Hull Safeguarding Children Partnership

PROCEDURES AND GUIDANCE

Female Genital Mutilation

Date of document:	**5th April 2023**
Date document agreed:	**25th May 2023**
Date for next Review:	**May 2026**

CONTENTS

Female Genital Mutilation (FGM)

1. Defining FGM

Female Genital Mutilation (FGM) is a collective term for procedures, that involve the partial or total removal of external genitalia, or other injury to the female genital organs for non-medical reasons; for example, cutting, pricking, piercing, incising, scraping and cauterization for cultural or other non-therapeutic reasons. The World Health Organisation has classified FGM into four types: Type 1 – Clitoridectomy, Type 2 – Excision, Type 3 – Infibulation, and Type 4 – Other (all other procedures). The practice is not medically necessary, extremely painful and has serious health consequences for the individual.

FGM is a form of abuse and is a violation of a women or girls individual human rights. This includes at the time when the mutilation is carried out or in later life. The age at which the procedure is carried out varies enormously according to the community. The procedure is typically performed on girls aged between 4 and 13, but in some cases, it is performed on new-born infants or on young women before marriage or pregnancy.

FGM has been a criminal offence in the UK since the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003 replaced the 1985 Act and makes it an offence for:

- UK nationals or permanent UK residents to carry out FGM abroad,
- Or to aid, abet, counsel, or procure the carrying out of FGM abroad, even in countries where the practice is legal.

The Serious Crime Act 2015 further made amendments to the Female Genital Mutilation Act 2003 Act including:

- The offence of failing to protect a girl from the risk of FGM.
- Additional territorial jurisdiction over offences of FGM committed abroad by UK nationals and those habitually, as well as permanently resident in the UK.
- Lifelong anonymity for victims of FGM; this includes a prohibition on communication or media that would identify victims of FGM.
- FGM Protection Orders which can be used to protect girls at risk.
- A mandatory reporting duty which requires specified professionals to report known cases of FGM in under 18s to the police.

For more detail, please refer to the government guidance via this link HM Government - Multi-agency statutory guidance on female genital mutilation - GOV.UK (www.gov.uk)

This guidance was updated in April 2020 and includes comprehensive information such as how to apply for FGM Protection Order's, a list of terms used for FGM in other languages and a list of supporting organisations. You can also **Click here** to access the Gov.uk website for Female Genital Mutilation.

This guidance should be used in line with normal local safeguarding procedures for children and young people and adults at risk; **normal safeguarding duties continues to apply**. Section 6(1) of the Female Genital Mutilation Act 2003 provides that the term "girl" includes

"woman"; for the purpose of this policy, girl (or female child) will refer to under the age of 18 years, whilst female will apply to that of an adult age 18 plus.

Globally it is estimated that between 100 million – 140 million women have undergone FGM; this equates to 3 million per year. Within England and Wales, it is estimated that 66,000 women have undergone FGM and 24,000 girls under the age of 15 are at risk. NHS England outlines that between 2nd quarter of 2015 and the 1st quarter of 2022 in England 74,785 women and/or girls were involved in Health Care Provision for identified FGM or where FGM procedure had already been undertaken (see NHS digital - https://files.digital.nhs.uk) whilst the latest Statutory Guidance for England and Wales places this at approximately 137,000 children and/or women. Global Figures from World Health Organisation place more than 200 million girls and/or women at having experienced FGM (Female genital mutilation (who.int). The most vulnerable age in which FGM is carried out is between infancy and 15 years of age and therefore this presents as the greatest age of risk, however, it can be carried out at any age. An NHS quick read guide to FGM facts and reporting duties can be found within Appendix 4 of this policy.

1. Where is FGM Practised?

FGM is practised in at least 30 countries (WHO 2022); FGM is common in Africa, Egypt, Ethiopia, Somalia, and Sudan, as well as Nigeria and Kenya, Togo, and Senegal. There are other countries in the Middle East that have FGM practices (including Yemen, Oman, Iraqi Kurdistan) and some countries in Asia. More information on these countries can be found on FORWARD (forwarduk.org.uk) website. Practitioners and professionals should familiarise themselves with the countries where FGM are more likely to take place, through doing so practitioner's and professionals will be more aware of potential concern's if working with children, young people, or their families from these areas in the future. As a result of immigration and refugee movements, FGM is now being practiced by ethnic minority populations in other parts of the world, including the UK, USA, Canada, Europe, Australia, and New Zealand. Cases of FGM do occur in the Humber region. Further details on data regarding FGM can be found on NHS digital (Please see appendix 6 for link details).

2. Cultural Underpinnings

The justifications given for the practise are multiple and reflect the ideological and historical situation of the societies in which it has developed. Reasons include:

- Custom and tradition.
- Suppression of a women's right to sexuality.
- Some cultures viewing FGM is a rite of passage into women hood.
- Religion, in the mistaken belief that it is a religious requirement.
- Preservation of virginity/chastity.
- Social acceptance, especially for marriage.
- Hygiene and cleanliness.
- Increasing sexual pleasure for the male.
- Family honour.
- A sense of belonging to the group and conversely the fear of social exclusion.
- Enhancing fertility.

None of these reasons are acceptable in UK law and FGM is not legal in the UK.

3. Consequences of FGM

Depending on the degree of mutilation, FGM can have several **short-term** health implications:

- Severe pain and shock.
- Death.
- Infection.
- Urine retention.
- Injury to adjacent tissues.
- Immediate fatal haemorrhaging.
- Fractures can occur to the hips due to the force used during FGM procedures.

Long-term implications can entail:

- Extensive damage of the external reproductive system.
- Uterus, vaginal and pelvic infections.
- Cysts and neuromas.
- Increased risk of Vesico Vaginal Fistula.
- Complications in pregnancy and childbirth.
- Psychological damage.
- Pain during sexual intercourse.
- Sexual dysfunction.
- Difficulties in menstruation and urination.
- Urine infections.
- Impact of untreated fractures.

In addition to these health consequences there are considerable psycho-sexual, psychological, and social consequences of FGM.

4. Indicators

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

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

- The family belongs to a community in which FGM is practised.
- Maternal or other family member disclosure.
- An awareness by a midwife or obstetrician that the procedure has already been carried out on a mother, prompting concern for any daughters, girls, or young women in the family.
- Any girl whose older sibling has undergone FGM.

- The family make's preparations for a girl to take a holiday suddenly or under suspicious circumstances e.g., arranging vaccinations or planning an absence from school, parent may be none engaged in discussing the trip, its location, and details.
- When family or children talk about family (usually female elders) visiting from abroad as part of celebratory events.
- The girl talks about a 'special procedure/ceremony' that is going to take place.
- The girl may be seeking travel advice or have travel concern's and may be trying to reach out for help.

Other indicators exist that FGM may have or has already taken place, for example:

- A girl has had a change in behaviour after being absent from school; or
- A girl has health problems that may related to FGM, particularly bladder problems, increased time urinating and menstrual problems.
- The girl may be experiencing reoccurring Urinary Tract Infections or Pregnancy Difficulties.
- A girl/female may have made a disclosure.
- A mother/family member discloses that female child has had FGM.
- A girl or woman has difficulty walking, sitting or standing or looks uncomfortable.
- A girl or woman finds it hard to sit still for long periods of time, and this was not a problem previously.
- A girl avoids physical exercise or requires to be excused from physical education (PE) lessons without a GP's letter.
- There are prolonged or repeated absences from school or college (Stat guidance template (publishing.service.gov.uk)
- Increased emotional and psychological needs, for example withdrawal or depression, or significant change in behaviour.
- A girl or woman is reluctant to undergo any medical examinations.
- A girl or woman asks for help, but is not explicit about the problem.
- A girl talks about pain or discomfort between her legs.

5. Risk Factors

The most significant factor to consider when deciding whether a girl or woman may be at risk of FGM is whether her family has a history of practising FGM. In addition, it is important to consider whether FGM is known to be practised in her community or country of origin and whether there is a positive attitude towards FGM within that culture.

Given the hidden nature of FGM, individuals from communities where it takes place may not be aware of the practice. Women and girls who have undergone may not fully understand what FGM is, what the consequences are, or that they themselves have had FGM. Given this context, discussions about FGM should always be undertaken with appropriate care and sensitivity.

There are a number of factors in addition to a girl's or woman's community, country of origin and family history that could indicate she is at risk of being subjected to FGM. Potential risk factors may include:

- A female child is born to a woman who has undergone FGM
- A female child has an older sibling or cousin who has undergone FGM
- A female child's father comes from a community known to practice FGM

- The family indicate that there are strong levels of influence held by elders and/or elders are involved in bringing up female children
- A woman/family believe FGM is integral to cultural or religious identity
- A girl/family has limited level of integration within UK community
- Parents have limited access to information about FGM and do not know about the harmful effects of FGM or UK law
- A girl confides to a professional that she is to have a 'special procedure' or to attend a special occasion to 'become a woman'
- A girl talks about a long holiday to her country of origin or another country where the practice is prevalent
- Parents state that they or a relative will take the girl out of the country for a prolonged period
- A parent or family member expresses concern that FGM may be carried out on the girl
- A family is not engaging with professionals (health, education or other)
- A family is already known to social care in relation to other safeguarding issues
- A girl requests help from a teacher or another adult because she is aware or suspects that she is at immediate risk of FGM
- A girl talks about FGM in conversation, for example, a girl may tell other children about it – it is important to take into account the context of the discussion
- A girl from a practising community is withdrawn from Personal, Social, Health and Economic (PSHE) education or its equivalent
- A girl is unexpectedly absent from school
- Sections are missing from a girl's red book
- A girl has attended a travel clinic or equivalent for vaccinations / anti-malarials

There are a number of indications that a girl or woman has already been subjected to FGM:

This is not an exhaustive list of risk factors and indicators. If any of these indicators are identified professionals will need to consider what action to take. If unsure what action to take, professionals should discuss with their named/designated safeguarding lead.

NB girls are not always taken abroad. In some cultures, families collectively arrange for 'the cutter' to visit UK and carry out the procedure. Sometimes this can include several girls being subjected to FGM in succession.

6. Legal Position

The Female Genital Mutilation (FGM) mandatory reporting is a legal duty in the FGM Act 2003 (as amended by the Serious Crime Act 2015). This reporting duty came into effect in England on the 31st of October 2015. The legislation requires regulated health, social care professionals and teachers in England and Wales to make a report to the police where, in the course of their professional duties they are either:

- Informed by a girl under 18 that an act of FGM has been carried out on her; or
- Observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

Reports under the duty should be made as soon as possible after a case is discovered, and best practice is for reports to be made by the close of the next working day.

See section 2.1a of the Mandatory Reporting of Female Genital Mutilation. A copy of the FGM Mandatory Reporting Duty can be found here; FGM_Mandatory_Reporting_-_procedural_information_nov16_FINAL.pdf (publishing.service.gov.uk).This includes information on regulated roles and the process of how regulated professions should/should not become aware of FGM in practice.

Failure to do so may lead to prosecution of the Professional.

For the purposes of the duty, the relevant age is the girls age at time of disclosure or identification of FGM. It does not apply where a women aged 18 or over discloses, she had FGM when she was under 18. **Complying with the duty does not breach any confidentiality requirement or other restriction on disclosure which might otherwise apply.** The duty is an individual professional responsibility for that professional who becomes aware of the case to make a report; the responsibility cannot be transferred. The only exception to this is if you know that another individual from your profession has already made a report; there is no requirement to make a second. The duty does not apply in relation to at risk or suspected cases or in cases where the woman is over 18. Should a child be at risk or considered at risk then HSCP Safeguarding procedures must be followed, however, this may also involve informing the Police dependent upon the nature of risk e.g., concern of suspected immediate harm to the child (see flow chart page 12 of this policy). For more information, please see Working together to safeguard children - GOV.UK (www.gov.uk) and/or the Multi-agency statutory guidance on female genital mutilation - GOV.UK (www.gov.uk).

7. Opposing Statement

FGM is an extremely harmful practice with devastating health consequences for girls and women. Some girls die from blood loss or infection as a direct result of the procedure. Women who have undergone FGM are also likely to experience difficulty in childbirth and many also suffer from long-term psychological trauma.

The UK government's statement opposing FGM can be seen in **Appendix 5**. The opposing statement outlines what FGM is, the legislation and penalties involved and the help and support available. The statement is often referred to as a health passport.

There is no Biblical or Koranic justification for FGM and religious leaders from all faiths have spoken out against the practice.

8. Guidance and Procedure

General guidance preventing FGM is no easy task and has many complicating factors. Most practicing families do not see it as an act of abuse. FGM is a form of child abuse and violence against children and women and the needs of the child must always take priority. It is unlikely a single agency would be able to meet the multiple needs of someone affected by FGM, therefore it is important all agencies work together to achieve the best outcomes for somebody affected by FGM; as well as those at risk.

If professionals can identify signs that FGM have already taken place:

• The girl or women affected can be offered help to deal with the consequences of FGM.
• Enquiries can be made about other family members who may need to be safeguarded from harm.

• Criminal investigations into the perpetrators can be considered to prosecute those breaking the law and to protect others from harm.

Any indication or concern that a child is at immediate risk of or has undergone Female Genital Mutilation should result in a Child Protection referral to the Early Help and Safeguarding Hub (EHASH) 01482 448879 (out of hours 01482 304304) or the Police (101/999 dependent on the risk/urgency). Where a child is thought to be at risk of FGM, practitioners should be alert to the need to act quickly; this is to reduce the risk of a girl being abused through FGM procedures either in the UK or taken abroad for the procedure.

Professionals should not complete their own investigation. Children's Social Care are able to bring together different professionals to support the investigation process with the Police.

When talking about FGM, professionals should:

- Ensure that a female professional is available to speak to if the girl would prefer this.
- Make no assumptions.
- Give the individual time to talk and be willing to listen.
- Create an opportunity for the individual to disclose, seeing the individual on their own and in private.
- Be sensitive to the intimate nature of the subject matter.
- Be sensitive to the fact that the individual may be loyal to their parents and community.
- Use neutral language, if possible, whilst ensuring you are clear and address the concern; communities who practice FGM may not relate to the term FGM or mutilation. Using the terms 'cutting' or 'circumcision' may be more relatable terms. Practitioners can find out more about cultural variations of terms for FGM by visiting the National FGM Centre FGM Terminology for Website.pages (nationalfgmcentre.org.uk)

Every attempt should be made to work with the parents on a voluntary basis to prevent the abuse. It is the duty of the investigating team to look at every possible way that parental co-operation can be achieved, including the use of community organisations and/ or community leaders to facilitate the work with parents/ family. The child's interest is always paramount. Professionals have a responsibility to ensure that parents and carers of children know that FGM is illegal, and families know the authorities are actively tackling the issue. This knowledge alone may deter families from having FGM performed on their children and save girls and women from harm.

If no agreement is reached, the first priority is the protection of the child. This is through following your organisations safeguarding procedure and this policy. If a strategy meeting decides that the child is in immediate danger of mutilation and the parents cannot satisfactorily guarantee that they will not proceed with it than an Emergency Protection Order should be sought. If the child has already undergone FGM, the strategy meeting will need to consider carefully whether to continue enquiries or whether to assess the need for support services. If any legal actions are being considered, legal advice must be sought. A child protection conference should only be considered necessary if there are unresolved child protection issues once the initial investigation and assessment have been completed. Where FGM has been practiced, the Police will take the lead role in the investigation of a serious crime, working to common joint investigative practices and in line with strategy agreements.

10.What do I do to protect? How do I make a report?

Protection requires a proportionate and co-ordinated response.

The following are Child Protection concerns:

- A child for whom FGM is planned is at risk of significant harm; FGM is physical, emotional, and potentially sexual abuse.
- A child who is suspected to have had or has had FGM has experienced significant harm.

You should report your concerns for the child or young person to the Early Help and Safeguarding Hub (EHASH) and follow the steps within the below flow chart. Once informed, The Local Authority can enable S.47 enquiries. Mandatory Reporting to the Police should be made to 101. You must call 999 if you believe a child or women is at risk of imminent harm.

The flow chart (below) clearly outlines what you should do if you come across a case of FGM in practice. This flow chart highlights key scenario's linking to both EHASH and Mandatory Reporting to the Police pathway's; it includes how to make a referral and when. If you are concerned about a female adult at risk, then you should consider referring to Safeguarding Adults Team. Contact details for all these protection agencies are found below in 'Key Information'. The flowchart refers to risk assessment's; these can be found within **Appendix 1** from the Department of Health. There are 3 risk assessment's practitioners can undertake:

1) Pregnant Women (For Midwives, Doctor, or Health Professional to complete).
2) Non-Pregnant Adult Women (18 years and over) for any relevant professional to complete.
3) Girl (Under the age of 18 years) for any relevant professional to complete.

Practitioner's role is to identify concerns, to be able to contextualise their concerns and then report their concerns as appropriate as per the flow chart below. Your duty is not to investigate. There are 3 main scenarios' that under-pin the flow chart:

1) A girl is under the age of 18 years old where a referral must be made as per flow chart if risk assessment indicates concern.
2) A female over 18 years of age. FGM is illegal within the UK. Adults should be consulted and supported with their consent to any further specialist support. If you believe the girl is an adult at risk, then you should follow Hull Safeguarding Adult's Board (HSAB) Multi Agency Procedures.
3) A girl is pregnant or has child caring responsibilities; normal safeguarding duties apply. Consideration needs to be given to the female's role as a parent and if FGM may present a risk to any girls they care for or will care for in the short-term future.

KEY INFORMATION (FGM):

DEPENDENT ON AGE, UNDERSTANDING OR RISK, EXPLAIN/DISCUSS WITH THE GIRL:

1.) FGM is illegal in the UK,
2.) There are health consequences to FGM,
3.) As appropriate, ask the girl if they have been cut (language should be used sensitively and may differ dependent on someone's cultural background).

REMEMBER YOU ARE ACTIONING 2 POTENTIAL PATHWAYS:

1.) The duty for mandatory reporting. This for under 18 years of age to Police on 111 should you suspect or know FGM has taken place (or 999 should you perceive someone is at imminent risk of harm).
2.) Your normal safeguarding duties still apply. You must follow your local Safeguarding Children Procedure's and Protecting Adults at Risk Procedure's. Your normal safeguarding duties apply, and Local Safeguarding Procedures must be followed.

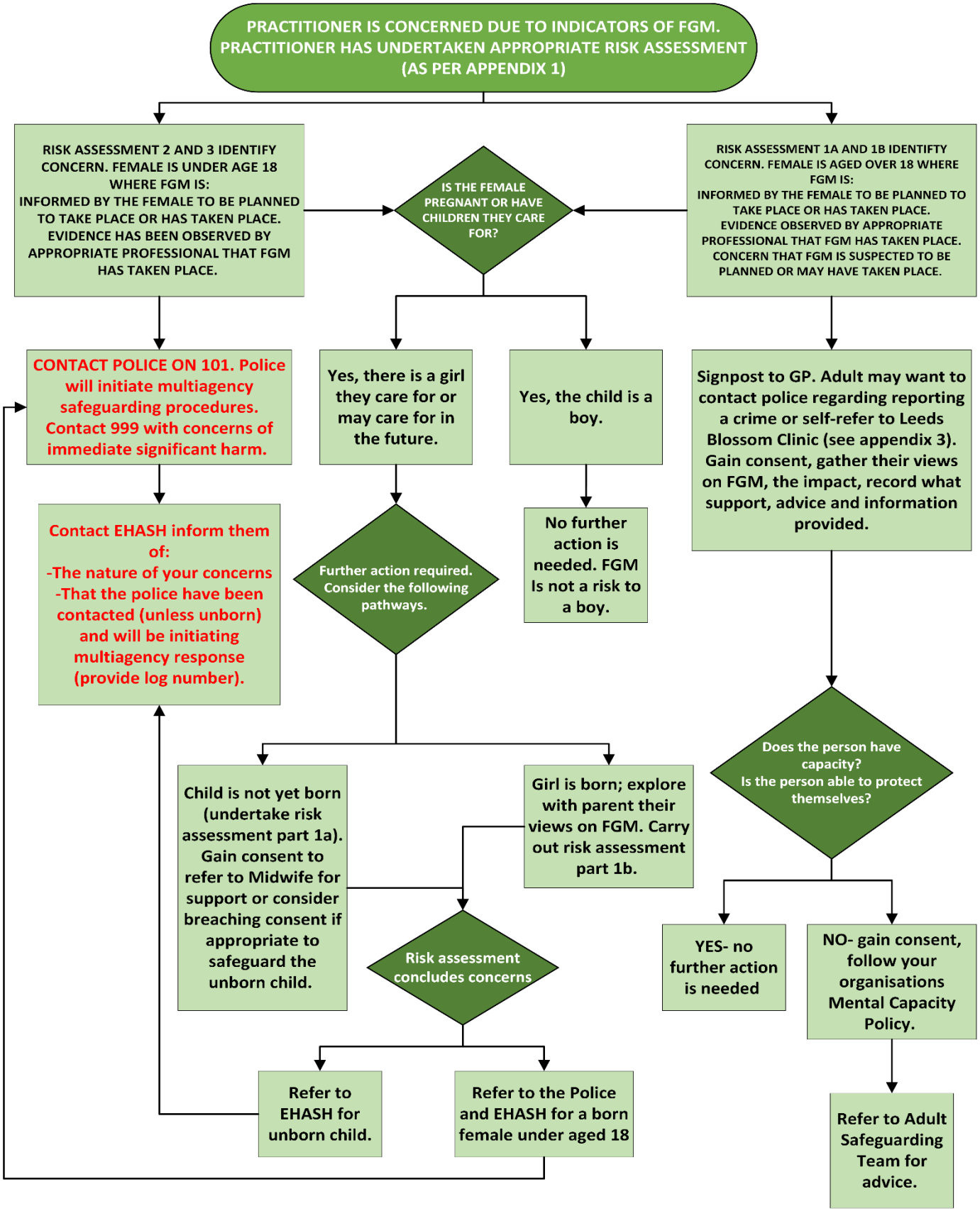
YOU MUST:

- Clearly Document all discussions and actions. You should document the steps you have taken under the policy.
- Consider (as appropriate) sharing information with relevant partners to support your safeguarding duties to children and people at risk.
- Always risk assess informing parent's or carers of concern; this may increase the risk of the procedure if not already take place; parents may be inclined to act quicker on their intent to have the procedure done before authorities can intervene. Information on discussing with parents FGM can be found here; HM Government - Multi-agency statutory guidance on Female Genital Mutilation (publishing.service.gov.uk).
- Use an independent accredited translation service if there is a language barrier.

TIMESCALES AND CONTACT NUMBERS:

- Mandatory Reporting to the Police should happen as soon as the case of FGM is discovered, however, it should be made within 24 hours to 101. Any immediate concern that a child has experienced (very recently) FGM should be reported immediately to the Police.
- Early Help and Safeguarding Hub (EHASH) referrals should be made as soon as possible and within 24 hours. Contact number is 01482 448879 (During office hours) or 01482 304304 (Out of Hours).
- Any immediate concern that a girl is at imminent risk of harm should be reported to 999 immediately.
- If there is an Adult at risk, then contact Adult Safeguarding Team on 01482 3 (in office hours) or (if out of office hours).

THINK: What are you worried about?



Appendix 2 demonstrates the steps taken upon notification to EHASH/Police for practitioners' information.

11.Roles in Responding to FGM

11.1 The role of Health Professionals

Health professionals encountering a girl or woman who has undergone FGM should be alert to the risk of FGM in relation to her:
• Female siblings.
• Daughters or daughters she may have in the future.
• Extended family members.

All girls/ women who have undergone FGM (and their boyfriends/ partners or husbands) must be told
that re-infibulation is against law and will not be done under any circumstances. Each woman should be offered counselling to address how things will be different for her afterwards.

11.2 What is re-infibulation?

Infibulation is the narrowing of the vaginal orifice with creation of a covering seal by cutting the labia minora and/or the labia majora. Re-infibulation is when the raw edges of this wound are sutured again, closing off the introitus, for instance following childbirth, recreating a small vaginal opening similar to the original appearance of infibulation.

Women often expect re-infibulation after birth and there are reports of medical practitioners being asked to perform this, which is contrary to the FGMA 2003. In some countries, women and girls are re-infibulated immediately after childbirth. Re-infibulation is more common is Sudan, Sierra Leone, Senegal, Somalia, Yemen, Tanzania, and Kenya.

It is important to note that even when women ask to be re-infibulated, the practice is still illegal.

Professionals should be aware of the potential safeguarding concerns that re-infibulation cases pose. This will vary on a case-by-case basis, and it is vital that professionals differentiate between:

i) Re-infibulation that has happened at some stage in a woman's life, which could have been pre-arrival to the UK.
ii) ii) Re-infibulation that has happened recently, possibly since another child was born.

In the latter case, it is likely that significant safeguarding concerns are present in respect of other girls within the family and due consideration should be given to sharing information via existing referral pathways.
Safeguarding risks exist to females who have had re-infibulation as they are highly likely to be part of a family that supports FGM, and this will pose an immediate risk to any other female children they have. A mother that has undergone FGM in one of the biggest single indicators that her daughter might be at risk of FGM.

Important considerations from a policing perspective will be where and when the woman was re-infibulated, who performed the procedure and how many girls are connected to the family. It is important to recognise the safeguarding risks that re-infibulation poses, in that those

who have had it are likely to be the most conservative and supportive of FGM and thus likely to undertake FGM on their children.

It is equally important to distinguish from a safeguarding perspective, between consenting adult women who undergo piercing from a qualified practitioner, and other piercing practices. Piercing is classed as type 4 FGM procedure. The piercing of girls aged under 18 is a safeguarding issue. Action could be taken against those involved, as it is likely that other criminal offences will have been committed. Multi–agency partnerships should clarify that children have not being subject to acts that would fall within the definition of mutilation under the FGMA 2003, and these acts subsequently being described as clitoral piercings to hide the offence committed. **This should be treated as a child protection concern.** Furthermore, a girl/ woman's apparent reluctance to comply with this UK law may raise further FGM concerns in relation to any parenting/caring for a girl they may already have or may have in the future.

11.3 RECORDING OF FGM

Following the publication in April 2014 of an Information Standard Notice (Female Genital Mutilation Prevalence Dataset):

- Where FGM is identified by a healthcare professional, they must now record this in the patient's health record.
- Acute Trusts must report the number of patients who have FGM in their active caseload to the Department of Health monthly. Completed Risk assessments by health care professionals should be recorded on the Risk Indicator System (RIS see appendix 1 guidance for link detail to Department of Health guidance).

There are a number of FGM clinics across the country run by specially trained doctors, nurses and midwives who understand FGM. They provide a range of treatment and support, including de-infibulation and counselling. A GP or midwife referral is usually required. Health Professionals have a role in educating the population regarding FGM, this will be in line with your organisation's strategy, however an opposing statement can be found within appendix 5 of this procedure and can be considered by Health Professionals in due course of their role in educating other's. You can find a list of specialists FGM support clinics below:

https://www.nhs.uk/conditions/female-genital-mutilation-fgm/national-fgm-support-clinics/

Alternatively, please see **appendix 3** of this policy for support agencies.

In all cases, it is good practice to discuss support options provided by NHS FGM clinics. Professionals have a responsibility to ensure that families know that FGM is illegal, and that the authorities are actively tackling the issue. This knowledge alone may deter families from having FGM performed on their children and save girls and women from harm.

11.4 The role of Children's Social Care

FGM is child abuse and should be dealt with in the same way as any other Child Abuse investigations. Social Care should:

- Explain FGM is illegal in culturally appropriate ways to families where girls may be deemed at risk.

- Consider and address potential barriers in engaging with families and children e.g., language, gender dynamics.
- Keep an open and enquiring mind; an offender/victim/witness is unlikely to tell you directly that FGM is being considered/has taken place. A robust investigation must be carried out when concerns are contextualised.
- If medical examinations are required these can only take place with consent, and within the bounds of appropriate protection orders which must be applied for.
- Make effective records and documents in line with procedures.
- Keep the individual who has made the referral informed of any assessment or actions unless this breaches confidentiality.
- Encourage the individual who made the referral to keep you updated with any new information.
- If a child is deemed to be at risk of FGM, a strategy meeting needs to be organised to assess the risk and agree a care plan involving appropriate agencies.
- Where a child is considered to be at risk always consider whether others in the household or extended family are also at risk of FGM.
- Work jointly with the police to deal with FGM from the early stages and to ensure that all information regarding FGM cases is shared.
- Remember to consult with other relevant professionals in that child's life, a child may not disclose to you, but may to a teacher or other known adult.
- Where FGM is concerned, there are likely to be no prior signs of physical or emotional abuse as with other child protection cases. This does not mean that a child will not be at imminent risk.
- Social care professionals must consider the risk factors relevant to FGM when assessing the risks to children.
- Work with specialist community organisations to build links with affected communities and to raise awareness, provide support and access those most at risk.
- Find out if the child is already known to children's services or the police following a previous incident, either locally or elsewhere.

11.5 The role of the Police

Ensure you understand the relevant laws relating to FGM. If you are unsure speak to a child protection officer or liaise with your supervisor. Consider immediate medical attention in any FGM investigation.

Be aware that you may come across a girl or young women at potential or actual risk of FGM at any time while carrying out other duties. In non-urgent cases consider use of Emergency Protection Orders, Care Orders and Supervision Orders, Inherent Jurisdiction, application for Wardship and Repatriation (if the victim is abroad). Officers should:

- Consider the health, well-being, and safety, under local safeguarding, of any girl or women who is at risk of or has undergone FGM.
- Gather intelligence through local force, national and international intelligence channels e.g., Police National Database (PND). Consider checks with Partnership Forces who may hold potentially relevant information and can advise on status.
- Consider the risk to the girl or women, or other siblings and relatives, where a child is at risk of, or has undergone, FGM.
- If you believed that a girl could be at immediate risk of significant harm, consider the use of police protection powers (section 46 of the Children Act 1989).

11.6 The role of Education

- Speak to your designated safeguarding lead or school nurse if you have any concerns about a child. They should be able to offer advice on contacting children's social services or the police.
- As an education professional, you can refer a case to Children's Social Care or the Police where you have concern.
- Keep Children's Social Care/Police informed with any further information if you refer a case.
- Identify girls who may be at risk in school; this may be based on their countries of origin. Identify any familial links, i.e., sisters, cousins, etc.
- Be aware of language barriers and do not use family members as interpreters.
- Raise awareness about FGM and the law in the school. Display the number of the FGM helpline in female toilets.
- Be observant regarding prolonged holidays or absences, notes excusing from participation in PE, etc.
- Seek specialist training for your staff and students by suitable providers (for a list of training resources and providers consult the online resource pack https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack
- Take steps to engage with local communities, including working with community agencies to educate on FGM.
- Consider the most appropriate way to educate and communicate FGM for your school's demographic. It can be included as part of formal lessons or one to one/small group conversations.
- Incorporate FGM into safeguarding policies and training.
- Work with other professionals and agencies to prevent FGM, including health professionals, welfare officers, Children's Centres, Children's Social Work Service, and the Police.
- Do not remove a child from the schools register after prolonged or unexplained absences.

Appendix 1 - Risk Assessments

The following risk assessments can be found from the Department of Health at FGM Professional Guidance Forms (publishing.service.gov.uk)

Guidance on using these risk assessments should be followed by practitioners using these risk assessments and can be found on Female Genital Mutilation Risk and Safeguarding (publishing.service.gov.uk)

Part One (a): PREGNANT WOMEN (OR HAS RECENTLY GIVEN BIRTH)

Date: _____ Completed by: _____

Assessment: Initial/On-going

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, 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 who have undergone FGM	☐	☐	
Woman or woman's partner/family 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	☐	☐	

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 risks, 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

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

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

Date: _____ Completed by: _____
Assessment: Initial/On-going

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	☐	☐	
A female family elder (maternal or paternal) is influential in family or 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	☐	☐	
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	☐	☐	
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 must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

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)

Date: _____ Completed by: _____
Assessment: Initial/On-going

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 female family elder 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 law	☐	☐	
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 family	☐	☐	

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 must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

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)

Date: _____ Completed by: _____

Assessment: Initial/On-going

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

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 e.g. 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	☐	☐	

ACTION

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

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

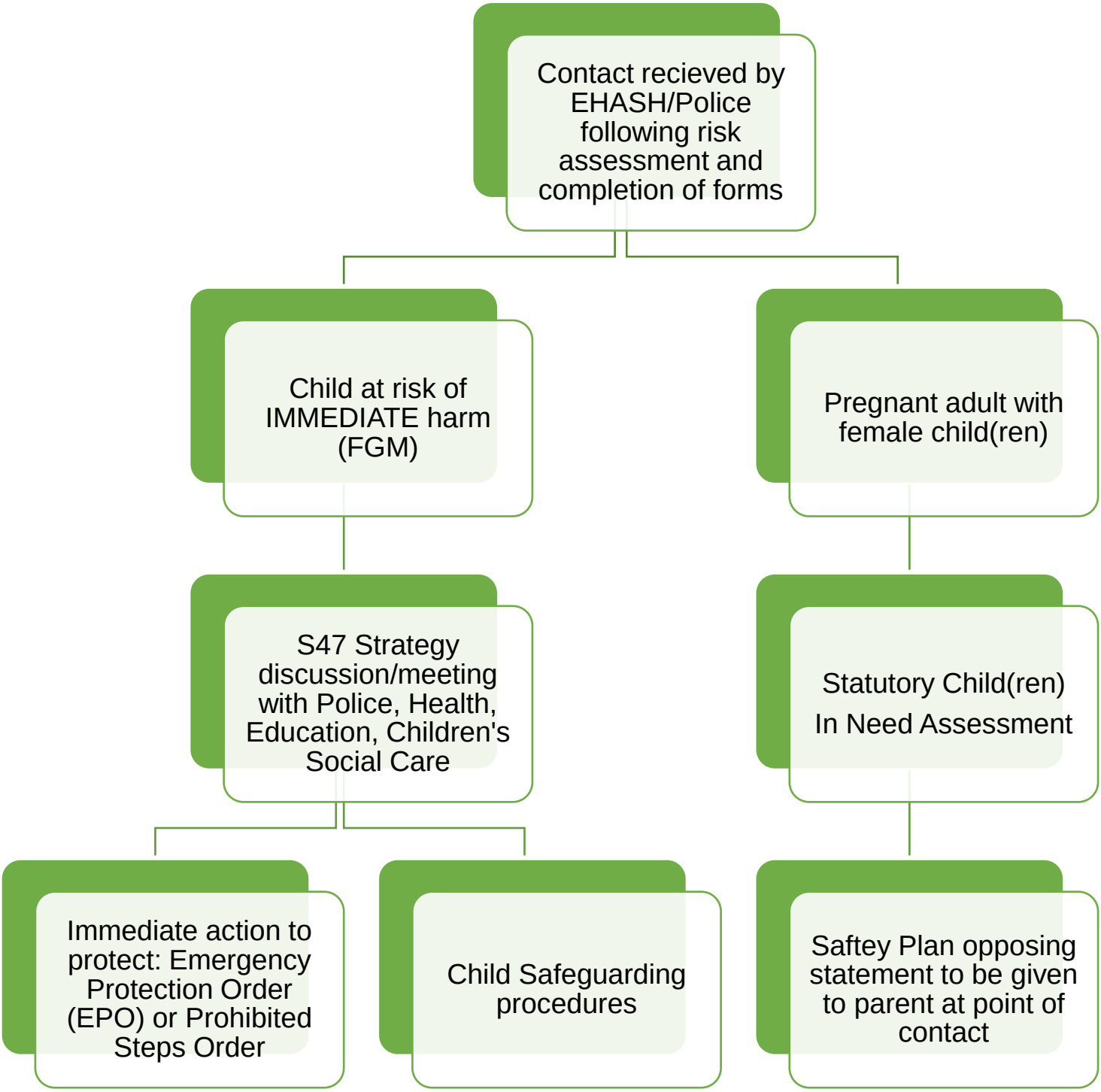
If you suspect but do not know that a girl has undergone FGM based on risk factors presenting, you should look to refer to Social Services / CAIT Team / police / MASH, in accordance with your local safeguarding procedures.

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

Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.

Appendix 2 - FEMALE GENITAL MUTILATION ESCULATION PATHWAY UPON NOTIFICATION



APPENDIX 3- USEFUL INFORMATION

NAME OF ORGANISATION	CONTACT
HULL SISTERS	07539321502 Hull Sisters | Womens Support Services | Hull | Connecting Women From All Backgrounds | Black and Minority Ethnic Women's Not For Profit Organisation
NHS Leeds Teaching Hospital Blossom Clinic 	07824580988 Female Genital Mutilation (FGM) (leedsth.nhs.uk)
Forward UK (Information/Charity)	Female genital mutilation | FORWARD (forwarduk.org.uk)
NSPCC	Female Genital Mutilation - Prevent & Protect | NSPCC
Karma Nirvana	https://karmanirvana.org.uk/ UK Helpline: 0800 5999 247

TRAINING

HSCP Online Training Female Genital Mutilation	HSCP Learning Programme 2023 - 2024

FURTHER INFORMATION

Female Genital Mutilation What it is and how to get help	FGM-Easy-Read-BB (003).pdf
UK Gov Female genital mutilation: resource pack	Female genital mutilation: resource pack - GOV.UK (www.gov.uk)

Appendix 4 – FGM RAPID READ NHS ENGLAND

NHS Female Genital Mutilation (FGM) / Rapid Read

WHAT IS FGM?

Female Genital Mutilation (FGM) comprises 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. FGM is commonly believed to be a way of ensuring virginity and chastity, and may be carried out shortly after birth, during childhood/ adolescence, just before marriage or during a woman's first pregnancy. **FGM is a form of both child abuse and gender-based violence, and is against the law.**

CLINICAL SIGNS TO LOOK OUT FOR

- Recurring urine infection, urine retention or incontinence
- Uterine, vaginal and pelvic infections
- Visual signs of partial or total removal of the external female genitalia, or other injury to the female genital organs or adjacent tissues
- Sexual dysfunction
- Complications in childbirth
- Psychosexual problems
- Depression

INDICATORS TO LOOK OUT FOR IN HEALTH SETTINGS

- Reluctance to undergo vaginal medical examinations
- Trauma and flashbacks
- Re-infibulation requested following childbirth
- Mother or older sibling has undergone FGM
- A girl talks about plans to have a 'special procedure' or to attend a special occasion/celebration to 'become a woman'

FGM Safeguarding and Risk Assessment: Quick guide for health professionals provides further information about FGM, its health implications, information on how to approach a discussion, and local terms.

THE LAW

Under the **Female Genital Mutilation Act 2003** and **Serious Crime Act 2015**, FGM is illegal. It is an offence to carry out and/or assist in FGM in this country or abroad, or to fail to protect a girl from FGM. Lifelong anonymity is provided to victims, and **FGM protection orders** can be issued to protect a girl from FGM.

NHS Safeguarding APP | Tool

@NHSsafeguarding
#NHSsafeguarding

MANDATORY REPORTING DUTY WHEN FGM HAS OCCURRED IN GIRLS UNDER 18

Female Genital Mutilation (FGM): Mandatory reporting duty requires regulated health and social care professionals and teachers to report if, as part of their work, they have observed physical signs of FGM having occurred in a child, or if a child has disclosed that they have had FGM. They must report directly to the Police via 101, and record when FGM is disclosed or identified as part of NHS healthcare. This is a personal duty and cannot be transferred. Non-regulated staff must discuss concerns with an appropriate professional.

Mandatory reporting is only one part of safeguarding against FGM and other abuse. Always ask your local safeguarding lead if you have concerns. The FGM Safeguarding Pathway offers clear guidance on when and how to report.

REQUIRED RECORDING WHEN FGM HAS OCCURRED

A mandatory recording requirement is in place for Acute Trusts, GPs and Mental Health Trusts to submit information, via the Health & Social Care Information Centre to the **Female Genital Mutilation Enhanced Dataset**. Your organisation should make clear how you include this information in your clinic notes/record system.

RECORDING THAT A GIRL UNDER 18 HAS A FAMILY HISTORY OF FGM

Female Genital Mutilation - Information Sharing (FGM-IS) is a national IT system that allows healthcare professionals to view, add and remove an FGM indicator to the NHS Spine, to support early intervention and ongoing safeguarding of girls under 18 who have a family history of FGM. See these **FGM-IS videos** for more information.

WHAT TO DO IF YOU HAVE A CONCERN

If you believe that a victim or potential victim of FGM is in immediate danger, always dial 999.

If you're worried about a child or woman but they are not in immediate danger, you must share your concerns via your safeguarding processes.

WHERE TO FIND OUT MORE

The Government's **Multi-agency statutory guidance on female genital mutilation** provides information and strategic guidance on FGM, and advice and support for frontline professionals.

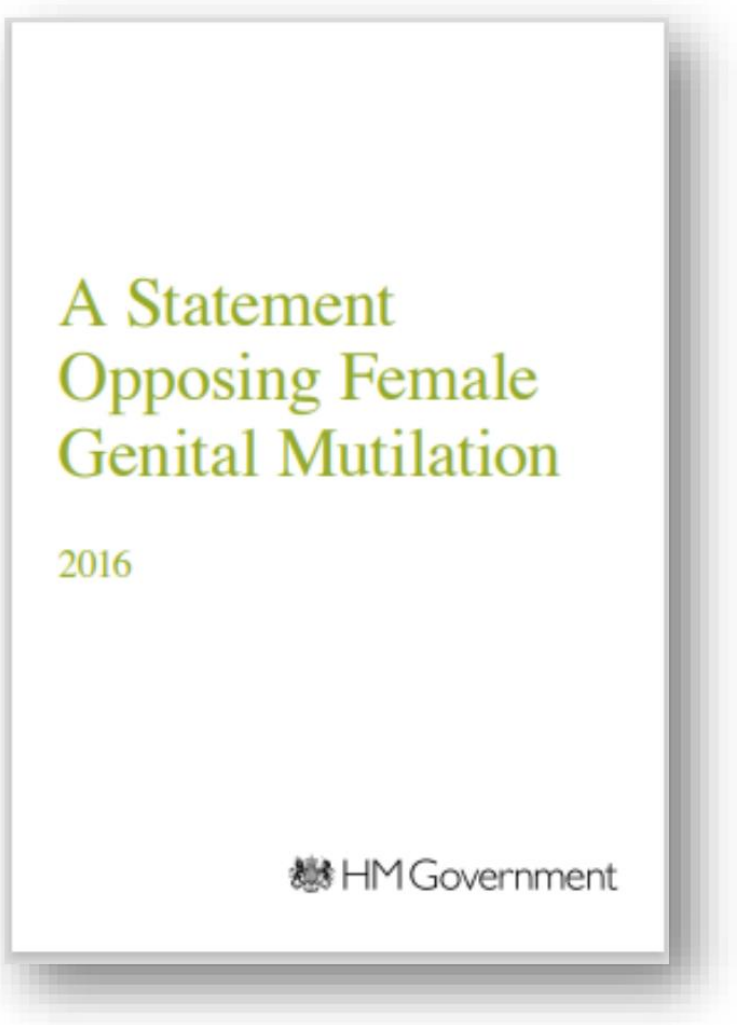
Female Genital Mutilation: Standards for training healthcare professionals is a structured curriculum for staff at all levels

The Home Office has created this **Female Genital Mutilation Resource Pack**. It includes a useful section on safeguarding, as well as links to more information.

Services for Girls and Women are available via the NHS. National FGM Clinics can be accessed by anyone in England, and women can self-refer.

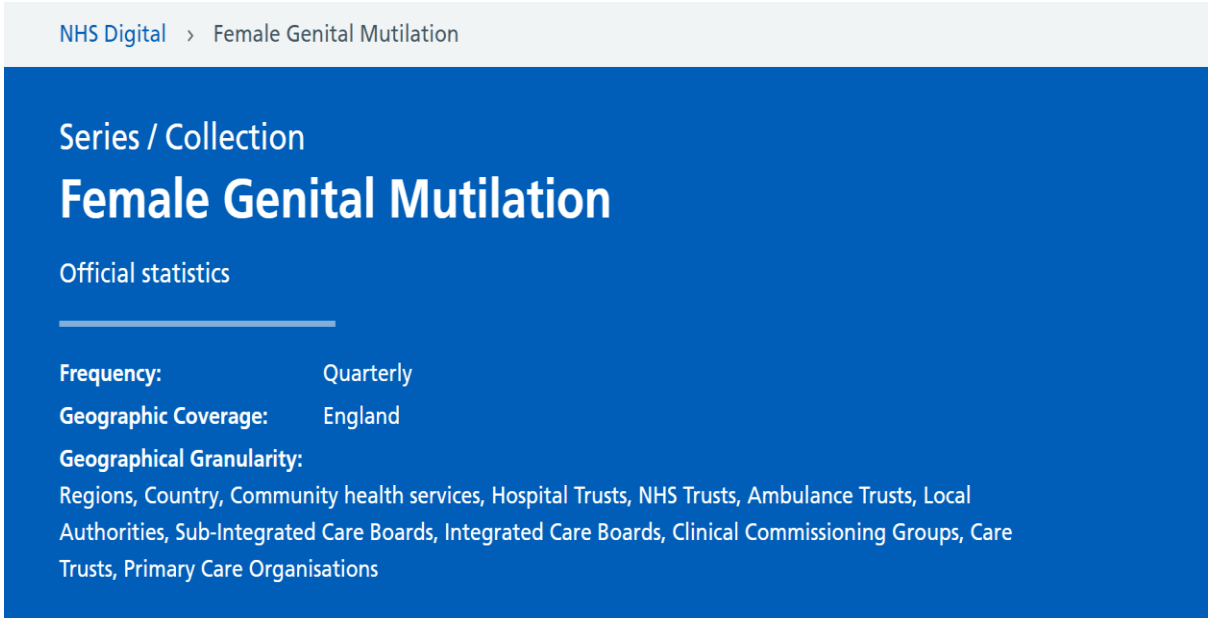
Appendix 5 – FGM OPPOSING STATEMENT

The UK government's statement opposing FGM can be found through the following link A Statement Opposing Female Genital Mutilation (publishing.service.gov.uk)



Appendix 6 – NHS DATASET FGM

NHS data set regarding FGM can be found through the following link [Female Genital Mutilation - NHS Digital]



Appendix 7- HM Government Multi- agency Statutory Guidance

Guideline for England & Wales- To be used in conjunction to Working Together to Safeguard Children (2018) and The Children Act (2004).

HM Government - Multi-agency statutory guidance on Female Genital Mutilation (publishing.service.gov.uk)

HM Government

Multi-agency statutory guidance on female genital mutilation

July 2020