Female Genital Mutilation (FGM): Hackney Protocol

1. PURPOSE

The main purpose of this protocol is to provide Health and Children's Social Care professionals, who are likely to come into contact with girls and women, with an understanding of Female Genital Mutilation (FGM) and what actions they should take to safeguard girls and women who they believe are at risk, or who have already undergone FGM.

This protocol will be reviewed annually and monitored as part of the 'Tackling and Preventing FGM Strategy'.

2. BACKGROUND

FGM comprises 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[1].

FGM is practised by families for a variety of complex reasons but often in the belief that it is beneficial for the girl or woman. However, **it has no health benefits and harms girls and women in many ways.**

FGM has been classified by the World Health Organisation into 4 types:

Type 1 – Clitoridectomy	Partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
Type 2 – Excision	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the 'lips' that surround the vagina).
Type 3 – Infibulation	Narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
Type 4 – Other	All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

[1] http://www.who.int/mediacentre/factsheets/fs241/en/

The age at which girls and women undergo FGM varies enormously between different communities. The procedure may be carried out when a girl is a newborn, during childhood or adolescence, just before marriage or during pregnancy.

3. OUR RESPONSIBILITIES

Everyone who works with children or families has a responsibility to ensure that procedures for safeguarding children are adhered to and statutory organisations, under Section 11 of the Children Act 2004, have a duty to safeguard and promote the welfare of children. This includes protecting girls who have had FGM or have been identified at risk of FGM.

In addition to the above duty, health professionals are required to record FGM. Since April 2014 (following the publication of the Data Standard[2]), it is mandatory for NHS healthcare professionals to record FGM in a patient's healthcare record, if they identify through the delivery of healthcare services that a woman or girl has had FGM.

In September 2014, it also become mandatory for Acute Trusts and Primary Care to collate and submit basic anonymised details about the number of patients treated who have had FGM to the Department of Health.

While there is no requirement to ask girls and women whether they have had FGM, professional judgement should be used to decide whether to ask the patient.

It is best practice to share information between healthcare professionals to support the ongoing provision of care and effort to safeguard women and girls against FGM. For example, after a woman has given birth, information about her FGM status should be included in the discharge summary record which is sent to the GP and Health Visitor. In addition, it is useful to include that there is a history of FGM within the Personal Child Health Record (often called the "Red Book").

Relevant legislation

Under the Female Genital Mutilation Act 2003, a person is guilty of an offence if they excise, infibulate or otherwise mutilate the whole or any part of a girl's or woman's labia majora, labia minora or clitoris, except for necessary operations performed by a registered medical professional on physical and mental health grounds. It is also an offence to assist a girl to perform FGM on herself. Any person found guilty of an offence under the Act will be liable to a maximum penalty of 14 years imprisonment or a fine or both.

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[2] FGM Prevention Programme: Requirements for NHS staff

The 2003 Act created extra-territorial offences to deter people taking girls abroad for mutilation but the victim or perpetrator must either be a UK national or a permanent UK resident. Therefore, the law failed to protect girls and cover perpetrators, with a different residency status. The Serious Crime Act 2015 blocked this loophole by covering those who are 'habitually resident' in the UK.

The **Serious Crime Act 2015** also brought in a number of other changes:

- **Duty to notify the police of FGM:** This section places a duty on those who work in 'regulated professions' namely healthcare professionals, teachers and social care workers, to notify the police when, in the course of their work, they discover that an act of FGM appears to have been carried out on a girl who is under-18. Failing to comply with the duty will be dealt with via existing disciplinary measures, which may include referral to the professional regulator and/or Disclosure and Baring Service as appropriate.

- **Female genital mutilation: anonymity for victims:** lifelong anonymity for alleged victims of FGM. The aim here is to increase reporting of FGM by encouraging victims to report FGM offences and to increase prosecutions by helping the victim feel safe in their anonymity if they report a crime against them.

- **Female genital mutilation: duty to protect a girl:** there is a new offence of failing to protect a girl under the age of 16 from FGM. A person is liable if they are 'responsible' (possess parental responsibility) for a girl or who has assumed responsibility for caring for a girl at the time when the offence is committed against her (this can include a Local Authority who as parental responsibility).

- **Female genital mutilation: FGM Protection Orders:** the high court or family courts will be able to make a protection order which can be used to protect a girl who may be at risk of an FGM offence or a girl to whom FGM has been committed. It will be a criminal offence to breach the order and the penalty will be a maximum penalty of five years imprisonment or as a civil breach punishable by up to two years' imprisonment.

4. CONSEQUENCES OF FGM

FGM involves removing and damaging healthy and normal female genital tissues, and hence interferes with the natural function of female bodies. The practice causes severe pain and has several immediate and long term health consequences, including difficulties in childbirth also causing dangers to the child.

The list below shows some of the short term and long consequences arising from FGM

- Severe pain
- Urinary and wound infections (such as Hepatitis B)
- Excessive bleeding
- Fractures or dislocation
- Difficulties menstruating
- Renal failure
- Damage to reproductive system
- Complications in pregnancy and child birth
- Emotional and psychological issues which may lead to long term mental health problems
- Difficulties with personal and family relationships
- Death

5. PREVALENCE OF FGM

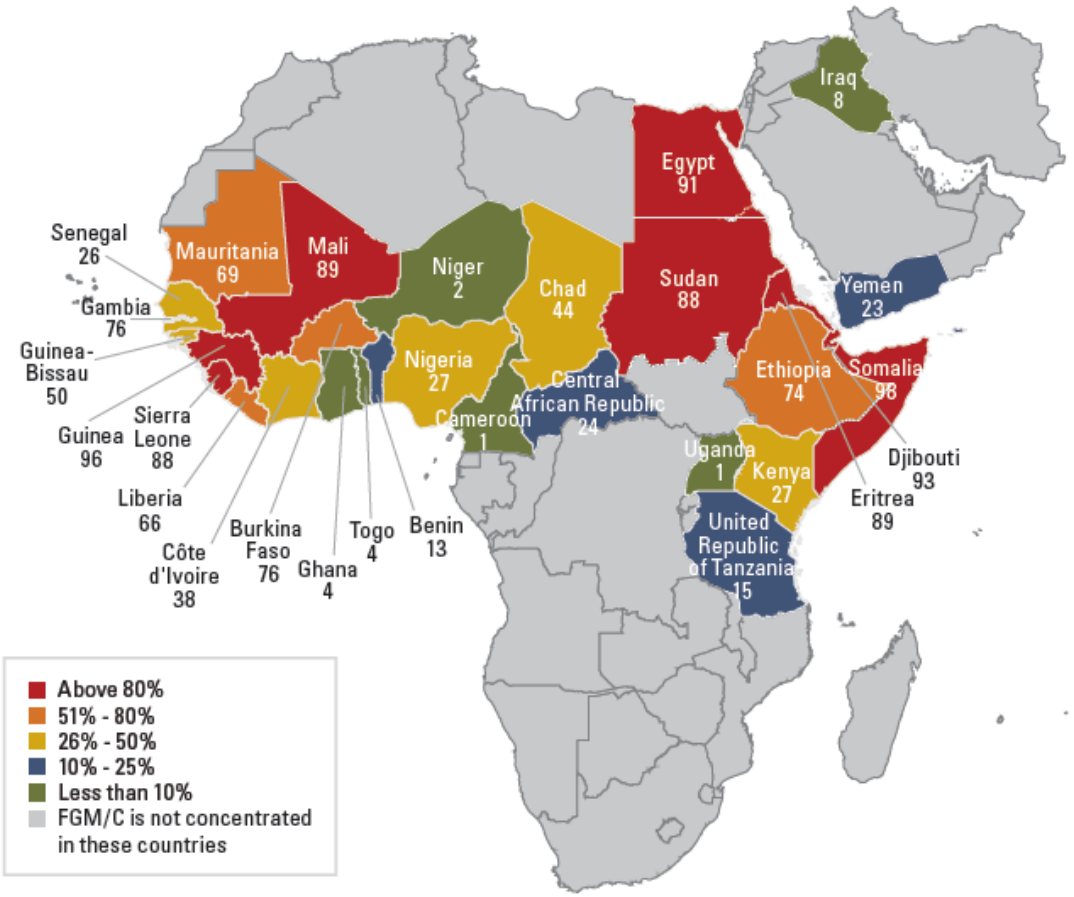
International prevalence

More than 125 million girls and women alive today have been undergone FGM in the 29 countries in Africa and Middle East where FGM is concentrated[3]. The World Health Organisation estimates that between 100 and 140 million girls and women worldwide have experienced FGM and around 3 million girls undergo some form of the procedure each year in Africa alone.[4]

As shown in Figure 1, the practice is mainly practiced in the western, eastern, and north-eastern regions of Africa. It is also practiced in some countries in Asia and the Middle East, and among migrants from these areas.

[3] UNICEF. Female Genital Mutilation/Cutting: a statistical overview and exploration of the dynamics of change, 2013.
[4] http://www.who.int/mediacentre/factsheets/fs241/en/

Figure 1. Prevalence of FGM among women aged 15-49 years in Africa and the Middle East



Source: UNICEF (July 2013), global databases based on data from Multiple Indicator Cluster Survey, Demographic and Health Survey and other national surveys, 1997-2012

National prevalence

A prevalence study in the UK estimated that approximately 60,000 girls under the age of 15 years in 2011 were born in England and Wales to mothers who had undergone FGM.[5]

It estimated that approximately 103,000 women aged 15 to 49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM.[6]

Local prevalence

[5] http://www.trustforlondon.org.uk/wp-content/uploads/2014/01/FGM-statistics-report-July-14.pdf
[6] Macfarlance & Dorkenoo 2014

A statistical study conducted in 2007 using the 2001 census data estimated that 921 women with FGM had given birth in Hackney between 2001- 2004.[7]

All women using Homerton Hospital antenatal services are routinely asked if they have been "cut" before mandatory recording came into effect in 2014. The Homerton has approximately 6,000 births a year and the number of women who disclosed a history of FGM, at booking for maternity care (usually 12 weeks) from January 1st 2008 to 31st December 2013 was 245 according to the Electronic Patients Record system. It is possible that a greater number of women do not disclose but are recognised later. The type of FGM is not recorded electronically.

The Homerton hospital undertakes about 10 FGM deinfibulations ("reversals") a year.

The Learning Trust has provided information from the annual school census on the number of pupils from different ethnic groups at schools across the borough. Of the countries where FGM is practised only 6 countries are covered by the school census. The number of girls whose parents are from a practising country was recorded as 3019 in 2013 and 3028 in 2014.

Between June 2014 and March 2015, 60 referrals were made to Children Social Care because there were concerns about potential risk of FGM. In none of the cases the girl had FGM performed.

[7] FORWARD 2007: 'A statistical study to estimate prevalence of female genital mutilation in England and Wales' available at http://www.forwarduk.org.uk/key-issues/fgm/research

6. HACKNEY FGM PROTOCOL

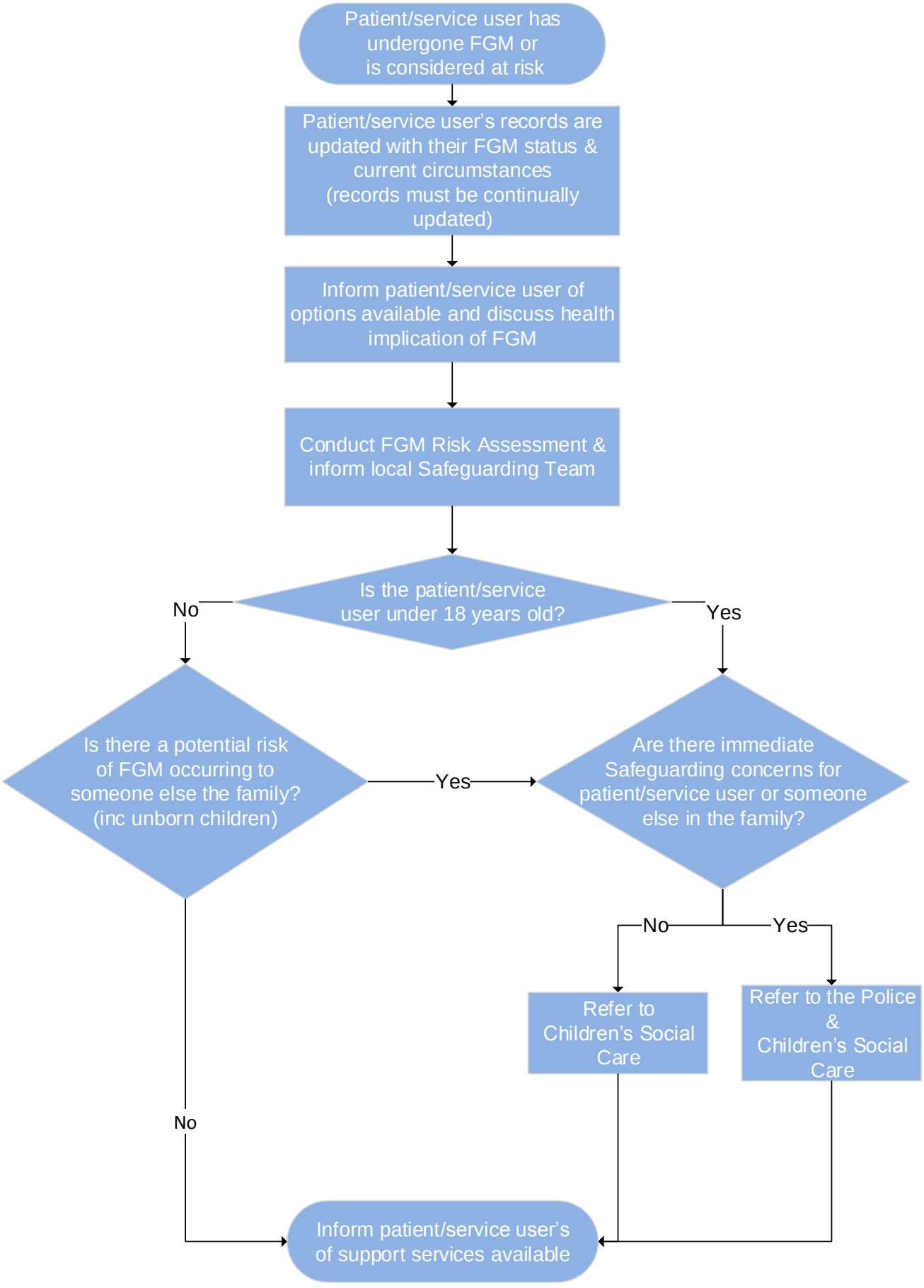
A	Health professionals should follow their organisation's FGM screening process for girls and women who come from communities where FGM is practised.
B	An appropriate risk assessment (see Appendix 2) should be completed if a girl or woman has undergone or been identified as being at risk of FGM. There are four different types of assessments: • For pregnant women PART ONE (A) should be completed • For non-pregnant women PART ONE (B) should be completed • For girls under 18 years deemed at risk of FGM PART TWO should be completed • For girls under 18 years who have had FGM PART THREE should be completed
C	If a girl or woman has had FGM this should be documented in their health record. A referral[8], along with the supporting risk assessment, should be sent to Children's Social Care (CSC) cscreferrals@hackney.gov.uk.cjsm.net, if: • FGM has occurred to a girl under the age of 18, or the girl is considered at risk of FGM • There are concerns that the woman or partner may not understand that FGM is illegal and/or there may be a risk of FGM to girls in their care
D	CSC will decide whether to undertake a statutory assessment of the children where the Health professional has identified a risk following the completion of a comprehensive FGM Risk Assessment.
E	CSC will check to see if there has been a previous referral or if a previous FGM related assessment has been undertaken. A new assessment process will not be started unless there is new information warranting such action. Information will be held on the CSC client system Framework-i
F	CSC, during screening and/or assessment, will explore with the family the risk to all the girls in the family of FGM. This can be undertaken by the First Access and Screening Team (FAST) or by one of the Access and Assessment Social Work Units.

[8] Professional judgement should be used to determine when a referral to the Police should be made, such as in cases where there is an immediate risk of harm or evidence that FGM has recently been carried out

G	Any CSC assessment/exploration will explore (but is not limited to): • the circumstances which led to the girl or woman being subjected to FGM • the immediate and wider family's belief system in relation to the practice of FGM • the family's contact with community and/or faith groups that support the practice of FGM • if the family are likely to be in contact with those who have previously or currently perform FGM • the influence of family and community beliefs and practices on the family • if there are other risks including Honour Based Violence, Early Forced Marriage or Child Trafficking • whether there are any plans for female children in the household to visit a country in which FGM is practiced • the capacity of the child's parents/carers to resist community and familial pressure to subject female children to FGM and to protect female children in their care from FGM • the child(s) views, knowledge and understanding of FGM (depending on age and understanding) • the child's experience of family life and family / community belief systems • whether female children in the household are able to access social / educational and health resources with an age-appropriate degree of autonomy • whether the child has a safe adult(s) she can access if she is worried about her safety or welfare • whether the child has already experienced or is likely to experience FGM during her childhood • whether a professional response is required to meet the child's needs, reduce risk or provide immediate protection
H	If a girl has experienced or is assessed to be at a high risk of being subjected to FGM, CSC will initiate a Child Protection Enquiry with Police and Health partners. Legal steps will be considered to respond to or prevent imminent harm.
I	If the CSC assessment does not identify safeguarding concerns in relation to a child CSC will end their involvement. CSC will inform the family and notify relevant professionals including

	school, GP, Health Visitor, School Nurse. Hackney Learning Trust of the outcome of the referral including any action taken and any need for further support and monitoring.
J	Girls identified during CSC assessment as being at risk of FGM may become subject: • of a Child Protection Plan depending upon the level of risk involved • of a Child in Need Plan
K	If a Child Protection Plan is initiated it will be regularly reviewed with a multi-agency professional group and the family to monitor levels of risk. If risk of FGM is reduced the Child Protection Plan will end and a Child In Need Plan will be implemented, monitored and reviewed before CSC end their involvement.

7. Appendix 1: FGM Protocol Flowchart for Health Professionals



8. Appendix 2: FGM Safeguarding Risk Assessment Guidance (for Health Professionals)

This guidance has been taken from the Department of Health (2015) and has been designed to support healthcare professionals to identify and consider risks relating to female genital mutilation, and to support the discussion with the patient and family members.

It should be used it to help assess whether the patient you are treating is either at risk of harm in relation to FGM or has had FGM, and whether your patient has children who are potentially at risk of FGM, or if there are other children in the family/close friends who might be at risk.
If when asking questions based on this guide, any answer gives you cause for concern, you should continue the discussion in this area, and consider asking other related questions to further explore this concern.

Having used the guide, you will need to decide:

- Do I need to make a referral through my local safeguarding processes, and is that an urgent or standard referral?
- Do I need to seek help from my local safeguarding lead or other professional support before making my decision? Note, you may wish to consult with a colleague at a Multi-Agency Safeguarding Hub, Children's Social Services or the local Police Force for additional support.
- If I do not believe the risk has altered since my last contact with the family, or if the risk is not at the point where I need to refer to an external body, then you **must** ensure you record and share information about your decision accordingly.

An URGENT referral should be made, out of normal hours if necessary, if a child or young adult shows signs of very recently having undergone FGM. This may allow for the police to collect physical evidence.

An urgent referral should also be made if the healthcare professional believes that there are plans perhaps to travel abroad which present a risk that a child is imminently likely to undergo FGM if allowed to leave your care.

In urgent cases, Children's Social Services and the Police will consider what action to take. One option is to take out an Emergency Child Protection Order. If required, an EPO is an

order made 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”.

In many other situations if a child or young adult under 18 years of age is discovered to have had FGM, a referral should be made through local safeguarding processes for Children’s Social Care and it is likely that this can be made during normal working hours and standard procedures, when the risk presented does not have an imminent or urgent element identified.

Part One (a): PREGNANT WOMEN

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

Date:_____Completed by:_____

Initial / On-going Assessment

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

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 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

For assistance with completing this assessment please contact your local Safeguarding Team

Woman is reluctant to undergo genital examination			

SIGNIFICANT OR IMMEDIATE RISK INDICATORS	**Yes**	**No**	**Details**
Woman already has daughters have undergone FGM			
Woman requesting reinfibulation following childbirth			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have 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.			

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 U.K.

For assistance with completing this assessment please contact your local Safeguarding Team

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

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

Date:_____Completed by:_____

Initial / On-going Assessment

INDICATORS	Yes	No	Details
CONSIDER RISK			
Woman already has daughters who have undergone FGM – who are over 18 years of age			
Husband/partner comes from a community known to practice FGM			
Grandmother (maternal or paternal) is influential in family or female family elder is involved in care of children			
Woman and family have limited integration in UK community			
Woman's husband/partner/other family member may be very dominant in the family and have not been present during consultations with the woman			
Woman/family have limited/ no understanding of harm of FGM or UK law			
Woman's nieces (by sibling or in-laws) have undergone FGM Please note:- if they are under 18 years you have a professional duty of care to refer to social care			
Woman has failed to attend follow-up appointment with an FGM clinic / FGM related appointment.			

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 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

For assistance with completing this assessment please contact your local Safeguarding Team

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

For assistance with completing this assessment please contact your local Safeguarding Team

Part Two: CHILD/YOUNG ADULT at risk (under 18 years old)

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

Date:_____ Completed by:_____

Initial / On-going Assessment

INDICATORS	Yes	No	Details
CONSIDER RISK			
Child's mother has undergone FGM			
Other female family members have had FGM			
Father comes from a community known to practice FGM			
A Family Elder such as Grandmother is very influential within the family and is/will be involved in the care of the girl			
Mother/Family have limited contact with people outside of her family			
Parents have poor access to information about FGM and do not know about the harmful effects of FGM or UK law			
Parents say that they or a relative will be taking the girl abroad for a prolonged period – this may not only be to a country with high prevalence, but this would more likely lead to a concern			
Girl has spoken about a long holiday to her country of origin/another country where the practice is prevalent			
Girl has attended a travel clinic or equivalent for vaccinations/anti-malarials			
FGM is referred to in conversation by the child, family or close friends of the child (see Appendix Three for traditional and local terms) – the context of the discussion will be important			

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 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

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Sections missing from the Red book. Consider if the child has received immunisations, do they attend clinics etc			
Girl withdrawn from PHSE lessons or from learning about FGM - School Nurse should have conversation with child			
Girls presents symptoms that could be related to FGM – continue with questions in part 3			
Family not engaging with professionals (health, school, or other)			
Any other safeguarding alert already associated with the Always check whether family are already known to social care			

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.			

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 U.K.

Please remember: any child under 18 who has undergone FGM should be referred to social services.

For assistance with completing this assessment please contact your local Safeguarding Team

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

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

Date:_____ Completed by:_____

Initial / On-going Assessment

INDICATORS	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			

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 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

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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.			

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 U.K.

Please remember: any child under 18 who has undergone FGM must be referred to Children and Young People's Service

For assistance with completing this assessment please contact your local Safeguarding Team