



Bromley Female Genital Mutilation Guidance Document

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Foreword

Bromley's Safeguarding Children Partnership has agreed a multi-agency intervention framework for identifying, assessing and responding to Female Genital Mutilation (FGM) across the multi-agency partnership. This is a joint protocol with the Bromley Safeguarding Adult Board; it covers both female children (under 18) and adult women who are at risk of or have undergone FGM.

We are totally committed to working together with all partners to ensure that early help and intervention is provided to enable and support women and children and reduce the prevalence of FGM. This commitment is set within the context of the existing legal and statutory guidance that FGM is an illegal practice and a collaborative effort is essential to ensure that children and families are safe and protected.

Bromley Safeguarding Children's Partnership has engaged with strategic partners to raise awareness of the risks of FGM and aims to ensure that services across the borough are equipped to respond to and reduce the practice of FGM.

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Independent Children and Young People Commissioner

Bromley Safeguarding Children Partnership

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1 BACKGROUND AND CONTEXT

1.1 Introduction

FGM is an illegal, extremely harmful practice and a form of child abuse and violence against women and girls and therefore should be dealt with as part of existing child and adult safeguarding / protection structures, policies and procedures.

The changing demographics across the UK, as well as the increasing need for inner London Boroughs to place children looked after in outer London boroughs means that front line staff in Bromley should be aware of the risk of female genital mutilation (FGM). It should also be noted that there is a higher percentage of children and young people in Bromley schools from BAME backgrounds compared to the resident population in Bromley. This reflects the number of children attending Bromley schools from neighbouring boroughs.

This guidance sets out Bromley's multi-agency response to FGM and aims to assist practitioners and managers in the prevention and detection of FGM. It focusses on identifying:

- children under 18 years old who have been victims of FGM
- children under 18 at risk of FGM
- pregnant women who have been victims of FGM and the risk that poses to their unborn female child
- adult women who have been victims of FGM
- adult women at risk of FGM

The guidance sets out processes for identification, referral and follow up support to provide these vulnerable groups with an appropriate joined up response. It also includes guidance on how to undertake a risk assessment. It has been developed using the Lambeth/Southwark protocol as a guide.

1.2 Definition of FGM

The World Health Organisation (WHO) defines female genital mutilation (FGM) as: "all procedures (not operations) which involve partial or total removal of the external female genitalia or injury to the female genital organs whether for cultural or other non-therapeutic/medical reasons" (WHO, Jan 2023). FGM has been classified by the WHO into four types:

- Type 1: Circumcision – This is the partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals) with or without removal of the clitoral hood/prepuce (the fold of skin surrounding the clitoral glans)
- Type 2: Excision – This is the partial or total removal of the clitoral glans and labia minora (the inner folds of the vulva), with or without removal of the labia

majora (the outer folds of skin of the vulva). After the healing process has taken place, scar tissue may form to cover the upper part of the vulva region

- Type 3: Infibulation (also called Pharaonic Circumcision) -This is the most severe form of female genital mutilation. This is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching (“sewn closed”), with or without removal of the clitoral prepuce/clitoral hood and glans
- Type 4: Unclassified - This includes all other harmful procedures to the female genitalia and any other procedure for non-medical purposes. It includes pricking, genital piercings, incising, scraping cauterizing and tattoos, as well as cosmetic procedures to female genitalia.

FGM is typically performed on girls aged between 4 and 13, but in some cases it is performed on new-born infants or on young women before marriage or pregnancy. See **Appendix F** for countries where FGM is practised. See **Appendix G** for details about the age when FGM is carried out, relating to the cultural background. It is important to bear in mind however, that this practice can also affect children from a mixed ethnic background who may have a Caucasian mother or father.

The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. WHO cites a number of reasons for why FGM takes place:

- 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

In its interagency statement on [Eliminating FGM \(2008\)](#), WHO states that in every society where it 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.

1.3 Genital Piercings

Genital piercings are commonly practised on consenting adult women by qualified practitioners. These cases do not raise safeguarding concerns and thus practitioners do not need to report cases to the Police. However, the World Health Organisation (WHO) classifies any piercing (upon adults or children) as Type IV FGM, and NHS Trusts and GP Practices must reflect the WHO’s classification when recording genital piercing cases on the FGM Enhanced Dataset.

Genital piercings performed on non-consenting women and/or girls are likely to raise safeguarding concerns and must be reported. Perpetrators could be prosecuted for an array of criminal offences depending on the circumstances. It is important that reporting informs safeguarding, where the distinction between commonly understood and other piercings is critical.

Practitioners should be alert to girls that have undergone genital piercings as a form of ritual, tradition or custom rather than other types of FGM. If there are concerns that FGM is being performed under the guise of genital piercings, then such cases must be treated as a safeguarding concern and must be reported.

1.4 Legal Framework

FGM has been a criminal offence in the UK since the **Prohibition of Female Circumcision Act 1985** was passed. The **Female Genital Mutilation Act 2003** replaced the 1985 Act and makes it an offence for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal. The law imposes a penalty of up to 14 years in prison and, or a fine.

A **new mandatory reporting duty for FGM in under 18-year-olds** was introduced via the Serious Crime Act 2015. The duty (as of October 2015) states that regulated health or social care professionals and teachers in England and Wales must report to the police if they either:

- are informed by a girl under the age of 18 that an act of FGM has been carried out on her, or
- observe physical signs which appear to show that FGM has been carried out on a girl under 18.

It is the personal duty of that professional; the duty to report to police cannot be passed on or delegated to another professional. See **Appendix E** a full list of regulated bodies included in the mandatory reporting duty.

As part of **FGM Enhanced Data Collection**, it is also now mandatory for any NHS healthcare professional to record within a patient's clinical record if they identify through the delivery of healthcare services that a woman or girl has had FGM. It is also now mandatory for all Acute Trusts, Mental Health Trusts and General Practitioners to submit details about the number of patients treated who have had FGM to the Department of Health every month.

FGM flags should only be added to FGM-IS following confirmation from the FGM Referral Centre or disclosure from Mother that she has survived FGM. See **Appendix B** for Referral Centre contact details.

1.5 Consequences of FGM

Depending on the degree of mutilation, FGM can have a number of short-term health implications:

1. Severe pain
2. Infection / fever
3. Urine retention / problems
4. Injury to adjacent / surrounding genital tissues
5. Immediate fatal / heavy bleeding (haemorrhaging)
6. Shock
7. Death

Long-term implications can entail:

1. Extensive damage of the external reproductive system
2. Uterus, vaginal and pelvic infections
3. Cysts, Scar tissue, Keloids and neuromas
4. Increased risk of Vesico- vaginal Fistula
5. Complications in pregnancy and childbirth, including newborn deaths
6. Psychological problems (depression, anxiety, PTSD, low-self-esteem etc.)
7. Sexual dysfunction (pain during intercourse, decreased satisfaction etc.)
8. Difficulties in menstruation
9. Need for later surgeries

In addition to these health consequences there are considerable psycho-sexual, self-esteem and social consequences of FGM where additional support may need to be provided.

2 RISK ASSESSMENT AND IDENTIFICATION

Person Centred Approach: *Whatever someone's circumstances, they have rights that should always be respected such as personal safety and accurate information about their rights and choices. Practitioners should listen to the victim and respect their wishes whenever possible. However, there may be times when a victim wants to take a course of action that may put them at risk – on these occasions, practitioners must explain all the risks to the victim and follow the necessary child or adult protection procedures.*

Research by the University of Bristol (2019) highlights the stigmatising and traumatising approaches to FGM for some communities in the UK in recent years. The report highlights valuable opportunities for policy makers to improve approaches to FGM safeguarding in schools, health care settings, and by social services and the police:

<https://www.bristol.ac.uk/policybristol/policy-briefings/fgm-safeguarding/>

2.1 Signs that a child may be at risk of FGM

The National FGM Centre has developed an online FGM Assessment Tool for Social Workers to help guide the assessment of cases where FGM is a concern:

<http://nationalfgmcentre.org.uk/fgm-assessment-tool/>

For health professionals, the National FGM Centre promotes the use of the Department of [Health FGM Safeguarding and Risk Assessment Quick Guide and Risk Assessment template](#).

There are a number of factors in addition to a girl's or woman's community that could increase the risk that she will be subjected to FGM:

- The position of the family and the level of integration within UK society. It is believed that communities less integrated into British society are more likely to carry out FGM.
- Any girl 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 girl who has a sister who has already undergone FGM must be considered to be at risk, as must other female children in the extended family.
- Any girl withdrawn from personal, social or health education may be at risk as a result of her parents wishing to keep her uninformed about her body and rights.
- The age at which girls undergo FGM varies enormously according to the community. It is typically performed on girls between 4 and 13 but the majority of cases are thought to take place between the ages of 5 and 8.
- FGM can happen to British girls in the UK as well as overseas (often in the family's country of origin). However, it is thought that school aged children can

be taken abroad at the start of the school holidays, particularly in the summer, in order for there to be sufficient time for them to recover before returning to their studies.

- It is 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 girl may confide that she is to have a 'special procedure' or to attend a special occasion to 'become a woman'.
- The girl's parents or close relatives may indicate they plan to 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 (See **Appendix F**).

Professionals need to consider context and as much background information as possible when assessing risk to a particular child. It is not enough to simply consider the country of origin as FGM practice varies by region, religion and language. Professionals can refer to Orchid Project tool when assessing risk: [Orchid Project Where does FGM/C happen? - Orchid Project](#)

2.2 Indicators that a girl or woman has already been subjected to FGM:

- A girl or woman may have difficulty walking, sitting or standing
- A girl or woman may spend longer than normal in the bathroom or toilet due to difficulties urinating
- A girl may spend long periods of time away from a classroom during the day with bladder or menstrual problems

2.3 Guide to asking a girl or woman about FGM

Front line professionals should be trained and competent in holding sensitive conversations regarding FGM. Agencies may have their own operational guidance on how to ask a woman or child about FGM and should discuss this with their safeguarding lead. The National FGM Centre has produced a Direct Work Toolkit. The Toolkit is aimed at children from the age of 7 upwards, with separate activities for parent(s)/carer(s) and young people:

<http://nationalfgmcentre.org.uk/fgm/fgm-direct-work-toolkit/>

It is considered best practice for midwives to ask women of all cultures regarding FGM, rather than women from particular communities. In some circumstances, it may not be appropriate to ask a woman, such as women or children receiving mental health services.

The following points should be considered when talking to a woman or child about FGM.

Asking the right questions in a simple, straightforward and sensitive way is key to establishing the understanding, information exchange and relationship needed to plan for the girl or woman's wellbeing and the welfare of any daughters she may have, or girls she may have access to.

- Different terminology will be culturally appropriate to the different cultures. Alternative approaches are to ask a woman whether she has undergone FGM by saying: 'I'm aware that in some communities women and girls undergo some traditional operation in their genital area. Have you had FGM or have you been cut/circumcised?'
- To ask about infibulation professionals can use the question: "*are you closed or open?*" This may lead to the woman providing the terminology appropriate to her language / culture.
- When asking a child, a professional can simplify the language by asking, "Has anything been done to you 'down there' or on your bottom?"
- Ask if they want to talk to someone who will understand them better.
- Ask if they need support in contacting other agencies for help or advice.

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.
- The practitioner should meet the woman in a place that she feels is safe / private.

If they insist on being accompanied during the interview with a teacher or advocate, ensure that the accompanying person understands the full importance of confidentiality, especially if the accompanying person is a member of their community.

For some, an interview will require an authorised accredited interpreter who speaks their dialect. Never use family members, friends, neighbours or those with influence in the community as interpreters. People may feel embarrassed to discuss personal issues in front of them and sensitive information may be passed on to others and place the person at risk of FGM in further danger. Furthermore, such an interpreter may deliberately mislead practitioners and or encourage the person to drop the complaint and submit to their family's wishes. It is not appropriate to use a child as an interpreter. If possible, do not use a male interpreter when talking to women.

Leaflets in a multiplicity of languages are available for professionals to give to women and their partners and can be downloaded from the NHS Website [here](#).

(Please scroll to the bottom of the page for the leaflets to download in various languages)

2.4 Holiday Plans

Professionals, particularly teachers, can ask children to tell them about their holiday plans. Sensitively and informally ask the child about planned extended holiday ask questions like such as:

- Where are you going?
- Who is going on the holiday with you?
- Have you been told what you will be doing during the holiday?
- How long do you plan to go for, and is there a special occasion planned?
- Do you have any concerns, fears, or anxieties about the holiday?

Questions for the parents include:

- Are they aware that the school cannot keep their child on roll if they are away for a long period?
- Are they aware that FGM including Sunna is illegal in the U.K even if performed abroad?

2.5 Physical Examinations

The mandatory reporting duty applies to cases you discover in the course of your professional work. **If you do not currently undertake genital examinations in the course of delivering your job then the duty does not change this.** Most professionals will only visually identify FGM as a secondary result of undertaking another action.

The National FGM Centre have produced a resource for FGM Medical Examination: Good Practice:

<http://nationalfgmcentre.org.uk/fgm/fgm-medical-examination/>

For healthcare professionals, if in the course of your work, you see physical signs which you think appear to show that a child has had FGM, a discussion needs to take place immediately with Children's Social Care, C&F Hub and the on-call paediatrician, before making the mandatory reporting. This will allow a Strategy discussion with the police to agree the most appropriate steps to take in tandem.

The duty does not require there to be a full clinical diagnosis confirming FGM before a report is made, and one should not be carried out unless you identify the case as part of an examination already underway and are able to ascertain this as part of that. **Unless you are already delivering care which includes a genital examination, you should not carry one out.**

For teachers and social workers, there are no circumstances in which you should be examining a girl. It is possible that a teacher or early years practitioner, for example, perhaps assisting a young child in the toilet or changing a nappy, may see something which appears to show that FGM may have taken place. In such circumstances, the staff member must make a report under the duty but should not conduct any further examination of the child.

Any examination of a child or young person should be in strict accordance with safeguarding children procedures and should (normally) be carried out by a consultant paediatrician, with experience of dealing with cases of FGM. When examination is required to investigate whether a child has experienced FGM, referral should be made to the Children's FGM Service at University College London Hospital by telephoning

0203 4475241 or emailing uclh.cypsafeguarding@nhs.net. If FGM is confirmed, the clinic offers management of the physical and psychological implications of FGM. Referrals are accepted by health professionals (including registered nurses and midwives), children's social services and police. The clinic also offers a review service for DVDs from clinicians working in other safeguarding services where FGM is suspected but not confirmed.

Examining older children and women needs to be approached with sensitivity, remembering that intimate examination requires the person's full consent and co-operation. 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 appropriate referrals are made as necessary.

3 REPORTING AND REFERRAL

This section sets out the multi-agency referral procedure:

- Where a child has undergone FGM
- Where a child is at risk of FGM
- When an expectant mother has undergone FGM
- When an adult woman has undergone FGM

FGM should be dealt with as part of existing child and adult protection procedures i.e. through local authority safeguarding structures, with the additional mandatory reporting duty to police for confirmed FGM in children under 18.

Although the duty of care for Children's Social Care extends to 25 for looked after children and children with special needs, for the purposes of FGM Mandatory Reporting, 'child' refers to under 18 years. Children and Adults Services should work together in the usual way with regard to looked after children and children with special needs.

All referrals to Bromley's Children's Social Care are made through its 'front door'. This is called the Children and Families Hub (C&F Hub) - with colleagues from the police and health co-located with local authority staff at the Civic Centre. This provides more cohesive decision making and sharing of appropriate information. Contact information for C&F Hub can be found in Section 6.

It is critical that FGM referrals are detailed and clear to ensure that assumptions are not made and subsequently miscommunicated between agencies. Referrals should include an accurate description of what has been seen or heard. If you initially referred via telephone, you would need to repeat the details in a written referral via the portal.

3.1 Confidentiality

Professionals and volunteers should not promise complete confidentiality to the victim (blanket confidentiality cannot be given to the individual as FGM is both a crime and child abuse that must be reported).

It is expected that individuals that make a referral to the police or Children's Social Care will not normally be able to remain anonymous. However, given the heightened sensitivity within communities that practise FGM and potential risk to those individuals, referrals made by members of the community who are working with a voluntary sector organisation can reasonably expect not to have this information passed to the family involved. They should still give their details and organisation contact information when making a referral but can request that they remain 'anonymous' with regard to the family or child who is the subject of the referral.

3.2 Referral: where a child under 18 years has undergone FGM

Where a child has undergone FGM, professionals should report to both the Police and the C&F Hub.

3.2.1 Mandatory Reporting Duty

If a child under 18 years old discloses to a professional that they have undergone FGM or you have observed a physical sign appearing to show FGM has been carried out, there is a mandatory duty on that professional to report to the police.

Report to the police by calling '101', the non-emergency number, within 48 hours. It is the personal duty of that professional; the duty to report to police cannot be passed on or delegated to another professional.

The duty applies to:

- Health or social care professionals regulated by a body which is overseen by the Professional Standards Authority for Health and Social Care- i.e., General Chiropractic Council; General Dental Council; General Medical Council; Health and Care Professions Council; Nursing and Midwifery Council, etc.
- Teachers (qualified or other persons employed or engaged to carry out teaching work).

See **Appendix E** for a full list of regulated professions.

When reporting to the Police:

- You must identify the girl and explain why the report is being made
- Provide your name and professional details
- Confirm that you have or will be undertaking safeguarding action under "Working Together to safeguard children", as appropriate
- Ensure you are given a reference number

Full details of the mandatory reporting duty can be found in the Home Office and Department for Education document: [Mandatory Reporting of FGM](#).

3.2.2 Referral to Bromley Children and Families Hub

The professional should also contact the Bromley C&F Hub without delay, in order to initiate a strategy meeting between professionals to assess support needed and wider safeguarding implications. Contact details for C&F Hub can be found in Section 6.

The referring agency should attempt to gather the relevant information before calling the C&F Hub:

- Confirmation that the family has been informed of the referral (unless this places child at immediate/further risk of harm)
- Full details of parents and all children in the family (including unborn with E.D.D)
- Information regarding extended family members who may have a significant influence
- Indicators/evidence that a girl or woman has already been subjected to FGM
- Confirmation whether appropriate advice and information to the family has already been provided regarding the law and harmful consequences of FGM and information as to the family's response
- Parental/carer attitudes and understanding about the practice and where appropriate child/young person's knowledge, understanding and views on the issue
- Any information as to whether previous children's social care assessments (in regard to other children of the family) relating to concerns regarding FGM have been completed and by whom.

3.3 Referral: where a child under 18 is at risk of FGM

The risk assessment and indicators set out in Section 2 of this protocol may lead a professional to believe a child is at risk of FGM, for instance if sisters have already undergone FGM or the professional has heard reference to a 'special procedure'. Where a child is thought to be at risk of FGM, practitioners should be alert to the need to act quickly, before the child is abused through the FGM procedure in the UK or taken abroad to undergo the procedure.

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 and / or community leaders to facilitate the work with parents / family. However, the child's interest is always paramount.

All agencies are expected to consider the risk and gather relevant information prior to making a formal referral to C&F Hub. However, **if the matter is urgent and you think there is an imminent risk, ring the police on 999 or C&F Hub team without delay.**

Where concerns are raised about a child, consideration should be given to whether siblings are at a similar risk.

The referring agency should attempt to gather the relevant information before calling the C&F Hub:

- Confirmation that the family has been informed of the referral (unless this places child at immediate/further risk of harm)
- Full details of parents and all children in the family (including unborn with E.D.D)
- Information regarding extended family members who may have a significant influence
- Specific factors which may heighten a girl's or woman's risk of being affected by FGM
- Any information / signs that may suggest that FGM may be about to take place soon
- Confirmation whether appropriate advice and information to the family has already been provided regarding the law and harmful consequences of FGM and information as to the family's response
- Parental/carer attitudes and understanding about the practice and where appropriate child/young person's knowledge, understanding and views on the issue
- Any information as to whether previous children's social care assessments (in regard to other children of family) relating to concerns re FGM have been completed and by whom.

3.4 Referral: where an expectant adult woman has undergone FGM

When a woman becomes pregnant, the midwife should complete an FGM maternity risk assessment. Midwives should ask women from all cultures and communities. Questions include:

- Has the woman undergone FGM?
- Is the husband/partner from a community known to practice FGM?
- Does the woman regard FGM as integral to her cultural or religious identity?
- Does the woman/husband have limited/no understanding of the harm caused by FGM or of the UK law?
- Have the woman's daughters/siblings/nieces undergone FGM?

If the FGM maternity risk assessment indicates that the unborn child may be at risk of significant harm (i.e. signs that the parents intend to subject child to FGM once born, or any other safeguarding concerns), a referral should be made to Bromley C&F Hub. However, **referral to the C&F Hub must not be introduced as an automatic response when identifying a pregnant adult woman with FGM**, and each case must continue to be individually assessed. **If the pregnant woman is under 18, the professional must report to the police as well as refer to Bromley C&F Hub**, as per the Mandatory Reporting Duty (see Section 3.2).

Midwives should offer pregnant women a referral to the Consultant led specialist clinic to discuss any health concerns they may have as a result of FGM.

3.5 Referral: where an adult woman has undergone 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 is an 'adult at risk' under Safeguarding Adults regulations (and therefore is considered to be unable to protect herself from harm). For 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 entirely 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.

Referral 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.

If a woman over the age of 18 has had FGM, or if you have good reason to suspect they are at risk of FGM having considered their family history or other relevant factors, you will need to consider what action should be taken. This is particularly important if the woman has young female children.

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 likely to be important to establish when and where this took place. This should lead to enquiries about other daughters, cousins or girls in the wider family context.

4 FOLLOW-UP RESPONSE BY AGENCIES

4.1 FGMPOs and follow-up by Police for a child under 18 years

Anyone can apply for a Female Genital Mutilation Protection Order (FGMPO) if they think someone they know is at risk of FGM. This will help to keep them safe. They can also request that someone else (e.g. from the Local Authority) applies for it on their behalf. It is also possible to apply for a FGMPO even if someone is already a victim of FGM, for example so that the victim cannot be prevented from returning to the UK. The application form and process are available on <https://www.gov.uk/female-genital-mutilation-protection-order>.

4.1.1 When a child under 18 years is at risk of FGM

If any officer believes that the girl could be at immediate risk of significant harm, they should consider the use of a Female Genital Mutilation Protection Order (FGMPO) or police protection powers under section 46 of the Children Act 1989 and remove the girl to a place of safety. In addition, local authority children's social care should consider the use of a Prohibitive Steps Order or Emergency Protection Order. The welfare of other children within the family, in particular female siblings, should be reviewed.

The investigation should be the subject of regular on-going multi-agency reviews to discuss the outcome and any further protective steps that need to be taken with regard to that girl and any other siblings.

4.1.2 When a child under 18 is thought to have already undergone FGM

If it is believed or known that a girl has undergone FGM, a strategy meeting must be held as soon as practicable (and in line with statutory guidance) to discuss the implications for the child and the coordination of the criminal investigation.

This should also be used as an opportunity to assess the need for support services such as counselling and medical help as appropriate. Police officers may want to refer to the Crown Prosecution Service's guidance document entitled '[Provision of Therapy for Child Witnesses Prior to a Criminal Trial](#)' as well as the [Department of Health Multi-Agency Practice Guidelines on FGM](#). A second strategy meeting should take place within ten working days of the initial referral.

4.1.3 Interviews conducted by Police about FGM

As with all criminal investigations, children and young people should be interviewed under the relevant procedure/guidelines (e.g. Achieving Best Evidence/ Video Recorded Interview) to obtain the best possible evidence for use in any prosecution. Consent should be obtained to record the interview and for allowing the use of the interview in family and/or criminal courts, unless this would hinder the investigation.

In addition, information gained from the interview process will enable a risk assessment to be conducted as to the risk to any other children or siblings. Corroborative evidence should be sought through a medical examination carried out by a doctor experienced in examining female genitalia.

4.2 Follow-up by Children's Social Care for children under 18 years

4.2.1 Where a child is at risk of FGM

If the information gathered suggests likelihood of FGM, then further to existing Child Protection Procedures a Section 47 investigation should be initiated.

On receipt of a referral, a strategy meeting/discussion must be convened within two working days and should involve the referring agency and representatives from the police, children's social care, health and where appropriate, education, and third sector services. Health providers or third sector organisations with specific expertise (e.g., FGM, domestic violence and / or sexual abuse) must be invited, and consideration may also be given to inviting a legal advisor.

Where the Section 47 Enquiry finds that the child is at risk of harm a Child Protection Conference may be appropriate in order to consider whether a Child Protection Plan is needed.

Where the outcome of the strategy meeting determines that the risk to the child is considered to be more immediate it may be necessary to seek appropriate legal orders to protect the child, such as an emergency protection order. If there is any suggestion

that the family still intends to subject that child to FGM, the first priority is the protection of the child, and the least intrusive legal action should be taken to ensure the child's safety. The first consideration should be informing the parents of the law and the dangers of FGM. This can be done by representatives from schools, local authority children's social care, health professionals and/or the police.

If threshold for a Section 47 investigation is not met, the management rationale must be provided and shared with partners.

4.2.2 When a child is thought to have already undergone FGM

A strategy meeting/discussion will need to consider carefully whether to continue enquiries or whether to assess the need for support services. The meeting needs to consider if the child or young person has health needs resulting from FGM and how they will 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.

Where FGM has been practiced, the police child abuse investigation team (CAIT) will take a lead role in the investigation of this serious crime, working to common joint investigative practices and in line with strategy agreements.

4.2.3 Strategy Meeting Considerations

The following issues should be part of the agenda in any strategy discussion regarding FGM:

- Use of an interpreter in all dealings with the family
- Provision of appropriate advice and information to the family where this has not already occurred, regarding the law and harmful consequences of FGM
- Where FGM has already occurred the Strategy Discussion should discuss how, where and when the procedure was performed and the implication of this
- The provision of counselling and support services to the child/young person
- Risk to siblings and other children in the community
- Any intelligence on who has or is to perform the mutilation
- The immediate health needs of the child
- The possibility for prosecution
- The referrer should be invited to Strategy meetings, regardless of whether professionals from the same sector/agency are also in attendance. This is so that detailed referral information can be shared with partners. Social Workers should consult with their team manager if there are concerns about whether or not to invite the referrer.

- The primary focus of a Strategy Meeting is risk of harm to the child. Where a LADO issue arises, this should be followed up immediately after the Strategy Meeting.

4.3 Follow-up to expectant mothers who have already undergone FGM

Midwives should offer pregnant women a referral to the Consultant led specialist clinic to discuss any health concerns they may have as a result of FGM. They can also signpost women to local support and community groups (see **Appendix B**).

If Children's Social Care (CSC) accepts the referral of a pregnant woman because of indications of future harm to the unborn child (FGM or other safeguarding concerns), CSC will record the information and continue to assess risk. Local safeguarding procedures will be initiated as and when appropriate (see section 4.2). Subsequent risk assessment and follow ups will not be carried out unless the unborn child is deemed to be at risk or the mother is under 18.

4.4 Follow-up to Adult Women at Risk of or who have had FGM

Professionals should seek to support women by offering referrals to community groups who can provide support, clinical intervention or other services as appropriate, for example through an NHS FGM clinic. See **Appendix B** for details

A woman may be under pressure from her husband, partner or other family members to allow or arrange for her daughter to be cut. Practitioners should also be aware that a woman from a non-practising country may have a partner from a FGM-practising country which may have consequences for their female children. Wider family engagement and discussions with both parents and potentially wider family members may be appropriate if it is safe to do so.

5 RECORDING AND INFORMATION SHARING

5.1 Health Recording of FGM: Enhanced Data Collection Requirements

It is now mandatory for any NHS healthcare professional to record within a patient's clinical record if they identify through the delivery of healthcare services that a woman or girl has had FGM.

Acute Trusts, GPs and mental health trusts now have a mandatory duty to collate and submit patient identifiable details about the number of patients treated who have had FGM to the Department of Health every month. This enhanced data collection will inform service development, commissioning intentions and needs analysis.

The requirement is to record FGM in a patient's healthcare record only if and when it is identified during the delivery of any NHS healthcare. Professionals are reminded to be aware of the risk factors, including country of origin (refer to **Appendix F**), and to use their professional judgement to decide when to ask the patient if they have had FGM. Further information is available at <https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/female-genital-mutilation-datasets>

A child's red book (0-5 years) can be used to document risk of FGM.

5.2 Social Care recording of FGM

All contact with the referrer should be recorded as well as the information gathered by the referrer.

There is a FGM risk factor which can be marked in the Children's Social Care software. The new statutory guidance for the Children in Need census also requires FGM to be recorded as a risk factor at the end of assessment.

In addition to this, the Social Care secure database has a FGM flag which can be used for individual cases.

The FGM factor should be reported when it is known or suspected that a girl has been subjected to FGM or is perceived to be at risk of FGM. With regard to 'at risk', it should only be recorded if the girl herself is perceived to be at risk, not if the only 'risk factor' is that her family is from a 'practising community'.

5.3 School Recording of FGM

All interventions should be accurately recorded by the persons involved in speaking with the child or young person. All recording should be dated and signed and give the full name and role of the person making the recording. Whenever a child transfers schools, it is important to ensure that the record and all assessments with regard to FGM are transferred.

5.4 Information Sharing

It remains best practice to share information between healthcare professionals to support the ongoing provision of care and efforts to safeguard women and girls against FGM. For example, after a woman has given birth, it is best practice to include information about her FGM status in the discharge summary record sent to the GP and Health Visitor, and to include that there is a family history of FGM within the Personal Child Health Record (PCHR), often called the 'red book'.

Children at risk of FGM will be monitored through to school leaving age using routine opportunities to have a discussion with parents to check that their views have not changed since the previous review. Routine opportunities include developmental checks, national child measurement programme and immunisation. Discussions should be documented within the child's records. These existing systems can effectively "track" or monitor and act on risk to ensure children are protected during vulnerable periods (such as school holidays, onset of puberty). This ensures a proactive approach to tackling FGM through engaging schools, families and children themselves in an age-appropriate way.

5.5 FGM Risk Information Sharing (FGM-IS)

FGM RIS provides a national IT system for sharing information highlighting a family's history of FGM. Information is added after the birth of a female infant to a mother who has undergone FGM. Information includes:

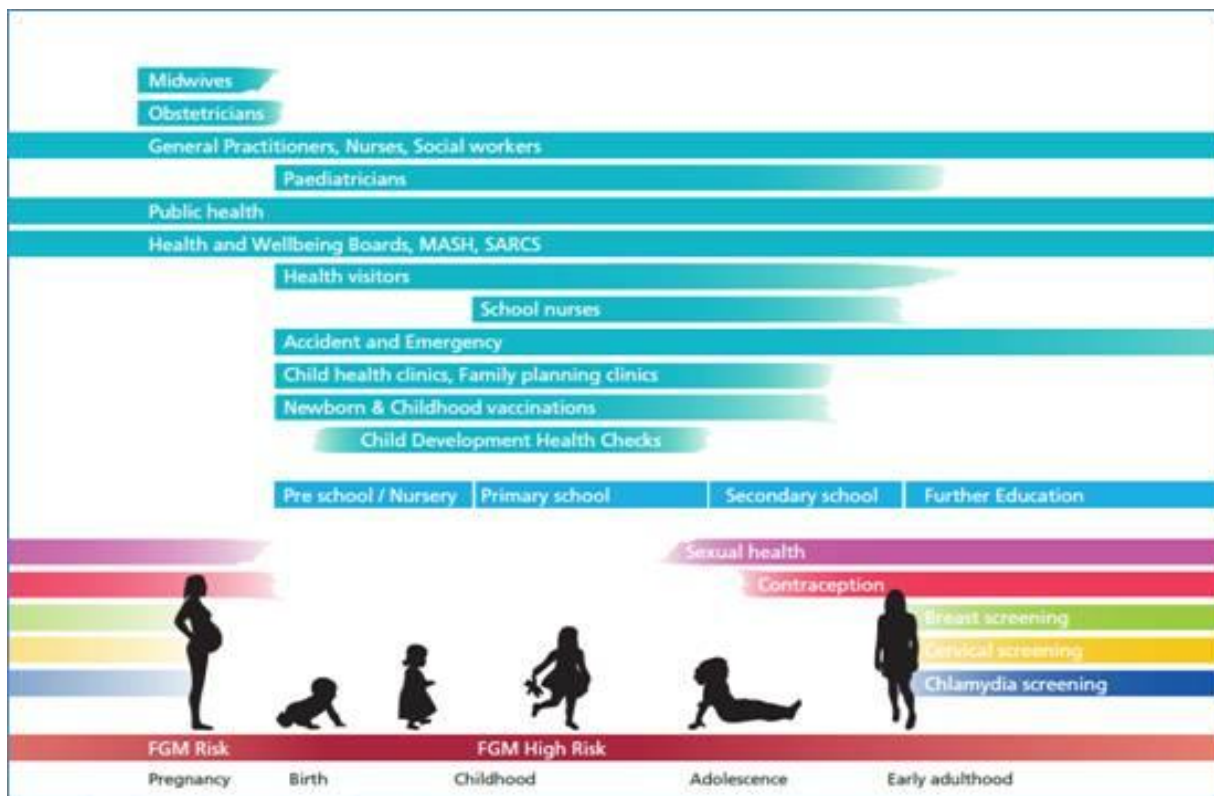
- An indicator a girl is potentially at risk of FGM
- The date the risk assessment for FGM was carried out and added to the system

Access to this information is controlled by NHS Smartcards and role-based access codes. This system prompts clinicians treating a girl that she has a family history of FGM.

Consent to share this information is not required, however in the interest of transparency all families that disclose a history of FGM are informed of the need to share information if a female child is delivered.

NHS organisations should be able to demonstrate compliance with the guidance and duty.

FGM flags must only be added to FGM-IS following confirmation from the FGM Referral Centre or disclosure from Mother that she has survived FGM. See **Appendix B** for Referral Centre contact details.



5.6 Community Responsibility to eradicate FGM

Community engagement is essential to prevent and eradicate FGM – focusing on the removal of barriers to empower women and girls to seek support and assistance. This should be facilitated by promoting open dialogue and active involvement. This is key to changing attitudes towards FGM in communities where it is still an accepted practice, using key community figures and faith leaders. Engagement is an essential part of change, as prevailing attitudes to the practice simply by “telling” people not to do it will not ultimately lead to full eradication of the practice.

Working with men should also be considered and the annual ‘FGM week’ in February is an opportunity to raise the profile of the need to prevent FGM.

6 CONTACT DETAILS AND ESSENTIAL INFORMATION

6.1 Review of Protocol

This protocol will be reviewed annually by the Bromley Safeguarding Children's Partnership, unless there are national changes to law or guidance, in which case it should be sooner.

6.2 Escalation Procedure

Please refer to the BSCP Escalation Policy at <http://www.bromleysafeguarding.org>

6.3 Local Authority Contact Details

Bromley Children Services Important Contact Details

Children and Families Hub
London Borough of Bromley Council
Civic Centre
Churchill Court
2 Westmoreland Road
BROMLEY BR1 1AS

Referrals should be made via the C&F Hub portal at: [Bromley Children and Families Hub](#)

If you need to discuss your referral first, you can:

Call: Children's services (Monday to Friday 8.30am - 5pm): 020 8461 7373 / 7379
Out of hours/weekends/public holidays 0300 303 8671

Email: Bromley Children and Families Hub (C&F Hub) CandFhub@bromley.gov.uk

Bromley Adult Social Care Important Contact Details

Adult Services Initial Response Team
London Borough of Bromley Council
Civic Centre
Churchill Court
2 Westmoreland Road
BROMLEY BR1 1AS

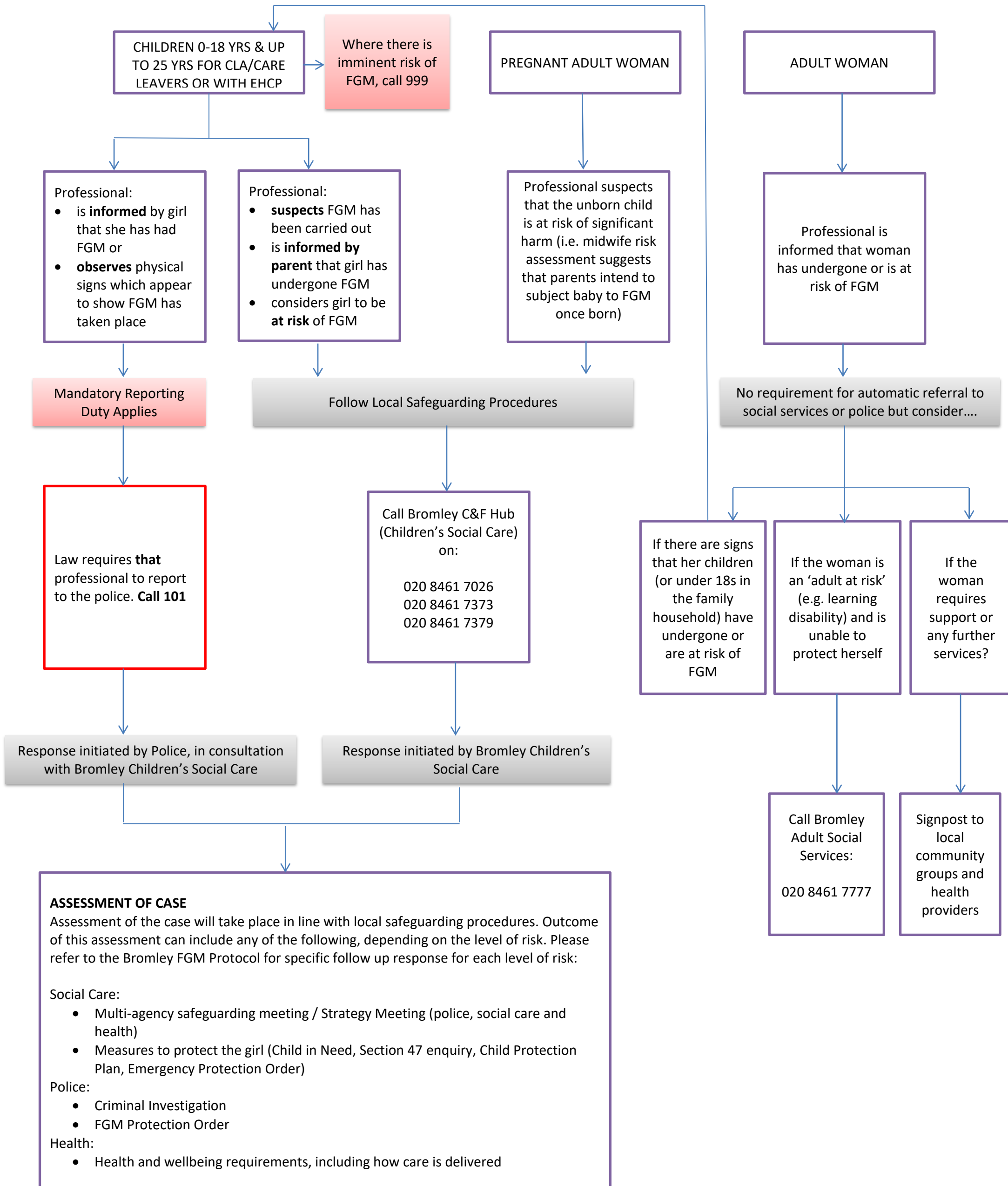
If you are concerned that an adult is at risk of abuse, call Bromley Council:
020 8461 7777

Out of hours emergencies only: 0300 303 8671 on Monday to Friday from 5.00pm to 8.30am, and during weekends.

Email: adultsocialcare@bromley.gov.uk

Appendix A: Bromley Multi-Agency Referral Pathway

This referral pathway can be used by all professionals including schools, health, local authority and voluntary sector



Appendix B

Support Services

National FGM Centre

The National FGM Centre's Vision is to keep children and young people safe from FGM and other Harmful Practices, including ending new cases of FGM by 2030. The National FGM Centre is a partnership between Barnardo's and the Local Government Association (LGA) and is funded by the Department of Education as part of its Children's Social Care Innovation Programme. The team includes frontline Social Workers, Children Service Managers and the National Lead for Strategic Partnering and Sustainability.

Resources can be found on their website, including: Direct Work Toolkit, Assessment Tool for Social Works, Medical Examination Guidance, Mandatory Reporting Guidance and Guidance for Healthcare Staff: <http://nationalfgmcentre.org.uk/fgm/>

Victim Support and Independent Domestic Violence Advocates

Victim Support provides Independent Domestic Violence Advocates (IDVA) in Bromley for women who are victims of domestic abuse, including FGM.

One IDVA is based at Princess Royal University Hospital (PRUH) and receives referrals directly from all departments, including the Emergency Department and Maternity. The IDVA provides support to any domestic abuse victim identified at the hospital and on discharge will refer out of borough residents to relevant services.

A second IDVA is a community based IDVA providing additional support to the local DV Service providers (Victim Support), overflow from the hospital IDVA and IRIS (Identification and Referral to Improve Safety) IDVA and also identifies gaps within the community with a focus on hard-to-reach communities.

The third IDVA works across 25 GP practices to deliver training to staff and to enhance referral pathways into the IDVA and other DV service providers.

FGM Service at University College London Hospital

Referral information for Healthcare Professionals: University College London

Consultant Gynaecologist

University College London Hospitals Foundation Trust

Clinic 3

[Elizabeth Garrett Anderson Wing](#)

235, Euston Road

London NW1 2BU

Tel No: Tel: 020 3447 9411

E-mail: uclh.fgmreferrals@nhs.net

uclh.admin.generalgynaecology@nhs.net

Children's FGM Service: University College London Hospitals

Children's Female Genital Cutting / Mutilation (FGC/M) service

University College Hospital

Children's Safeguarding

6th Floor North

250 Euston Road

London

NW1 2PG

Tel No: **020 3447 5241**

E-mail: uclh.cypsafeguarding@nhs.net

Children's Referrals

Tel No: **020 3447 7396**

E-mail: uclh.cypsafeguarding@nhs.net

Where do tertiary referrals come from?

Social services, health professionals, as well as self-referrals. The clinic offers a second opinion on DVD recordings of genital examinations from clinicians working nationally in other services where FGC/M is suspected. GOV.uk Female genital mutilation: help and advice

Bromley Community Wellbeing Service for Children and Young People

<https://bromley-y.org/>

Telephone: 020 3770 8848

Bromley Y is a long established local agency offering free therapeutic support to young people between the ages of 0 -18 years. Bromley Y aims to provide a safe, friendly environment for young people to explore the difficulties that they may be experiencing, helping them to identify new ways forward. They aim to provide the highest quality, non-discriminatory service for young people and their families who live in Bromley.

NSPCC FGM Helpline

Email: help@NSPCC.org.uk Telephone: 0800 028 3550

You can also search for help and advice in your area using your postcode:

<https://www.gov.uk/female-genital-mutilation-help-advice>

Appendix C FGM Training

Training from government

- [Female genital mutilation - GOV.UK](#) an e-learning tool from the Home Office; www.gov.uk/government/collections/female-genital-mutilation
- [Female Genital Mutilation - elearning for healthcare](#)
- The Female Genital Mutilation programme (e-FGM) is made up of five 20 to 30 minute elearning sessions which are designed to improve the knowledge and awareness amongst healthcare professionals of some of the issues which FGM has on women and children.

Training from other sources:

- The [Foundation](#) for Women's Health Research and Development (FORWARD) trains professionals and organisations on FGM and child protection issues - their sessions are tailored to the specific needs, issues and concerns of individuals and organisations and include:
 - **FGM Training Programme**, [Accredited Professionals Training | FORWARD](#) accredited and tailored developed training for professionals on FGM
 - **FGM awareness sessions for schools by FORWARD**, [Schools & Higher Education | FORWARD](#) FGM awareness sessions for students, plus teacher training on FGM and how to respond appropriately

Videos

- **'Survivors' Voices: Health Consequences of FGM'** is available on: <http://nationalfgmcentre.org.uk/fgm/>
- **'Ending female genital mutilation'** is available on You Tube. To reach communities the Home Office has produced a DVD with interviews with health professionals, survivors and the NSPCC. This DVD will help supported advocates within communities, such as community leaders, to run educational sessions on FGM in trusted environments and to start conversations on the issue. This film is 8 minutes long.
- **'Think again'** is available on You Tube and is a thought-provoking film, produced by FORWARD, which follows a 12-year-old's struggle between family hope and safeguarding her rights.

- FGM is child abuse. Link: [FGM is child abuse](#), by NHS Choices. It contains a 5-minute film produced by NHS Choices about what FGM is and where to find help if you or someone you know is at risk of FGM.

Appendix D References

- [Children Act of 1989](#)
- [Pre-Trial Therapy | The Crown Prosecution Service](#)
- [Department of Health Guidance \(2016\) Female Genital Mutilation Risk and Safeguarding: Guidance for Professionals \(May 2016\)](#)
- [Department of Health Guidance \(2017\) FGM Safeguarding and Risk Assessment: Quick guide for Health Professionals](#)
- [Department of Health \(2015\): Commissioning Services to Support Women and Girls with Female Genital Mutilation](#)
- [HM Government: Working Together 2023](#)
- [Home Office and Department of Education \(2014\): Multi-Agency Practice Guidelines on FGM](#)
- [London Safeguarding Children Board \(2015\): London Safeguarding Procedures](#)
- [Royal College of Midwives \(2015\): Tackling FGM in the UK- Intercollegiate recommendations for identifying, recording and reporting](#)
- [Tackling FGM in the UK | Royal College of Nursing \(2013\)](#)
- [Serious Crime Act 2015](#)

- **World Health Organisation (2008): Eliminating Female Genital Mutilation – An Interagency Statement on behalf of OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO**

Appendix E

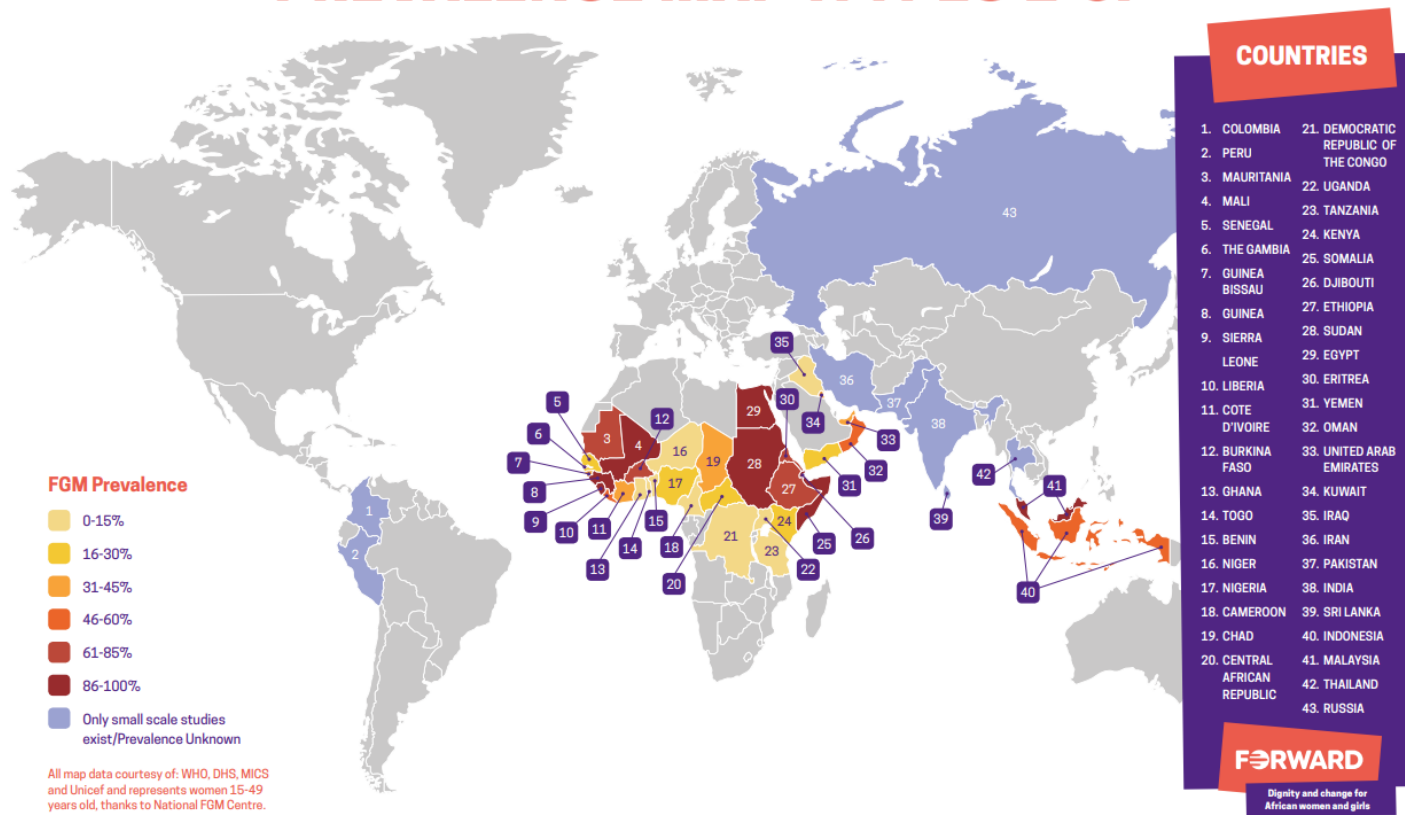
List of Regulated Bodies Included in Mandatory Reporting Duty

The duty applies to all regulated professionals (as defined in section 5B(2)(a), (11) and (12) of the 2003 Act) working within health or social care, and teachers. It therefore covers:

- Health and social care professionals regulated by a body which is overseen by the Professional Standards Authority for Health and Social Care (with the exception of the Pharmaceutical Society of Northern Ireland). This includes those regulated by the:
 - General Chiropractic Council
 - General Dental Council
 - General Medical Council
 - General Optical Council
 - General Osteopathic Council
 - General Pharmaceutical Council
 - Health and Care Professions Council (whose role includes the regulation of social workers in England)
 - Nursing and Midwifery Council
- Teachers - this includes qualified teachers or persons who are employed or engaged to carry out teaching work in schools and other institutions, and, in Wales, education practitioners regulated by the Education Workforce Council.
- Social care workers in Wales.

Appendix F- For interactive prevalence map: <http://nationalfgmcentre.org.uk/world-fgm-prevalence-map/>

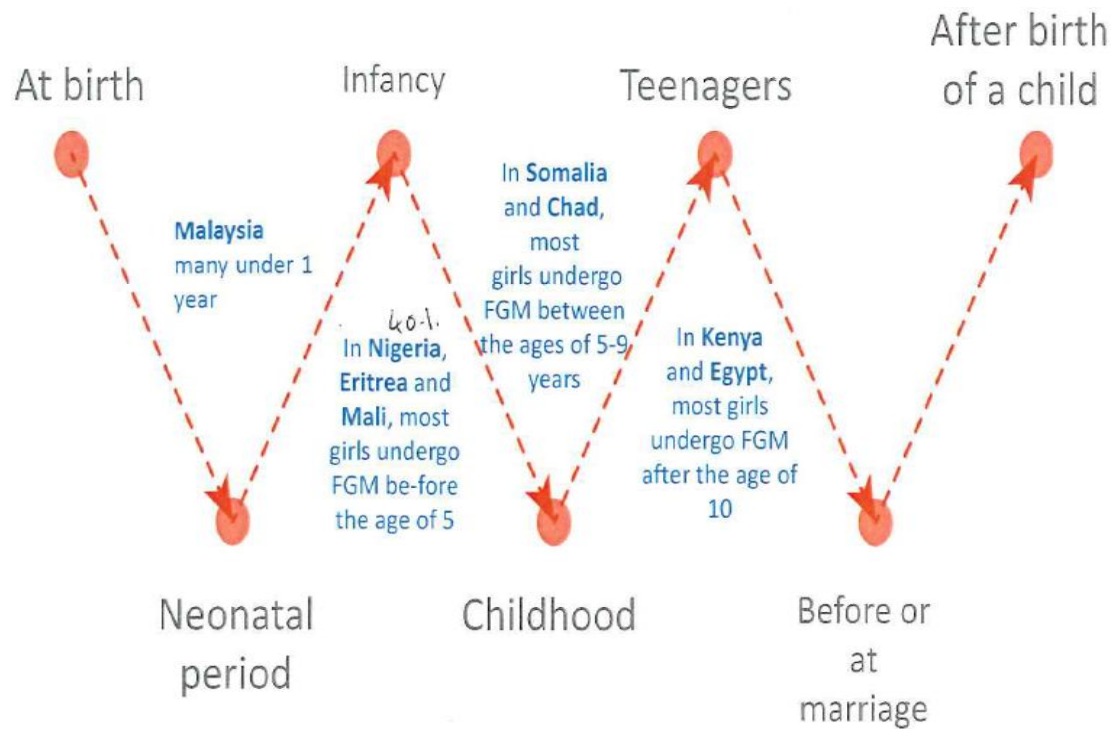
GLOBAL FEMALE GENITAL MUTILATION (FGM) PREVALENCE MAP (TYPES 1-3)



Appendix G

Age when FGM is likely to practised, based on cultural background

In 50% of cases FGM is carried out before the age of five



Reproduced with permission of the author, Dr Deborah Hodes, Consultant Paediatrician at University College London Hospital.

Appendix H Traditional and Local terms for FGM

The table below provides alternative terminology for FGM. Please note that this is not an exhaustive list.

| Country | Term Used for FGM | Language | Meaning |
|--------------|--|------------------------|---|
| Gambia | Niaka | Mandinka | Circumcision/Cutting |
| | Kuyango | Mandinka | Meaning "the affair "but also the name for the shed built for initiates |
| | Musolla Karoola | Mandinka | Meaning 'the women's side/that which concerns women |
| Egypt | Thara | Arabic | Deriving from the Arabic word 'Tahar' meaning to clean/purify |
| | Khitan | Arabic | Circumcision- used for both FGM and male |
| | Khifad | Arabic | Deriving from Arabic word 'khafad' meaning to lower (rarely used in everyday language |
| Ethiopia | Mergez | Amharic | Circumcision/cutting |
| | Abusm | Harrari | Name giving ritual |
| Eritrea | Kutari | Swahili | Circumcision-used for both FGM and male circumcision |
| | Mekhnishab | Tigreña | Circumcision/Cutting |
| Kenya | Kutairi | Swahili | Circumcision of girls |
| | Kutairi was ichana | Swahili | Circumcision of girls |
| Nigeria | Ibi/Ugwu | Igbo | The act of cutting-used for both FGM and male circumcision |
| | Didabbe fun omobirin/ila kiko fun omobirin | Yoruba | Religious tradition/obligation for Muslims |
| Mali | Sunna | Soussou | Religious tradition/obligation-for Muslims |
| Sierra Leone | Bondo | Temenee/Mandingo/Limba | Integral part of the initiation into adulthood-for Muslims |

General

| | | | |
|-----------------|-------------------|-------------|---|
| | Bondo/Sonde | Mendee | Integral part of an initiation rite into adulthood |
| | Sunna | Soussou | Religious tradition/obligation for Muslims |
| | Bondon | Limba | Religious tradition/obligation for Muslims |
| Somalia | Halalays | Somali | Derived from Arabic 'halal' ie. 'sanctioned'-implies purity. Used by Northern & Arabic speaking Somalis |
| | Gundiin | Somali | Circumcision used for both FGM and male circumcision |
| | Qodiin | Somali | Stitching/tightening/sewing refers to infibulation |
| Sudan | Tahoor | Arabic | Deriving from the Arabic work 'tahir' meaning to purify |
| | Khifad | Arabic | Deriving from Arabic word 'khafad' meaning to lower (rarely used in everyday language) |
| Chad- the Ngama | Gadja | Chad Arabic | Adapted from 'ganza' used in the Central African Republic |
| Sara subgroup | Fanadu di Mindjer | Kriolu | 'Circumcision of girls' |
| Guinea Bissau | Niaka | Mandinka | Literally to 'cut/weed clean' |
| Turkey | Kadin Sunneti | Turkish | |

As found in the **Female Genital Mutilation Risk and Safeguarding: Department of Health Guidance** HM Government (2016) Multi-Agency Statutory Guidance on Female Genital Mutilation

