Pan Merseyside

Female Genital Mutilation (FGM) Protocol

Developed by

Merseyside Protecting Vulnerable People

Harmful Practices Group

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Merseyside Community Safety Partnership

FEMALE GENITAL MUTILATION (FGM) Multi-Agency Protocol

RELATED GUIDANCE

Ending violence against women and girls (VAWG) Strategy 2016-2020 (Home Office, 2016)

FGM: Care for patients and safeguarding children, BMA July 2011

FGM Multi-Agency Practice Guidelines: Home Office 2016

FGM Risk & Safeguarding: Guidance for professionals: DOH 2015

FGM Enhanced Dataset Clinical Audit Platform Operational Guidance: Health and Social Care Information Centre 2015

Merseyside Forced Marriage Protocol 2018

NICE guidance – Domestic Violence and Abuse: How Health Services, Social Care and the Organisations They Work with Can Respond Effectively 2014

SCCI 2026 Requirements Specification FGM Enhanced Dataset: Health and Social Care Information Centre 2015

Serious Crime Act 2015

Tackling FGM in the UK – Intercollegiate recommendations for identifying, recording & reporting 2013

WSCB Responding to Children & Young People at Risk from Domestic Violence and Abuse - Policy and Guidance for Professionals 2015

WSCB Responding to Adults at Risk from Domestic Violence and Abuse - Policy and Guidance for Professionals 2015

Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children (HM Government, 2018)

Acknowledgements

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NOTE

Any information or concern that a child or **Adult at risk** is at immediate risk of, or has undergone, FGM should result in a **Safeguarding Referral to the Local Authority Social Care** and the **local Police Protecting Vulnerable Persons Unit**.

The Home Office has launched free online training produced by the virtual college. It can be accessed at **https://www.FGMelearning.co.uk/**

This course is useful for anyone who is interested in gaining an overview of FGM, particularly frontline staff in healthcare, police, border force and children's social care

Contents

Section A: Background Information

1. Introduction

Merseyside Safeguarding Boards recognises that FGM has been carried out for centuries, and it directly causes serious short and long term medical and psychological complications. Consequently it is considered to be a physically abusive act.

This protocol covers female children under the age of 18 and adult females including those who come under the Care Act 2014 definition of an Adult at risk (see **Glossary**). These groups of females will have similar needs for support and protection but different legislation and routes to safety will apply.

1.2 Community Engagement

To prevent FGM in the future as agencies we need to work closer with practising communities and foster stronger links so together we are able to break the taboo and silence surrounding the harmful practice of FGM.

2. What is FGM

The World Health Organisation (WHO) states that FGM (FGM):

"*Comprises of 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*"

WHO Fact sheet No. 241 (February 2014)

FGM is also known as Female Circumcision (FC) and Female Genital Cutting (FGC). The reason for these alternative definitions is that it is better received in the communities that practice it, who do not see themselves as engaging in mutilation.

FGM is included within the revised (2013) government definition of **Domestic Violence and Abuse**.

3. FGM is Classified into Four Major Types

1. 'Clitoridectomy which is the partial or total removal of the clitoris and, in rare cases, the prepuce (the fold of skin surrounding the clitoris);
2. Excision which is the 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 1 and II account for 75% of all worldwide procedures;
3. Infibulation which is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, and sometimes outer, labia, with or without removal of the clitoris; Type III accounts for 25% of all worldwide procedure and is the most severe form of FGM;
4. All other types of harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

4. Local Terms for the Procedure

These include tahara in Egypt; tahur in Sudan; and bolokoli in Mali, which are words synonymous with purification.

Several countries refer to Type 1 FGM as sunna circumcision* (which means usual practice/tradition in Islam). It is also known as kakia, and in Sierra Leone as bundu, after the Bundu secret society.**
Type III FGM (infibulation) is known as "pharaonic circumcision" in Sudan, and as "Sudanese circumcision" in Egypt. ***

* Rahman, A and Toubia, N: FGM – A Practical Guide to Worldwide Laws and Policies (Zed Books, 2000)
**Kasinga, Fauziya and Bashir, Layli Miller: Do They Hear You When You Cry (1998)
*** Elmusharaf, S.; Elhadi, N; Almroth, L: Reliability of self reported form of FGM and WHO classification: cross sectional study (2006)

5. Who Practices It

FGM is practiced around the world in various forms across all major faiths. **Appendix 9: World Map of FGM**. Today it has been estimated that currently, about three million girls, most of them under 15 years of age, undergo the procedure every year. The majority of FGM takes place in 29 African and Middle Eastern countries, and also includes other parts of the world; Middle East, Asia, and in industrialised nations through migration which includes; Europe, North America, Australia and New Zealand. Globally the WHO estimates that between 100 and 140 million girls and women worldwide have been subjected to one of the first three types of FGM.

There are substantial populations of people in the UK from countries where FGM is endemic; in London, Liverpool, Birmingham, Sheffield, Cardiff and Manchester (HM Government 2006).

It should be noted that FGM is not purely an African issue, although there is greater prevalence there. In the UK FGM has been found among Kurdish communities; Yeminis, Indonesians and among the Borah Muslims.

It is important to recognise that the migrant populations may not practice FGM to the same level as their country of origin; a migrant's reason for being in the UK may well be avoidance of FGM and second and third generation migrant populations may have very different attitudes towards FGM than their parents. However that same second or third generation may often be the children or adults at greatest risk of having the procedure carried out.

5.1 Estimated prevalence of FGM

FGM's prevalence in the UK is difficult to estimate because of the hidden nature of the crime. However, a report published in July 2014 by Equality Now and City University has estimated that:

Approximately 60,000 girls aged 0-14 have been born in England and Wales to mothers who had undergone FGM;
Approximately 103,000 women aged 15-49, and approximately 24,000 women aged 50 and over who have migrated to England and Wales, are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM;
Combining the figures for the three age groups, an estimated 137,000 women and girls with FGM, born in countries where FGM is practiced, were permanently resident in England and Wales in 2011.

Information is now regularly being collected to gain a national picture of the prevalence of FGM by The Health & Social Care Information Centre (HSCIC). The "FGM Prevalence Dataset" (ISB 1610) provides data from acute hospital providers in England.

It is an aggregated return of the incidence of FGM including women who have been previously identified and are currently being treated (for FGM related or non FGM related conditions as at the end of the month) and newly identified women within the reporting period. In October 2014 the first prevalence figures were published:

Key facts

For the month of September 2014:

125 of the 160 eligible acute trusts in England submitted signed off data.

1,279 active cases (i) and 467 newly identified (ii) cases of FGM were reported nationally.

Definitions

Patients identified as having a history of any FGM type prior to the reporting period and still being actively seen/treated for FGM-related conditions or any other non-related condition at the end of the month. Note: does not include those patients within NUMBER OF PATIENTS WITH FGM NEWLY IDENTIFIED IN REPORTING PERIOD (i.e. identified within this reporting period)

Patients first identified during the reporting period as having undergone FGM. This will include those diagnosed/identified within the provider within the month.

Figure 1: The % prevalence rates of FGM in girls and women aged 15-49 years within the top 15 practicing countries.

Rank	Country	Continent	Survey Type	Year	%
1	Somalia	Africa	MICS*	2006	97.0
2	Egypt	Africa	DHS**	2005	95.8
3	Guinea	Africa	DHS	2005	95.6
4	Sierra Leone	Africa	MICS	2005	94.0
5	Djibouti	Africa	MICS	2006	93.1
6	Sudan	Africa	Local Survey***	2006	89.3
7	Eritrea	Africa	DHS	2002	88.7
8	Mali	Africa	DHS	2006	85.2
9	Gambia	Africa	MICS	2005-6	78.3
10	Ethiopia	Africa	DHS	2005	74.3
11	Burkina Faso	Africa	MICS	2006	72.5
12	Mauritania	Africa	MICS	2007	72.2
13	Guinea-Bissau	Africa	MICS	2006	44.5
14	Ivory Coast	Africa	MICS	2006	36.4
15	Kenya	Africa	DHS	2003	32.2

It important to understand that countries with a lower prevalence rate could have high rates of FGM within the various ethnic groups such as Iraq, and Iran where overall prevalence rates are low but within the Kurdish communities the rate of FGM is high. Equally in India and Pakistan prevalence rates within the Muslim Bohra community is over **90%**.

*The Multiple Indicator Cluster Surveys (MICS) are a survey program developed by the United Nations Children's Fund to provide internationally comparable data on the current situation for children and women in developing nations throughout the World

** Demographic and Health Surveys. The 'Measure DHS Project' is a project which measures health and population statistics within developing nations. DHS is ran by Macro International, Inc. and is funded by the United States Agency for International Development (USAID) with contributions from other donors such as UNICEF, UNFPA, WHO, UNAIDS.

***The Sudan data comes from the 'Sudan Household Health Survey'.

6. Religion and FGM

Muslim scholars have condemned the practice and are clear that FGM is an act of violence against women. Furthermore, scholars and clerics have stressed that Islam forbids people from inflicting harm on others and therefore most will teach that the practice of FGM is counter to the teachings of Islam. However, many communities continue to justify FGM on religious grounds. This is evident in the use of religious terms such as “sunnah” that refer to some forms of FGM (usually Type I).

FGM is not practiced amongst many Christian groups except for some Coptic Christians of Egypt, Sudan, Eritrea and Ethiopia. The Bible does not support this practice nor is there any suggestion that FGM is a requirement or condoned by Christian teaching and beliefs.

FGM has also been practiced amongst some Bedouin Jews and Falashas (Ethiopian Jews) and again is not supported by Judaic teaching or custom.

7. Communities At Risk of FGM in the UK

UK communities that are most at risk of FGM include Kenyans, Somalis, Sudanese, Sierra Leoneans, Egyptians, Nigerians, Eritreans and Ethiopians. However women from non-African communities that are at risk of FGM include Yemeni, Kurdish (Iraqi, Iranian and Turkish country of origin), Indonesian, Malaysian, Pakistani women and Indian women (Muslim Bohra Community).

8. Health Impact

FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls’ and women’s bodies.

Many women appear to be unaware of the relationship between FGM and its health consequences; in particular the complications affecting sexual intercourse and childbirth which can occur many years after the mutilation has taken place.

8.1 Health Impact Complications Are Common and Can Lead to Death

The highest maternal and infant mortality rates are in FGM-practicing regions*. The actual number of girls who die as a result of FGM is not known. However, in areas of Sudan where antibiotics are not available, it is estimated that one-third of the girls undergoing FGM will die.**

8.2 Immediate Physical Problems

Intense pain and/or haemorrhage that can lead to shock during and after the procedure;
Occasionally death;
Haemorrhage that can also lead to anaemia;
Wound infection, including tetanus. Tetanus is fatal in 50 to 60 percent of all cases;***
Urine retention from swelling and/or blockage of the urethra;
Injury to adjacent tissues;
Fracture or dislocation as a result of restraint;
Damage to other organs.

A 1991 survey of 1,222 women in four Kenyan districts indicated that 48.5% of the women experienced haemorrhage, 23.9% infection, and 19.4% urine retention at the time of the FGM operation.****

* Sudan Household Health Survey

**Women's Policy: FGM - Women's Health Equity Act of 1996: Legislative Summary and Overview (July 12, 1996)

***Institute for Development Training: Health Effects of Female Circumcision: A Training Course in Women's Health, Chapel Hill, NC: Institute for Development Training (1986)

****Maendeleo Ya Wanawake Organization and the Program for Appropriate Technology in Health: Quantitative Research Report on Female Circumcision in Four Districts in Kenya (Nairobi, 1993)

9. Long-term Health Implications

In the UK, girls and women affected by FGM will manifest some of these long term health complications. They may range from mild to severe or chronic.

Excessive damage to the reproductive system;

Uterine, vaginal and pelvic infections;

Infertility;

Cysts;

Complications with menstruation;

Psychological damage; including a number of mental health and psychosexual problems, e.g. depression, anxiety, post traumatic stress, fear of sex* **. Many children exhibit behavioural changes after FGM, but problems may not be evident until adulthood

Abscesses;

Sexual dysfunction;

Difficulty in passing urine;

Increased risk of HIV transmission/Hepatitis B/C – using same instruments on several girls;

Increased risk of maternal and child morbidity and mortality due to obstructed labour. Women who have undergone FGM are twice as likely to die during childbirth and are more likely to give birth to a stillborn child than other women.*** Obstructed labour can also cause brain damage to the infant and complications for the mother (including fistula formation, an abnormal opening between the vagina and the bladder or the vagina and the rectum, which can lead to incontinence).

* British Medical Association - FGM: caring for patients and safeguarding children (2011)

** Toubia, N. FGM: A Call for Global Action, Women, Ink (New York,1993)

*** Koso-Thomas, O: The Circumcision of Women: A Strategy for Eradication (Zed Books, London, 1987)

10. The Myths of why Circumcision is Necessary Vary Between Ethnic Groups

Among some of the more common myths are:

Myth	Fact
Circumcision protects the sexual morality of girls before marriage and women within marriages. Women that aren't circumcised are not in control of their sexual urges and are likely to be sexually promiscuous	FGM makes no difference to a woman's libido but usually prevents her from enjoying sex. Pre or extra marital sex also occurs in women who have been mutilated.
If the clitoris is not cut it will harm the husband during intercourse	The clitoris gives a woman pleasure and does not cause harm to the husband but can enhance the sexual experience for

	both of them.
Girls that are not circumcised do not reach puberty, nor do they develop female shapes and are not able to get pregnant.	Girls reach puberty and conceive in communities not practising FGM. FGM can lead to infertility.
Babies that are in contact with the clitoris during birth will die.	The clitoris causes no harm to the newborm baby.
If the clitoris is not removed, it will continue to grow until it develops into the size of a penis.	The clitoris stops growing after puberty.
If a woman does not undergo FGM her genitals will smell	Infection from any type of FGM can cause a smell.

11. Common Justifications for FGM

See also **Forward UK website**.

Maintain family honour and a girl's virginity;

Improving a girls marriage prospects;

Protecting perceived cultural and religious beliefs and traditions.

In some communities the bridal price for an uncircumcised girl is lower or non-existent, bringing an economic reason for keeping the custom. For these reasons alone, many mothers and grandmothers are the advocates of FGM for their young daughters or granddaughters.

Some men are brought up to believe that they have no way of knowing that their bride is a virgin unless she is circumcised. A bride who is not a virgin has little value in many African communities.

In some communities, the uncircumcised are considered unclean and are not permitted to enter a part of a house where worship takes place. They may be excluded from prayer and other religious rites. This can have an emotional impact on uncircumcised adults and children.

FGM is a form of child and adult physical abuse. However, the issue is complex and despite its very severe health consequences, some parents and others who want their daughters to undergo this procedure do not intend it, or regard it, as an act of abuse.

FGM is a social norm and communities are socialised into accepting FGM as essential and those who fail to conform may be ostracised or stigmatised. In general FGM aims to promote acceptance and sense of belonging.

12. Risk Factors that Heighten the Girl's/Woman's Risk of Being Subjected to FGM

The family comes from a community that is known to practice FGM;

Any female child born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family;

Any female who has a relative who has already undergone FGM must be considered to be at risk;

The socio-economic position of the family and the level of integration within UK society can increase risk.

13. Protective Legislation

See also **Appendix 2: Legislation on FGM**.

Criminal Legislation

FGM has been a criminal offence in the UK since The **Prohibition of Female Circumcision Act 1985.**

The Act was repealed by **The FGM Act 2003** and closed a loophole which enabled victims to be taken outside of the jurisdiction for the purposes of FGM, without sanction. **The FGM Act 2003** made it unlawful for UK nationals and, at that time, 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 FGM is legal. The legislation was designed to prevent families and carers from taking girls abroad to undergo the procedure. The Act increased the maximum penalty for being found guilty of FGM from 5 to 14 years imprisonment. The **FGM Act 2003** also made it a criminal offence to re-infibulate following an FGM procedure.

The **Serious Crime Act 2015** has strengthened the legislative framework around tackling FGM by amending and adding to the FGM Act 2003. This included the introduction of FGM Protection Orders (similar to Forced Marriage Protection Orders).

FGM Protection Orders

FGM Protection orders can be obtained in either the Family court, on application, or in a Criminal Court as part of an ongoing criminal case. This civil order can be made by a court to protect a girl or a woman who has either been, or may become, a victim of FGM. The orders may contain prohibitions, restrictions or requirements as the court considers appropriate e.g.:

- Not to force the victim (the 'person to be protected', PTBP) into marriage
- Not to take the PTBP abroad
- Not to make travel arrangements
- To hand over passports / travel documents to the court
- Not to use or threaten violence to the PTBP

This list is not exhaustive. Any condition which may help to protect the victim can be requested.

Ordinarily, where the 'person to be protected' is under 18, or is considered to be an 'adult at risk' the local authority will make the application as a relevant third party. Other parties, including the police, are required to ask leave of the court to make an application.

Full details about how to make an FGMPO application can be found on the **Gov.uk website**.

Safeguarding duties

FGM is considered to be a form of child abuse (it is categorised under the headings of both **Physical Abuse** and **Emotional Abuse**). A local authority may exercise its powers under **Section 47** of the Children Act 1989 if it has reason to believe that a child is likely to suffer or has suffered FGM.

FGM is also an abuse of female adults usually categorized under honour based abuse and domestic abuse definitions. Where a female adult is also defined as an **Adult at risk**, additional support mechanisms would be available through local social care teams and adult safeguarding processes.

Other Powers / Orders

The Police have **Police Protection** powers where there is reasonable cause to believe that a child or young person, under the age of 18 years, is at risk of **Significant Harm**. A police officer may (with or without the cooperation of social care) remove the child from the parent and use the powers for 'police protection' (section 46 of the Children Act 1989) for up to 72 hours.

The Local Authority has further powers under Section 44 of the Children Act 1989. Under this section, the Local Authority may apply for an **Emergency Protection Order** (EPO). The Order authorizes the applicant to remove the girl and keep her in safe accommodation for up to 8 days. This Order is often sought to ensure the short term safety of the child.

An EPO can be followed by an application from the Local Authority for a **Care Order**, **Supervision Order** or an Interim Order (sections 31 and 38 of the Children Act 1989). Without such an application, the EPO will lapse and the local authority will no longer have **Parental Responsibility** for the child.

There will be cases where a Care Order is not appropriate, possibly because of the age of the young person. A Local Authority may ask the Court to exercise its inherent jurisdiction to protect the young person.

Once a young person has left or been removed from the jurisdiction, the options available to police, Local Authority and other services become more limited. In such situations an application may be made to the High Court to make the young person a Ward of Court and have them returned to the UK.

When a British national seeks assistance at a British Embassy or High Commission overseas and wishes to return to the UK, the Foreign and Commonwealth Office (FCO) will do what it can to assist or repatriate the individual. Although there will be limitations where there are restrictions on movement of British consular staff within that country.

In addition to FGMPOs private law remedies can be used as a form of legal protection. For example a **Prohibited Steps Order** under Section 8 Children Act 1989 can be used to prevent a child being taken abroad or from having the procedure. A Non Molestation Order under Part IV of the Family Law Act 1996 may also be used as protection for the child or adult. The Domestic Violence Crime and Victims Act 2004 make the breach of a Non Molestation Order a criminal offence.

It may be possible for victims of FGM to claim compensation from the **Criminal Injuries Compensation Authority**. The injuries must be reported to the police.

International legislation

There are two international conventions containing articles which can be applied to FGM. Signatory states, including the UK, have an obligation under these standards to take legal action against FGM. These include **The UN Convention on the Rights of the Child** and **The UN Convention on the Elimination of All Forms of Discrimination against Women**. FGM breaches several of these rights.

14. Additional useful resources

A pocket guide to the UK law on FGM is available to girls at risk to help them speak out against the practice. The leaflet a **Declaration against FGM (FGM) for Families and Girls** is designed to slip in the back of a passport allowing girls to present it as a formal document to friends or family reminding them that FGM is against the law in the UK. It also sets out what the penalties are for

offenders, including a maximum fourteen year custodial sentence, as well as advice on help and support;

The NSPCC staff a 24 hour helpline to protect children and young people affected by FGM. Anyone worried about a child being or has been a victim of FGM can contact 0800 028 3550 for information and support;

Revised (2016) statutory guidance **Keeping Children Safe in Education** includes advice on FGM. The Education Secretary has written to all schools in England to ask them to help protect girls from FGM (FGM);

The government has appointed a consortium of leading anti-FGM campaigners to deliver a global campaign to end FGM. The consortium will work across Africa to bring about a transformation in attitudes towards FGM.

Section B: Practice Guidance

15. Safeguarding: Actions to be taken by Single and Multi-Agency Workforce

There are three circumstances relating to FGM which require identification and intervention:

Where someone is at risk of FGM:

Where someone has undergone FGM;

Where a prospective mother has undergone FGM.

Professionals and volunteers in most agencies have little or no experience of dealing with FGM. Encountering FGM for the first time can cause people to feel shocked, upset, helpless and unsure of how to respond appropriately to ensure that a child, and/or a mother/any female adult, is protected from harm or further harm. The following agency specific guidance may help support the professional.

15.1 When someone is at risk of FGM

Indicators that FGM may soon take place:

Family history and family coming from a community known to practice FGM

Parents state that they or a relative will take the child out of the country for a prolonged period;

A child may talk about a long holiday (usually within the school summer holiday) to her country of origin or another country where the practice is prevalent;

A child may confide to a professional that she is to have a ‘special procedure’ or to attend a special occasion;

A professional hears reference to FGM in conversation, for example a child may tell other children about it;

15.2 Where someone has undergone FGM

Signs that FGM has taken place:

Prolonged absence from school with noticeable behaviour changes on the girl's return;

Longer/frequent visits to the toilet particularly after a holiday abroad, or at any time;

Some girls may find it difficult to sit still and appear uncomfortable or may complain of pain between their legs;

Some girls may speak about ‘something somebody did to them, that they are not allowed to talk about';

A professional overhears a conversation amongst children about a `special procedure' that took place when on holiday;

Young girls refusing to participate in P.E regularly;

Recurrent Urinary Tract Infections (UTI) or complaints of abdominal pain.

Dysmenorrhea

If you identify a female under 18 has had FGM contact the police via 101 (see Appendix 7a)

Any information or concern that a child or Adult at risk is at immediate risk of, or has undergone, FGM must result in a safeguarding referral to the **Local Authority Social Care** and the **Public Protection Investigation Unit**. **Immediate danger dial 999**

16. Social Care Actions for Safeguarding Children, and Adult at risk at Risk of or who have Undergone FGM

When information is received by Social Care, the Referral must be discussed with the Duty/MASH Manager who will subsequently inform the appropriate team in line with local policies and procedures**. In all cases, professionals should not discuss the referral with the parents/carers/family until a multi-agency action plan has been agreed.**

On receipt of referral, a **Strategy Meeting** must be called as soon as possible within two working days – see **Strategy Discussions Procedure**.

If a referral is received concerning one female in a family, consideration must be given to whether other females in that family are also at similar risk. There should be consideration of other females from other associated families once concerns are raised about an incident or the perpetrator of FGM.

In response to the initial referral, a senior social care representative will convene and chair a Strategy Meeting. It will be the senior social care representative's responsibility to access relevant information on the practice, and identify specialist help within **Merseyside** and nationally (**Nestac**) to assist in the sensitive planning of enquiries. Sourcing specialists should not stop or delay any initial intervention from taking place.

See also **Appendix 3: Useful Contacts**.

See **Appendix 7: Decision-making and Action Flowchart for Professionals in LA Children's Social Care**.

The Strategy Meeting should include:

- A senior social care representative, to chair and co-ordinate the meeting;
- The allocated social worker;
- A senior member of the local Police Protecting Vulnerable Persons Unit (D/Sgt)
- A legal representative should be available for consultation;
- Appropriate health representation
- Designated/Named Dr for Safeguarding Children:
- FGM consultant (Obstetrics & Gynaecology)
- A specialist in FGM from the statutory or voluntary sector; (e.g. IDVA/Savera UK)
- For children, the lead health professional, if available
- Any other professional deemed appropriate by the social care manager.

The Strategy Meeting must establish whether parents or the girl/woman has had access to information about the harmful aspects of FGM and the law in the UK. If not this information should be made available to them.

The Strategy Meeting should consider the need for medical assessment and / or therapeutic services for the female.

An FGM Strategy Meeting should cover, at a minimum, the following issues:

- Family history and background information;
- Scope of the investigation, what needs to be addressed and who is best placed to do this;
- Roles and responsibilities of individuals and organisations within the investigation, with particular reference to the role of the police in identification and investigation of any criminal offences;
- If FGM has already taken place, the police should consider whether the FGM has taken place against UK legislation and, if so, the matter should be crimed irrespective of where the procedure was performed. (N.B. where the girl was a foreign national at the time of the FGM, the FGM happened overseas and no British nationals or residents were involved, an offence of FGM according to UK law may not have been committed and advice should be sought from the Force Crime Registrar)
- Whether a medical examination/treatment is required and if so who will carry out what actions, by when and for what purpose (N.B. any medical examination of a child should take place at the Rainbow Centre under forensic conditions)
- Consideration of the need for a FGMPO
- Consider provision of support / counselling for FGM survivors
- What action may be required if attempts are made to remove the child / adult from the country;
- Identify key outcomes for the child/adult and their family including safety plans for any other children in the family at risk of FGM, and implications and impact on the wider community.

17. Assessment

Where a female has been identified as at risk or has had FGM, it may not be appropriate to take steps to remove the child or an **Adult at risk** from an otherwise loving family environment. Experience has shown that often the parents themselves can experience pressure to agree to FGM and see it as the best thing they can do for their daughter's marriageable status. It is also important to recognise that those seeking to arrange the FGM are unlikely to perceive it to be harmful and, on the contrary, believe it to be legitimised by longstanding traditions. Therefore it is essential that when first approaching a family about the issue of FGM a thorough assessment should be undertaken, with particular focus on:

Parental/carer attitudes and understanding about the practice and where appropriate;

Child/young person/Adult at risk's knowledge, understanding and views on the issue. For Adult at risk a **Capacity** assessment will be required to see whether the legislation of the Mental Capacity Act 2005 applies.

Every attempt should be made to work with parents/carers on a voluntary basis to prevent abuse. It is the duty of social care to look at every possible way that parental/family co-operation can be achieved. However, the child's/adult's best interest is always paramount.

Some thought and consideration should be given to where the assessment is undertaken. For example it may be beneficial to talk to the family/affected female outside the home environment to encourage them to talk freely and acknowledge the impact FGM would have.

An interpreter must be used in all interviews with the family, and more importantly the affected female, if their first language is not English. The interpreter must not be a family relation and must not be known by the family. The interpreter should be female if possible, however as in the case of Honour Based Abuse professionals to be aware of the risk that some interpreters may support FGM and all measures must be put in place to eliminate that risk.

In cases where an interpreter is not used and English is not the female's first language, the reasons for not using an interpreter must be recorded, as part of the assessment.

Appropriate communication aids must be offered for affected females who have difficulties communicating due to disability/illness and this should be documented within the record.

All interviews should be undertaken in a sensitive manner, and should only be carried out once.

With regards to children - parental consent (except if that would increase the risk to the child) and the child's agreement should be sought before interviews take place. All attempts must be made to work in partnership with parents, and to endeavour for parents to retain full parental rights in these circumstances; where consent is not given, legal advice should be sought.

Adults who are vulnerable need to be interviewed alone and a Capacity assessment completed. Capacity is decision-specific – the decisions to be assessed may include whether they can consent to travel abroad when there is a risk of their family arranging for them to undergo FGM. If they are not able to make a decision or safeguard themselves, then a **Best Interests** decision should be made. When an adult lacks Capacity and needs to be safeguarded the Local Authority can apply to the **Court of Protection** to give them powers to protect an individual. Adult at risk who are assessed as having Capacity but are at risk of coming to harm can be protected using the powers contained within the inherent jurisdiction of the high court. Other adults may be protected for example through non molestation orders and FGM protection orders.

The Strategy Meeting should reconvene as agreed to discuss the outcomes and recommendations from the assessment and continue to plan the protection of the female. At all times the primary focus is to prevent the female undergoing any form of FGM by working in partnership with parents, carers and the wider community to address risk factors. However where the assessment identifies a continuing risk of FGM then, the first priority is protection and the local authority should consider the need for:

Legal action;

Criminal prosecution;

An Initial Child Protection Case Conference/Adult Safeguarding Conference.

If a Child Protection Case Conference is deemed necessary and a **Child Protection Plan** is to be formulated, the Category of Abuse or Neglect should be **Physical Abuse**.

For Adults, a Safeguarding Plan will be formulated and monitored in accordance with the local Safeguarding Board Procedures **(See Appendix 5)**

Following all enquiries into FGM, regardless of the outcome, consideration must be given to the therapeutic/counselling needs of the female and the family.

Medical examination, if necessary must only be undertaken with the child's and the parents' consent or the consent of the adult female. If the adult lacks the Capacity to consent to the examination; then a Best Interests decision can be made for them. Where parents do not consent, legal advice should be sought.

In the majority of cases there should only be one medical examination of the child or woman. In cases where subsequent medicals are required, clear reasons for this decision should be recorded as part of the assessment.

If a medical/surgical procedure is required, and parents refuse consent, legal advice must be sought immediately.

Children in Immediate Danger

Where the child appears to be in immediate danger of FGM and parents cannot satisfactorily guarantee that they will not proceed with it, and then an **Emergency Protection Order** or FGMPO should be sought

When the immediate danger to the child/young person has been addressed, a Strategy Meeting should be convened.

Adults in Immediate Danger

Adults in immediate danger – When an adult is in immediate danger, contact the police. Protection can also be obtained by making an application for an FGM Protection Order or, in cases where an adult lacks capacity under the Mental Capacity Act 2005, by use of an emergency order issued by the Court of Protection. Where an adult who lacks Capacity is being put under duress to comply with a situation, seek immediate legal advice; in some instances it will be necessary to approach the High Court for an emergency interim order.

If there is no evidence of risk

If the safeguarding enquiry concludes that there is no clear evidence of risk to the female then Social Care will:

Consult the female's GP and a child's Health Visitor or School Nurse about this conclusion and invite her/him to notify Social Care if any further information challenges it;

Notify appropriate professionals involved with the family of the enquiry and the stage at which it was concluded;

Inform the family and the referrer that the enquiry has been concluded;

Consider whether any child may be a Child in Need or if the adult requires a community care assessment and, if so, offer appropriate services and offer the family/carers any appropriate support services.

If it appears that no other females are at risk

Social Care will take no further action other than to liaise with health services to review any health concerns for the female who has undergone the procedure;

Regardless of where the FGM has been performed, if a British national / resident arranged it the police will seek information for the possible prosecution of the perpetrator;

Social Care will notify the female's GP and a child's Health Visitors/School Nurse and invites her/him to notify them if any changes in the situation give rise to further concerns, e.g. the mother giving birth to further girls;

If there are concerns about younger girls in the family, Children's Services must convene a Strategy Meeting as soon as possible to discuss whether any protective action can be taken.

18. Procedure for Safeguarding Children and Adults from FGM within Education / Leisure and Community and Faith Groups

See also **Keeping Children Safe in Education**

Teachers, other school staff, volunteers and members of community groups may become aware that a female is at risk of FGM (see **Section 15.1, When someone is at risk of FGM**) through a parent / other adult, a child or other children disclosing that:

The procedure is being planned;

An older child or adult in the family has already undergone FGM.

A professional, volunteer or community group member who has information or suspicions that a female is at risk of FGM should consult with their agency or group's designated safeguarding adviser (if they have one) and should make an immediate **Referral to LA Social Care** and **Local Police Protecting Vulnerable Persons Unit**

The Referral should not be delayed in order to consult with the designated safeguarding adviser, a manager or group leader, as multi-agency safeguarding intervention needs to happen quickly.

Once concerns are raised about FGM there should also be consideration of possible risk to other females in the practicing community.

Where a teacher identifies a 'known' case of FGM in a girl under 18, the teacher must report the case directly to the police using 101. See **Home Office procedural information - Mandatory Reporting of Female Genital Mutilation** for further information.

19. Procedure for Safeguarding Children and Adults from FGM within the Health Sector

Health professionals in GP surgeries, sexual health clinics, Women's Health, A&E and maternity services are the most likely to encounter a girl or woman who has been subjected to FGM. All girls and women who have undergone FGM should be given information about the legal and health implications of practicing FGM. Health Professionals should remember that some females may be traumatised from their experience and have already resolved never allow their daughters to undergo this procedure.

Health Professionals should deal with FGM in a sensitive and professional manner, and not exhibit signs of shock when treating patients affected by FGM. They should ensure that the mental health needs of a patient are taken into account.

Guidance on Recording FGM Information

When a patient is treated by an acute hospital, and FGM is identified, this should always be recorded in the patient clinical record, as part of the full clinical history. This is in accordance with the **multi-agency guidelines.**

In Merseyside it has been agreed that in certain departments, it is routine to enquire whether a woman has FGM, namely maternity, family planning clinics, sexual health services, obstetrics and gynaecology departments, and urology although this list is not exhaustive.

The suggested "Trigger question" is: "**Have you had any female circumcision/cutting or piercing, or any surgery to your genital area?"** (Use appropriate language depending on the client's needs). If there is a positive response to this question further clarification should be sought **see appendix 1**

FGM may be identified in many other clinical settings, with those of note being Accident & Emergency, mental health services. However, in all circumstances staff must act upon warning

signs such as a history of repeat Urinary Tract Infections, a planned holiday to countries / areas of high prevalence for a girl to undergo a special ceremony, or a family history of FGM.

The many warning signs which should be acted upon are to be found in the **multi-agency guidance**, **Intercollegiate Report** and other Royal College publications which may lead to identifying FGM.

Mandatory recording and reporting for Healthcare providers

It is mandatory for health professionals to record the presence of FGM in a patient's healthcare record whenever it is identified through the delivery of NHS healthcare.

The patient's health record should always be updated with whatever discussions or actions have been taken. If the patient has had FGM, referral to a specialist FGM clinic should always be considered. In addition, where the patient is under 18, the health professional has a mandatory duty to report to police. See **Home Office procedural information - Mandatory Reporting of Female Genital Mutilation** for further information.

Where the patient is an 'adult at risk' according to the Care Act 2014, a safeguarding referral should be made to Adult Social Care.

Where an adult is not considered to be an 'adult at risk', they are entitled to patient confidentiality and referrals to police / social care are not required, unless the patient has female children.

If a child or young person under 18, or an 'adult at risk' is identified as being at risk of FGM, a safeguarding referral should be made to Social Care and information shared with the GP and health visitor as part of safeguarding actions.

Each health organisation will need to introduce methods of collection and issue clear instructions on how and where to record FGM within their own systems with immediate effect, and consider how best to support teams, through either additional professional training and/ or guidance.

It will need to be determined locally how the collection of information to support the FGM Prevalence Dataset will be managed, (including any data capture mechanisms), the main impact on staff and the organisation will be; communicating to all staff about the mechanisms that will be used to capture the relevant data and how this will be undertaken locally. This will include where the tools are located and how these will be accessed.

Since April 2014, it has been a mandatory requirement for NHS hospitals to record:

If a patient has had FGM;

If there is a family history of FGM;

If an FGM-related procedure has been carried out on a women - (deinfibulation).

Since 2015, all acute hospitals have had a duty to report this data centrally to the Department of Health on a monthly basis. Mental Health Trusts and GP practices. This is part of a wide ranging programme of work in development to improve the way in which the NHS will respond to the health needs of girls

GPs, and Practice Nurses: A question about FGM could be asked when a routine new patient history is being taken from girls and women. Information on FGM could be included in a welcome pack which is given to new patients. In addition those that attend for health checks or travel vaccinations from affected communities could be asked about FGM and advised about its health impacts.

GP's and Practice Nurses should be vigilant to any health issues such as resistance to partake in cervical smear testing. When a female attends the practice presenting with symptoms related to

urology/gynaecology/sexual health problems the FGM trigger question must be asked and the pathway in **Appendix 8** followed

In accordance with the new mandatory reporting requirements; The GP/Nurse should document in the patients record if a female patient has (if this is known):

Undergone FGM;

What type of FGM;

If there is a family history of FGM;

If any FGM-related procedure has been carried out on a women - (including de-infibulation).

Further clarification questions **(appendix 1)** should be asked to determine if there are any safeguarding issues. The risk assessment **(Appendix 6)** will help to determine the most appropriate referral pathway. They should be offered/referred for additional support. Document any advice or leaflets provided. Leaflets are available in different languages from **https://www.gov.uk/government/publications/statement-opposing-female-genital-mutilation.** Professionals should consult with their child protection adviser and with the DUTY/MASH about making a referral to them.

In all cases of FGM identified (whether there are safeguarding issues identified or not), the information should be submitted via the local incident reporting system this will enable the practice to receive support if required, it will also enable the anonymised data to be uploaded to the HSCIC dataset.

Where a prospective mother has undergone FGM

Midwives and nurses should be aware of how to care for women and girls who have undergone FGM during the antenatal, intrapartum and postnatal periods. They should discuss FGM at the initial booking visit to all women. They should document if the woman has:

Undergone FGM;

What type;

If there is a family history of FGM;

If any FGM-related procedure has been carried out on a women - (including deinfibulation).

They must also document what plan is in place for delivery. Document that the woman has been told about the health risks and the law and given a leaflet in an appropriate language (if available) that explains the health risks of FGM, the law and local support services. All this information should be shared with appropriate health professionals (including the GP and the Health Visitor). Professionals should consult with their safeguarding leads for guidance and support.

If a girl or woman who has been de-infibulated requests **re-infibulation/re-suturing** after the birth of a child, and/or the child is female or there are daughters in the family, **health professionals should consult with their safeguarding leads and with LA Children's Social Care about making a referral to them. Re-infibulation is illegal in the UK**.

Whilst the request for re-infibulation is not in itself a safeguarding issue, the fact that the girl or woman is apparently not wanting/able to comply with UK law due to family pressure and / or does not consider that the procedure is harmful raises concerns in relation to female children she may already have or may have in the future.

Some women may be pressured to ask for re-infibulation by their partner. This would come under the category of **Domestic Violence and Abuse** and local protocols must be followed – see **Domestic Violence and Abuse**.

Health visitors are in a good position to reinforce information about the health consequences and the law relating to FGM. Health visitors should discuss the risks of FGM and document the parent's response and the advice and any leaflets given to explain the law relating to FGM (leaflets in different languages can be printed from the website: **https://www.gov.uk/government/publications/statement-opposing-female-genital-mutilation**)

Any concerns about a parent's attitude towards FGM should be taken seriously and appropriate referrals made. Professionals should consult with their safeguarding leads about making a referral to social care and inform the family's GP of the referral

Midwives and Health visitors should seek to record this information to ensure that all relevant health professionals are aware of the FGM incident and any concerns for female children.

School Nurses are in a good position to reinforce information about the health consequences and the law relating to FGM. The school nurse should work closely with the child's school supporting them with any concerns. The school nurse should be vigilant to any health issues such as recurrent urinary tract infection that may indicate FGM has been undertaken. If the school nurse has contact with any family that originates from a country where FGM is practiced, they should discuss the risks of FGM and document the parent's response along with any advice and leaflets provided to explain the law relating to FGM. Any concerns about a parent's attitude towards FGM should be taken seriously and appropriate referrals made.

Mental Health Practitioners need to be aware of the risks associated with FGM if girls/women from FGM practising countries attend, particularly with Post Traumatic Stress Disorder for example. If a disclosure is made regarding FGM, this should be documented and professionals should consult with their child or adult safeguarding lead about the appropriate course of action.

Emergency Departments and Walk-in Centres need to be aware of the risks associated with FGM if girls/women from FGM practising countries attend, particularly with urinary tact infections (UTIs), menstrual pain, abdominal pain, or altered gait for example. Their assessment should include assessing the risks associated with FGM. This should be documented and professionals should consult with their child or adult safeguarding lead about making a referral to social care.

See **Section 12, Risk Factors that Heighten the Girl's/Woman's Risk of Being Subjected to FGM**.

Health services for Asylum Seekers & Refugees. Where initial health assessments for asylum seekers and refugees are undertaken, the health professional can introduce a discussion about FGM. They should document if the female has undergone FGM and what type. They must also document that the woman has been told about the law and given a leaflet in an appropriate language (if possible) that explains the risks of FGM, the law and local support services. All this information should be shared with appropriate health professionals (GP, Health Visitor etc). Professionals should consult with their safeguarding lead about making a referral to social care.

20. Procedures for Police Officers/Police Staff

See also **Making Referrals to Children's Social Care Procedure**.

It is a legal requirement that any under 18 year old who has had FGM is reported to the Police via the 101 non –emergency number. This may mean that the police may be the first point of contact for a referrer and should follow the agreed local pathway for referral to Children's social Care **(see Appendix 7a).**

There is a risk that the fear of prosecution of family members may prevent those concerned from seeking help and support from relevant agencies and in particular medical help as a result of long term complications caused by FGM.

In many communities where the practice of FGM is prevalent, children who may have undergone/be due to undergo FGM may accept it as part of their religious/cultural upbringing due to a lack of understanding of the potential criminal offence being committed and future health complications that may prevail.

Police will work with other agencies to obtain relevant support and guidance for the victim. Where relevant they can work with other professionals to prevent FGM by educating parents/carers about the legislation relating to FGM and possible consequences.

Police staff working with Children - If a girl is at risk of undergoing or has already undergone FGM, the duty inspector must be made aware and support should be sought from the Local Police Protecting Vulnerable Persons Unit where the victim resides. Relevant safeguards should be put in place immediately in order to prevent any risk of harm to the child.

Risk to any other children should be considered and acted upon immediately;

The investigation should be dealt with as a child safeguarding issue taking cognisance of any honour-based violence issues.

If any officer believes that the girl could be at immediate risk of **Significant Harm**, they should consider the use of **Police Protection Powers** under section 46 of the Children Act 1989.

The Local Police Protecting Vulnerable Persons Unit should commence **Strategy Meetings** with Children's Services and relevant agencies.

If it is believed or known that a girl has undergone FGM, a Strategy Meeting must be held as soon as practicable (and in any case within two working days) to discuss the implications for the child and the coordination of the criminal investigation (see section 16)

A second Strategy Meeting should take place within ten working days of the initial Referral.

Children and young people should be interviewed under the relevant procedure/guidelines (e.g. **Achieving Best Evidence**) to obtain the best possible evidence for use in any prosecution.

A medical examination should be conducted by a qualified doctor trained in identifying FGM Most Hospitals have in house specialists.

Adults: Consultant in Obstetrics & Gynaecology

Children: Designated Dr/ Named Dr Safeguarding Children

Consideration should be given as to the effective use of a specialist FGM nurse. In all cases involving children, an experienced paediatrician should be involved in setting up the medical examination. This is to ensure that a holistic assessment which explores any other medical, support and safeguarding needs of the girl or young woman is offered and that appropriate referrals are made as necessary.

21. When an Adult Female has Undergone/is about to Undergo FGM

These incidents should be dealt with by the Local Police Protecting Vulnerable Persons Unit as a form of Domestic Violence and Abuse/Honour Based Abuse. Relevant risk assessments (such as the domestic abuse risk indicator checklist) and safeguards should be put in place and referrals to partner agencies made as appropriate in order to ensure the victim receives all relevant support.

Part of the investigation should entail identification of any persons who seek to aide, abet or procure someone to commit FGM. Contrary to Section 1 and 2 of the Act and with a view to identifying other victims.

Early Crown Prosecution investigative advice will be sought by the Police under the FGM Protocol between Merseyside Police and CPS Mersey-Cheshire Dec 2013.

If the adult female is an **Adult at risk**, the adult safeguarding process should be initiated and an urgent Strategy Meeting arranged. Note however if the adult has **Capacity** and does not give consent the safeguarding process would not be taken forward unless there was a wider 'public interest' element to the case. Immediate protection may be secured through the **Court of Protection** or the High Court.

22. Links to Forced Marriage and Domestic Violence and Abuse

There can be a link between FGM and **Forced Marriage**, particularly in adults/teenagers when the woman may be mutilated shortly before the marriage. Professionals should be alert to this and consider a joint response to the Forced Marriage through local protocols alongside protection from FGM – see **Forced Marriage and Honour Based Violence Procedure**.

A woman/girl who has been subjected to FGM may have numerous gynaecological problems and this may make consummation of her marriage or sexual activity with her partner very uncomfortable/painful/impossible. In some communities it is expected that the man will 'open' the woman/girl before the wedding following type III FGM. This may be with a sharp instrument. The female may be frightened, not consent to this, suffer re traumatisation and fear/be ostracised from her community as her husband may not stay with her if she does not consent to this.

Women and girls may be raped within their relationship and suffer pain and re-traumatisation every time a partner demands sex. Some men may be more understanding and the couple may seek **support**. It is important to consider the wider support needs a woman may have including immigration, housing, debt, childcare and counselling support through community groups and domestic abuse specialist support. She may need to be referred to her local Multi Agency Risk Assessment Conference if the risk of forced marriage, serious injury or death is high.

See the WSCB/WSAPB procedures for information on **Domestic Violence and Abuse** and **Forced Marriage and Honour Based Violence**

23. Support for Girls and Women Affected by FGM

There are two main areas of support that should be offered to all women and girls affected by FGM - Counselling, and de-infibulation for type III (see **Section 3, Types of FGM**).

Counselling

Girls and women suffering from anxiety, depression or who are traumatised as a result of FGM should be offered counselling and other forms of therapy. All girls and women who have been undergone FGM should be offered counselling to discuss how deinfibulation will affect them. Parents, husbands boyfriends, partners can also be offered counselling. The Mental Health Services should identify a consultant psychiatrist to lead on FGM.

De-Infibulation/Reversal

This is a small procedure to open the scar carried out in a specialist clinic usually under local anaesthetic. The skin will be stitched at either side of the scar to keep it from healing together again and will usually heal very quickly. This should enable normal intercourse and child birth and reduce the number of infections a girl/woman may suffer. It does not replace tissue that has been removed and more scar tissue may form but it can improve a female's quality of life.

Appendix 1: Guidance for Interviewing Parents/Children/Adult at risk

Ask

Ask children/Adult at risk to tell you about their holiday. Sensitively and informally ask the family about their planned extended holiday ask questions like;

Who is going on the holiday with the child/adult?

How long they plan to go for and is there a special celebration planned?

Where are they going?

Are they aware that the school cannot keep their child on roll if they are away for a long period?

Are they aware that FGM including Sunna is illegal in the U.K even if performed abroad? Use term that may be familiar with as FGM may not always be understood.

If you suspect that a child / adult is a victim of FGM you may ask them;

Your family is originally from a country where girls or women are circumcised – Do you think you have gone through this or at risk of this practice?

Has anything been done to you down there or on your bottom?

Would you like support in contacting other agencies for support, help or advice?

Inform them that you have to share information confidentially with relevant agencies if you are concerned that they or someone else is at risk of being harmed.

These questions and advice are guidance and each case should be dealt with sensitively and considered individually and independently.

Record

All interventions should be accurately recorded by the persons involved in speaking with the child or adult. All recording should be dated and signed and give the full name and role of the person making the recording.

Refer

To Public Protection and Investigation Unit, Social Care or Health/Voluntary sector for medical follow up or support services.

Appendix 2: Legislation on FGM

Prohibition of Female Circumcision Act 1985

FGM (FGM) has been a specific criminal offence since 1985, with the introduction of the Prohibition of Female Circumcision Act 1985. However a 'loophole' was identified in the legislation, in that taking girls who were settled in the UK abroad for FGM was not a criminal offence. It is this 'loophole' that the FGM Act 2003 ('the Act') intended to close.

FGM Act 2003

The Act was brought into force on 3 March 2004 by the FGM Act 2003 (Commencement) Order 2004. The provisions of the Act only apply to offences committed on or after the date of commencement. For offences committed before 3 March 2004 the Prohibition of Female Circumcision 1985, as re-enacted in the FGM Act 2003, continues to apply.

The Act affirmed that it was illegal for FGM to be performed, and that it was also an offence for UK nationals or permanent UK residents to carry out, or aid, abet, counsel or procure the carrying out of FGM abroad on a UK national or permanent UK resident, even in countries where the practice is legal.

The Act was amended by the Serious Crime Act 2015, which removed the reference to 'permanent' UK resident, and defined a UK resident as someone who is 'habitually resident' in the UK. The Serious Crime Act also introduced new sections to the FGM Act to introduce new criminal offences and protective orders.

The following paragraphs outline the sections of the FGM Act 2003, as amended by the Serious Crime Act 2015.

Section 1: Offence of FGM

Section 1 of the Act makes it a criminal offence to excise, infibulate, or otherwise mutilate the whole or any part of a girl's labia majora, labia minora or clitoris. Although the Act refers to "girls", it also applies to women.

Defence

No offence is committed by a registered medical practitioner who performs a surgical operation necessary for a girl's physical or mental health. Nor is an offence committed by a registered midwife or a person undergoing a course of training with a view to becoming a registered medical practitioner or registered midwife, but only if the operation is on a girl who is in any stage of labour, or has just given birth, and is for purposes connected with the labour or birth (see section 1 of the Act).

This applies if the surgical operation is carried out:

In the UK: or

Outside the UK, by persons exercising functions corresponding to those of a UK approved person.

Section 1(5) makes it clear that in assessing a girl's mental health, no account is taken of any belief that the operation is needed as a matter of custom or ritual. An FGM operation, therefore, could not legally occur on the ground that a girl's mental health would suffer if she did not conform to the prevailing custom of her community.

There is no fixed procedure for determining whether a person carrying out an FGM operation outside the UK is an overseas equivalent of a medical practitioner etc for the purpose of

subsection (4). If a prosecution is brought, this will be a matter for the courts (in the UK) to determine on the facts of the case.

Section 2: Assisting a girl to mutilate her own genitalia

It is not an offence for a girl to carry out an FGM operation on herself. However, a person is guilty of an offence if he aids, abets, counsels or procures a girl to excise, infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris (see section 2 of the Act).

Section 3: Assisting a non-UK person to mutilate overseas a girl's genitalia

Section 3 of the Act makes it an offence for a person to aid, abet, counsel or procure the performance outside the UK of a relevant FGM operation that is carried out on a UK national or UK resident by a person who is not a UK national or UK.

So the person who, for example, arranges by telephone from his/her home in England for his/her daughter (who is a UK national or usually resides in the UK) to have an FGM operation carried out abroad by a foreign national (who is not a UK national or does not usually live in the UK) is guilty of an offence.

The exception for necessary surgical operations that applies for the purposes of section 1 of the Act also applies to section 3.

Section 3A: Failure to protect a girl from risk of genital mutilation

This section was introduced by the Serious Crime Act 2015. This section means that if an offence under section 1, 2 or 3 of the FGM Act is committed against a girl under the age of 16, each person who is responsible for the girl at the time the FGM occurred will be liable under the new offence. To be "responsible" for a girl, the person will either:

- have 'parental responsibility' and have 'frequent contact' with the girl, or
- be a person aged 18 or over who has assumed responsibility for caring for the girl "in the manner of a parent".

The requirement for "frequent contact" is intended to ensure that a person who, in law, has parental responsibility for a girl, but who in practice has little or no contact with her, would not be liable.

"In the manner of a parent" is intended to ensure that a person who is looking after a girl for a very short period such as a babysitter would not be liable.

Section 4: Extension of Sections 1 to 3A to Extra-territorial acts or omissions.

Section 4 of the Act makes it an offence for any UK national or resident to carry out any act under Section 1 – 3A outside the UK. For the purposes of this section, the offence will be treated as though it has been committed in England, Wales or Northern Ireland.
The effect of this extension on section 1 is that it is an offence for a UK national or UK resident to carry out an FGM operation outside the UK. By virtue of section 8 of the Accessories and Abettors Act 1861, it will also be an offence for a person in the UK (or a UK national or UK resident outside the UK) to aid, abet, etc a UK national or UK resident to carry out an FGM operation outside the UK. For example, if a person in the UK advises his UK national brother over the telephone how to carry out an FGM operation abroad, he would commit an offence.

The effect of the extension on section 2 is that it will be an offence for a UK national or UK resident outside the UK to aid, abet etc. a person of any nationality to carry out an FGM operation on herself wherever it is carried out.
The effect of the extension of section 3 is that it will be an offence for a UK national or UK resident outside the UK to aid, abet etc. a foreign national (who is not a UK resident) to carry out an FGM operation outside the UK on a UK national or UK resident. For example, a UK resident who takes his UK resident daughter to the doctor's surgery in another country so that an FGM operation can be carried out will commit an offence.

Section 4A: Anonymity of victims

This section was introduced by the Serious Crime Act 2015 and provides for the anonymity of victims by prohibiting the publication of any information that would be likely to lead to the identification of a person against whom an FGM offence is alleged to have been committed. It is hoped that this will encourage more victims of FGM to come forward.

Section 5: Penalties for offences

A person guilty of an offence under Section 1, 2 or 3 is liable:

- On conviction on indictment, to imprisonment for a term not exceeding 14 years or a fine (or both);
- On summary conviction, to imprisonment for a term not exceeding six months or a fine not exceeding the statutory maximum (or both).

A person guilty of an offence under Section 3A is liable:

- On conviction on indictment, to imprisonment for a term not exceeding 7 years or a fine (or both);
- On summary conviction in England and Wales to imprisonment for a term not exceeding twelve months or a fine (or both).
- On summary conviction in Northern Ireland to imprisonment for a term not exceeding six months or a fine not exceeding the statutory maximum (or both).

A person guilty of an offence under Section 4A is liable on summary conviction to an unlimited fine.

Section 5A: Female Genital Mutilation Protection Orders

Section 5A was introduced by the Serious Crime Act 2015 and provides for the making of FGM Protection Orders (FGMPOs).

Orders can be obtained in either the Family or Criminal Court. This is a civil law measure which can be made by a court to protect a girl who has either been, or may become, a victim of FGM. The orders may contain prohibitions, restrictions or requirements as the court considers appropriate and apply to conduct within or outside England and Wales. Examples include surrendering passports, prohibiting travel, or prohibiting others from making arrangements for FGM. The Crown court can also make a FGMPO without application where there are on-going criminal proceedings for FGM, for example to protect siblings.

Breach of a FGMPO is a criminal offence and can be dealt with by the family court or the criminal court. Breach of an Order is punishable on summary conviction with up to 12 months'

imprisonment or a fine; or on conviction on indictment, with up to 5 years' imprisonment or a fine. When dealt with by the family court, it is punishable by up to 2 years imprisonment.

Section 5B: Duty to notify police of FGM

This section was introduced by the Serious Crime Act 2015. Regulated health and social care professionals and teachers are required to report cases of FGM in girls under the age of 18, which they identify in the course of their professional work, to the police. The duty applies where the professional is informed by the girl that FGM has been carried out or where the professional observes physical signs which appear to show that FGM has been carried out and that there is no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected to labour of birth. This duty applies to all doctors, nurses, midwives and teachers.

The FGM notification -

- is to be made to the chief officer of police for the area in which the girl resides using 101;
- must identify the girl and explain why the notification is made;
- must be made before the end of one month from the time when the person making the notification first discovers that an act of female genital mutilation appears to have been carried out on the girl;
- may be made orally or in writing.

Section 6: Definitions

Section 6 gives definitions of terms used in the legislation. This section was amended by the Serous Crime Act 2015 to remove the definition of a permanent UK resident and replace it with the definition for a 'UK resident'.

The term 'girl' includes 'woman'.

A United Kingdom national is an individual who is:

- A British citizen, a British overseas territories citizen, a British National (Overseas) or a British Overseas citizen;
- A person who under the British Nationality Act 1981 is a British subject; or
- A British protected person within the meaning of that Act.

A United Kingdom resident is an individual who is habitually resident in the United Kingdom.

For more information regarding legislation on FGM please see **Female Genital Mutilation Act 2003** and the **CPS FGM Legal Guidance**.

Appendix 3: Useful Contacts

Third Sector Agencies Working With FGM

Foundation for Women's Research and Development (FORWARD)
Tel: 0208 960 4000
Email: **forward@forwarduk.org.uk**

The NSPCC 24hour helpline to protect children and young people affected by FGM
Tel: 0800 028 3550

NESTAC - Drop in groups across the North West for girls and women affected by FGM
Tel: 01706 868993
Mob: 07862 279289
Email: **peggy@nestac.org**

Childline
24 hour helpline for children: 0800 1111

National 24 hour Domestic Violence Helpline
24-hour Helpline: 0808 2000 247

Statutory Agencies Working with FGM

Local Authority referral points for children across Merseyside

Merseyside Police

Local Police Protecting Vulnerable Persons Unit

FGM Clinics

There are several specialist FGM clinics in many large UK cities. Some are linked to an antenatal clinic; others may be within a community clinic or GP surgery. All of these clinics are NHS clinics and therefore free of charge. Most clinics are run by specially trained doctors, nurses, or midwives.

A point to note is that some victims may not want to use local clinics due to fear of being recognised by local community.

How to access an FGM clinic

If you wish to go to refer to any of the clinics, you should check if a GP referral, is required as most clinics do not do not take self-referrals. If the woman is pregnant, a midwife may be able to refer.

Multi-Cultural Antenatal Clinic – Liverpool Women's Hospital
Crown Street
Liverpool L8 7SS
Tel: 0151 702 4180 or 0151 702 4178
Mobile: 07717 516134
Open: Monday-Friday 8.30am-4.30pm
Contact: Ronnie Gilbertson or Joanne Topping

Link Clinic held on a Monday between 9am and 1.30pm.

http://www.liverpoolwomens.nhs.uk/Our_Services/Maternity/Specialist_antenatal_clinics.aspx

St Mary's Hospital – Gynaecology & Midwifery Departments
Dr Fiona Reid MD MRCOG
Consultant Urologist

The Warrell Unit
St Mary's Hospital
Manchester

St Mary's Hospital Consultant Paediatric Gynaecologist
Dr Gail Busby
Tel 44 (0) 161 276 1234
Email: **Gail.busby@cmft.nhs.uk**

Black Association of Women Step Out (BAWSO)
Wrexham Office
33 Grosvenor Road
Wrexham
LL11 1BT
Tel: 01978 355 818
Fax: 01978 355 707
http://www.bawso.org.uk/contact-us/wrexham-2/

Local Contacts:

Liverpool:

Careline/children	**0151 233 3700**
Careline/Adult	0151 233 3800
Savera UK: BME support across Merseyside & Cheshire)	0151 709 6588 (general enquires) Helpline: 0800 107 0726 **Info@saverauk.co.uk** **www.saverauk.co.uk**
Women's Health Information and Support Centre	0151 707 1826
Amadudu (BME women refugees)	0151 734 0083
ABC Domestic Violence Project	0151 484 2484
South Liverpool Domestic Abuse Service	0151 494 2222
Liverpool Domestic Abuse Service	0151 263 7474

Knowsley:

Knowsley Access Team (KAT)	**0151 443 2600.**
Knowsley Access Team	0151 443 2600
Knowsley Domestic Violence Support Services	0151 548 3333
Knowsley Victim & Witness Support Co-ordinator	0151 443 2820
Savera UK: BME support across Merseyside & Cheshire	0151 709 6588 (general enquires) Helpline: 0800 107 0726 **Info@saverauk.co.uk** **www.saverauk.co.uk**

Sefton:

Sefton MBC Customer Access Team	0151 9343737

(Adult/Children Safeguarding referral	
Vulnerable Victim Advocacy Team (VVAT)	0151 934 5142
Sefton Women's & Children's Aid (SWACA)	0151 922 8606
Rape & Sexual Abuse (RASA)	0151 922 9385
Savera UK: BME support across Merseyside & Cheshire	0151 709 6588 (general enquires) Helpline: 0800 107 0726 **Info@saverauk.co.uk** **www.saverauk.co.uk**

St.Helens:

Independent Domestic Violence Advocate	01744 743200
Children's services First Respond Team	01744 676993/6537
Any safeguarding advice for Children or adult	During working hours 01744 676600 Outside hours 0345 0500 148/0845 0500 148
Savera UK: BME support across Merseyside & Cheshire	0151 709 6588 (general enquires) Helpline: 0800 107 0726 **Info@saverauk.co.uk** **www.saverauk.co.uk**
Chrysalis Centre for Change	01744 451309
Helena Extra DV services/Refuge	01925 220541

Wirral:

Wirral Family Safety Unit	**0151 606 5442**
Children's Social Care	0151 606 2006
Adults Social Care	0151 606 2006
Wirral Women's and Children's Aid	0151 643 9766
Savera UK: BME support across Merseyside & Cheshire	0151 709 6588 (general enquires) Helpline: 0800 107 0726 **Info@saverauk.co.uk** **www.saverauk.co.uk**

Appendix 4: Glossary

Angurya cuts: A form of FGM type 4 that involves the scraping of tissue around the vaginal opening.

The term "**closed**" refers to type 3 FGM where there is a long scar covering the vaginal opening. This term is particularly understood by the Somali and Sudanese communities

Infibulation is derived from the name given to the Roman practice of fastening a 'fibular' or 'clasp' through the large lips of a female genitalia (usually within marriage) in order to prevent illicit sexual intercourse.

Re-infibulation (sometimes known as or referred to as reinfibulation **or** re-suturing): The re-stitching of FGM type 3 to re-close the vagina again after childbirth (illegal in the UK as it constitutes FGM).

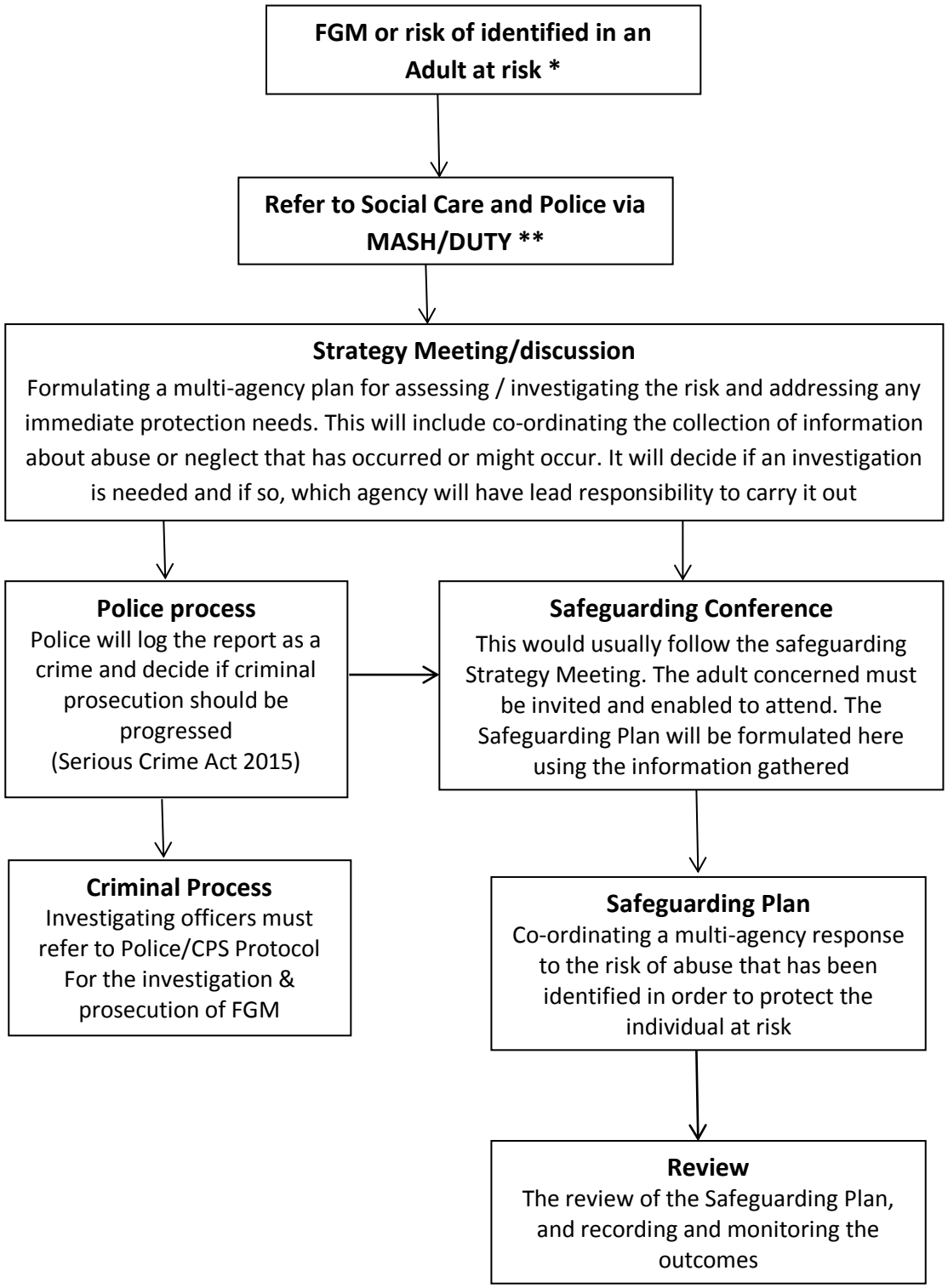
Sunna: the traditional name for a form of FGM that involves the removal of the prepuce of the clitoris only. The word 'sunna' refers to the 'ways or customs' of the prophet Muhammad considered to be religious obligations (wrongly in the case of FGM). Studies show, however, that the term 'sunna' is often used in FGM practicing communities to refer to all forms of FGM, not just FGM that involves only the removal of the hood of the clitoris

Adult at risk: The safeguarding Guidance within the Care Act 2014 (Chapter 14) replaces the 'No Secrets' Guidance (2000) regarding an adult at risk.

Under the Care Act 2014 safeguarding duties apply to an adult who:

- Has need for care and support (whether or not the local authority is meeting any of those needs) and
- Is experiencing, or at risk of , abuse or neglect; and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

Appendix 5: Decision-making and Action Flowchart for Safeguarding Adults at risk



***Adult at risk:** as defined in the Care Act 2014 (chapter 14)

**** Referral:** This should be in writing within 24 hours of identification of the FGM

Appendix 6: FGM Safeguarding and Risk assessment Guidance

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 practiced? (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-judgmental.

- 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 addition consideration may be given to obtaining an FGM Protection Order as detailed in appendix 2.

In many other situations if a child or young adult under 18 years of age is discovered to have had FGM, it should be reported to the Police via the 101 non –emergency number. The police will refer 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
SIGNIFICANT OR IMMEDIATE RISK			
Woman already has daughters have undergone FGM			
Woman comes from a community known to practice FGM			
Woman requesting reinfibulation following childbirth			
Woman has undergone FGM herself			
Woman is considered to be a adult at risk and therefore issues of mental capacity and consent should be considered, if she is found to have FGM			
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 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			
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			

Please remember: any child under 18 who has undergone FGM should be reported to the police via 101 non-emergency number. The police will then refer 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 adult at risk and therefore issues of mental capacity and consent should be triggered if she is found to have FGM			

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

Please remember: any child under 18 who has undergone FGM should be reported to the police via 101 non-emergency number: The police will then refer to social services.

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 reported to the police via 101 non-emergency number: The police will then refer 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)

Date: _____ Completed by: _____

Initial/On-going Assessment

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

Indicator	Yes	No	Details
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 previously			
Girl presents to GP or A & E with frequent urine, menstrual or stomach problems			
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			
Family/child already known to social services – if known, and you have identified FGM within a family you must share this information with social services			
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			

Please remember: any child under 18 who has undergone FGM should be reported to the police via 101 non-emergency number. The police will then refer 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.

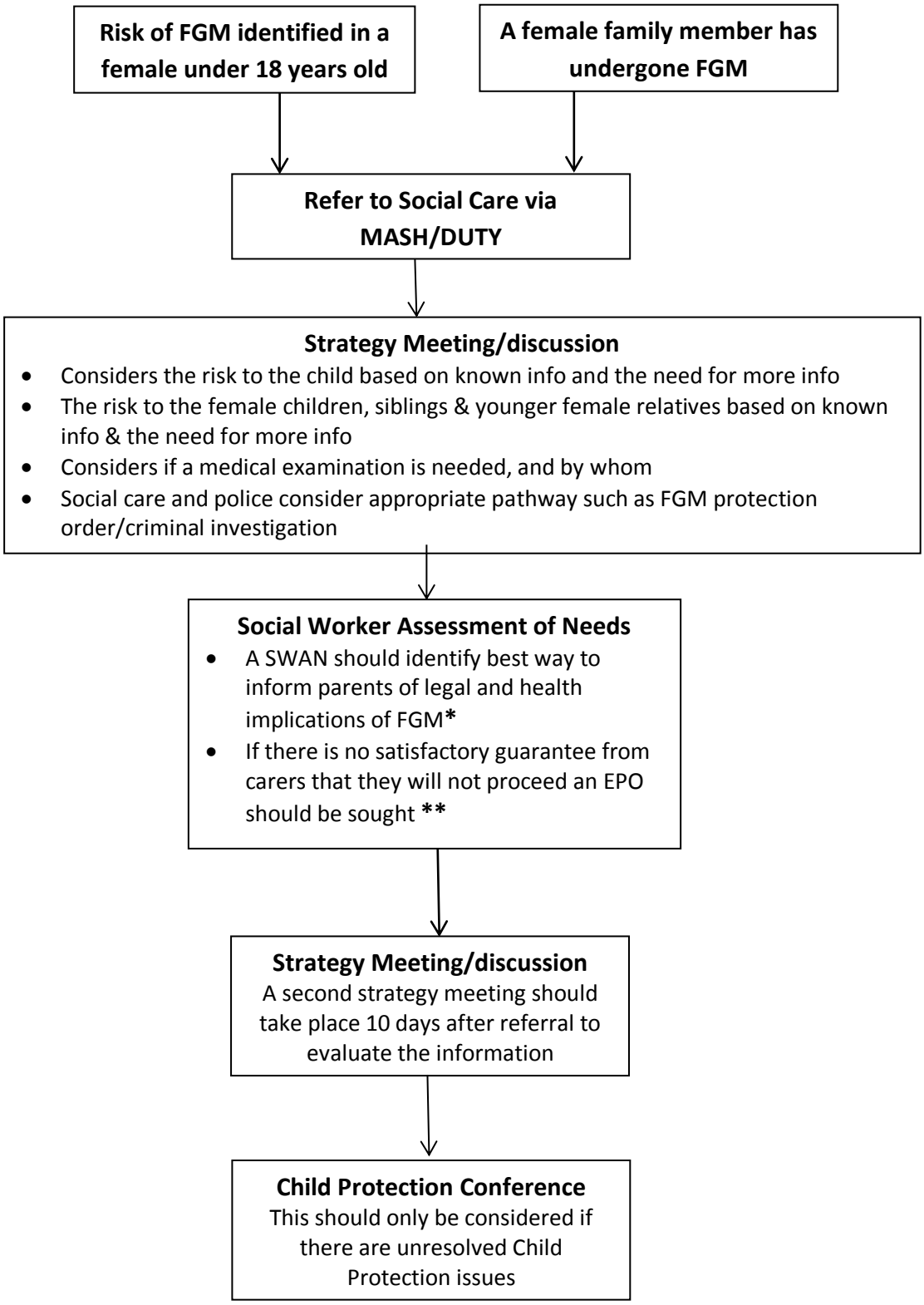
Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures.

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

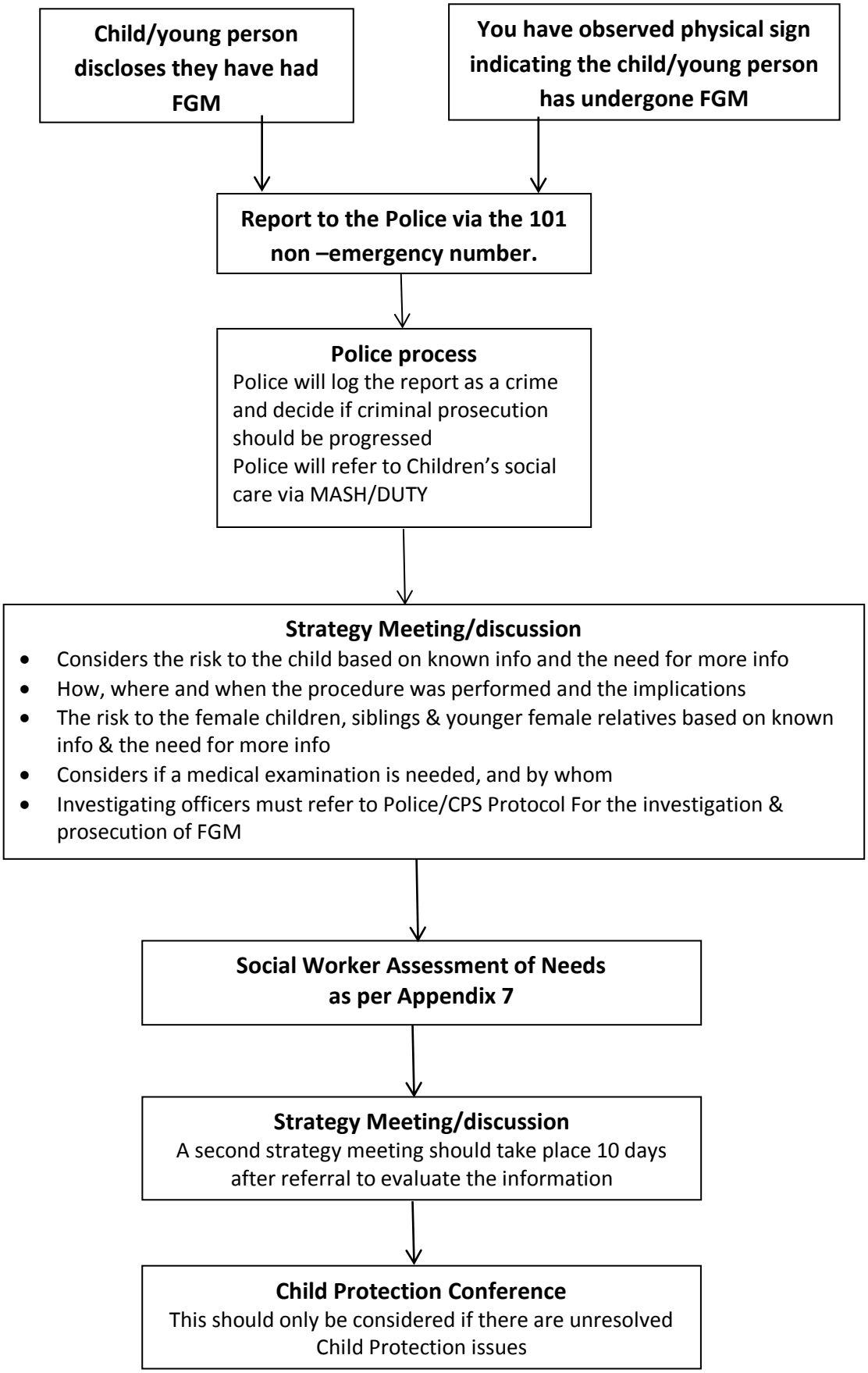
Appendix 7: Decision-making and Action Flowchart for Safeguarding Children RISK OF FGM



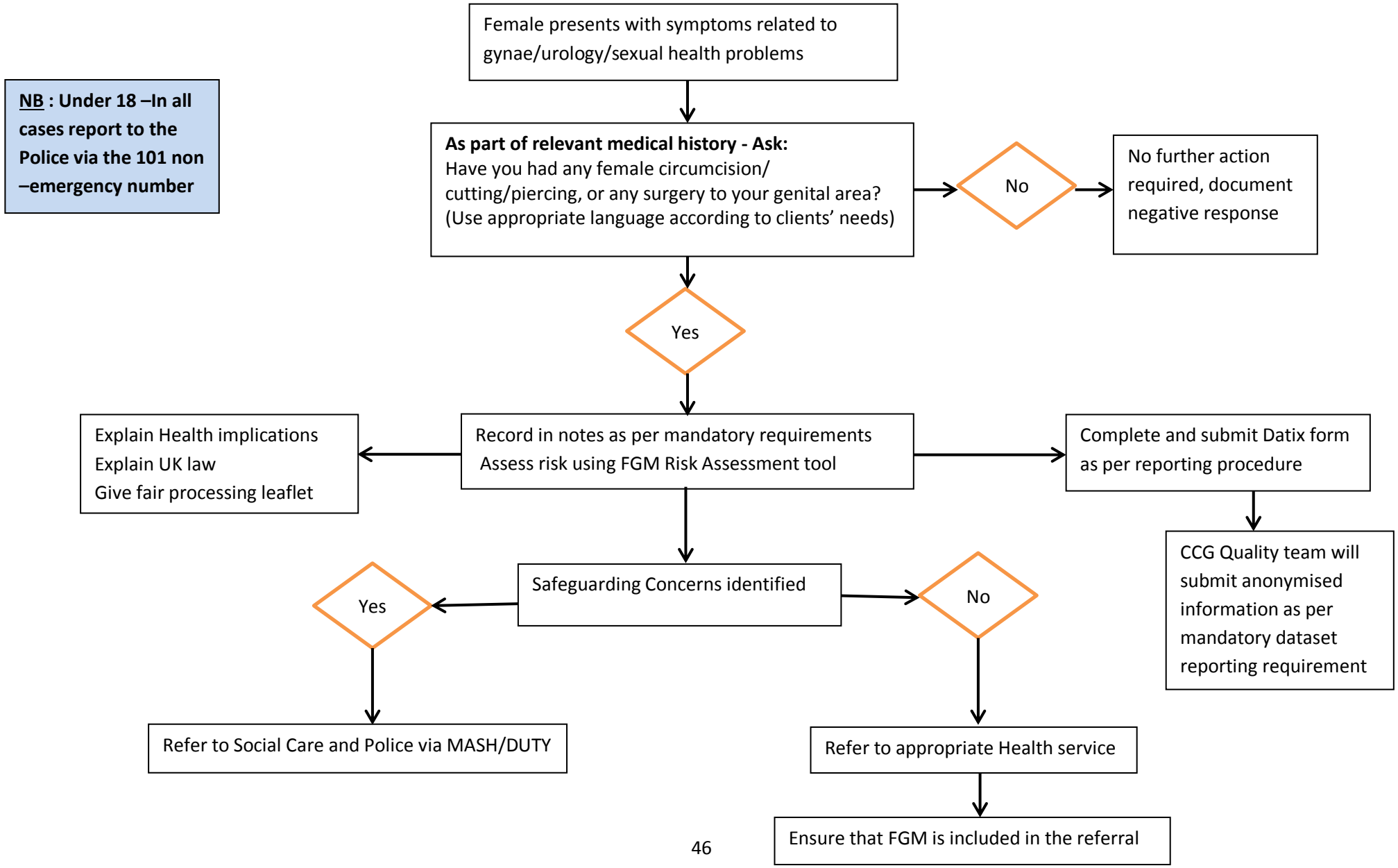
* Assess the potential risk to any female children in the family

** If any legal action considered legal advice must be sought

Appendix 7a : Decision-making and Action Flowchart for Safeguarding Children ACTUAL FGM



Appendix 8: Flowchart for Wirral GP Practice staff



Appendix 9: World Map