



**BROMLEY**  
SAFEGUARDING ADULTS  
BOARD

# Bromley Female Genital Mutilation Guidance Document

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## **Foreword**

Bromley's Safeguarding Children Board 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 Board 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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# 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 Black Minority Ethnic (BME) residents represent 22.6% of the population in Bromley; however, BME represents 31.8% of the school 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.

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 reasons" (WHO, 1996). FGM has been classified by the WHO into four types:

- Type 1: Circumcision - Excision of the prepuce with or without excision of part or all of the clitoris
- Type 2: Excision (Clitoridectomy) - Excision of the clitoris with partial or total excision of the labia minora. After the healing process has taken place, scar tissue forms 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. Infibulation often (but not always) involves the complete removal of the clitoris, together with the labia minora and at least the anterior two-thirds and often the whole of the medial part of the labia majora

- Type 4: Unclassified - This includes all other procedures on the female genitalia, and any other procedure that falls under the definition of female genital mutilation given above. It includes prickings, genital piercings 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.

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 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 for 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.

## **1.4 Consequences of FGM**

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

1. Severe pain and shock
2. Infection
3. Urine retention
4. Injury to adjacent tissues
5. Immediate fatal haemorrhaging

Long-term implications can entail:

1. Extensive damage of the external reproductive system
2. Uterus, vaginal and pelvic infections
3. Cysts and neuromas
4. Increased risk of Vesico Vaginal Fistula
5. Complications in pregnancy and child birth
6. Psychological damage
7. Sexual dysfunction
8. Difficulties in menstruation

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 should explain all the risks to the victim and follow the necessary child or adult protection procedures.*

### 2.1 Signs that a child may be at risk of FGM

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)

## 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 guidance on how to ask a woman or child about FGM and should discuss this with their safeguarding lead.

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 Choices Website [here](#).

## 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.

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, this is the point at which the duty applies –**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, preferably with experience of dealing with cases of FGM. 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 21 for looked after children and to 25 for 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 Multi Agency Safeguarding Hub (MASH), 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 MASH can be found in Section 6.

### 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 MASH 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 the both the Police and the MASH.

#### 3.2.1 Mandatory Reporting Duty

If a child under 18 years old discloses to a professional that they have undergone FGM or where physical signs indicate 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 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 MASH (Children's Social Care)**

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

The referring agency should attempt to gather the relevant information before calling the MASH:

- 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 regards to other children of 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 MASH. However, **if the matter is urgent and you think there is an imminent risk, ring the police on 999 or MASH 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 MASH:

- 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 regards 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 MASH. However, **referral to the MASH 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 MASH**, 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 Follow-up by Police for a child under 18 years**

If officers or members of police staff believe that a girl may be at risk of undergoing FGM, the duty inspector must be made aware and an immediate referral should be made to their local child abuse investigation team (CAIT).

Outside the core hours, the duty inspector must ensure that appropriate protection measures are put in place and the on-call CAIT DS is spoken to. The CAIT will in turn make an immediate referral to the relevant local authority children’s social care team.

#### **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) 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

### **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 MASH accepts the referral of a pregnant woman because of indications of future harm to the unborn child (FGM or other safeguarding concerns), MASH 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.

### **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 'Guardian' for use by the Social Care front door. 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 which is a change that will go live from April 2016.

In addition to this, the Social Care secure database has a FGM flag which can be used for individual cases. This will also go live from April 2016.

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 assessment with regard to FGM are transferred.

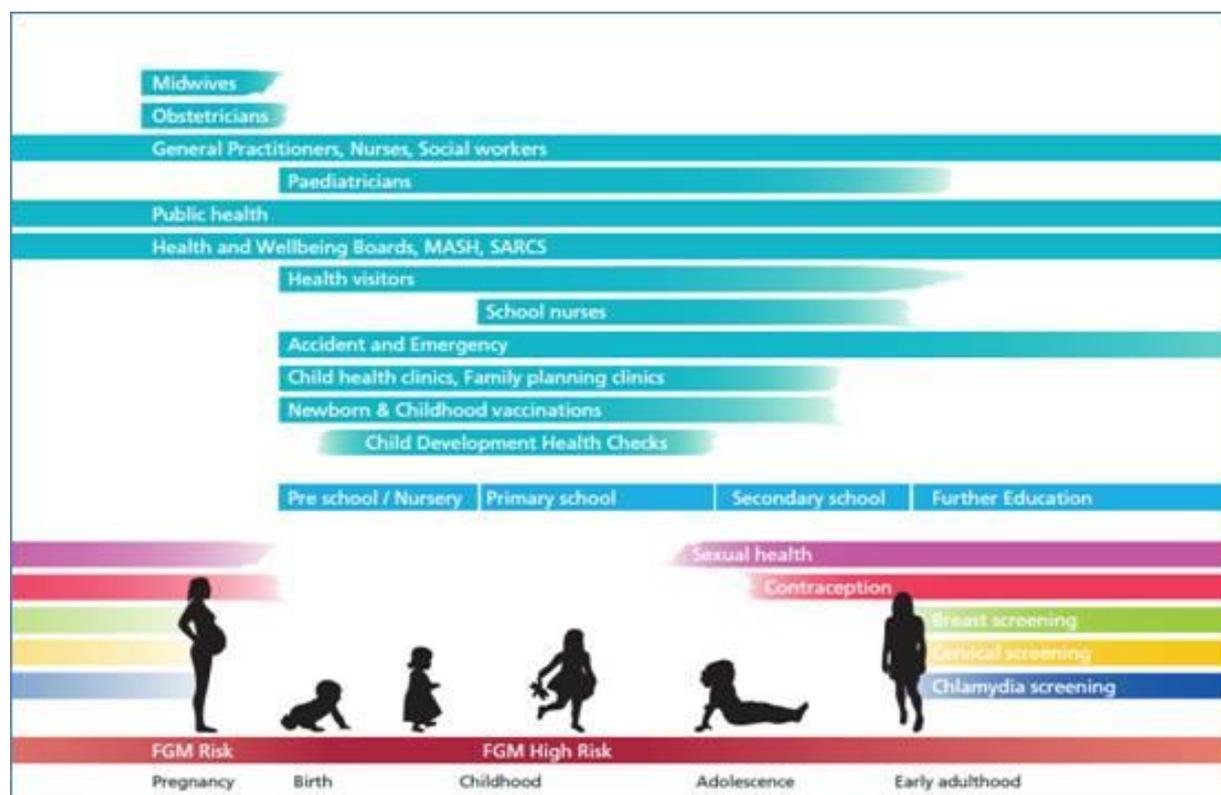
### **5.4 Information Sharing**

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.

NHS community staff are also required to share this information, such as sexual health clinics / GUM clinics. The illustration below taken from the [Intercollegiate Guidelines on FGM](#) clearly illustrates the routine opportunities that are already in place and should be utilised to measure and monitor FGM risk.



## 5.5 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 Policy and Procedures Sub Group of the BSCB, unless there are national changes to law or guidance, in which case it should be sooner. Any amendments, changes and additions will be ratified by the Bromley Safeguarding Children’s Boards.

### **6.2 Escalation Procedure**

Please refer to the BSCB Escalation Policy [here](#).

### **6.3 Local Authority Contact Details**

#### **Bromley Children Services Important Contact Details**

Multi Agency Safeguarding Hub (MASH)  
London Borough of Bromley Council  
Civic Centre  
Stockwell Close  
Bromley BR1 3UH

The MASH referral form (Referral into Social Care) can be found on:  
<http://www.bromleysafeguarding.org/documentdetails.asp>

MASH telephone numbers:

020 8461 7026

020 8461 7373

020 8461 7379

Out of hours emergency duty social worker:

0300 303 8671

Email: [mash@bromley.gov.uk](mailto:mash@bromley.gov.uk)

Secure Email: [mash@bromley.gcsx.gov.uk](mailto:mash@bromley.gcsx.gov.uk)

#### **Bromley Adult Social Care Important Contact Details**

Adult Early Intervention Service  
London Borough of Bromley Council  
Civic Centre  
Stockwell Close  
Bromley BR1 3UH

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

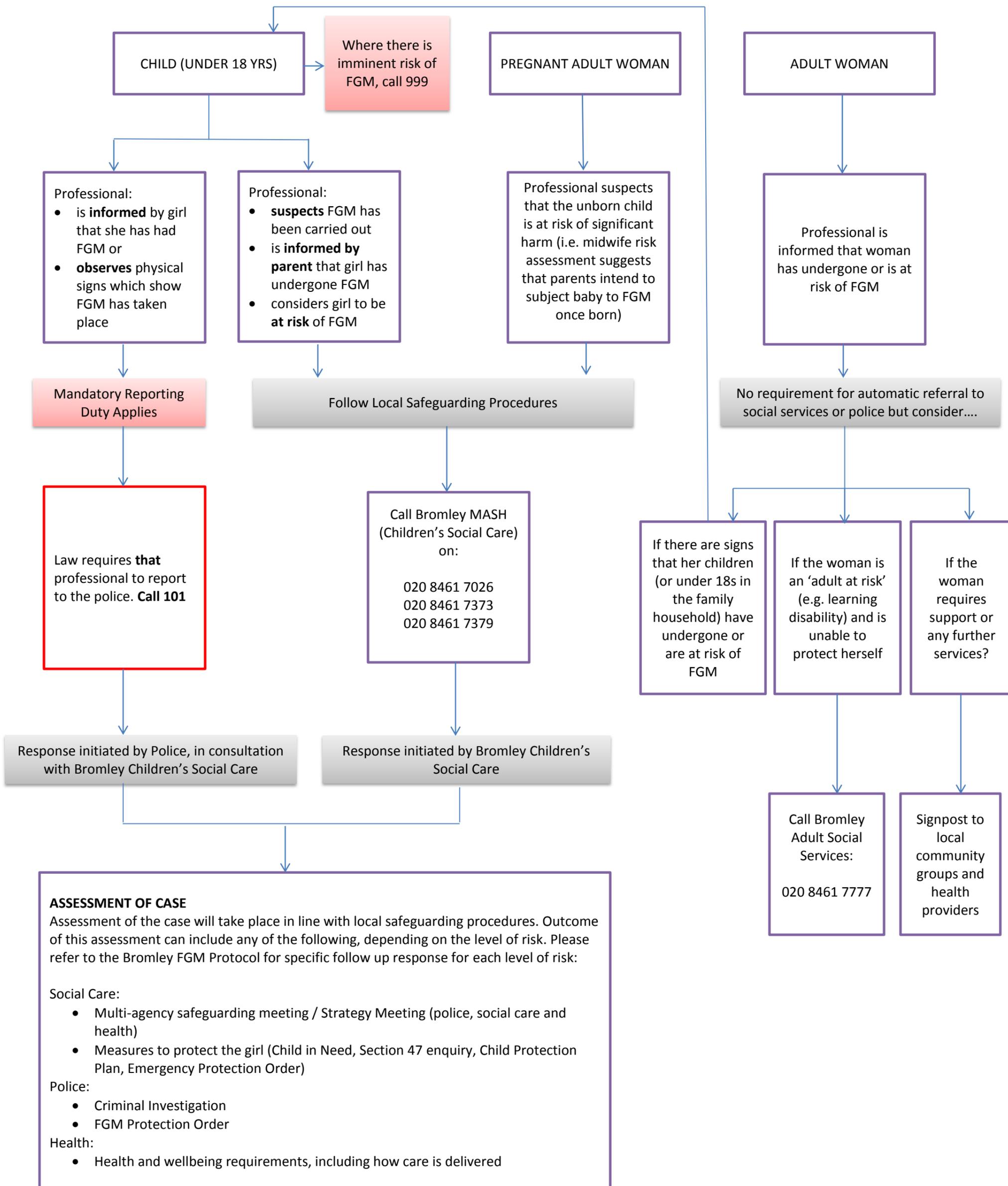
Out of hours emergencies only: 0300 303 8671 on Monday to Friday from 5.00pm to  
8.30am, and during weekends.

Email: [adult.early.intervention@bromley.gov.uk](mailto:adult.early.intervention@bromley.gov.uk)

Secure Email: [adult.early.intervention@bromley.gcsx.gov.uk](mailto:adult.early.intervention@bromley.gcsx.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**

### **Community Based Support Organisations**

#### **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), over flow 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.

#### **African Well Woman's Clinic**

Guy's & St Thomas's Hospital,  
8th Floor c/o Antenatal Clinic,  
Lambeth Palace Road,  
London,  
SE1 9RT

[www.gstt.nhs.uk](http://www.gstt.nhs.uk)

Telephone: 0790795642576

Opens every day. A specialist clinic which offers midwifery, obstetric and relevant gynaecological care for women who have undergone FGM. Also offers de-infibulation. Please ring Comfort Momoh first for an appointment. Languages spoken: English and Yoruba. Monday-Friday 9am-5.30pm. Criteria: Londonwide. Referrals: Self/professional referral.

#### **Daughters of Eve**

<http://www.dofeve.org/>  
Telephone: 07983030488

Daughters of Eve is a non-profit organisation that works to protect girls and young women who are at risk from female genital mutilation (FGM). By raising awareness about FGM and sign-posting support services they aim to help people who are affected

by FGM and ultimately help bring an end to this practice.

Their wider work is to advance and protect the physical, mental, sexual and reproductive health rights of young people from female genital mutilation practicing communities. They recognise that FGM occurs in the context of wider harmful practices and that young people often have many different problems. They take a holistic approach, offering advice and support to help young people in as many ways as possible.

### **Manor Gardens**

<http://www.manorgardenscentre.org/dahlia-support-fgm-survivors/>  
[www.mayacentre.org.uk](http://www.mayacentre.org.uk). [leyla@manorgardenscentre.org](mailto:leyla@manorgardenscentre.org)

Telephone: Maya Centre referral line: 0207 272 0995

Email: [admin@mayacentre.org.uk](mailto:admin@mayacentre.org.uk)

The Dahlia Project is a therapeutic support group and individual counselling service for women who have undergone FGM. This project is a partnership between Manor Gardens' Health Advocacy Service and The Maya Centre. They can provide support for women and girls who have undergone FGM. They can help women meet other women who have undergone FGM in a support group. Together, women can share experiences, learn ways to cope with the effects of FGM and build confidence to challenge the practice. It's a safe, non-judgemental space, and completely free.

### **Bromley Community Wellbeing Service for Children and Young People**

<http://www.bromleywellbeingcyp.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: [fgmhelp@nspcc.org.uk](mailto:fgmhelp@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

- **Recognising and Preventing FGM**, an e-learning tool from the Home Office: [www.fgmelearning.co.uk](http://www.fgmelearning.co.uk)
- **FGM e-learning programme on the eLearning for Healthcare website**: NHS organisations and professionals can access this training, which consists of 5 sessions that provide training on all aspects of FGM and standard care provision principles - NHS organisations should consider the training need within their organisation, and implement a training plan accordingly

### 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 and tailored developed training for professionals on FGM
  - **FGM awareness sessions for schools by FORWARD**, FGM awareness sessions for students, plus teacher training on FGM and how to respond appropriately
- **Values vs Violence** provides training to primary and secondary schools using the '**Cut – some wounds never heal**' DVD. This is a tool to raise awareness and understanding of FGM issues in schools and communities, 'Enter the password vvvuk2010 to view this film. Teachers should follow the **lesson plan** when viewing this film.
- Project Azure provides a range of training packages and DVDs on FGM, available to teachers, students and parents, and for outreach work. You can access these from the **POLKA website**. You will need to call 020 7161 2888 first, as the site is only available to police staff.

### Videos

- '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. 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**
- **Crown Prosecution Service (2002): Provision of Therapy for Child Witnesses Prior to a Criminal Trial**
- **Department of Health Guidance (2015) Female Genital Mutilation Risk and Safeguarding: Guidance for Professionals**
- **Department of Health Guidance (2015) Female Genital Mutilation Risk Assessment Safeguarding: Tool for Health Colleagues**
- **Department of Health (2015): Commissioning Services to Support Women and Girls with Female Genital Mutilation**
- **HM Government (2015): Working Together 2015**
- **Home Office and Department of Education (2014): Multi-Agency Practice Guidelines on FGM**
- **London Safeguarding Children Board (2015): London Child Protection Procedures**
- **Royal College of Midwives (2013): Tackling FGM in the UK- Intercollegiate recommendations for identifying, recording and reporting**
- **Serious Crime Act 2015**
- **World Health Organisation (2008): Eliminating Female Genital Mutilation – An Interagency Statement**

## Appendix E

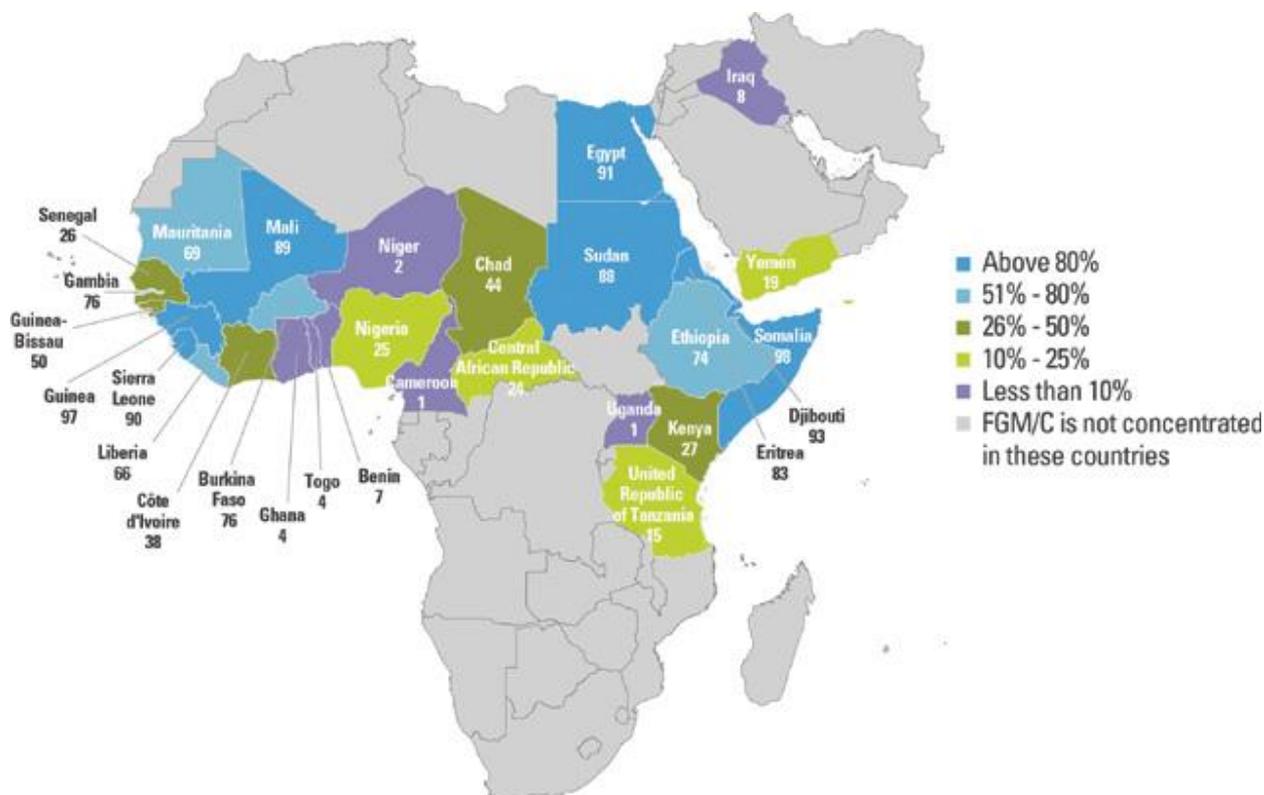
### List of Regulated Bodies Included in Mandatory Reporting Duty

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 Countries Where FGM is practised

FGM is concentrated in a swathe of countries from the Atlantic coast to the Horn of Africa and parts of the Middle East



FGM has also been documented in communities including:

- Iraq
- Israel
- Oman
- the United Arab Emirates
- the Occupied Palestinian Territories
- India
- Indonesia
- Malaysia
- Pakistan

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C

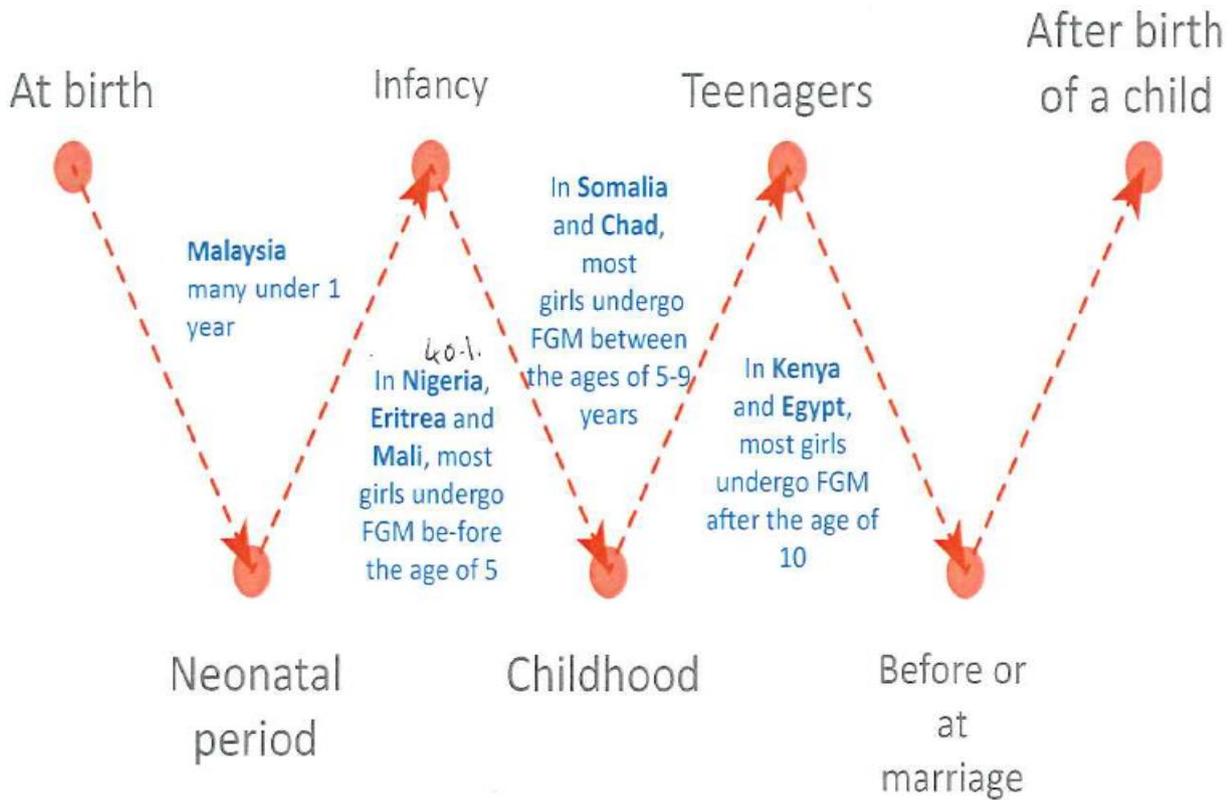
Note: In Liberia, girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM/C since it is performed during initiation into the society.

Source: UNICEF global databases, 2014, based on DHS, MICS and other nationally representative surveys, 2004-2013. <http://www.data.unicef.org/child-protection/fgmc> as found in the **Female Genital Mutilation Risk and Safeguarding: Department of Health Guidance for Professionals March 2015.**

## 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
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	Mekhnishab	Tigrena	Circumcision/Cutting
Kenya	Kutari	Swahili	Circumcision-used for both FGM and male circumcision
	<b>Kutairi</b>	<b>Swahili</b>	Circumcision of girls
Nigeria	Ibi/Ugwu	Igbo	The act of cutting-used for both FGM and male circumcision
	Sunna	Mandingo	Religious tradition/obligation for Muslims
Sierra Leone	Sunna	Soussou	Religious tradition/obligation-for Muslims
	Bondo	Temenee/Mandingo/Limba	Integral part of the initiation into adulthood-for Muslims
	Bondo/Sonde	Mendee	Integral part of an initiation rite into adulthood
Somalia	Gundiniin	Somali	Circumcision used for both FGM and male circumcision
	Halalays	Somali	Derived from Arabic 'halal' ie. 'sanctioned'-implies purity. Used by Northern & Arabic speaking Somalis
	Qodiin	Somali	Stitching/tightening/sewing refers to infibulation
Sudan	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
	Tahoor	Arabic	Deriving from the Arabic work 'tahar' meaning to purify
Chad- the Ngama	Bagne		Used by the Sara Madjingaye
Sara subgroup	Gadja		Adapted from 'ganza' used in the Central African Republic
Guinea Bissau	Fanadu di Mindjer	Kriolu	'Circumcision of girls'
Gambia	Niaka	Mandinka	Literally to 'cut/weed clean'
	Kuyango	Madinka	Meaning "the affair " but also the name for the shed built for initiates
	Musolula Karoola	Mandika	Meaning 'the women's side/that which concerns women

As found in the [Female Genital Mutilation Risk and Safeguarding: Department of Health Guidance for Professionals March 2015](#)

## Document Contributors

This document has been developed using the Lambeth/Southwark protocol as a guide.

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