NHS
University Hospitals Sussex
NHS Foundation Trust
St Richards, Worthing & Southlands Hospitals

Female Genital Mutilation (FGM) Guideline	
Summary statement: How does the document support patient care?	By providing evidence based guidance with regard to the management of FGM.
Staff/stakeholders involved in development:	Named Midwife Safeguarding Named Nurse Safeguarding Obstetric Anaesthetists, Obstetric Consultants and Senior Midwifery Staff
Division:	Women and Children's
Department:	Maternity
Responsible Person:	Chief of Service
Author:	Named Midwife for Safeguarding Maternity Chapter – Obstetric Consultant
For use by:	Staff involved in the recognition and management or FGM. Mandatory reporting and mandatory recording of FGM.
Purpose:	To provide evidence-based guidance in the recognition, recording, reporting and management of FGM.
This document supports:	Department of Health (2015), WHO guidelines on the management of health complications from Female Genital Mutilation. (2016)
Key related documents:	Protocol for Safeguarding Children Protocol for Safeguarding Adults Maternity Guidelines
Approved by:	Joint Obstetric Guideline Group (JOGG)
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If you require this document in another format such as Braille, large print, audio or another language please contact the Trusts Communications Team	
Reference Number:	CG14020

Version	Date	Author	Status	Comment
1.0	April 2016	Gail Addison	Archived	New Trust-wide Guideline
2.0	May 2019	Gail Addison	Archived	Addition of appendices 3 & 7. Review to ensure mandatory reporting procedure.
3.0	June 2022	A.Stienen-Durand Obstetric Registrar	LIVE	3 year review No significant amendments made. Guideline now Maternity specific. Trust safeguarding policy has an FGM section and now references to this guideline.

Contents

Female Genital Mutilation (FGM) Guideline

1.0 Introduction and scope

University Hospitals Sussex (SRH & WH) is committed to the well-being and safety of women and children who present to this organisation. This guideline outlines the legislation, principles and guidance that inform the practise of all health care professionals in all areas that deliver services to women and their children in relation to the practice of Female Genital Mutilation (FGM).

2.0 Aim

This guideline aims to provide support and advice to all staff who have a responsibility to safeguard children and protect and support adults from the abuses associated with FGM.

3.0 Abbreviations used in this document

FGM - Female Genital Mutilation	**HSCIC -** Health & Social Care Information Centre
WHO - World Health Organisation	**FGM-IS -** FGM Information Sharing

4.0 Definition

FGM comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.
It has no health benefits and harms girls and women in many ways.

FGM is most often carried out on girls between infancy and fifteen years of age. It is also referred to as cutting, female circumcision, cutting and infibulation. It has no health benefits and is a severe form of violence against women and girls.

5.0 Types of FGM

The four FGM types defined by the World Health Organisation (2016) are:

- **Type 1 –** Partial or total removal of the clitoris (clitoridectomy) and/or the prepuce.
- **Type 2 –** Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
- **Type 3 –** Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

- **Type 4 –** All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, pulling, piercing, incising, scraping and cauterization.

6.0 The legal and regulatory responsibilities of UK health professionals

All health professionals should be aware of the Female Genital Mutilation Act 2003 which makes it illegal (regardless of their nationality or residence status) to:

- Perform FGM in England and Wales (Section 1 of the 2003 Act).
- Assist a girl to carry out FGM on herself in England and Wales (Section 2 of the 2003 Act).
- Assist (from England or Wales), a non-UK person to carry out FGM outside the UK on a UK national or UK resident (Section 3 of the 2003 Act).
- If the mutilation takes place in England or Wales, the nationality or residence status of the victim is irrelevant.
- If an offence under sections 1,2 or 3 of the 2003 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 could be guilty of an offence under Section 3A of the 2003 Act.
- The 2003 Act places a mandatory duty on health and social care professionals and teachers to notify the police where they discover that FGM has been carried out on a girl under 18 years of age during the course of their work.

6.1 Serious Crime Act 2015

- Introduced a new offence of failing to protect a girl from FGM.
- Provided lifelong anonymity for victims.
- Introduced an FGM protection order which might include surrendering a person's passport.
- Introduced mandatory reporting to the police for cases where FGM is identified in a person under 18 years of age.

7.0 Prevalence

FGM is practised in at least 30 African countries (appendix 7). The single most important risk factor determining whether a person undergoes a ritual procedure is her country of origin. The majority of women who come from Somalia, Sudan, Ethiopia and Sierra Leone will have some form of FGM. The global incidence of FGM is over 200 million and every year some 3 million girls and women are at risk of FGM (WHO).

Prevalence in the UK is difficult to estimate because of the hidden nature of the crime. However, it is estimated that over 20 000 girls under the age of 15 are at risk from FGM in the UK each year and that 66 000 women in the UK are living with the consequences of FGM (NSPCC, 2016).

There is likely to be 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.

Since October 2014, the Health and Social Care Information Centre have regularly published official statistics relating to the number of patients treated in the NHS. All reports are published at www.hscic.gov.uk/fgm and since January 2015, these have included some statistics relating to patient numbers at local acute trust level.

8.0 Safeguarding

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

Safeguarding girls at risk of harm of FGM poses specific challenges because the families involved may give no other cause for concern with regard to their parenting responsibilities or relationships with their children. However there still remains a duty for all professionals to act to safeguard people at risk.

There are four key issues to consider:

1. An illegal act being performed on a female, regardless of age.
2. The need to safeguard girls and young women at risk of FGM.
3. The risk to girls and young women where a relative has undergone FGM.
4. Situations where a girl may be removed from the country to undergo FGM.

Anyone who has concerns about a child's welfare should make a referral to the local authority children's social care. If professionals believe that an individual has undergone FGM, they must consider the risks to other girls and women who may be related to or living with her and / or her family.

9.0 Mandatory reporting

From October 31st 2015 a mandatory duty to report cases of FGM was introduced through the Serious Crime Act 2015.

All regulated health or social care professionals must report cases of FGM to the police if:

- A girl under 18 tells them they have had FGM.
- They see physical signs that a girl has had FGM.

This applies to registered professionals in NHS and private healthcare settings, during the course of their work.

9.1 How to report FGM

If you are concerned that a child may have had FGM or be at risk of it, and they tell you that they have FGM or you observe physical signs that appear to show FGM, the mandatory reporting duty applies and you must call 101 (the police non-emergency number) to make a report.

You must:

- Report the case as soon as possible (at latest before the end of the next working day).
- Record all decisions and actions.
- Be prepared for a police officer to call you back.
- Inform your local safeguarding lead of the case.

For Further information and guidance refer to:
https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare

10.0 Guidance

Appendix 4 and appendix 6 are pathways that offer professionals guidance to identify and consider risks relating to female genital mutilation, and to support the discussion with the patient and family members.
They 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 you need to make a referral through the local safeguarding processes, and is that an urgent or standard referral?
- Do you need to seek help from my local safeguarding lead or other professional support before making your decision? 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 you do not believe the risk has altered since your last contact with the family, or if the risk is not at the point where you need to refer to an external body, then you must ensure you record and share information about your decision accordingly.

For further copies of risk assessment tools visit:
http://www.westsussexscb.org.uk/professionals/female-genital-mutilation/

Or they can be found on the Trust intranet at:
http://nww.westernsussexhospitals.nhs.uk/safety/child-protection-and-safeguarding/prevent/

Patient and staff information leaflets can also be found on the Trust intranet.

11.0 Mandatory recording

There is a mandatory requirement for trusts to submit patient specific details whenever FGM is identified or when patients have been treated in relation to FGM. Although the data set contains person identifiable information these data are only used for data quality purposes. Personal details collected via this data collection are not disclosed or used for any other purpose.

Data is currently collected from Sexual Health, Gynaecology and Paediatric services, on the basis these areas are most likely to encounter FGM but officially, all specialties should be covered by the data collection.

11.1 Female Genital Mutilation Datasets

The Female Genital Mutilation Enhanced Dataset began collecting data on 1 April 2015.

The Health & Social Care Information Centre (HSCIC) is collecting data on FGM within England on behalf of the Department of Health and NHS England. This is to support the Department of Health's and NHS England FGM Prevention Programme. The data is collected to improve the NHS response to FGM and to help commission the services to support women who have experienced FGM as well as safeguarding women and girls at risk of FGM.

11.2 What does it measure?

The FGM Enhanced Information Standard (SCCI 2026) instructs all clinicians to record into clinical notes when a patient with FGM is identified, and what the type of FGM is.

Data should be submitted every time the woman or girl has treatment related to her FGM or gives birth to a baby girl, and every time FGM is identified (by a clinician or self-reported), not just the first time.

The dataset includes: patient demographic data, specific FGM information, referral and treatment information.

The FGM Datasets use the World Health Organisation's (WHO) definitions for the four types of FGM.

11.3 Patient objections

If a patient raises an objection within the care delivery setting (i.e. within the GP surgery or the hospital), the local organisation must consider this objection within their own processes, and ensure they record within the healthcare record the outcome of this decision (i.e. whether or not to disclose information to HSCIC).

If the objection is not raised at this point, and the patient's information is submitted, they can still choose to contact HSCIC at a later date to raise an objection at the following email address: enquiries@hscic.gov.uk. The objection will be automatically enforced and the patient's data will be removed from the dataset. If the objection is raised with the HSCIC, they do not automatically have to accept this request and remove the information. However, due to commitments made by the Secretary of State for Health, patient objections for FGM data collection must always be treated as an automatic 'stop processing' request. This is a Government policy decision that goes beyond the law's requirements.

The FGM mandatory recording dataset tool can be found: http://nww.westernsussexhospitals.nhs.uk/safety/child-protection-and-safeguarding/fgm/?from_search=FGM

Locally all cases of FGM are reported to Information.Team@wsht.nhs.uk

12.0 FGM Information Sharing (FGM-IS)

FGM-IS is a national IT system for health that allows clinicians across England to note on a girl's record within the NHS Summary Care Record application that they are potentially at risk of FGM. The FGM-IS allows the potential risk of FGM to be shared confidentially with health professionals across all care settings until a girl is 18 years old. Authorised health professionals with the relevant security permissions on their NHS Smartcard are able to access FGM Information Sharing.

The main groups of health professionals who use the system to add or view information are those most likely to observe and identify the warning signs associated with the potential risk of FGM. This system can be viewed by clinicians working in the organisation including clinical staff working in sexual health, maternity, gynaecology and A&E. For further details of this system and responsibilities details can be found at FGM enhanced dataset: NHS staff responsibilities - GOV.UK (www.gov.uk).

13.0 Maternity specific guidance

13.1 Identification of FGM

13.1.1 At booking

All women, irrespective of their country of origin, should be sensitively asked for a history of FGM at their booking antenatal visit so that FGM can be identified early in the pregnancy. It must be appreciated that these women do not choose to undergo FGM and come from areas where this is considered the “norm”. Therefore, they need to be treated in a non-judgemental manner.

If required, an interpreter who is not a family member is recommended, giving careful consideration to the sensitive nature of FGM as well as professional issues (i.e. confidentiality).

Some suggested lead questions may be: “Have you been closed?” or “Did you have the cut or the operation as a child?” Further questions could be: “Do you have any problems passing urine or with menstruation?” or “How long does it take to pass urine?”

Identification of FGM must be fully recorded within the maternity information system.

13.1.2 Antenatal care

Once FGM has been identified it is important that the woman receives support, information, advice and counselling. The midwife should offer referral to a consultant with adequate experience in the field of FGM. Some women will prefer to see a female doctor. Where possible this request should be accommodated. There is a designated lead on both sites for FGM and antenatal clinic will ensure appropriate referral.

Referral must be done as early as possible (to enable antenatal intervention if necessary). If a woman declines a referral this should be documented. It is imperative that these women are treated in a kind and sympathetic manner.

At this initial appointment an assessment should be carried out by the named consultant using the proforma (Appendix 2) to record the type of FGM and the plan for de-infibulation.

13.1.3 De-infibulation

Women with type 3 FGM will require antenatal de-infibulation for a vaginal birth. This should be offered antenatally and should ideally be performed at around 20 weeks of gestation. This both reduces the risk of miscarriage and allows time for healing before birth. If this is declined they should be seen again at 30 weeks for further discussion regarding plans surrounding birth. The decision on this and procedure must be carried out by a senior obstetrician with adequate experience in this field.

The procedure may be performed under a local or regional anaesthesia depending on maternal choice following an informed discussion. Adequate analgesia is essential to limit the risk of further psychological harm.

Before de-infibulation, the following should be carried out:

- MSU for bacteriuria.
- Group and save (due to potential risk of haemorrhage).

Technique for de-infibulation:

- Identify urethra and insert urinary catheter if possible.
- Infiltrate infibulation scar with local anaesthetic whilst placing surgical forceps behind the scar to prevent injury to underlying tissues.
- Incise along midline infibulation scar either with scissors or a knife and extend anteriorly until the external urethral meatus is visible.

- Cutting diathermy can be used to reduce bleeding.
- Use fine absorbable suture material.
- Consider prophylactic antibiotics

Intrapartum de-infibulation can be carried out in the first stage if there is inadequate access for vaginal examinations but this will increase the risk of bleeding. An epidural must be offered. It is preferable to perform intrapartum de-infibulation as the head is crowning to reduce the chance of bleeding. In this situation the on-call Consultant should attend and should supervise or perform the repair. Ideally consent for this should be taken antenatally.

It is important to remember that de-infibulation does not restore physical or emotional normality.

Note: it is possible that obstetricians / midwives may be asked to re-infibulate a woman following a vaginal birth. Any postnatal repair, whether following spontaneous tearing or deliberate de-infibulation, should ensure bleeding is controlled, but must not reproduce the original infibulation or result in a vaginal opening that makes intercourse difficult or impossible. Infibulation under any circumstances is a criminal offence in the UK. The WHO recommends suturing of raw edges to prevent spontaneous re-infibulation, but this should be done with a continuous locked stitch to allow the raw edges to heal independently.

13.1.4 Potential Complications of FGM

The following are potential difficulties or complications that may occur during the antenatal or intrapartum period and should be discussed antenatally with the woman and her partner:

- An increased risk of urinary tract infection
- Difficulty performing internal examinations
- Difficulty in catheterising the bladder
- Difficulty in applying a fetal scalp electrode
- Delay in second stage
- Risk of spontaneous perineal laceration
- The need for an anterior midline episiotomy
- Experience of “flashbacks” to time of FGM during vaginal examination

13.1.5 Intrapartum Care

Mode of birth

Caesarean birth is not absolutely indicated unless de-infibulation is not possible, this decision must be made with the woman by the named lead Consultant for women with FGM.

Women with profound psychological effects (particularly if FGM was carried out in adolescence) may request an elective caesarean, however most women with FGM would prefer a vaginal birth and are successful.

Recommendations for vaginal births

- Birth on the labour ward.
- IV access and group and save.
- Epidural analgesia is recommended if anterior episiotomy will be required in labour
- The Birth Centre can be considered if successful de-infibulation and the woman has had a previous vaginal birth without complications.

13.1.6 Postnatal Care

The aim of postnatal care should be to provide support for the women and her baby for any physical and psychological complications that may arise. The midwife should provide this in the postnatal period with appropriate referral after this time. If de-infibulation has occurred the woman will experience changes in micturition, menstruation and coitus.

It is also important to consider whether child protection is an issue when a female child is born (see Appendix 5).

14.0 Support & advice

Female Genital Mutilation Risk and Safeguarding Guidance for professionals' (2015)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf

https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare

Home Office: Mandatory Reporting procedural information
https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information

Safeguarding women and girls at risk of FGM
https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm

Female Genital Mutilation: Multi- Agency Practice Guidelines
https://www.gov.uk/government/publications/female-genital-mutilation-guidelines

Health Education England FGM e-Learning programme
www.e-lfh.org.uk/programmes/female-genital-mutilation/

NSPCC FGM Helpline 0800 028 3550
fgmhelp@nspcc.org.uk

NHS Choices FGM webpage for professionals
www.nhs.uk/fgmguidelines

Pan Sussex Child Protection and Safeguarding Procedures
http://sussexchildprotection.procedures.org.uk

WSSCB – www.westsussexscb.org.uk

Working Together to Safeguard Children (2015)
http://www.workingtogetheronline.co.uk/

FGM enhanced dataset: NHS staff responsibilities - GOV.UK (www.gov.uk)

Audit

Suggested auditable questions:

All women, irrespective of their country of origin, have been sensitively asked for a history of FGM at their booking antenatal visit so that FGM can be identified early in the pregnancy.

Any cases of FGM have been reported to the police by the healthcare professional if:

- A girl under 18 tells them they have had FGM.
- They see physical signs that a girl has had FGM.

All cases of FGM must be:

- Reported as soon as possible (at latest before the end of the next working day).
- Recorded and all decisions and actions documented.
- The health professional should be prepared for a police officer to call them back.
- Local safeguarding lead must be informed of the case.

Any women who have had FGM have been referred for obstetric review with the designated lead for FGM.

Defibrillation should be offered around 20 weeks and re-offered at 30 weeks if declined.

References

British Medical Association (1996) Female Genital Mutilation: Caring for Patients and Child Protection. London. Revised 2001.

Department of Health: Commissioning services to support women and girls with female genital mutilation (March 2015).

Department of Health: Female Genital Mutilation Risk and Safeguarding Guidance for professionals (March 2015).

Department of Health: FGM Prevention Programme Understanding the FGM Enhanced dataset – updated guidance and clarification to support implementation.(September 2015).

Female Genital Mutilation Act (2003) The Stationary Office Ltd. London

Gordon,H. (1998) Female Genital Mutilation. The Diplomate 1998; 5:86-90

HM Government (2014) Multi-Agency Practice Guidelines: Female Genital Mutilation.

HM Stationary Office: Tattooing of Minors Act 1969.

Momoh,C. (2000) Female Genital Mutilation also known as Female Circumcision: Information for Health Professionals 2nd edition, Guy's & St Thomas' Hospital Trust. London

Multi-Agency Practice Guidelines: Female Genital Mutilation (Feb 2011) HM Government. Department of Health.

Prohibition of Female Circumcision (1985). The Stationary Office London

Royal College of Midwives (1998). Female Genital Mutilation (Female Circumcision)

Position Paper 21. London.

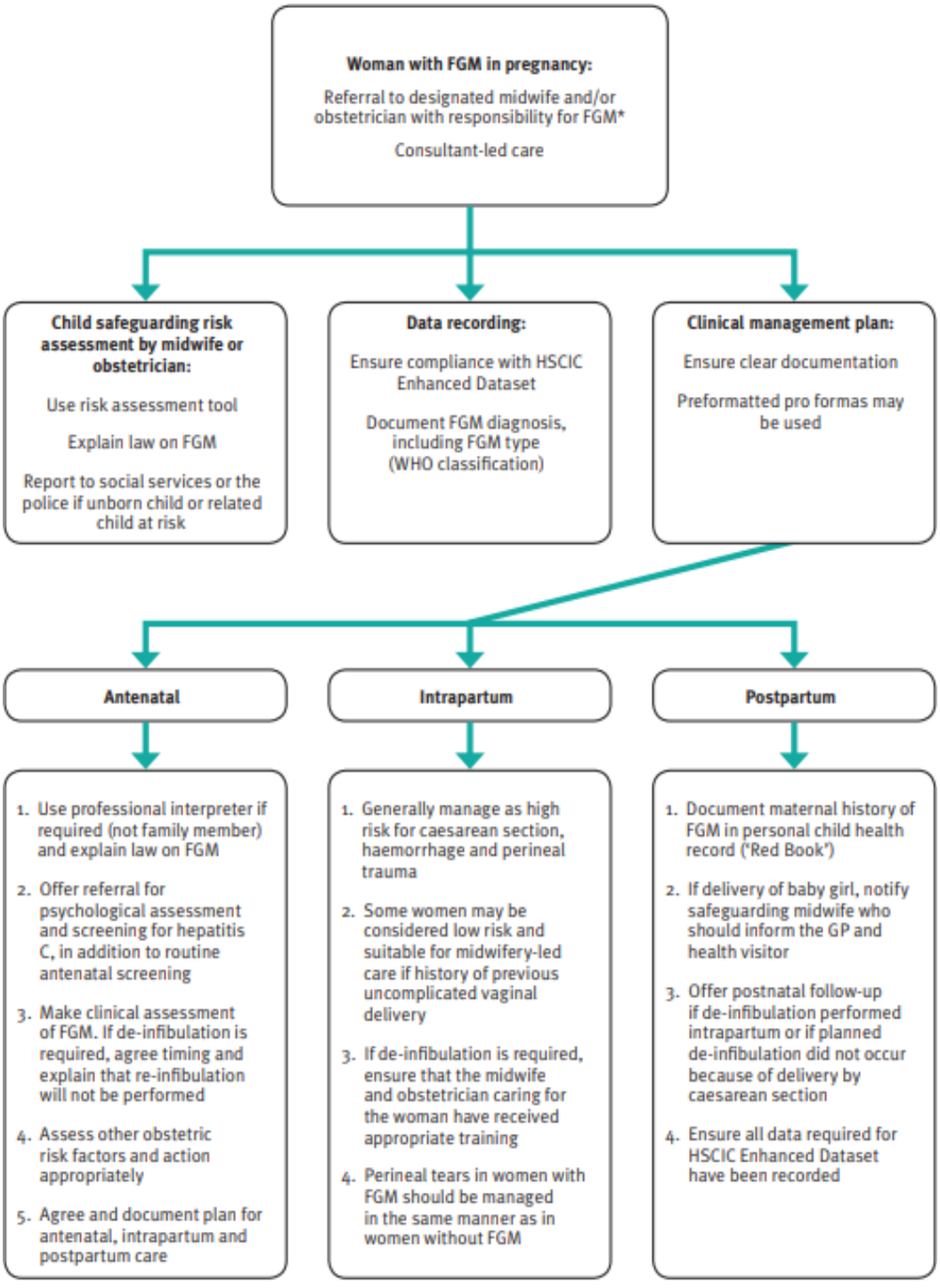
Royal College of Obstetricians and Gynaecologists (1997) Female Circumcision.

World Health Organisation (2016). WHO guidelines on the management of health complications from Female Genital Mutilation. Geneva: World Health Organisation.

Royal College of Obstetricians and Gynaecologists (2015) Female Genital Mutilation and its Management, Green-top Guideline No. 53.

Appendix 1: Plan of care for Women with FGM in Pregnancy

Flow chart taken from RCOG Green-top guideline no. 53 (2015)



* Local protocols will determine which elements of care (child safeguarding risk assessment, data recording, clinical management plan) should be undertaken by the designated midwife or obstetrician responsible for women with FGM and which may be undertaken by other appropriately trained midwives or obstetricians

Appendix 2: FGM Proforma

Please do not print this document from the guideline

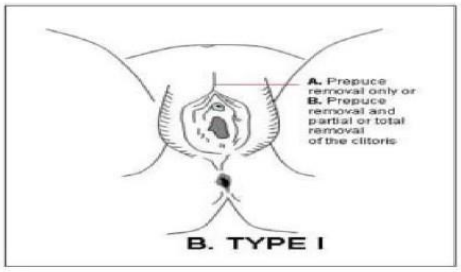
Please complete or Affix Patient Label Unit No: …… NHS No: …… Surname …… Forenames ……	Western Sussex Hospitals NHS NHS Foundation Trust **Ward/Dept ……..** **FGM Proforma**

Date: **Gestation first seen:** **Seen by:**

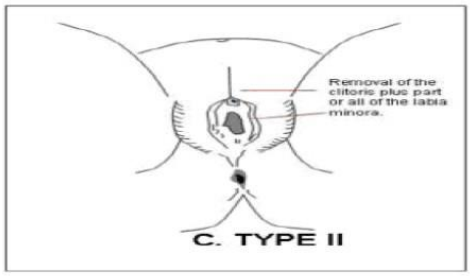
Please circle symptoms as appropriate:

Urinary:	Recurrent Urinary Tract Infections	Yes / No
	Abnormal Stream	Yes / No
Menstrual:	Dysmenorrhoea	Yes / No
	Menorrhagia	Yes / No
Sexual:	Dyspareunia	Yes / No
Other:	Keloid / Abscess / Vaginal Infections Chronic / Genital Pain	

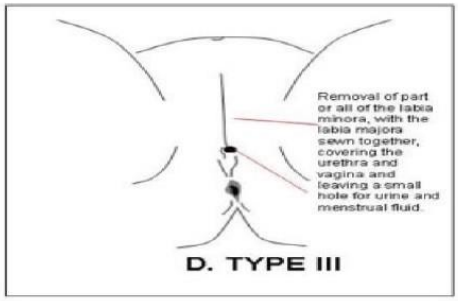
EXAMINATION FINDINGS ON INITIAL ASSESSMENT



Type 1: Prepuce removal only or partial or total removal of the clitoris
Comments:



Type 2: Removal of the clitoris and part or all of the labia minora.
Comments:



Type 3: Removal of part or all of the labia minora with the labia majora either being sewn together covering the urethra and vagina leaving only a small opening for urine and menstrual fluid.
Comments:

FGM Proforma. Version 1 November 2014

CONSENT

Patient informed about inability to re-infibulate (re-sew) after deinfibulation: ☐

MANAGEMENT (Circle as appropriate)

Deinfibulation: Antenatal / Labour 1st Stage / Labour 2nd Stage

Deinfibulation if presents unbooked to Labour Ward: Yes / No Gest .....Wks

DETAILS OF BOOKING OF DEINFIBULATION

Planned date of procedure: / /
Place: Labour Ward: In Theatre / In Room
Analgesia preference: LA / Spinal
Name of Consultant to perform procedure:
Confirm Consultant aware ☐

Labour recommendation:
1.Manage labour as normal: Yes / No
2. Medio-lateral episiotomy as required: Yes / No
3. Inform SpR / Cons when in labour Yes / No
4/ Deinfibulation in labour (Anterior Midline) Yes / No

DEINFIBULATION PROCEDURE

Operator (Name and Grade):..... (Cons / SpR)

Assist (Name and Grade):..... (Cons / SpR)

Incision (Anterior Midline / Other): .....

Repair Edges: Interrupted / Continuous / Other .....

Suture Materials: Vicryl-Rapide / Vicryl / Other .....

Anaesthesia / Analgesia: Local / Pudendal block / Regional / Entonox

Antibiotics: Yes / No

TTO: Codydramol / Paracetamol / Other .....

FOLLOW UP

Required: Yes / No

Antenatal Clinic appointment date: / /

Other: .....

Appendix 3: FGM safeguarding flowchart

Does the patient originate from an area where cutting or circumcision is practised?

NO – no further action required

Yes

Do you believe the patient has been cut?

Yes

No – but family history

Patient is under 18 or vulnerable adult

If you suspect she may be at risk of FGM:
Use the safeguarding risk assessment guidance to help decide what action to take.
*** If child is at imminent risk of harm, initiate urgent safeguarding response.**
*** consider if a child social care referral is needed.**

Patient is **under** 18

Call **101** to report basic details of the case to the Police under **Mandatory reporting duty**
Police will initiate a multi-agency safeguarding response.

Patient is **over** 18

Does she have any female children or siblings at risk of FGM?

- If pregnant inform named midwife for safeguarding to complete FGMIS.
- If non pregnant inform children's safeguarding team to complete FGMIS
- Complete the children's safeguarding online information sharing form.
- Safeguarding team to decide whether referral to social care is required.

<u>For all patients who have had any type of FGM</u>
Complete FGM enhanced dataset (can be found on Staffnet: http://nww.westernsussexhospitals.nhs.uk/safety/child-protection-and-safeguarding/prevent/
Noting all relevant codes and send to:
uhsussex.information.team@nhs.net
Inform relevant safeguarding team

<u>Local contact details:</u>
Children's Safeguarding Team – 07825257118
uhsussex.childrenssafeguarding@nhs.net

Midwifery Safeguarding Team
uhsussex.safeguardingmidwives@nhs.net
NSPCC FGM Helpline: 0800 028 3550

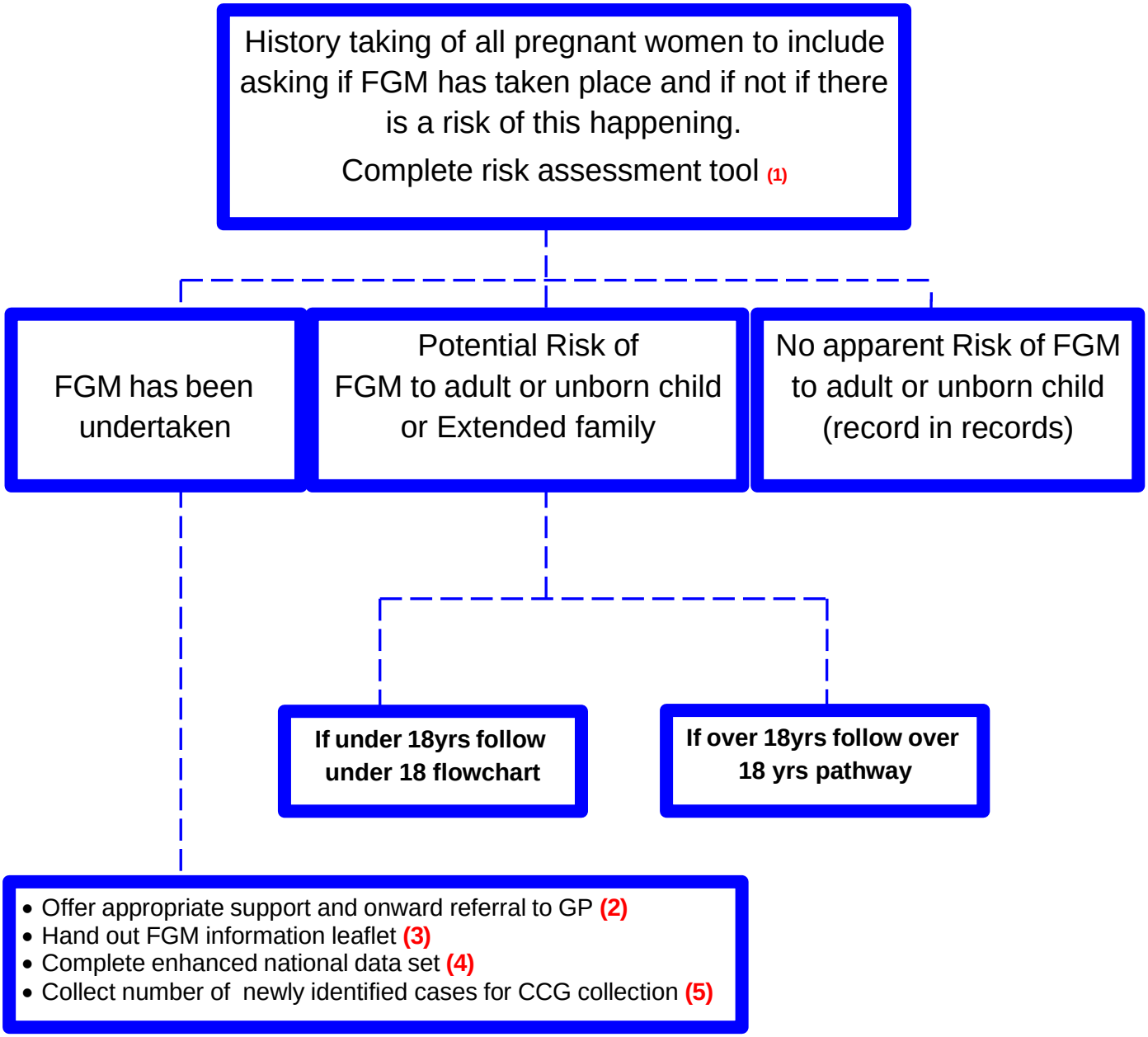
For all patients:

1. Clearly document all discussion and actions with patient /family in patient's medical record.
2. Explain FGM is illegal in the UK.
3. Discuss the adverse health consequences of FGM.
4. Share safeguarding information with Health Visitor, School Nurse & GP.

If a girl appears to have been recently cut or you believe she is at imminent risk, <u>act immediately</u> – this may include phoning **999**.
REMEMBER: Mandatory reporting is only one part of safeguarding against FGM and other abuse.
Always ask your local safeguarding lead if in doubt

Appendix 4: FGM risk flowchart for unborn female child or other female child in the family

Pregnant Women – deciding whether the unborn child (or other female child in the family) are at risk of FGM or whether the women herself is at risk



1. Risk Assessment Tool for Pregnant Women

Date:……

Completed by:……
Initial/On-going Assessment

Part One (a): PREGNANT WOMEN

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 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.			
Women/family has limited integration in UK community.			
Women and/or husband/partner have limited/no understanding of harm of FGM or UK law.			
Women's nieces or 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 members are very dominant in the family and have not been present during consultations with the woman.			
Woman is reluctant to undergo genital examination.			
SIGNIFICANT OR IMMEDIATE RISK			
Woman already has daughters who have undergone FGM.			
Woman requesting reinfibulation following child birth.			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she found to have FGM.			
Woman says that FGM is integral to cultural or religious identity.			
Family are already known to social care services – if known, and you have identified FGM within a family, you must share this information with social services.			

ACTION

Ask more questions - if one indicator leads to 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 judgment, 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:-

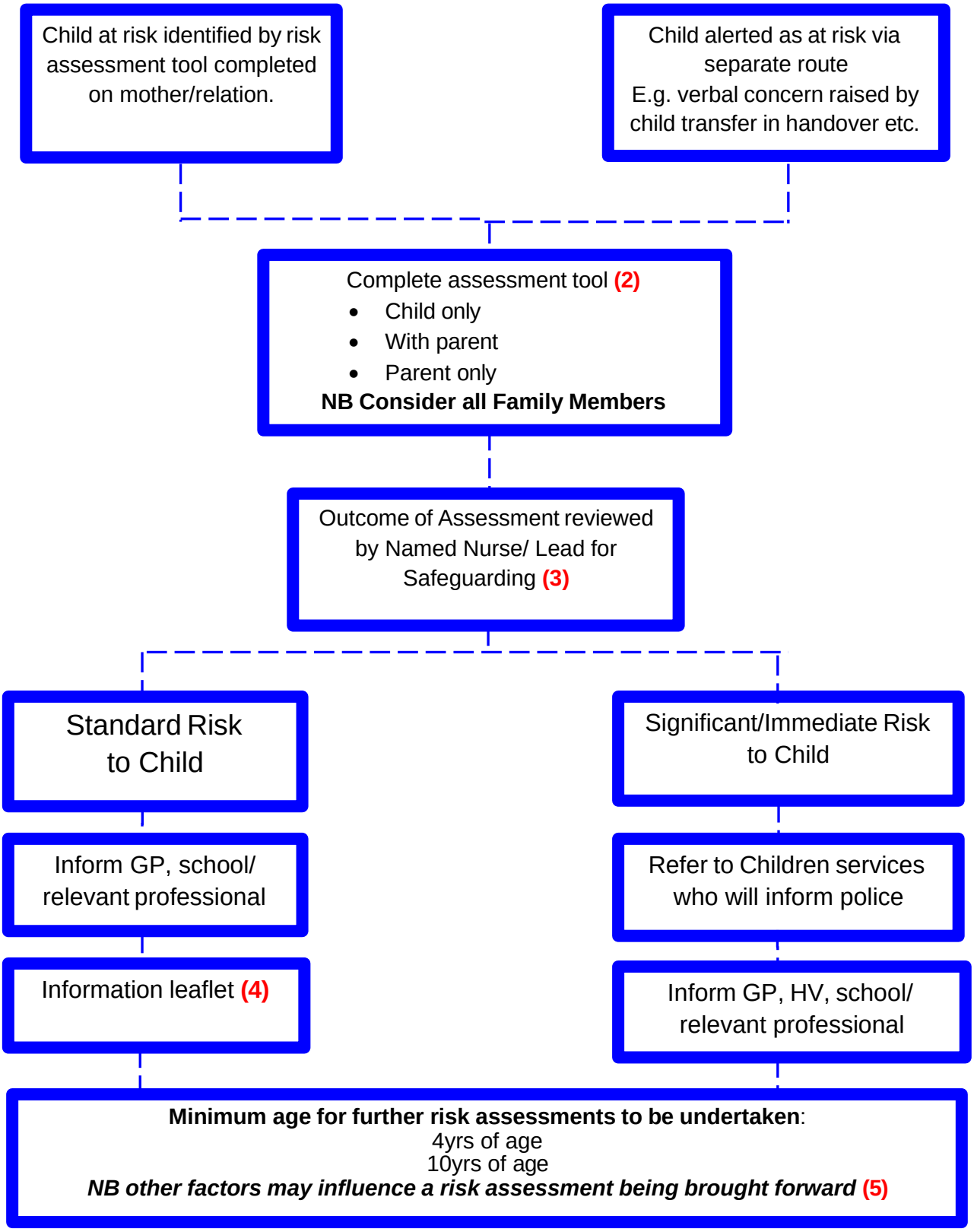
- Share information of any identified risk with the patient's GP.
- Document in notes.
- Discuss the health complications of FGM and the law in the UK.

2. **Client may need referral for counselling, surgery etc. make referral to GP.**
3. **Information Leaflet.**
4. **For further information on hscic FGM enhanced dataset visit: Female Genital Mutilation (FGM) enhanced dataset: GDPR information - NHS Digital**
5. **Inform your named nurse/safeguarding lead that you have seen newly identified case of FGM. Named Nurses/Lead for Safeguarding to submit numbers to Designated Nurses bi- monthly.**

Appendix 5: Child / young adult (under 18 yrs) at risk of FGM

Child/Young Adult (under 18rs) is at risk of FGM

NB. If has already undergone FGM -> MASH/Children's services -> Strategy (1)



1. Tool to help when considering whether a child has FGM

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

This is to help when considering whether a child has had FGM.

Date:…….. Completed by……..……
Initial/On-going Assessment

Indicator	Yes	No	Details
CONSIDER RISK			
Girl is reluctant to undergo any medical examination.			
Girl has difficulty walking, sitting or standing or looks uncomfortable.			
Girl finds it hard to sit for long periods of time, which was not a problem previously.			
Girl presents to GP or A&E with frequent urine, menstrual or stomach problems.			
Increased emotional and psychological needs e.g. withdrawal, depression or significant change in behaviour.			
Girl avoiding physical exercise or requiring to be excused from PE lessons without a GP's letter.			
Girl has spoken about having been on a long holiday to her country of origin/another country where the practice is prevalent.			
Girl spends a long time in the bathroom/toilet/long periods of time away from the classroom.			
Girl talks about pain or discomfort between her legs.			
SIGNIFICANT OR IMMEDIATE RISK			
Girl asks for help.			
Girl confides in a professional that FGM has taken place.			
Mother/family member discloses that female child has had FGM.			
Family/child are already known to social services – if known, and you have identified FGM within the family, you must share this information with social services.			

ACTION
Ask more questions - if one indicator leads to 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 judgment, 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.

2. Risk Assessment Tool for Child/Young Adult under 18 years of age

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.

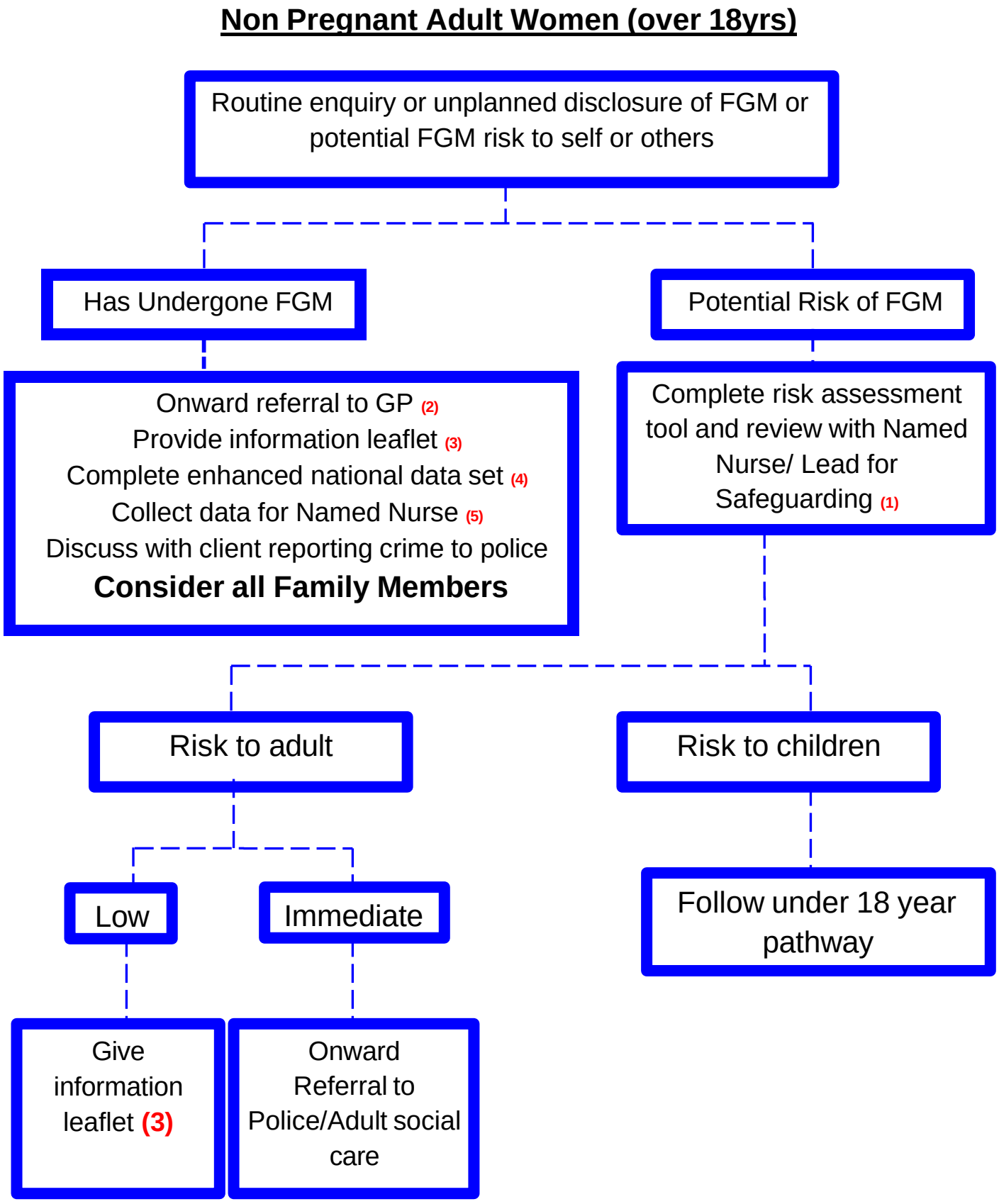
Date:…….. Completed by……..……
Initial/On-going Assessment

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 a girl.			
Mother/Father have limited contact with people outside of her family.			
Parents have poor access to information about FGM and do not known 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 or 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.			
Girl 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 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 judgment, 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.

3. Complete Risk Assessment Tool for Child/Young Adult under 18 years of age and review your assessment findings with Named Nurse or lead for Safeguarding.
4. FGM information leaflet.
5. The risk of FGM can change at any time and therefore whist the child/young's people risk should be reassessed at 4 year and 10 years, any significant changes i.e. influential family member who believes in FGM moves into the family home etc. should result in assessment of current risk.

Appendix 6: FGM flowchart for non-pregnant women over 18 yrs



1 Risk Assessment Tool for Non-Pregnant Women

Date:……
Completed by:……..
Initial/On-going Assessment

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

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 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 influenced in family or female family elder is involved in care of children.			
Woman and family have limited integrated 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 been limited/no understanding of harm of FGM or UK law.			
Women's nieces (by sibling or in laws) have undergone FGM. Please note – if they are under 18 years you have a professional duty of care to refer to social care.			
Woman has failed to attend follow up appointment with an FGM clinic/FGM related appointment.			
Family are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services.			
SIGNIFICANT OR IMMEDIATE RISK			
Woman/family believe FGM is integral to cultural or religious identity.			
Woman already has daughters who have undergone FGM - who are under 18 years of age.			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be triggered if she is found to have FGM.			

ACTION

Ask more questions - if one indicator leads to 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 judgment, 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 referred to police and social services.

2. **Client may need referral for counselling, surgery etc make referral to GP**
3. **Information Leaflet**
4. **For further information on hscic FGM enhanced dataset visit: Female Genital Mutilation (FGM) enhanced dataset: GDPR information - NHS Digital**
5. **Inform your named nurse/safeguarding lead that you have seen newly identified case of FGM. Named Nurses/Lead for Safeguarding to submit numbers to Designated Nurses bi-monthly**

Appendix 7: Prevalence of FGM