Brent LSCB
FEMALE GENITAL MUTILATION
MULTI-AGENCY RISK ASSESSMENT GUIDANCE

July 2014
This guidance document was developed by Brent Local Safeguarding Children Board (LSCB) with contributions from all partner agencies and the voluntary sector.

All professionals have a duty to act to safeguarding girls and women at risk of FGM with four key issues to consider:

- FGM is illegal (FGM Act 2003)
- FGM for children is a form of child abuse
- FGM is not a religious practice, it is part of some cultures
- FGM can give rise to a range of acute, chronic physical conditions and psychological disorders; some health effects are potentially life threatening

Professionals have a legal duty to protect girls from FGM. In the UK, Section 31 of the Children Act (1989) sets out the thresholds for intervention of the unborn child of a prospective mother or a child/ren who is likely to suffer or is suffering from “significant harm”.

The Children Act 1989 defines ‘harm’ as “ill-treatment or the impairment of health or development”.¹

Where there is a suspicion or concern about FGM professionals must report, refer cases, document responses and share information between agencies

A: RISK TO FACTORS TO CONSIDER IN CHILDREN, GIRLS AND WOMEN

- Any female child born to a woman who has undergone FGM
- Any female child whose older sibling has undergone FGM
- Risk to other children in the woman or child’s household
- Women from areas with a high prevalence of FGM- At least 28 countries in Africa including Ethiopia, Egypt, Guinea, Sudan, Gambia, Burkina Faso, Somalia, Mali, Nigeria, Senegal and Central African Republic. A few countries in the Middle East including Yemen, Iraq Kurdish communities and Saudi Arabia
- Relative requesting FGM of a baby
- Relatives having undergone FGM
- Visits/holiday to area abroad where FGM is prevalent
- Higher risk age 5-8 years (but any aged child can be at as much risk)
- Prolonged absence from school
- Girl or woman may have frequent urinary or menstrual problems
- Girl withdrawn from personal, social and health education and sport
- Woman requesting re-infibulation post birth
- Women who are escaping violence within the family home

¹ ‘Development’ means physical, intellectual, emotional, social or behavioural development
B: SOCIAL CARE

- Where FGM referrals come to the attention of Children Social Care, a Section 47 assessment must be initiated.
- Parental cooperation; not making themselves available to see a Social Worker and discuss FGM openly.
- Parents who move quickly after their child is identified as being at risk of FGM
- Parental understanding and acceptance that FGM is illegal in the UK and their willingness to prevent their child being abused in this way.
- Where parents are unwilling or unable to protect their child from FGM the level of protection a child will need including CP plan or Children Looked After.
- If a child is going to be looked after by another family member their collusion in any activity that might increase the risk of FGM to a child
- Where an interpreter is being used, ensure they have had training in the area of FGM
- Please refer to the guidance: [http://www.londonscb.gov.uk/fgm/](http://www.londonscb.gov.uk/fgm/)

C: METROPOLITAN POLICE

- Strategy meeting within 48 hours Police, Children’s Social Care, Education, Health. (A second strategy meeting should take place within 10 working days of the initial referral)
- ABE Interview child/children and any female siblings if applicable. Consider significant witnesses.
- Medical Examination; Corroborative evidence is to be sought through a Medical examination conducted by a clinician with the competencies for such an examination.
- Where a child refuses to be interviewed or undergo medical examination, assistance is to be sought from an intermediary or community organisation.
- Search suspects and premises for documents and electronic devices that may provide evidence of arrangements for FGM / travel for FGM.
- Book certified Interpreters
- Liaise with local Borough Forensic Manager
- Consider assistance from international agencies and other agencies (ie. Foreign Commonwealth Office, International Social Services, Borders and Immigration agency
- Investigative Strategy – Apply golden hour principles and identify any intelligence opportunities
- Consult Crown Prosecution Service (CPS) at an early stage.
- Consider Cultural and Community Resources Unit (CCRU)

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

If any Police Officer or Police Staff is made aware that an adult female has undergone FGM, a multi-agency meeting must be convened to consider the risks to the woman. This meeting should discuss any potential risk to any girls within the family (and extended family) and consider initial and core assessments of those girls. It should also consider providing supportive services for the woman, including counselling and medical assistance.
D: HEALTH

- Professionals should identify girls at risk of FGM as early as possible and a clear plan of action including communication with relevant agencies detailed in records.
- Professionals should refer all woman and girls identified as having undergone FGM who give birth to female children to the Brent Family Front Door for discussion and review.
- All suspected cases where FGM is identified in a woman who presents at maternity services, the implication for the woman and her future child should be discussed by the midwife or doctor.
- Professionals should provide time for one to one conversations and information to women and girls from practising communities, encouraging girls and young women to report harm such as the prevention of physical and sexual abuse.
- Professionals should be familiar with the full, relevant practice guidance when dealing with any case of suspected FGM.

E: EDUCATION

- Knowing that the family belongs to a community in which FGM is practised and is making preparations for their female child to take a holiday, arranging vaccinations or planning absence from school.
- A child talking about a ‘special procedure/ceremony’ that is going to take place.
- Prolonged absence from school.
- Noticeable behaviour change on return and long periods away from classes or other normal activities, possibly with bladder or menstrual problems.
- Female children who find it difficult to sit still and look uncomfortable or may complain of pain between their legs after returning from a trip abroad or a school absence.
- Female children who avoid activity such as PE they would have engaged in prior to a holiday or school absence.
- A female child talking of something somebody did to them that they are not allowed to talk about.

All educational professionals must in the first instance inform the schools Designated Teacher for Child Protection who will follow the full, relevant practice guidance when dealing with any case of suspected FGM.

LINKS TO PROFESSIONAL RESOURCES on Prevention and Care of FGM


HM Government (2011) Multiagency Practice Guidelines: Female Genital Mutilation

Royal College of Midwives (RCN) Tackling FGM in the UK (2013) intercollegiate recommendations for identifying, recording and reporting