Buckinghamshire BSCB Safeguarding Children Board

Safeguarding Girls and Women at Risk of Abuse through Female Genital Mutilation

Guidance and Procedure

Version Control			
Version number	**Date**	**Author**	**Comments and nature of update**
V1.0	November 2010		Original Document
V2.0	January 2013		Revised by Policies and Procedures Sub Group
V3.0	March 2016	Sandra Parsons	Draft revision in line with draft of new strategy
V3.1	June 2016	Matilda Moss	Further work on draft
V3.2	August 2016	Matilda Moss	To reflect feedback from multi-agency working group:
V3.3	January 2017	Matilda Moss	Additional content added around adults and mental capacity in discussion with Safeguarding Adults Board.

Contents	Page No
Section 1: Introduction	
Section 2: Key Principles	
Section 3: Legal Status	
Section 4: Definition and types of Female Genital Mutilation	
Section 5: Prevalence (International, National and Local)	
Section 6: Cultural Context	
Section 7: Signs and Indicators	
Section 8: Health Implications of FGM	
Section 9: Procedure for responding to FGM	
Section 10: Health Professionals	
Section 11: Information Sharing	
Section 12: Mandatory Reporting and the FGM Enhanced Dataset	
Section 13: Talking to Women and Children	
Section 14: Requests for Re-infibulation	
Section 15: Interpreters	
Appendix A: FGM Screening Tool / Risk Assessment	
Appendix B: Key Questions for discussing FGM with women	
Appendix C: Terms for FGM in different languages	

1. Introduction

1.1 Female Genital Mutilation (FGM) is considered child abuse in the UK and is a grave violation of the human rights of girls and women. It has intolerable long-term physical and emotional consequences for the survivors and has been illegal in the UK for over 30 years. It is estimated that 137,000 girls and women in the UK are affected by this practice,[i] but this is likely to be an underestimation.[ii]

1.2 This multi-agency FGM guidance and procedure is produced to support agencies in Buckinghamshire to work effectively together to tackle FGM. **Agencies should continue to refer to relevant specialist professional guidance alongside this document.**

1.3 This document should also be read in conjunction with:

- Government Statutory Guidance on Female Genital Mutilation. This should be read and followed by all professionals who are working to safeguard and promote the welfare of children and vulnerable adults.
- BSCB Thresholds document and procedure for what to do if you are concerned about a child in Bucks
- The government's procedural information for professionals subject to the FGM mandatory reporting duty

2. Key Principles

2.1 All agencies/services should be alert to the possibility of FGM, and their approach should include a preventative strategy that focuses upon education, as well as the protection of girls / women at risk of significant harm.

2.2 The following principles should be adhered to:

- The safety and welfare of the girl / woman is paramount.
- All agencies/services and staff, including volunteers, should act in the interest of the rights of the girl / woman, as stated in the UN Convention on the Rights of the Child (1989)
- All decisions or plans for the girl / woman should be based on thorough assessments which have a sensitive approach to the issues of age, race, culture, gender, religion. Stigmatisation of the girl / woman or their specific community should be avoided.
- Buckinghamshire's agencies/services should work in partnership with members of affected local communities, to develop support networks and appropriate education programme.

3. Legal Status

3.1 The momentum to end FGM has grown significantly in the last four years due to various campaigners raising awareness of the issue and the government strengthening its stance on FGM.[iii] The UK government is committed to eradicating this harmful practice within a generation[iv] and has strengthened the legal framework to help achieve this.

Mandatory Reporting Duty (October 2015): Introduced under Section 5B of the 2003 Female Genital Mutilation Act, the duty requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s to the police which they identify in the course of their professional work. See Section 12 of this guidance for further details

Serious Crime Act (2015): This strengthened the 2003 Female Genital Mutilation Act with the following measures:
1) **Created a new offence** of failing to protect a girl from FGM. Anyone with parental responsibility for a girl under 16 who was mutilated will be potentially liable if they did not take steps to prevent it.
2) **Granted** life-long anonymity for persons against whom a female genital mutilation offence is alleged to have been committed.
3) **Enabled** a court to grant an "FGM protection order" for the purposes of:
   a) protecting a girl against the infliction of a genital mutilation offence, or
   b) protecting a girl against whom any such offence has been committed.

Female Genital Mutilation Act (2003): This replaced the 1985 Act in England, Wales and Northern Ireland.[1]

Made the following an offence:
1) To aid, abet, counsel or procure a person who is not a UK national or permanent UK resident to undertake a relevant act of FGM outside the UK.
2) To aid, abet, counsel or procure a girl to excise, infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris.
On conviction of indictment: a fine, or imprisonment for a term not exceeding 14 years, or both.

Prohibition of Female Circumcision Act (1985): It became an offence for any person:
a) to excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person.
b) to aid, abet, counsel or procure the performance by another person of any of those acts on that other person's own body.
On conviction or indictment: a fine or imprisonment for a term not exceeding 14 years or both.

4. Definition and Types of Female Genital Mutilation

4.1 The World Health Organisation (WHO) defines female genital mutilation as: "*all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons*".

4.2 FGM has been classified by the WHO into four types:

- **Type 1 - Clitoridectomy:** Partial or total removal of the clitoris and, rarely, the prepuce (the fold of skin surrounding the clitoris) as well.

- **Type 2 - Excision:** Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are 'the lips' that surround the vagina).

- **Type 3 - Infibulation:** Narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner and sometimes outer labia, with or without removal of the clitoris. This is the most extreme form of FGM.

- **Type 4 - Other:** All other harmful procedures to the female genitalia for non-medical purposes for example, pricking, piercing, tattooing, incising, scraping and cauterising the genital area. Type 4 is noted by professionals to be common among practising communities. However, it is also the type that often goes unnoticed and therefore not recorded.

4.3 FGM is known by a number of names, including female genital cutting or circumcision. The names 'FGM' or 'cut' are increasingly used at the community level, although they are still not always understood by individuals in practicing communities, largely because they are English terms. Appendices B and C provide further information to help professionals talk about FGM with different communities, including the various names that may be used for FGM across different communities.

4.4 Those who are affected by FGM may be born to parents from FGM practising communities or women resident in the UK who were born in countries that practice FGM. These may include (but are not limited to) immigrants, refugees, asylum seekers, overseas students or the wives of overseas students.

4.5 The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out at any time, including when the girl is newborn, during childhood, adolescence, at marriage or during the first pregnancy. However, in the majority of cases FGM takes place between the ages of 5-8 and therefore girls within that age bracket are at a higher risk.

5. Prevalence

5.1 The Buckinghamshire Strategy for Tackling FGM contains more detailed information on the prevalence of FGM at an international, national and local level. A summary of key points is listed below.

5.2 The International Picture

- Globally 100 – 140 million women and girls have undergone FGM and a further 3 million girls undergo FGM every year in Africa. [v]
- Most of the females affected live in 28 African countries, with some also from parts of the Middle East and Asia. In Somalia, Sudan, Djibouti, Egypt, Guinea and Sierra Leone, FGM prevalence rates are over 90%.

5.3 The National Picture

5.3.1 The prevalence of FGM in the UK is difficult to estimate because of its hidden nature. However, a report published in July 2014[vi] estimated that as of 2011:

- Approximately 60,000 girls aged 0-14 were 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 practised, were permanently resident in England and Wales in 2011.

5.4 The Local Picture

5.4.1 There is an uneven distribution of cases of FGM around the country, with more occurring in those areas of the UK with larger communities from the practising countries. Whilst this would not make Buckinghamshire an area of high FGM prevalence, there are some areas close by that are likely to have far more cases such as Oxford, Reading, Slough and Milton Keynes.

5.4.2 The Buckinghamshire Joint Strategic Needs Assessment (JNSA) has used 2011 census data to estimate the number of women aged 15-49 years in Buckinghamshire and within each of the four Districts who may have undergone FGM.[vii]

- Approximately 792 (0.16% of the total population) Buckinghamshire resident women aged 15-49 years may have undergone FGM. In addition there will also

be women aged 50 and over who have undergone FGM who are not included in these estimates.
- The highest number of women aged 15-49 estimated to have undergone FGM live in Wycombe District Council, although the proportion of the total population is slightly higher in South Bucks than in other Districts.
- In Wycombe District Council there are estimated to be 257 women (0.15% of total residents) who have had FGM, 238 (0.14% of total residents) in Aylesbury Vale District Council, 161 (0.24% of total residents) in South Bucks District Council, and 136 (0.15% of total residents) in Chiltern District Council.

5.4.3 Since the mandatory reporting duty was implemented in October 2015 (see section 12), no cases of FGM in Buckinghamshire have been reported to Thames Valley Police that could be recorded as a crime under Home Office Counting Rules.

5.4.4 Data on FGM prevalence can also be derived from The Female Genital Mutilation (FGM) Enhanced Dataset (see section 13). This is a repository for individual level data collected by healthcare providers in England. As of September 2016, all statistical releases relating to Buckinghamshire have data suppressed for statistical reasons, indicating between 0 and 4 reported cases for each reporting period.

5.4.5 It is important professionals understand how to follow relevant reporting procedures so that we have an accurate picture of the prevalence of FGM in Buckinghamshire. Professionals should also be aware that as the demographics of our community shift over time, it is possible that we will see an increase in residents from those countries where FGM is prevalent.

6. Cultural Context

6.1 The procedure is often carried out by an older woman in the community, who may see conducting FGM as a prestigious act.

6.2 The procedure can involve the girl / woman being held down on the floor by several women. It is often carried out without medical expertise, attention to hygiene or an anaesthetic. Instruments used have been known to include un-sterilised household knives, razor blades, broken glass and stones. The girl / woman may undergo the procedure unexpectedly, or it may be planned in advance.

6.3 The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. Increasingly, however, FGM is being performed by health care providers.[viii]

6.4 The WHO cites a number of reasons for the continuation of FGM, such as:

- Custom and tradition
- A mistaken belief that FGM is a religious requirement
- Preservation of virginity/chastity
- Social acceptance, especially for marriage
- A belief that it will increase marriageability
- Hygiene and cleanliness
- Increasing sexual pleasure for the male
- Family honour
- A sense of belonging to the group and conversely the fear of social exclusion
- Enhancing fertility

6.5 Religion and FGM

- Muslim scholars and faith leaders, including the Muslim Council of Britain, have condemned the practice and are clear that FGM is an act of violence against women. Further, scholars and clerics have stressed that Islam forbids people from inflicting harm on others and therefore the practice of FGM is counter to the teachings of Islam.
- The Bible does not support this practice nor is there any suggestion that FGM is a requirement or condoned by Christian teaching and beliefs.

7. Signs and Indicators

7.1 Specific factors that may heighten a child's risk of being subjected to FGM include:

- Girl's mother has undergone FGM
- Other family members have undergone FGM
- Father comes from a community known to practice FGM
- Mother / family have limited contact with people outside of her family
- Parents have poor access to information about FGM and do know about the harmful effects of FGM or UK law
- Girl/family has limited level of integration within UK community
- Girl/women repeated fail to attend or engage with health and welfare services
- A family elder such a grandmother is very influential within the family and is / will be involved in the care of the girl

7.2 Indications that FGM may be about to take place include:

- Parents say 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 be more likely to 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 family (see Appendix C for traditional and local terms) – the context of the discussion will be important
- Girl withdrawn from PHSE lessons or from learning about FGM at school
- Girl has confided in another that she is to have a ‘special procedure’ or to attend a ‘special occasion’. Girls has talked about going away ‘to become a woman’ or to ‘become like my mum and sister’
- The girl or a sibling may ask for help
- A parent or family member expresses concern that FGM may be carried out on a child

7.3 Indications that FGM may have already taken place include:

- Girl is reluctant to undergo any medical examination
- Girl spends long periods of time in the bathroom / toilet / away from the classroom
- Girl has spoken about having been on a long holiday to her country of origin / another country where the practice is prevalent
- Increased emotional and psychological needs such as withdrawal, depression or significant changes in behaviour
- Girl presents to GP or A&E with frequent urine, menstrual or stomach problems
- Girl talks about pain or discomfort between her legs
- Girl has difficulty walking, sitting or standing and looks uncomfortable
- Girl finds it hard to sit still for long periods of time, which was not a problem previously
- Girl is avoiding physical exercise or requiring to be excused from PE lessons without a GP letter
- A child may ask for help or confides in a professional that FGM has taken place
- Mother of family member discloses that FGM has taken place

8. Health Implications of FGM

8.1 Short term consequences of FGM may include:[ix]

- Severe pain during the procedure and healing
- Shock, which may be caused by pain and / or haemorrhage
- Excessive bleeding
- Difficulty in passing urine and faeces due to swelling and pain

- Infections or septic shock are common, particularly as the procedure can be carried out in unhygienic conditions and/or with instruments that are not sterilised.
- Psychological consequences due to the pain, shock and use of physical force by those performing the procedure
- Death can be caused by haemorrhage or infections

Blood born viruses (for example Hepatitis B and C and HIV) and Tetanus are also a potential risk due to non-sterile equipment being used.

8.2 Long term consequences may include:

- Chronic pain
- Infections, particularly of the reproductive and urinary tracts
- Abscesses, painful cysts or keloids (excessive scar tissue formed at the site of the cutting)
- Menstrual problems
- Birth complications such as prolonged labour, recourse to caesarean section, postpartum haemorrhage and tearing
- Danger to the new-born, with high death rates and reduced Apgar scores
- Increased risk of HIV infection and transmission in adulthood due to an increased risk of bleeding during intercourse
- Psychological consequences such as fear of sexual intercourse, post-traumatic stress disorder, anxiety, depression and memory loss
- Loss of pleasure in sex and / or loss of ability to experience orgasm

8.3 Results from research in practicing African communities are that women who have undergone FGM have the same levels of Post-Traumatic stress Disorder as adults who have been subject to early childhood abuse. Research also indicates that the majority of the women (80%) suffer from affective (mood) or anxiety disorders.[x]

9. Procedure for responding to FGM

9.1 The following circumstances relating to FGM require identification and intervention:

- It is known that an adult woman has undergone FGM and there are no children or pregnant women in the household
- It is known that an adult woman has undergone FGM and there is an unborn child / female child(ren) in the family or household. However, FGM has not been identified in them and there are no signs that FGM is imminent

- It is known that an adult woman has undergone FGM, there is a female child / children in the family or household and there is suspicion FGM has occurred or may be imminent
- A female child / children have been subjected to FGM and this is confirmed by a disclosure or evident on examination.

9.2 Please refer to the following flow diagram to guide you through the procedure in Buckinghamshire for each of these circumstances.

Multi-Agency FGM Pathway

FGM / risk of FGM is identified or suspected, for example through

- Routine enquiry
- Disclosure
- Physical findings during examination
- Girl talks about attending 'special celebration' in high prevalence country of origin

See Section 7 of Multi-Agency FGM Guidance for further detail on potential signs and indicators of FGM

Explore consequences of FGM for the woman / girl (physical / psychological / legal) and any ongoing risk of FGM for any children / unborn children in the household. Avoid using a family member as an interpreter.

- Complete most relevant FGM screening tool (See Appendix A of Multi-Agency FGM Guidance)
- Provide information on the illegal status of FGM in the UK
- Inform that you will need to share information with the GP and any other relevant professional involved in the girl / woman's care (e.g. Health Visitor, midwife)
- Provide and discuss leaflet on FGM in appropriate language (see section 13 of the FGM Guidance for suggested leaflets) and advise on available support

Adult female identified as FGM victim and no female children or pregnant women in the family / household.

Treat as **LOW** / **FUTURE risk**

- Discuss with woman
- Ongoing preventative work with woman & family recommended
- Refer to services to manage psychological / physical / legal impact

- Inform GP with consent
- Flag internal records

Adult female identified as FGM victim and unborn child / female child(ren) in family / household. No FGM or signs of imminent FGM identified in them.

Treat as **LOW** / **FUTURE risk**

- Discuss with family **if safe to do so**
- Ongoing preventative work with woman & family recommended
- Refer to services to manage psychological / physical / legal impact

- Inform GP & other relevant services (eg midwife, social worker, health visitor). If consent is not given professionals may wish to reconsider risk level risk
- Flag internal records

Female childr(ren)/ vulnerable adult* in family/ household and:

- Suspicion FGM has occurred
- Signs of possible procedure suspected
- Signs procedure is planned / imminent

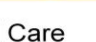
Treat as **HIGH** / **IMMEDIATE risk**

- Refer child to Children's Social Care using Multi-Agency Referral Form (MARF)
- Refer vulnerable adult to Adult Social Care
- Call Police on 999 if immediate action required

Female child(ren) / **vulnerable adult*** in family / household already subjected to FGM – confirmed by disclosure or evident upon examination.

Treat as **HIGH** / **IMMEDIATE risk**

- Refer child to Children's Social Care using MARF. Agencies subject to **Mandatory Reporting Duty** must also report to Police on 101
- Consider referring vulnerable adult to Adult Social Care
- Call Police on 999 if immediate action required



For child: Multi-agency strategy discussion led by Children's Social Care

- Legal advice may sought and action taken
- Consider if medical examination at SARC (Sexual Assault Referral Centre) is required
- Section 47 Enquiry which may lead to Child Protection Conference and Plan
- If Child Protection Plan is not keeping girl safe from harm, Children's Social Care will consider legal proceedings including FGM Prevention Order, Supervision Order or Care Order.

For vulnerable adult: Multi-agency response to be agreed in-line with local safeguarding procedures.

9.3 All professionals are encouraged to complete a risk screening tool for any case of FGM, whether it is known or suspected. This will help with the assessment of the situation, decision making and record keeping. A screening tool is provided at Appendix A.

9.4 In all cases, professionals should consider dialling 999 if immediate Police action is needed.

9.5 In cases where it is **known that a child has undergone FGM** (if a professional has seen evidence of it or heard about it directly from the child) professionals must make a referral to Children's Social Care using the Multi Agency Referral Form (MARF). Regulated professionals working within health or social care, and teacher, must also act in accordance with the FGM Mandatory Reporting Duty (see section 12) by reporting the case without delay to the police on 101.

9.6 If there are reasons to **suspect that a child has been abused through FGM**, (for example, see signs and symptoms listed in Section 7), the professional or the Safeguarding Lead from the organisation should make a referral to Children's Social Care using the MARF.

9.7 In cases where it is **known or suspected that a vulnerable adult has undergone FGM**, the professional should consider making a referral to Adult Social Care. Consideration should be given to how recently the FGM was undertaken and the impact on the individual. If there are any doubts about whether a referral should be made, the professional can ring the Multi-Agency Safeguarding Hub (MASH) for advice on 0800 137 915.
* In this content, a vulnerable adult is defined as someone who has care and support needs.[1]

9.8 If there is a perception that **a child may be at risk of FGM in the future** it is important to determine whether this risk is high and immediate, or low and future. All professionals should complete an FGM risk screening tool (see Appendix A) to help with the assessment of the situation, decision making and record keeping.

9.9 If there is concern that a **vulnerable adult may be at risk of FGM in the future** it is important to determine whether this risk is high and immediate, or low and future. All professionals should complete an FGM risk screening tool (see Appendix A) to help with the assessment of the situation, decision making and record keeping.
* In this content, a vulnerable adult is defined as someone who has care and support needs.[2]

[1] The Care Act 2014 sets out a minimum threshold in term of adult care and support needs: www.legislation.gov.uk/ukpga/2014/23/contents/enacted
[2] The Care Act 2014 sets out a minimum threshold in term of adult care and support needs: www.legislation.gov.uk/ukpga/2014/23/contents/enacted

9.10 An example of a high/immediate level of risk is if a girl is talking about a 'special' ceremony, going on a long holiday, or if a woman who has had FGM and gave birth to a girl admits to be supporting the practice.

9.11 An example of a low/future level of risk is when a woman who has had FGM and gave birth to a girl speaks against cutting her daughter.

9.12 Professionals should see to undertake a holistic assessment of the family given the pressure to undertake FGM can come from other members of the family such as female family elders.

9.13 In all cases the risk to other female children in the family and extended family must be considered, and all parents/carers should be given information on FGM explaining that it is illegal to carry it out in the UK or to take their child abroad and they have a statutory responsibility to protect their child from this practice.

9.14 If it has been determined that the risk is high/immediate it is important to act quickly – before the child is abused by being subjected to FGM in the UK, or taken abroad to undergo the procedure.

9.15 Every attempt should be made to work with parents to prevent abuse of FGM occurring. All professionals should ensure that parental co-operation is achieved wherever possible, including the use of community organisations and / or community leaders to facilitate the work with parents / family.

9.16 However, if it is not possible to reach an agreement and if the parents cannot guarantee that they will not proceed with the mutilation, the first priority is protection of the girl / woman and appropriate measures should be taken such as an Emergency Protection Order, Police Protection or an FGM Prevention Order should be sought.

9.17 There may be cases where the risk is determined as low at the time of the assessment, for example if a mother who has had FGM speaks against mutilating her daughter. However, as the child is growing up the risk might change from low to high and it is important that all agencies follow their internal procedures, and complete and attach an appropriate risk screening tool to the child's health records for future reference.

9.18 Regardless of the age of the girl or woman, or when the procedure took place, all professionals should make appropriate referrals to support those suffering from the physical or emotional consequences of FGM.

9.19 There is no requirement for automatic referral of other adult women with FGM to adult social services or the police. Healthcare professionals should be aware that any disclosure may be the first time that a woman has ever discussed her FGM with anyone. Referral to the police must not be introduced as an automatic response

when identifying adult women with FGM, and each case must continue to be individually assessed. Healthcare professionals should seek to support women by offering referral to specialist organisations that can provide support, and for possible clinical intervention or other services as appropriate. The wishes of the woman must be respected at all times.

10. Health professionals

10.1 Health professionals in GP surgeries, sexual health clinics and maternity services are the most likely to encounter a girl or woman who has been subjected to FGM. A question about FGM should be incorporated when the routine patient history is being taken and professionals should consider the advice provided in Section 13 about talking to a child or woman about FGM.

11. Information Sharing

11.1 As with any form of child abuse, when FGM / risk of FGM is identified it is important that information is shared appropriately with relevant professionals. This will help ensure the right measures are put in place to safeguard against the risk of FGM or to meet the physical and psychological needs of those who have undergone FGM.

11.2 You should discuss openly with the girl / woman and, where possible, with the parents of a girl, how, why and with whom information will be shared and seek their consent. **However, be aware that by alerting a girl's family, you may place her at increased risk of harm.** Professionals should take this into account and remember that consent for information sharing is not required where there is evidence the child is suffering or at risk of suffering significant harm, or in order to prevent a criminal offence from taking place.

11.3 The risk of FGM can change over time and if information has been shared then professionals who are in contact with a child in the future may be in a good position to spot signs of imminent or actual FGM. For example, if a midwife has shared information with a GP that a mother has had FGM, when her daughter attends the GP Practice with urine and stomach problems this may prompt early questioning about possible FGM.

11.4 Information should always be shared in line with the BSCB Information Sharing Code of Practice and the Government's information sharing advice for safeguarding practitioners.

11.5 The multi-agency pathway diagram provides further guidance on information sharing in relation to FGM. However, if you are unsure whether you can share information, then please refer to the BSCB Information Sharing Code of Practice and the government guidance. If you are in doubt, speak to your designated safeguarding lead as soon as possible.

11.6 For known cases of FGM, those agencies subject to the Mandatory Reporting Duty must share information in order to make a report (see below). Whilst it is good practice to discuss that you will need to share information to make a report, consent is not required. In cases where mandatory reporting has taken place, this does not negate the need to share information with other relevant professionals.

12. Mandatory Reporting

12.1 On the 31st October 2015 a new duty was introduced that requires all regulated professionals working within health or social care, and teachers, to report 'known' cases of FGM in girls aged under 18 to the police. This is an individual rather than a corporate duty.

12.2 'Known' cases are those where either a girl discloses that FGM has been carried out on her, or where a professional observes physical signs on a girl appearing to show that FGM has been carried out. For example, if a doctor sees that a girl aged under 18 has had FGM they will need to make a report to the police. Similarly if a girl tells her teacher that she has had FGM, the teacher will need to report this to the police.

12.3 To make a report you should call the Police on 101 and state you wish to make a report under the FGM mandatory reporting duty. Reports should be made as soon as possible after the FGM is discovered, and best practice is to complete the report by the close of the next working day.

12.4 All agencies should ensure relevant frontline staff understand this duty and how to make a report. The professional consequences for failing to report a known case of FGM in a child are very serious.

12.5 Professionals subject the duty and their employers should refer to the government guidance on mandatory reporting. This includes a list of those professionals covered by the report and more detail on how to make a report.

12.6 The government has also published additional information on the mandatory duty for health care professionals in England

13 The FGM Enhanced Dataset

13.1 Some agencies will also need to submit data on FGM to the FGM Enhanced Dataset.

13.2 This dataset was set up to collect information on the prevalence of FGM from across the NHS in order to support a response to FGM that is based on an understanding of need. The Information Standard (SCC 12026 FGM Enhanced

Dataset) requires clinicians across all NHS healthcare settings to record in clinical notes when patients with FGM are identified, and what type it is.

13.3 It became mandatory for all acute trusts to collect and submit the FGM Enhanced Dataset from 1st July 2015 and all mental health trusts and GPs from 1st October 2015. Community services within mental health trusts can participate. Sexual Health and GUM clinics do not need to submit FGM information but the legal obligation to appropriately share information for safeguarding purposes still applies.

13.4 All relevant agencies should ensure their staff are familiar with these requirements. Further information on the dataset can be found at www.digital.nhs.fgm.

14 Talking to women and children

14.1 Professionals discussing FGM with a child or woman suspected to be abused through FGM should tailor their response appropriately, including:

- Arranging for an interpreter if this is necessary and appropriate (avoid using a family member as an interpreter)
- Creating an opportunity for the child / woman to disclose, seeing the child / woman on their own
- Using simple language and asking straightforward questions
- Giving the opportunity to be accompanied by someone they know and trust
- Using terminology that the child / woman will understand, e.g. the child / woman may not view the procedure as abusive
- Being sensitive to the fact that the child / woman will be loyal to their parents
- Being willing to listen and giving the child / woman time to talk
- Getting accurate information about the urgency of the situation, if the child is at risk of being subjected to the procedure
- Giving the message that the child / woman can come back to you again
- Being sensitive to the intimate nature of the subject
- Making no assumptions
- Being non-judgemental (condemning the practice, but not blaming the girl/woman)
- Understanding how she may feel in terms of language barriers, culture shock, that she, her partner, her family are being judged
- ‘Circumcised’ is not medically correct and although ‘mutilation’ is the most appropriate term, it might not be understood or it may be offensive to a woman from a practising community who does not view FGM in that way. Different terminology will be appropriate to the different cultures (see Appendix C)
- Giving a clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM if / when they have daughters
- Carrying out Mental Capacity Assessment as necessary

14.2 Professionals can refer to 'Key questions for interviewing women with FGM' (Appendix B) to start a conversation on FGM. The following leaflets may also be useful for practitioners who are discussing FGM with women and children:

- FGM: The Facts (Home Office)
- More about FGM (Department of Health) – available in several different languages
- A guide on FGM for young people (Forward UK)

15 Requests for re-infibulation

15.1 After childbirth, a girl / woman who has been deinfibulated (a surgical procedure to open up the scar tissue to restore the normal vaginal opening, commonly called a 'reversal') may request re-infibulation. All girls / women who have undergone FGM (and their partners or husbands) must be told that re-infibulation is against the law and will not be done under any circumstances. Each woman should be offered counselling to address how things will be different for her afterwards.

15.2 If a woman continues to request re-infibulation this should be treated as a potential child protection concern, as the girl / woman's apparent reluctance to comply with UK law, may have implications for her own children if they are female. Professionals should consult with their agency's designated safeguarding lead and make a referral to Children's Social Care using the MARF.

16 Interpreters and Independent Mental Capacity Advocates

16.1 Wherever possible, a professional female interpreter should be used for a girl / woman known to have limited English. This will reduce misunderstanding, increase the likelihood of identification of FGM and any additional physical, psychological and social concerns. Use of family members is not advised as they may influence decisions and inhibit true expression of the woman's feelings.

16.2 Always brief / debrief the interpreter, explain the purpose of the meeting, ensure they understand the issue and are happy to talk about FGM. We must remain aware that the interpreter may have experienced FGM, hence may have difficulty discussing it. Alternatively, they may view FGM as a valuable practice, hindering the interpretation process.

16.3 Always check that the girl / woman is happy to continue with the chosen interpreter, as communities affected by FGM are often small and therefore interpreters may be known socially by the girl / woman. The importance of confidentiality should be stressed to all parties involved.

16.4 In the case of an adult with care and support needs, it may be necessary to appoint an Independent Mental Capacity Advocate (IMCA) to support them with

decision making. Further information, including how to book n IMCA can be found at: www.pohwer.net/buckinghamshire

Appendix A FGM Screening Tool / Risk Assessment

This section provides 4 short risk assessments that can be used by relevant professionals in the following scenarios:

1. **Child under 18 years old:** Use when considering whether a child has had FGM

2. **Child under 18 years old:** Use when considering whether a child may be at risk of FGM or whether there are other children in the family for whom a risk assessment may be required.

3. **Non-Pregnant woman over 18 years old:** Use when considering whether any female children are at risk of FGM, whether there are any 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 FGM.

4. **Pregnant woman:** Use when considering 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 FGM.

NB, all of these assessments tools can also be used for adults with care and support needs.

Name ______________________________
DOB _______________________________
NHS number _______________________
Completed by ______________________
Initial/ On-going assessment

FGM Risk Assessment Tool for Child or Young Adult (under 18)

Please use this tool when considering whether a child has had FGM.

Indicator	Yes	No	Details
CONSIDER RISK			
Girl is reluctant to undergo any medical examination			
Girl has difficulty walking, sitting or standing or looks uncomfortable			
Girl finds it hard to sit still for long periods of time, which was not a problem previously			
Girl presents to GP or A&E with frequent urine, menstrual or stomach problems			
Increased emotional and psychological needs 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			
Gil spends a long time in the bathroom/toilet/long periods of time away from the classroom			
[illegible]			
HIGH OR IMMEDIATE RISK			
Girl asks for help			
Girl confides in a professional that FGM has taken place			
Mother/family member discloses that female child has had FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM should be referred to Children's 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.

High or Immediate risk – if you identify one or more high or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should refer to Children's Social Care in line with the BSCB multi-agency FGM pathway

Any action taken should reflect the urgency of the situation. Where emergency measures are required consider calling the Police on 999.

Professionals subject to the mandatory reporting duty must report 'known' cases of FGM to the Police on 101.

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

FGM Risk Assessment Tool for Child or Young Adult (under 18)

Please use this tool 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 law			
Parents say that they or a relative will be taking the girl abroad for a prolonged period – this may not only be to a country with high prevalence, but this would more likely lead to a concern			
Girl has spoken about a long holiday to her country of origin/another country where the practice is prevalent			
Girl has attended a travel clinic or equivalent for vaccinations/anti-malarials			
FGM is referred to in conversation by the child, family or close friends of the child (see Appendix Three for traditional and local terms) – the context of the discussion will be important			
Sections missing from the Red book. Consider if the child has received immunisations, do they attend clinics etc			
Girl withdrawn from PHSE lessons or from learning about FGM - School Nurse should have conversation with child			
Girls presents symptoms that could be related to FGM – continue with questions in part 3			
Family not engaging with professionals (health, school, or other)			
Any other safeguarding alert already associated with the Always check whether family are already known to social care			

Name ______________________________
DOB ______________________________
NHS number ________________________
Completed by _______________________
Initial/ On-going assessment

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.

High or Immediate risk – if you identify one or more high or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should refer to Children's Social Care in line with the BSCB multi-agency FGM pathway

Any action taken should reflect the urgency of the situation. Where emergency measures are required consider calling the Police on 999.

Professionals subject to the mandatory reporting duty must report 'known' cases of FGM to the Police on 101.

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
HIGH OR IMMEDIATE RISK			
A child or sibling asks for help			
A parent or family member expresses concern that FGM may be carried out on the child			
Girl has confided in another that she is to have a 'special procedure' or to attend a 'special occasion'. Girl has talked about going away 'to become a woman' or 'to become like my mum and sister'			
Girl has a sister or other female child relative who has already undergone FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM should be referred to Children's 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.

High or Immediate risk – if you identify one or more high or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should refer to Children's Social Care in line with the BSCB multi-agency FGM pathway

Any action taken should reflect the urgency of the situation. Where emergency measures are required consider calling the Police on 999.

Professionals subject to the mandatory reporting duty must report 'known' cases of FGM to the Police on 101.

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

FGM Risk Assessment Tool for Non-Pregnant Women (over 18)

Name ______________________________
DOB ________________________________
NHS number _________________________
Completed by _______________________
Initial/ On-going assessment

Please use this tool 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			
HIGH OR IMMEDIATE RISK			
Woman/family believe FGM is integral to cultural or religious identity			
Woman already has daughters who have undergone FGM – who are under 18 years of age			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be triggered if she is found to have FGM			

Please remember: any child under 18 who has undergone FGM should be referred to Children's 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.

High or Immediate risk – if you identify one or more high or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should refer to Children's Social Care in line with the BSCB multi-agency FGM pathway

Any action taken should reflect the urgency of the situation. Where emergency measures are required consider calling the Police on 999.

Professionals subject to the mandatory reporting duty must report 'known' cases of FGM to the Police on 101.

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

FGM Risk Assessment Tool for Pregnant Women

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

Indicator	Yes	No	Details
CONSIDER RISK			
Woman comes from a community known to practice FGM			
Woman has undergone FGM herself			
Husband/partner comes from a community known to practice FGM			
A female family elder is involved/will be involved in care of children/unborn child or is influential in the family			
Woman/family has limited integration in UK community			
Woman and/or husband/partner have limited/ no understanding of harm of FGM or UK law			
Woman's nieces of siblings and/or in-laws have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment.			
Woman's husband/partner/other family member are very dominant in the family and have not been present during consultations with the			
Woman is reluctant to undergo genital examination			
HIGH OR IMMEDIATE RISK			
Woman already has daughters have undergone FGM			
Woman requesting reinfibulation following childbirth			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have			
Woman says that FGM is integral to cultural or religious identity			
Family are already known to social care services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM should be referred to Children's Social Care

Name ____________________
DOB ____________________
NHS number ____________________
Completed by ____________________
Initial/ On-going assessment

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.

High or Immediate risk – if you identify one or more high or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should refer to Children's Social Care in line with the BSCB multi-agency FGM pathway

Any action taken should reflect the urgency of the situation. Where emergency measures are required consider calling the Police on 999.

Professionals subject to the mandatory reporting duty must report 'known' cases of FGM to the Police on 101.

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 B: 3 Key Questions for discussing FGM with women

This is an amended version of the document developed by the Oxfordshire Safeguarding Children Board.

1. Known FGM women: Read any existing information you have relating to the woman and determine whether you need to go through screening tool again.

Start with a short discussion and introduction

As [health visitor/GPs/midwives] we are informed of a woman's medical history. I understand that you were cut/circumcised when you were a child. I understand that this is a sensitive subject/difficult for you. I know you have spoken about this previously to [health visitor/midwife/GP] but I would like to discuss this with you.

- *Is there anything I can help you with in this?*
- *Do you feel your daughter/s are at risk of being cut?*
- *Do you need any help or support for your own experience of being cut?*

Do FGM screening tool if this has not already been done by previous health professional. If not done and there is YES to any questions follow BSCB procedure

2. Not known if mother had FGM and her or partner from country/cultural background were FGM is significant risk.

Start with a short discussion and introduction

You / your partner are from [name country] where a high number of women are cut / circumcised when they are young girls. Women who have experienced this can find this traumatic. It affects their physical health, emotional health, childbirth and sexual relations. I would like to ask you a few questions. I appreciate this is a sensitive subject to talk about

- *Is this something that has happened to you? Have you been cut/circumcised when you were young?*
- *Has anyone in your family or partner's family been cut?*
- *Are there any influences/reasons why would you ever consider having your daughter cut/circumcised? (if yes, follow BSCB guidance)*
- *Do you feel that your daughter/s are at risk of being cut/circumcised by anyone in your family or in your circle of friends?*

If there is YES answered to any of the following, the FGM risk assessment tool should be done and BSCB procedure followed.

3. Universal

In some cultural backgrounds women are cut / circumcised when they are young girls. Women who have experienced this can find this traumatic. It affects their physical health, emotional health, childbirth and sexual relations.

- *Is this something you have knowledge or experience of?*
- *Do you need any further information?*
- *Do you need any further help or support?*

Appendix C Terms for FGM in different languages

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

	Fanadu di Omi	Kriolu	Circumcision of boys
GAMBIA	Niaka	Mandinka	Literally to ‘cut / weed clean’
	Kuyango	Mandinka	Meaning ‘the affair’ but also the name for the shed built for initiates
	Musolula Karoola	Mandinka	Meaning ‘the womens side’ / ‘that which concerns women’

[i] http://www.nhs.uk/conditions/female-genital-mutilation/pages/introduction.aspx
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf
[ii] http://about-fgm.co.uk/about-fgm/world-prevalence/uk-prevalence/
http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/201/20105.htm
[iii]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/383075/Mandatory_Reporting_for_FGM_Consultation_Framework_v6.pdf
[iv] https://www.gov.uk/government/news/pm-hosts-girl-summit-2014-a-future-free-from-fgm-and-child-and-forced-marriage
[v] United Nations Children’s Fund (2013). Female Genital Mutilation / Cutting: A Statistical overview and exploration of the dynamics of change. UNICEF, New York.
[vi] Equality Now and City University
[vii] Around 11,747 people (male and female, all ages) were recorded in the 2011 census as born in a country where FGM is practised. Approximately half of these residents were females and 61% of the population from the Black African/Caribbean ethnic group were in the 15-49 age group. Applying these proportions to the total residents who were born in a country where FGM is practised, the total number of females aged 15-49 were estimated by country of birth for Buckinghamshire and for each of the four Districts. The total number of women aged 15-49 years who may have had FGM was estimated by applying the FGM country specific prevalence to the above estimated number of women residents aged 15-49 who were born in a country where FGM is practised.
viii (World Health Organisation 2010)
ix Female genital mutilation fact sheet 2009
x (Behrendt A et al, 2005)