



Bristol Safeguarding
Children Board

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Female Genital Mutilation Safeguarding Guidance

2017-
2020

These Guidelines aim to support professionals who are working with families who many have had Female Genital Mutilation (FGM) or they come from areas where it is practiced. These guidelines can be read in conjunction with the BSCB FGM strategy to see how Bristol is responding to the need for Prevention, Protection and Provision to support community work and engagement to end FGM in a Generation.

The BSCB would like to thank the members of the FGM Delivery and Safeguarding Partnership, FGM affected communities and the young people who campaign for an end to FGM in a Generation for their contribution to these guidelines.

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Purpose of the Guidance

This guidance is aimed at professionals, volunteers and communities who have contact with children 0-18 years of age and groups working with adults/ parents who care for children who may be at risk of or have undergone any type of Female Genital Mutilation (FGM).

These guidelines focus on the safeguarding role related to FGM. These guidelines accept that they cannot cover the whole FGM programme reflected in the Bristol model and the level of community engagement which empowers women men and young people. It does not give any detailed account of the Bristol Ideal project which supports schools in their wider work around gender based violence including work on FGM.

FGM is not an acceptable practice, it is illegal in the UK (FGM Act 2003- <http://www.legislation.gov.uk/ukpga/2003/31/contents>), it is a form of child abuse under UK Law and is a form of gender based violence.

This guidance has been developed by members of the FGM delivery and safeguarding partnership and wider multi-agency partners who come from both acute and community workforces. The FGM delivery and safeguarding partnership is a multi-agency group and functions as a working group of the BSCB. It focuses of community based safeguarding engagement work with adults, young people and professionals with a goal to end FGM in a generation. This work supports the initiatives from the 'Girls Summit 2014 (<https://www.gov.uk/government/news/girl-summit-2014-outcomes-and-commitments>)

Individuals who have concerns about FGM may have different levels of contact with the child and their family. This guidance aims to support any one to assess the risk to the child, to ensure effective information sharing, education and support is offered to the child and family to prevent FGM and make appropriate referrals to safeguard and protect the girl.

This guidance is primarily for victims of FGM who are under 18 years of age however women over 18 years of age may still need safeguarding, support and interventions. The Bristol Safeguarding Adults Board (BSAB) does recognise FGM as a form of abuse against women. It is important that anyone who is concerned about FGM should 'Think Family' and should safeguard appropriately and look at wider family networks and the risks to other girls. Any assessment should include education that FGM is illegal in the UK and a form of child abuse. It should also include sign posting to support services for both physical and emotional needs for any victims of FGM.

This guidance will also consider the services that are available to support those affected by FGM and the partnership work that is needed to end FGM in a generation. This will be covered in the section on preventative work

This guidance takes account of the following documents related to FGM and safeguarding children:

- FGM guidelines on the South West Child Protection Procedures¹
- London safeguarding children board FGM guidelines and toolkit (2009)
- Tackling FGM in the UK; Intercollegiate document (2013)
- Home affairs select committee: FGM: A case for a national action plan (July 2014)
- Home office FGM resource tool (2014)
- Oxford safeguarding children board FGM guidelines (2014)
- Female Genital Mutilation: a Councillors Guide (2015)²
- Working together to safeguard children (2015)
- Multi-Agency statutory guidance on FGM (home office 2016)³
- Keeping children safe in education (2016)
- Bristol Against Violence and Abuse- FGM- (2017)⁴

What is FGM

The World Health Organisation (2017⁵) has classified FGM as:

'all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organ for non-medical reasons'

The WHO have categorised FGM into 4 types:

Type 1- **Clitoridectomy**

partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and or the prepuce (the fold of skin surrounding the clitoris).

Type 2- **Excision**

partial or total removal of the clitoris and the labia minora, (the vagina has two skin fold which protect and moisturise the vagina. The labia minora are the inner skin fold called 'lips' that surround the vagina).

Type 3- **Infibulation/ Pharaonic circumcision**

Narrowing of the vaginal opening by removing the labia minora and majora (out lips protecting the vagina) to leave a small hole about 5mm. This hole allows for urine flow, menstrual flow, intercourse and child birth.

¹ SWCPP- FGM procedures-

http://www.proceduresonline.com/swcpp/bristol/p_fem_gen_mutil.html?zoom_highlight=FGM

² FGM: Councillors Guide http://www.local.gov.uk/documents/10180/5854661/L14-567+FGM+guidance+for+councillors_09.pdf/7196465e-4b63-4b58-b527-a462f5b5cc9d

³ <https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation>

⁴ BAVA information on FGM- <http://www.bava.org.uk/types-of-abuse/female-genital-mutilation/>

⁵ WHO/UNICEF- <http://www.who.int/mediacentre/factsheets/fs241/en/>

Type 4 **Unclassified /Other**

All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

FGM and other forms of Gender Based Violence

FGM is a form of gender based violence. Other forms of 'honour based violence include Forced Marriage and Domestic Abuse. If these other forms of abuse are identified when working with a girl suspected of FGM the practitioners should review both the local and national guidelines on Forced marriage⁶⁷.

Implications of FGM for a child's health and welfare

The health implications for a child who has had FGM can be severe and depending on the type of FGM even fatal. There are challenges for professionals in assessing risk related to FGM. Generally families that practice FGM will have limited or no obvious indicators other than the risks of FGM. It is important that Professionals understand the trauma FGM can cause and the emotional impact and physical abuse the child will have experienced. This experience will be individual to the child and cannot be limited to the risks associated to the type of FGM undertaken.

The short-term health implications from FGM can include (this can be from any type of FGM):

- Severe pain
- Emotional and psychological shock (exacerbated by having to reconcile being subjected to the trauma by parents, extended family and friends and those trusted by the child)
- Haemorrhage
- Wound infections including Tetanus and blood borne viruses (including HIV and Hepatitis B and C)
- Urinary retention
- Injury to adjacent tissues
- Fracture or dislocation as a result of being restrained for the FGM
- Damage to other organs
- Death

The longer term implications for women and girls who have been subject to FGM Types 1 and 2 are likely to be related to the trauma of the actual procedure and the emotional impact of being restrained for the FGM. Nevertheless, analysis of World Health Organisation

⁶ National Forced marriage guidance- <https://www.gov.uk/guidance/forced-marriage#guidance-for-professionals>

⁷ BSCB Guidance on Forced Marriage- https://www.bristol.gov.uk/documents/20182/35012/Forced%20Marriage%20and%20Safeguarding%20Final%202011%20v1_09.pdf/613e12a1-c9cb-4b0f-b7a7-7ae6c6226040

data has shown that as compared to women who have not undergone FGM, women who had been subject to any type of FGM showed an increase in complications in childbirth, worsening with Type 3. Therefore, although Type 3 creates most difficulties, professionals should respond proactively for all FGM types.

The long term health problems caused by FGM Type 3 are severe and include:

- Difficulties in passing urine and chronic urine infections
- Difficulties in menstruation
- Chronic vaginal and pelvic infections
- Renal impairment and possible renal failure
- Damage to the reproductive system including infertility
- Infibulation cysts, neuromas and keloid scar formation (keloid scarring is described as scars that don't stop growing. They "invade" the surrounding healthy skin and become bigger than the original wound.
- **Women with FGM Type 3 require special care during pregnancy and childbirth.** Complications in pregnancy and delay in the second stage of childbirth
- Maternal or foetal death
- Psychological damage; including a number of mental health and psychosexual problems including depression, anxiety, and sexual dysfunction and Post Traumatic Stress Disorder (PTSD)

Mental health problems

In FGM practising communities, the procedure is generally performed on pre-pubescent and adolescent girls usually without anaesthetics and with instruments such as razor blades. Case histories and personal accounts from women note that FGM is an extremely traumatic experience for girls and women that stay with them for the rest of their lives.

Young women who have received psychological counselling in the UK, reported feelings of betrayal by parents, incompleteness, regret and anger.⁸⁹ It is possible that as young women become more informed about FGM this problem may be more frequently identified.¹⁰ There is increasing awareness of the severe psychological consequences of FGM for girls and women which become evident in mental health problems.

The research^{11,12,13} involving FGM practicing African communities varies widely and the quality of the research indicates they are small sample sizes. There are indications that

⁹ Haseena Lockhat, 2004, 'Female Genital Mutilation: Treating the Tears', London: Middlesex University Press

¹⁰ Excised girls requiring psychological counselling was highlighted by women's organization attending a recent Equality Now 'Annual Meeting for Grassroots Activism to End Female Genital Mutilation' which took place from the 20-22 October 2005 in Nairobi, Kenya.

¹¹ Behrendt, A. et al, 2005, 'Posttraumatic Stress Disorder and Memory Problems after Female Genital Mutilation', Am J Psychiatry 162:1000-1002, May

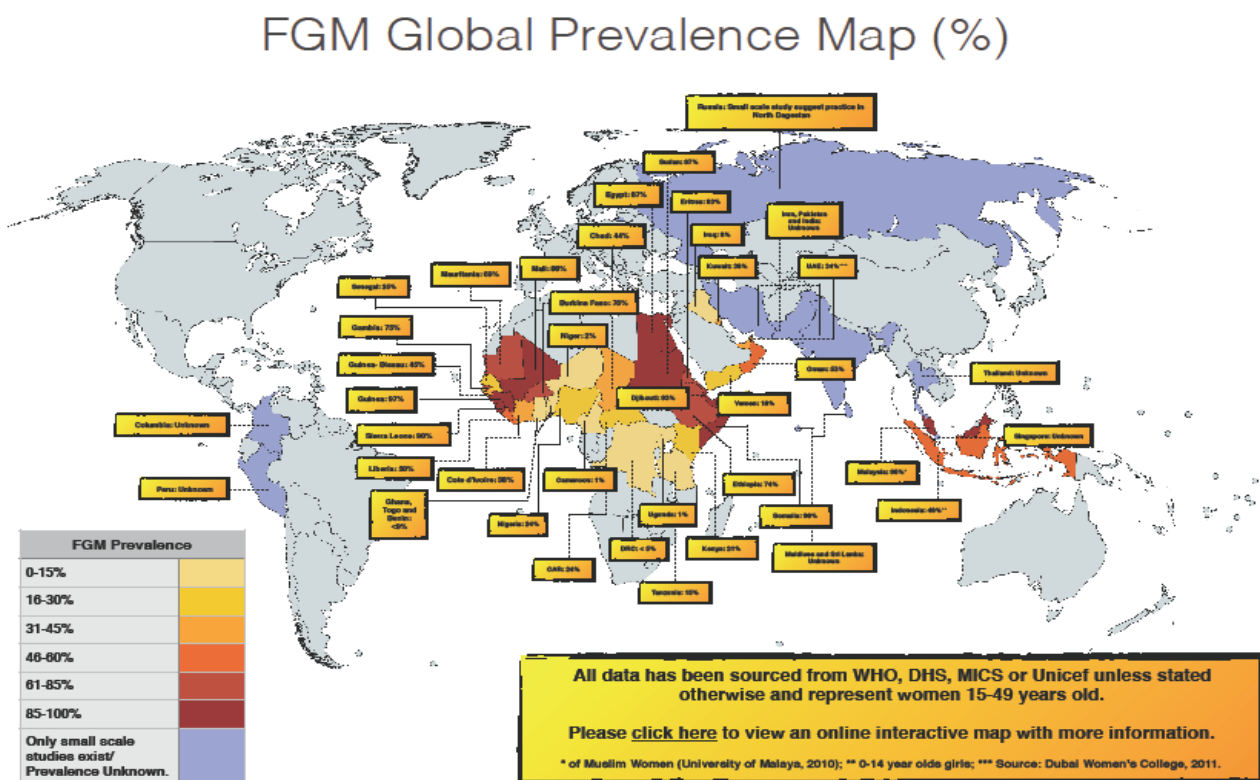
women who have undergone FGM may experience Post Traumatic Stress Disorder as adults but this can vary from 20-80% depending on the study. The studies do identify some protective factors which include being supported by communities who understand FGM.

Where does it happen

FGM is practiced in 30 African countries, the Middle East and specific parts of Asia¹⁴. The attached map highlights the countries it is practiced in and the prevalence of this practice. It is also carried out in the UK and many other countries where FGM affected communities live. Therefore FGM is a worldwide issue. Because FGM is a ‘taboo’ subject it is difficult to get accurate data on the prevalence of FGM and the types of FGM practiced.

There are many maps that reflect where FGM is practiced, below are a few websites which offer interactive Maps that give details about the Types of FGM practiced the laws in the country and the prevalence. Below is a link to some of these interactive maps.

<http://nationalfgmcentre.org.uk/world-fgm-prevalence-map/>



<http://www.dofeve.org/about-fgm.html>

¹² Zurynski et al 2015- FGM:a systematic review of literature on health professionals knowledge, attitudes and clinical practice- <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4676087/>

¹³ Knipscheer et al 2015, FGM and mental health- <http://pb.rcpsych.org/content/pbrpsych/early/2015/08/11/pb.bp.114.047944.full.pdf>

¹⁴ Data from UNICEF accessed Jan 2017- <http://data.unicef.org/resources/female-genital-mutilation-cutting-country-profiles/>

Local Context

In Bristol we have a large number of communities that come from areas where FGM is practiced, these countries include; Somalia, Sudan, South Sudan, Eritrea, Egypt and Gambia. This is not an exhaustive list but highlights some of the FGM affected communities that have been working with professionals in Bristol to raise awareness of the health and psychological risk linked to FGM.

When does it happen

Each country, village or tribe which practices FGM will practice it at different ages. Appendix 1 has a chart of the country and the type of FGM practiced, the age it may practice it and the laws on FGM for that country.

There is limited data to know if the communities still follow the same practice (e.g. age and timescales) if they live in the UK. There are a number of factors which may affect them adhering to these same time lines. These factors include;

- access to someone who can undertake the FGM
- the cost of travelling to an area/ country where FGM can be performed
- extended holiday to undertake FGM and healing can be difficult because of the limited school holiday

In the UK the summer months are considered a high risk time because the girl will need time to heal especially if she has had type 3 FGM. It can take up to 6 weeks for type 3 FGM to heal. If the girls in a family are of a similar age, they may all have it done together because;

- of the cost of travel
- finding someone who can undertake the FGM

There is some concern that communities that practice FGM may be practicing FGM earlier to avoid monitoring and detection from schools and nurseries.

FGM happens to British girls in the UK as well as overseas. Professionals must be alert to this risk. Everybody should be vigilant for any signs or indicators that FGM is being planned or has happened.

FGM should not be considered a 'one off incident', it is rare it will be repeated to a child but it has been recorded (especially for type 3) that there is a risks of FGM being repeated after a woman has given birth. If there are any requests for the woman to be re-infibulated/closed after child birth this should be seen as a high risk indicator for any girls in the family.

Why does it happen

The WHO states that in every society where FGM is practised, FGM is the manifestation of gender inequality that is entrenched in social, economic and political structures. FGM is a form of violence against women and girls.

FGM is a complex issue. Despite the harm it causes, many women from FGM practising communities consider FGM normal and part of their cultural identity. Women are highlighted as the main drivers in continuing the practice of FGM, but this varies across FGM affected communities. The influence that men have is often underestimated. Men are not openly campaigning to end this practice and a large number of the reasons given for continuing the practice are related to men and marriage.

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
- 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

Professionals need to be mindful that if communities are displaced and living in isolation to their country of origin, they may hold on to cultural practices that keep them connected to their country of origin. The empowerment and community engagement work undertaken in Bristol supports the work referenced in UNICEF 2013¹⁵ which highlights FGM affected communities change practice through education, knowledge and empowerment.

Although FGM is practised by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. **There is no valid religious text** that promotes FGM and it is practised by all religions; Muslims, Christian, Jews and secular communities but not one of these religions or groups practices FGM in total.

¹⁵ UNICEF- data review 2013- https://data.unicef.org/wp-content/uploads/2015/12/FGMC_Lo_res_Final_26.pdf

Prevalence

National Picture

UNICEF estimates that over 200 million girls and women worldwide have experienced female genital mutilation¹⁶.

City University London and Equality Now undertook an estimate review of the prevalence of FGM in the UK using the 2011 census data¹⁷. This data reflects the overall numbers of women aged 15-49, who were permanently resident in England and Wales but born in FGM practising countries increased by 99,000 in ten years to 283,000 in 2011. (pg. 3)

From 1996 to 2010, 144,000 girls were born in England and Wales to mothers from FGM practising countries. It is estimated that 60,000 of these girls aged 0-14 in 2011 were born to mothers with FGM.

In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM.

Local context

In Bristol there is no one accurate system to identify girls at risk of FGM. In 2014 Public Health England were commissioned by the Police and Crime Commissioner to undertake 'FGM in Bristol: exploration of available data'. The data for this study indicated nearly 1400 girls came from FGM practicing countries. The study does recognise the limitations of the data and the challenge in accessing this data because it is self-reported by individuals who identify their ethnicity when registering their children at school, or accessing health services, because of these factors it is thought this is an underestimate of the potential number of girls who live in families affected by FGM.

The large majority of children identified by this Bristol data come from communities that practice type 3 FGM. The estimates of prevalence in these countries of origins vary depending of the reports written. The generally accepted data indicates that areas around the horn of Africa still practice type 3. There are indications some communities may be changing the type of FGM they have traditionally practiced. The general movement appears to be from type 3 to type 1 or 4. This still is a form of child abuse and gender based violence. As information is collected via the enhanced data set we should have a better picture of the risks related to FGM and the types of FGM practiced.

¹⁶ UNICEF- global concerns- http://data.unicef.org/wp-content/uploads/2016/04/FGMC-2016-brochure_250.pdf

¹⁷ Macfarlane A, Dorkenoo E. (2015) *Prevalence of Female Genital Mutilation in England and Wales: National and local estimates*. London: City University London and Equality Now/(http://www.city.ac.uk/_data/assets/pdf_file/0009/226287/FGM-statistics-report-21.07.14-no-embargo.pdf)

The prevalence data on the practice of FGM in the UK is limited and everybody has a role to play in public health work. This includes;

- raising awareness about the risks of FGM and
- the fact FGM is illegal for any British citizen and
- is a form of child abuse.

NHS England and the Department of Health have placed a 'Mandatory Recording Duty' on all Acute Health Trusts, Mental Health Trust and GPs to collect data on FGM. This information is collected centrally. An anonymised quarterly report is published to support health commissioners to identify unmet health needs related to FGM. This data has identified Bristol as an area of high recording of FGM cases¹⁸.

Legislation

It is illegal under UK law to subject a girl or women to any form of FGM either in this county or abroad (children act 2003)¹⁹

The Serious Crime Act 2015²⁰

Key points

FGM is illegal in England and Wales under the Female Genital Mutilation Act 2003. As amended by the Serious Crime Act 2015, the Female Genital Mutilation Act 2003 now includes:

- An offence of failing to protect a girl from the risk of FGM
- Extra-territorial jurisdiction over offences of FGM committed abroad by UK nationals and those habitually (as well as permanently) resident in the UK
- Lifelong anonymity for victims of FGM
- FGM Protection Orders which can be used to protect girls at risk; and
- A mandatory reporting duty which requires specified professionals to report known cases of FGM in under 18s to the police

Full explanations of all these key points can be found in the 'Multi-Agency Statutory Guidance on FGM- 2016'²¹

¹⁸ NHS Digital FGM Enhanced Data set Dec 2016-

<http://www.content.digital.nhs.uk/catalogue/PUB22619/fgm-jul-2016-sep-2016-exp-qual.pdf>

¹⁹ FGM Act 2003- http://www.legislation.gov.uk/ukpga/2003/31/pdfs/ukpga_20030031_en.pdf

²⁰ Serious crime act 2015- FGM fact sheet-

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416323/Fact_sheet_-_FGM_-_Act.pdf

²¹ Multi-agency Statutory Guidance 2016-

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512906/Multi_Agency_Statutory_Guidance_on_FGM_-_FINAL.pdf

Failing to protect

- This means an offence of FGM may have been committed on a girl under 16 if the person who was 'responsible' for her care did not take all reasonable action to protect her from FGM.
- The 'Responsible person' may be a parent, or the carer or someone who has taken on this role and is over 18 years.

Example:

The carer has sent a young child on holiday to a country where FGM is practiced, to stay with people whose beliefs of FGM are either unknown or they promote the practice of FGM. If the child then undergoes FGM the carer did not take all 'reasonable' actions to protect her.

Extra-Territorial Offences

- The extra-territorial offences are intended to cover taking a girl abroad to be subjected to FGM
- This now covers girls who are 'Habitually Resident'. This change means it does not rely on any legal status e.g. UK National / UK Resident

FGM Protection Orders (FGMPO)

- An FGMPO is a civil order which may be made for the purpose of protecting a Girl from FGM
- FGMPO applications are made to the High Court or Family Court by:
 - The girl herself (victim) or
 - a 'relevant third Party' - this has been specified as the Local Authority
 - any other party/ agency wanting to make an application can apply 'with the leave of the court'
 - certain Family Courts can make an FGMPO application
 - Criminal Proceedings can apply for an FGMPO if relevant
 - An application for an FGMPO is not an alternative to the work of the police/ CPS. The FGMPO can run concurrently with Criminal proceedings
- A breach of an order may result in a fine and or imprisonment
- An FGMPO can protect both **ACTUAL** and **POTENTIAL** victims of FGM
- When an FGMPO has been made, the information will, be shared with:
 - The LA **if they have not applied for the order**
 - The police so they are aware of the order
 - Other agencies will be notified if it is 'proportionate' for them to hold this information e.g.
 - A GP may see a family about foreign travel.
 - Schools/ education settings

- If the child has an FGMPO and there are risk of FGM identified there should be a discussion with First Response and the agency who has applied for the FGMPO so any further investigation can be undertaken
- AN FGMPO can be a supportive tool for families who are seeking asylum from the risks of FGM in their country of origin

FGM Mandatory Reporting Duty

On 31st October 2015 a new legal requirement was placed on 'Regulated Professionals' to report all 'Known' cases of FGM to the Police.

- Section 74 of the Serious Crime Act 2015, inserts Section 5B into the FGM Act 2003 and places a Mandatory Duty on regulated professionals to report known cases of FGM directly to the Police.
- A regulated professional is:
 - Health and Social Care professionals who are regulated by a body overseen by the professional standards authority for health and social care this includes:
 - Health
 - GPs, Dentists, Opticians, Pharmacists, Chiropractors, Nurses, Midwives
 - Social Care- Social Workers in England
 - Teachers- this includes and Education Practitioners regulated by the Education Workforce Council
 - **You cannot delegate this duty to any other professional you must report this personally**
- The 'Mandatory Duty' applies when:
 - You are informed by a girl under 18 that an act of FGM has been carried out on her

Or

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

Reports under this duty must be made as soon as possible. In exceptional cases the maximum time scale is 1 month²².

Failure to comply with the duty will be dealt with in accordance with the existing performance procedures in place for each profession. FGM is child abuse, and employers and the professional regulators are expected to pay due regard to the seriousness of breaches of this duty.

²² As required by section 5B (5) (c) of the 2003 Act (as amended by the Serious Crime Act 2015).

FGM Mandatory Reporting Duty: Additional Resources

Information for professionals, including on how to make a report, is available at: www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information

Additional information for health care professionals in England is available at: www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare

How to complete a 'Mandatory Duty to report a case of FGM'

- Phone 101 and state 'I am carrying out my Mandatory Duty to Report a case of FGM'
- Give all your details: Name, Contact Details, Role , Place of Work
- Give the details of your Organisations/ Agencies Designated Safeguarding Lead
- The Girls details: Name Age/Date of Birth, Address, Wider Family (If known)

You will be given a Police Reference Number for the call, record this number in your records. This is proof you have undertaken your '**MANDATORY DUTY TO REPORT CASES OF FGM**'.

While the Police should share this information with Social Care, it is best practice in Bristol to contact First Response and notify them of this information. Give them the Police Reference Number so they can track the case and support any safeguarding investigations.

You must also notify your organisations Safeguarding Lead that you have reported a case of FGM to the Police.

Example of cases requiring mandatory reporting

- A girl tells a teacher she has had FGM
- A teacher /nurse notices a child has symptoms related to FGM and asks her about FGM and she discloses she has had FGM
- Social working in completing an assessment with a family talks to the child about her culture and she discloses FGM
- Teacher/ asylum social worker/ health care professional is talking to a child who is new in to the country. The child says she has had FGM done.
 - Even though the FGM may have happened outside the country this **MUST** still be reported.
- A health care professional examining a 17 year old girl sees she has a genital piercing
 - Piercings are included in type 4 FGM and are part of the mandatory duty to Report cases of FGM

Statutory safeguarding role related to FGM

Anyone working with children who recognise any risks associated to FGM has a Statutory Duty to report this information to First Response. While the mandatory Duty to report is for 'Regulated Professions' the '**STATUTORY DUTY**' to safeguarding children applies to everyone.

Signs and symptoms related to FGM (including emotional impact)

Below are some indications that FGM may be planned, these statements in isolation do not prove FGM will happen but they are indicators for further investigation to exclude the risks of FGM.

- It may be possible that families will practise FGM in the UK when a female family elder is around, particularly when she is visiting from a country of origin
- A professional hears reference to FGM in conversation, for example a child may tell other children about it;
- A girl may confide that she is to have a 'special procedure' or to attend a special occasion to 'become a woman'
- A girl may request help from a teacher or another adult if she is aware or suspects that she is at immediate risk
- Parents state that they or a relative will take the child out of the country for a prolonged period
- A girl may talk about a long holiday to her country of origin or another country where the practice is prevalent
- Parents seeking to withdraw their children from learning about FGM
- Any female child born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family
- Any female child who has a sister who has already have undergone FGM must be considered to be at risk, as must other female children in the extended family

Indications that FGM may have already taken place include:

- A child may spend long periods of time away from the classroom during the day with bladder or menstrual problems
- A child may have difficulty walking, sitting or standing
- There may be prolonged absences from school
- A prolonged absence from school with noticeable behaviour changes on the girl's return could be an indication that a girl has recently undergone FGM
- A girl or woman may be particularly reluctant to undergo normal medical examinations

- Professionals also need to be vigilant to the emotional and psychological needs of children who may / are suffering the adverse consequence of FGM, e.g. withdrawal, depression etc.
- A child may ask for help or confide in a professional
- A child requiring to be excused from physical exercise lessons without the support of her GP
- A girl or woman may ask for help, but may not be explicit about the problem due to embarrassment or fear
- A girl may talk about pain or discomfort between her legs
- A girl or woman may have frequent urinary, menstrual or stomach problems
- Young women may seek help and advice about painful intercourse or the psychological impact of FGM on their sexuality

The statements above are not an exhaustive list they are indicators that FGM should be considered and further assessments undertaken. Individuals working with the families should discuss their concerns with their safeguarding leads.

The Department of Health have developed a risk assessment template²³ this supports health care professionals in recognising risks related to FGM appendix 2a. Bristol has adapted this tool to so anyone working with children can make an assessment of the girls risk from FGM

Appendix 2b:

Guide to asking about FGM

Each community that practices FGM will have different words, phrases and terms to describe the different types of FGM. Practitioners should be sensitive to the girl and their families but not culturally blind to the risks of FGM you may need to use an interpreter to full explore any risks. Always check that you know the views values and opinions of the interpreter before you use them. **YOU SHOULD NEVER USE FAMILY MEMBERS TO TRANSLATE.**

You can mirror the preferred words the girl or family use but you need to be clear what the joint understanding of the types of FGM is. Appendix (1) provides a list of names that may be familiar to different FGM affected communities.

²³ DoH (may 16/Jan 2017) FGM Safeguarding and risk assessment: quick guide for health professionals/ Risk assessment template <https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm>

Some key phrase you may want to use are:

- When asking a woman whether she has undergone FGM you may want to ask: 'I'm aware that in some communities women undergo some traditional practices in their genital area between their legs. Have you had FGM or been cut/ circumcised or closed?'
- In pregnancy all women will be asked questions similar to this; "Have you had any changes to your genital area such as FGM, female circumcision , being cut, closed, had any tattoo's, piercings or changes to your genital area that may impact on your pregnancy or delivery?"
- To ask about Infibulation/ Type 3 FGM professionals can use the question: "*Are you closed or open?*" This may lead to the woman providing the terminology appropriate to her language / culture, and you can mirror the language she uses.
- Always clarify that "FGM includes all forms including type 1 sometimes called Sunna"
- Asking the right questions in a simple, straightforward and sensitive way is key to establishing a good working relationship with the family. This will reduce misunderstandings and improve outcomes for the girl.
- If you are in an education setting, it may not be appropriate to ask a parent whether they have had FGM. However, this should be part of a referral if a mother discloses this voluntarily.

Remember:

- They may wish to be interviewed by a practitioner of the same gender.
- They may not want to be seen by a practitioner from their own community.

In cases where someone is disclosing:

- Develop a safety and support plan in case they are seen by someone "hostile" at or near the department, venue or meeting place e.g. prepare another reason why they are there.
- If they insist on being accompanied during the interview e.g. by a teacher or advocate, ensure that the accompanying person understands the full implications of confidentiality especially with regard to the person's family. For some, an interview may require an authorised accredited interpreter who speaks their dialect such as Language Line.

Safety procedures and referrals to Children's Social Care

There are a variety of circumstances relating to FGM which require further assessment and possible investigation and interventions, these include:

- **Where a child is at risk of FGM – See 'Risk Assessment Tool for FGM' (Appendix 2)**
- **Where a child has been abused through FGM**
- **Where a (prospective) mother has undergone FGM**

- **If the family are leaving the country for an extended period of time travelling to an area with a high prevalence of FGM**

Professionals and volunteers in most agencies may have little or no experience of dealing with Female Genital Mutilation. When they come across FGM for the first time they can feel shocked, upset, helpless and unsure of how to respond appropriately to ensure that a child, and/or a mother, is protected from harm or further harm. It is important to recognise these feelings but not let them be a barrier to access help and support for the child.

Complete confidentiality should not be promised to any adult or child raising FGM concerns (blanket confidentiality cannot be given to the individual as this is both a crime and child abuse that must be reported). It is also helpful to remember that although 'mutilation' is the most appropriate term, it might not be understood or it may be offensive to a woman from a practicing community who does not view FGM in that way.

When considering any safeguarding risks for a child it is always best practice to engage the parents/ carers of the child. There are a few exceptions to this and these include;

- **When you feel talking to the parents would put the child at greater risk of harm**
- **If there is the risk that information related to criminal activity may be lost or destroyed or you feel your life or that of others may be put at risk**
- **If talking to the parents may encourage them to avoid professional contact or abscond with the child**

These cases are rare and the exception and you must justify your decision not to talk to the parents when making your referral. This situation is more likely to happen when you suspect FGM is being planned or if you think it has recently happened. If you are in any doubt talk to the safeguarding lead within your organisation. Police officers can seek advice from the Police Safeguarding Coordination Unit. If you have no safeguarding lead in your organisation or you are not a professional you can speak to:

- the NSPCC FGM hotline for support (Tel 0800 028 3550) or
- First Response (Tel 0117 9036444).
- If you are concerned about the immediate safety of a child out of hours, you should contact the Emergency Duty Team for advice without delay (Tel 01454 615165).

If, through use of the 'Risk Assessment Tool for FGM', a potential risk of FGM is identified for a child, you should report the concerns immediately to First Response.

If you believe a child has had FGM, Mandatory Reporting Duties follow as per page 13

Once a referral has been received by First Response their role is to triage the case; balancing risk and protective factors. First Response will then decide upon the appropriate pathway within Social Care (dependent upon the level of assessed risk at this time).

It is important to recognise as previously highlighted that FGM may be the only RISK factor for these families. If there is a risk of FGM this must be fully explored. Assessing risk in isolation is very difficult. Protective factors may include:

- actively working to end FGM
- positively seeking out information to protect daughters

These protective factors will need to be confirmed and professionals should maintain the same standards of 'healthy scepticism' for this FGM as they do for all other forms of abuse.

In cases where there is not felt to be an immediate risk of FGM to a child and the potential for harm is unclear, Children's Social Care may choose to undertake enquires as a single agency in order to establish whether the threshold for a strategy discussion is met or not. These enquires must take into consideration all background information and identified protective factors. A discussion with the Police Safeguarding Coordination Unit should also be considered in cases where the threshold for a strategy discussion is not felt to be met (i.e. there is not enough information to indicate that a child is at risk of significant harm).

If an Immediate Risk is identified for any child, or the referral information suggests a significant risk of harm, Children's Social Care will convene a Strategy Discussion to plan and agree the next actions. The participants of the Strategy Discussion should include: Children's Social Care, the Police Safeguarding Coordination Unit and Health (see box below). Others who should be considered include education staff should also be considered if the children are school age and the person who made the referral.

Health

The person coordinating the strategy will need to ensure there is agreement on who needs to be contacted in health and who will do this. Groups that should be considered are the GP, Health Visitor, the school nurse and Midwife these are all individual agencies with their own records.

What is a Strategy Discussion?

A Strategy Discussion is a Multi-Agency meeting or telephone discussion between lead professionals who are experts in child protection.

Participants are sufficiently senior to contribute specialist knowledge to the discussion. Participants should include: Children's Social Care, the Police Safeguarding Coordination Unit, Health and the input of the referring agency.

"Sit down"/face to face Strategy Discussions are used for critically serious cases and often involve inviting a legal representative, an example of this would include when Social Care believe that there are sufficient grounds to consider an FGM Protection Order.

Why have a Strategy Discussion?

Social Care should convene a strategy discussion whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm.

What should a Strategy Discussion be used to do?

Share available information and agree the conduct and timing of any potential criminal investigation;
Decide whether an assessment under s47 of the Children Act 1989 should be initiated.
Consider action points for example if there will be a single or joined agency investigation.
Plan how the s47 enquiry should be undertaken including the need for medical treatment, and who will carry out what actions, by when and for what purpose.
Agree what action is required immediately to safeguard and promote the welfare of the child, and/ or provide interim services and support. If the child is in hospital, decisions should also be made

The likely outcome will be for Police and Social Care to jointly talk to families about their views and values related to FGM and their knowledge about the law and the need to protect children. In most cases this is even when the threshold for a Strategy Discussion has not been met. The outcome from this meeting may include asking families to sign a Declaration or Written Undertaking that they understand that FGM is illegal, that they will not subject their daughters to FGM and they will protect their daughters from anyone who may plan FGM for their daughters. **APPENDIX 3** gives a template which can be used. Information given to the Home Affairs select committee²⁴ indicated 'the practice of signing agreements not to perform FGM with families at risk has proven effective' (page 31). A copy of the Written Undertaking should be shared with the Police, School and the child's GP. This is a preventative measure to support families protecting their daughters.

If concerns remain that a child may be at significant risk of FGM following the initial Strategy Discussion and the completion of any agreed actions (i.e. a meeting with the family), at this stage consideration should be given to convening a 'sit down' Strategy Meeting. As well as key professionals from agencies working with the family, Children's Social Care should consider the need for a legal advisor to attend the meeting.

In all cases involving children where FGM has been suspected or there are indicators that it has happened, an experienced Paediatrician should be involved in setting up the medical examination. Examining children and teenagers needs to be approached with sensitivity, remembering that intimate examination requires the full consent and co-operation of any child. It is important that young women can maintain a healthy body image whenever possible, particularly if they were previously unaware they had been subjected to FGM and sensitive language needs to be used in these discussions.

It is important any medical exam undertaken employs a holistic approach which explores any other medical, support and safeguarding needs of the girl or young woman, and that

²⁴ <https://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/201/201.pdf>

appropriate referrals are made as necessary. These examinations must be undertaken by a senior Community Paediatrician experienced in examining female genitalia. If there are no indicators that FGM has happened this includes physical signs, intelligence it has happened or a disclosure. The need for a Child Protection Medical will need to be discussed with a Consultant Community Paediatrician before one is raised with the family. This will ensure the consideration of who will seek informed consent from the family for the medical.

Any child protection medical for FGM must be conducted in a timely fashion if it is indicated FGM has recently happened. Any medical should consider the need for a safe environment and experienced staff to support the child and their family through this intimate examination. If there is no immediate risk, the examination can be planned so the experience is as child friendly and supportive to the child and family as possible.

The Paediatrician will give initial feedback to the Social Worker of the outcome of the medical and then complete a full Child Protection Medical Report. This Report should be shared with Health Staff who will have continued contact with the child e.g. Health Visitor, School Nurse, GP. The information will also be available to the Police through the child protection process and strategy meetings. If FGM is identified then the practitioner who observed it has a '**MANDATORY DUTY**' to report this to the police by telephoning 101 as highlighted above. The reference number for your mandatory reporting will need to be recorded in the child's records and should be included on the Child Protection Medical report.

Every attempt should be made to work with parents on a voluntary basis to prevent the abuse. It is the duty of the investigating team to look at every possible way that parental co-operation can be achieved, including the use of community organisations working to end FGM to facilitate the work with parents / family. **However, the child's interest is always paramount.**

If no agreement is reached, the first priority is protection of the child and the least intrusive legal action should be taken to ensure the child's safety.

If the outcome of the Strategy Meeting / Discussion determines that the child is in immediate danger of mutilation and parents cannot satisfactorily guarantee that they will not proceed with it, then legal advice may be sought, and consideration be given to an FGM prevention order.

For children who have already undergone FGM

If the child has already undergone FGM (Section 5B of the FGM Act 2003 - Mandatory Reporting Duty) the strategy meeting / discussion will need to consider carefully the needs of other girls in the family this includes the unborn child. This may involve new assessment and investigations. The strategy should also consider if the child or young person has health needs resulting from the FGM and how they will be supported to access appropriate health care if needed. If any legal action is being considered, legal advice must be sought.

A child protection conference should only be considered necessary if there are unresolved child protection issues once the initial investigation and assessment have concluded. For

children who have had FGM it is important to explore when this took place (was it prior to the family coming to the UK) and any associated risks to other children within the family.

Where FGM has been practiced on a child and this is believed to have taken place after the family moved to the UK or if they were born here, the police will take a lead role in the investigation of this serious crime, working to common joint investigative practices and in line with strategy agreements.

What should professionals do if they are still worried about a family?

If professionals are worried their views have not been considered and they still feel there is a risk of FGM in the family. The person who made the referral can follow the BSCB escalation process²⁵.

There are 5 steps to this process but most cases are resolved through discussion with the teams involved to understand the assessments undertaken and the safety decisions made.

Adults at Risk of or have had FGM-

The wishes of the woman must be respected at all times. There is no requirement for automatic referral of adult women with FGM to Adult Social Services or the Police-unless the woman has other vulnerabilities and is unable to protect herself from future harm especially linked to Gender Based Violence.

FGM is illegal for both women and girls. If a woman aged over 18 is identified as being at risk of FGM and she is deemed to meet the criteria in the Care Act 2014 of having care and support needs then a safeguarding referral should be considered to Care Direct using the link attached- <https://www.bristol.gov.uk/social-care-health/form-contact-adult-care-services>

Example,
An adult may have a physical or learning disability and therefore the issues of mental capacity and ability to consent need to be formally investigated. Safeguarding Adults Procedures would seek to provide a Protection Plan for and with that Adult at Risk who might otherwise be vulnerable to harm. All professionals should be aware that any disclosure may be the first time that a woman has ever discussed FGM with anyone

There is no Mandatory Duty to report women who had had FGM to the Police. Each case must continue to be individually assessed.

Professionals should seek to support women by offering referrals to community groups who can provide support, clinical intervention or other services as appropriate. The Bristol Community Rose clinic would be supportive in assessing the woman's health needs link to her FGM. There is a clear need to take a think family approach to any adult disclosure.

²⁵ BSCB- Resolution of professional difference between agencies regarding work relating to the safety of children- <https://www.bristol.gov.uk/policies-plans-strategies/bscb-protocols-for-multi-agency-action>

Professionals working with the adult should consider the risks of FGM to any Girls in the family.

This also applies if there is a disclosure about a child. Consideration should be given to the adult women in the family to ensure they know about health services that can support them. These services can include

- talking about if FGM has happened
- what type of FGM has happened
- any risk to the woman's ongoing health needs

Think Family work around FGM

Many women may still be under pressure from a husband, partner or other family members to allow or arrange for a daughter to be cut. Wider family engagement and discussions with both parents and potentially wider family members may be appropriate if it is safe to do so.

If pregnant, the welfare of the unborn child or others in the extended family must be considered at this point, as these children are potentially at risk and safeguarding action must be taken.

If a woman discloses she has adult daughter(s) over 18 who have already undergone FGM, even if the daughter does not want to take her case to the police, it is important to establish when and where this took place. This may lead to enquiries about other daughters, cousins or girls in the wider family context.

This is a complex area, and many women have greater influence in decision-making with regards to FGM when they are outside their country of origin, and may therefore elect to discontinue FGM practice.

Support Services

There is Multi-Agency Statutory Guidance on FGM²⁶; these guidelines encourage each professional group to develop their own specific guidance. Appendix 5 provides information on how key statutory agencies in Bristol will respond to prevention and safeguarding in relation to FGM. There are numerous professional guidelines also available to support professionals. This information is presented as a flow chart.

Every attempt should be made to work with parents on a voluntary basis to prevent Female Genital Mutilation (FGM) occurring on any child or adult. In Bristol we have a number of ways families and young people can be supported.

Professionals should aim to build relationships with families in order to inspire trust in our services

²⁶ Multi-Agency Statutory Guidance on FGM 2016-
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512906/Multi_Agency_Statutory_Guidance_on_FGM_-_FINAL.pdf

Bristol Community Rose Clinic

Women affected by FGM can self-refer to the Bristol Community Rose Clinic²⁷. Contact details: 07813 016 911

This is a commissioned service offering support for women over 18 years who have had FGM and may need opening procedures for type 3 to improve their health and well-being. It is staffed by female GPs and professionals.

It also provides support to women who may want to know more about how their FGM may impact on their health and wellbeing.

The services will also talk about safeguarding and the law related to FGM

If a woman has any identified mental health or emotional needs she can be sign posted to appropriate support.

Preventative work

BSCB recognise that preventative work is a much better approach to safeguarding. The BSCB has an agreed FGM strategy which is linked to the wider business work plan for the BSCB. It is recommended that organisations that work with parents and children who are at risk of FGM should screen for this and provide advice and support before a child is put at risk. The Department for Health, Department for Education and the Home Office have clear guidance for staff on what they should do:

Department of Health; There is a Mandatory Duty to record all contacts related to FGM from Acute Trusts, Mental health trusts and GPs to central government via NHS Digital²⁸. This recording requires all acute trust to ask women about FGM and this will provide an opportunity to raise awareness and screen girls at risk in the wide family. This recorded data is confidential and cannot be shared with any agency. If any Health Professional identifies a safeguarding concern then they must still follow this guidance and protect the child.

Department of Education; There was guidance sent out to all schools in 2016 'Keeping children safe in Education'²⁹. This included guidance for schools to

- undertake FGM training,
- to recognise the risk of FGM for their school population and
- To ensure they had robust school policies that reflected how to manage FGM.

²⁷ Bristol Community Rose clinic- <https://www.bristolccg.nhs.uk/your-health-local-services/help-and-support/fgm/>

²⁸ NHS Digital FGM enhanced Data set for acute Health trust, GPs and mental health trusts- <http://content.digital.nhs.uk/fgm>

²⁹ Keeping children safe in education sept 2016- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/550511/Keeping_children_safe_in_education.pdf

Ofsted were also given the role to check these systems are in place when they completed their inspections of schools.

Home office; the Director of Public Prosecutions has made a commitment that they will actively look at any FGM case and consider prosecution.

The Girls Summit 2014 UK; The Girls Summit in 2014 was hosted by the UK government and looked at FGM and Child and Early Forced Marriage (CEFM). It made a pledge to end FGM in a generation. The UK government made announcements and pledges that have influenced guidance since 2014. These commitments were:

- Consultation on the introduction of new Civil Protection Orders for FGM
- New legislation that will mean parents can be prosecuted if they fail to protect their daughters being cut
- Lifelong anonymity for victims of FGM if they make an allegation
- New specialist FGM service to include social care. To support 'proactively identifying and responding to FGM concerns'. This work will be led by the Chief Social Worker
- Encouraging agencies, organisations and individuals to sign the International Charter
- Mandatory Duty for Doctors, Teachers and others to report when things happen

For full information about the Girl Summit 2014: <https://www.gov.uk/government/topical-events/girl-summit-2014>

FGM Delivery and Safeguarding Partnership

There is an FGM Delivery and Safeguarding Partnership. This group meets 4 times a year and two of the meetings are in the evening so young people can contribute in person to the meetings. This group is co-chaired by a statutory agency and a Community Health Advocate. Its role is to coordinate the FGM work in Bristol and is supported by the main statutory agencies, local and national charities / NGO's working on the 'End FGM' agenda and individuals and politicians who want to support the work in Bristol. It reports to the BSCB, the BSAB and the Bristol Domestic and Sexual Abuse (BDSA) Strategy Group.

There is a dedicated section at every meeting to talk about safeguarding and child protection work. This group organises conference and campaigns to raise awareness of the issues related to FGM and ways communities and professionals can work together to safeguard and protect girls and women from FGM. The work undertaken is reflected in a document which highlights this 'The Bristol Model' of engagement³⁰. Other resources and leaflets can be found on the Bristol Against Violence and Abuse Website (BAVA)³¹.

³⁰ BAVA website 'the Bristol Model' - <http://www.bava.org.uk/wp-content/uploads/The-Bristol-Model.pdf>

³¹ BAVA FGM resources- <http://www.bava.org.uk/types-of-abuse/female-genital-mutilation/>

Work with Young people

In Bristol there are two active groups of young people working on the END FGM agenda. Empowering Bristol³² are Linked to FORWARD and they support both local and national campaigns to end FGM and they work closely with local communities. They organise and run campaigns including the summer campaigns. These are linked to local universities so education of professionals includes knowledge of the issues related to FGM.

Integrate UK³³ are a charity that campaigns on a number of gender based violence issues. They are led by young people and they engage at all levels using various media including music and drama. They have been very successfully in engaging the government and influencing change nationally at both a practical and policy level. They have a strong activist approach but also engage with young people in a variety of settings. They have developed training packages for schools and they offer both peer education and education for professionals on the FGM agenda.

Working with Women from FGM affected Communities

FORWARD³⁴ have worked in partnership with Refugee Women of Bristol³⁵ (RWOB) on the FGM agenda. They have trained 48 Community Health Advocates (CHAs) they provide both outreach work and a drop in service for women on a range of issues around empowerment and the issues related to FGM. The CHAs also support the BSCB FGM Training and deliver training to other professionals. They have also developed skills in parenting groups linked to local primary schools.

FGM Learning Resources

- Home Office e-learning package free to access Free training: <https://www.fgmelearning.co.uk/>
- Health staff employed by the NHS – e-learning for health 5 modules on FGM including safeguarding, the law, obstetric care, community engagement, general awareness. : <http://www.e-lfh.org.uk/programmes/female-genital-mutilation/>

Useful resources to support your work on FGK

- Collection of Home office documents on FGM hey include
 - Fact sheet on FGM PO
 - Fact sheet on Mandatory reporting
 - FGM Resource pack <https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack>

³² Empowering Bristol- Blog- <http://forwarduk.org.uk/why-im-a-youth-advocate-on-fgm/> ; http://news.bristol.gov.uk/young_people_s_voices_at_the_heart_of_campaign_to_end_fgm

³³ Integrate UK (previously known as Integrate Bristol)- <http://integrateuk.org/>

³⁴ FORWARD Bristol- <http://forwarduk.org.uk/>

³⁵ RWOB- Empowering women- <http://www.refugeewomenofbristol.org.uk/drop-in-centre/fgm-project/>

- Statement opposing FGM- FGM Passport
- FGM the Facts
- End FGM campaign material

<https://www.gov.uk/government/collections/female-genital-mutilation>

- Bristol Against Violence and Abuse: <http://www.bava.org.uk/types-of-abuse/female-genital-mutilation/>

LSCB and FGM Guidelines Reviewed – Bibliography

<http://www.cumbrialscb.com/LSCB/professionals/femalegenitalmutilation.asp>

http://www.holytrinityschool.org.uk/images/policy/Female_Genital_Mutilation.pdf

<https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/female-genital-mutilation-fgm/legislation-policy-and-guidance/>

<http://www.lscbbirmingham.org.uk/index.php/fgm>

<http://suffolkscb.org.uk/procedures/lscb-policies-guidance-and-protocols/>

<http://suffolkscb.org.uk/procedures/lscb-policies-guidance-and-protocols/>

<http://www.haringeylscb.org/female-genital-mutilation-fgm>

<http://lrsb.org.uk/fgm-female-genital-mutilation>

<http://www.harrowscb.co.uk/guidance-for-practitioners/female-genital-mutilation/#>

<http://www.sandwellscb.org.uk/wp-content/uploads/2016/08/Item-3.-Joint-Adults-and-Childrens-FGM-Policy-draft-v0.2-18.04.2016-final.pdf>

<http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Appendix to Safeguarding policy for FGM.pdf>

<http://www.peterboroughlscb.org.uk/children-board/fgm/>

Risk assessment tools

<http://www.sabberkshirewest.co.uk/media/1197/fgm-risk-assessment-tool.pdf>

<http://surreyscb.procedures.org.uk/hkphh/procedures-for-specific-circumstances/female-genital-mutilation>

http://www.resolution.org.uk/site_content_files/files/fgm_toolkit.pdf

Appendix 1

Table of types of FGM related to the countries that practice and the laws in place

Country	Term used for FGM	Language	Meaning	Type of FGM*	Age it is practiced** Practiced at all ages	The Countries Law on FGM***
Egypt	Thara	Arabic	Deriving from the Arabic word 'tahir' meaning to clean / purify	Type 3 or 4	5-14 years	2008
	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	Type 3	0-4 years	2004
	Absum	Harrari	Name giving ritual			
Eritrea	Mekhnishab	Tigreña	Circumcision/cutting	All forms mainly type 1 & 3	0-4 years	2007
Kenya	Kutairi	Swahili	Circumcision - used for both FGM and male circumcision	All forms Mainly type 2	5-9 years	2001 & 2011
	Kutairi was ichana	Swahili	Circumcision of girls			
Nigeria	Ibi/Ugwu	Igbo	The act of cutting - used for both FGM and male circumcision	All forms mainly type 2	0-4 years	2015
	Sunna	Mandingo	Religious tradition/obligation - for Muslims			
Sierra Leone	Sunna	Soussou	Religious tradition/obligation - for Muslims	All forms	Even across 0-18	No law in place (june 2014- 28 girls too many) but
	Bondo	Temenee/ Mandingo/Li	Integral part of an initiation rite into adulthood - for non Muslims			

Country	Term used for FGM	Language	Meaning	Type of FGM*	Age it is practiced** Practiced at all ages	The Countries Law on FGM***
		mba		mainly type 1 & 2	years	girls must be 18 years before they can consent to FGM.
	Bondo/Sonde	Mendee	Integral part of an initiation rite into adulthood - for non Muslims			
Somalia	Gudinniin	Somali	Stitching/tightening/sewing refers to infibulation	All forms mainly type 2 & 3	5-9 years	
	Halalays	Somali	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)			
	Qodiin	Somali	Deriving from the Arabic word 'tahaar' meaning to purify			
Sudan	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)	Type 3	5-14 years	Type 3 made illegal in 1946 all forms 2009 (south Sudan 2008)
	Tahoor	Arabic	Deriving from the Arabic word 'tahaar' meaning to purify			
Chad - the Ngama	Bagne		Used by the Sara Madjingaye	All forms mainly type 2	5-9 years	2003
Sahara subgroup	Gadja		Adapted from "ganza" used in the Central African Republic			
Guinea-Bissau	Fanadu di Mindjer	Kriolu	Circumcision of girls	All forms mainly type 2	5-9 years	2011
	Fanadu di Omi	Kriolu	Circumcision of boys			
Gambia	Niaka	Mandinka	Literally to cut/weed clean	All forms mainly	∞ aged under 10 years	2015
	Kuyango	Mandinka	Meaning "The Affair", also the name for the			

Country	Term used for FGM	Language	Meaning	Type of FGM*	Age it is practiced** Practiced at all ages	The Countries Law on FGM***
			shed built for initiates	type 1 & 2		
	Musolula Karoola	Mandinka	Meaning "the women's side"/"that which concerns women"			

*Data from Unicef- FGM/ Cutting/ a statistical overview and exploration of dynamics of Change (2013)

https://www.unicef.org/publications/index_69875.html

**data from WHO FGM Reproductive data (2016) - <http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/> (based on the countries own figures , this does not take into account families living in other countries.

#- Data on Sudan taken from Ending FGM in Sudan- <http://countryoffice.unfpa.org/filemanager/files/sudan/facts/fgm.pdf>

#- data from 28 girls too many re Sudan- <http://28toomany.org/countries/sudan/>

*** FAQ on FGM answers dec 2015- <http://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions>

∞ data on Gambia- March 2015- http://www.28toomany.org/media/file/profile/Gambia_v5_high.pdf

***Data on Sierra Leone (June 2014)- 28 girls too many- [http://www.28toomany.org/media/uploads/sierra_leone_\(june_2014\).pdf](http://www.28toomany.org/media/uploads/sierra_leone_(june_2014).pdf)

Appendix 2a

Risk assessment tool for FGM

Health Staff

The Department of Health have created a FGM risk assessment for health staff. This tool supports your health assessment of:

- Pregnant women
- Non-pregnant Adults
- Girls under 18 year may be at risk of FGM
- Girl under 18 you suspect has had FGM

This assessment tool can be accessed via the link below:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/576051/FGM_risk_assessment_templates.pdf

Appendix 2b

Referral Risk Assessment for staff in all areas

This tool overleaf has been developed by the FGM lead in the Local Authorities Safeguarding in Education Team.

FGM Referral Risk Assessment



This risk assessment is intended to act as a reflective tool to encourage professionals to think about a wider set of risk factors which one might need to think about if making a referral. Please refer to the BSCB FGM guidance for more information around its usage.

You may want to retain a copy of this for your safeguarding/ child protection records or include as part of a safeguarding referral.

If you are concerned about FGM potentially taking place or having already taken place refer to First Response for a safeguarding assessment – you may not have all the information to make a holistic assessment as a single agency. If it is a case under Mandatory Reporting duty that you must notify the police via 101.

Part 1 Professionals details	
Name:	
Agency:	
Email:	
Telephone:	
Date Completed:	
Have you discussed this with a colleague in supervision, reflective practice, or sought advice? If so, who was this colleague? When did this happen (date)?	
Part 2 Subject's Details	
Family Name	
First Names	
Alternative names	
Date of Birth	
Address:	
Parent/Guardian/Carer	
Ethnicity	
Physical or Learning Disabilities/Communication disorders/SEN	

Using the descriptions below, choose one answer from the 4 sections and score between 0-5 depending on the level which most closely reflects the situation of the young person. Additional information / analysis can be included to support the risk assessment

FGM Referral Risk Assessment



1.Ethnicity and Social Integration	Score	Assessor analysis/reflection
Child and family are not from a risk affected community.	1	
Child and family are from a risk affected community, but do not strongly identify with their culture or practices, or are not from a tribe that practices.	2	
Child and family are from a risk affected community but are well integrated and engaged well with community resources.	3	
Child and family are from a risk affected community and strongly identify with traditional cultural practices.	4	
Child is from a risk affected community, and has recently come into the country. Members of the family are socially isolated and strongly identify with traditional cultural practices.	5	
		SCORE
2.Education	Score	Assessor analysis/reflection
Engaged in full time education. There are no concerns around engagement.	1	
In full time education but child/ young person withdrawn and socially isolated.	2	
In full time education but child withdrawn from PSHE lessons, may present with emotional and behavioural needs.	3	
Parents have requested extended leave/ Child discussing going on a long holiday, to her own country of origin, or where practice is prevalent. Child missing from education or does not attend a provision.	4	
Very poor attendance with a high prevalence of illness identified. Has presented to the GP or A&E with frequent urine, menstrual or stomach problems. Child will avoid physical exercise or will ask to be excused from PE lessons.	5	
		SCORE

FGM Referral Risk Assessment



3. Family's FGM Practice and attitude	Score	Assessor analysis/reflection
Family members have not undergone FGM and are open and willing to discuss worries. Parents may have had social work intervention and signed a written agreement.	1	
Children and the family members have limited/ no understanding of harm of FGM or UK Law.	2	
Wider family have undergone FGM. The parents know that the practice is wrong but are worried about pressure from the wider family members.	3	
Immediate family members have undergone FGM. Parents will acknowledge it is illegal however there are concerns about professional engagement.	4	
Parents believe FGM is integral to cultural or religious identity and have voiced an intention for their child to have the procedure done. Parents may be accepting of 'one type' but 'not others'.	5	<div style="border: 2px solid black; padding: 5px; width: fit-content; margin-left: auto;">SCORE</div>
4. Engagement with Professionals	Score	Assessor analysis/reflections
Child and family engage well with professionals and actively participate openly and honestly.	1	
Child and family engage with professionals only when needed.	2	
Child and family do not feel that professional is required even when a need is identified.	3	
Child and family have poor engagement. They miss appointments and do not respond to calls or letters.	4	
Child and Family are wary of and distrust professionals and will actively avoid talking to or engaging with professionals.	5	<div style="border: 2px solid black; padding: 5px; width: fit-content; margin-left: auto;">SCORE</div>

GREEN: 0 – 7 Standard risk:
Routine support and advice about FGM.
(level 1 in the BSCB threshold document)

Smaller number of risk factors identified:
 Child maybe from risk affected community, however parents have a progressive attitude and are actively against the practice of FGM. The family may be well integrated and are well positioned to access support from community resource and universal services.

AMBER: 8 – 13 Medium Risk:
Discuss with your Child protection supervisor and monitor the case. If you are concerned make a referral to First Response for a safeguarding assessment to be carried out.
(level 2 in the BSCB threshold document)

There are multiple risk factors to consider:
 This may contribute towards the children being at higher risk. Parents or children maybe may not be actively thinking about FGM, but are more vulnerable to pressure from the community or wider family members. Parents may not have a full understanding of the impact of FGM and may need further support and advice about how to protect their children. Mothers may have had the procedure done themselves and are actively against the practice.

You may need to have a conversation with the family about their attitude towards FGM.
You might need to consider a referral to preventative community programmes such as FORWARD and INTEGRATE.

RED: 14 – 20 High Risk:
You need to make a referral to First Response. If it is under the Mandatory Reporting duty, then you need to make a report this to the police via 101.
(level 3 in the BSCB threshold document)

There are high concerns that parents and family members are open to the practice:

 The family may associate with communities and wider family members who actively practice. Parental attitudes maybe supportive of FGM and will perceive the practice as part of their culture or religion.

 The family may engage in high risk behaviours and there is a likelihood of the child being a victim of FGM even if the parents are not in agreement with the practice. There is a high risk that the child may have had the procedure done already.

FGM Mandatory Reporting Duty?	YES/ NO
The girl is under the age of 18 and: a) Tells you she has had FGM, or b) has signs which appear to show she has had FGM	If YES. Take action now. You must phone the police on 101. The professional who identifies FGM must report it as soon as possible. This is your personal legal duty.

Final Score:	/20	Risk level:	
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FGM Referral Risk Assessment



Other considerations:

N.B Please read in conjunction with the BSCB guidance. If FGM is highly likely to have happened, you would need to be aware not to compromise a police investigation. Please be clear that information here is for observations and information given voluntarily.

Voice/experience of the child	What does the child think/ feel? Have they made any comments about their circumstances? Remember TED (Tell me, Explain, Describe).	
Family views/ understanding	Does the family speak English? Are they worried about what will happen next?	
Professional views	If there is a strong professional view that the FGM risk is higher than the score this should influence the action taken by the person doing the assessment and a referral should be considered	

Next Steps			
Providing information to the children & parent/carer	Yes	No	Reason for not providing this information
Informed that FGM is illegal in the UK			
Explained how they have a duty to protect their daughters from FGM			
Explain they have a duty to protect their daughters from others who may want to practice FGM on them			
Informed about the health consequences of FGM			
Advised where to access community support services – such as FORWARD or Integrate UK.			
Informed that you may have to other professionals who could support or safeguard the family.			
Obtained consent to share information with relevant agencies.			
Professional actions	Yes	No	Reason for not taking further action
Sought advice from another agency or your CP/ safeguarding lead.			
Made a referral to police/social care.			
Maintained a record of the conversation			

Appendix 3

Template for a written undertaking/ agreement that a family will not practice FGM. N.B

This should only be used by social care and the police as part of a Multi-Agency assessment.

Police Reference Number :		
Name of child, parent or carer	Date of birth:	Passport number
Date written undertaking completed:		
What are we worried about?/the purpose of this written undertaking:		
<p>Children’s Services and the Police are worried about Female Genital Mutilation. They have come to visit you today ...because you are leaving the country and going to _____ from _____ until _____ ORbecause there has been a referral of concern regarding _____ that indicates a potential risk of FGM</p> <p>By signing this agreement there is an expectation that you will ensure that XXX and any other females born into your family are protected against ever having Female Genital Mutilation of any type, including type 1.</p>		
What is working well?/Positive and protective factors		
<p>This section is an opportunity for the Social Worker and Police to demonstrate that the family are not being investigated for poor parenting or being criminalised and that they are being listened to.</p> <p>Examples: <i>“The family have engaged with the Social Worker.” “their children are doing well in school” “they have welcomed us having a conversation with their children” “has told us about their own experience of Female Genital Mutilation” “Fatima told us that....”</i></p>		
Action agreed/safety plan :		
Action:	Who is responsible	
X understands the law that Female Genital Mutilation is an illegal practice in the UK and knows that it is illegal to take any child that is a UK resident to another country for Female Genital Mutilation. X intends to keep the law		

<p>X has been provided with 'A statement opposing Female Genital Mutilation' and a leaflet about Female Genital Mutilation in the language that they have identified that they can read (_____)</p> <p>X agrees to not allow FGM to be performed on X and any other females born into the family within or outside the UK</p> <p>X agrees not to leave X and any other females born into the family with anyone that could cause harm to them, this includes performing FGM on them.</p> <p>X agrees for a medical to be completed on their child on their return from X if there are any concerns that FGM has been performed on X.</p>	
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What will happen if the written undertaking is breached:

If this written undertaking is breached, the Police will investigate and Children Services will further assess the situation which may lead to Child Protection Procedures and potentially care proceedings and prosecution under the Serious Crime Act 2015. The parents could face up to 14 years in prison and a fine.

Name of party to the agreement:	
Signed:	
Name of party to the agreement:	
Signed:	
Name of party to the agreement on behalf of Bristol City Council:	Social Worker
Signed:	
Was there an interpreter present? Name:	
Company:	

Date and time of review of agreement:			
A copy of this agreement will be provided to the following agencies	Name	Agency	Role
			Doctor
			School
			Health Visitor/Midwife
			Police

Appendix 4- FGM Pathways for professional groups

How professional groups respond to FGM.

The following pages contain FGM Pathways for:

1. Social Care: Referral Reporting
2. Social Care: Referral Process
3. Education
4. Health

Concern about a female below the age of 18

She discloses to a regulated professional that she has had FGM. Or: Regulated Professional sees FGM in child under 18

Concerns that the family have requested extended leave

There is an identified risk of FGM using the checklist

MANDATORY REPORTING DUTY

Dial 101 and report to the Police at the earliest opportunity.

The witness professional only discharges their mandatory duty by phoning 101 and making the report. This can be done within 28 days however we recommend that this is done as a matter of urgency.

Raise your concerns with your designated Child Protection lead or line manager.

Is it safe to discuss the concerns with the family? **Do NOT** to talk to the family if doing so puts the child at risk of absconding or that it means that the child may go missing.

Report concerns to First Response

0117 903 6444

Have the full details of all of the family ready to hand along with all of the information that you have gathered.

The safeguarding lead to have a discussion with the family **Record the conversation**. Ask what, where, how, who and when questions. Gather an understanding of their thoughts and beliefs. Their ethnic origin and particular tribe they belong to. Tell them about the law – and record what their understanding is.

If they are requesting extended leave: find out the purpose of their visit and length of stay.

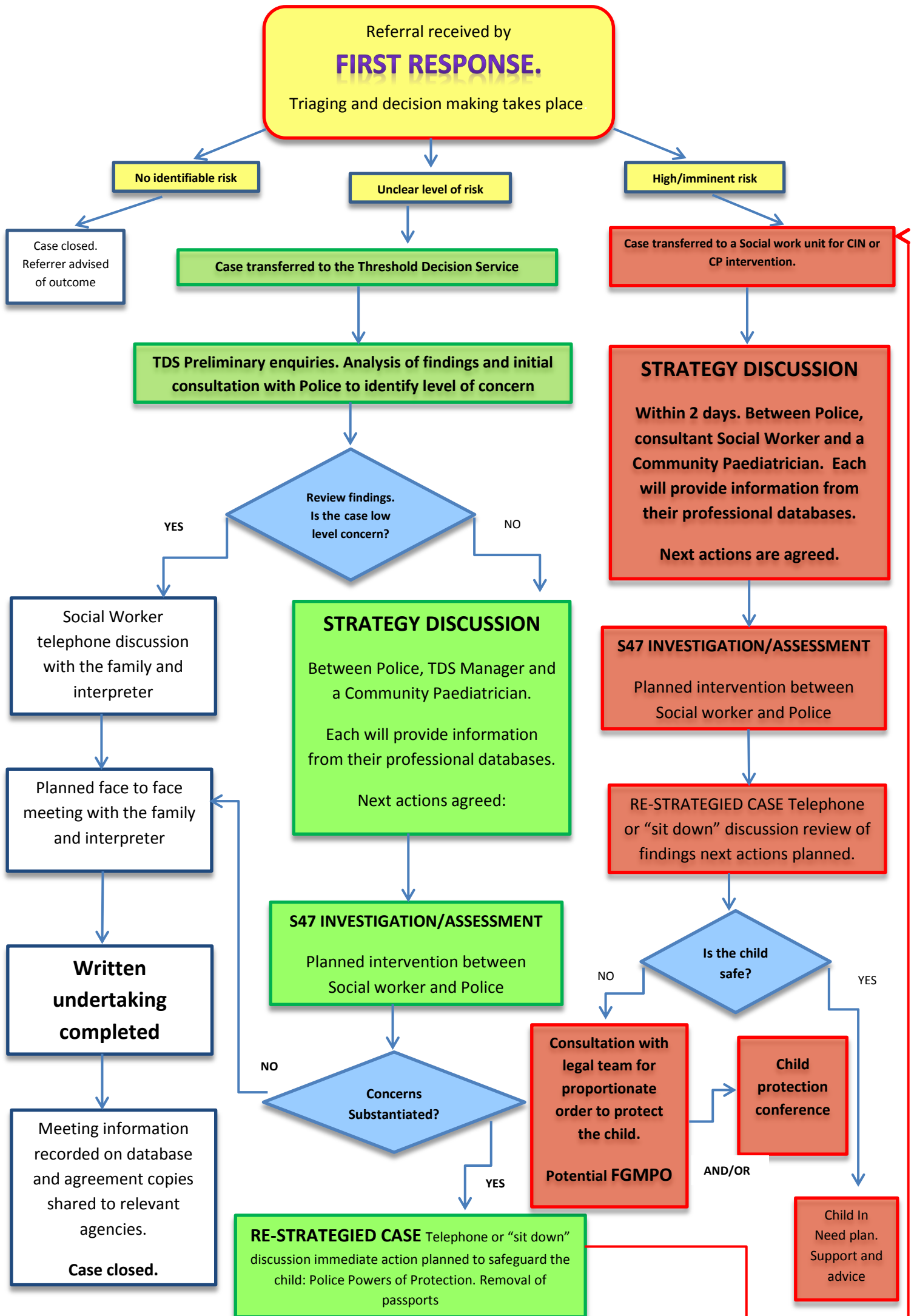
Obtain consent to refer to First Response

Record the family's attitude to the referral.

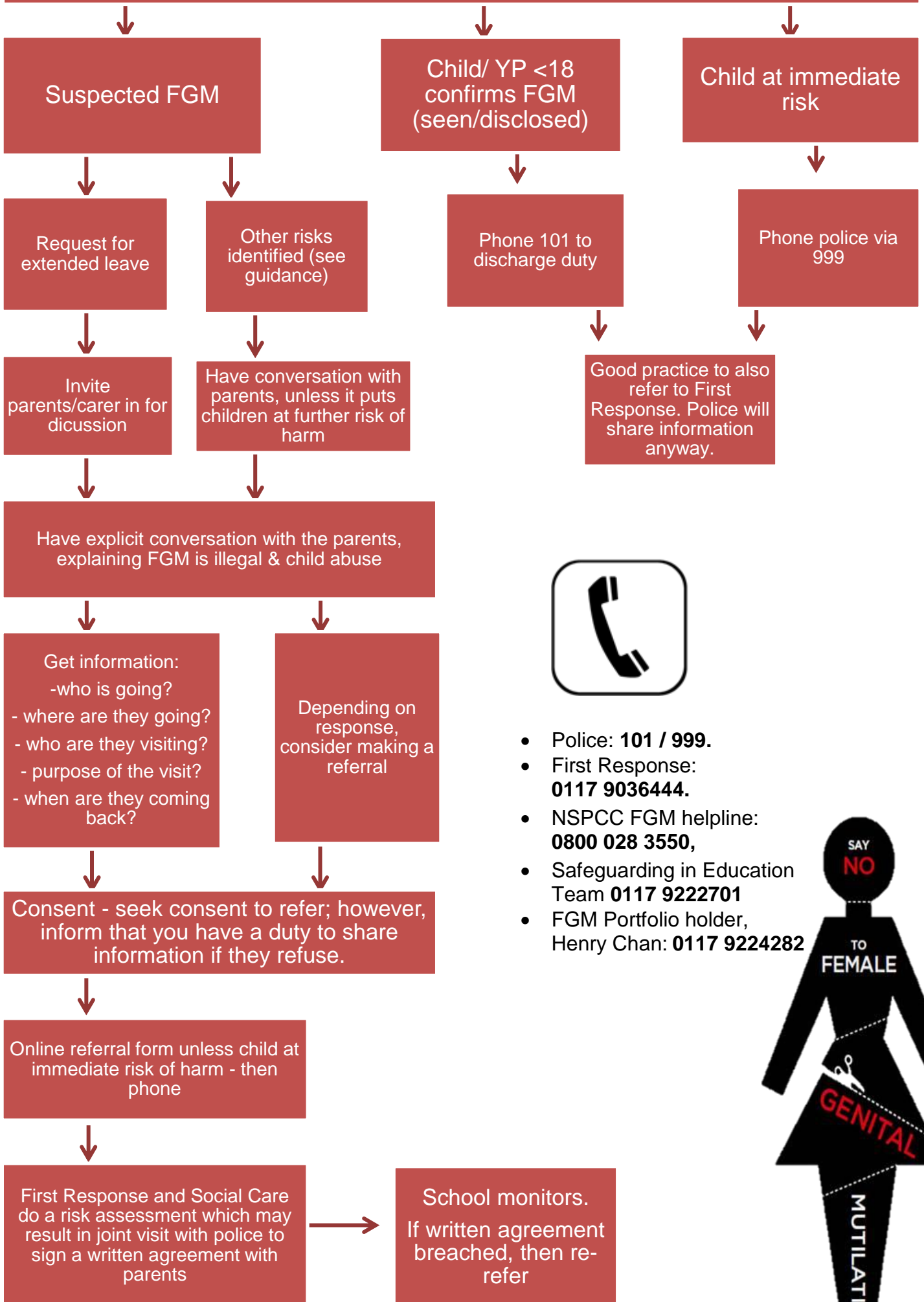
Do your findings suggest the family from a risk affected community? Or that they are going to a risk affected home country?

Keep all information and findings recorded safely for future reference.

Offer support and advice. Continue to be vigilant and monitor the family where possible.



Risk Identified



- Police: **101 / 999.**
- First Response: **0117 9036444.**
- NSPCC FGM helpline: **0800 028 3550,**
- Safeguarding in Education Team **0117 9222701**
- FGM Portfolio holder, Henry Chan: **0117 9224282**



FGM Pathway: Health

Key factors which are important for ALL health professionals to recognise

- Ask all women from FGM affected communities if they know about FGM, or, if they have been cut/ closed/ stitched or circumcised themselves.
- Provide the public health information to all family members about the laws on FGM, the need to safeguard and protect girls from FGM and sign post them to any support that they may need to deal with any issues related to FGM.
- Always record the information in the individuals records that this discussion has happened and list any leaflets or support offered.
- Always use an interpreter if the family do not understand English. Do Not Use Family members as this may breach their confidentiality and there may be a risk of information being lost in translation.
- Always 'THINK FAMILY' and consider if there are any other girls at risk of FGM in the family and who can help with an assessment of their risks and need.
- Remember any disclosure or identification of FGM in a child under 18 must be reported to the Police under the 'Mandatory Duty to report' using the 101 number. Always contact First Response as well to ensure the safeguarding needs of the girl and if her family are assessed.

Midwives:

- Ask ALL expectant mothers at the pregnancy booking appointment if they have been '*cut, circumcised or pierced in the genitalia area, or if they are open or closed*', or '*if they have had a procedure that will make it difficult to give birth.*'
- If the pregnant woman is under 18 and discloses she has had FGM you must follow the Mandatory Duty to report this to the Police using the 101 number. You should also notify First Response.
- Ensure this information is recorded on the maternity booking I.T data-base (Euroking or Medway) and in the client's hand-held maternity records.
Note: ask the woman on her own and with an interpreter if required. If the woman has had FGM further discussion should include the father of the baby.
- Document all discussions re FGM in maternity records.
- If the woman has advised she has undergone FGM, and is able to specify that this is Type III, ensure referral for consultant-led care to advise re plan of birth.
- Use pictures to assist when asking what type of FGM the woman has had and record her answer.
- Give expectant parents information re the law of FGM, the health consequences and the safeguarding risks associated with FGM.
- Consider if other daughters in the household are at risk of FGM and refer to social care if indicated.
- Ensure a referral is made to the local social care triage agencies (following the 12th week gestation) informing them of the assessment you have completed and the advice you have given to the woman and her partner (if appropriate).
- Social Care will check their records to ensure there are no known safeguarding concerns.
- Ensure a copy of the booking pro-forma is supplied to the Health Visiting team, which will notify these professionals of the FGM risks in the family.
- Advise GP of reported FGM (via the routine booking letter, asking the GP to record this information).
- If the newborn infant is female; Community Midwife will ensure this information is shared with the Health Visitor and the GP.
- If there are concerns that there is a plan for a child to undergo FGM (either within the UK, or that the child is being removed from the U.K for the FGM procedure to take place outside of the U.K.). This should be reported **immediately** to the First Response and the Police

- If there are concerns that a child (i.e. under the age of 18) has undergone an FGM procedure, then consider your role to Mandatory Report this to the police. If the child has told you or you have physically seen that FGM has happened then report this to the police on 101. You must also report this to First Response so they can assess the safety of the child or young woman – follow SWCPP procedures.
- Follow Trust Guidelines regarding reporting FGM and any concerns thereof.

Health Visitors

- Health Visitors will talk to all families where at least one parent comes from a countries that practice FGM about the law of FGM, the health consequences, the rights of all women and girls to live free of any gender based violence and sign post people to any support services as required. This will reinforce any public health messages given to them by the Midwifery teams.
- To record in the Childs Red book on page 3 under 'are there any particular illnesses or conditions in the mothers or fathers family that you feel are important' if FGM is known and what advice and support have been given to the family.
- If there are other girls in the family or new female girls joining the family the risks must be reviewed.
- If there any families who are new to the UK or to Bristol the families risks associated to FGM must be reviewed.
- Consider using the 'DH FGM Risk Assessment Tool' to support any assessment, including the family health needs assessment.
- Document your assessments in the child's records.
- Inform the GP of this identified history of FGM and share the outcome from your assessment. If there are school aged children in the same family notify the School Health Nurse in their school of the assessment of risk you have completed with the family.
- When the child is transferring to school. Ensure this information is shared with any School Health Nurse linked to the school the child attends.
- If you identify any safeguarding concerns through contact with families who are associated with an FGM risk these cases MUST be raised with your named Nurse or safeguarding team.

School Nurses

- The School Nurse will reinforce the messages on the FGM law, the health consequences, the rights of the girls to be protected from Gender Based Violence. This can include sign posting to any support services.
- The School Health Nurse will consider completing a Family Health Needs Assessment on any child who is new to this country.
- Consider using the 'DH FGM Risk Assessment Tool' to support any assessment, including the family health needs assessment.
- Document your assessments in the child's records and their red book if available.
- Document any information given to parents of children.
- If talking to a child consider using the NSPCC 'PANTS' strategy to talk about FGM to young children.
- Work in partnership with the child, parents and the school if there are any identified needs.
- Inform the GP of any history of FGM and what actions have been taken.
- If there are younger children in the family share the information with the Health Visitor.
- If there are any health issues identified that may indicate FGM discuss these with the named Nurse or your safeguarding team.
- If you identify any safeguarding concerns through contact with families who are associated with an FGM risk these cases **MUST** be raised with your named Nurse or safeguarding team.

GP and Practice Nurses

- Ask all women (especially Mothers from High Risk FGM countries) at registration with the practice or when they are access their cervical screening if they have been 'cut', 'closed', 'circumcised', or had any 'piercings' or 'FGM' which may make any examination more difficult.
- Ask all expectant mothers the same question.
- Record 'that FGM has been identified' on EMIS for both the mother and the children. Ensure these family members are linked through the 'family key'.
- Ensure any information shared from Other Professionals, Midwives, Health Visitors or School Nurses are also recorded and link to all the children and the family.
- Consider placing an alert on 'the girl's' records that there is an FGM risk in the family. This alert can be removed when the girl is 18

years old.

- Ensure any risks or alerts are transferred to the new GP if the family move practice.
- Be vigilant to any health issues that may suggest FGM has happened e.g. recurrent UTI, continual menstrual pain etc.
- Always provide advice to families when they are travelling abroad and seek foreign travel vaccinations. Go through 'the FGM Health Passport', and document your assessment and the families understanding of their need to protect any girls from FGM.
- If you have any safeguarding concerns linked to the risks around FGM then speak to the Link GP in your practice or contact the designated safeguarding nurse in Bristol CCG for advice and support.

Adult Mental Health Services/ Child and Adolescent Mental Health Services

- If a woman / girl is accessing mental health support and they come from an FGM affected community, ensure FGM is considered in your initial assessment.
- If FGM is recognised ensure the appropriate mental health support is offered.
- If the patient is under 18 you will need to make a mandatory referral to the Police using the 101 number. Using this guidance you must also report this to First Response.
- Seek advice and support from your safeguarding team.
- If you receive a disclosure from another client about a potential risk of FGM to a girl either in their family or community, support this person to make a referral to the NSPCC FGM Hotline, First Response or the Police.
- If the person making the disclosure will not make a referral speak to your safeguarding team and decide who will make a referral.
- If you identify a risk of FGM for any woman or girl you must think family and consider other girls who could be at risk. Using the DH FGM Risk Assessment Tool may be helpful.
- You should share this information with the GP and any other health professional who could provide support and further safeguarding to any girls or the family.
- Document the information you have received and ensure this is recorded. The data must be submitted monthly through the 'mandatory FGM Enhanced Data collection process.'

Hospitals/A&E/ Emergency departments/ Urgent Care Centres / Minor injury Units/ Walk-in –Centres

- If FGM is identified in any Hospital or Emergency Care Department when treating a patient. The staff must record the type of FGM they have seen, together with a full clinical history including when the FGM happened. Each area should have a process to capture key information needed for the 'FGM enhanced data set' which is a mandatory requirement for Health Trusts.
- If the girl/woman has recently had FGM you **MUST** consult with the Trust's Safeguarding Lead and follow your procedures for making a Safeguarding Referral.
- Record all your assessments and conversations with the girl/woman and the family.
- Ensure this information is also shared with the appropriate members of the primary health care team (GP, Health Visitor etc.).
- Always provide information on the law and FGM and the need to safeguard girls from FGM.
- If you have any concerns related to FGM always check the NHS Spine to see if there are any alerts or risks identified.

Sexual Health Services

- If FGM is identified in any girl under 18 accessing any sexual health services, you will need to make a mandatory referral to the police using the 101 number. Using this guidance you must also report this to First Response
- Always notify your safeguarding team to inform them of this referral.
- If FGM is identified in women over 18 you will need to complete an assessment to see if there is any risk to any other girls under 18 in the family. This risk assessment should be shared with the GP and any other professional who could provide support and a wider safeguarding assessment of these younger girls.
- Sexual Health services are not under any Mandatory Duty to record the FGM status of their patients and share this with eth Department of health. However it is important to consider recording in the patient's records that FGM has been identified and what advice and support has been offered. This should include explaining about the laws on FGM, and the duty on families to protect their daughters.
- If you identify a woman or girl has had FGM you must complete a holistic assessment including her emotional, physical and mental health needs. Sign post her to any appropriate services and record this information.
- If you have identify any safeguarding risk from your assessment, contact your named safeguarding professional or safeguarding team.

Assessment services for Asylum Seekers and Refugees

- When a family from an FGM affected country seek asylum or refuge in Bristol they can access 'The Haven' service based at Montpellier Health Centre. These families will be offered a full health assessment which will include asking about the FGM status of all women and girls.
- If a woman has had FGM she will be offered any support or sign posting to services if she has any complications from the FGM either physical or emotional. She will receive information about the laws on FGM and the adult's duty to protect and safeguard girls from FGM.
- If the Girl is under 18 and she has had FGM the staff at The Haven will complete a full holistic assessment and offer appropriate support appropriate to the girl's age, development and health needs. They will also have a Mandatory Duty to report this to the Police using the 101 number. They must also notify First Response.
- As the FGM happened outside the UK this investigation will reflect a proportionate response and offer appropriate support to the family and advice on how to protect other girls from FGM