University Hospitals of Leicester NHS
NHS Trust

Safeguarding risk associated with Female Genital Mutilation

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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

- Merged Obstetric guideline C32/2008 with the Trust policy B24/2019
- Removed reference to Maternity A-Form and replaced with maternity safeguarding referral on ICE

KEYWORDS

Clitoridectomy, Cutting, Defibulation, Female circumcision, FGM, Infibulation, Re-infibulation

1. INTRODUCTION AND OVERVIEW

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trust Policy and Procedures providing professionals, practitioners and anyone working with adults, children and young people with an understanding of FGM and what action they should take to safeguard women and girls who they believe may be at risk, or have already been harmed through FGM.

1.2 Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act 2003. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies. It is primarily, though not exclusively, carried out on minors. Adult safeguarding issues may arise where there is re infibulation (where a woman is reclosed) after childbirth or coercion for FGM to take place in connection with marriage.

1.3 University hospitals of Leicester have a MANDATORY reporting duty where there are identified safeguarding concerns.

1.4 FGM is a form of abuse and is a violation of a child or adult's human rights and can result in both short term and long term medical complications. FGM is illegal, has no health benefits and is harmful and abusive both physiologically and psychologically. Professionals, volunteers and individuals coming across FGM for the first time can feel shocked, upset, helpless and unsure of how to respond appropriately to ensure that children are protected from harm. They may be afraid of tackling the issue due to perceived cultural sensitivities. However, they must adhere to this Policy.

1.5 FGM is a deeply rooted tradition, widely practiced mainly among specific ethnic populations in Africa and parts of Asia, which serves as a complex form of social control of women's sexual and reproductive rights. In England and Wales, women from non-African communities which are most likely to be affected by FGM include Yemeni, Iraqi Kurd and Pakistani women.

1.6 The age at which FGM is subjected on women and girls varies enormously depending on the community or ethnic group that the woman or girl belongs to. The procedure may be carried out when a girl is new born, during childhood or adolescence, just before marriage or during the first pregnancy. However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 and therefore girls within that age bracket are at a higher risk.

1.7 The Children Act 2004 requires all statutory agencies to take responsibility for safeguarding and promoting the welfare of every child and within this legislative framework supported by statutory guidance (Working Together 2018) professionals and volunteers from all agencies have a responsibility to safeguard children from being abused through FGM.

2. WHO THE POLICY APPLIES TO AND ANY SPECIFIC EXCLUSIONS

2.1 This policy applies to all staff who work within University Hospitals of Leicester NHS Trust ("UHL").

2.2 This includes all staff who may work in a bank/locum capacity or have honorary contracts. This policy must be read in conjunction with local joint Local Safeguarding Children Board ("LSCB") policies and procedures. Unregistered healthcare professionals also have a reporting duty if FGM is disclosed to them during the course of their work for the Trust. These staff members must escalate the concern to staff who are registrants and with the support of the safeguarding team follow the referral process within the policy.

2.3 This FGM policy provides guidance for frontline professionals and their managers in:

• Identifying when a child may be at risk of being subjected to FGM and responding appropriately to protect the child; • Sharing information nationally by identifying risk of FGM on the national spine to protect children, providing early intervention and on-going protection of girls at risk of FGM • Measures which can be implemented to prevent and ultimately eliminate the practice of FGM.

3. ROLES AND RESPONSIBILITIES

3.1 This policy applies to all members of Medical, AHP, Nursing and Midwifery staff within the University Hospitals of Leicester NHS Trust.

3.2 The Board Director lead for this Policy is the Chief Nurse

3.3 Compliance with the Policy will be monitored by University Hospitals of Leicester through the Safeguarding Assurance Committee.

3.4 Managers of staff at all levels are responsible for ensuring that the staff, for which they are responsible, are familiarised with and adherent to this policy.

Figure 1: Female Genital Mutilation Maternity procedure

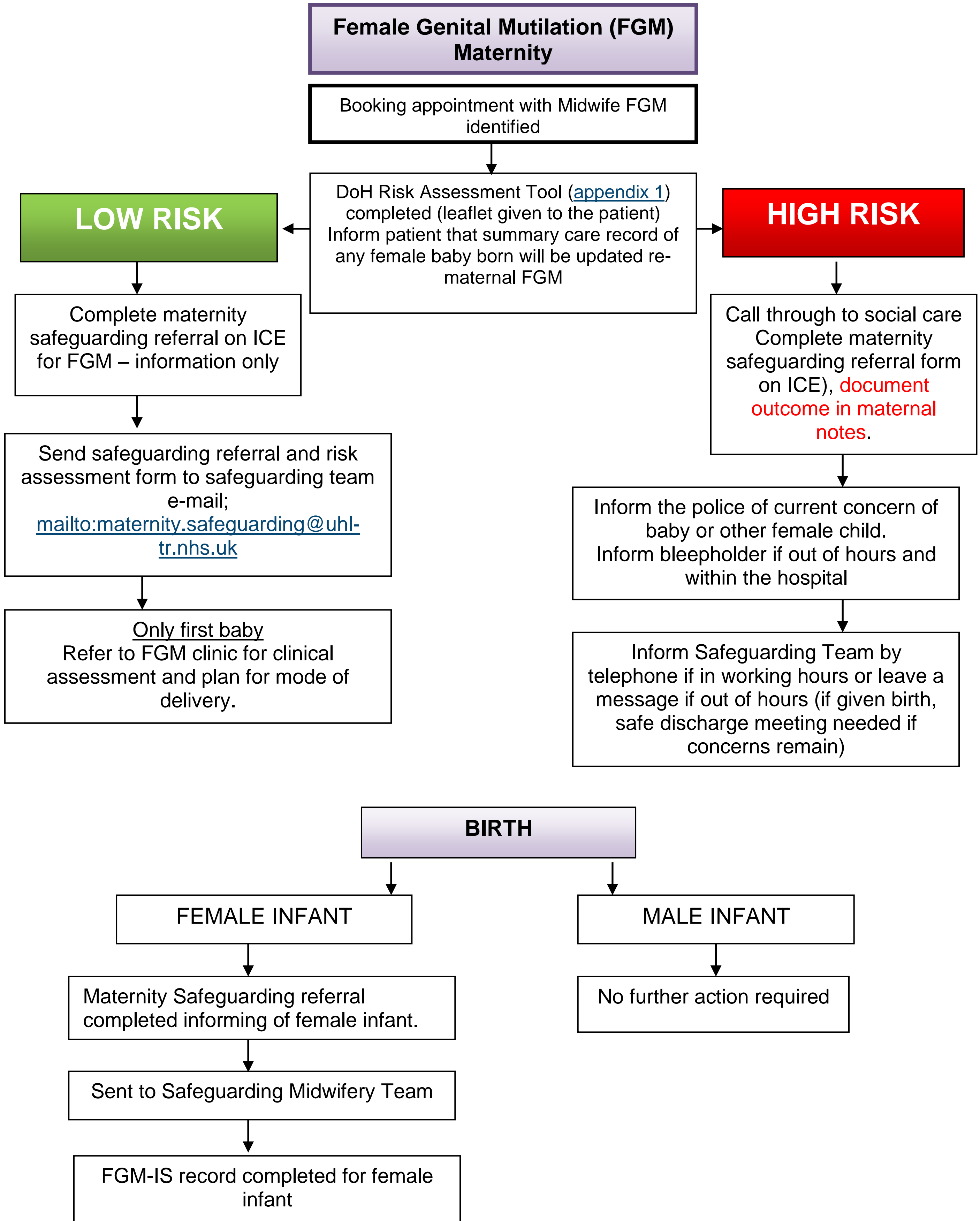
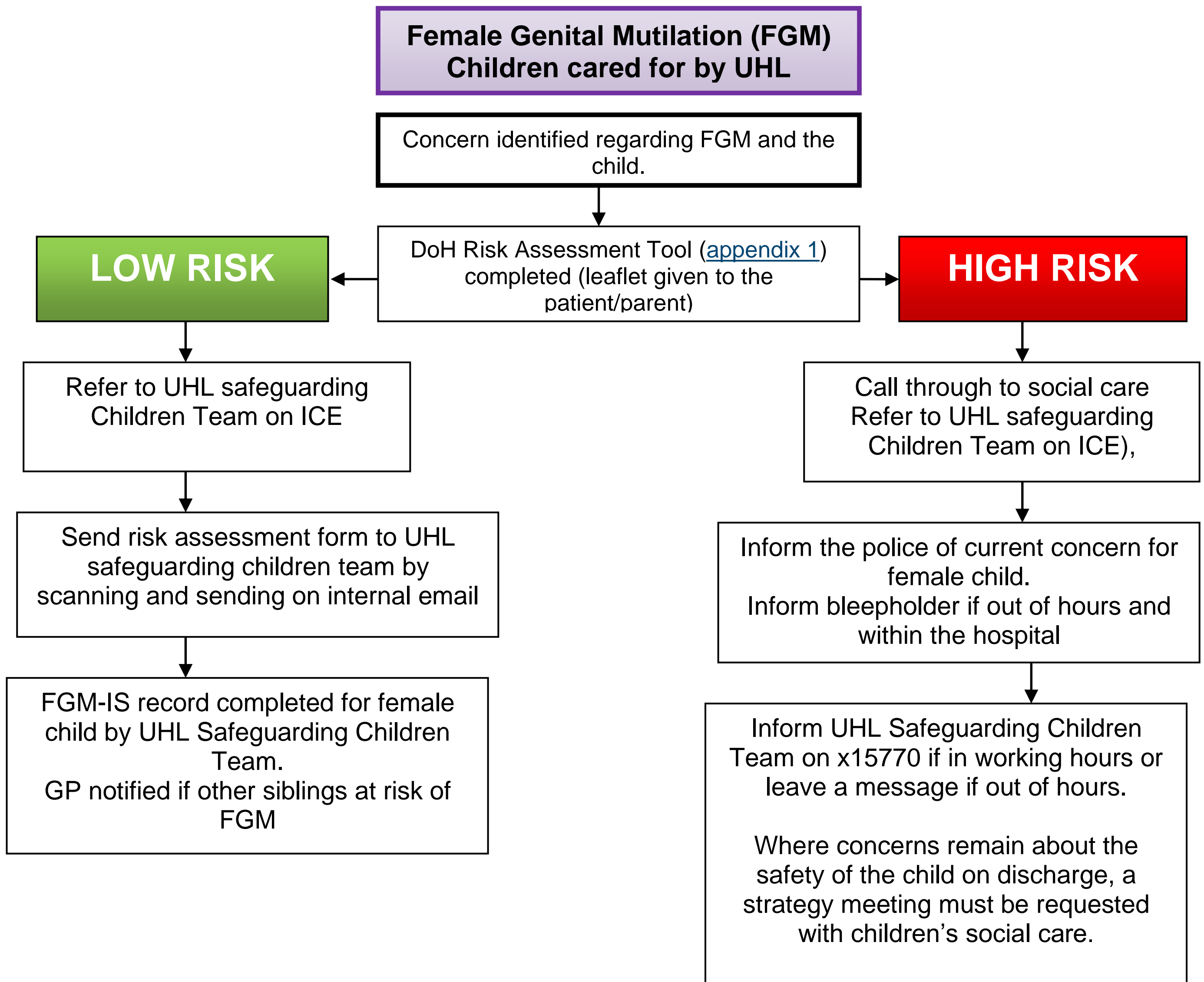


Figure 2: Female Genital Mutilation Children cared for by UHL procedure



4. DEFINITIONS

4.1 The World Health Organisation (WHO) defines FGM as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" (WHO, 1996).

4.2 The most common types of FGM are excision of the clitoris (Type 1), and excision of the clitoris and labia minora (Type 2) — accounting for up to 80% of all cases. The most extreme type is infibulation (Type 3), which constitutes about 15% of all procedures, but is practised among as many as 90% of women from Somalia, Djibouti and Northern Sudan — with a consequently higher rate of complications

FGM has been classified by the World Health Organisation into the following 4 categories:-

- Type 1 - Clitoridectomy: partial or total removal of the clitoris (the small sensitive erectile part of the female genitalia) In rare cases the prepuce (hood of the clitoris) only is removed.
- Type 2 - Excision: partial or total removal of the clitoris and the labia minora, with or without the excision of the labia majora.
- Type 3 - Infibulation: narrowing of the vaginal opening by cutting and re- positioning the inner, or outer, labia, with or without removal of the clitoris
- Type 4 - Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

Diagram 1: Normal Female Genitalia

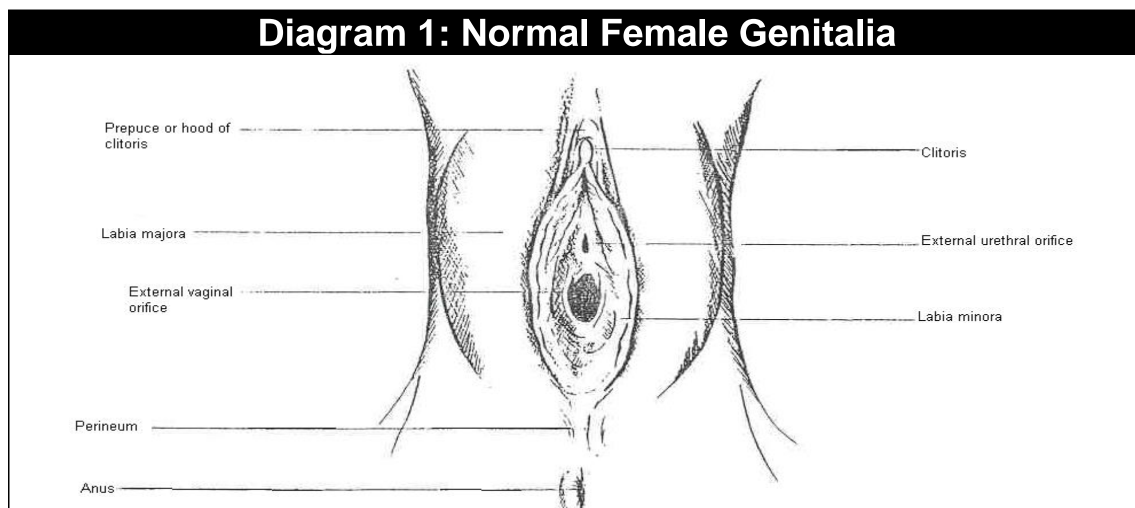
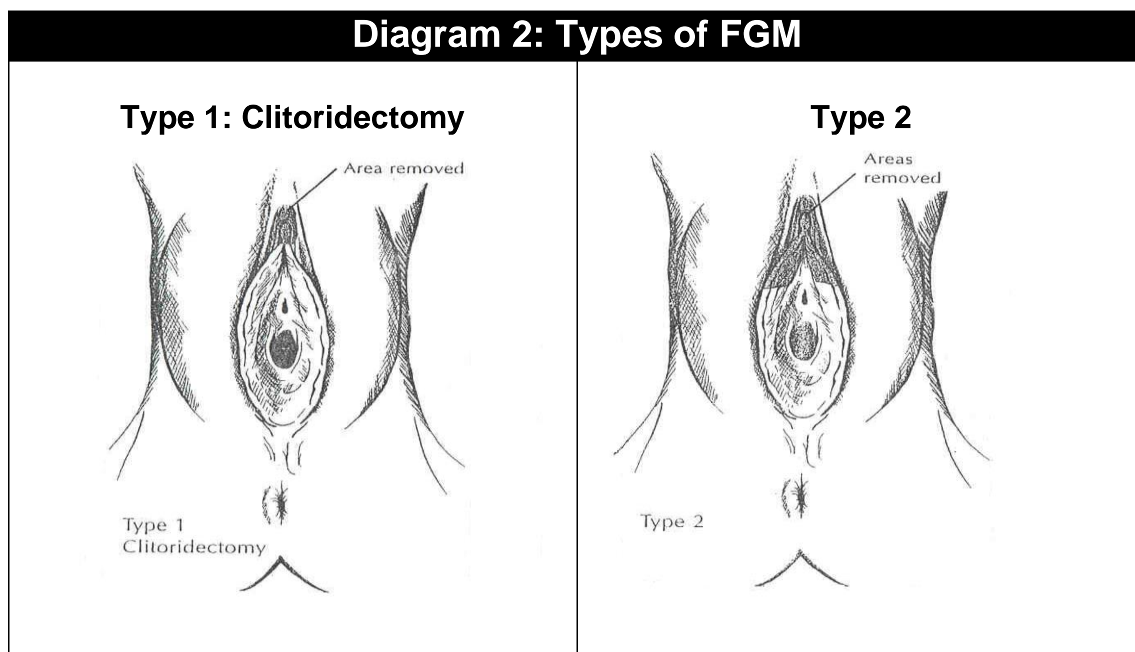
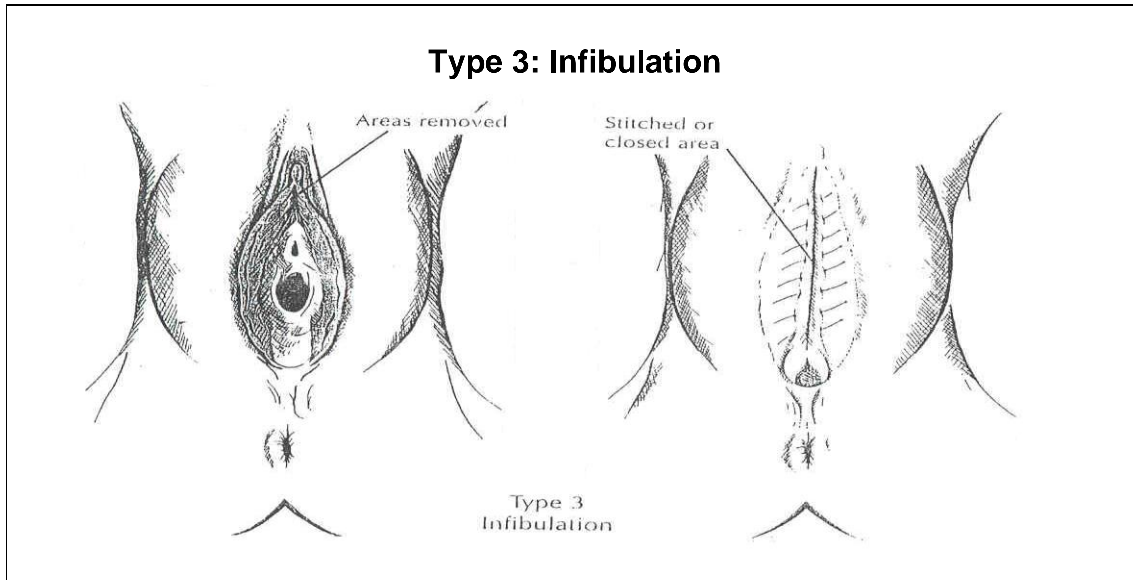


Diagram 2: Types of FGM

Type 1: Clitoridectomy	Type 2





Type 3: Infibulation

5. EPIDEMIOLOGY

FGM is practised for a variety of complex reasons, usually in the belief that it is beneficial for the girl and a rite of passage to womanhood. It has no health benefits, but on the contrary can have serious health consequences. FGM is a human rights violation and a form of child abuse. It is a severe form of violence against women and girls.

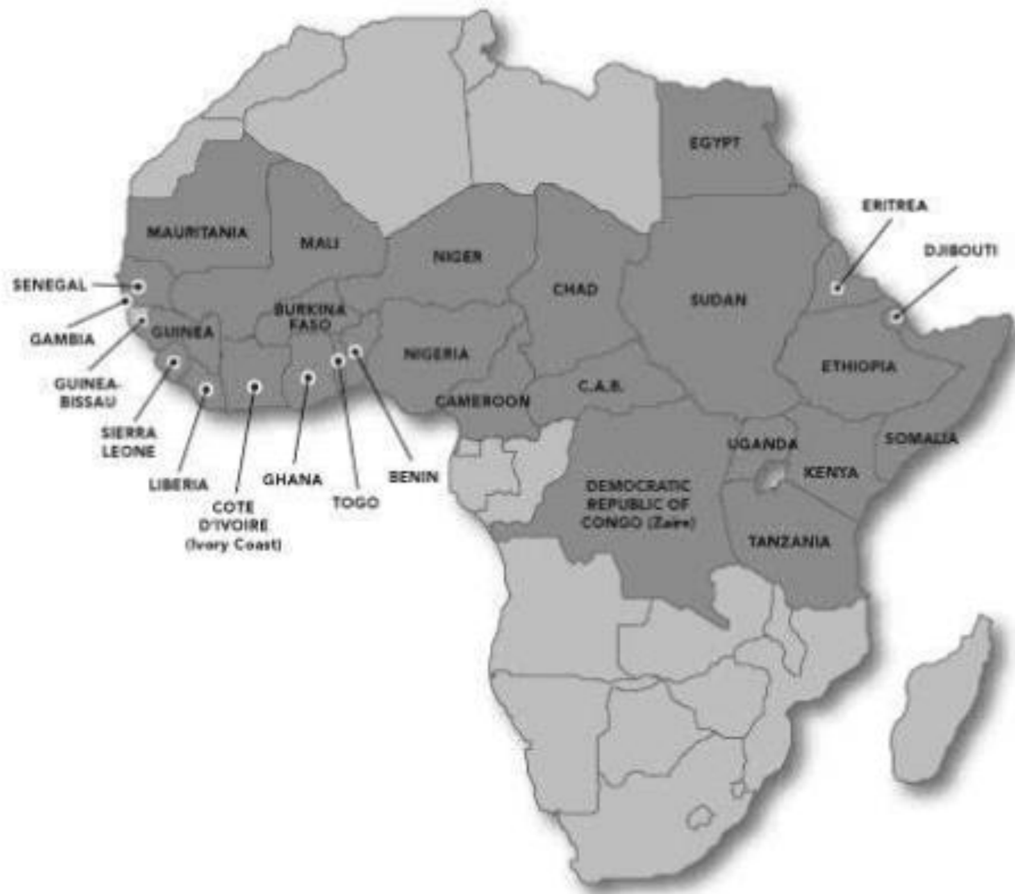
Those performing FGM are usually traditional practitioners with no formal medical training who practise without anaesthetics using crude instruments. However, in some countries e.g. Egypt, Sudan, Kenya, doctors undertake the majority of FGM procedures.
According to the World Health Organisation (WHO) Female Genital Mutilation (FGM) is practiced in approximately 29 countries in Africa, Yemen, Iraqi Kurdistan and parts of Indonesia and Malaysia. Much smaller numbers have been recorded in India, Pakistan, Sri Lanka, UE, Oman, Peru and Colombia.

In the United Kingdom it is often seen among immigrants from:

- Somalia
- Eritrea
- Mali
- Sudan
- Ethiopia
- Sierra Leone
- Nigeria
- Iraqi Kurdistan

The type of FGM varies between countries; the highest prevalence of type 3 is in Somalia, Sudan, Eritrea and Djibouti. In some communities women undergo re-infibulation after childbirth.

African countries with communities practicing FGM



Source: Hosken FP. Female Genital Mutilation; Estimate: total number of girls and women mutilated in Africa. *Lexington MA: Women's International Network News*, 1997.

6. LEGISLATION, RISK ASSESSMENT AND REFERRAL

6.1 All health professionals must be aware of the Female Genital Mutilation Act 2003 in England, Wales and Northern Ireland and the Prohibition of Female Genital mutilation Act 2005 in Scotland.

6.2 FGM is a criminal offence and subject to prosecution. All HealthCare professionals have a mandatory duty to report this. The Serious Crime Act 2015 requires regulated health and social care professionals in England to make a report to the police where, in the course of their professional duties, if FGM is confirmed in a girl under 18 (non-pregnant or pregnant). FGM can be confirmed either on examination or because the patient or parent says that an act of FGM has been carried out on her; or observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with any stage of labour or birth. These must all be reported to the Police via 101 number (9-101 from within UHL), children's social care and if pregnant,

maternity safeguarding referral on ICE by the person who initially identified the FGM. Reporting to the police is mandatory and this must be within 1 month of confirmation (2015)

6.3 Complying with the duty does not breach any confidentiality requirement or other restriction on disclosure which might otherwise apply as All HealthCare professionals have a mandatory duty to report FGM. Since April 2014 it has been mandatory for NHS hospitals to record the presence of FGM in the patients' health record and notify the GP and Health visitor.

6.4 From April 2019 FGM-IS is operational within UHL. FGM-IS (female genital mutilation- information sharing) is an Alert that is placed onto a female child's summary care record on the NHS spine identifying that they are from a family that has a history of FGM. The alert can then be seen by any health professional who provides care to the child and has access to the summary care record. The summary care record on the NHS spine must be completed for a female child that is at Risk of FGM following completion of the DOH FGM risk assessment (appendix 1)

6.5 If a female child has been born to a mother who has undergone FGM herself and the mother states that she would have her daughter undergo FGM an urgent referral to social care must be made identifying the risk to the child and a report made to the police on 101. (9101 from within UHL)

6.6 It is mandatory to RECORD information given about FGM. It is mandatory for health care professionals to record the presence of FGM in a patient's healthcare records whenever it is identified through the delivery of NHS healthcare. The patients' health record should always be updated with whatever discussions or actions have been taken.

6.7 If a pregnant woman discloses that she had FGM and is now over 18yrs of age the welfare of her unborn child or others in her extended family must be considered at this point, as these children are potentially at risk and safeguarding action must be taken accordingly. Complete the risk assessment tool from DOH. (see appendix 1.) to identify the level of risk posed to the unborn if it were to be a female infant. Once completed, you must submit a maternity safeguarding referral on ICE to the safeguarding team including the completed risk assessment tool identifying the level of risk to the unborn. If the level of risk is high in relation to the baby or child under the age of 18yrs you MUST inform the Safeguarding Team, and make an urgent referral to social care and the police on 9-101.

6.8 If the family are already known to social care services and FGM is known or identified within the family then the referral must be made (regardless of the outcome of the risk assessment). (LSCB, 2017)

6.9 If there is no/low risk identified following the use of the assessment tool, complete the maternity safeguarding referral on ICE sending both the referral and the risk assessment to the Safeguarding Team for information on the safeguarding system only.

6.10 It is not necessary to report all pregnant women to social services or the police. An individual risk assessment should be made. All health professionals should be aware of the Department of Health's guidance on FGM risk assessment and safeguarding. [6]

6.11 If the woman who has had FGM herself gives birth to a female infant a maternity safeguarding referral on ICE MUST be completed and sent to the maternity safeguarding team to enable the safeguarding team to update the FGM-IS on the child's Summary Care Record on NHS spine. (FGM-IS)

6.12 There is no requirement to report non-pregnant women aged over 18 years to the police or social services unless another child is at risk.

6.13 If FGM has been identified for any patient in the Trust then this should be included in any discharge documentation so that the patients GP is made aware of the patients FGM status.

6.14 If a child that is receiving care from UHL is identified as being at risk of FGM then a safeguarding referral on ICE should be made and a copy of the DOH risk assessment tool (see appendix 1) sent to the children's safeguarding team. Identifying the level of risk. If the child is at high risk of FGM report immediately to the police and children's social care and the children's safeguarding team. The safeguarding team will update the child's summary care record on the NHS spine via FGM –IS for both high and low risk cases.
gov.uk/government/FGM_risk_assessment_templates.pdf

6.15 It is illegal to arrange or assist in arranging for a UK national or UK resident to be taken overseas for the purpose of FGM.

6.16 It is an offence for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal.

6.17 It is an offence for those with parental responsibility to fail to protect a girl from the risk of FGM

6.18 Health professionals must be familiar with the Health and Social Care Information Centre (HSCIC) FGM Enhanced Dataset and explain its purpose to the woman. The requirement for her personal data to be submitted without anonymisation to the HSCIC, in order to prevent duplication of data, should be explained as well as that all personal data are anonymised at the point of statistical analysis and publication.

7. Complications of FGM

7.1 FGM has short and long term complications and health professionals should be aware of those [(8)].

Short term complications:

- Haemorrhage
- Urinary retention
- Infection
- Death

Long term complications:

- Genital scarring (Keloid, epidermoid inclusion cysts)
- Recurrent UTI's
- Dyspareunia, sexual dysfunction
- Psychological sequelae (anxiety, flash backs, PTSD)
- Menstrual difficulties/ dysmenorrhoea
- Genital infections, PID
- HIV, Hepatitis B
- Neuroma of clitoris causing pain
- Infertility
- Obstetric complications (see below)

7.2 Possible complications during labour and delivery:

- Retention of urine, difficulties in catheterising
- Prolonged / obstructed labour
- Difficulty if performing vaginal examinations, resulting in inadequate monitoring in labour
- Increased number of episiotomies and/or perineal lacerations
- Increased incidence of postpartum haemorrhage
- Increased neonatal morbidity mortality (because of obstructed or prolonged labour)
- Postpartum wound infections
- Maternal death from obstructed labour and postpartum haemorrhage
- **Increased risk of stillbirth and neonatal death**

8. Obstetric Management of women with FGM

a) Antenatal management:

When a patient with FGM is identified, the fact that they had FGM must be documented in the medical records regardless of whether FGM is the reason for presentation. The woman should be informed that her personal data will be forwarded to the FGM Enhanced Dataset (HSCIC see below) for the purpose of FGM prevalence monitoring.[9]

Data will be submitted via a FGM Prevalence Dataset on a monthly basis. This is an anonymised return which will be coordinated by the central information team. To enable gathering of the data a local reporting tool is available on UHL Connect and this is the form that should be completed. If the woman does not need to attend the clinic then it should be completed by the midwife at booking.

A maternity safeguarding referral form should be completed at booking for all women with FGM.
Where a woman with FGM attends the FGM clinic, the clinic specific tool should be completed by the Consultant or Midwife working within that clinic.
Where a woman attends another clinic or is being cared for within the community then the tool should be completed by the hospital Doctor / Midwife or Community Midwife.

Pregnant women with FGM should be referred to the specialist FGM clinic at LRI led by a Midwife and Consultant Obstetrician and Gynaecologist. **Women who previously had a vaginal birth or who have been de-infibulated or have been seen in the above clinic in a previous pregnancy do not need to be referred**.
The FGM Risk Assessment form within the hand held notes should be completed by the Midwife at booking.

All physical and psychological aspects of FGM will be addressed in the FGM clinic as well as safe guarding issues.

Psychological support should be offered

Inspection and assessment whether de-infibulation is necessary should be done.
For women with type 3 FGM, where vaginal assessment in labour is unlikely to be possible, de-infibulation should be offered antenatally.

De-infibulation is a minor procedure and can be performed with local anaesthetic in the FGM clinic, unless the woman expressly wishes a spinal anaesthetic.

De-infibulation:

Ideally de-infibulation is performed antenatally around 20 weeks. Some women do not wish to have this done antenatally in which case an intrapartum care plan needs to be made. It can also be performed after Caesarean section.

b) Intrapartum Management of women with TYPE 3 FGM:

These women have to be treated sensitively, in a non-judgemental way and with respect for the cultural differences.

It is important to remember that apart from the physical and psychological trauma of the procedure they often experienced the emotional upset of migration, separation of their family and civil war.

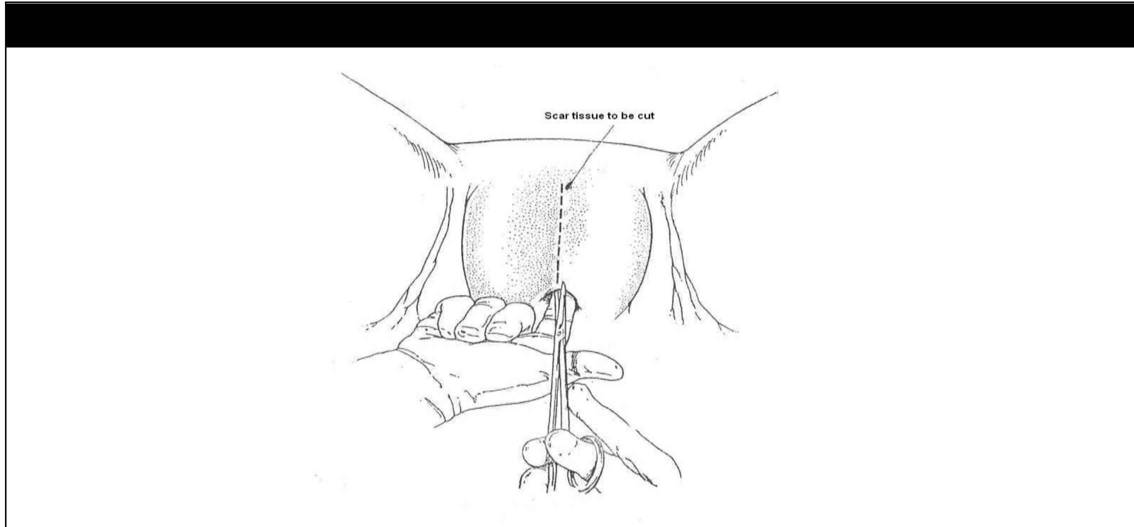
If the woman presents in labour, de-infibulation should be performed during the 1st stage unless vaginal examination and catheterisation is easily possible. If the latter is the case, de-infibulation should be performed in 2nd stage. An assessment whether an episiotomy is also needed should be made thereafter.

Adequate pain relief is important and may help avoid flash-backs and should be available to all women.

If the woman does not want an epidural for labour, de-infibulation can be performed with local anaesthetic.

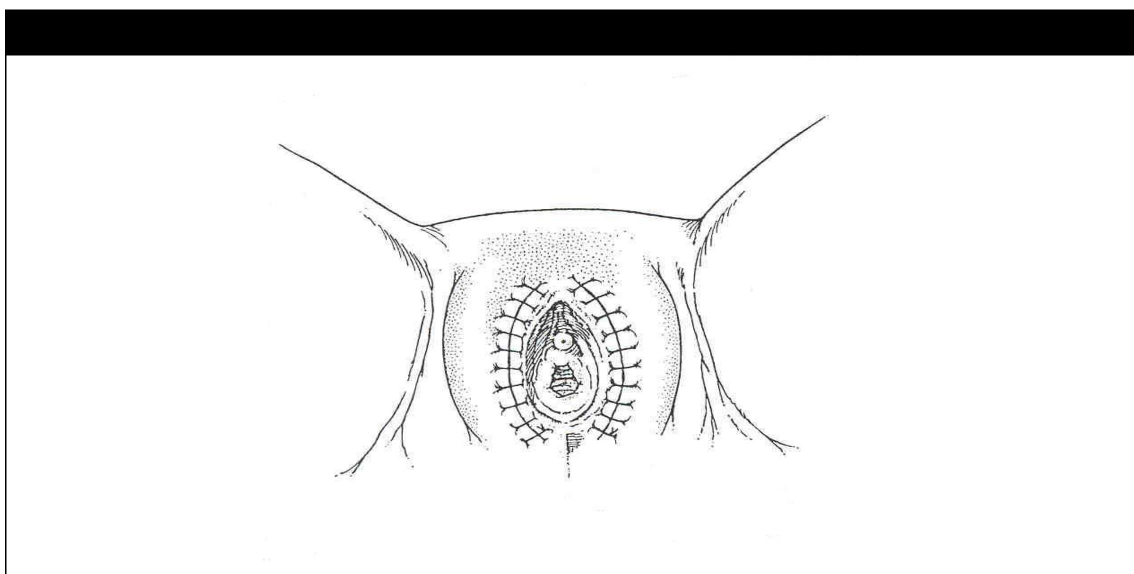
If de-infibulation planned at delivery is not undertaken because of recourse to Caesarean section, perioperative de-infibulation should be discussed.

De-infibulation method:



Give an anterior midline incision to expose the urethra. As with all procedures, informed consent in essential. In the 2nd stage of labour scissors should be used, but if de-infibulation is performed in the 1st stage or antenatally, a scalpel and/or scissors can be used.

Following delivery, prompt assessment regarding suturing should be made. **Re-infibulation (i.e. stitching back to previous state) is illegal and MUST NOT be carried out.**
The edges of the labia should be oversewn with Vicryl Rapide 3/0. This can be done immediately, if bleeding, or after delivery.



b) Postpartum Management:

- Adequate analgesia must be prescribed.
- Women who have had de-infibulation in labour, a postnatal follow-up appointment should be arranged for 6 weeks in the FGM clinic at LRI.

9. FGM in Non-Pregnant women

- Women may be referred by their GP or a sexual health clinic. The referral should be directed to the FGM clinic.
- Women should be able to self-refer to the FGM clinic
- Women who present to gynaecology with symptoms not attributable to FGM should be asked whether they have had the procedure and if so this and the type should be documented.
- Clinicians should be aware that psychological sequelae and impaired sexual function can occur with all types of FGM and psychological support should be offered.
- Women who are likely to benefit from de-infibulation should be counselled and offered the procedure before pregnancy, ideally before first sexual intercourse.

Clitoral reconstruction is not funded by the NHS and should not be performed as current evidence suggests high complication rates without conclusive evidence of benefit.

Female genital cosmetic surgery (FGCS) may be prohibited unless it is necessary for the patient's physical or mental health. All surgeons who undertake FGCS must take appropriate measures to ensure compliance with the FGM Acts.

10. EDUCATION AND TRAINING REQUIREMENTS

10.1 All staff will receive training to enable them to implement the policy as appropriate to their role. This training will be delivered locally within teams and within the mandatory face to face safeguarding training programmes and E learning modules. Training will be as per directive in intercollegiate guidance January 2019

10.2 New staff will receive this training within six months of commencement of employment. This training is mandatory for staff directly involved in the care of children and pregnant women.

11. PROCESS FOR MONITORING COMPLIANCE

What key element(s) need(s) monitoring as per local approved policy or guidance?	Who will lead on this aspect of monitoring? Name the lead and what is the role of other professional groups	What tool will be used to monitor/check/ observe/asses/ inspect Authenticate that everything is working according to this key element from the approved policy?	How often is the need to monitor each element? How often is the need complete a report ? How often is the need to share the report?	How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes.
Recognising and reporting cases of FGM within UHL	Safeguardi ng Lead	Audit and monitoring	Annual	Safeguarding assurance committee

12. EQUALITY IMPACT ASSESSMENT

12.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

12.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

13. SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

1. Royal College of Midwives, Royal College of Nursing, Royal College of Obstetricians and Gynaecologists, Equality Now, Unite. Tackling FGM in the UK: Intercollegiate recommendations for identifying, recording and reporting. London: RCM; 2013

2. Female Genital Mutilation Act 2003. The Stationary Office. 2003. http://www.hmso.gov.uk/acts/acts2003/20030031.htm.

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7. Berg RC, Underland V, Odgaard-Jensen J, Fretheim A, Vist GE. Effects of female genital cutting on physical health outcomes: a systematic review and meta-analysis. BMJ Open 2014;4:e006316

8. Department of Health. Female Genital Mutilation Risk and Safeguarding. Guidance for professionals. London: DH; 2015

9. Health and Social Care Information Centre. Female Genital Mutilation (FGM) Enhanced Dataset. Requirements Specification. [Leeds]: HSCIC; 2015

10. Mandatory Reporting and Assessment Tool in relation to Female Genital Mutilation (DOH) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachmen t_data/file/573782/FGM_Mandatory_Reporting_-_procedural_information_nov16_FINAL.pdf

11. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachmen t_data/file/525405/FGM_mandatory_reporting_map_A.pdf (mandatory reporting map)

12. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/fi le/576051/FGM_risk_assessment_templates.pdf

Appendix 1: Assessment tools

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

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

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

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

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

ACTION

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

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

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

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

In all cases:-

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

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

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

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

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

Indicator	Yes	No	Details
CONSIDER RISK			
Woman already has daughters who have undergone FGM – who are over 18 years of age			
Husband/partner comes from a community known to practice FGM			
A female family elder (maternal or paternal) is influential in family or is involved in care of children			
Woman and family have limited integration in UK community			
Woman's husband/partner/other family member may be very dominant in the family and have not been present during consultations with the woman			
Woman/family have limited/no understanding of harm of FGM or UK law			
Woman's nieces (by sibling or in-laws) have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment			
Family are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

SIGNIFICANT OR IMMEDIATE RISK			
Woman/family believe FGM is integral to cultural or religious identity			
Woman already has daughters who have undergone FGM			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be triggered if she is found to have FGM			

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

ACTION

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

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

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

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

In all cases:–

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

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

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

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

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

ACTION

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

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

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

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

In all cases:-

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

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

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

ACTION

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

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

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

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

In all cases:–

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

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

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

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

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

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

ACTION

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

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

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

In all cases:-

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

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