Department of Health

Female Genital Mutilation Risk and Safeguarding

Guidance for professionals

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Department of Health

Female Genital Mutilation Risk and Safeguarding

Guidance for professionals

Prepared by FGM Prevention programme team, Department of Health

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Chapter 1. Safeguarding against FGM

Safeguarding against FGM

FGM is not an issue that can be decided on by personal preference – it is an illegal, extremely harmful practice and a form of child abuse and violence against women and girls.

Each NHS organisation will have local safeguarding protocols and procedures for helping children and young people who are at risk of or facing abuse. These should include multi-agency policies and procedures, consistent with those developed by their Local Safeguarding Children Board. If organisations have not already done so, these should be reviewed to include handling cases where FGM is alleged or known about, or where there is a potential risk of FGM identified. As FGM is a form of child abuse, professionals have a statutory obligation under national safeguarding protocols (e.g. Working Together to Safeguard Children 2013) to protect girls and women at risk of FGM. These policies and procedures should consider the characteristics around FGM, ensuring that the response to FGM includes the sharing of information with multi-agency partners throughout the girl's childhood, and that if, or when, the risk facing the girl changes (which may mean it escalates or even becomes less immediate), this is identified and consideration is given as to whether or not a change in subsequent safeguarding actions are required. It must always be remembered that fears of being branded 'racist' or 'discriminatory' must never weaken the protection that professionals are obliged to provide to protect vulnerable girls and women.

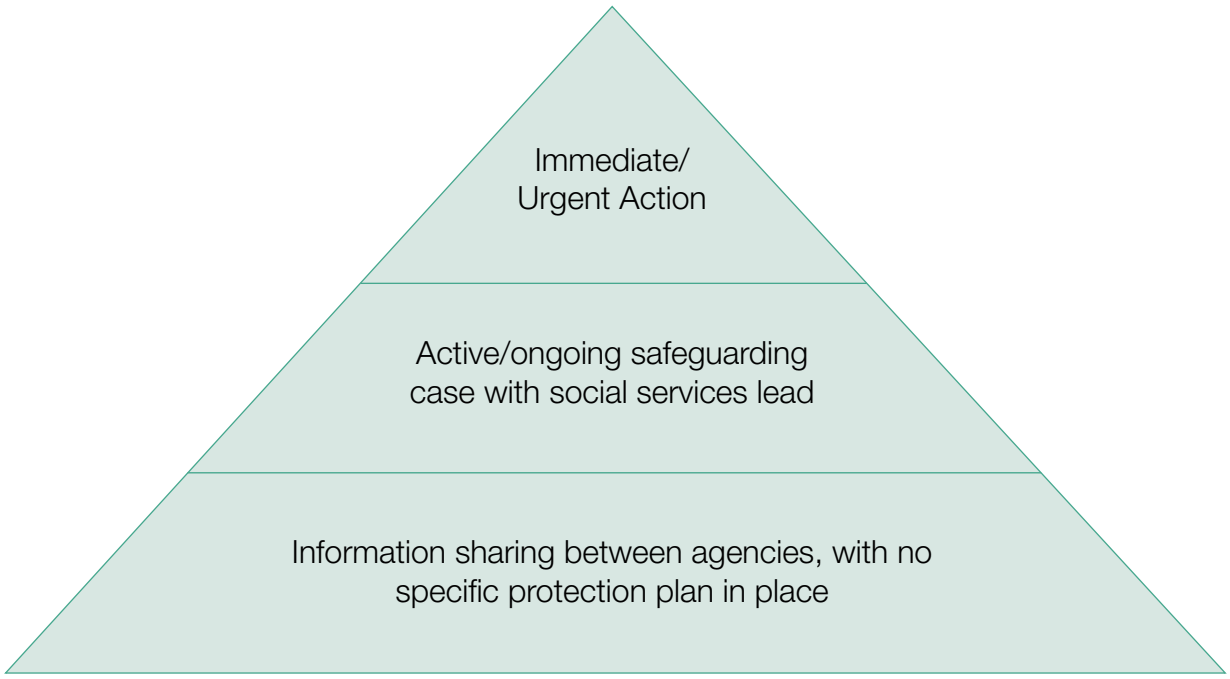
One specific consideration when putting in place safeguarding measures against FGM is that the potential risk to a girl born in the UK can usually be identified at birth, because through the ante-natal care and delivery of the child, NHS professionals can and should have identified that the mother has had FGM. However FGM can be carried out at any age throughout childhood, meaning that identifying FGM at birth can mean that any safeguarding measures adopted may have to be in place for more than 15 years over the course of the girl's childhood. This is a significantly different timescale and profile compared with many of the other forms of harm, against which the safeguarding framework provides protection. This difference in approach should be recognised when putting in place policies and procedures to protect against FGM.

This guidance has been developed to provide information about the specific issues frequently encountered when dealing with FGM. In addition, it provides a framework which organisations may wish to adopt to support professionals in the ongoing consideration of risks pertaining to FGM.

Once concerns have been raised about FGM, there should also be a consideration of potential risk to other girls in the family and practising community. Professionals should be alert to the fact that any one of the girl children amongst these groups could be identified as being at risk of FGM and will need to be responded to as a 'child in need' or a 'child in need of protection'.

Information sharing in relation to FGM

Given the need to potentially safeguard over a significant proportion of a girl's childhood, it is appropriate to recognise here that there are a number of different responses to safeguard against FGM, and appropriate course of action should be decided on a case by case basis, with the expert input from all agencies involved.



Whilst there is little information known about the number of on-going safeguarding cases in relation to FGM in England, discussions with key stakeholders support the view that the number of cases and the type of responses needed or already underway can be reflected with the above pyramid diagram. The importance of sharing information between practitioners and between agencies in relation to girls potentially at risk of FGM, and in relation to discussions held with family members around safeguarding must not be under-estimated – this information is vital to all agencies involved, to inform decisions on what the best course of action is to protect anyone at risk of FGM.

Multi-agency approach to safeguarding and when to refer

Working across agencies is essential to effective safeguarding efforts. This is reflected throughout the HM Government Multi-Agency Practice Guidelines on FGM, and should be a central consideration whenever discussing safeguarding girls from FGM.

Given the introduction of mandatory data recording and collection in the NHS, and the discussions around the new mandatory reporting duty which will require reports to be made to the police for all cases of FGM identified in patients under 18 years of age, there has been

some confusion around when referrals should be made to Children's Social Services, and whether there is a national policy on this.

Children and vulnerable adults: If any child (under-18) or vulnerable adult in your care has symptoms or signs of FGM, or if you have good reason to suspect they are at risk of FGM having considered their family history or other relevant factors, they must be referred using standard existing safeguarding procedures, as is the procedure with all other instances of child abuse. This referral is initially often to the local Children's Services or the Multi-Agency Safeguarding Hub, though other arrangements may be in place locally. Additionally, when a patient is identified as being at *risk* of FGM, this information must be shared with the GP and health visitor as part of safeguarding actions (See section 47 of the 1989 Children Act). Please note, this will change with the introduction of the mandatory reporting duty (see Chapter 5).

Adults: There is *no* requirement for automatic referral of adult women with FGM to adult social services or the police. Healthcare professionals should be aware that any disclosure may be the first time that a woman has ever discussed her FGM with anyone. Referral to the police must not be introduced as an automatic response when identifying adult women with FGM, and each case must continue to be individually assessed. The healthcare professional should seek to support women by offering referral to community groups who can provide support, and clinical intervention or other services as appropriate, for example through an NHS FGM clinic. The wishes of the woman must be respected at all times. If she is pregnant, the welfare of her unborn child or others in her extended family must be considered at this point, as these children are potentially at risk and safeguarding action must be taken accordingly.

As already highlighted, there has been little research in outcomes of safeguarding against FGM within the UK or similar health systems. However, there are multiple accounts that women who have ongoing physical and/or psychological problems, and who recognise that these are a result of FGM, are less likely to support or carry out FGM on their own children. This is also reported in women who are involved or highly supportive of FGM advocacy work and eradication programmes. However, any woman may still be under pressure from her husband, partner or other family members to allow or arrange for her daughter to be cut. Wider family engagement and discussions with both parents and potentially wider family members may be appropriate.

If a woman discloses she has adult daughter(s) over 18 who have already undergone FGM, even if the daughter does not want to take her case to the police, it is likely to be important to establish when and where this took place. This should lead to enquiries about other daughters, cousins or girls in the wider family context. If a decision has been taken within the family not to carry out FGM on a UK-born female child, this can allow for a useful conversation to ascertain whether this was as a result of a change in attitude, a fear of prosecution, or due to a lack of opportunity or other motivations. This is a complex area and many women have greater influence in decision-making with regards to FGM when they are outside their country of origin, and may therefore elect to discontinue FGM practice. Again, all information should be recorded and shared with the appropriate multi-agency partners.

Chapter 2. Existing Guidance and legislative framework

The status of this document

This document provides practice guidance, and is designed to provide an example which can be used to implement day-to-day frontline processes; it is not a substitute for existing multi-agency practice guidelines or statutory guidance.

Multi-Agency Practice Guidelines: Female Genital Mutilation

In 2011, the government launched multi-agency practice guidelines for front-line professionals such as teachers, GPs, nurses and police.[1] The guidelines aims to provide advice and support to frontline professionals who have responsibilities to safeguard children and protect and support adults from the abuses associated with FGM. No single agency can adequately meet the multiple needs of someone affected by FGM, so these guidelines set out a multi-agency response and strategies to encourage agencies to cooperate and work together.

The guidelines provide information on: identifying when a girl (including an unborn girl) or young woman may be at risk of FGM and responding appropriately to protect them; identifying when a girl or young woman has had FGM and responding appropriately to support them; and measures that can be implemented to prevent and ultimately eradicate the practice of FGM.

The guidelines make clear that FGM is child abuse and a form of violence against women and girls, and therefore should be dealt with as part of existing child and adult safeguarding/ protection structures, policies and procedures.

A recent Home Office review of the guidelines found that whilst the guidelines are largely deemed to be very useful, there is a lack of awareness of their existence.

Working together to safeguard children

The Department for Education published statutory guidance in 2013 titled *Working together to safeguard children*.

1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf

This guidance covers:

- the legislative requirements and expectations on individual services to safeguard and promote the welfare of children; and
- a clear framework for Local Safeguarding Children Boards (LSCBs) to monitor the effectiveness of local services.

The guidance replaces Working Together to Safeguard Children (2010); The Framework for the Assessment of Children in Need and their Families (2000); and Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004 (2007). Links to relevant supplementary guidance that professionals should consider alongside this guidance can be found at Appendix C.

This statutory guidance should be read and followed by a range of professionals including those working in health services. Whilst the guidance does not make specific provision for safeguarding activities relating to FGM, it sets out requirements around information sharing which are required to effectively safeguard against FGM and all forms of child abuse.

Female Genital Mutilation Act 2003 and amendments brought through Serious Crime Act 2015

In England, Wales and Northern Ireland, FGM is illegal under the Female Genital Mutilation Act 2003 (this offence captures mutilation of a female's labia majora, labia minora or clitoris), and in Scotland it is illegal under the Prohibition of Female Genital Mutilation (Scotland) Act 2005.

Under the 2003 Act, a person is guilty of an offence if they excise, infibulate or otherwise mutilate the whole or any part of a girl's or woman's labia majora, labia minora or clitoris, except for necessary operations performed by a registered medical practitioner on physical and mental health grounds; or an operation performed by a registered medical practitioner or midwife (or a person undergoing training with a view to becoming a medical practitioner or midwife) on a woman who is in labour or has just given birth, for purposes connected with the labour or birth (these exceptions are set out in section 1(2) and (3) of the Act).

There are new legislative measures being brought through the Serious Crime Act 2015 which will strengthen the legislative framework around tackling FGM. However, healthcare professionals are not expected to investigate or make decisions upon whether a case of FGM was a crime or not, under the legislation. All cases should be dealt with under existing safeguarding frameworks, which for children under 18 who have undergone FGM would mean a referral to Children's Social Care and/or the police as appropriate.

When treating an adult woman with FGM, it should be considered whether she is at risk of further violence, and therefore whether she herself needs protection and support, as well as whether she has any children, whether there are children within her care, or in her extended family or wider network who may also need protection. Annex 1 provides a sample framework to help professionals identify women and girls at risk, and to have conversations following this identification. Once any safeguarding requirements have been considered and acted upon, if it is decided that she as an individual adult is not currently facing risk of further abuse, she should still be offered support should she wish to make a report to the police in relation to her having undergone FGM. Healthcare professionals should offer this support whether the FGM she may wish to report appears to have been a crime in the UK or within a different country.

Chapter 3. Methodology

Existing risk assessment frameworks/tools

During October and November 2014, the FGM Prevention programme team identified and collected a number of existing FGM risk assessment frameworks in use across NHS services.

The content of these ranged significantly.

The team reviewed the documents and compiled a single draft framework which aimed to capture all potential risk from the frameworks reviewed, removing duplicated risk factors and challenging whether each individual element could provide information pertinent to the ongoing assessment of risk/potential risk.

Patient pathway analysis

The team identified standard care pathways where risk or potential risk of FGM was likely to be or could be identified. The assumption was that clinicians were aware of the risk factors and signs of which to be aware, and therefore were able to identify the opportunities to consider risk of FGM.

In addition, the team approached this from a different direction by considering the full range of risk factors which could lead to an FGM concern, or at least the need for further discussions to take place.

It was identified that whilst there are many contact points with women and girls where potential FGM risk could be identified; the concept of a discussion around safeguarding could and should remain broadly constant. The questions and risk factors considered in each discussion would not relate primarily to the *type* of care contact in which the discussion was taking place, but to the patient, whether she is an adult or child, and whether she is pregnant.

Considering this work in conjunction with reviewing the existing risk assessment frameworks, the model from Oxford LSCB had also identified that their tool primarily worked on this basis.

The tool was then reviewed, cross-referencing other documents and developed into a draft document.

Workshop review

A number of workshop review sessions and individual consultation meetings were held with stakeholders from across the professions, including acute, community and mental health settings and with both extensive and more limited experience with FGM to date.

The stakeholders involved in these consultations are credited in Annex 2.

The document was reviewed, debated and circulated for comment, and amendments made accordingly.

Pilot

Considering the limited timescales available to the FGM Prevention programme and the challenge that any outcomes from effective safeguarding will take many years to evidence, it was decided to publish guidance ahead of full piloting of the document.

As with all guidance, organisations will need to consider an appropriate implementation schedule themselves, with options to review, adapt, initially pilot, assess outcomes, further review, and introduce to standard local protocols and policies.

Chapter 4. How to use this document

Local adaptation

The guidance includes a risk assessment framework tool which supports a professional to know the type of risk to look for, and the specific factors which are most likely to affect families with girls who are at risk of FGM.

The tool is not exhaustive, however. It may be that working within a particular community, there is a specific risk factor. For example, it is known that in certain communities FGM is closely associated to when a girl reaches a particular age. If a Trust/organisation are working in an area where detailed risk factors such as this are known, the tool should be adapted to incorporate this knowledge. However, care must be taken not to narrow the considerations to too small a field. Firstly, whilst it may be known what the population with the highest FGM prevalence and/or with the highest number of patients within an area is, it is always possible that patients from other communities will also present. If adapting the tool, always ensure that this does not result in a narrowing that causes other patients who may need safeguarding to be excluded.

Links with local safeguarding procedures and multi-disciplinary teams

The guidance must be reviewed and local processes updated to take into account how this can be used in conjunction with the existing local safeguarding framework.

Frequent references are made within the guidance to the local safeguarding lead/framework. When adapted to suit a local setting, it should be considered whether these references can include specific details of the local arrangements in place.

There are also regions in England where a policy to refer a child of a mother with FGM to either an FGM service (often social services led) or to Children's Social Care at birth / during the mother's pregnancy is in place. This guidance is not intended to replace or alter local processes and arrangements, but is a base-line tool which can be used in all circumstances. If a threshold has been agreed between multi-disciplinary teams or at the Local Safeguarding Children's Board (LSCB), this will remain in place. However, with this guidance, some LSCBs or areas may decide to review this document and their policy, and consider whether they wish to make any changes in light of this, but it is not a mandated provision. It should be noted, there is no national policy to refer all pregnant women with FGM to social services.

An important element in all the risk templates in Annex One is the consideration of whether the patient (woman, child, pregnant woman) and/or her family are already known to social services, and whether there are any existing safeguarding arrangements in place, prior to the identification of potential risk of FGM. In all situations, professionals should ensure they

consider whether there are wider safeguarding issues ongoing, and whether the social worker managing the case is aware that concerns relating to FGM have newly been identified, and any information identified must be shared.

Ongoing discussions

Risk can only be considered at a particular moment in time. Healthcare professionals should take the opportunity to continue their discussions around FGM throughout the standard delivery of healthcare. If for example a health visitor or GP has been passed information from a midwife about potential risk of FGM, at the next appointment with the woman/child, the HV/GP should look to discuss this, and may use the appropriate part of this guidance to help structure the conversations on an ongoing basis.

Service support – interpreters

Care must be taken to ensure that an interpreter is available, as this will be required in many appointments relating to FGM.

The interpreter should be an authorised accredited interpreter and should not be a family member, not be known to the individual, and not be an individual with influence in the individual's community.

Observing the partner or family member, if either are present, during the consultation

If a woman or child is accompanied by a partner or parent/relative/guardian respectively, the health and social care professional must be vigilant and aware of the signs coercion and control as detailed by the Crown Prosecution Service (CPS) http://www.cps.gov.uk/publications/equality/domestic_violence.html in the Serious Crime Act 2015. Identifying these characteristics will assist the professional during the risk assessment in parts 1,2 and 3.

Training for healthcare professionals

Introducing a safeguarding process using this guidance will not replace the need to train healthcare professionals.

NHS organisations and professionals can access an FGM e-learning programme on the eLearning for Healthcare website, www.e-lfh.org.uk, consisting of 5 sessions providing training on all aspects of FGM and standard care provision principles.

NHS organisations should consider the training need within their organisation, and implement a training plan accordingly. If adopted, the training should ensure that professionals are able to confidently use this guidance.

Information sharing processes

Comprehensive information sharing practices must be introduced in order to develop a resulting effective and long term approach to safeguarding against FGM.

Any concerns, whether identified through using this guidance or through discussion with the patient and family, should be recorded within the patient's records by the healthcare professional who has obtained the information.

Information relating to safeguarding concerns should routinely be shared with other key professionals within the child's life. In practice this means that concerns identified should be shared with the patient's GP and her health visitor (HV) or school nurse (SN), depending on the age of the child who is potentially at risk of FGM.

On completion of the risk guidance form, it is good practice to share the outcome with the GP and HV/SN. This is whether the information is identified within a maternity setting, in an accident and emergency department, within a travel clinic, or any other healthcare setting. GPs and HV/SNs themselves should not forget to routinely share information themselves; if risks are identified within the GP practice, this should be shared with the HV/SN, and vice versa.

At birth, when a family history of FGM is identified, it is a requirement to record this detail within the Personal Child Health Record (or red book).

All maternity discharge records must include relevant information, if the mother has FGM, and this must be shared with the GP and the health visitor.

In April 2014, the Information Standards Board published *ISB 1610 Female Genital Mutilation Prevalence Dataset Standard Specification*[2] and supporting documentation. This standard required all NHS organisations to record information about FGM within the patient population in healthcare records, and introduced a requirement for acute trusts to report this to the Health and Social Care Information Centre on a monthly basis, by September 2014.

As of April 2015, the Standardisation Committee for Care Information (SCCI) are publishing the *SCCI 2026 – FGM Enhanced Dataset Requirements*[3] and supporting documentation. This extends the data collection requirements to include all Mental Health Trusts and GP practices, and confirms the local data sharing practices which must be adopted.

Health passport – Statement opposing female genital mutilation

The Government publish a 'Statement Opposing Female Genital Mutilation' leaflet, commonly referred to as the Health Passport. This pocket-sized document sets out the law and the potential criminal penalties that can be used against those allowing FGM to take place. It is designed to be discreetly carried in a purse, wallet or passport.

It can be used by families who have immigrated to the UK and do not want their children to be subjected to FGM, but still feel compelled by cultural and social norms when visiting family abroad. It has been supported and signed by Ministers from the Home Office, Department of Health, Ministry of Justice, Department for Education and the Director of Public Prosecutions (DPP). In Holland a similar document is used, where it has supported families and has sent a strong signal that FGM is unacceptable.

Organisations should consider routinely offering this leaflet to patients when discussing FGM. Copies can be obtained from the Department of Health orderline in June 2015, https://www.orderline.dh.gov.uk. Until then, copies can be requested from the Home Office by emailing FGMEnquiries@homeoffice.gsi.gov.uk.

2 http://www.isb.nhs.uk/documents/isb-1610/amd-01-2014/1610012014spec.pdf

3 www.hscic.gov.uk/isce/publication/scci2026

Care Pathway provision

All organisations should ensure that they have identified appropriate arrangements with regard to both providing care and support to patients with FGM, and to meeting the associated safeguarding requirements.

Many organisations may in particular need to consider how to support a patient under 18 who has undergone FGM. A child or young adult (under 18 years) discovered to have had FGM requires a referral to social care. She is highly likely to also require a specialist paediatric appointment to ascertain any physical or mental health needs. Part of this is likely to include identifying what type of FGM she has had, and the assessment will need to be appropriate to her age.

Professional sensitivity in delivery care

Health care professionals need to be sensitive to the fact that women and families may have been under intense cultural/social pressure within their country of origin to practise FGM.

Professionals need to consider how to discuss FGM without being judgemental, and whilst being sensitive. Organisations may wish to consider using the NHS Choices video resource *Women talking about their personal experiences of FGM* or the Health Education England 'Communication' elearning session to help staff gain confidence when talking about FGM with patients.

NSPCC Helpline

Organisations should also ensure that professionals are aware of the NSPCC FGM helpline, 0800 028 3550. This is helpline can support both professionals or family members concerned that a child is at risk of, or has had FGM.

Chapter 5. Future work

FGM Risk Indication System

From summer 2015 we will introduce a system that allows a clinician to record on a child's healthcare record that she is potentially at risk of FGM at some point in her childhood/lifetime. This information will be accessible to all healthcare professionals throughout childhood, highlighting that they need to consider the potential risk of FGM as and when they provide care, as well as whether they need to take any action in this regard. The system will be available via the NHS Summary Care Record application.

First use of this system is scheduled for summer 2015. Successful implementation will be dependent upon the user understanding of risk of FGM, and ongoing awareness and consideration through the early years of a girl's life. For the system to succeed, a critical factor will be the use of a tool such as Annex A. Therefore, it is recommended that organisations look to take on this guidance, which will act as preparation for this new change.

Further information will be released in due course.

Mandatory Reporting duty

A new mandatory duty is being introduced through the Serious Crime Act to report cases of FGM.

The move follows a public consultation which sought views from a wide range of professionals, community groups, survivors and law enforcement on how a mandatory reporting duty could work and who it should apply to. A summary of responses to the consultation has also been published today.

The mandatory duty will:

- Apply in cases of 'known' FGM – i.e. instances which are disclosed by the victim and/or are visually confirmed. This is in line with the majority of the consultation responses
- Be limited to girls under 18 – those responding to the consultation held differing views on whether the duty should be limited to under 18s, but a number highlighted concerns regarding extending the duty to adults, including the risk that this could deter women from seeking medical advice and assistance
- Apply to all regulated healthcare and social care professionals, and teachers

- Require reports to be made to the police within one month of initial disclosure/ identification – depending on the circumstances of the case, this will not necessarily trigger automatic arrests; the police will then work with the relevant agencies to ensure an appropriate safeguarding response is put in place which places the interests of the child front and centre
- Failure to comply with the duty will be dealt with via existing disciplinary measures, which may include referral to the professional regulator as appropriate – this will ensure that all breaches are dealt with appropriately and in accordance with the specifics of the individual case and is in line with the approach favoured by the majority of respondents to the consultation

The new duty does not yet apply as of March 2015 and we will work with NHS England and partner organisations including the professional bodies to widely communicate this new duty as and when it is implemented.

Annex 1. Female Genital Mutilation (FGM) Safeguarding Risk Assessment Guidance

Introduction

The aim is to help make an initial assessment of risk, and then support the on-going assessment of women and children who come from FGM practising communities (using parts 1 to 3). For a list of communities where FGM is prevalent please see part 6.

INTRODUCTORY QUESTIONS:–

(1) Do you or your partner come from a community where cutting or circumcision is practised? (See part 6 for map. Please remember you might need to consider that this relates to the patient's parent's country of origin; see part 7 for local terms).

(2) Have you been cut? It may be appropriate to use other terms or phrases.

If you answer YES to questions (1) or (2) please complete one of the risk templates.

PART ONE:– For an adult woman (18 years or over)

(a) PREGNANT WOMAN – ask the introductory questions.

If the answer is YES to either question, use part 1(a) to support your discussions.

(b) NON-PREGNANT WOMAN where you suspect FGM.
For example if a woman presents with physical symptoms or emotional behaviour that triggers a concern (e.g. frequent urinary tract infections, severe menstrual pain, infertility, symptoms of PTSD such as depression, anxiety, flashbacks or reluctance to have genital examination etc., see part 5); or if FGM is discovered through the standard delivery of healthcare (e.g. when placing a urinary catheter, carrying out a smear test etc.), ask the introduction questions.

If the answer is YES to either question, use part 1(b) to support your discussions.

PART TWO:– For a CHILD (under 18 years)

Ask the introductory questions (see above) to either the child directly or the parent or legal guardian depending upon the situation.

If the answer to either question is yes OR you suspect that the child might be at risk of FGM, use part 2 to support your discussions.

PART THREE:– For a CHILD (under 18 years)

Ask the introductory questions (see above) to either the child directly or the parent or legal guardian depending upon the situation.

If the answer to either question is yes OR you suspect that the child has had FGM (see part 5), use part 3 to support your discussions.

In all circumstances:

- The woman and family must be informed of the law in the UK and the health consequences of practising FGM.

- Ensure all discussions are approached with due sensitivity and are non-judgemental.
- Any action must meet all statutory and professionals responsibilities in relation to safeguarding, and be in line with local processes and arrangements.
- Using this guidance does not replace the need for professional judgement in relation to the circumstances presented.

GUIDANCE

The framework is designed to support healthcare professionals to identify and consider risks relating to female genital mutilation, and to support the discussion with the patient and family members.

It should be used it to help assess whether the patient you are treating is either at risk of harm in relation to FGM or has had FGM, and whether your patient has children who are potentially at risk of FGM, or if there are other children in the family/close friends who might be at risk.

If when asking questions based on this guide, any answer gives you cause for concern, you should continue the discussion in this area, and consider asking other related questions to further explore this concern. Please remember either the assessment or the information obtained must be recorded within the patient's healthcare record. The templates also require that you record when and by whom it and at what point in the patient's pathway this has been completed.

Having used the guide, you will need to decide:

- Do I need to make a referral through my local safeguarding processes, and is that an urgent or standard referral?
- Do I need to seek help from my local safeguarding lead or other professional support before making my decision? Note, you may wish to consult with a colleague at a Multi-Agency Safeguarding Hub, Children's Social Services or the local Police Force for additional support.
- If I do not believe the risk has altered since my last contact with the family, or if the risk is not at the point where I need to refer to an external body, then you must ensure you record and share information about your decision accordingly.

An URGENT referral should be made, out of normal hours if necessary, if a child or young adult shows signs of very recently having undergone FGM. This may allow for the police to collect physical evidence.

An urgent referral should also be made if the healthcare professional believes that there are plans perhaps to travel abroad which present a risk that a child is imminently likely to undergo FGM if allowed to leave your care.

In urgent cases, Children's Social Services and the Police will consider what action to take. One option is to take out an Emergency Child Protection Order. If required, an EPO is an order made under Section 44 of the Children Act 1989 enabling a child to be removed to a place of safety where there is evidence that the child is in "imminent danger".

In many other situations if a child or young adult under 18 years of age is discovered to have had FGM, a referral should be made through local safeguarding processes for Children's Social Care and it is likely that this can be made during normal working hours and standard procedures, when the risk presented does not have an imminent or urgent element identified.

Part One (a): PREGNANT WOMEN

Date: _____ Completed by: _____

Initial/On-going Assessment

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

Indicator	Yes	No	Details
CONSIDER RISK			
Woman comes from a community known to practice FGM			
Woman has undergone FGM herself			
Husband/partner comes from a community known to practice FGM			
A female family elder is involved/will be involved in care of children/unborn child or is influential in the family			
Woman/family has limited integration in UK community			
Woman and/or husband/partner have limited/ no understanding of harm of FGM or UK law			
Woman's nieces of siblings and/or in-laws have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment.			
Woman's husband/partner/other family member are very dominant in the family and have not been present during consultations with the woman			
Woman is reluctant to undergo genital examination			

SIGNIFICANT OR IMMEDIATE RISK			
Woman already has daughters have undergone FGM			
Woman requesting reinfibulation following childbirth			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have FGM			
Woman says that FGM is integral to cultural or religious identity			
Family are already known to social care services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM should be referred to social services.

ACTION

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

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

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

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

Part One (b): NON-PREGNANT ADULT WOMAN (over 18)

Date: _____ Completed by: _____

Initial/On-going Assessment

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

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

Please remember: any child under 18 who has undergone FGM should be referred to social services.

ACTION

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

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

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

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

Part 2: CHILD/YOUNG ADULT (under 18 years old)

This is to help when considering whether a child is AT RISK of FGM, or whether there are other children in the family for whom a risk assessment may be required.

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

ACTION

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

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

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

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

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

Please remember: any child under 18 who has undergone FGM should be referred to social services.

ACTION

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

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

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

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

Part 3: CHILD/YOUNG ADULT (under 18 years old)

This is to help when considering whether a child HAS HAD FGM.

Date: _____ Completed by: _____

Initial/On-going Assessment

Indicator	Yes	No	Details
CONSIDER RISK			
Girl is reluctant to undergo any medical examination			
Girl has difficulty walking, sitting or standing or looks uncomfortable			
Girl finds it hard to sit still for long periods of time, which was not a problem previously			
Girl presents to GP or A & E with frequent urine, menstrual or stomach problems			
Increased emotional and psychological needs eg withdrawal, depression, or significant change in behaviour			
Girl avoiding physical exercise or requiring to be excused from PE lessons without a GP's letter			
Girl has spoken about having been on a long holiday to her country of origin/another country where the practice is prevalent			
Girl spends a long time in the bathroom/toilet/long periods of time away from the classroom			
Girl talks about pain or discomfort between her legs			

SIGNIFICANT OR IMMEDIATE RISK			
Girl asks for help			
Girl confides in a professional that FGM has taken place			
Mother/family member discloses that female child has had FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM should be referred to social services.

ACTION

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

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

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

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

Part 4: Types of Female Genital Mutilation

Female genital mutilation is classified into four major types. The WHO definitions[4] of the following are

- Type 1: 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).
- Type 2: Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
- Type 3: Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
- Type 4: Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

4 http://www.who.int/mediacentre/factsheets/fs241/en/

Part 5: Consequences of FGM[5]

Many men and women in practising communities can be unaware of the relationship between FGM and its harmful health and welfare consequences as set out below, in particular the longer-term complications affecting sexual intercourse and childbirth.

1. Short-term implications for a girl's health and welfare

The short-term consequences following a girl undergoing FGM can include:

- severe pain
- emotional and psychological shock (exacerbated by having to reconcile being subjected to the trauma by loving parents, extended family and friends)
- haemorrhage
- wound infections, including tetanus and blood borne viruses (including HIV and Hepatitis B and C)
- urinary retention
- injury to adjacent tissues
- fracture or dislocation as a result of restraint
- damage to other organs
- death.

2. Long-term implications for a girl's or woman's health and welfare

The longer-term implications for women who have had FGM Types 1 and 2 are likely to be related to the trauma of the actual procedure, while health problems caused by FGM Type 3 are more severe and long-lasting, However, all types of FGM are extremely harmful and cause severe damage to health and wellbeing. World Health Organization research has shown that women who have undergone FGM of all types, but particularly Type 3, are more likely to have complications during childbirth.

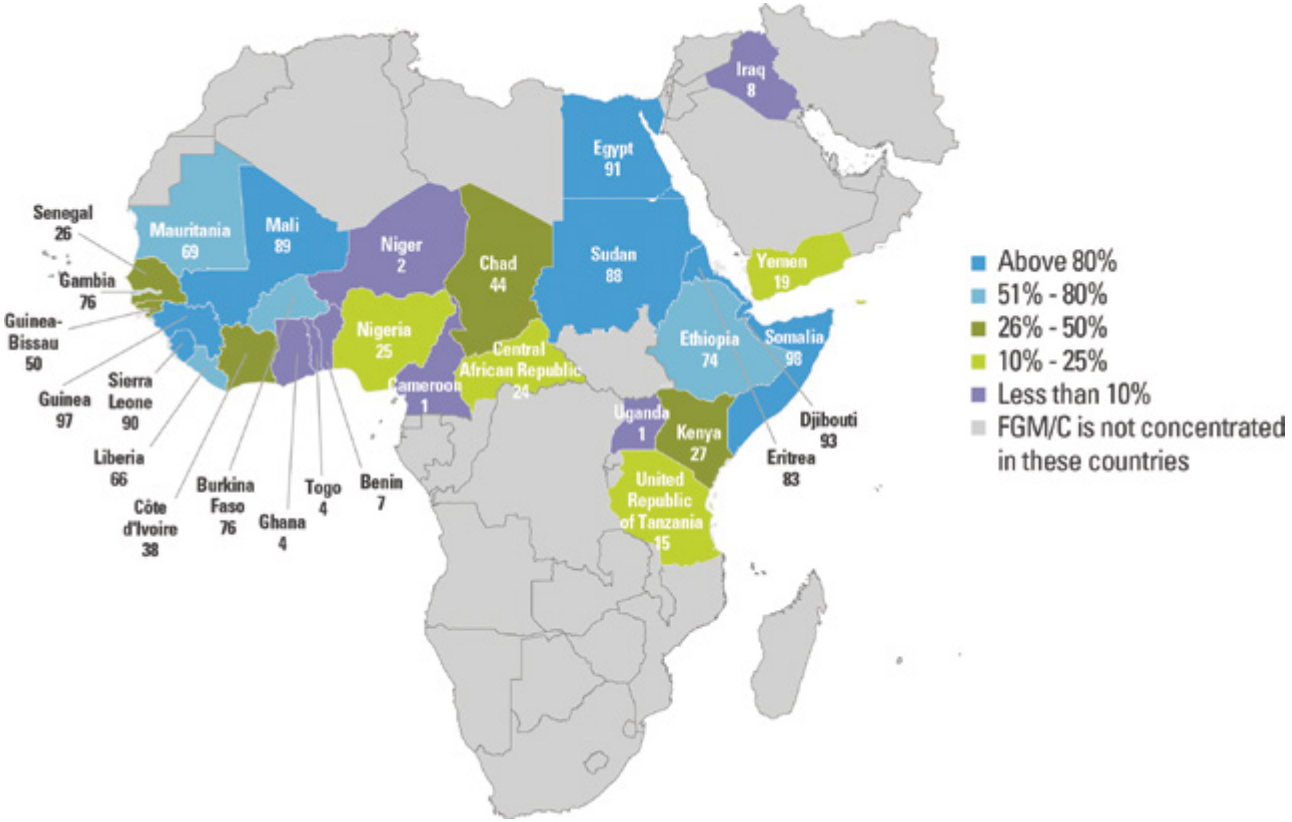
The long-term health implications of FGM can include:

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

[5] Extract from Multi-Agency Practice Guidance: Female Genital Mutilation, HMG 2014

Part 6: Countries that practice FGM

FGM/C is concentrated in a swathe of countries from the Atlantic coast to the Horn of Africa



FGM has also been documented in communities including:

- Iraq
- Israel
- Oman
- the United Arab Emirates
- the Occupied Palestinian Territories
- India
- Indonesia
- Malaysia
- Pakistan

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

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

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

Part 7: Traditional and local terms for FGM

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

Annex 2. Contributors

Existing risk assessment/screening tool reviewed:

- Oxfordshire Safeguarding Children Board FGM Screening Tool
- Imperial College Healthcare NHS Trust risk assessment documents
- Royal Free Questionnaire and Screening Doc
- FGM screening questions – North Middlesex University Hospital NHS Trust
- Wandsworth FGM risk identification leaflet
- Lambeth SCG FGM Procedures

In consultation with (and thanks to):

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Department
of Health

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