23	175	7.01	188	7.12	183	6.90	676
Kensington and Chelsea	92	4.39	104	4.90	103	4.69	101	4.64	400
Lambeth	289	6.64	308	7.09	373	7.87	394	8.35	1,364
Lewisham	152	4.12	172	4.52	188	4.80	213	5.28	726
Newham	331	6.90	339	6.87	367	7.19	345	6.70	1,381
Southwark	347	8.74	374	9.15	439	10.18	431	9.76	1,590
Tower Hamlets	105	2.90	119	3.12	139	3.52	166	4.08	528

Local authority	2001		2002		2003		2004		Total
or region of residence	Number	%	Number	%	Number	%	Number	%	Number
Wandsworth	131	3.19	138	3.43	157	3.65	174	4.05	600
Westminster	109	4.30	124	4.93	141	5.17	125	4.63	499
Inner London	2,470	5.53	2,719	6.00	3,015	6.35	3,035	6.30	11,235
Barking and Dagenham	82	3.42	100	4.15	122	4.74	167	6.08	471
Barnet	151	3.76	174	4.22	200	4.70	208	4.70	733
Bexley	25	0.96	29	1.16	36	1.38	53	1.99	143
Brent	356	9.13	382	9.27	403	9.28	422	9.83	1,563
Bromley	41	1.22	31	0.92	46	1.28	43	1.22	162
Croydon	106	2.43	121	2.79	132	2.91	148	3.08	506
Ealing	348	7.99	342	7.77	333	7.50	371	7.85	1,393
Enfield	122	3.28	165	4.18	196	4.85	247	5.91	730
Greenwich	158	4.96	195	5.85	202	5.88	230	6.22	785
Harrow	138	5.38	150	5.90	169	5.99	183	6.45	639
Havering	6	0.26	8	0.36	15	0.64	17	0.67	47
Hillingdon	126	3.94	121	3.70	145	4.37	177	5.12	569
Hounslow	161	5.18	184	5.73	184	5.61	222	6.17	752
Kingston upon Thames	19	1.08	15	0.84	21	1.14	19	0.95	74
Merton	40	1.52	39	1.55	41	1.51	58	2.07	179
Redbridge	103	3.33	114	3.56	125	3.73	156	4.51	498
Richmond upon Thames	16	0.68	8	0.33	16	0.64	18	0.71	58
Sutton	13	0.63	16	0.76	17	0.77	17	0.77	63
Waltham Forest	128	3.68	143	4.03	174	4.66	189	4.82	635
Outer London	2,139	3.66	2,337	3.94	2,577	4.16	2,945	4.57	10,000
LONDON	4,609	4.47	5,056	4.83	5,592	5.11	5,980	5.31	21,235
Oxford	23	1.53	24	1.54	18	1.10	38	2.24	103
Crawley	10	0.81	13	1.03	13	0.99	28	2.06	64
Reading UA	40	2.04	34	1.75	42	2.11	42	2.00	158
Slough UA	51	2.76	54	2.92	58	2.92	71	3.51	234
Milton Keynes UA	59	2.11	81	2.83	101	3.25	96	3.03	336
Brighton and Hove UA	29	1.04	29	1.07	28	0.93	26	0.91	112
Rest of South East	132	0.18	169	0.23	163	0.21	215	0.27	688
SOUTH EAST	344	0.39	404	0.46	423	0.47	516	0.56	1,695
Bristol, City of UA	78	1.68	115	2.47	180	3.62	239	4.58	612
Rest of South West	38	0.09	44	0.10	67	0.15	72	0.15	227
SOUTH WEST	116	0.24	159	0.33	247	0.48	311	0.60	839
England and Wales	6,256	1.06	7,109	1.20	8,090	1.31	9,032	1.43	30,487

Figure 2 Map showing estimated percentage of maternities to women with FGM in England and Wales, 2001 and 2004

2004

6.4 Estimates of the number of girls/women under 15 years of age who are at risk or have undergone FGM

Table 7 shows that at least 24,012 girls and women are at high risk or may have already undergone FGM, Type III and that 8,913 are at high risk or may have undergone FGM, Type II. In the countries where the prevalence of FGM is high the most common age for the FGM procedure is between 6 and 8 years. Adding the numbers aged four or under in 2001 to those born from 2002 to 2004 suggests that an estimated 15,710 girls were at high risk of Type III FGM and 5,573 were at high risk of Type II in 2005.

Table 7 Estimated numbers of girls at risk of or subject to FGM in England and Wales

	FGM Group of Country				
	1(i) High risk of FGM Type III	1(ii) High risk FGM Type I or II	2 Med risk FGM Type I or II	3 Low risk FGM Type I or II	Total
Born in FGM practising country and enumerated in 2001 census					
Aged **under 1 year** in 2001	191	71	35	171	468
Aged **1-4 years** in 2001	1201	359	348	1,082	2,990
Aged **5-9 years** in 2001	2177	610	811	2,279	5,877
Aged **10-14 years** in 2001	3231	932	1152	4,090	9,405
Total	6,800	1,972	2,346	7,622	18,740
Born in England or Wales 1993-2004 to mother who was born in an FGM practising country, derived from birth registration data					
Aged **under1 year** in 2001	1,861	643	964	3229	6,697
Aged **1-4 years** in 2001	5,084	2,049	4,243	12,710	24,086
Aged **5-8 years** in 2001	2,894	1,798	5,255	13,571	23,518
Born **2002-2004**	7,373	2,451	3,026	12,485	25,335
Total	**17,212**	**6,941**	**13,488**	**41,995**	**79,636**
Grand total	**24,012**	**8,913**	**15,834**	**49,617**	**98,376**

7. Discussion

The estimates presented in this report are subject to several limitations. For some countries where FGM, is practised, data on the prevalence of FGM are very sparse and this uncertainty in the prevalence will affect our estimates. Using Census data for England and Wales to estimate numbers of women born in countries where FGM is practised overcomes the problems due to the lack of estimates for small groups from the previous study based on the Labour Force Survey. The Census also produces more reliable estimates than a sample survey. Even so, Census data are still likely to underestimate numbers in some groups who may be reluctant to participate in the census because of concerns about residence status or who may not be living in a conventional or legal dwelling.

In addition our method underestimates numbers as the Census does not identify second generation women who may be subject to this traditional practice. Basing the probability of having FGM purely on the country of birth does not take account of the ways in which the practice might change with migration. There is some evidence that it declines with migration to the West.11 For these estimates, this is likely to affect only women who left their country of birth before the usual age of undergoing FGM.

An additional problem of basing the probability of having FGM on country of origin is that in many countries it is particular regions or specific ethnic groups who practise FGM. These groups may be more or less likely than others to migrate to the West. Data on changes in practice with migration are very sparse. Two studies of Somalis, one in London11 and one in Sweden,[23] suggest changes in attitudes against FGM although newspaper reports on two recent prosecutions on FGM in the Somali community in Sweden[24] suggest that the practice is hidden.

Although imprecise, the migration data suggested that there were was a net inflow from countries practising FGM. In particular, there is a net inflow from Somalia where FGM is nearly universal. Increasing numbers of maternities to women born in Somalia made a substantial increase to the rise in estimated proportions of maternities to women with FGM.

The results presented here are the most rigorous estimates to date. To obtain a clearer picture of actual prevalence among both migrant and second generation women, a survey of women giving birth in the UK would be needed, however. As well as being useful in their own right, the data presented here also provide a useful framework for designing such a survey.

8. Conclusions

The estimates derived through these analyses suggest that nearly 66,000 women with FGM were living in England and Wales in 2001 and their numbers are likely to have increased since then.

This is reflected in the increase in the estimated percentages of all maternities which were to women with FGM from 1.06 per cent in 2001 to 1.43 per cent in 2004.

There were nearly 16,000 girls aged 8 or younger at high risk of WHO Type III FGM and over 5,000 at high risk of WHO Type I or Type II. In addition over 8,000 girls aged 9 or more had a high probability of already having type III FGM and over 3,000 a high probability of having types I or II.

The estimates of FGM provided in this study highlight the need not only to enhance health care for girls and adult women who have already undergone FGM but calls for systematic actions to prevent FGM being passed on to the younger generation. Despite the limitations of these estimates, they suggest that the numbers of women living in England and Wales with FGM are substantial and increasing. Action is therefore needed to provide appropriate care to girls and women concerned and to prevent FGM being passed on to the younger generation.

Women with FGM are largely but not exclusively concentrated in particular areas, but there are many other areas of the country where there are smaller numbers of affected women. It is therefore important to ensure that services in all areas respond to their needs and the potential risks to their daughters.

9. Recommendations

Given that the estimates of FGM provided in this study suggest that the numbers of women living in England and Wales with FGM are substantial and are increasing.

Given that there are girls living with FGM; and given that over 20,000 under 15 year old girls are potentially at risk of FGM, the following are recommended for intensified action on FGM elimination and care for women and girls with complications due to FGM:

1. A survey should be undertaken to provide more reliable estimates of the prevalence of FGM in England and Wales. The data presented in this study provide a useful framework for designing such a survey
2. Further research on FGM is needed to increase knowledge in the following areas:

(a) Attitudes, perceptions and motivations of women and families from FGM practising countries, including those who have stopped practising it and are opposed to it, reasons for continuing the practice and factors precipitating change.

(b) Barriers to FGM prevention and care by health and social workers who frequently have to deal with attempted FGM and other groups who work to prevent FGM.

(c) The health complications particularly the psychological and the sexual aspects of FGM.

(d) How women with FGM perceive health services.

(e) Evaluation of approaches and programmes against FGM.

3. Data on FGM should be collected routinely by health and social services in order to inform the provision of better care and service provision for women and girls who have undergone FGM and for girls at risk of undergoing FGM. The Department of Health and the Department for Children, Schools and Families should provide the policy framework and guidance for documentation and the collection of data on FGM within clinical practice and within child protection.
4. Women with FGM are largely but not exclusively concentrated in particular areas, but there are many other areas of the country where there are smaller numbers of affected women. It is important to ensure that services in all areas respond to their needs and the potential risks to their daughters. All strategic health authorities, primary care trusts, acute trusts and foundation hospitals should ensure that services including commissioning of services in all areas respond to the health needs of women and girls with FGM.

5. As well as girls at risk of FGM there are substantial numbers of girls under15 likely to have undergone FGM. Girls with FGM Type III may have restricted mobility, in case the scar splits, difficulties in participating in sports, difficulties with urination and menstruation and they may need psychological support. In order to improve access to health care and support for affected young people, it is important that professionals in the health and education professionals are alert and respond to their needs.
6. FGM care and prevention should be mainstreamed into existing strategies that respond to the needs of women and girls with FGM and the potential risks to their daughters, for example through Child Health, Sexual Health and Maternity Improvement strategies working through Local Area Agreements and Local Strategic Partnerships.
7. There is a need for an understanding of FGM not just as a health issue but primarily as an issue of violence against women and an abuse of girl children. Thus FGM should be given equal status with other forms of child abuse and all Social Services, Health, Education and the Police Child Protection Units should update their child protection policy and procedures to include FGM.
8. All education and training programmes on child abuse, reproductive and sexual health care should incorporate FGM, but most importantly, because of the large turnover of staff in social services and health, FGM education should be incorporated into the core curricula of professionals in social, health, education and the police.
9. FGM prevention and care should be fully mainstreamed into the government child care provisions through the implementation of 'Every Child Matters' and into the National Service Framework for Children, Young People and Maternity Services.
10. FGM prevention should be integrated into the work of the joint Home Office and Foreign and Commonwealth Office Unit on Forced Marriages as FGM occurs in similar context. Messages to schools regarding forced marriage could easily and usefully incorporate information about FGM. New refugees, particularly from countries with high prevalence of FGM should be targeted with information on the illegality of FGM.
11. The voluntary sector and community groups' involvement is crucial to address issues of prevention as well as delivery of services that take FGM issues into account. Thus community action on FGM should be strengthened and promoted for all the FGM practising communities.

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765-767 Harrow Road
London NWI0 5NY
Tel: 0208 960 4000
Fax: 0208 960 4014
Email: forward@forwarduk.org.uk
www.forwarduk.org.uk
UK Registered Charity No: 292403

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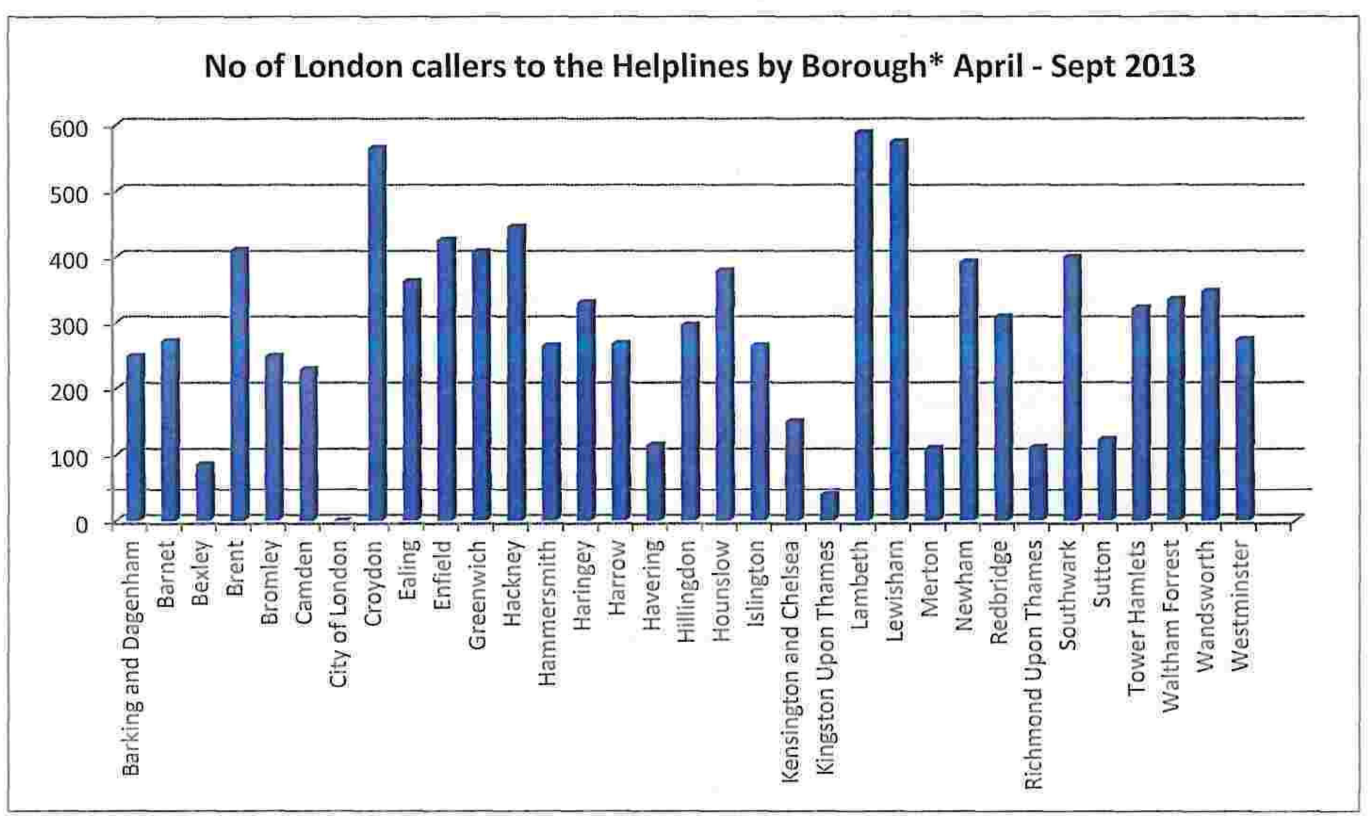
Funded by the Department of Health

design/print: www.thumbprintcreations.com t: 020 7613 3331

Update on impact: October 2013

In the 6 months from 1st April to 31st September 2013 the Domestic and Sexual Violence Helplines:

- Responded to **11,886** callers from London
- Referred 1,499 women in London to a refuge space
- Provided information on welfare benefits, immigration, medical, housing and/or legal rights to 4,291 callers in London
- Carried out online crisis and safety planning for 4,928 callers in London



*A further 2,187 calls were received from London where the Borough was unknown.

The ASCENT Project

The partners delivering London domestic and sexual violence helpline services are doing so as part of the ASCENT project. ASCENT is a project of the London Violence against Women and Girls (VAWG) Consortium, delivering a range of services for survivors of domestic and sexual violence, under six themes, funded by London Councils.

For more information about this project, please do not hesitate to contact Nicki Norman, Director of Operations, Women's Aid - n.norman@womensaid.org.uk

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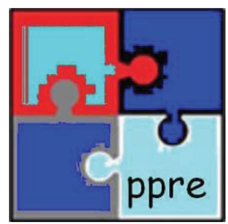


Counting the Somali Community In Brent

Sam Waples

John Eversley

ppre CIC

64 Antill Road

London E3 5BP

ppre@onetel.com

0208 9890 3710

September 2013

Counting the Somali community

Previous estimates of the Somali community have been based on Immigration, asylum claims, National Insurance, Languages spoken, country of birth and apportionment of national survey proportions to the local area.

These are all likely to underestimate the size of the community. The estimates are often based on old data and/or have wide margins of error.

The method we have used is based on matching two sources: The GP register and the School Census.

The GP register was from February 2013. The way the register is being compiled is changing. It used to be all people living in Brent wherever they are registered with a GP. It is changing to be a register of people who have a Brent GP, wherever they live. The list we used is a hybrid of the two. The register includes children with a Date of Birth up to the 26th February 2013. There are, of course some people who are not registered with a GP. However our experience of analysing many administrative datasets and census returns is that people are more likely to be registered with a GP than to appear in any other dataset.

The School Census is updated three times a year. We used the January 2013 Census. Potentially it gives us three ways to identify children as Somali: their national origins (Often described as 'Ethnicity'), the languages they speak and their names. We did not match the language field at the individual level in this case but at the aggregate level we identified that that only 50 Somali speaking children did not identify themselves as Somali. We also looked at an earlier Brent school Census database and identified that of 60 children who simply identified themselves as Black African only six said they spoke Somali and 37 said they spoke English. It is possible that some of these English speaking 'Black African' children are Somali but it is a very small number. Finally because we have done this exercise before (see over) we have a large database of distinctively Somali names. We can therefore identify as Somali people who may have lived in countries other than the UK or Somalia and children of Somali origin who do not speak Somali. A possible source of underestimation is that the school census does not include children at private schools. From what is known about the socio economic profile of the Somali community it is likely that the vast majority of Somali children are at state schools. Data from Free schools are not included.

GP Register

Based on 322k probable population of Brent our estimate of the Somali population is 10,375.

Compared to other boroughs:

Borough	Somali population	Year of data
Brent	10,375	2013
Newham	6,512	2011
Haringey	5,012	2012
Tower Hamlets	4,645	2010
Waltham Forest	3,804	2011
Greenwich	2, 877	2011
Hackney	2,013	2011
Waltham Forest	3,804	2011
Barking and Dagenham	592	2011

Outside London

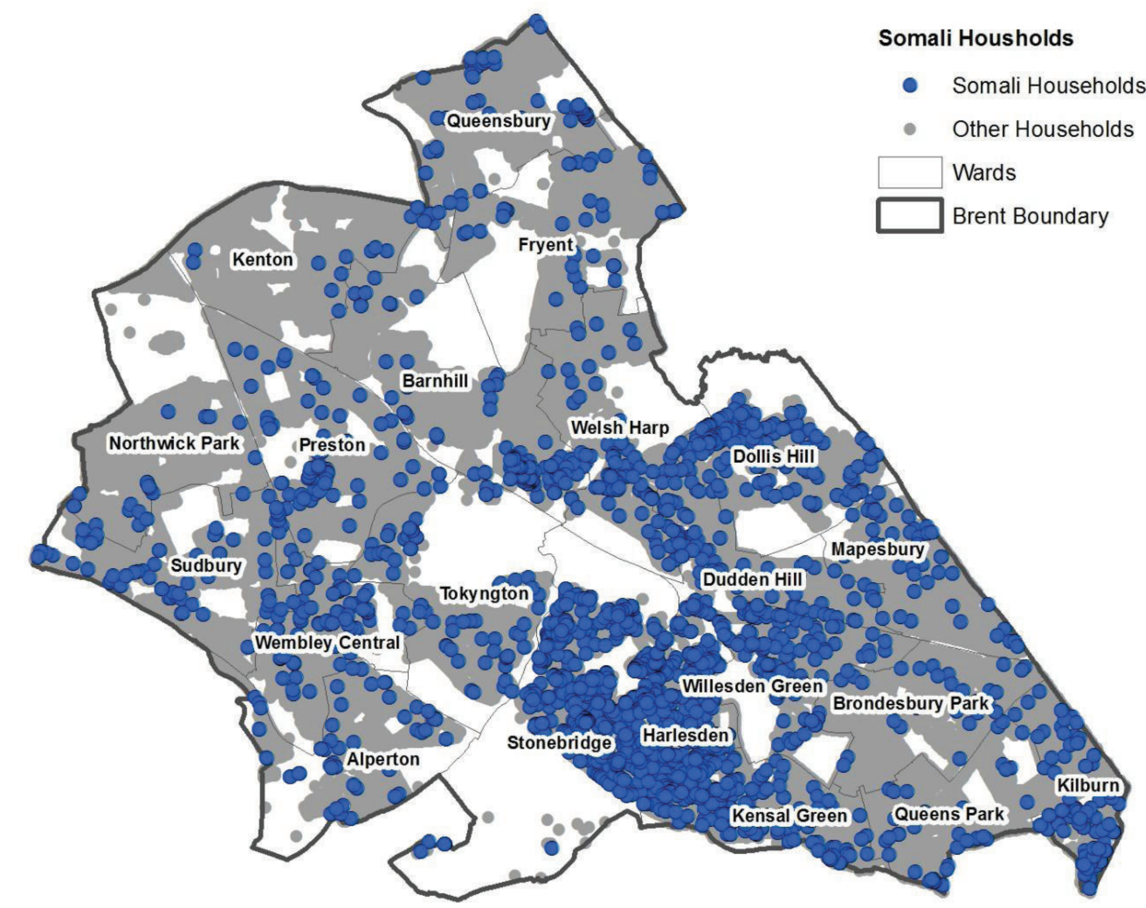
- Luton 1,360 (2010)

When we did the analysis of the 2008 school census Ealing had the largest Somali pupil population followed by Brent. We have no reason to think this has changed.

Age and Gender Population Distribution

Age	Somali Population				Total Brent Population	% Somali
	Female	Male	Unknown	Total		
<5	679	664	1	1344	22976	5.8
5-9	818	825	0	1644	19913	8.3
10-14	742	756	1	1500	17778	8.4
15-19	618	652	3	1273	17802	7.1
20-24	383	362	0	745	23050	3.2
25-29	350	306	1	657	34312	1.9
30-34	298	258	1	557	33631	1.7
35-39	284	274	0	558	26223	2.1
40-44	323	334	1	658	23478	2.8
45-49	222	272	0	494	21820	2.3
50-54	138	174	2	313	19617	1.6
55-59	71	114	2	186	15494	1.2
60-64	61	59	1	121	12313	1.0
65-69	60	39	1	99	9851	1.0
70-74	53	40	0	93	8283	1.1
75-79	46	24	0	70	6854	1.0
80-84	25	19	0	43	4683	0.9
85-89	10	3	0	13	2343	0.6
90+	5	2	0	7	1180	0.6
Total	*5185*	*5178*	*13*	***10375***	*321601*	*3.2*

Location of Somali Households (A Somali Household in this instance is defined as a Household where at least half of the residents are Somali)



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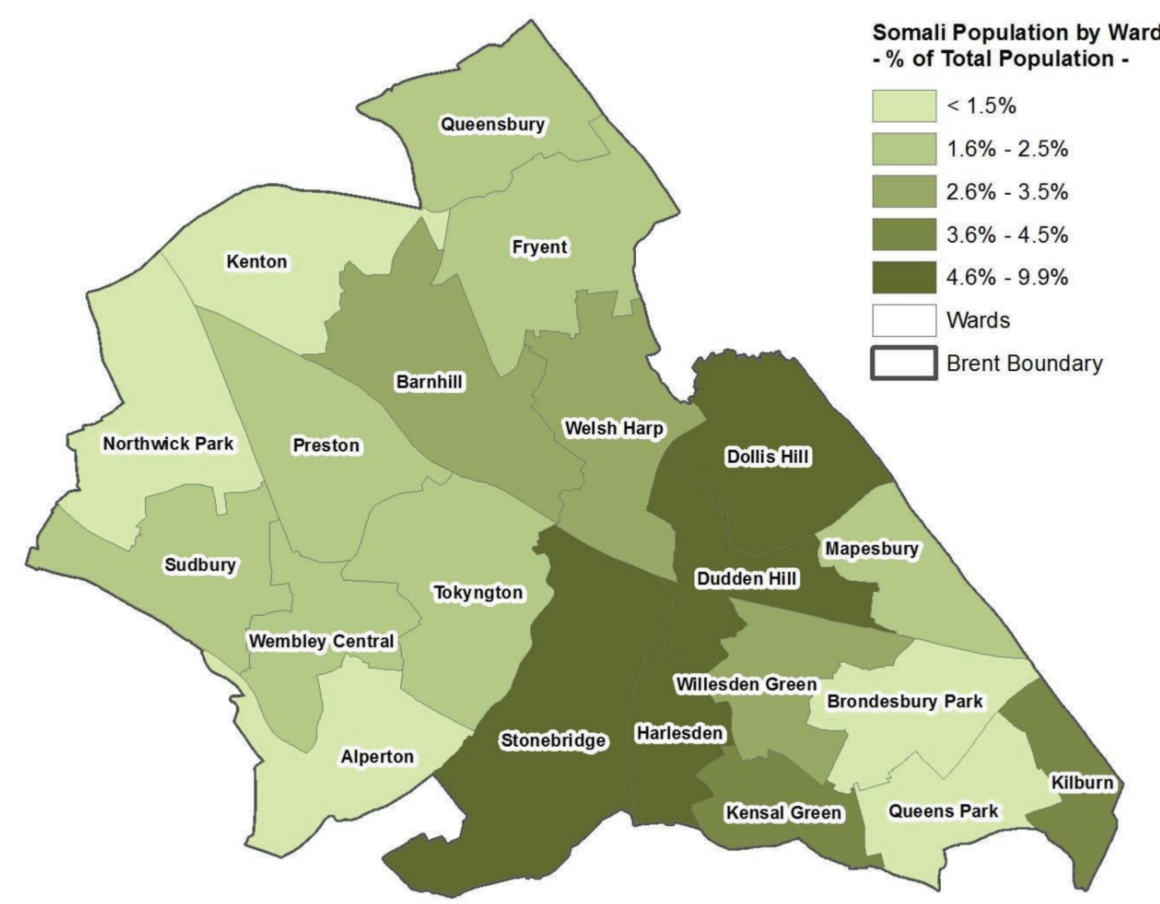
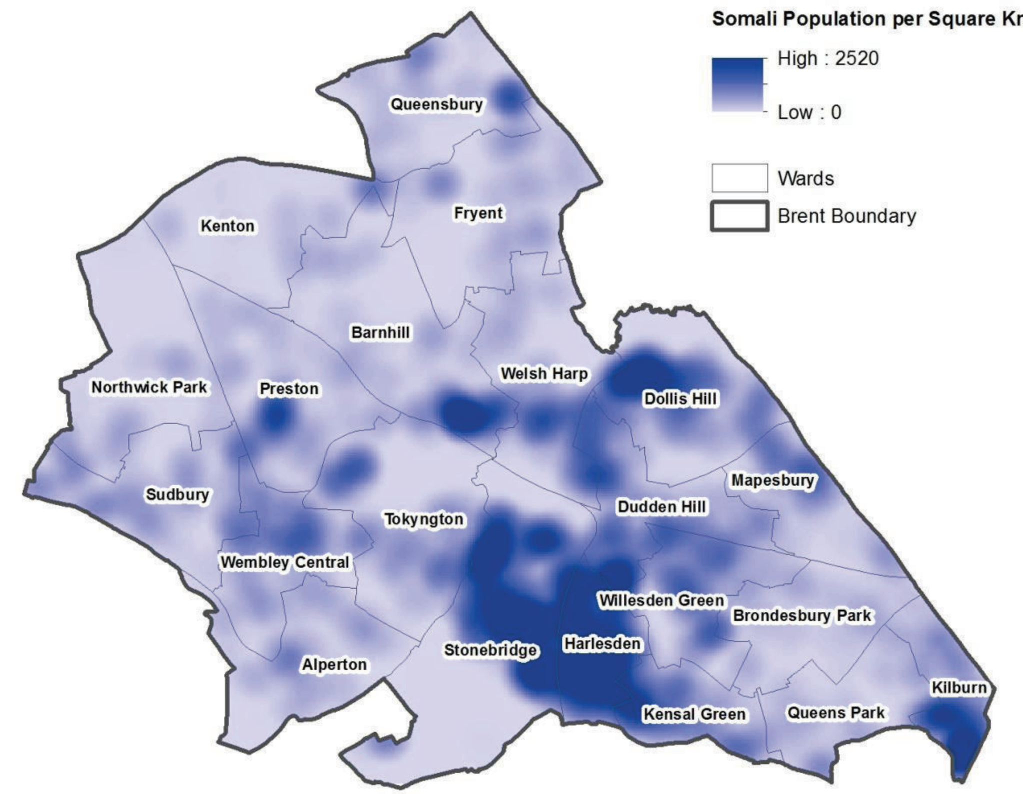
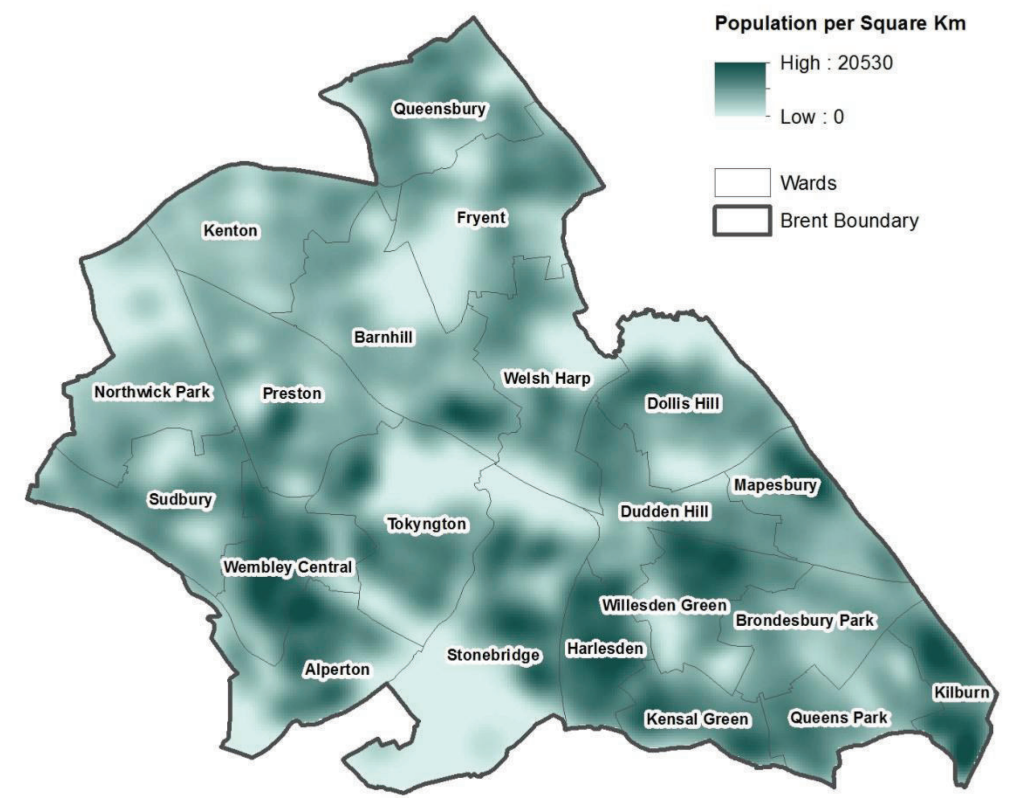
Somali Population by Ward



Somali Population Density (compared to general population density distribution below)





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STRICTLY EMBARGOED UNTIL: THURSDAY 00:01 6 FEBRUARY 2014

Postcode lottery: police recording of reported 'honour' based violence

Report on research undertaken by the Iranian and Kurdish Women's Rights Organisation (IKWRO) on police records of 'honour' based violence

January 2014

FOREWORD

In undertaking the research for this report we, the Iranian and Kurdish women's rights Organisation (IKWRO), set out to ascertain the scale of reported 'honour' based violence (HBV) in the UK and to check that police forces are properly recording HBV cases.

Flagging (labelling) of HBV cases is essential to enable the safeguarding of victims and those at risk. It allows the scale of the reported problem to be understood, both locally and nationally, and helps prevent under-resourcing. Once an HBV case is properly flagged, it reduces the risk of other police officers failing to identify it as HBV, not acting appropriately and endangering the victim, for example by negotiating with their family or community. It is also crucial for risk profiling and risk management.

We submitted Freedom of Information Requests to every police force across England, Wales, Northern Ireland and Scotland. We were encouraged by the fact that we received a response from every police force. I would like to take this opportunity to thank each police force for their co-operation.

What became apparent from the responses, is that it is not possible to establish the full scale of reported HBV. This is because a significant proportion, 20% of police forces, failed to flag all HBV cases reported to them. This failure puts lives at risk.

In this report we have set out recommendations to help 'honour' based violence be tackled effectively. We hope that the government, the Association of Chief Police Officers, all police forces and Her Majesty's Inspectorate of Constabulary will commit to implementing these recommendations, to ensure the protection of those at risk of HBV.

I would like to thank Sara Browne, our Campaigns Officer for writing this report and to all staff at IKWRO who supported this project.

Diana Nammi

Diana Nammi
Executive Director, IKWRO

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Appendix - Infographic

1 Background

1.1 The Iranian & Kurdish Women's Rights Organisation

The Iranian and Kurdish Women's Rights Organisation (IKWRO) is a registered charity which was founded in 2002 in response to extremely poor understanding of and inadequate responses to 'honour' based violence by the police and other front-line agencies.

IKWRO provides advice, advocacy, support, referral and counselling services to Kurdish, Farsi, Arabic, Turkish, Pashtu, Dari and English speaking women and girls living in the UK who are facing 'honour' based violence, forced marriage, child marriage, female genital mutilation and domestic abuse. We provide support and advice to frontline professionals. We deliver training to professionals and women and give presentations in schools and colleges as well as campaigning for better laws, policies and implementation.

1.2 Definition of 'honour' based violence

The Association of Chief Police Officers' (ACPO) definition of 'honour' based violence (HBV) is as follows;

> ***'Honour based violence' is a crime or incident, which has or may have been committed to protect or defend the honour of the family and/or community'.***

In their national 'Honour Based Violence Strategy' (herein referred to as HBV Strategy) which was implemented on 30 September 2008 and remains current, ACPO stated that the term 'honour' based violence is used *'to include Forced Marriage (FM) (so often the driver for or context in which HBV is committed) and Female Genital Mutilation (FGM).'*

In this research, we requested figures for reported 'honour' based violence, however we were concerned to find that there is inconsistency in what the UK's police forces include under this category. For example, some police forces, such as the Metropolitan Police, flag forced marriage cases separately from, rather than under the term 'honour' based violence. We also understand that some police forces do not include female genital mutilation under the category 'honour' based violence.

IKWRO believes that some of this inconsistency may flow from the definition (above) which is too vague to underpin concerted action. We therefore propose this fuller and more explanatory definition which will help people understand and identify 'honour' based violence more easily.

> ***'Honour' based violence is normally a collective and planned crime or incident, mainly perpetrated against women and girls, by their family or their community, who act to defend their perceived honour, because they believe that the victim(s) have done something to bring shame to the family or the community.***
>
> ***It can take many forms including: 'honour' killing, forced marriage, rape, forced suicide, acid attacks, mutilation, imprisonment, beatings, death threats, blackmail, emotional abuse, surveillance, harassment, forced abortion and abduction.***

In addition to our concerns about inconsistency in how HBV cases are recorded, we are also concerned, that some police officers still do not have a proper understanding of HBV. This prevents them from properly investigating incidents and crimes, recording all pertinent information and acting appropriately

to protect victims. We believe that this fuller, more explanatory definition will help police understanding of HBV as will better, regular training and effective risk assessment and management tools.

1.3 THE ASSOCIATION OF CHIEF POLICE OFFICERS' POSITION ON THE FLAGGING (LABELLING) OF HONOUR BASED VIOLENCE CASES & WHY FLAGGING IS CRUCIAL

1.3.1 Identifying the scale of HBV & ensuring resources meet needs

The first of the ***'stated priorities for the police service'*** in the HBV Strategy (2008) is;

> ***'to identify the scale of HBV in all police services across the UK.'***

ACPO therefore made it clear in the HBV Strategy 2008 that there is a need for every police force to flag (label) HBV cases and to understand the prevalence of HBV reporting.

Provided every police force accurately flags every reported HBV case, each police force can easily identify the scale of reported HBV. This would also mean that ACPO would be in a position to obtain national figures for reported HBV and analyse the issue.

So what happens when a police force fails to flag HBV cases? To ascertain how many HBV cases have been reported to them, they have to manually check each file. Unfortunately, it appears that this is unlikely to happen, since it is prohibitively resource and time intensive. This prevents not only the local police force, but also ACPO from having the data that they need to be able to assess the prevalence of reported HBV.

ACPO states in their HBV Strategy 2008 that;

> ***'identifying the scale of the problem is essential if services are to be underpinned by an evidence base; are to be tailored to the needs of the communities being served; are to be sensitive and appropriate and are to be developed in line with identified and/or emerging trends and patterns. By identifying the scale of honour based violence, police services will be able to allocate resources appropriately, target interventions, deploy more effectively'.***

ACPO also state in their HBV Strategy 2008 that;

> ***'regular reports (every six months) will be required by the ACPO and Home Office Working Groups so that a more complete view of the scale of HBV is available.'***

It follows that without this data, these objectives cannot be achieved.

With the introduction of local commissioning, through Police Crime Commissioners (PCC's), it is now even more essential for every UK police force to accurately flag all reported HBV cases as this will help avoid under-resourcing where there is need. When assessing these figures PCC's must factor in underreporting;

a problem in all domestic abuse cases and in particular with HBV. Furthermore PCC's should appreciate that the figures may not reflect the true scale of reported HBV, as some police officers could fail to identify HBV, particularly if not all police officers are fully trained on the issue. All police officers, at every level, need effective, regular training to ensure that they understand, can identify and appropriately handle HBV cases.

1.3.2 Reducing risk of police officers failing to identify HBV cases & responding inappropriately

It is essential that all police officers handling an HBV case, including 999 and 101 telephone responders, understand from the outset that it is an HBV case. To ensure that anyone at risk is protected, and not further endangered, knowledge about HBV needs to be applied. There are important 'dos and don'ts' which must be followed.

Some examples of what the police must do:

Recognise that any family member or community member of the person/ people at risk may be a perpetrator.

Recognise that there may be many perpetrators, including people not known to the victim (such as bounty hunters and contract killers). This means the victim may be at risk even if far away from their family.

*Some examples of what the police must **not** do:*

They must never inform the family or community about their involvement, or interview a victim in front of any family or community member, or attempt to mediate as doing so would put the person/ people who are at risk in greater danger.

If a police officer flags an HBV case, this reduces the risk of all other police officers, who may be involved at that stage, or a later time, failing to identify it as HBV. Therefore the risk of the police acting inappropriately and failing to protect the victim or endangering them further is reduced.

Sadly, there have been a number of cases which the police have failed to identify as HBV, where they have not acted appropriately to protect the victim, and have put the victim in greater danger.

One example is the case of Banaz Mahmod. She was murdered in an 'Honour' Killing in 2006. Before her murder she reported HBV to the police five times. On the last of these occasions, on New Years Eve 2005, her father made her drink alcohol and then attempted to murder her. She managed to escape and the policewoman handling her case that night failed to understand the context, disbelieved Banaz and took the view that she was just a girl who had drunk too much. The police informed Banaz's father that she had raised a complaint and the police went to Banaz's family home to interview her in front of them. A few weeks later, in London

on 24 January 2006, Banaz was raped and murdered in by her family and her body was later found buried in a suitcase in Birmingham.

Flagging is essential to prevent multiple police failure to identify HBV and trigger the appropriate approach.

With HBV cases, there is a real likelihood that the case could be encountered by a number of different police officers, at different times and in different places.

It is probable that police officers could encounter an HBV case over a long time span. This is because the risk to those in danger never disappears, until the perpetrators are satisfied that they have regained their 'honour', by erasing the person/ people that they believe have brought shame to the family and community.

It is likely that police officers in different areas may encounter an HBV case because people at risk often move to try find safety, however there are likely to be a high number of potential perpetrators, who could be spread across the UK and abroad.

In a case that IKWRO was involved with, our client and her children had to be moved to 8 different refuges because she and her children were being pursued by her family and members of the community. Perpetrators went to refuges and shops in different areas with pictures of her to try to find her.

The greater the numbers of officers that are involved in a case, the more likely it is that one or more of them will fail to identify it as HBV, and as a result will not act appropriately to protect the victim, which could put them in greater danger.

Therefore every single police force must identify and flag all HBV cases and information about cases must be able to easily be safely shared between all police forces.

1.3.3 Risk profiling

Flagging HBV cases is important for effective risk profiling. In HBV cases there is a significant likelihood that other family members could already have experienced HBV. This is key intelligence which can help the police to safeguard all family members at risk. If all cases of HBV are flagged, this assists the police with their risk assessment and risk management.

In the case of Banaz Mahmod, her sister Bekhal was already under police protection, because their brother had tried to kill her in what a clear 'honour' based violence case. If the police had flagged Bekhal's case as being HBV, they would have

had a record of the Mahmod's being a family that took 'honour' very seriously, and when Banaz reported, it would have been noted that the Mahmod's were perpetrators of 'honour' based violence and her reporting is likely to have been taken more seriously.

1.3.4 Importance of flagging all HBV cases; incidents as well as crimes

Significantly, ACPO's definition of 'Honour' based violence, which is set out at 1.2 of this report above, includes not only crimes but also incidents. Importantly ACPO recommends;

> ***'that each force puts in place the mechanism to record the number of HBV incidents reported.'***

It is vital that as well as recording and flagging every HBV crime, that every reported HBV incident is also recorded and flagged.

HBV cases can escalate very quickly, from what someone without a proper understanding of HBV might interpret as a trivial incident, to extreme violence and 'honour' killing. To protect people at risk of HBV, all reported incidents must be taken seriously, investigated thoroughly and acted upon appropriately and sensitively. Furthermore the case must be fully recorded and flagged as HBV, so that all police officers involved from the start, and at any later stage, know to apply the appropriate approach.

We know from our work with women and girls at risk that eight years on from the murder of Banaz Mahmod, there are still cases where the police are failing to identify risk and are not taking steps to protect the person/ people reporting to them.

Recently a woman came to IKWRO who had just been turned away from a police station. The police had asked her if she had any bruises and she told them that she did not. They asked her if there was a history of violence against her and she told them there was not. They asked her if she was being forced into a marriage and she told them that no she was not. She explained to them that her family believed that she had brought them dishonor because she had fallen in love with a man who they had not chosen and she was scared that they would harm her. The police did not take a statement from her. They told her that no crime was committed and told her to go home. IKWRO undertook a risk assessment the same day and we found her to be at high risk of HBV. We accompanied her to the same police station and they then accepted that she was at high risk.

To ensure this does not happen, every police officer needs to be properly trained to understand and identify HBV and every HBV case must be flagged, to reduce the risk of their colleagues failing to identify the case and acting inappropriately.

Recording incidents, as well as crimes, gives a more accurate picture of reported HBV prevalence. Reported incidents must be flagged by every police force, so that they can easily understand the true scale of reported HBV locally. This is imperative if they are to respond to the issue effectively. It is also essential so that Police Crime Commissioners have accurate data to help ensure that the issue is not under-resourced.

Furthermore, unless each police force flags all reported HBV incidents, as well reported crimes, which would enable ACPO to easily identify the national scale of reported HBV, ACPO cannot effectively address the issue.

1.3.5 Need to flag HBV cases throughout the criminal justice process

But flagging HBV cases when they are reported and investigated is not enough. It is vital that every HBV case is flagged and remains flagged at every stage, including when a charge is pressed, and if it results in a conviction. This is essential, so that the case can be properly understood and dealt with appropriately by all who handle it.

Flagging at every stage is also crucial so that all police forces and ACPO can gather data on the scale of HBV at the different stages of the criminal justice system. This information is vital to enable effective planning to address HBV.

1.3.6 Importance of consistency

In their HBV Strategy, ACPO state that;

> ***'the ambition is to achieve consistency in terms of identifying an honour based violence incident, recording such incidents and the collation and analysis of this data.'***

This is vital so that HBV cases are not missed and so that accurate information can be obtained both locally by individual police forces and nationally by ACPO about the scale of HBV.

2. METHODOLOGY

In August 2013, IKWRO submitted requests under the Freedom of Information Act 2000 to every police force in; England, Wales and Northern Ireland (in total 44 forces). Each police force was asked the following:

For the full year of 2012, please can you confirm;

1. How many incidents of 'honour' based violence your police force recorded?
2. How many of these incidents led to criminal charges being pressed?
3. How many of the charges referred to in question 2 resulted in convictions?

For the full year of 2012 there were eight regional police forces in Scotland, which on 1 April 2013 were amalgamated into one force; Police Scotland.

In August 2013, under the Freedom of Information (Scotland) Act 2002, the following request was submitted to Police Scotland;

Separately, for each of the former regional police forces in Scotland, please can you confirm;

1. How many incidents of 'honour' based violence your police force recorded?
2. How many of these incidents led to criminal charges being pressed?
3. How many of the charges referred to in question 2 resulted in convictions?

3 FINDINGS

3.1 SUMMARY OF FINDINGS

More than one in five police forces in England, Wales, Northern Ireland and Scotland failed to flag and provide data for both HBV incidents and crimes reported in 2012. It was therefore not possible to establish the scale of HBV reported in 2012.

Please refer to the infographic at Appendix 1.

It should be noted that police figures must always be treated with caution; the police may fail to identify and/ or record a case as 'honour' based violence. It must also be remembered that reported HBV does not represent the prevelence of HBV within the UK as many HBV cases are never reported to the police.

3.2 SOME POLICE FORCES FAILED ENTIRELY TO FLAG HBV CASES

These forces (see 3.2.1 below) failed to flag all HBV cases including; incidents, crimes, cases where a charge had been pressed and convictions.

They were unable to provide any of the information that was requested. They stated that in order to gather the requested data they would need to manually search through each case. They claimed exemption under the relevant Act; the Freedom of Information Act 2000 and the Freedom of Information (Scotland) Act 2002.

3.2.1 England, Wales & Northern Ireland

Derbyshire Constabulary stated;

> ***'the Constabulary utilises a computerised crime recording system to log all reported crimes. Whilst the system has some search facilities it cannot search for 'honour' based violence crimes per se. Given that there is no central register for these crimes the only way to extract the data would be to open each crime and read notes to see whether or not it is relevant to this application.'***

Gloucestershire Constabulary stated;

> ***'unfortunately, there is no central register for the information you have requested. Due to there being no Home Office Crime Category for 'honour' based crimes, the reports would only be recorded on the Constabulary's system as an incident. Our incident recording system does not have a flag or marker for 'honour' based crime and therefore we would have to manually review all incidents for the year requested to see if they would fall under your request remit.'***

Staffordshire Police stated;

> ***'there is no specific system to easily retrieve the required data. There are thousands of incidents which would require a manual search of each crime to investigate whether it is 'honour' based violence'.***

3.2.2 Scotland

The response from Police Scotland regarding four of the former eight police forces, which existed prior to it's formation on 1 April 2013; Dumphries and Galloway, Northern, Fife and Strathclyde, was that;

> ***'there was no way of extracting this information from the incident and crime recording systems without examining each individual record, which would be a considerably time consuming task given the number of crimes reported in each legacy force every year.'***

IKWRO is however encouraged by the following statement from Police Scotland;

> ***'the Lead officer for the ACPOS HBV working group identified that there was both under-reporting and a lack of identifying and recording of HBV incidents throughout the eight different forces. She identified this gap and as a result a national recording mechanism was agreed and put in place from 6 December 2012.'***

IKWRO intends to carry out further research to investigate whether, since the formation of Police Scotland on 1 April 2013, lessons learned from the earlier failures are being addressed in practice.

3.3 SOME POLICE FORCES FLAGGED ONLY CRIMES & NOT INCIDENTS

These forces stated that the data they provided was specifically for crimes, not incidents;

Avon and Somerset Constabulary, Hampshire Constabulary, Police Service Northern Ireland, West Mercia Police and **Surrey Police.** The later stated;

> ***'Results are extracted from a live Crime Information System (CIS) which is subject to change over time…only notifiable crimes are included (those which police are required to notify formally to the Home Office)'.***

3.4 SOME POLICE FORCES FAILED TO FLAG HBV CASES IN WHICH A CHARGE WAS PRESSED

These forces are **Bedfordshire Police**, **Cleveland Police** and **Lancashire Constabulary.**

3.5 OTHER FINDINGS

3.5.1 There is significant variation in how 'honour' based violence is interpreted; some forces include Forced Marriage and others do not. For example, the Metropolitan Police record Forced Marriage under a separate category.

3.5.2 Some forces claimed exemption to providing data on the basis that disclosure could impede investigations.

4. SUMMARY

It is IKWRO's view that following some significant progress culminating in the publishing of ACPO's HBV strategy in 2008, that subsequently ACPO has neglected the issue of HBV. This is demonstrated by the fact that no HBV review or action plan has been published since the 2008 HBV Strategy, despite it clearly being stated in the strategy that it was due to be reviewed on 30 September 2010.

This neglect is further illustrated by the finding from this research that more than one in five UK police forces failed to flag all HBV incidents and crimes, despite it being clear in the ACPO HBV Strategy 2008 that this is essential.

5. RECOMMENDATIONS

The following recommendations are made on the basis of IKWRO's findings from this research, as well as IKWRO's expertise on HBV. Our expertise comes from over 11 years of campaigning on this issue and providing front-line services to women and girls at risk of HBV.

1. **Adopt fuller more explanatory definition:** The government, police and all statutory and voluntary organisations should adopt this fuller more explanatory definition;

   'Honour' based violence is normally a collective and planned crime or incident, mainly perpetrated against women and girls by their family or their community, who act to defend their perceived honour, because they believe that the victim(s) have done something to bring shame to the family or the community.

   It can take many forms including: 'honour' killing, forced marriage, rape, forced suicide, acid attacks, mutilation, imprisonment, beatings, death threats, blackmail, emotional

abuse, surveillance, harassment, forced abortion and abduction.

2. **An inspection of current police handling of HBV:** Her Majesty's Inspectorate of Constabulary (HMIC) should carry out an inspection into the handling of HBV by UK police forces and ACPO. This should include an examination of training provided on HBV for all levels of police officer, including telephone responders (101 and 999) and the response to, recording, analysis and monitoring of HBV.

3. **Greater Transparency:** ACPO and Police Scotland should operate with much greater transparency with regards to HBV strategy.

4. **Greater partnership working to keep women and girls safe:** ACPO should work much more closely with, and meet regularly with HBV stakeholders, including charity organisations with expertise in HBV, such as IKWRO, to ensure shared learning and progress in tackling HBV.

5. **Police recording and flagging of HBV should be made a statutory requirement.**

6. **Every police force should flag HBV at every stage:** ACPO must ensure that every police force in England, Wales and Northern Ireland has a system in place to flag all cases of reported 'honour' based violence, including both incidents and crimes, as well as cases in which a charge is pressed. ACPO should set and publicise a date by which all police forces must demonstrate that this system is operational. If any police force fails to comply, ACPO should publicise their failure and take all steps in their power to ensure timely compliance.

7. **Scotland:** Police Scotland must ensure that it learns from the mistakes of the former Scottish police forces, highlighted by the former Association of Chief Police Officer's Scotland and that it flags all cases of reported 'honour' based violence, including both incidents and crimes, as well as cases in which a charge is pressed.

8. **Regular reporting essential:** In line with ACPO's HBV Strategy 2008; ACPO should collect ***'regular reports (every six months)'*** on HBV from each police force. ACPO should carefully analyse this data and produce reports on their findings, which they should publish. ACPO should learn from their findings and demonstrate this in subsequent reports. Police Scotland should so the same.

9. **Training for police officers:** ACPO and Police Scotland must ensure that every police officer, including telephone responders (101 and 999), is sufficiently and regularly trained to ensure that they properly understand and can identify HBV cases. ACPO and Police Scotland should publicise details about training on HBV for all levels of police officers.

10. **Home Office Crime Category for HBV** should be set up and implemented by all police forces.

11. **National recording system of all non-crimed incidents:** should be put in place and implemented by all police forces.

12. **ACPO HBV network needed:** ACPO should set up a network of named HBV leads for each police force. For the larger police forces such, as the Metropolitan Police, each borough/ area should also have a named HBV lead. Police Scotland should do the same. The contact details of these named leads should be made publically available so that they are easily accessible to all police, agencies, charities and individuals who may need to contact them. Should the individual leave their post, they should immediately be replaced and the contact list should be updated.

13. **Clearer responsibilities:** Each named HBV lead, referred to at Recommendation 12, should keep an updated list of, and be familiar with, every HBV case reported within their area. They should be in a position to easily be able to safely share information about each HBV case, as appropriate.

14. **Ensure effective implementation in each police force:** The HBV leads network, referred to at Recommendation 12, should have responsibility for ensuring that regular, effective HBV training is implemented at all levels within their area and that all reported HBV incidents, crimes and cases in which charges are pressed, are flagged and reported to ACPO in accordance with Recommendations 6 and 8.

15. **Access to help on the ground:** We understand from discussions with police that currently when a police officer is called out to a domestic abuse incident, they should take a booklet with them which includes a D.A.S.H. risk assessment which they must apply. We recommend that the standard risk assessment must include questions to ascertain whether the person or people at the scene are at risk of HBV. The risk assessment must always be carried out in full and there should be penalties for police officers who fail to do this. The booklet should include the referral details of support organisations with specialist knowledge of HBV, such as IKWRO, as well as the definition at recommendation 1 and the key do’s and don’ts for HBV cases.

16. Child protection policy for all front-line agencies must ensure that HBV is thoroughly addressed including requiring regular, effective training of all staff.

Appendix 1

Police recording of 'Honour' Based Violence (HBV) 2012

4 out of 8 former Scottish police forces failed entirely to flag HBV cases;
Dumphries & Galloway,
Northern,
Fife,
Strathclyde

Northumbria
Durham
Cleveland
Cumbria
North Yorkshire
PSNI
Humberside
Lancashire
West Yorks
Merseyside
GMP
South Yorks
Cheshire
Derbys
Notts
Lincolnshire
North Wales
Staffs
Norfolk
Leicestershire
W Mids
Northants
Cambs
Suffolk
West Mercia
Warks
Dyfed-Powys
Beds
Herts
Essex
City of London
Gloucs
Thames Valley
Gwent
South Wales
Met
Wiltshire
Surrey
Kent
Avon & Somerset
Hampshire
Sussex
Dorset
Devon & Cornwall

Failed entirely to flag HBV cases
Flagged only HBV crimes not incidents
Failed to flag HBV charges

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Brent Harmful Practice Case Studies

Case Study 1 - Female Genital Mutilation

FORWARD was contacted by social services from the London Borough of Brent regarding a case involving several children believed to be at risk of FGM. FORWARD provided support, advice and guidance for the family and local social services. One-to-one support sessions and emotional support were delivered to the mother who was also provided with information about FGM in a culturally sensitive way, information about the law. As a woman who had undergone FGM, she was also signposted to FGM specialist services for medical care and counselling.

FORWARD delivered group sessions with for the young girls, providing them with FGM information in an age appropriate format. The girls were also provided with emotional support and advice to guide them through the challenging situation. The young girls were provided with information about services and options for where to go if they or their peers felt at risk.

- FORWARD also worked with other family members including the father to ensure that children were supported and safeguarded.
- FORWARD provided social services with a report as well advice on best practice and cultural sensitivity.
- FORWARD believes that the HP Strand will be able to ensure that more women and young women are supported and protected

Case Study 2 - Forced Marriage Case Study

A young Asian young woman was referred to the AWRC by her teacher at college. The young woman was being forced to marry one of her cousins in Pakistan, by her parents. They had found out that she had a boyfriend from a different cultural background, which they did not approve of. As a result they beat her and attempted to strangle her. The parents had further threatened to break her legs, arms and kill her if she did not do what they said. The parents had accused her for becoming too "westernised" by developing relationships before marriage, deviating from her culture and for bringing shame on the family. The young women feared for her safety and did not want to return home.

The AWRC provided the following support:

- Risk assessment /Safety planning advice.
- MARAC referral
- IDVA referral
- Reported the threat of honour based violence to the police (worker accompanied her).
- Reported violence to the GP – (worker accompanied her).
- Provided emotional support
- Made referral to a refuge, provided her with taxi fare to travel.
- Provided follow up support

Case Study 3 – Honour Based Violence Case Study

A young Asian Women started dating a young Asian man who seemed like a nice man at first. After a while it became clear that the relationship was not working and she decided she wanted to end it. The young man was aware all along that our relationship was a secret, and due to his controlling behaviour, began to use this against her. He threatened to tell her family about their relationship, which was absolutely, terrified her. The thought of what her parents would do if they found out petrified her. Honour was embedded in her family

“I’ve never known any different. Having a relationship with a man would bring dishonour to the family. It’s not just my mother and father that I had to worry about.”

The young women continued to see the young man for fear of her finding out – this was effectively against her will, again she tried to end the relationship and the threats continued.

“I thought about them all the time. The anxiety was always there, it’s not a nice feeling to have. I kept on blaming myself for getting into the position I found myself in. Eventually I decided enough was enough, I could not go on living my life in this way.”

The young women lived with the threats for a year before she contacted the AWRC,

The AWRC provided the following support:

- Risk assessment /Safety planning advice
- Reported the threat of honour based violence to the police (worker accompanied her).
- Provided emotional support
- Provided follow up support

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Female Genital Mutilation (FGM) in Islington: A Statistical Study

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Executive Summary

The purpose of this study is to establish a more detailed picture of Female Genital Mutilation (FGM) in Islington. The study adapted the method used by the Foundation for Women's Health, Research and Development (FORWARD; 2007) which used UK census data and national and regional FGM prevalence data to estimate the number of women and girls in the UK who were likely to have undergone FGM. This study combined FGM prevalence data with language and ethnicity data for Islington to produce a similar estimate. There are several key findings:

There are 1,812 girls aged 0 – 18 in Islington who are at risk of (or who may have already undergone) FGM, and this is undoubtedly an underestimate.

This number represents 10.2% of the 0-18 female population in Islington.

There are 1289 girls in the highest risk category for FGM; they are from backgrounds where FGM is effectively universal in their country of origin.

This number represents 7.3% of the 0-18 female population.

A significant proportion of girls in the two highest risk categories are aged 0-7 (47% in category 1 and 63% in category 2)

The data presented here is based on self reporting of language and ethnicity therefore this is very likely to be an underestimate. Whilst the conclusion of this study is not that every one of these girls will undergo, or will have already undergone FGM, cultural background is the most important risk factor and there are a number of countries in the world where FGM is practiced on a universal scale. Therefore, it is vital that we are fully aware of the level of risk to girls and young women in Islington from all backgrounds and that we do not assume that living in the UK where FGM is illegal, is enough to eradicate the practice.

This study is a starting point, designed to help us estimate the likely level of risk around this practice, and to help us ensure we are protecting all Islington residents. FGM is one of the serious violent crime types within the Violence Against Women and Girls (VAWG) agenda, and Islington Council's VAWG Strategy 2011-15 outlines the Council's aims and objectives around VAWG over the next four years. Conducting this study was part of the work plan that underpins Islington's *Violence Against Women and Girls Strategy 2011-15 and t*he recommendations at the end of this report will feed into the Council's work plan around FGM and VAWG.

1. Introduction

1.1. The purpose of this study is two-fold. Firstly, it will provide some background to the practice of female genital mutilation (FGM); the procedure itself, its causes and impacts, and the profile of those most at risk. Secondly, this report will draw together information we have locally to establish an estimation of the level of risk to girls and young women in Islington.

1.2. This study uses a methodology similar to that used in the 2007 report by the Foundation for Women's Health, Research and Development (FORWARD; 2007); combining country and regional statistics on FGM prevalence with local data to estimate the numbers of girls and young women likely to be at risk of FGM. Islington is the first local authority in the UK to use this method to assess the risk of FGM in the local area.

2. Background and context

Definition

2.1. The World Health Organisation (WHO) defines FGM as comprising 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, and has categorised FGM into four major types:

i) **Clitoridectomy**: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

ii) **Excision**: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).

iii) **Infibulation**: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

iv) **Other**: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Reasons Given for the Practice

2.2. There are a number of different reasons given for FGM by different communities, most of which stem from traditional beliefs about the importance of controlling a woman's sexuality, preserving virginity and promoting fidelity. FGM is sometimes also practised for aesthetic reasons.

2.3. In many communities FGM is seen as an important rite of passage for girls entering adulthood, it is continued both to maintain a traditional custom but also because it is widely believed to be beneficial to women; many believe it is more hygienic, that it makes women cleaner, and some even mistakenly believe it may make childbirth safer.

Health Implications

2.4. FGM has no health benefits and is associated with a range of long and short term harmful health and welfare consequences. The following are just some of the potential physical consequences of FGM, but the list is by no means exhaustive:

- Severe pain
- Wound infections
- Chronic vaginal, pelvic and urine infections
- Difficulties with menstruation and passing urine
- Renal impairment and possible failure
- Complications in pregnancy
- pain during sex and lack of pleasurable sensation
- Damage to the reproductive system, including infertility
- Increased risk of HIV and other STIs
- Death in childbirth

2.5. It is widely acknowledged that there are also a number of psychological and psychosexual consequences associated with FGM, including:

- low libido
- depression
- anxiety and sexual dysfunction
- flashbacks during pregnancy and childbirth
- substance misuse and/or self-harm

2.6. There is also an increasing body of research demonstrating the link between FGM and a number of psychological syndromes and anxiety disorders. A study undertaken in Senegal in 2003 found that women who had suffered FGM in childhood showed a significantly higher prevalence of Post Traumatic Stress Disorder (PTSD).

Prevalence Worldwide

2.7. Internationally FGM is recognised as a human rights violation. Yet the World Health Organisation (WHO) estimates that between 100 and 140 million women and girls worldwide have undergone the procedure and that in Africa alone around 3 million girls undergo the procedure every year.

2.8. There are 28 African countries where FGM is known to be practiced, and although less statistical information is accessible the practice has also been

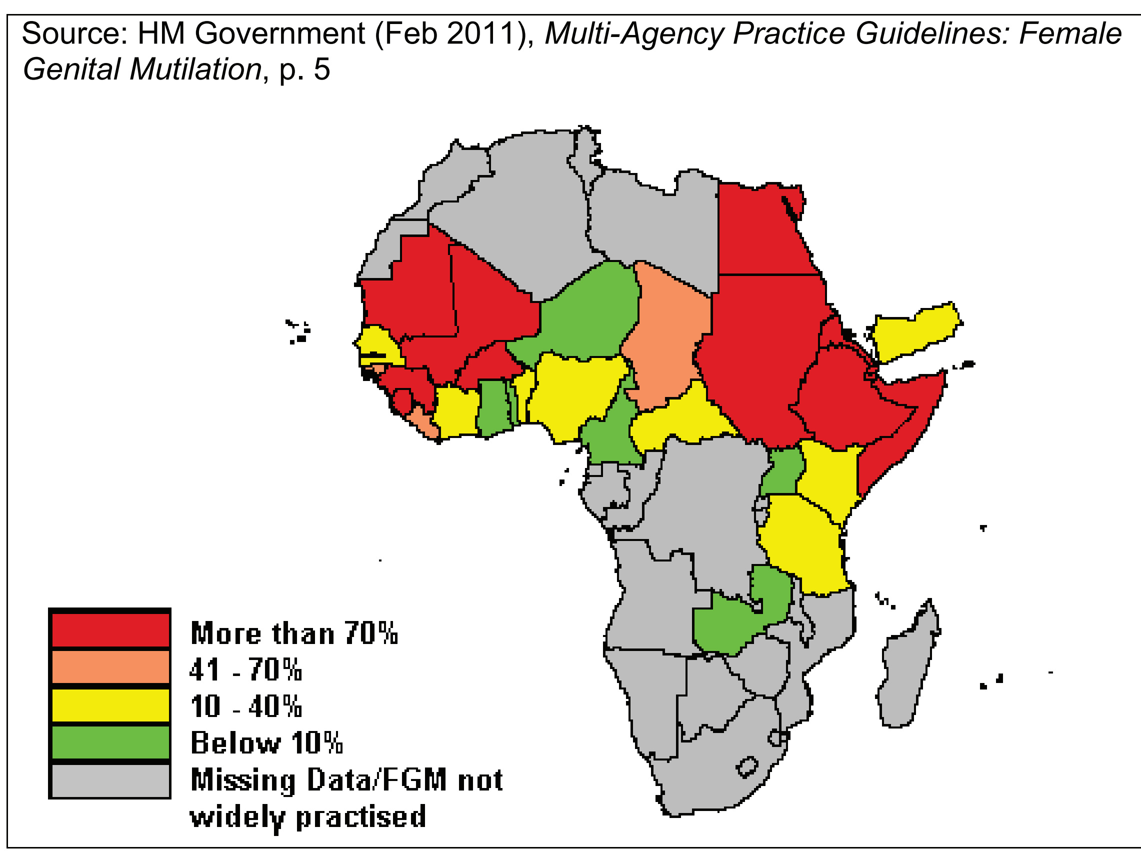
documented in Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan.

2.9. A 2010 study by WADI, Association for Crisis Assistance and Development Co-operation used a mixture of questionnaires and interviews to establish an estimate of the prevalence of FGM in the Kurdish Autonomous Region of northern Iraq. The result of the study was that the overall FGM prevalence rate in this region was 72.7%.

2.10. In addition to this, a WADI press release from 9th April 2012 announced that a new study conducted by WADI and a local women's rights organisation investigated the prevalence of FGM in Kirkuk (outside of the Iraqi Kurdistan region) and found a prevalence rate of 65.4% among Kurdish women living in Kirkuk and 25.7% among Arab women in Kirkuk.

2.11. The map below shows estimated rates of FGM across Africa.

Source: HM Government (Feb 2011), *Multi-Agency Practice Guidelines: Female Genital Mutilation*, p. 5



Risk Factors

2.12. The highest risk of FGM is obviously among girls and young women from FGM practising communities and within this there are further characteristics that obviously increase the risk level:

- Level of integration of a family into society
- Girls born to mothers who have undergone FGM

- Girls whose sisters have already undergone FGM

2.13. The age at which girls are likely to undergo FGM varies across different communities. The highest risk period is believed to be between the ages of 5 and 9, although it is important to note that there have been reports of FGM being performed on newborns, in childhood, adolescence or before marriage.

FGM in the UK

2.14. In the UK FGM is illegal under the Female Genital Mutilation Act 2003. Despite this, a study into UK prevalence by FORWARD based on 2001 census data estimated that over 20,000 girls under the age of 15 could be at high risk of FGM in England and Wales each year; and nearly 66,000 women are living with the consequences of FGM.

2.15. In February 2011 the Government published the Multi-Agency Practice Guidelines on FGM, which aimed to provide support to all front line professionals who have responsibility for safeguarding children and adults from the abuses associated with FGM.

2.16. The UK Government estimates that the prevalence of FGM in the UK is not evenly distributed and that higher prevalence is likely to be found in areas with larger populations from practicing countries, and London is listed as an area where rates of FGM are likely to be high.

2.17. It is believed that FGM is carried out on British girls both in the UK and overseas, often in the family's country of origin. As a result girls are at particular risk during school holidays, especially the long summer holiday, when they can be taken overseas and have a significant period of time to recover before returning to school.

2.18. Islington has a very diverse community with populations from all over the world. There are a number of community groups and projects in the borough that do work with communities to raise awareness about the harmful health and welfare consequences of FGM, and support women and girls who have undergone the procedure.

2.19. Female Genital Mutilation is one of the serious violent crime types within the Violence Against Women and Girls (VAWG) agenda. Islington Council has a VAWG strategy that outlines the Council's aims and objectives over the next four years. The VAWG Strategy is delivered through a number of working sub-groups with responsibility for different areas and FGM comes under the Harmful Traditional Practices (HTP) sub-group.

2.20. Part of the work plan of the HTP VAWG sub-group was to use local data and information to provide an estimate of the risk profile of girls and young women in Islington.

3. Methodology

3.1. Following a similar method to that used by FORWARD in their 2007 report on the UK prevalence of FGM, the purpose of the study was to establish an estimate of the level of risk to girls in Islington using country prevalence data from international sources, and local data on language and ethnicity from our own databases (where FORWARD used census data for a national estimate).

3.2. The first stage was to identify the country and regional prevalence rates of FGM in countries around the world. This was done using estimates available through the World Health Organisation (WHO), and a number of regional or country based Demographic and Health Surveys (DHS). For prevalence rates among Kurdish women this was done using the study by WADI as the WHO doesn't have prevalence data specifically for the Kurdistan region.

3.3. After a list of countries had been established, a full list of all ethnicities and languages associated with those countries was produced. These ethnicities and languages were used to run a search through the database of Islington children. This Data Warehouse is a central collection of records that draws together a number of databases and reporting systems used in the borough including council tax, housing, schools and others.

3.4. Due to the variety of ages at which FGM can be performed it was decided to focus on girls aged 0 -18, so the Data Warehouse was used to establish the numbers of female 0-18 year olds in Islington whose ethnicity or language indicated they were from an FGM practising community.

3.5. The information that came back from the Data Warehouse was carefully cleaned and checked to make the count as accurate as possible.

3.6. Language and ethnicity were looked at for each individual and it was decided that language would be used as the basic measure for this study as the language records were more detailed and could be most easily associated with particular countries. Ethnicity was still considered where language information alone was not sufficient to establish whether the individual belonged to a practising community. Age was also included in the profiles and the results are published below.

3.7. All the data analysed was anonymous, the records viewed showed only certain characteristics, with all information that would have allowed personal identification removed.

Advantages

3.8. The fact that the Data Warehouse is a central collection of a number of different databases meant that we were able to access as wide a range of

information as possible, and that we could identify siblings and children living in the same household to further increase the accuracy of results.

3.9. The use of language as well as ethnicity allowed a more accurate estimate to be drawn from the data since there were a number of individuals for whom only one was listed, and often for children we have information on language and not on ethnicity, so it enabled us to identify more of those potentially at risk.

3.10. The use of language also allowed greater accuracy as it meant the estimates did not have to rely on national prevalence estimates only. For example, in a country such as Nigeria, the overall country prevalence rate is comparatively low (29.6%), but there are significant regional variations in the prevalence rate revealed through the 2003 DHS. The survey revealed that in Nigeria prevalence was found to be as low as 0.4% in some areas and as high as 56.9% in others. The use of language data in this study allowed a more accurate appraisal of the risk level as it was possible to identify the prevalence rate associated with individual languages.

3.11. Previous estimates on FGM prevalence, including the 2007 estimate by FORWARD, have used country of birth and ethnicity as the proxies from which to estimate FGM prevalence or risk. This method has the limitation that it does not include those of a second generation who may have been born in the UK but whose background would still indicate that they are at high risk of FGM. Including language data in this estimate enables us to identify those from FGM practising communities regardless of their country of birth.

3.12. These estimates are based on live data, which means that they are likely to be more up to date than those that were, for example, based on a particular population survey such as the 2001 census, which is now over ten years out of date.

Limitations

3.13. The limitation identified by FORWARD, that there is insufficient research on the impact of migration on FGM practice, also applies to this study. The dearth of research in this area means that this study uses country of origin prevalence to reach estimates, and we cannot know how different prevalence in migrant communities is likely to be from those in country of origin.

3.14. The study by Morison et al (2004) conducted a survey with a sample of young Somali men and women living in London. The sample consisted of 80 Somali men and 94 Somali women all aged 16 – 22. In this study 70% of the women reported having undergone FGM, and two thirds of those had undergone type iii. The study also found that there was a significant difference in the prevalence of FGM between girls who had arrived in the UK before age 6 (42%) and those who had arrived when aged 11 or older

(91%). Whilst this study provides some insight, there is a need for more research to fully understand the impact of migration to the UK in terms of FGM practice.

3.15. The evidence is limited by the fact that we only have information on those 0 -18 year olds or their siblings about whom we have at one point collected ethnicity or language data. The fact that this relies on self reporting means that it is this is very likely to be an underestimate.

3.16. Where an individual's language is one that is extremely widely spoken, such as Arabic, they will have not been counted in this study unless additional information was available on their ethnicity or nationality. This is because there are some Arabic speaking countries associated with a high prevalence of FGM and others with a very low, or no evidence of FGM at all. Since it cannot be assumed that all speakers of the language are from countries where FGM is practiced, they have been excluded. This inevitably means there has been some under-counting.

4. Results

4.1. The full list of languages which existed within the Data Warehouse and were counted in this study are shown in Table 1 below.

Table 1 – List of Identified Languages	
Afar-Saho	Krio
Akan/Twi-Fante	Kurdish
Amharic	Lingala
Arabic (Egypt)	Nigerian (Language not known)*
Arabic (Iraq)	Nzema
Arabic (Sudan)	Oromo
Arabic (Yemen)	Pashto/Pakhto
Bambara	Somali
Berber (Tamashek)	Swahili/Kiswahili
Ebira	Temne
Edo/Bini	Tigre
Efik-Ibibio	Tigrinya
Esan/Ishan	Urdu
Ewe	Urhobo-Isoko
Hausa	Wolof
Igbo	Yoruba
*This category was used to describe those whose ethnicity was listed as Nigerian but for whom there was no language data available.	

4.2. Each of these languages is associated with a country or region where FGM is known to be practiced. Where languages are associated with more than one country, the ethnicity was examined and this often indicated the country of origin. Where there was no clear country of origin the country selected was the one most associated with the language.

4.3. The list of languages with countries (or regions) and associated prevalence rates (where available) is shown in Table 2 below.

Table 2 – List of Languages and Associated Prevalence Rates

Language	Country/Region	Prevalence Rate (%)
Afar-Saho	Djibouti	93.1
Akan/Twi-Fante	Ghana	3.8
Amharic	Ethiopia	74.3
Arabic (Egypt)	Egypt	91.1
Arabic (Iraq)	Iraq	N
Arabic (Sudan)	Sudan	90
Arabic (Yemen)	Yemen	38.2
Bambara	Mali	85.2
Berber (Tamashek)	Sierra Leone	94
Ebira	Kwara state, Nigeria	9.6
Edo/Bini	Edo state, Nigeria	34.7
Efik-Ibibio	Akwa Ibom State and Cross River State, Nigeria	34.7
Esan/Ishan	Edo state, Nigeria	34.7
Ewe	Ghana	3.8
Hausa	Northern Nigeria	0.4
Igbo	SE Nigeria	40.8
Krio	Sierra Leone	94
Kurdish	Turkey/Iran/Iraq	72.7
Lingala	CAR	25.7
Nigerian (Language not known)	Nigeria	29.6
Nzema	Ghana	3.8
Oromo	Ethiopia	74.3
Pashto/Pakhto	Afghanistan/Pakistan	N
Somali	Somalia	97.9
Swahili/Kiswahili	Congo*	5
Temne	Sierra Leone	94
Tigre	Northern Sudan	90
Tigrinya	Eritrea	88.7
Urdu	Pakistan	N

Urhobo-Isoko	Delta State, Nigeria	34.7
Wolof	Senegal	28.2
Yoruba	SW Nigeria	56.9
N = Not Known (countries where FGM has been documented but where there is little or no data available) *From listed ethnicity		

4.4. The total count for girls aged 0-17 whose language or ethnicity or both indicated that they could be at risk of FGM was 1,812. The numbers of girls listed as speaking the 32 languages above is shown in Table 3 below:

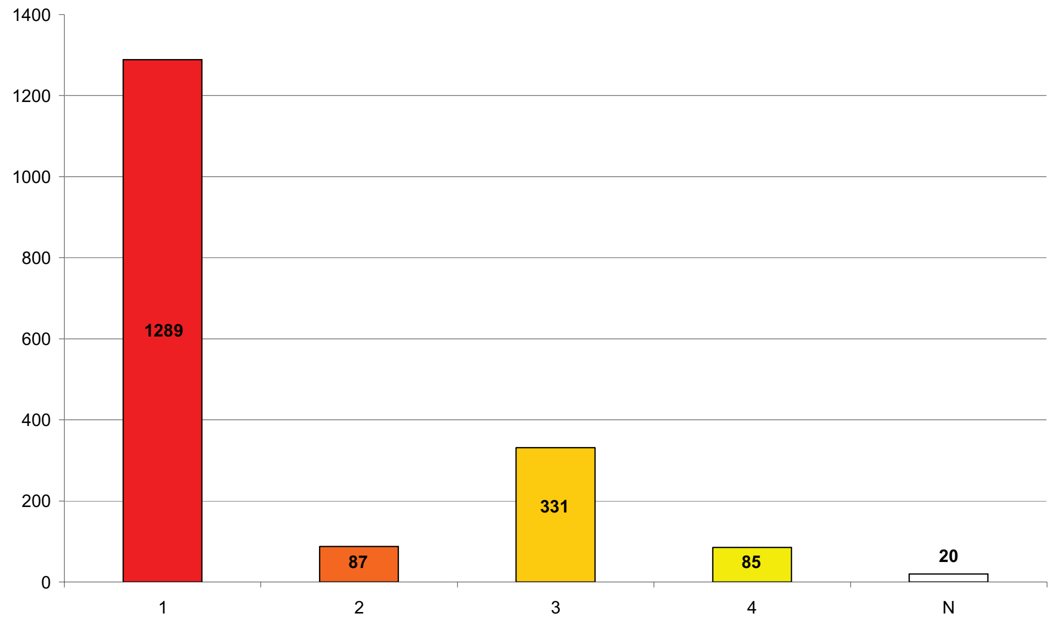
Table 3 – Numbers of Girls Speaking Each Language			
Language	**No. of Girls**	**Language**	**No. of Girls**
Afar-Saho	3	Krio	6
Akan/Twi-Fante	69	Kurdish	104
Amharic	85	Lingala	3
Arabic (Egypt)	19	Nigerian (lang not known)	30
Arabic (Iraq)	16	Nzema	1
Arabic (Sudan)	40	Oromo	2
Arabic (Yemen)	6	Pashto/Pakhto	2
Bambara	2	Somali	1092
Berber (Tamashek)	3	Swahili/Kiswahili	3
Ebira	5	Temne	1
Edo/Bini	8	Tigre	11
Efik-Ibibio	1	Tigrinya	112
Esan/Ishan	5	Urdu	2
Ewe	4	Urhobo-Isoko	4
Hausa	3	Wolof	1
Igbo	28	Yoruba	141
Grand Total			**1812**

4.5. By adapting the categories used in UNICEF's 2005 report, and FORWARD's 2007 report, this study designated 4 categories of FGM prevalence.

Table 4 – Categories of FGM Prevalence	
Category	**Description**
1 (Universal Prevalence)	85 – 100%
2 (High Prevalence)	75 – 84%
3 (Medium Prevalence)	25 – 74%
4 (Low Prevalence)	Under 25%

Table 4 shows the four categories and Chart A below shows the number of girls in Islington by Category, established using their language:

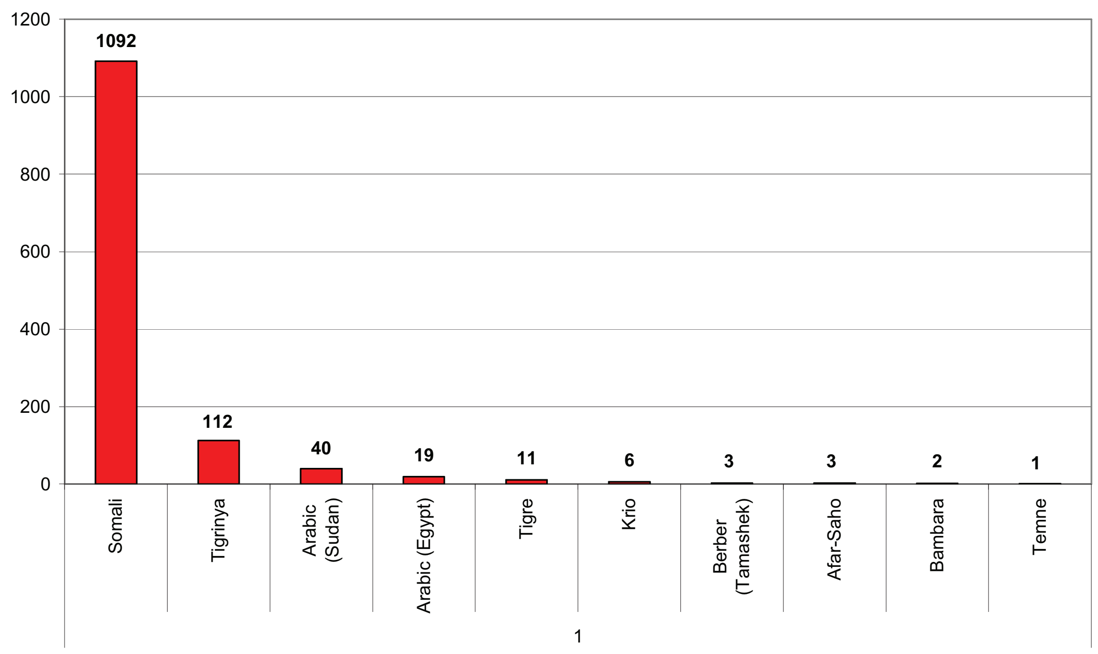
Chart A – Number of Girls by FGM Prevalence Category



4.6. As Chart A illustrates, the highest number of girls are in the highest risk categories; they are from FGM practising communities where there is a universal prevalence rate in countries of origin. ‘N’ represents the number of girls whose language indicates they are from a practising community but where prevalence is not known.

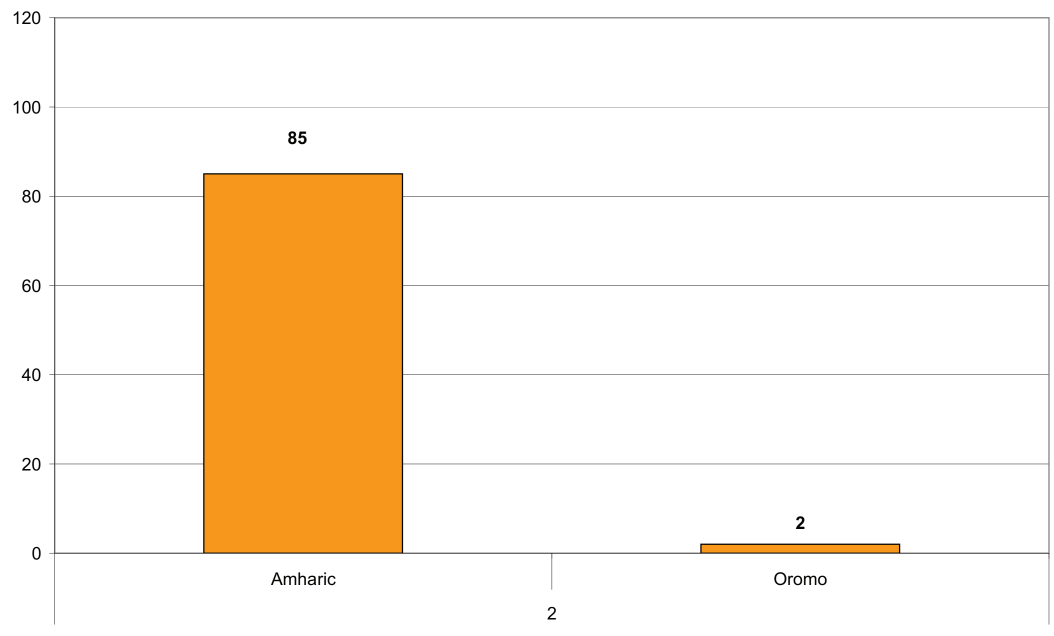
4.7. Charts B – F show a breakdown of the languages in each FGM prevalence category.

Chart B – Language Breakdown in Category 1



4.8. Chart B illustrates that Somali speakers make up a very large majority of those in the highest risk category where the FGM prevalence rate in country of origin is classed as universal.

Chart C – Language Breakdown in Category 2



4.9. Chart C shows just two languages; Amharic and Oromo, both primarily spoken in Ethiopia, a country with an FGM prevalence rate of just over 74%.

Chart D – Language Breakdown in Category 3

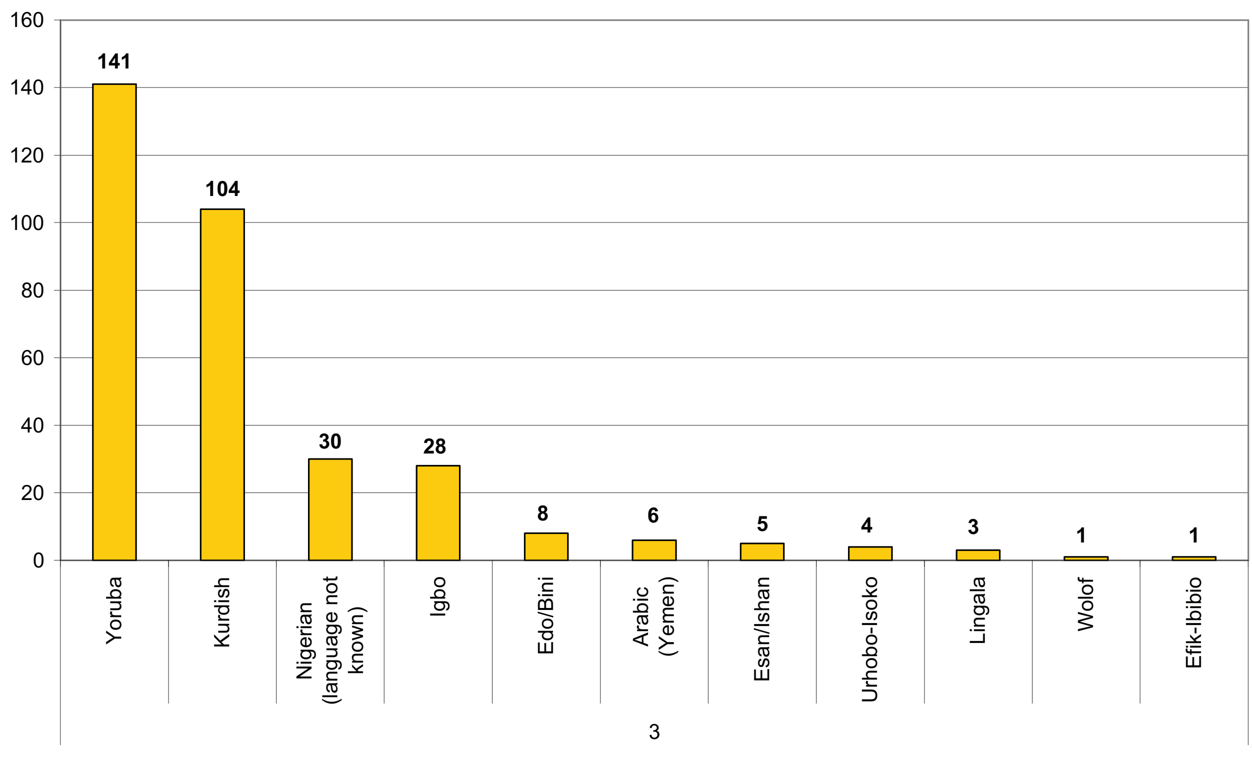
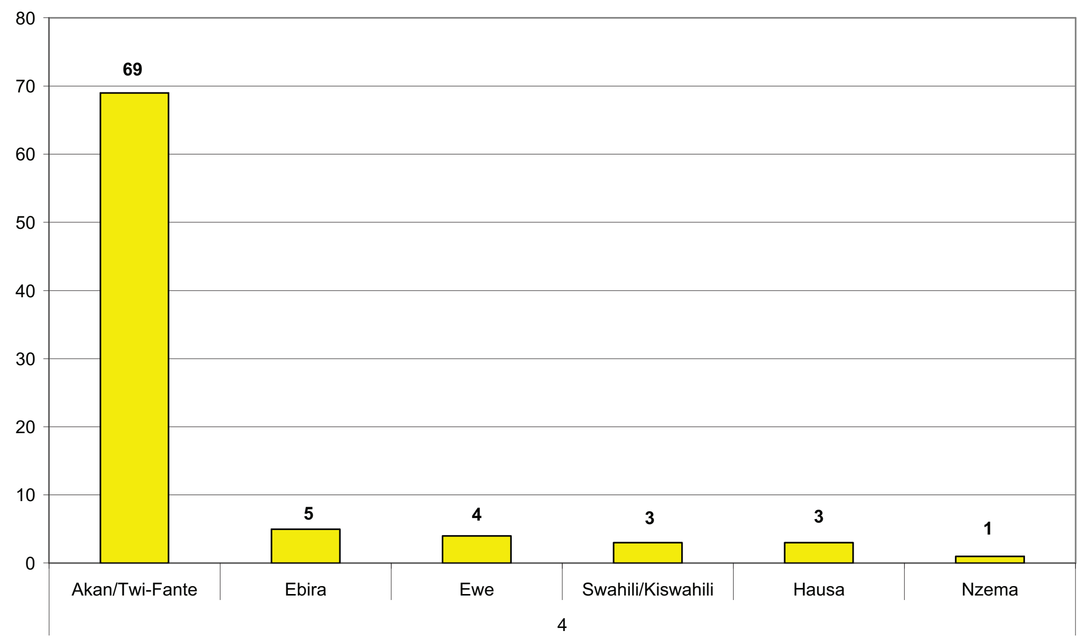


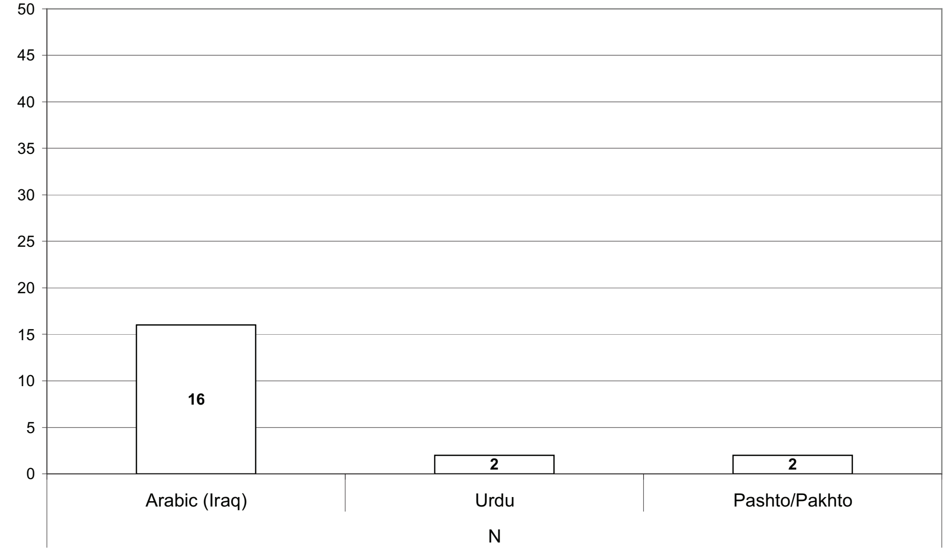
Chart E – Language Breakdown in Category 4



4.10. Charts D and E show the spread of languages across the medium and low prevalence categories. The most common being West African languages spoken in Nigeria (in Chart D) and Ghana (in Chart E), as well as Kurdish (Chart D).

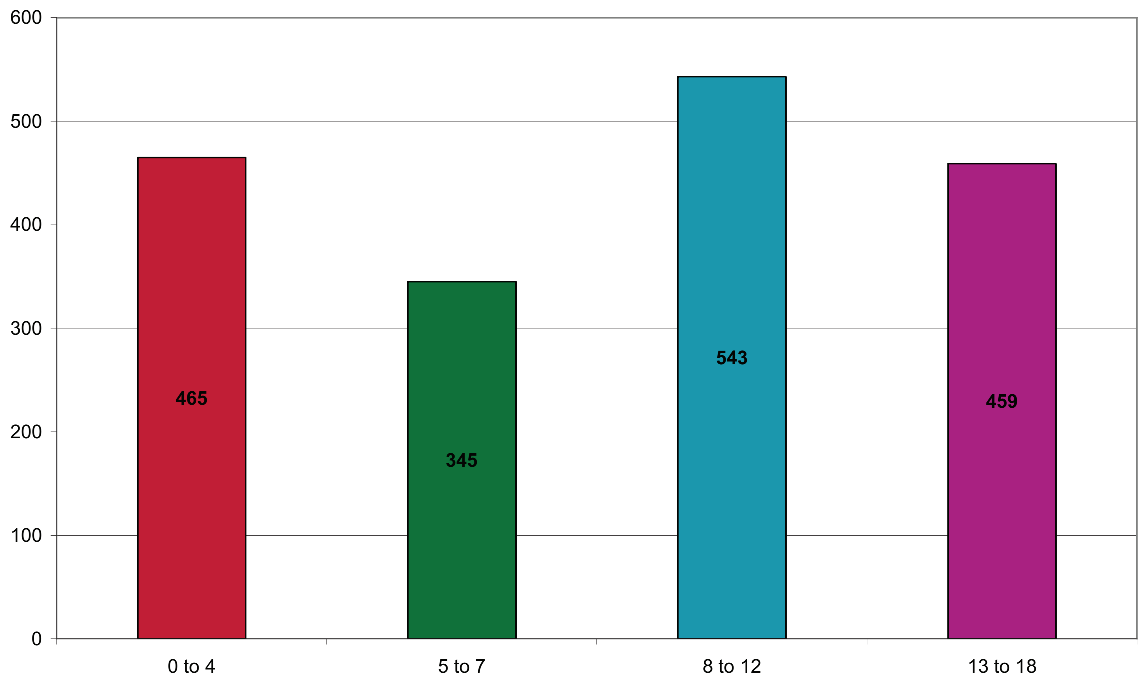
4.11. Chart F shows the number of girls speaking languages from communities where there is not enough information available to estimate prevalence rates. The numbers in this category are very low overall. Arabic speakers from Iraq are the majority, and although there has been one study looking at prevalence rates among Arab women in Kirkuk in Iraq, there is not enough evidence to estimate a prevalence rate for Arab speakers across Iraq.

Chart F – Language Breakdown where Prevalence is Not Known (N)



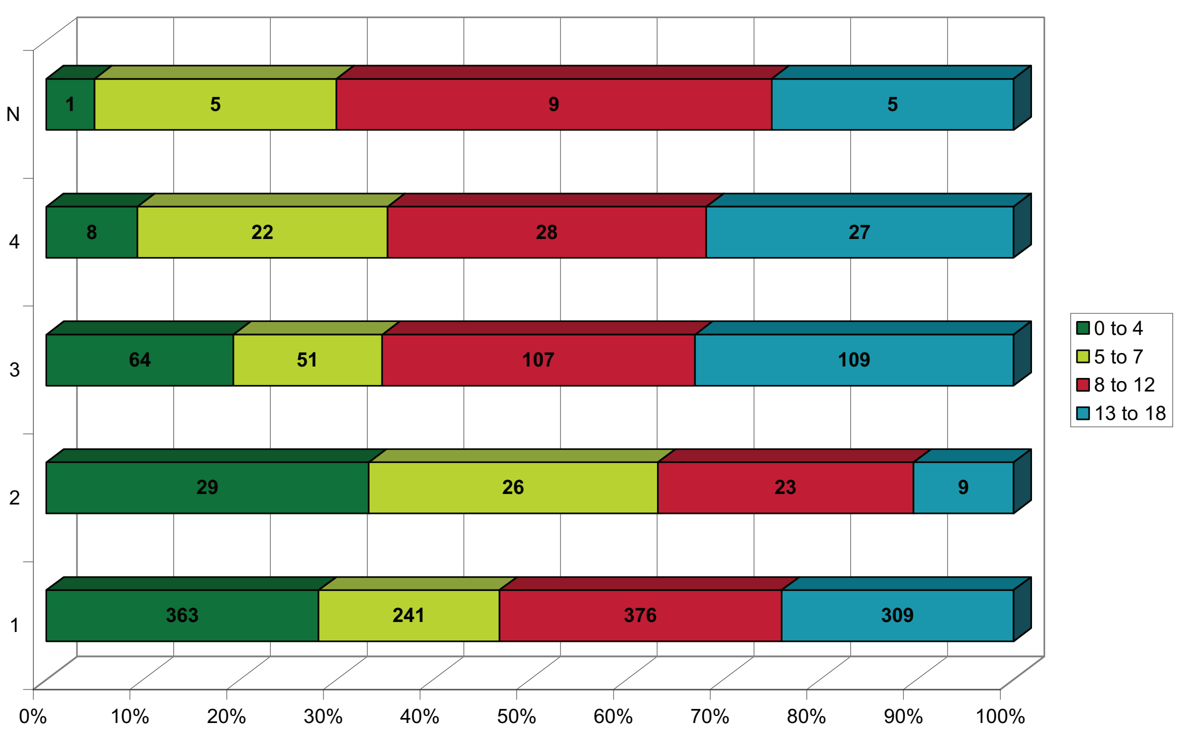
4.12. The ages of the girls identified are shown below in Chart G in four categories: 0-4, 5-7, 8-12 and 13-18. As the chart shows, there is reasonably even distribution across all the age groups.

Chart G – Age of Girls Identified



4.13. Chart H shows the percentage age breakdown for each FGM prevalence category.

Chart H – Age Breakdown by FGM Prevalence Category



4.14. The chart illustrates that the higher risk categories, 1 and 2 see a relatively even distribution across the age groups. Category 3 has a relatively high number of 13 – 18 year olds and Category 4 has a relatively low number of 0 – 4 year olds.

4.15. Categories 1 and 2 both have a significantly higher proportion of girls in the 0-7 group than categories 3 and 4 (47% and 63% as against 34% and 35%).

5. Discussion

5.1. The overall count indicates that we have 1,812 girls aged 0 – 18 in Islington who are potentially at risk of, or who will already have undergone, FGM. As discussed above, this is likely to be an underestimate as the data is reliant upon self reporting of language and ethnicity.

5.2. The Office for National Statistics mid year population estimates for 2010 estimate the 0 – 18 female population in Islington to be 17, 696. Therefore the numbers of girls identified in this study represent 10.2% of the 0-18 female population in Islington.

5.3. The study identified 1289 girls in the highest risk category for FGM; that is they come from backgrounds where the prevalence rate is effectively universal in their country of origin. This constitutes 7.3% of the 0-18 female population.

5.4. Even bearing in mind that there has been insufficient research into the impact of migration on the continuation of FGM, the extremely high prevalence rates in countries of origin should still be cause for concern.

5.5. Somali speakers constituted the highest number in the study, with 1092 girls identified. The most recent estimate of FGM prevalence in Somalia is 97.9%, the highest in the world. These girls are at the highest risk.

5.6. The finding in the study by Morison et al (2004) that 91% of young Somali women surveyed who had come to the UK older than age 11 had undergone FGM, perhaps suggests that age at time of migration could be considered as another risk factor in future research.

5.7. There were 20 girls identified as belonging to communities where FGM has been documented but where there is insufficient evidence to estimate prevalence. It is important that these communities are not overlooked when considering risks around FGM locally.

5.8. The age breakdown revealed that a significant proportion of the girls in the two highest risk categories were 7 and under. This has implications for what support or interventions are most appropriate when we consider that the most likely age when FGM will be performed is 5 – 9.

6. Conclusions and Recommendations

6.1. The conclusion of this research is that there is a risk to girls in Islington around FGM. 1 in 10 girls aged 0-18 in Islington come from a background where FGM is practiced, and over 70% of these are girls from backgrounds where levels of FGM practice are near universal.

6.2. There are pockets of good practice in Islington, including a number of community groups that provide support and advocacy in relation to FGM, and a specialist midwife at the Whittington hospital who has expertise in FGM and in conducting the necessary operation to reverse type iii.

6.3. This work forms a crucial part of the response to FGM locally, but there is currently no co-ordinated response to FGM across the borough. The nature of the issue requires that there be a joined up response from health (including mental health), education, social care (because FGM is a safeguarding issue), the police, the local authority and the voluntary and community sector.

6.4. The basis for this multi-agency response can be found in the Government's *Multi-Agency Practice Guidelines: Female Genital Mutilation* (2011) published last year. Below are some recommendations for action we can take around FGM locally. More detail on the implementation of these recommendations can be found in the agency-specific chapters of the Guidelines.

6.5. Further research could focus on identifying whether there are particular locations in the borough where there are concentrations of populations with high FGM prevalence to allow targeting of resources.

6.6. This study has focused on 0 – 18 year old girls but further statistical analysis could try and identify numbers of adult women from FGM practising communities who may require support around FGM. The publication of data from the 2011 Census may assist with this.

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July 2012

For more information about this study please contact: **Katie Furniss, Violence Against Women and Girls Project Officer.**
Tel: 020 7527 8682
Email: katie.furniss@islington.gov.uk

STONEBRIDGE SCHOOL
SAFE GUARDING POLICY
January 2014

SAFEGUARDING POLICY

STONEBRIDGE SCHOOL 2014

Agreed by Governors: January 2014
Agreed by Staff: January 2014

The policy is to be reviewed: SPRING 2017

INTRODUCTION

The governors and staff of Stonebridge School fully recognise the contribution they make to the safeguarding of children. We recognise that all staff, teaching and non-teaching, including volunteers, have a full and active part to play in protecting our pupils from harm[1].

All staff and Governors believe that our school should provide a caring, positive, safe and stimulating environment which promotes the social, physical, emotional and moral development of the individual child.

The aims of this policy are:

- To support the child's development in ways that will foster security, confidence and independence
- To raise the awareness of both teaching and non-teaching staff of the need to safeguard children and of their responsibilities in identifying and reporting possible cases of abuse.
- To provide a systematic means of monitoring children known or thought to be at risk of harm.
- To emphasise the need for good levels of communication between all members of staff.
- To develop a structured procedure within the school to be followed by all members of the school community in cases of suspected abuse.
- To develop and promote effective working relationships with other agencies, especially Social Services and the police.
- To ensure that all adults who work within the school environment have carried out a full and current DBS check in order that their suitability is checked.
- To ensure all members of the school community are treated with dignity and respect.

[1] HARM should be read with reference to any kind of physical, sexual, emotional abuse or any kind of neglect.

PROCEDURES

Our school procedures for safeguarding children will be in line with LA and LSCB procedures (Local Safeguarding Children's Board). We will ensure that:

- The HT and Assistant Head Teacher with responsibility for Inclusion, will act as the Designated Teachers for Child Protection at Stonebridge School. They will both undertake regular training.

- There is a senior member of staff who will act in the designated teachers' absence, the Deputy Head, who will also receive appropriate training.

- The Designated Teachers for Child Protection will be the first person to be approached in the light of any concerns, allegations or disclosures.

- Both DTCP will update the Child Protection record and share information. Cases will be allocated for one DTCP to take a lead on but regular meetings will take place to review progress and to offer supervision to each other.

- The DTCP will meet each term to monitor the update of the Child Protection record for the school to ensure it is an accurate and up to date record. Cases at this point may also be reallocated.

- All members of staff are familiar with the categories and definitions used when referring to Child Protection. (See Appendix 1 - 4)

- All members of staff develop their understanding of the signs and indicators of abuse. (See Appendix 1 - 4)

- All members of staff know how to respond to a pupil who discloses abuse. They will ensure that time is given to the child in order that they can fully concentrate on the child's disclosure and that this time is found as a matter of urgency. This information will then be passed on via the Child Protection Report form (see Appendix 5) and / or by speaking to a Designated Teacher for Child Protection – forms will be given to the Head Teacher PA.

- The Designated Teachers for Child Protection will ensure that the correct Child Protection forms for monitoring, recording and reporting to formal settings are made available to staff. Staff will ensure that these forms are kept confidentially, kept up to date and completed in line with deadlines. (See Appendix 5 -9 for copies of these forms)

- Safeguarding and Child Protection will be included in all staff handbooks and group training and professional meetings throughout the academic year.

- All parents/carers are made aware of the responsibilities of staff members with regard to child protection procedures. A Child Protection statement will be included in all school parent hand books.

- Our procedures will be regularly reviewed and up-dated following a three year cycle outlined at the end of this policy.

- All new members of staff will be given a copy of our Safeguarding Policy as part of their induction into the school.

- Training undertaken by the designated teachers for child protection and staff will be documented and filed.

CHILD PROTECTION & SUPPORTING CHILDREN

We recognise that the school has a role to play in supporting children who are experiencing great challenges in their lives. We also recognise that these challenges may be of a child protection nature. We acknowledge that the school may provide the only stability in the lives of children who have been abused or who are at risk of harm. We recognise that the school should fully understand how being a victim of abuse can manifest itself in numerous ways. We recognise that the school must endeavour to put in place systems and training in order that all members of staff can act appropriately. Children will always be given time and privacy to talk to a member of staff in order to discuss issues that are affecting them or worrying them.

We appreciate that a child who is abused or witnesses violence may find it difficult to develop and maintain a sense of self worth. We understand that a child in these circumstances may feel helpless, humiliated and may feel self blame.

We accept that research shows that the behaviour of a child in these circumstances may range from that which is perceived to be normal to aggressive or withdrawn.

Our school will therefore support all pupils by:

- Encouraging self-esteem and self-assertiveness whilst not condoning aggression or bullying – PSHE , Circle Time, Comments Box, Article 12, Inclusion officer support, Lunchtime Clubs, Art Therapists and Place 2 Be (where appropriate)
- Promoting a caring, safe and positive environment within the school – Class Rights and Responsibilities, School Core Values, Year Group assemblies, and School Collective Worship, PSHE, Circle Time
- Offering the support of Place 2 Be counsellors at the school and by working closely with the School Project Manager.
- Holding regular Inclusion meetings with key school based professionals – every half a term.
- Liaising and working together with all other support services and those agencies involved in the safeguarding of children.
- Notifying Social Services as soon as there is a significant concern.
- Providing continuing support to a pupil about whom there have been concerns when moving from one class teacher to another or who leaves the school by ensuring that appropriate information is forwarded under confidential cover.
- Ensuring that children who are at risk are closely monitored.
- Ensuring that monitoring procedures are up to date and regularly reviewed.
- Children will be given time & privacy should they wish to talk to an adult.

RESPONSIBILITIES

The designated teacher for child protection is responsible for:

- Adhering to the LSCB (Local Safeguarding Children Board), LA and school procedures with regard to referring a child if there are concerns about possible abuse.

- Keeping written records of concerns about a child even if there is no need to make an immediate referral.

- Ensuring that ongoing monitoring of children is kept up to date.

- Ensuring that action points agreed at Child Protection Conferences, Child Protection Reviews and Core Group Meetings are carried out. (see record sheet Appendix 10)

- Ensuring that accurate and up to date information about individual children is presented at Child Protection Conferences.

- Ensuring that all such records are kept confidentially and securely and are separate from pupil records.

- Ensuring that an indication of further record-keeping is marked on the pupil's general records and that all records are passed on to their next school.

- Ensuring that any pupil currently with a Child Protection plan who is absent without explanation for two days is referred to their key worker at Social Services and that the attendance of children with a Child in Need Plan (CIN) is monitored closely and any concerns referred to their key social worker.

<u>TYPES OF ABUSE (See appendix 1 – 6) for definitions and signs.</u>

There are four main types of abuse and these are:

- Physical abuse including FGM (Female Genital Mutilation)
- Emotional abuse including domestic violence
- Sexual abuse
- Neglect

Physical Abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after. This situation is commonly described using terms such as factitious illness by proxy or Uncaused syndrome by proxy and cutting (including female genitalia).

Physical Abuse Continued - Female Genital Mutilation (FGM)

FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health

consequences, both at the time when the mutilation is carried out and in later life. It is acknowledged that some FGM practising families do not see it as an act of abuse, however it is illegal in the UK and suspicions of FGM having already taken place or knowledge of girls at risk must be reported. It is also against the law to groom or prepare a girl to have any type of FGM. FGM is known by a number of names, including ‘female genital cutting’, ‘the cut’, ‘circumcision’ or ‘initiation’. The age at which girls undergo FGM varies enormously according to the community. **The procedure may be carried out when the girl is new-born, during childhood or adolescence, just before marriage or during the first pregnancy.** However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 years old and therefore girls within that age bracket are at a higher risk. FGM is a deeply rooted tradition, widely practised mainly among specific ethnic populations in Africa and parts of the Middle East and Asia. FGM has also been documented in communities in **Iraq, Israel, Oman, the United Arab Emirates, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan**.

Emotional abuse

Emotional abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill-treatment of a child, though it may occur alone. Emotional abuse also happens when a child is subjected to witnessing domestic abuse between both or one of his/her parents.

Domestic Abuse - Emotional abuse continued

Domestic abuse is any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. A child who is subjected to domestic abuse either through directly observing it or is exposed to its effects is emotionally scarred and is under a lot of stress. Domestic Abuse chips away at feelings of self-worth and independence. Domestic abuse can also include *verbal abuse* such as yelling, name-calling, blaming, and shaming. It can also include controlling behaviours like financial control, Isolation and intimidation, these are all aspects of emotional abuse. The physical, psychological and emotional effects of domestic abuse on children can be severe and long-lasting. Some children become withdrawn and find it difficult to communicate, others may act out the violence or aggression they have witnessed, or blame themselves for the abuse. All children living with abuse are under a great deal of stress and need support.

Sexual abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Neglect
Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

CONFIDENTIALITY

- We recognise that all matters relating to Child Protection are of a Confidential nature and should be treated as such.

- The Designated Teachers will disclose information about a pupil to the key member of staff on a Need to know basis only. This information will only be passed on to relevant members of staff by the Key member if and when it is required.

- All staff must be aware that they have a professional responsibility to share information with other agencies in order to safeguard children.

- All staff must be aware that they cannot and must not promise a child to keep a secret.

SUPPORTING STAFF

We recognise that staff working in the school who have become involved with a child who has suffered harm, or appears to be likely to suffer harm may find the situation stressful and upsetting. We will support such staff by providing an opportunity to talk through their anxieties with a designated teacher and to seek further support as appropriate. The Designated Teachers for CP act as each other's supervision support. All members of staff can approach Place to Be for this support if required.

ALLEGATIONS AGAINST STAFF

We understand that a pupil may make an allegation against a member of staff.
If such an allegation is made the following action will be taken:

- The member of staff receiving the allegation will immediately inform the Head Teacher / Deputy Head Teacher and not enter into a dialogue.
- The head teacher on all such occasions will discuss the content of the allegation with the LA Lead Officer for Child Protection (LADO).
- If the allegation made to a member of staff concerns the Head teacher, the designated teacher / deputy will immediately inform the Chair of Governors who will consult with the LAs Lead Officer for Child Protection (LADO).
- The school will follow the LEA procedures for managing allegations against staff, a copy of which will be readily available in the school.

WHISTLE BLOWING

We recognise that children cannot be expected to raise concerns in an environment where the staff fail to do so. All staff should be aware of their duty to raise concerns, where they exist, about the attitude or actions of colleagues. These concerns should be brought to the attention of the Head Teacher or Deputy Head Teacher.

PHYSICAL INTERVENTION

We acknowledge that staff must only ever use physical intervention as a last resort and at all times be the minimal force necessary to prevent injury to another person. We understand that physical intervention of a nature which causes injury or distress to a child may very well be considered under child protection or disciplinary procedures. The school follows the LSCB guidelines on the use of restraint and is covered in the school Restraint Policy.

SAFEGUARDING CHILDREN

BULLYING

Our policy on bullying is set out in our school Anti – Bullying Policy and Behaviour Policy. We acknowledge that to allow or condone bullying may lead to consideration under child protection procedures.

RACIST INCIDENTS

Our policy on racist incidents is set out in a separate policy. It acknowledges that a single serious incident, repeated racist incidents or to allow or condone racism may lead to consideration under child protection procedures.

PREVENTION

We recognise that the school plays a significant part in the prevention of harm to our pupils by providing pupils with good lines of communication with trusted adults, supportive friends and an ethos of protection.

The school community will therefore:

- Establish and maintain an ethos where children feel secure, are encouraged to talk and are always listened to – Article 12 Group, Circle Time, Lunchtime Clubs, Art Therapy Support and Place to Be.
- Ensure that all children know there is an adult in the school whom they can approach if they are worried or in difficulty.
- Include in the curriculum opportunities for PSHE which equip children with the skills they need to stay safe from harm and to know to whom they should turn for help – Curriculum Map for PSHE across the school.
- The school also has an E-safety policy which emphasises how children can be safe when using the Internet. Staff are trained and themes of e-safety are looked at through the curriculum and assemblies throughout the year.
- The school monitors attendance and punctuality rigorously and any concerns are followed up with an initial letter from the head teacher and

persistent absences are referred to the Educational Welfare Officer (EWO).

Outside agencies – working in partnership

- The school works very closely with outside agencies to support children and families. This includes health services, speech and language therapist, social care and the Educational Welfare Officer (EWO).

Safer Recruitment

- The school is committed to safer recruitment and ensures that members of staff have DBS and this is updated every 4 years as agreed by governors.
- The school holds a single Central Record with relevant data for all members of staff.

HEALTH AND SAFETY

Our Health & Safety policy and our Educational Visits Policy is set out in separate documents. They reflect the consideration we give to the protection of our children both within the school environment and when undertaking school trips and visits away from the school environment.

Accidents and Welfare

- If an accident occurs, the child/ren are sent to the medical room. The Welfare officer then judges whether any medical attention is required. In cases when children are medically attended to, a letter is sent home to the parents and a copy of a HSL is kept on file. There is also a list of children who visit the medical room. The welfare officer is first aid trained as well as a number of other adults in various classes in the school. Where a child requires medication regularly, a meeting is held with the welfare officer and parent/carer and a plan is set out, outlining the frequency of the medication and dosage. The parent also signs a letter to consent that the welfare officer can administer the medication.

Intimate Care

- Intimate care is any care which involves carrying out an invasive procedure (such as cleaning up a pupil after they have soiled themselves) to intimate personal areas. The school is committed to ensuring that all staff responsible for intimate care of children will undertake their duties in a professional manner at all times. Please see Intimate Care Policy for more details.

Site Safeguarding

- The school safe guards the site in a variety of ways. All entrances to the school building are secure. Access to the school site is via the main office and all visitors are expected to sign in and wear a visitor's badge. All members of the school have a fob and an identification badge which has their name and role. A weekly survey is carried out by the site manager and the fire alarm is tested on a weekly basis as well. On-going issues are raised by staff and these are put on the school's intranet for the site staff to deal with. These are monitored regularly and actions and outcomes are written in response to issues.

Fire Drills

- Fire drills are carried out half termly and the findings are reported to the governors and actions are written and followed up by site staff.

Inappropriate Behaviour

- The school expects all the school community to adhere to the schools core values of Consideration, Positive Attitude and Respect. Where any visitor is causing harassment, anxiety and distress, (HAD) the school will record such incidents and further action such as a ban from the school premises may be enforced.

APPENDICES

- **APPENDIX 1 – Definition & Signs – Physical Abuse (including FGM)**
- **APPENDIX 2 – Definition & Signs – Emotional Abuse (including Domestic abuse)**
- **APPENDIX 3 – Definition & Signs – Sexual Abuse**
- **APPENDIX 4 – Definition & Signs – Neglect**
- **APPENDIX 5 – Child Protection Report Form**
- **APPENDIX 6 – Every Child Matters (ECM) Summary of Needs**
- **APPENDIX 7 – Individual Child Protection Record Sheet**
- **APPENDIX 8 – Stonebridge Welfare Check/Core Group Record Sheet**
- **APPENDIX 9 – Confidential Incident Record Sheet**
- **APPENDIX 10 – Confidential Meeting Record Sheet**
- **APPENDIX 11 – Record of CP Meeting & Action Form**

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF ABUSE?

PHYSICAL ABUSE

DEFINITION:
Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after. This situation is commonly described using terms such as factitious illness by proxy or Uncaused syndrome by proxy.

SIGNS:

- Marks and Bruises
- Suspicious stories about how marks made
- Frequent bumps etc
- Broken Bones
- Frightened / nervous at simple movements / jumpy
- Jumping when adult raises voice
- Introverted, shy or withdrawn
- Tearful
- Poor behaviour / Bullying others
- Repeating inappropriate behaviour/ bullying
- Violent outbursts
- Hair missing
- Scratches / burns
- Stories include violent descriptions / pictures depict regularly violent scenarios
- Hitting or aggressive to other children
- Sleeping in class
- Self conscious when changing for PE
- Restless and fidgety
- Wetting / soiling them self
- Mood swings
- Little contact with other children
- Poor attendance
- Use of bad language
- Physically threatening behaviour
- Shouting

(STONEBRIDGE CPD 16/12/13)

Additional signs:
CONSTANT INJURIES THAT CAN ALWAYS BE EXPLAINED / CHANGE OF MOOD / WITHDRAWN OR AGGRESSIVE / CHANGE OF CHARACTER OR BEHAVIOUR / SELF COMFORT / VERBAL ABUSE / NON-COOPERATION / POOR HEALTH / UNKEPT / FEAR OF ADULTS / ABSENCES / STRANGE BEHAVIOUR AFTER WEEKENDS OR HOLIDAYS / FORGOTTEN PE KIT / FLINCHING IN RESPONSE TO SUDDEN MOVEMENTS / FREQUENT MEDICAL APPOINTMENTS / DO NOT WANT TO GO HOME AT THE END OF THE DAY / UNABLE TO FORM RELATIONSHIPS WITH ADULTS / SELF PROTECTION / GUARDING / LACK OF EYE CONTACT / CONSTANTLY ILL WITH NO REAL SYMPTOMS / FEARFUL OF ADULTS

FEMALE GENITAL MUTILATION (FGM) IS PHYSICAL ABUSE

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF FGM?

DEFINITION:
FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. FGM is against the law except when performed by a registered medical profession on medical or mental health grounds. It is also illegal for someone to arrange for a child to go abroad with the intention of having her circumcised.

SIGNS

- Difficulty walking, sitting or standing
- Spending longer than normal in the bathroom or toilet due to difficulties urinating.
- Fracture or dislocation of legs/arms as a result of restraint
- Spend long periods of time away from a classroom during the day with bladder or menstrual problems
- Severe pain in groin area
- Haemorrhage
- Being withdrawn - emotional and psychological shock (exacerbated by having to reconcile being subjected to the trauma by loving parents, extended family and friends);
- Urinary infections
- Detached / isolated
- Change in physical appearance/dress & body language
- Withdrawn aggressive
- Unable to form relationships with adults
- Changes in attitude, personality or behaviour
- Changes in interaction with others
- Feelings shown through writing or art work
- Peer group problems
- Extremes of emotion
- Underachieving

(STONEBRIDGE CPD 16/12/13)

Any suspicions of a child at risk of having or having had FGM must be reported immediately to the Head teacher or Designated teacher for Safe guarding. Girls aged 5 to 8 years are most risk.

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF ABUSE?

EMOTIONAL ABUSE
DEFINITION: Emotional abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill-treatment of a child, though it may occur alone. Children witnessing domestic abuse between the parents or carers is also emotional abuse.
SIGNS: • Low self esteem • Withdrawn / frightened / shy • Secretive • Makes little eye contact • Emotionally finds it difficult to maintain relationships with peers and adults • Jumpy or stuttering during conversations with adults • Cries a lot / very sensitive • A Loner • Pictures use mainly dark colours • Stealing • Mood swings • Lack of concentration • Very quiet, speaks little • Poor social skills • Bullies others • Very unsettled • Anti-social behaviour • Lack of confidence (STONEBRIDGE CPD 16/12/13) Additional signs: WETTING / SOILING / SELF HARM / SELF COMFORT / ROCKING / CHANGE IN APPETITIE / UNDEACHIEVEMENT / TIMID / TEARFUL / ANOREXIC / BULIMIC / DO NOT WANT TO GO HOME AT THE END OF THE DAY / ATTENTION SEEKING / CHANGES IN STANDARD OF WORK / DEPRESSION / INTROVERTED / WITHDRAWN / CHANGES IN RELATIONSHIPS / NO FRIENDS / HARD TO MAKE FRIENDS / NEEDY / CLINGY / CHANGE IN PHYSICAL APPEARANCE/DRESS & BODY LANGUAGE / WITHDRAWN AGGRESSIVE / CHANGES IN ATTITUDE, PERSONALITY OR BEHAVIOUR / CHANGES IN INTERACTION WITH OTHERS / PEER GROUP PROBLEMS / EXTREEMS OF EMOTION / ALIEN TO PRAISE

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF DOMESTIC ABUSE?

DOMESTIC ABUSE IS EMOTIONAL ABUSE

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF DOMESTIC ABUSE?

DEFINITION: Domestic abuse is any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. A child who is subjected to domestic abuse either through directly observing it or is exposed to its effects is affected emotionally and is under a lot of stress.

SIGNS

- Disproportionate reactions (overly apprehensive, tearful, angry or fearful)
- Withdrawn or quiet
- Negative relationships with opposite sex (children and peers)
- Aggression or bullying
- Tantrums
- Vandalism
- Problems in school, truancy,
- Difficulty with speech problems that were not there before
- Difficulties with learning
- Attention needing
- Struggle to make or keep friendships
- Reluctance to come to school
- Reluctance to go home with parents
- Aggressive comments or language (sometimes not expected for that age)
- Self-harming
- Nightmares or insomnia
- Bed-wetting
- Anxiety, depression, fear of abandonment
- Feelings of inferiority
- Constant colds, headaches, mouth ulcers, asthma, eczema
- Seem afraid or anxious to please
- Need for constant acceptance
- Be possessive over friends or belongings

(STONEBRIDGE CPD 16/12/13)

Additional signs:

CHANGE OF MOOD / WITHDRAWN OR AGGRESSIVE / CHANGE OF CHARACTER OR BEHAVIOUR / SELF COMFORT / VERBAL ABUSE / NON-COOPERATION / / UNKEPT / FEAR OF ADULTS / ABSENCES / STRANGE BEHAVIOUR AFTER WEEKENDS OR HOLIDAYS /EXTREME RESONSES TO CORRECTION/ FLINCHING IN RESPONSE TO SUDDEN MOVEMENTS / FREQUENT MEDICAL APPOINTMENTS / DO NOT WANT TO GO HOME AT THE END OF THE DAY / UNABLE TO FORM RELATIONSHIPS WITH ADULTS / SELF PROTECTION / GUARDING / LACK OF EYE CONTACT / CONSTANTLY ILL WITH NO REAL SYMPTOMS / FEARFUL OF ADULTS

APPENDIX 3

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF ABUSE?

SEXUAL ABUSE

DEFINITION:

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

SIGNS:

- Hides under clothes / baggy clothes
- Inappropriate physical contact with other chn
- Withdrawn / shy
- Aggressive to chn of the opposite sex
- Scared of others
- Don't like being touched
- Touch themselves or others
- Won't change for PE
- Very quiet or loud
- Use of sexual language
- Stories or drawings include sexual connotations
- Exposing self
- Hesitate when wanting to talk to teacher
- Soiling/ wetting / stains on underwear
- Repeated Urine problems
- Re-enacting sexualised behaviour as part of play
- Bruising
- Sexually specific behaviour or / and language
- Abusive to other chn
- Little physical contact, finds hugs touches difficult will move away.

(STONEBRIDGE CPD 16/12/13)

Additional signs:

SEXUAL PLAY – HOME CORNER / PLAYGROUND / INAPPROPRIATE / PROVOCATIVE SEXUAL LANGAUGE / MEDICAL DIFFICULTIES / CHANGE OF MOOD / WITHDRAWN OR AGGRESSIVE / CHANGE OF CHARACTER OR BEHAVIOUR / MASTERBATION / ANOREXIC / BULIMIC / SELF HARMING / DO NOT WANT TO GO HOME AT THE END OF THE DAY / SECRETIVE / WITHDRAWN / CHANGE IN PHYSICAL APPEARANCE/DRESS & BODY LANGUAGE / UNABLE TO FORM RELATIONSHIPS WITH ADULTS

WHAT SIGNS MAY A CHILD EXHIBIT IF THEY ARE A VICTIM OF NEGLECT?

NEGLECT

DEFINITION:

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

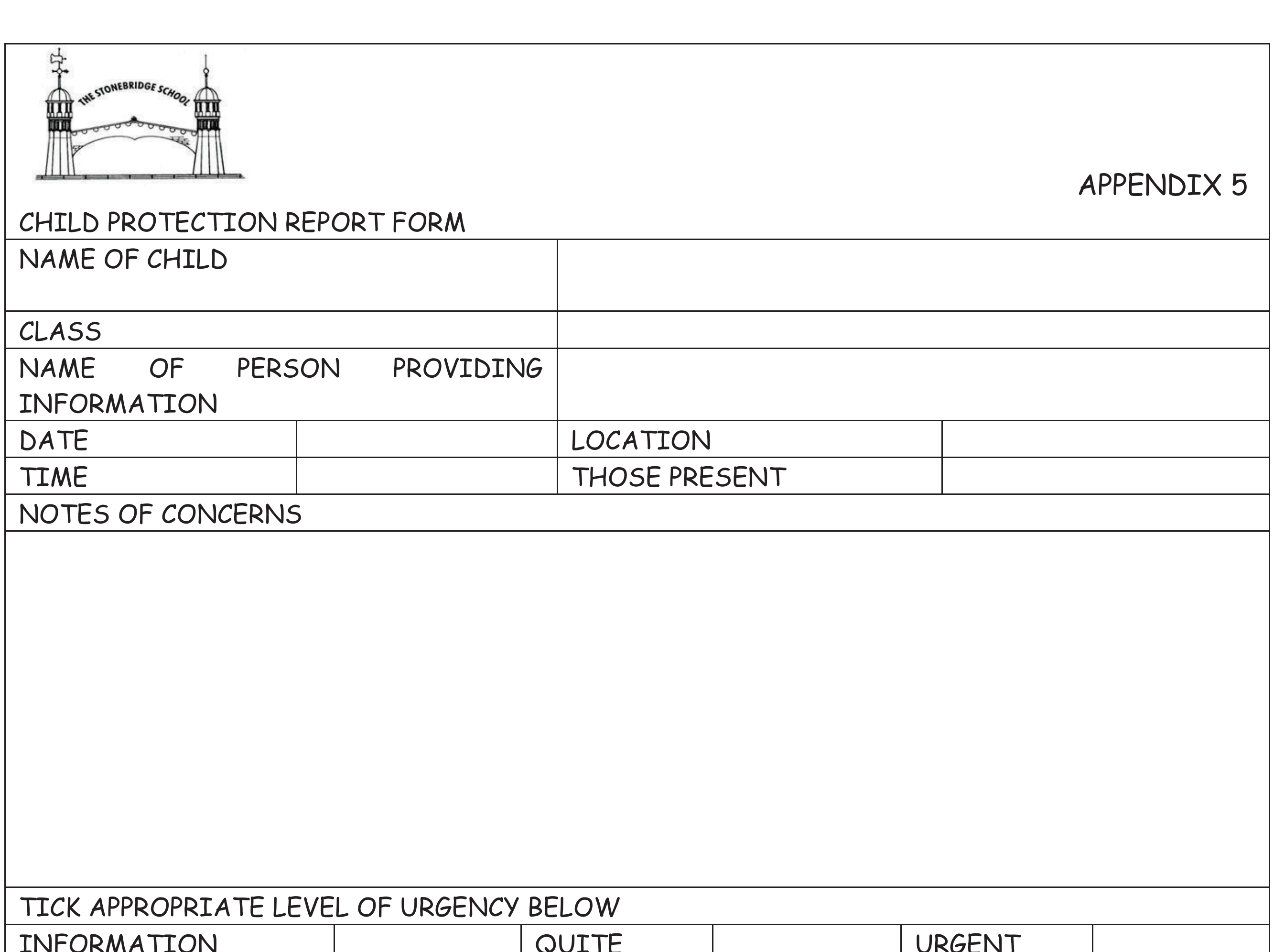
SIGNS:

- Child smells, clothes are dirty, hair un brushed
- Appears unhealthy but is always in school when unwell
- Low attendance – EWO involvement
- No Breakfast
- Is unfamiliar with basic routines of feeding self and toileting etc
- Always hungry
- Late before and after school
- Attention seeking / needs praise to feel confident
- Poor hygiene, does not know how to use toilet properly
- Angry
- Parents have little contact with school. Do not attend parents evening
- Homework not completed / PE kit repeatedly forgotten
- Correct clothes not worn to school i.e. not warm enough in winter, not cool enough in summer
- Steal things
- Come to school on their own when they are too young
- Lying
- Older siblings care for younger chn and take on the parent role.
- Cries a lot
- Makes slow progress
- Packed lunch does not provide child with a balanced diet
- Over eats at lunchtime
- Untidy / unkempt
- Parents do not follow up medical requests form school i.e. need for eyes to be tested.
- Instability in family, different carers/ boyfriends
- Sleeps in class / Goes to sleep late little routine at home

(STONEBRIDGE CPD 16/12/13)

Additional signs:

INADEQUATE PACKED LUNCH / UNKEMPT / CRUFFY / SLEEPING DURING LESSONS / OVERLY TIRED / REPEATED HEALTH PROBLEMS THAT GO UNCHEACKED OR ARE NOT DEALT WITH / HEADLICS / RINGWORM NOT DEALT WITH AND CONSTANTLY REOCCUR /DISORGANISED / ATTENDANCE / PUNCTUALITY (END & BEGINNING OF DAY) / DO NOT WANT TO GO HOME AT THE END OF THE DAY / OVERWEIGHT / UNABLE TO FORM RELATIONSHIPS WITH ADULT / CONTENT OF WRITING OR DRAWING / UNDERACHIEVING



APPENDIX 5

CHILD PROTECTION REPORT FORM

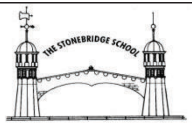
NAME OF CHILD			
CLASS			
NAME OF PERSON PROVIDING INFORMATION			
DATE		LOCATION	
TIME		THOSE PRESENT	
NOTES OF CONCERNS			
TICK APPROPRIATE LEVEL OF URGENCY BELOW			

INFORMATION		QUITE URGENT		URGENT	

CHILD PROTECTION REPORT FORM

NAME OF CHILD			
CLASS			
NAME OF PERSON PROVIDING INFORMATION			
DATE		LOCATION	
TIME		THOSE PRESENT	
NOTES OF CONCERNS			
TICK APPROPRIATE LEVEL OF URGENCY BELOW			

INFORMATION		QUITE URGENT		URGENT	



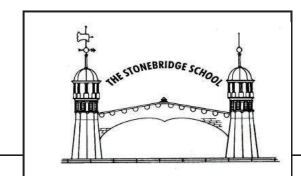
APPENDIX 6

EVERY CHILD MATTERS SUMMARY OF NEEDS	
Name of Child:	
Year Group:	Date:
Purpose of Summary:	
BE HEALTHY	
STAY SAFE	
ENJOY & ACHIEVE	
MAKE A POSITIVE CONTRIBUTION	
ECONOMIC WELLBEING	
Signature and Role of Person filling in form:	

APPENDIX 7

CHILD PROTECTION RECORD – CLASS TEACHER NAME OF CHILD : START DATE :	
DATE	**COMMENT / OBSERVATION**

APPENDIX 8



STONEBRIDGE SCHOOL
Shakespeare Avenue
Harlesden
London NW10 8NG
Tel: 020 8965 6965

Fax: 020 8838 0784

STONEBRIDGE SCHOOL WELFARE CHECK / CORE GROUP			
NAME OF CHILD			
DATE OF BIRTH		YEAR GROUP	
ADDRESS			
INFORMATION REQUESTED BY			
DATE			
ACADEMIC PROGRESS AND ACHIEVEMENT			
BEHAVIOUR AND SOCIAL RELATIONSHIPS			
ATTENDANCE & PUNCTUALITY			
CONTACT WITH PARENTS / CARERS			
ANY SPECIFIC INCIDENTS OR MATTERS OF CONCERN			
ADDITIONAL INFORMATION REQUIRED			
CLASS TEACHER SIGNATURE		DATE	
DTCP SIGNATURE		DATE	

APPENDIX 9

CONFIDENTIAL

Incident Sheet

Name of Child ___________________________ Date of Birth ___________

Chronology of incidents and concerns

Date	Time	Location	Those Present

Notes of incidents / allegations or observation giving rise to concern.

Name ____

Designation _____________________________________

Signature _______________________________________

Date ____

Date received by designated teacher for inclusion in the Child Protection File _________

APPENDIX 10

CONFIDENTIAL

Meeting Record Sheet

Present: ______________________________ Date ____________________

Name of Child ___________________________ Date of Birth ____________

General outline of Concerns

Issues discussed and action agreed:

Name ____

Designation ____________________________________

Signature ______________________________________

Date ____

Date received by designated teacher for inclusion in the Child Protection File __________

APPENDIX 11

RECORD OF CHILD PROTECTION MEETING & ACTION	
Name of Child:	
Year Group:	Date:
Purpose of Meeting:	
Those present:	
NOTES	
ACTION & BY WHOM	WHEN COMPLETED
Signature and Role of Person filling in form:	