Female Genital Mutilation (FGM)

Guidance for Primary Care

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FLOW CHART / KEY STEPS QUICK REFERENCE SUMMARY

1.0 INTRODUCTION

1.1 The World Health Organisation (WHO) defines Female Genital Mutilation as: “All procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons” (WHO 2010).

1.2 In 2014 it was estimated that 137,000 women and girls living in the UK have experienced FGM. There are no Local Authorities in the UK free from FGM (City University London 2015). Since 2015, 34,450 women and girls have attended an NHS facility where FGM was identified. In quarter two of 2023, 290 women and girls presented at an NHS setting in Southwest England.

1.3 FGM is a form of child abuse and is recognised as a human rights violation by the UN; there is no justification for it under any circumstances. FGM has been illegal in the UK since 1985, and it is also illegal to take a girl abroad to undergo FGM if they are a British citizen or habitually resident in the UK.

1.4 All NHS staff have a statutory responsibility to safeguard girls from being abused through FGM. **This is separate from the mandatory duty for professionals to report any confirmed cases of FGM (seen or reported by the child themselves) in girls under 18 to the Police. The mandatory duty is a personal duty which requires the individual professional who becomes aware of the case to make a report – the responsibility cannot be transferred.**

1.5 **This is not the same as having responsibility to examine a child to confirm FGM or not – this is a highly specialised examination at the FGM service at The Bridge SARC and SHOULD NOT take place at a GP practice, Emergency Department or in Paediatric department even if requested by Police or CSC.**

1.6 More detail on mandatory reporting for children who have had FGM and a further two reporting systems for FGM (FGM-IS and FGM enhanced dataset) can be found in section 4.

1.7 More detail on safeguarding adults at risk of harm and children from FGM can be found in section 6.

2.0 DEFINITIONS

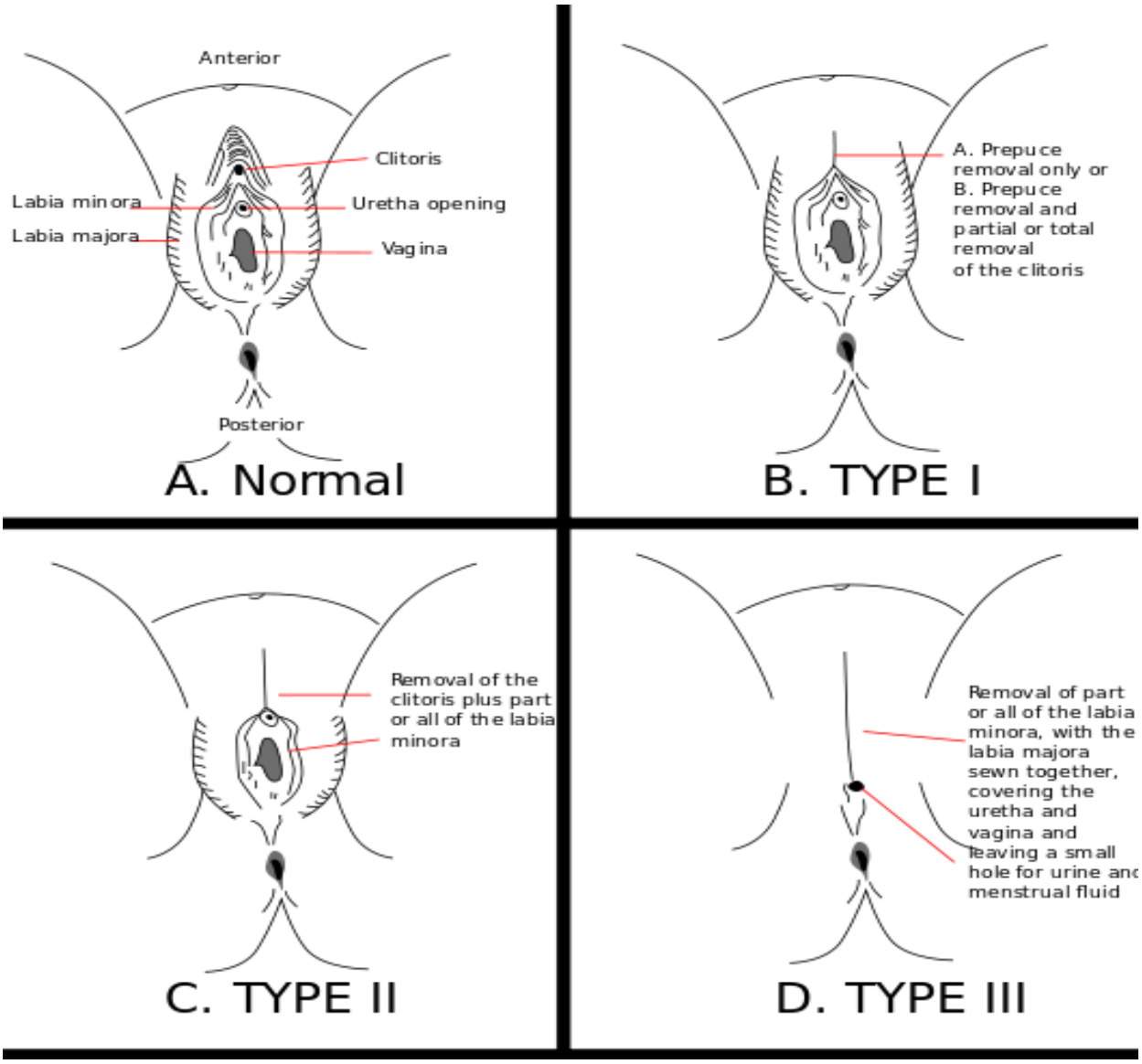
2.1 There are four types of FGM classified by the WHO:

Type I: Partial or total removal of the clitoris and/or the prepuce (Clitoridectomy).

Type II: Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora.

Type III: (Infibulation) Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or labia majora, with or without excision of the clitoris.

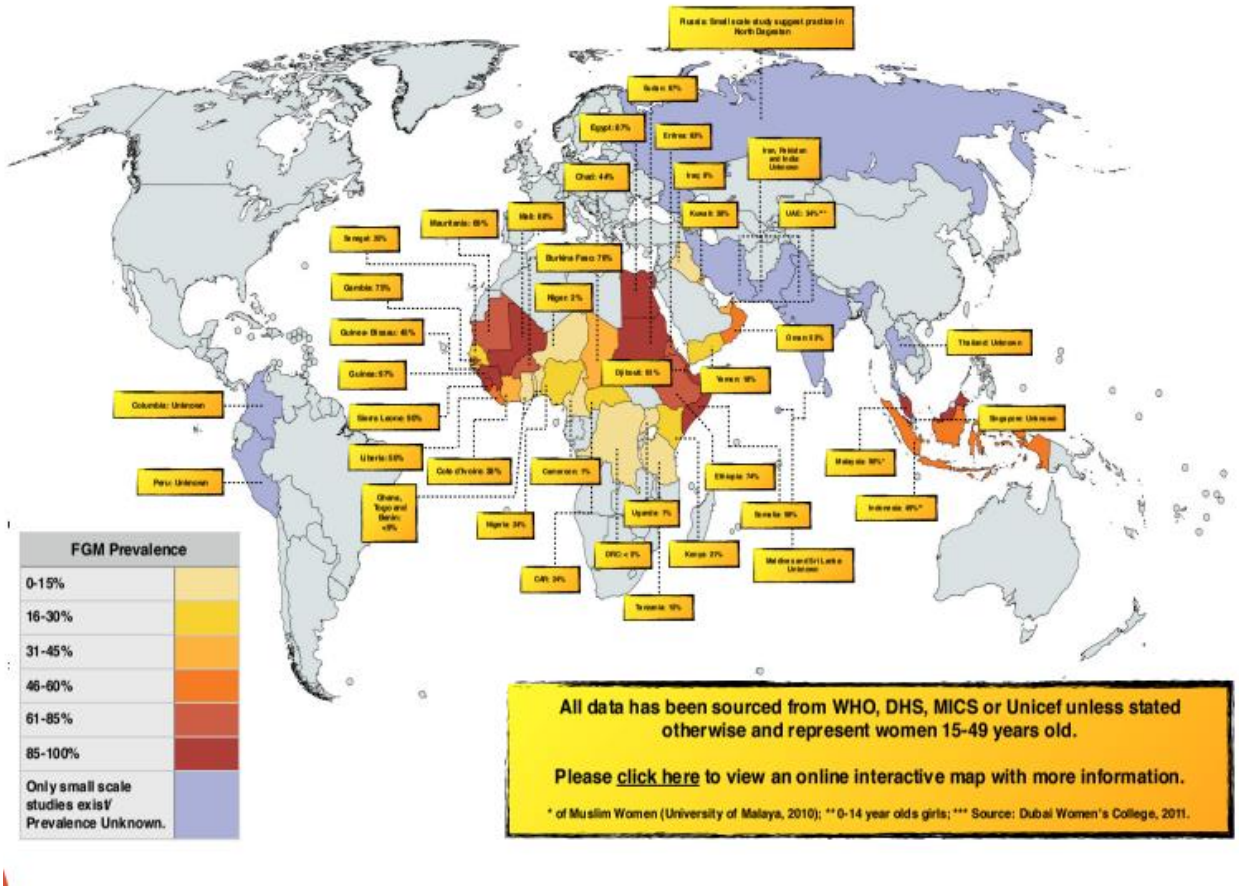
Type IV: All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising. (NB. the legal status of piercing is unclear in the UK).



2.2 Ninety percent are either Type I, II or IV, while Type III (Infibulation) is only found in 10% of known cases.

2.3 The single most important risk factor determining whether a woman undergoes a ritual procedure is her country of origin. Any woman who comes from an FGM practicing country falls within the “at risk” group, especially if the prevalence is high e.g. Somalia, Egypt, Sudan.

2.4 FGM is practised mainly in Africa (approximately 30 countries) – women from any West African country are particularly at risk. It is also practised in the Middle East, India and Indonesia, with recent cases coming from Yemen and Afghanistan. The global incidence is 130 million with two million experiencing a procedure annually.



2.5 FGM is not a requirement for any religious doctrine, but it serves as a complex form of social control of women's sexual and reproductive rights.

2.6 Survivors of FGM have varied preference. Some survivors find the term mutilated to be offensive, others feel that mutilation should be used to convey the level of violence. Some survivors prefer cutting to mutilation. There are also a number of other terms in other languages - a list of terms can be accessed via FGM Terminology (nationalfgmcentre.org.uk)

3.0 FGM AND THE LAW

3.1 The Female Genital Mutilation Act 1984 made FGM an offence to be carried out in the UK on any female.

3.2 The Female Genital Mutilation Act 2003 consolidates the 1984 Act making it not only an offence to perform FGM in England, Wales or Northern Ireland, but also an offence to:

1. Aid, abet, counsel or procure any female under 18 to carry out FGM on herself in England, Wales or Northern Ireland or
2. Aid, abet, counsel or procure a non-UK national from carrying out FGM outside the UK on a UK national or permanent UK resident.

3.3 If mutilation takes place in England, Wales or Northern Ireland, the nationality or residence status of the victim is irrelevant.

3.4 Section 4 of the Female Genital Mutilation 2003 Act makes it an offence for a UK national or permanent resident to perform FGM abroad.

4.0 REPORTING AND INFORMATION SHARING OF FGM

4.1 There are three separate mechanisms for reporting and information sharing on FGM, depending on circumstances. These are independent of safeguarding responsibilities.

- For children under 18 with **confirmed** FGM – **MANDATORY REPORTING OF FGM TO POLICE AND FGM ENHANCED DATASET**
- For adult women with **confirmed** FGM – **FGM ENHANCED DATASET**
- For children **at risk** of FGM – **FGM-IS**

MANDATORY REPORTING FOR CHILDREN UNDER 18 TO POLICE

4.2 If a child under 18 discloses they have had FGM or there are signs that make a clinician suspicious that FGM has been performed, it is a mandatory requirement for the clinician to report this to the Police. This is dependent on the age the child presents to a clinician NOT the age that an adult woman says she has had FGM performed. The mandatory duty applies only to children who disclose FGM themselves, or in whom there is clinical suspicion, not when a parent or relative alleges FGM has been performed (in this circumstance a multiagency safeguarding response should still take place, not just mandatory reporting). The duty applies to those who have had FGM prior to entering the country as well as those with concerns about FGM having been performed recently or in the UK. A medical examination is not required at this stage to confirm type or presence of FGM if examination is not planned for the care of the child otherwise.

4.3 A telephone call must be made to the Police in the area that the child resides via the 101 system. An alternative is to email a report to the Police on https://www.avonandsomerset.police.uk/report/crime-or-incident . If the child is deemed to be in immediate danger, then a telephone call to 999 is needed.

4.4 The duty does not replace requesting Children's Social Care involvement or other safeguarding actions. At the GP practice, the Safeguarding Lead needs to be informed.

4.5 All actions need to be recorded carefully in the clinical record.

4.6 The reporting duty is personal to the individual to whom the patient presents – it cannot be deferred to another. The only amendment to this is if the case has already been referred by someone else in your department. There is no need to make two reports to the Police.

4.7 The duty includes girls under 18 who have had genital piercings as this is also illegal under the act and classified as type IV FGM.

FGM ENHANCED DATASET

4.8 From October 2015 it became mandatory for all GP practices to report FGM to the Department of Health (DOH) every month. The purpose of this obligation is to provide information on the prevalence and effects of FGM. This will help develop the national response to FGM and data to commission services.

4.9 The FGM Enhanced Dataset report provides a set of patient specific data for any woman or girl with confirmed FGM who presents for an appointment where FGM is discussed or treated. This does NOT include when a woman or girl is seen for an unrelated condition where FGM is not discussed or treated at that appointment.

4.10 Data is collected via the NHS England Clinical Audit Platform or CAP, new users must register to access CAP. Once registered, users can access CAP online. Data can be submitted directly into CAP or upload a file. Data needs to be submitted by end of each calendar quarter.

More information about the FGM enhance dataset, CAP registration and about how to access it is available on: Health professionals and NHS organisations - NHS England Digital

4.11 In order to make this mandatory return, it is expected that any service who sees a woman or girl with confirmed FGM at any time where FGM is discussed or treated will take the following steps:

1. If first appointment, ask age of FGM, country of origin and country of FGM, and whether the woman has any female children and if they have had FGM.
2. Discuss the illegality of FGM in the UK and check her understanding of the law.
3. Explain that her data will be automatically put onto the enhanced dataset. This data entry does not require consent - instead women need to ask for their data to be removed if they do not wish it to be there. Provide her with the following weblink https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/female-genital-mutilation-datasets/patients-your-fgm-information-and-how-we-use-it or give her the information leaflet on the FGM dataset. Information leaflets in several languages can be found on https://www.nhs.uk/conditions/female-genital-mutilation-fgm/. These leaflets explain how she can ask for her data to be removed from the dataset if she so wishes.
4. Plan treatment and safety planning as later in this guideline.
5. Document contemporaneously within the client records and updated alerts.

FGM-IS

4.12 FGM-IS is a national IT system that supports the early intervention and ongoing safeguarding of girls under the age of 18 who are at risk of FGM. It has the following functions:

- Enables medical professionals to record when a girl under 18 has a family history of FGM.
- Shares that information with other professionals who treat her as she grows up.
- Prompts the clinicians to consider if they need to take safeguarding/other action.

4.13 When a child or female infant is identified as being at risk of FGM i.e. a family member has had FGM, an alert will be added to the child's National Care Record Service (on the NHS Spine). An alert will also be placed on all local healthcare systems and the GP practice will be responsible for updating EMIS.

The following SNOMED CT codes should be used for FGM:

FGM – female genital mutilation	429744008
Discussion about FGM (female genital mutilation)	713255007
Family history of FGM (female genital mutilation)	902961000000107
Discussion about FGM (female genital mutilation) with carer	932301000000101
Discussion about illegality of female genital mutilation	979461000000100
Discussion about health implications of female genital mutilation	979481000000109
Defibulation of vulva	442290007

4.14 At the birth of a female infant at risk, it will be the duty of the Named or Deputy Named Midwife to enter alerts on FGM-IS and community midwife to perform a risk assessment and inform the GP.

4.15 If female children are found to be at risk after the postnatal period (such as older children of a pregnant woman or hidden children) then it will be the duty of Public Health Nursing and GP to record the children on FGM-IS and perform a risk assessment.

4.16 Further information on FGM-IS can be found on https://digital.nhs.uk/services/female-genital-mutilation-information-sharing

5.0 TALKING ABOUT FGM - SENSITIVITY

5.1 Health care professionals need to be sensitive to the fact that women and families may have been under intense cultural/social pressure from within their country of origin to practise FGM. Professionals need to consider how to discuss FGM without being judgemental and whilst being sensitive. You may wish to use the NHS Choices

video resource of women talking about their personal experiences of FGM or the Health Education England 'Communication Skills for FGM Consultations' e-learning session https://www.e-lfh.org.uk/programmes/female-genital-mutilation/ to help you gain confidence when talking about FGM with patients.

5.2 All girls and women should be asked sensitively about FGM if they present to healthcare from a country at risk or at booking to maternity from any country.

5.3 Where a woman has a hearing impairment or her first language is not English, arrangements should be made for an interpreter to be present. Wherever possible, it should be ascertained from the woman whether the interpreter is suitable. Family members and friends should never be used to interpret interviews of this kind.

5.4 Any woman with a disability, learning disability or autism or who may lack capacity may need the professional to make reasonable adjustments to enable her to take part in this conversation.

5.5 Simple language should be used including direct questions such as:

"Have you been closed? Were you circumcised? Have you been cut below?"

5.6 It is important to ensure the family/young person understand the illegality of this practice whilst being sensitive to FGM as an embedded custom.

5.7 It is important to take detailed records, particularly of the country of origin, type of FGM, the age at which FGM was carried out, who by and in which country. This must be carefully documented including details of discussions with the parent/carer.

6.0 SAFEGUARDING RESPONSIBILITIES AND FGM

Adults at risk of harm and children

6.1 Safeguarding in these circumstances is a challenge because families may give no other cause for concern i.e. in every other way, they may be loving families who are simply doing what they feel is best (or are told what is best for their child). Where professionals believe that an individual has undergone FGM, they must also consider the risk to other girls in the extended family.

6.2 If any child (under 18) discloses to a regulated professional that they have had FGM, or if a professional observes that she has had FGM, they must report to the police, using the 101 non-emergency number or form (see section 4). If an adult at risk of harm is identified as having had or being at risk of FGM, this should be responded to within the existing safeguarding processes to protect adults at risk of harm.

6.3 If an adult discloses to a professional that a child has had FGM, this is a report of child abuse. The professional should follow local safeguarding processes, which would normally mean referring to the police and/or social services. This is because a crime has been committed, and a child has suffered physical (and potentially other) abuse. After all referrals to either the police or social services, the multi-agency safeguarding

response would usually include a referral to a specialist service, to confirm the girl has had FGM. For Somerset, this is The Bridge in Bristol.

6.4 If you suspect a child (or adult at risk) may have FGM or is at serious or imminent risk of FGM, having considered their family history or other relevant factors, you should make a referral, as is the procedure with all other instances of abuse, to Children's or Adult Social Care. Additionally, when a patient is identified as being at risk of FGM, this information must be shared with other relevant professionals, as part of a safeguarding response. In the case of a girl under 18 the FGM-IS on the National care records service (NHS Spine) should also be set which will alert other healthcare professionals to the risk of FGM (see section 4).

6.5 If you identify an imminent risk to a child (or adult at risk), then an immediate telephone referral should be made to Police (999) and a request made for Children's Social Care involvement to allow preventative measures to be taken via a multi-agency Strategy Discussion. Measures considered at Strategy Discussion might include an FGM Protection Order (Schedule 2 of the Female Genital Mutilation Act 2003). This is an order granted by the family court which can order prohibitions, requirements and restrictions which could, for example, include surrendering of passports. Also, if required, Children's Social Care can also request an Emergency Protection Order under Section 44 of the Children Act 1989 enabling a child to be removed to a place of safety where there is evidence that the child is in "imminent danger".

6.6 If the adult of risk of harm may lack capacity or is felt to be being coerced into the decision, an application to the court under inherent jurisdiction may need to be considered. Advice in these circumstances should be sought from the ICB Mental Capacity & Deprivation of Liberty Strategic Lead.

6.7 If it is identified that a child (or adult at risk of harm) has a family history or details which mean she may be at risk of FGM, but after risk assessment there is insufficient information to suggest that the risk is imminent or serious, the professional should discuss the case with their safeguarding lead or with Somerset ICB safeguarding team, sharing information between professionals and agencies appropriately and considering early intervention options with colleagues from Social Care.

6.8 The FGM risk assessment tool provided by the Department of Health (FGM Professional Guidance Forms) can help assess and document the level of risk in a family (Appendix A-D).

Adult Women

6.9 There is no requirement for automatic referral of adult women with FGM to Adult Social Care or the police. Healthcare professionals should be aware that any disclosure may be the first time that a woman has ever discussed her FGM with anyone. Reporting to the police must not be introduced as an automatic response when identifying adult women with FGM, and each case must continue to be

individually assessed. The healthcare professional should seek to support women by offering referral to community groups who can provide support, and for possible clinical intervention or other services as appropriate, for example through an NHS FGM clinic. The wishes of the woman must be respected at all times, though consideration should be made to whether the woman lacks capacity in any way or may be coerced or controlled by another. In such circumstances, advocacy and/or a safeguarding referral may be appropriate.

6.10 The nearest National NHS FGM support clinic to Somerset is the Rose Clinic in Bristol. Contact Details are:

Phone: 07813016911 or email: bristolrose.clinic@nhs.net

Eastville Medical Practice, East Trees Health Centre, 100a Fishponds Road, Bristol, BS5 6SA.

Women can self-refer or a referral can take place by a clinician working with the woman.

6.11 Additional support may be found with third sector agencies such as: Daughters of Eve, FORWARD, NSPCC and the National FGM Working Group. Contact details can be found on FGM: Organisations offering advice and support - Womankind Worldwide.

Adult daughters

6.12.1 If a woman discloses she has an adult daughter(s) over 18 who has undergone FGM, even if the daughter does not want to report FGM to the police, it is important to establish when and where this took place. This should lead to enquiries about other female children within the wider family context. If a decision has been taken within the family not to carry out FGM on a UK-born female child, this can allow for a useful conversation to ascertain whether this was as a result of a change in attitude, a fear of prosecution, or due to a lack of opportunity or other motivations. 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. All information should be recorded and shared with the appropriate multi-agency partners.

6.12.2 There has been little research in outcomes of safeguarding against FGM within the UK or similar health systems. However, there are multiple accounts that women who have ongoing physical and/or psychological problems, and who recognise that these are a result of FGM, are less likely to support or carry out FGM on their own children. This is also reported in women who are involved or highly supportive of FGM advocacy work and eradication programmes. However, any woman may still be under pressure from her husband, partner or other family members to allow or arrange for her daughter to be cut. Wider family engagement and discussions with both parents and potentially wider family members may be appropriate.

7. PAEDIATRIC GUIDANCE

7.1 Indicators that a child may be at risk of having FGM:

- Country of origin
- Mother or older sibling having FGM
- Girls withdrawn from personal & social education lessons (the rationale for this being that the families do not wish their children to be educated about normal female anatomy, normal sexual practices, or the empowerment and self-determination of women).
- Girls trying to travel to their country of origin particularly at the beginning of the school holidays.
- Visiting female elder.
- Mention of a “special ceremony” or becoming a woman.

7.2 There is no doubt the FGM is carried out on girls and young women in the UK as well as those that are taken overseas. There is emerging evidence that because of the increased awareness of society (and safeguarding partners in particular) to the risks of FGM, that “cutters” may be visiting the UK during school holidays to perform FGM. It is therefore important to be alert to visiting family elders at the beginning of the school holidays.

7.3 A risk assessment of girls at risk of FGM (Appendix C editable form at Female Genital Mutilation Risk and Safeguarding (publishing.service.gov.uk) should take place at first contact with a service and when changes in family circumstances take place such as those above. For any child at risk, full details should be shared with the practice’s safeguarding lead. A safeguarding referral then should be made to Children’s Social Care and Police, with mechanism dependant on urgency of risk identified.

7.4 Indicators that FGM may have taken place:

- Walking difficulties
- Trouble sitting for prolonged periods (e.g. in school)
- Long periods in the toilet as they struggle to pass urine
- Repeated absences from school
- Not brought to hospital/health appointments
- Behaviour change
- Frequent urinary tract infections
- Period problems
- Disclosure

7.5 If indicators are present of FGM having occurred, then the clinician should inform the practice safeguarding lead and make a referral to Children's Social Care. A risk assessment using the paediatric risk assessment form (Appendix D) may help record concerns prior to making referrals. The clinician identifying possible FGM having occurred to a child or young person under the age of 18 also needs to report the case within 24 hours to Police as in section 4. If there are indicators of FGM having occurred recently, then an urgent referral to Police and Children's Social Care should take place, for an urgent multi-agency response which is likely to involve a medical assessment at the local FGM assessment service at the Bridge in Bristol. This also needs to address risk for any other female child relatives, and a plan of protection to be instigated.

Follow up care:

7.6 Support should always be offered in the form of information, a specialist clinic, counselling and support groups. An interpreter may be required, do not use a family member, and ensure that the interpreter has received appropriate training in FGM matters and understands the illegality. Be aware that the communities in which FGM is practiced tend to be very close and care must be taken to ensure that the translator is not someone with close links to this particular community.

7.7 Consideration should also be made regarding referral to psychological services to access appropriate counselling and support services to manage the long-term psychosocial FGM and sequelae.

8. MONITORING

Element of policy for monitoring	Section	Monitoring method - Information source (e.g. audit)/ Measure / performance standard	Item Lead	Monitoring frequency /reporting frequency and route	Arrangements for responding to shortcomings and tracking delivery of planned actions
Mandatory reporting	**4**	Audit/Annual safeguarding self-assessment	ICB FGM Lead	Annual	
FGMIS	**4**	Audit	ICB FGM Lead	Annual	
FGM Enhanced Dataset	**4**	Measure	ICB FGM Lead	Annual	

9. REFERENCES

Female Genital Mutilation Act 2003. Female Genital Mutilation Act 2003 (legislation.gov.uk)

Female Genital Mutilation and it's management. Royal College of Obstetricians and Gynaecologists. Green Top Guideline no 53. July 2015. gtg-53-fgm.pdf (rcog.org.uk)

Female Genital Mutilation Risk and Safeguarding: Advice for Professionals. DOH. May 2016. Female Genital Mutilation Risk and Safeguarding (publishing.service.gov.uk)

Home Office FGM Resource Pack. February 2023. Female genital mutilation: resource pack - GOV.UK (www.gov.uk)

Home Office. Mandatory reporting of FGM. January 2020. Mandatory reporting of female genital mutilation: procedural information - GOV.UK (www.gov.uk)

Home Office Multiagency Statutory Guidance on FGM. July 2020. Multi-agency statutory guidance on female genital mutilation - GOV.UK (www.gov.uk)

Keeping Bristol Safe Partnership FGM Guideline. February 2023. kbsp-fgm-policy-final.pdf (bristolsafeguarding.org)

NHS Choices FGM. Female genital mutilation (FGM) - NHS (www.nhs.uk)

NHS Digital - FGM datasets. September 2023. Female Genital Mutilation Datasets - NHS Digital

NHS Digital - FGM enhanced dataset. November 2018. SCCI2026: Female Genital Mutilation Enhanced Dataset - NHS Digital

WHO Clinical Handbook for the care of women and girls living with FGM. April 2018. Care of girls and women living with female genital mutilation (who.int)

Working Together to Safeguard Children 2023. December 2023. Working together to safeguard children - GOV.UK (www.gov.uk)

APPENDIX A – RISK ASSESSMENT PREGNANT WOMEN AND RECENTLY BIRTHED

Editable version at [Female Genital Mutilation Risk and Safeguarding (publishing.service.gov.uk)]

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

Date: _____ Completed by: _____

Assessment: Initial/On-going

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

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

ACTION

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

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

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

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

In all cases:–

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

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

APPENDIX B – RISK ASSESSMENT NON-PREGNANT ADULT WOMEN

Editable version at [Female Genital Mutilation Risk and Safeguarding (publishing.service.gov.uk)]

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

Date: _____ Completed by: _____

Assessment: Initial/On-going

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

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

ACTION

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

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

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

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

In all cases:–

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

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

APPENDIX C – RISK ASSESSMENT CHILD/YOUNG ADULT AT RISK – 2 PAGES

Editable version at [Female Genital Mutilation Risk and Safeguarding (publishing.service.gov.uk)]

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

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

Date: _____ Completed by: _____

Assessment: Initial/On-going

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

ACTION

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

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

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

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

In all cases:-

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

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

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

ACTION

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

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

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

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

In all cases:–

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

APPENDIX D – RISK ASSESSMENT CHILD/YOUNG ADULT

Editable version at [Female Genital Mutilation Risk and Safeguarding (publishing.service.gov.uk)]

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

Date: _____ Completed by: _____

Assessment: Initial/On-going

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

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

ACTION

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

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

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

In all cases:-

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

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

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