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Edinburgh and the Lothians Inter-Agency Procedures for the Protection of Girls and Women at Risk of Female Genital Mutilation (FGM)

Foreword

Local authorities, NHS boards and Police Scotland are responsible together for the protection of children and adults at risk in their area, and for the assessment and management of risk of harm posed by offenders. Chief executives and divisional police commanders ensure the discharge of these responsibilities through a variety of multi-agency arrangements, typically Child Protection Committees, Violence Against Women Partnerships, Adult Protection Committees, and Offender Management Committees. In some areas, broader Public Protection Committees exist, which has involved the amalgamation of the above committees under one framework. All committees report to local Chief Officer Groups (known in some areas as Critical Services Oversight Groups).

The four councils, single health board and two Police Scotland divisions covering the Edinburgh and Lothians work together wherever possible, demonstrating improved efficiency and shared resources. This provides opportunities for synergy and best value in public protection.

The Edinburgh and the Lothians Inter-Agency Procedures for the Protection of Girls and Women at Risk of Female Genital Mutilation (FGM) are evidence of our commitment to deliver high quality services for our children and young people under 18 years of age.

The Scottish Government has articulated its vision for Scotland's children in the publication of the refreshed National Guidance for Child Protection in Scotland (2014), setting out that all children and young people have the right to be cared for and protected from harm and abuse and to grow up in a safe environment, in which their rights are respected and their needs met. Children and young people should get the help they need, when they need it, and their welfare is always paramount. This document reflects the child protection arrangements set out in both the National Guidance for Child Protection in Scotland and the forthcoming National Guidance for responding to FGM in Scotland.

This document provides the procedures and processes to be followed by all services in dealing with concerns about FGM. The procedures reflect our collective commitment to inter-agency collaboration and joint responsibility in this vitally important area of work. They are mandatory for all staff from all agencies.

Contents

Introduction and Scope

These procedures are for all front line practitioners and volunteers who work with children and young people aged 0-18 as well as those working with parents and carers of children. It is for all agencies within Edinburgh and the Lothians; Police, Social Work, NHS Lothian, Education and the voluntary sector.

These procedures are primarily a child protection procedure for those under the age of 18 years; it provides information and directs individuals to appropriate guidance for adults who have been affected by FGM or may be at risk of FGM.

Female Genital Mutilation (FGM)

- **is not an acceptable practice,**
- **is illegal in the UK**
- **is a form of child abuse under UK law.**

These procedures sit within the framework of:

- The Edinburgh and Lothians Interagency Child Protection Procedures (2015)
- The National Guidance for Child Protection in Scotland (2014)
- Tackling FGM in the UK Intercollegiate recommendations for identifying, recording and reporting National intercollegiate guidance for FGM
- Getting it Right for Every Child

Guiding Principles

It is the duty of all professionals to look at every possible way that parental cooperation can be achieved, including the use of community organisations, to facilitate work with the parents and other family members. 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 with the least intrusive legal action being taken to ensure the child's safety.

This document is to guide those working with children and families as they:

- Approach and discuss this sensitive topic confidently
- Identify any girl who may be at risk of FGM
- Act appropriately in response to this concern
- Share information across and within agencies appropriately
- Initiate child protection procedures as indicated
- Gather, document and retain information meaningfully
- Contribute to education about and prevention of FGM within communities

If you are concerned about the immediate safety of a child or adult call police on 999

If there is an acute health need such as bleeding, acute pain, fever or similar call 999 or go immediately to an Accident and Emergency department.

Female Genital Mutilation (FGM) is a collective term for all procedures which include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons or any other injury to the female genital organs for non-medical reasons. FGM is a harmful practice. It can cause long-term mental and physical harm, difficulty in giving birth, infertility and even death.

FGM (FGM) is recognised internationally as a violation of human rights and a form of violence against women and girls.

FGM is practised in over 28 African countries, parts of the Middle and Far East. The following countries have the highest incidence of FGM: Djibouti (98%), Egypt (97%), Eritrea (95%), Guinea (99%), Mali (94%), Sierra Leone (90%), and Somalia (98-100%).

There is very little data documenting prevalence in the UK and Scotland because of the lack of reporting, knowledge or training. In 2004, it was estimated that 74,000 women in the UK had undergone FGM and a further 7,000 under the age of 17 were at risk. (The Department of Health, CMO Update 37,2004).

There were at least 23,979 men, women and children born in one of the 29 countries identified by UNICEF (2013) as an 'FGM-practising country', living in Scotland in 2011.

According the 2011 census, there were a total of 3,583 people living in Edinburgh from an FGM-practising country, with a further 190 in East Lothian, 153 in Midlothian and 320 in West Lothian (2011 census).

In terms of prevalence, the largest communities in Scotland potentially affected by FGM in 2011 were Nigeria (2,554), Somalia (1,559), Egypt (1,203), Kenya (741), Sudan (659), Eritrea (355), Sierra Leone (332) and the Gambia (281).

In 2012 there were 363 female births to mothers born in FGM practising countries in Scotland, representing a fivefold increase over the previous decade.

These procedures have been produced to support professional decision making in order to safeguard and promote the welfare of women and children affected by FGM.

International Standards

There are two international conventions, which contain articles, which apply to FGM. Signatory states, including the UK, have an obligation under these standards to take legal action against FGM.

The UN Convention on the Rights of the Child, ratified by the UK Government on 16th December 1991, was the first binding instrument explicitly addressing harmful traditional practices as a human rights violation. It specifically requires Governments to take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

The UN Convention on the Elimination of All Forms of Discrimination against Women, which came into force in 1981, recognises FGM as a form of gender based violence against women. It calls on signatory Governments to take appropriate and effective measures with a view to eradicating the practice, including introducing appropriate health care and education strategies.

These conventions have been strengthened by two world conferences. The International Conference on Population and Development (ICPD, Cairo, September 1994) mentioned and condemned FGM specifically in several of its articles. The World Conference on Women (Beijing 1995) also condemned FGM and called upon Governments to actively support programmes to stop it.

Legislation in Scotland

The Prohibition of Female Genital Mutilation (Scotland) Act (2005) makes it unlawful to carry out any FGM procedures on a girl or a woman. The Legislation makes it an offence to aid, abet, counsel, procure or incite a person to:

- Commit FGM
- Assist a girl to commit FGM on herself
- For someone in the UK to arrange or assist FGM to be performed out with the UK by a person who is not a UK national or permanent UK resident

It is an offence under the act for UK nationals, or permanent UK residents, to carry out FGM abroad, even in countries where the practice is not banned by law.

An amendment to the Prohibition of Female Genital Mutilation (Scotland) Act (2005) was passed by the UK Parliament within the UK Serious Crime Bill 2014. This change came into effect in 2015, and replaced the term "**permanent resident**" with "**habitually resident**". This will ensure that a person who is not legally termed a 'permanent UK resident' will still be able to be tried in the Scottish Courts.

Home Office statistics indicate that FGM is much more common than people realise, both worldwide and in the UK. The Legislation also allows a convicting court to refer the victim and any child living in the same household as the victim, or person convicted of the offence, to the reporter to the Children's Hearing. The reporter has grounds to refer such children to a children's hearing, under section 67 of the Children's Hearings (Scotland) Act 2011. These provisions also give the reporter grounds to refer to a children's hearing any other children who are, or become, or are likely to become members of the same household as either the victim or the offender.

Section 60 of the Children's Hearings (Scotland) Act 2011 outlines the local authority's duty to provide information to Principal Reporter:

(1) If a local authority considers that it is likely that subsection (2) applies in relation to a child in its area, it must make all necessary inquiries into the child's circumstances.

(2) This subsection applies where the local authority considers:

(a) That the child is in need of protection, guidance, treatment or control,

And

(b) That it might be necessary for a compulsory supervision order to be made in relation to the child.

(3) Where subsection (2) applies in relation to a child the local authority must give any information that it has about the child to the Principal Reporter.

The Police are subject to a similar duty under section 61 of the 2011 Act.

Information Sharing and Governance

Professionals in all agencies need to be confident and competent in sharing information appropriately, both to protect children from being abused through FGM and to enable children and women who have been abused through FGM to receive physical, emotional and psychological help[1].

Professionals in all agencies should share information in line with 7.4 of the Edinburgh and Lothians Inter-Agency Child Protection Procedures

Further details on information sharing can be located within Getting it Right for Every Child in Edinburgh and the Lothians: A Practitioner Guide to Information Sharing, Confidentiality and Consent to Support Children and Young People's Wellbeing

Section 60 of the Children's Hearings (Scotland) Act 2011, outlines the local authority's duty to provide information to Principal Reporter.

Section 61 of the Children's Hearings (Scotland) Act 2011 outlines a constable's duty to provide information to Principal Reporter.

Prevalence

An indication of FGM prevalence is attached as appendix A.

FGM is a deeply rooted tradition, widely practiced mainly among specific ethnic populations in Africa, the Middle East and parts of Asia.

The World Health Organisation (WHO) estimates that between 130-140 million girls and women have experienced FGM and up to two million girls per year undergo some form of the procedure each year.

FGM is practiced in more than 28 countries in Africa and in some countries in Asia and the Middle East, however in each of those countries the extent of the practice varies.

Women from non-African communities who are most likely to be affected by FGM include those from Yemeni, Iraqi, Kurdish communities, Malaysia and Pakistan.

[1] There is an advisory position from the Information Commissioner for Scotland relating to information sharing for child protection which can be found at ico.org.uk

Cultural Underpinnings

Female genital mutilation is a complex issue; despite the harm it causes, many women from FGM practicing communities consider FGM normal and desirable. FGM is linked to concepts of 'purity', beauty and suitability for marriage.

Infibulation, where there is closing or some form of stitching over the vaginal opening (see 'FGM types' on page 8) is strongly linked to concepts of virginity and chastity. It is used as a measure to prevent penetrative sexual intercourse outside marriage. In some cultures it is considered necessary at the time of marriage for the prospective husband and his family to see a woman 'closed'. In some instances both mothers will then take the woman to be 'cut open' enough to be able to have penetrative sexual intercourse. Women may also require further procedures to 'open' the closing over the vagina in order to give birth. The consequences of this are pain, bleeding, varying degrees of incapacity and psychological trauma.

Following delivery of an infant, women may be subject to further FGM procedures to 'close' her again. If a woman requests such a procedure following delivery of an infant, this must be taken seriously by all professionals. It is illegal to play any part in this. The desire for this form of FGM, or 're-infibulation' indicates a lack of understanding of the harmful effects of FGM, the legal aspects of FGM, and any daughter of a woman in these circumstances is regarded as being at high risk FGM.

Although FGM is practiced by secular communities, it may be claimed to be carried out in accordance with religious beliefs. However, neither the Bible nor the Koran justifies FGM. In 2006, senior Muslim clerics at an international conference on FGM in Egypt pronounced that FGM is 'not Islamic'.

Parents who support the practice of FGM may believe and say that they are acting in the child's best interests. The reasons they give include that it:

- Brings status and respect to the girl;
- Preserves a girl's virginity / chastity;
- Is part of being a woman;
- Is a rite of passage;
- Gives a girl social acceptance, especially for marriage;
- Upholds the family honour;
- Gives the girl and her family a sense of belonging to the community;
- Fulfils a religious requirement
- Perpetuates a custom/tradition;
- Helps girls and women to be clean and hygienic;
- Is cosmetically desirable; and
- Childbirth safer for the infant.

There is no justification to subject any woman or girl to FGM.

Cultural Change in the UK

Communities where FGM is traditionally practiced may exert considerable pressure, control and sometimes coercion towards women and parents of girls regarding FGM. Affected families may be extremely vulnerable. For example they may have few English language skills, be financially insecure, fleeing persecution in their country of origin, and be socially isolated or dependent on a few families known to them. The practice of FGM is also associated with forced marriage and young age at marriage. The powerful effect of 'shame' relating to FGM should be acknowledged and understood by professionals. There are increasing instances where young men and women who have grown up in the UK (and assimilated British cultural beliefs and attitudes) are experiencing difficulties amongst their peer group, e.g. young men rejecting girlfriends when they discover that she had FGM as a girl or discovering that not all girls are subjected to FGM. Young people who resist FGM can also experience conflict within their family and community.

Principles Supporting these Procedures

The following principles should be adopted by all agencies in relation to identifying and responding to children (and unborn children) at risk of or who have experienced female genital mutilation and their parent/s:

- The safety and welfare of the child is paramount;
- All agencies act in the interests of the rights of the child as stated in the UN Convention (1989);
- FGM is illegal and is prohibited by the Female Genital Mutilation Act 2003 and Prohibition of Female Genital Mutilation (Scotland) Act 2005;
- It is acknowledged that some families see FGM as an act of love rather than cruelty. However, FGM causes significant harm both in the short and long term and constitutes physical and emotional abuse to children;
- All decisions or plans for the child/ren should be based on good quality assessments and be sensitive to the issues of race, culture, gender, religion and sexuality, and avoid stigmatising the child or the practicing community as far as possible;
- Accessible, acceptable and sensitive Health, Education, Police, Children's Social Work and Voluntary Sector services must underpin this procedure;

All agencies should work in partnership with members of local communities, to empower individuals and groups to develop support networks and education programmes.

Types of FGM

FGM and other terms (see glossary) have been classified by the WHO into four types:

Type 1 (Circumcision): Excision of the prepuce with or without excision of part of or the entire clitoris.

Type 2: (Excision or Clitoridectomy): Excision of the clitoris with partial or total excision of the labia minora (small lips which cover and protect the opening of the vagina and the urinary opening). After the healing process has taken place, scar tissue forms to cover the upper part of the vulva (external female genitalia) region.

Type 3: (Infibulation or 'Pharaonic Circumcision'): This is the most extensive 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 (the outer lips of the genitals). The two sides of the vulva are then sewn together with silk, catgut sutures, or thorns leaving only a very small opening to allow for the passage of urine and menstrual flow. This opening is often preserved during healing by insertion of a foreign body.

Type 4 (Unclassified): This includes all other operations on the female genitalia including pricking, piercing or incising of the clitoris and or labia; stretching of the clitoris and or labia; cauterisation by burning of the clitoris and surrounding tissues; scraping of the tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above.

In practice it can be difficult to define the anatomy affected by FGM, and to allocate one of the WHO 'types'. A specialist examination by appropriately trained and experienced professionals is best practice.

Age and Procedure

The age at which girls are subjected to female genital mutilation varies greatly, from shortly after birth to any time up to and including adulthood. FGM is usually carried out by the older women in a practicing community, for whom it can be a way of gaining prestige and a source of income.

The arrangements for the procedure usually include the child being held down on the floor by several women and the procedure carried out without medical expertise, attention to hygiene and/ or anaesthesia. The instruments used include unsterilised household knives, razor blades, broken glass and stones. In addition, the child is subjected to the procedure unexpectedly. Increasingly some health professionals are performing FGM in the belief that it offers more protection from infection and pain. However, the medicalisation of FGM is condemned by all international groups, including the WHO.

Names for FGM

FGM is known by a number of names, including female genital cutting or circumcision. The term female circumcision is unfortunate because it is anatomically incorrect and gives a misleading analogy to male circumcision. The names 'FGM' or 'cut' are increasingly used at the community level, although they are still not always understood by individuals in practicing communities, largely because they are English terms.

For example, the Somali term for FGM is 'Gudnin' and the Sudanese word for FGM is 'Tahur'. A list of some terms used by different communities is attached as Appendix B.

Consequences of FGM

The health implications of the FGM procedure are variable and can be severe to fatal for a child, depending on the type and circumstances of the FGM carried out (Appendix C).

As with all forms of child abuse or trauma, the impact of FGM on a child will depend upon such factors as:

- The severity and nature of the violence;
- The individual child's innate resilience;
- The warmth and support the child receives in their relationship with their parent/s, siblings and other family members;
- The nature and length of the child's wider relationships and social networks;
- Previous or subsequent traumas experienced by the child;
- Particular characteristics of the child's gender, ethnic origin, age, (dis)ability, socio-economic and cultural background.

Short Term Implications for a Child's Health and Welfare

Short term health implications can include:

- Severe pain;
- Emotional and psychological shock (exacerbated by having to reconcile being subjected to the trauma by loving parents, extended family and friends);
- Haemorrhage (bleeding);
- Wound infections including Tetanus and blood borne viruses (including HIV and Hepatitis B and C);
- Urinary retention;
- Injury to adjacent tissues;
- Fracture or dislocation as a result of restraint;
- Damage to other organs;
- Death

Long Term Implications for a Girl or Woman's Health and Welfare

The longer term implications for women who have been subject to FGM Types 1 and 2 are likely to be related to the distress of the actual procedure and sexual function. Nevertheless, analysis of World Health Organisation data has shown that, as compared to women who have not undergone FGM, women who had been subject to any type of FGM showed an increase in complications in childbirth, worsening with Type 3. Therefore, although Type 3 creates most difficulties, professionals should respond proactively for all FGM types.

The health problems caused by FGM Type 3 are significant – urinary problems, difficulty with menstruation, pain during sex, lack of pleasurable sexual sensation, psychological problems, infertility, vaginal infections, specific problems during pregnancy and childbirth.

Women with FGM Type 3 require special care during pregnancy and childbirth.

The long term health implications of FGM include:

- Chronic vaginal and pelvic infections;
- Difficulties in menstruation;
- Difficulties in passing urine (takes a long time)and chronic urine infections;
- Renal impairment and possible renal failure;
- Damage to the reproductive system, including infertility;
- Infibulation cysts, neuromas and keloid scar formation;
- Complications in pregnancy and delay in the second stage of childbirth;
- Maternal or foetal death;
- Psychological damage; including a number of mental health and psychosexual problems including depression, anxiety, and sexual dysfunction;
- Increased risk of HIV and other sexually transmitted infections.

Mental Health Problems

Case histories and personal accounts from women note that FGM is an extremely traumatic experience for girls and women that stay with them for the rest of their lives.

Young women receiving psychological counselling in the UK report feelings of betrayal by parents, incompleteness, regret and anger. It is possible that as young women become more informed about FGM this problem may be more frequently identified. There is increasing awareness of the severe psychological consequences of FGM for girls and women, which become evident in mental health problems.

The results from research in practicing African communities are that women who have undergone FGM have the same levels of Post Traumatic Stress Disorder as adults who have been subject to early childhood abuse, and that the majority of the women (80%) suffer from affective (mood) or anxiety disorders.

The fact that FGM is 'culturally embedded' in a girl or woman's community does not protect her against the development of Post Traumatic Stress Disorder and other psychiatric disorders.

Professional Response

From the child protection perspective, there are three circumstances relating to FGM which require identification and intervention:

- Where a child is at risk of FGM
- Where a child has been abused through FGM
- Where a prospective mother (pregnant woman) has undergone FGM

Many professionals and volunteers in most agencies in Scotland have little or no experience of female genital mutilation. When coming across FGM for the first time, they can feel shocked, upset, helpless and unsure of how to respond appropriately to ensure that a child, and/or a mother, is protected from harm or further harm.

Concern about being 'racist' can be a barrier to professionals reacting to or enquiring about FGM. This should not prevent the professionals from following child protection guidance and procedures.

The appropriate response to FGM is to follow the Edinburgh and Lothians Inter-Agency Child Protection Procedures to ensure immediate protection and support for the child/ren. The Inter-Agency Referral Discussion will fully consider the most appropriate response to a child suspected of having undergone FGM as well as a child at risk of undergoing FGM, which may include:

- Arranging for an interpreter if this is necessary and appropriate; **Note that this should not be a family member or originate from the same community network as the child or extended family.**
- Creating an opportunity for the child to disclose, seeing the child on their own. **Always consider a Joint Investigative Interview**;
- Using simple language and asking straightforward questions;
- Using terminology that the child will understand, e.g. the child is unlikely to view the procedure as abusive;
- Being sensitive to the fact that the child will be loyal to their parents;
- Giving the child time to talk;
- Getting accurate information about the urgency of the situation, if the child is at risk of being subjected to the procedure;
- Giving the message that the child can come back to you again.
    - Being sensitive to the intimate nature of the subject;
    - Making no assumptions;
    - Asking straightforward questions;
    - Being willing to listen;
    - Being non-judgemental (condemning the practice, but not blaming the girl/woman);
    - Understanding how she may feel in terms of language barriers, culture shock, that she, her partner, her family are being judged;
    - Giving a clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM if or when they have daughters.

Identifying a Child who has been Subject to FGM or who is at Risk of being Abused through FGM

Professionals in all agencies, and individuals and groups in the community, need to be alert to the possibility of a child being at risk of or having experienced female genital mutilation.

Appendix E **outlines multi-agency child protection decision making and action flowcharts, which should be followed. These are also contained within the** NHS Lothian Single Agency Procedures for the Protection of Girls and Women at Risk from Female Genital Mutilation (FGM)

A child at risk of FGM; key risks

1. Family's country of origin has FGM practising communities
2. Mother (or other female relative, including sibling) has had FGM
3. Intention re FGM by child/ family member/ possible perpetrator/ non protective views
4. Upcoming trip to country of origin or out of UK
5. UK survivors of FGM have reported that individuals travel to the UK for the purposes of carrying out FGM or are already within the UK and carry out FGM.

'Intention' or 'non protective views' may be indicated by;

- FGM may be more likely if a female family elder with generally traditional views is part of the community or is visiting;
- A child may confide to a professional that she is to have a 'special procedure' or to attend a 'special occasion';
- A professional hears reference to FGM in conversation, for example a child may tell other children about it;
- A child may request help from a teacher or another adult.

Indications that FGM may have already taken place include:

- A child may spend long periods of time away from the classroom during the day with bladder (taking a long time to pass urine) or menstrual problems;
- There may be prolonged absences from school. A time of increased risk is during school holiday periods, which allows healing to take place; therefore before and after school holidays are key for greater awareness by professionals who have regular contact with the child;
- A prolonged absence from school with noticeable behaviour changes on the girl's return could be an indication that a girl has recently undergone FGM;
- Professionals also need to be vigilant to the emotional and psychological needs of children who may/are suffering the adverse consequence of the practice, e.g. withdrawal, depression etc;
- A child may confide in a professional;
- A child requiring to be excused from physical exercise lessons;
- A child may ask for help.

Professionals and Volunteers from all Agencies Responding to Concerns

Any information or concern that a child is at risk of, or has undergone, female genital mutilation should result in a child protection referral to agencies (Police Scotland, NHS Lothian or Children and Families Social Work) as in the Edinburgh and Lothians Inter-Agency Child Protection Procedures.

Protection of Adults at Risk of Harm

Where there are any suspicions or knowledge that a woman aged 18 years or over is at risk of FGM, a referral to adult protection services may be appropriate if the person is unable to safeguard their own well-being, property, rights or other interests. In such instances and where the person is more vulnerable because of a disability, disorder, illness or infirmity, they may be deemed an 'adult at risk of harm consideration should be given to initiating an Adult Protection IRD as per the Adult Support and Protection (Scotland) Act, 2007. Making a referral under this route does not detract from the need to contact Police Scotland.

Where the person is 18 and over and not known to services and you do not believe they are an adult at risk (as above) Police Scotland remain the sole referral route.

16 - 17 year olds

Young people, especially those aged 16 and 17, can present specific difficulties to agencies as there may be occasions when it is appropriate to use both child and adult protection frameworks. **If there is any doubt, a child protection referral should be made. The age of the individual concerned should not be a barrier to an Inter-agency Referral Discussion taking place. A response proportionate to the level of risk being effected is the priority**.

Use of Interpreters

Use of any interpreter or translator should only be through approved services such as the Interpretation and Translation Services. The girl or woman should be given the opportunity to express a preference for a male or female interpreter.

The interpreter should not be:

- A family member
- Known to the individual
- Someone with influence in the individual's community.

Other steps that should be taken when working with an interpreter include:

- Checking the dialect spoken before making arrangements
- Having a briefing meeting with the interpreter, prior to the discussion with the girl or woman
- If the interview is not a Joint Investigative or other forensic interview and the girl or woman wishes to be accompanied during the discussion, check that she understands the full extent of the discussion and the impact of having someone with her. If she insists, have a brief meeting with the accompanying person and establish the rules of confidentiality
- Explain the role of the interpreter at the beginning of the discussion
- Ensure that the interpreter does not add their own information or opinion.

Risk Assessment Document

Because it is recognised that staff in Edinburgh and the Lothians may not be familiar with dealing with FGM regularly, the FGM risk assessment document, attached as appendix D, should be used. This provides a structured approach to guide one or more professionals in their approach to gathering information and having discussions about FGM with families. This should ensure that key issues have been discussed clearly and appropriately and then documented.

The FGM inter-agency procedures outline the process for ensuring that this information stays with the relevant individual's records, whether they are an adult or child. The aim is to facilitate the protection of any at risk children and adults over time, while preventing unnecessary revisiting of previous discussions and information gathering.

Appendix E **outlines multi-agency child protection decision making and action flowcharts, which should be followed. These are also contained within the** NHS Lothian Single Agency Procedures for the Protection of Girls and Women at Risk from Female Genital Mutilation (FGM)

Police Scotland

Reports that a girl or woman has been subject of FGM or concerns that a girl or woman may be at risk of FGM can come to the attention of officers and members of police staff from various sources, including direct reporting by a girl or woman; a named or anonymous member of the public; via statutory agencies such as education; health and local authority social work or 3rd sector advocacy and support services. FGM may also be identified incidentally as part of unrelated duties such as responding to other concerns or when conducting investigations into other crimes of offences.

Children

Initial Action in Responding to Girls at risk of FGM including an unborn child

Details of any disclosure made to a first contact police officer or member of police staff should be carefully noted in the officer's personal notebook or other recording system i.e. STORM incident as soon as practicable. Such a disclosure and any initial interaction with a child should be regarded quite different from a Joint Investigative Interview. In such circumstances the child should be allowed to provide any voluntary account or information, however, should not be 'interviewed' or questioned in detail about the commission of or planned commission of FGM as this may undermine the reliability or admissibility of any information subsequent interview. The primary consideration must be the immediate safety of the child.

The Prohibition of Female Genital Mutilation (Scotland) Act 2005 makes it illegal to perform or arrange to have FGM carried out in Scotland or abroad. A sentence of 14 years imprisonment can be imposed which highlights the gravity of the offence. FGM should always be seen as a cause of significant harm. As such, when there is information to suggest that a girl has been, is or is likely to be subject of FGM and may be at risk of significant harm, **all officers or members of police staff must immediately signpost to their supervisor and Divisional Public Protection Unit, or if out with hours, the duty senior CID officer/ Duty Inspector, who will be responsible for assessing the level of risk to the child or any other children. This should not be interpreted to mean a child protection joint investigation will commence on every occasion. What it will provide that our interface with partner agencies will reflect common standards of practice; shared language and understanding and provide a sensitive, proportionate response by specialist officers who are fully conversant with Police Scotland's Child Protection - FGM Standard Operating Procedure, national guidance and local interagency child protection procedures to enable such procedures to be considered and implemented if necessary.**

On all occasions information and intelligence databases must be researched in relation to the child and their family background. The minimum checks to be carried out by Police Scotland are:

- Police National Computer (PNC)
- Police National Database (PND)
- Criminal History System (CHS)
- Scottish Intelligence Database (SID)
- Violent and Sexual Offenders Register (ViSOR)
- Command and Control system
- Crime Management system
- Vulnerable Persons Database

The Edinburgh and Lothians Inter-Agency Child Protection Procedures must be invoked for any child who has been subjected to FGM or where there is information that other risk factors are present.

On occasions where there is insufficient information to determine whether child protection procedures should be invoked, and more information is required to inform decision making the Divisional PPU or on duty senior CID officer should make an information sharing request to core partners (Social Work, Health and if appropriate Education) to share relevant information in relation to the child or any other child. This may result in an action for the most appropriate partner to engage with the child and her family in an attempt to gain further information. While PPU officers should be in a position to speak with parents/ carers about the law and health implications and work collaboratively, the decision about which professional is best place to engage with a child and their family about FGM needs to be carefully considered and should be agreed (and documented) between agencies.

The outcome of family engagement must be shared with Social Work, Health and Police Scotland. If necessary child protection procedures will be instigated and decisions around investigation (joint or single agency); joint investigative interview and type of medical examination will be made by Social Work and Police in consultation with Health during any subsequent IRD.

Imminent Risk of Significant Harm

In most cases where there are concerns about FGM, these are not associated with imminent risk. However, if a child is about to leave the country; there is information about a fleeing family; clear intent for FGM to be carried out within the UK or any other abusive or negligent behaviour which places a child or unborn baby at immediate risk of significant harm, the Duty Inspector must ensure that effective protection measures are put in place immediately and primary investigation commences in liaison with the Divisional PPU or duty senior CID Officer. Child Protection Procedures will be immediately instigated, during which time consideration will be given to the application for a Child Protection Order or other relevant protection order.

On occasions where the risk is such that it is not practicable for a CPO or other relevant order to be applied for, Section 56 of the Children's Hearing (Scotland) Act 2011 provides for emergency measures, specifically a constable's power to remove a child to a place of safety. Section 59 of the Children's Hearing (Scotland) Act 2011 relates to the obstruction offence. A child may not be kept in a place of safety under this section for a period of more than 24 hours, therefore, as soon as practicable after a child is removed under this section, the Principal Reporter must be informed. In addition, officers must inform their supervisor and Divisional PPU or on duty senior CID officer immediately powers under Section 59 of the Children's Hearing (Scotland) Act 2011 have been used to instigate child protection procedures.

Adult Victims of FGM or Adults at Risk of FGM

The overarching principles outlined above apply to adult victims of FGM or adults at risk of becoming the victim of FGM. **First responding officers or members of police staff must immediately signpost to their supervisor and Divisional Public Protection Unit, or if out with hours, the duty senior CID officer, who will be responsible for assessing the level of risk to the adult. This will ensure a sensitive, proportionate response by specialist officers**. While FGM is usually not undertaken for the sexual gratification of another, the circumstances of the act are such that when the victim or potential victim is an adult a Sexual Offences Liaison Officer will be deployed for the purposes of interview and act as a single point of contact.

Support from survivor advocacy services should always be considered prior to any interview taking place.

Officers must consider whether the adult victim or potential victim may have additional needs, such as interpretation services; an appropriate adult if any mental disorder is suspected or if the adult may be an adult at risk as per the Adult Support and Protection (Scotland) Act 2007. Any such concerns must be immediately highlighted to the Divisional PPU so that all necessary support can be provided or Adult Support and Protection Procedures instigated.

As above, the primary consideration must be the safety of the victim or potential victim.

Factors to Consider

During an investigation into FGM it will be important to establish the timing of the victim and individual family members' entry and exit of the UK. Securing passports; other travel documentation or payment receipts etc. which may be of particular evidential value.

All female members of the household and female relatives of the index case must be considered as being at risk of FGM and included in any risk assessment and safety planning.

For children; families and communities affected by FGM their previous experience of 'authority' figures, including the police, whether abroad or within the UK and Scotland may have been negative or traumatic e.g. asylum seeking communities. This may add barriers to collaborative and meaning communication in addition to what is a sensitive subject.

If appropriate, a request may be made for an appropriately trained medical professional to conduct a medical examination. It may be in the child's or woman's best interest to have a medical examination for health and wellbeing purposes, without the need for forensic corroborative evidence a crime has not been committed within a country where unlawful. e.g. the FGM was carried out prior to entry into the UK. **In all cases involving children, an experienced paediatrician should be involved in decision making and arranging medical examinations.**

When a criminal investigation is raised, the interviewing of children and young people must be undertaken in line with the Scottish Government Guidance on the Joint Investigative Interviewing of Child Witnesses in Scotland 2011, in order to obtain best evidence.

If any legal action is being considered, early consultation with the Crown Office and Procurator Fiscal Service (COPFS) is important.

Police Procedures

On all occasions a restricted VPD Concern Form and SID should be submitted at the point of reporting/ referral; updated as necessary and, on all occasions, at the conclusion of any investigation. To ensure the integrity and safety of those involved any STORM incident will also be restricted.

A crime report must be raised as soon as there is information that a crime has taken place in line with the Scottish Crime Recording Standards.

Officers should refer to the following documents on the force intranet:

- Child Protection Standard Operating Procedures (SOP)
- Honour Based Violence, Forced Marriage and Female Genital Mutilation SOP
- Scottish Government Guidance on the Joint Investigative Interviewing of Child Witnesses in Scotland (2011)
- National Guidance for Child Protection in Scotland (2014)
- Adult Support and Protection SOP
- Appropriate Adults SOP
- Interpreting and Translating Services SOP

Note: the Victim and Witnesses (Scotland) Act 2014 provides for victims of specific crimes to specify a gender preference in relation to an interviewing officer and to gender preference for medical examiner. This does not specifically include FGM, but would be considered best practice.

Education: Guidelines for Teachers and Other Education Staff

The National Guidance for Child Protection in Scotland (2014) states that **FGM should always be seen as a cause of significant harm and local child protection procedures should be invoked**. Education staff should work closely with other agencies. The welfare of the child/ young person is always the primary concern. Flowcharts 3 and 4 should be followed.

Key points

The Children and Young People (Scotland) Act 2014 and the Getting It Right for Every Child approach require practitioners in all services for children and adults to meet children and young people's wellbeing needs, working together if necessary to ensure children and young people reach their full potential. When starting primary 1, key information about FGM risk assessment will be shared from a child's health visitor to the head teacher, to ensure that those in daily contact with a child are aware of the level of risk of FGM and any relevant related information (see appendix G). It is important to remember that risk assessment is a dynamic process, and a 'conversation' that continues through a girl's life. Education staff are most lilely to become aware of factors that may bring about change to level of risk, such as a visit abroad, a visit from a family elder, or a special upcoming ceremony.

Education is a universal service. Children and young people spend up to six hours a day in the care of schools and early learning and childcare centres. These services build up strong relationships with children, young people and their parents by creating a positive ethos and culture based on mutual respect and trust.

Children and young people may feel safe at school and that they can trust education staff. So they may be more likely to confide in them.

Education services can also monitor attendance and be sensitive to changes in physical and mental health (see Appendix C). They may therefore notice children and young people at risk.

A child at risk of FGM; 4 key risks

- Family's country of origin has FGM practicing communities
- Mother (or other female relative, including sibling) has had FGM
- Intention re FGM by child/ family member/ possible perpetrator/ non protective views
- Upcoming trip to country of origin or out of UK

'Intention' or 'non protective views' may be indicated by;

- FGM may be more likely if a female family elder with generally traditional views is part of the community or is visiting;
- A child may confide to a professional that she is to have a 'special procedure' or to attend a 'special occasion';
- A professional hears reference to FGM in conversation, for example a child may tell other children about it;
- A child may request help from a teacher or another adult.

Principles and general guidance

As with all child protection matters, staff should involve parents/carers unless the latter are the source of risk or harm.

Independent schools have child protection procedures in place. The response to suspected FGM should be the same as in a local authority school; child protection procedures should be followed.

Education staff should know the risk factors and indicators of FGM, including children going on extended holidays to areas where FGM is practised and behaviour change on return.

If there are other child welfare or protection concerns, these should be part of the risk assessment process.

Schools and early learning and childcare centres should include information on FGM within their annual child protection update. There is more information on the Education Scotland website at: education.gov.scot

Education Scotland working with partners and Education Authority staff have produced a short supported PowerPoint presentation, which authorities and head teachers can use to raise awareness of FGM in schools and early years settings.

Education staff should raise awareness of FGM and its legal implications with children and young people. For example, health and wellbeing (personal, social, health education) and RME courses could inform children and young people about FGM and the harm it causes. Education staff should also support children and young people to recognise and realise their rights within the United Nations Convention on the Rights of the Child (UNCRC).

Within Curriculum for Excellence, children and young people are entitled to personal support to enable them to:

- review their learning and plan for next steps
- gain access to learning activities which will meet their needs
- plan for opportunities for personal achievement
- prepare for changes and choices and be supported through changes and choices.

This is particularly significant for children and young people who have been affected by FGM. All children and young people should have frequent and regular opportunities to discuss their learning with an adult who knows them well and can act as a mentor, helping them to set appropriate goals for the next stages in learning. It is essential that support is provided to remove barriers that may have been caused by FGM or other issues that might restrict their access to the curriculum because of their circumstances or short or longer term needs.

School Nurses

Please also refer to the NHS Lothian Procedures for the Protection of Girls and Women at Risk of Female Genital Mutilation (FGM), which is attached below.

Colleges and Universities

Where students are under 18 years of age, further educational establishments should follow their existing child protection policies when there is concern regarding a potential risk of FGM or if a student discloses that she has undergone FGM.

Universities are less likely to encounter girls at risk of FGM but they may become aware that a student is concerned about a younger female relative, for example, or who discloses that she has undergone this herself when younger. They should consider how best to respond in such circumstances, seeking the guidance of appropriate agencies in drawing up their policies.

Students from countries with communities affected by FGM with children often attend Scottish universities for both undergraduate and post graduate degrees. Clear measures should be taken by University authorities to inform and support their students about this issue, preferably before they arrive in this country. They should offer clear information about the legal situation regarding FGM in Scotland, and information about who to go to for further information and support within health services, university pastoral services, social work, and voluntary organisations.

Actions for all Education Staff

Be aware that a woman or girl can be subject to FGM more than once.

Staff responding to FGM should be aware that even apparently low-level concerns may point to more serious and significant harm. FGM is different from many other areas of child protection, because there are often no other child protection risk factors or indicators. It is not until FGM is discussed openly and directly that any indication of risk can be gained. Practitioners should consider all cases with an open mind and not make any assumptions about whether FGM has, has not, or is likely to occur. Staff need to be alert to the possibility of FGM; regarding both children they already know and in cases where concerns about children are not stated at the outset, including other females in the family or household.

Any information or concern that a girl is at immediate risk of, or has undergone FGM should result in a child protection referral to Children and Families Social Work or Police Scotland on the day the concern arises.

Where a concern does not require an immediate child protection response, it should be acknowledged quickly, indicating when a measured and proportionate response will be made. Flow charts 3 and 4 should be followed. Under GIRFEC arrangements, a child's planning meeting should be convened. Staff should, discuss and liaise with the child's Named Person.

If a child protection response is required, the Edinburgh and Lothians Inter-Agency Child Protection Procedures will be used to initiate an IRD.

Schools often have a relationship with the parents and are often best placed to discuss with parents their concerns. The Named Person may wish to ask the parents further questions:

Ask straight forward questions using simple language:

- Give the reason as to why you are asking to meet such as 'I hear you are going (back) to Somalia, how long will you be visiting for?'
- Is it a holiday to visit family or friends?
- Is there a special occasion?
- I note that you come from a country where FGM/C or Cutting is practiced, tell me how do you feel about FGM/ Cutting?
- Do the family you are going to visit believe in FGM/C or Cutting?
- Do you think you will be under pressure from family to have your daughter FGM/C/Cut?

Try to arrange the meeting for a time when you can speak to the woman her on her own. This is particularly important if you feel at any time that the woman is nervous or intimidated by her partner, Offer the opportunity to return to you at any time if they wish to speak further.

Siblings as well as other girls in the family such as cousins, where known, should be considered as being part of this referral.

A Senior Education Manager should be informed.

School, Early Years, Family and Community Centre staff and partner agencies will support the child /young person as relevant.

A letter has been issued to schools from the Cabinet Secretary for Education and Lifelong Learning and the Minister for Commonwealth Games and Sport around Female Genital Mutilation (FGM).

Record

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. This information should be stored in the Child Protection 'red' folder. The risk assessment document in Appendix H outlines key areas for discussion.

Appendix E **outlines multi-agency child protection decision making and action flowcharts, which should be followed. These are also contained within the** NHS Lothian Single Agency Procedures for the Protection of Girls and Women at Risk from Female Genital Mutilation (FGM)

Voluntary Sector

Any professional, volunteer or community group member who has information or suspicions that a child is at risk of FGM should consult with their agency or group's child protection adviser (if they have one) and should make an immediate referral to social work. Police Scotland can also be called on 101.

The referral should not be delayed in order to consult with your child protection adviser, a manager or group leader, as multi-agency intervention needs to happen quickly.

If there is a concern about one child, siblings and household members must be referred at the same time.

NHS Lothian

NHS Lothian staff should follow the NHS Lothian Single Agency Procedures for the Protection of Girls and Women at Risk from Female Genital Mutilation (FGM), which is attached below.

Children and Families Social Work

All notifications of concern about children should be taken seriously.

Children and families social work should investigate, initially, under Section 60 of the Children's Hearings (Scotland) Act 2011.

Local authorities have a duty to promote, support and safeguard the wellbeing of all children in need in their area, and, insofar as is consistent with that duty, to promote the upbringing of children by their families by providing a range and level of services appropriate to children's wellbeing needs. When the local authority receives information which suggests a child may be in need of compulsory measures of supervision, social work services will make enquiries and give the Children's Reporter any information they have about the child. The Role of the Registered Social Worker in Statutory Interventions: Guidance for Local Authorities stipulates that, where children are in need of protection and/or in danger of serious exploitation or significant harm, a registered social worker will be accountable for:

- carrying out enquiries and making recommendations where necessary as to whether or not the child or young person should be the subject of compulsory protection measures;
- implementing the social work component of a risk management plan and taking appropriate action where there is concern that a the Child's Plan is not being actioned; and
- making recommendations to a children's hearing or court as to whether the child should be accommodated away from home.

Children and family social workers also either directly provide, or facilitate access to, a wide range of services to support vulnerable children and families, increase parents' competence and confidence, improve children's day-to-day experiences and help them recover from the impact of abuse and neglect. For children in need of care and protection, social workers usually act as Lead Professional, co-ordinating services and support as agreed in the Child's Plan.

In fulfilling the local authorities' responsibilities to children in need of protection, social work services have a number of key roles. These include co-ordinating multiagency risk assessments, arranging Child Protection Case Conferences, maintaining the Child Protection Register and supervising children on behalf of the Children's Hearing.

Social work response to FGM

Appendix E **outlines multi-agency child protection decision making and action flowcharts, which should be followed. These are also contained within the** NHS Lothian Single Agency Procedures for the Protection of Girls and Women at Risk from Female Genital Mutilation (FGM)

Practitioners responding to FGM should be aware that even apparently low-level concerns may point to more serious and significant harm. Practitioners should consider all cases with an open mind and not make any assumptions about whether FGM has, has not, or is likely to occur. Practitioners need to be alert to the possibility of FGM; regarding both children they already know and in cases where concerns about children are not stated at the outset, including other females.

All concerns, including those that do not require an immediate child protection response should be acknowledged quickly, indicating when a measured and proportionate response will be made. Practitioners should, in all cases, discuss and liaise with the child's Named Person and other professionals involved with the family as part of the assessment process. Practitioners may find it helpful to develop a family tree, or genogram, to assess all familial links and influence.

Careful consideration should be given to the inclusion and communication with the child and their parents. The parents should be seen separately and there should be an assessment of whether their views differ. This should include consideration of the use of an interpreter, which professional should undertake this task and how best to do undertake it. Practitioners should find out if the parents and child have had information about FGM, its harmful effects and the law in Scotland. If not, practitioners should give 'A Statement Opposing Female Genital Mutilation' to the parents and, where appropriate, the child. Additional information can be obtained from www.womenssupportproject.co.uk.

Practitioners should consult with the social work lead for FGM (Service Manager for Children's Practice Teams).

A decision will be made about whether concerns should be progressed under Child Protection procedures. Consideration will also be given to how the child's wellbeing needs can be met, and whether or not a Child's Plan is required.

The need to gather information must always be balanced against the need to take any immediate protective action. At this stage, information gathered may only be enough to inform an initial assessment of the risk to the child or children. On the basis of the assessment of risk, social work, health and police will need to decide whether any immediate action should be taken to protect the child and any others in the family or the wider community.

Children at Immediate Risk of Harm

If a child protection response is required, the Edinburgh and Lothians Inter-Agency Child Protection Procedures will be used to initiate an IRD.

If these criteria are not met, but the referring professional still has a high level of concern about risk of FGM, then an IRD should be initiated regardless.

It is critical that information-gathering involves all other key services as appropriate. Agency records should be checked and any previous agency involvement or any known relevant medical history, including that relating to parents/carers, should also be sought and considered.

The FGM risk assessment document should be used to guide the gathering and documentation of information and discussions with family and is attached as appendix D. The risk assessment should be clear on the antecedents to FGM, the type of FGM undertaken and the family background. **The assessment should give cognisance that a women or girl can be subjected to FGM more than once**. The document should be used as a fluid tool and not a unique checklist. The risk assessment should then be recorded on the social work information management system (i.e. Swift, Mosaic or Framework) under the heading "FGM risk assessment summary".

Every attempt should be made to work with parents on a voluntary basis to prevent harm to any child. 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 to facilitate the work with parents/family. However, the child's interests are always paramount.

If no agreement is reached, the first priority is the protection of the child and the least intrusive legal action should be taken to ensure the child's safety.

Where necessary, consideration should be given to referring the child to the Reporter to the Children's Hearing.

The primary focus is to prevent the child undergoing any form of FGM, rather than removal of the child from the family.

If agencies agree, as part of the IRD that a child is in immediate danger of FGM and the parents cannot satisfactorily guarantee that the child will not be subjected to FGM, then a Child Protection Order should be sought. Emergency police powers may also be used.

If a Girl has Already Undergone FGM

Be aware that a women or girl can be subjected to FGM more than once.

If a child has already undergone FGM, there must be an IRD to consider how, where and when the procedure was carried out and the implications of this.

The IRD will need to decide whether to continue enquiries or assess the need for support services. This will include the risks of further FGM and the risk of FGM to other women and girls.

If legal action is being considered, practitioners must seek legal advice from local authority solicitors.

A child protection case conference is not usually needed for a girl who has already undergone FGM, nor should her name be listed on the Child Protection Register unless she is still at risk of significant harm or neglect. However, in consultation with the child, parents and health colleagues, practitioners should consider referral for counselling and medical support suitable for the girl's age.

A child protection case conference is only necessary if there are unresolved child protection issues after the initial investigation and assessment are complete.

Reducing the Prevalence of FGM

The Role of the Child Protection Committee or Public Protection Committee (the Committee)

In some areas, Child Protection Committees have been subsumed into a broader Public Protection Committee framework, which may include arrangements for Adult Support and Protection; Child Protection; Violence Against Women; Drugs and Alcohol; and Offender Management.

Child Protection Committees are locally-based, inter-agency strategic partnerships responsible for the design, development, publication, distribution, dissemination, implementation and evaluation of child protection policy and practice across the public, private and wider third sectors in their locality and in partnership across Scotland. Their role, through their respective local structures and memberships, is to provide individual and collective leadership and direction for the management of child protection services across Scotland. They work in partnership with their respective Chief Officers' Groups and the Scottish Government to take forward child protection policy and practice across Scotland.

The functions of a Child Protection Committee (CPC) are **continuous improvement, strategic planning, public information** and **communication**. The work of the Committee must be reflected in local practice and meet local needs.

The Committee should undertake initiatives in relation to FGM which fulfil these duties and responsibilities.

Committees are responsible for ensuring that single agency and inter-agency training on safeguarding and promoting welfare is provided in order to meet local needs, i.e. that staff who have responsibility for child protection work are acquainted with child protection procedures in relation to FGM and are confident working with local preventative programmes relating to FGM.

The Committees may consider developing and supporting a centralised virtual team of experts to advise professionals on the prevention of FGM in the community and the appropriate professional response to individual cases; similar to a network of support.

Data Recording and Monitoring Systems

Scottish government national guidance states that:

- 'Data recording and monitoring systems should be reviewed to include FGM where possible'.
- 'All agencies should gather, record and collate data about FGM. This is important for understanding the needs of individuals and communities, for commissioning services and for raising awareness. It also helps with identifying risk, intervening promptly, and noticing what is happening within communities.'
- 'Health boards should gather data in order to assess local health and social care needs and to contribute to ISD national data gathering from hospitals, community services and GP practices.'

The GP 'Read Coding' system is in place for primary health care, and there is a hospital based system for coding of in and out patient cases (ISB). The two systems, however, do not connect. It is important for all cases that come to light to social work, police and education as well as different health sectors are collated.

Risk assessment should have multiagency overview and input if appropriate. Therefore, a regular multiagency meeting to take an overview of cases including those that reach IRD threshold and those that are being addressed within the GIRFEC framework is required. This process will allow an appropriate multiagency senior overview for governance. Confidential data on cases where there are at risk girls, who have had risk assessments for FGM carried out by any agency or health sector, will then be kept by the child protection team within community child health. Appropriate liaison with public health colleagues and the committees can then proceed to ensure that appropriate services and supports can put in place.

More Information and Support

World Health Organisation (WHO) Fact Sheet on FGM

Scottish Legislation on FGM

National Training Resources website
A range of resources and recommended reading on FGM

DARF (Dignity Alert and Research Forum) - Scottish organisation providing information on FGM and campaigning against the practice in the UK and in Africa

FORWARD - UK organisation raising awareness of FGM and campaigning against its practice. Also provides support

Daughters of Eve - provides support to those with experience of FGM

Edinburgh and Lothians Inter-Agency Child Protection Procedures (2015)

National Guidance for Child Protection in Scotland (2014)

Getting it Right for Every Child in Edinburgh and the Lothians: A PRACTITIONER GUIDE TO INFORMATION SHARING, CONFIDENTIALITY AND CONSENT TO SUPPORT CHILDREN AND YOUNG PEOPLE'S WELLBEING

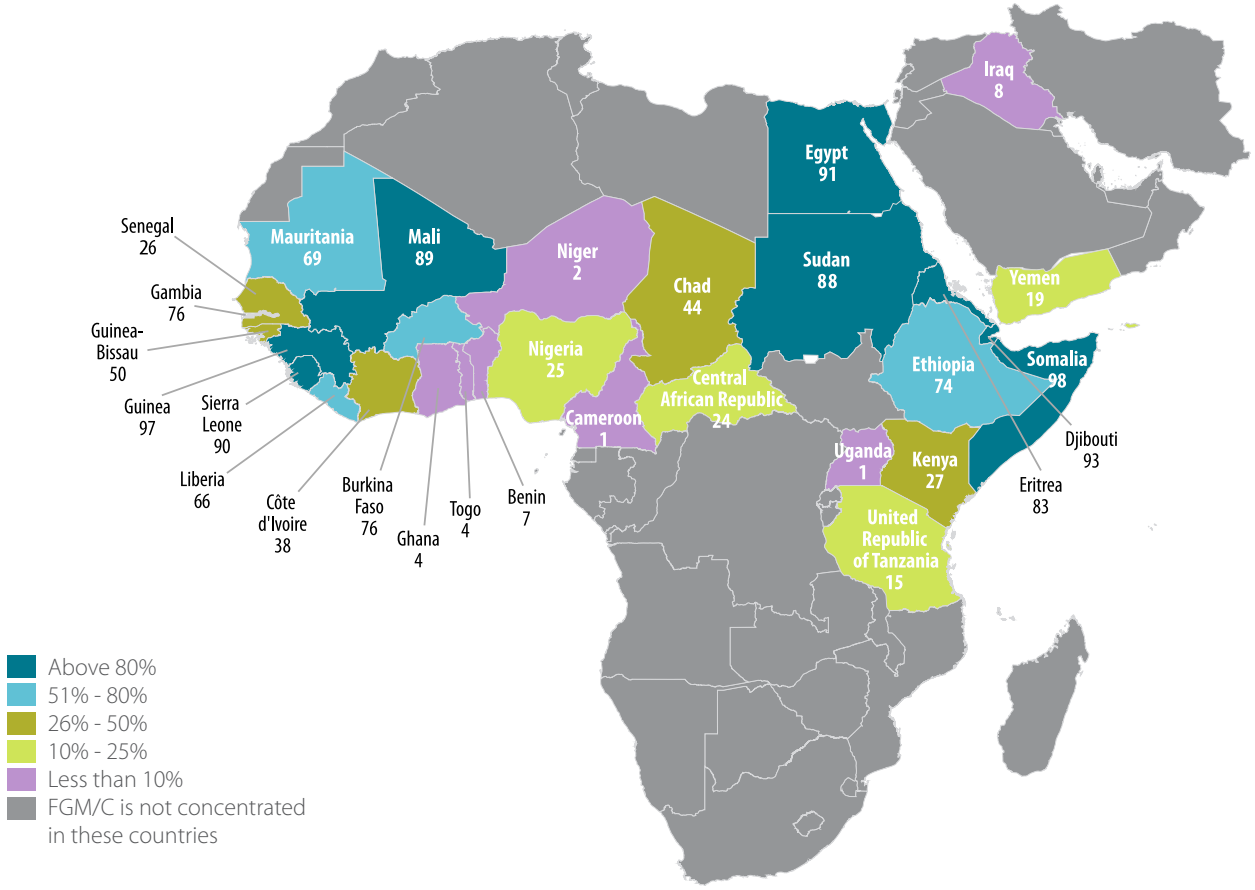
The Centre for Youth and Criminal Justice supports improvement in youth justice and aims to strengthen the creation, sharing and use of knowledge and expertise.

Framework for Risk Assessment Management and Evaluation (FRAME)

Appendices

Appendix A | Countries that Practice FGM (UNICEF, 2014)

FGM/C is concentrated in a swathe of countries from the Atlantic coast to the Horn of Africa.



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

FGM has also been documented in communities including:

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

Appendix B | FGM Terms Used in Practicing Countries

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 circumcision
	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
ETHIOPIA	Megrez	Amharic	Circumcision/cutting
	Absum	Harrari	Name giving ritual
ERITREA	Mekhnishab	Tigregna	Circumcision/cutting
KENYA	Kutairi	Swahili	Circumcision – used for both FGM and male circumcision
	Kutairi was ichana	Swahili	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 an initiation rite into adulthood – for non-Muslims
	Bondo/Sonde	Mendee	Integral part of an initiation rite into adulthood – for non-Muslims
SOMALIA	Gudiniin	Somali	Circumcision used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word 'halal' ie. ' sanctioned' – implies purity. Used by Northern and 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 word '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	Mandinka	Meaning 'the affair' but also the name for the shed built for initiates
	Musolula Karoola	Mandinka	Meaning 'the women's side'/'that which concerns women'

Appendix C | Organisations and Useful Contacts

Foreign and Commonwealth Office Forced Marriage Unit

The Forced Marriage Unit is a single point of confidential advice and assistance for those at risk of being forced into marriage overseas.

Tel: **020 7008 0151**

From overseas: **+44 (0)20 7008 0151**

Opening hours: **Monday to Friday, 9am to 5pm**

Out of hours: **020 7008 1500**
(ask for the Global Response Centre)

Email: fmu@fco.gov.uk

Website: www.fco.gov.uk/forcedmarriage

Bright Choices

Bright Choices is a service operating in Edinburgh which provide a range of services to individuals and families who are affected by Honour Abuse and Honour-Based Violence (HBV) and FGM.

Address: **Bright Choices, Sacro**

Tel: **0131 622 7500 (ext: 309) / 07772 652 864**

Email (non-secure): **General enquiries**
brightchoices@sacro.org.uk

Email (secure): **Referrals/confidential information**
brightchoices@sacrosecure.org.uk.cjsm.net

National Domestic Abuse Help Line

Tel: **0800 0271234**

Support is available 24/7

Stonewall Scotland

Campaign for equality and justice for gay, lesbian, bisexual and transgender (LGBT) people living in Scotland.

Tel: **0131 474 8019**

Email: info@stonewallscotland.org.uk

LGBT centre for Health and Wellbeing

The LGBT centre provides a varied programme of services, events, courses and groups for LGBT people.

Address: **9 Howe Street, Edinburgh EH3 6TE**

Tel: **0131 523 1100**

Opening hours: **Monday to Friday, 9am to 5pm**

Email: admin@lgbthealth.org.uk

LGBT Helpline Scotland

Tel: **0300 123 2523**

Opening hours: **Tuesdays & Wednesdays 12noon to 9pm**

Shakti Women's Aid

Shakti offers support and information to all black minority ethnic women, children and young people who are experiencing or fleeing domestic abuse, forced marriage and other honour based violence issues. They also have refuge accommodation.

Tel: **0131 475 2399**

Opening hours: **Monday to Friday, 10am to 5pm**

Website: www.shaktiedinburgh.co.uk

Saheliya

Saheliya is an organisation, which provides a safe and confidential service that supports the mental health and well being of Black and Minority Ethnic women in Edinburgh. Services include counselling, support, befriending and advocacy.

Address: **125 McDonald Road, Edinburgh**

Tel: **0131 556 9302**

Opening hours: **Monday to Friday, 9am to 5pm**

Website: www.saheliya.co.uk

Amina Muslim Women's Resource Centre

Amina works with mainstream agencies to establish the barriers that prevent Muslim women from accessing services and participating in society. They provide direct helping services and community development to Muslim women.

Free phone helpline number: **0808 801 0301**

Dundee: **01382 224 687**

Opening hours: **Monday to Friday, 9.30am to 5pm**

Glasgow: **0141 585 8026**

Email: www.mwrc.org.uk

Beyond the Veil

Beyond the Veil educate and inform the public to clear misconceptions and myths surrounding Islam.

Address: **c/o 1 House O'Hill Road, Edinburgh, EH4 2AJ**

Email: nasim.azad69@yahoo.co.uk

Iranian and Kurdish Women's Rights Organisation

The Iranian and Kurdish Women's Rights Organisation provide advice; support, advocacy and referral in Arabic, Kurdish and Farsi to help women, girls and men escape the dangers of "honour" killing, forced marriage and domestic abuse.

Tel: **0207 920 6460**

Opening hours: **Monday to Friday 9:30am and 5:30pm**

Email: ikwro@yahoo.co.uk

Scottish Women's Aid

Scottish Women's Aid,

Address: **2nd Floor, 132 Rose Street, Edinburgh EH2 3JD**

Tel: **0131 226 6609**

Fax: **0131 226 2996**

Email: contact@scottishwomensaid.org.uk

Hemat Gryffe Women's Aid (Glasgow based)

Hemat Gryffe provides support, advice and temporary accommodation to women and children from the BME community who experience domestic abuse or forced marriage.

Tel: **0141 353 0859**

Opening hours: **Monday to Friday, 9am to 5pm**

Email: hemat.gryffe@ntlbusiness.com

Rape Crisis (Scotland)

Rape Crisis Scotland (RCS) is the national office for the rape crisis movement in Scotland.

Address: **46 Bath Street, Glasgow, G2 1HG**

Tel: **0141 331 4180**

Fax and Minicom: **0141 332 2168**

Email: info@rapecrisisscotland.org.uk

The Rape Crisis Scotland National Helpline provides crisis support for anyone in Scotland affected by sexual violence at any time in their lives.
Rape Crisis Scotland Helpline: 08088 01 03 02 (free number) everyday, 6pm to midnight.

UK Human Trafficking Centre

Address: PO Box 4107, Sheffield, South Yorkshire S1 9DQ

Tel: **01142 523 891**

Email: info@ukhtc.org

Edinburgh rape Crisis Centre

Address: 1 Leopold Place, Edinburgh EH7 5JW

Tel: **0131 557 6737**

Email: info@ercc.scot

Email: support@ercc.scot

Karma Nirvana

Karma Nirvana - honour crimes and forced marriages

Address: **PO Box 148, Leeds LS13 9DB**

Honour Network Helpline: **0800 5999 247**

Website: http://www.karmanirvana.org.uk/

Appendix D | FGM Risk Assessment Document

This is a sensitive child protection document. No details of this report should be disclosed unless the information is relevant and proportionate for a child protection concern.

Use this to guide gathering of information and document discussions with family and between professionals

You may be the first person to broach the subject of FGM with a woman or at risk child (health visitor, GP, midwife, obstetrician, paediatrician, school nurse, other healthcare worker, social worker, teacher, police officer or volunteer). You may be the IRD participant and carrying out the risk assessment discussion with the carer(s).

Work to the relevant flowcharts, guidance about having discussions, map of affected communities and symptoms within the procedures.

There are likely to be several discussions about FGM in relation to a child / family at risk. You do not have to have discussed FGM directly but if you are aware that FGM is a risk, then gathering information and documenting it will allow clear and proportionate actions and decisions to be made now and in the future.

You don't have to ask all of the questions listed but if you have discussed any of the areas then you must document that you have.

You must then share this document with those professionals continuing to work with the family about FGM.

Complete the table on page 9 stating who completed each part. This may be more than one person in which case the name of each should be documented.

If at any stage you think there is imminent risk of harm, take action and make an immediate child protection referral.

Part 1

a) Initial information

b) When a woman or child has had FGM

Part 2

a) Risk Assessment – direct discussion with parent/s / family

b) Legal aspects

c) Medical aspects

d) View of parent/s / family and outcome of discussion

e) Information sharing and communication

Part 1a Initial Information

Name (child or woman)
DOB
Address
Contact phone number
Name of parents or other family members present
Relationship to child
DOB
Address
Contact phone number
Date discussion initiated
Place / location / setting
Who started the discussion / information gathering?
Which agency or organisation does this person belong to?
What is the subject's / family's country of origin?
What links do they have with the country of origin?
Are there any plans for a trip to country of origin or other country where FGM is practiced? (make child protection referral)

What visa / passport do they have?
What is the subject's first language?
What level of English language is used if any?
What other languages are spoken?
Did you use a translator?
Language used
Organisation
Translator's full name
Contact number
Notes

Part 1b Woman or Child as had FGM Performed

(If more than one family or household member has had FGM, complete a separate page for each person)

*** Remove or block out this section prior to copying to child's notes**

What terminology / word is used to describe the FGM?
Which country (including region or tribe) was it carried out in?
When was FGM carried out? / How old was she?
By whom?
Does she still have contact with this person? Other circumstances?
What type of FGM (if known or clear - it may not be)?
Any medical symptoms or complications? *
Any treatment received since FGM? *
Do you need to discuss or offer facilitating referral for (further) medical assessment and treatment, including psychological support? *
Does the subject's GP or other health professional know about the FGM?

Who else knows about the FGM? *
What are the woman's views about the FGM or the parents' views if the subject is a child?
Were you able to gain a realistic impression of their views?
Do they appear to see FGM as acceptable and 'normal'?
Has the woman expressed a desire to have the procedure carried out on their / a child? (you must make a child protection referral if not already done)
What are the child's father's / woman's partner's views about the FGM?
Were you able to gain a realistic impression of their views?
Do they appear to see FGM as acceptable and 'normal'?
Have they expressed a desire to have the procedure carried out on their / a child? (you must make a child protection referral if not already done)

What support services have been accessed, for example – health, Shakti, Saheliya, Bright Choices, church/ faith groups) (Offer information or help to contact if appropriate)
Does the woman feel threatened, afraid or intimidated by anyone regarding FGM? If yes from whom?
Are there any active associated issues such as forced marriage, honour based crime, domestic violence?
Have you or do you need to consider adult protection procedures for the adult who has had FGM or the parent?
Does the person have a social worker?
If a child, does the Named Person know about FGM risk?
Has there been a clinical assessment of the type of FGM? If so, by whom?

Date of examination
Outcome 'Any further clinical information? (include EDD if pregnant)
Offered deinfibulation?
If a professional is working with a family over several visits, or there is an IRD, there may be a large amount of information gathered to inform the risk assessment, identify protective factors, safety planning, etc. This should be referred to, attached or summarised here:

Part 2a) Direct Discussion with Parents / Family

Record Details of: child at risk, those present and professional leading the discussion

NAME AND D.O.B. OF AT RISK CHILD / CHILDREN

Name.....
Address.....
DOB.....
Tel no.....

Name.....
Address.....
DOB.....
Tel no.....

Name.....
Address.....
DOB.....
Tel no.....

Name.....
Address.....
DOB.....
Tel no.....

NAME, D.O.B. OF PARENTS / FAMILY MEMBERS PRESENT (including relationship to child)

Name.....
Address.....
DOB.....
Tel no.....
Relationship to Child.....

Name.....
Address.....
DOB.....
Tel no.....
Relationship to Child.....

Name.....
Address.....
DOB.....
Tel no.....
Relationship to Child.....

Name.....
Address.....
DOB.....
Tel no.....
Relationship to Child.....

Part 2b) Legal Aspect

LEGAL ASPECTS Have you explained that:	Tick when discussed Yes	No	Notes
FGM is illegal in the UK?			
It is illegal to take a child out of the country to have FGM performed, even if it is legal in that country?			
Anyone who carries out, facilitates, or encourages FGM faces prosecution and imprisonment?			
Is treated as child abuse by the UK authorities?			
Have you given the information leaflets that include all of the above points? (Appendix I)			
If yes, which document did you give?			
Who did you give it to?			
What language was this in?			
Are you confident that the subject fully understands the content of the LEGAL ISSUES above?			

Part 2c) Medical Aspects

MEDICAL ASPECTS Have you discussed that:	Tick when discussed Yes	No	Notes
FGM is associated with many serious medical complications?			
Can cause death in some cases?			
If relevant, have you asked if the person suffers from these symptoms?			
If yes to above, have you offered to refer for assessment and if possible medical treatment?			

Part 2d) Views of Parent/s / Family and Outcome of Discussion

CHILD PROTECTION	**Tick when discussed** Yes	No	**Notes**
Did the child's parents / carers ALL overtly commit to protecting their child / children from FGM?			
Are you and they clear that there are no other individuals who might carry out or facilitate FGM on the child / children?			
Outcome There was good communication in an appropriately supported environment and I / we as the professional/s are clear that the above points have been addressed completely and there are no outstanding child protection concerns.			
There were difficulties with communication or an incomplete picture was obtained that means further work and engagement with the family will be needed. Significant uncertainty and concerns remain? **Make a child protection referral.**			
Action Taken			

Part 2e) Information Sharing and Communication

IRD has been initiated **Yes** ☐ **No** ☐

If an IRD been carried out for this child

Date initiated.....

eIRD number? (if applicable).....

Outcome of IRD.....

CPCC / NO FURTHER ACTION / OTHER (state).....

.....

Notes.....

.....

.....

.....

Sharing Document with GP
GP's are pivotal to information holding and continuity through a child's life. It is ESSENTIAL that this document is shared with the GP.

This is the responsibility of the IRD health participant (if IRD held); the midwife if maternity case; health visitor for pre-school child; social worker if school aged child.

Remember to remove marked sections on page 2 before copying to child's notes.

Sent to GP by (PRINT):.....

Designation:.....

Date:.....

Share with Child Protection Advisor
Send copy to Child Protection Advisor, Community Child Health

Sent to CPA by (PRINT):.....

Designation:.....

Date:.....

GP Actions
1. 'Read Code'
2. Ensure that a copy of this entire document is in the **GP notes of the woman** with FGM **and all female children**; should be shared with maternity services at booking of any subsequent pregnancies
3. Ensure that a copy of the document is in the **health visitor notes** of all female children

Part 1 Completed by

Name:.....

Designation:.....

Tel no.:.....

Date:.....

Part 2 Completed by

Name:.....

Designation:.....

Tel no.:.....

Date:.....

Appendix E | Multi-Agency Child Protection Decision Making and Action Flowcharts

Flowchart 1 - Pregnant Woman from a Country with Communities Known to be Affected by FGM

Flowchart 2 - Baby Born to Woman who has had FGM - Not Previously Known to Health Services or Not Recognised Until Labour

Flowchart 3 - Concerns about Pre-school Girl who May be at Risk of FGM

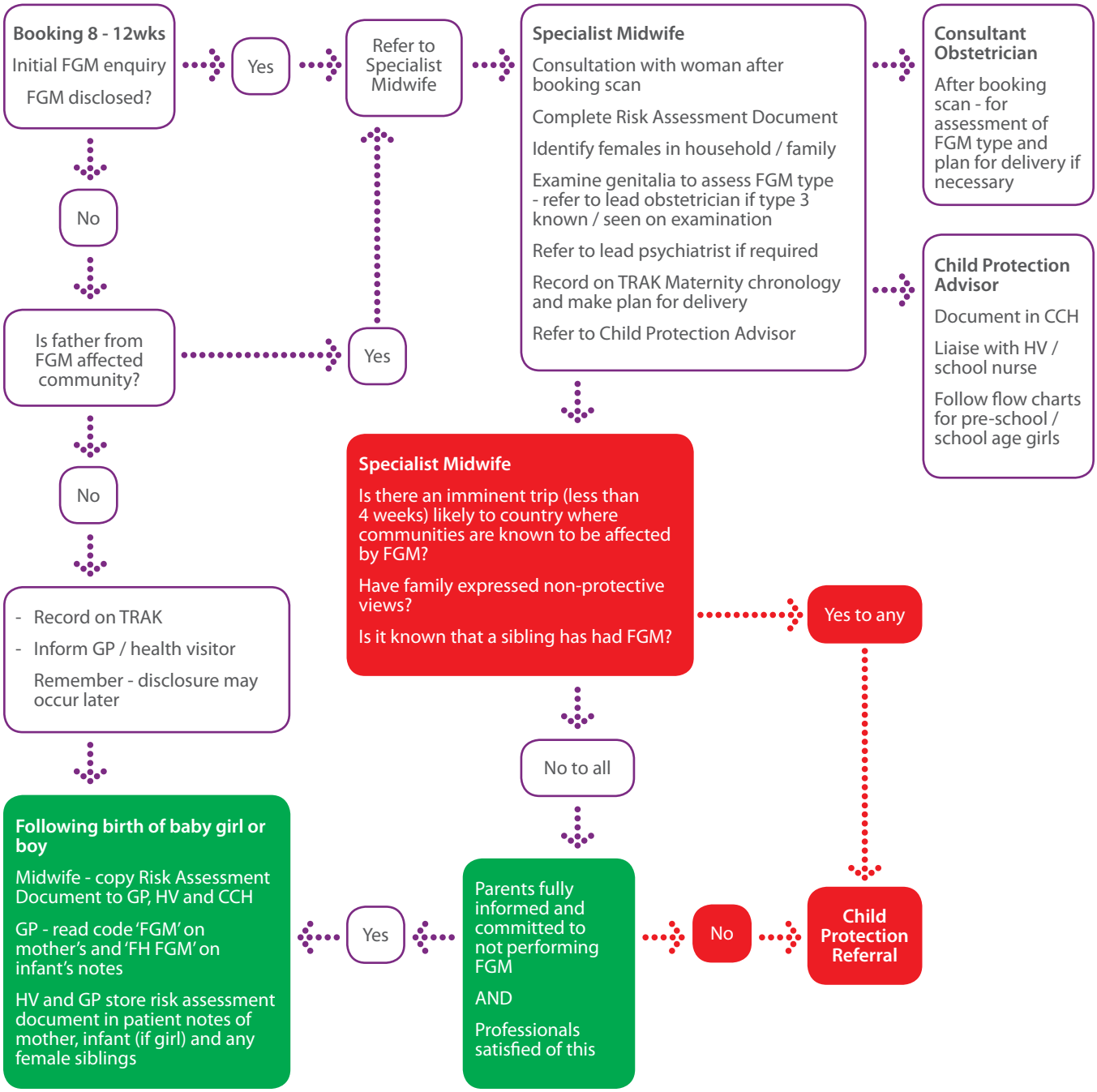
Flowchart 4 - Concerns about School Age Girl who May be at Risk of FGM

Flowchart 5 - Responding to a Woman in a Clinical Setting with (possible) FGM

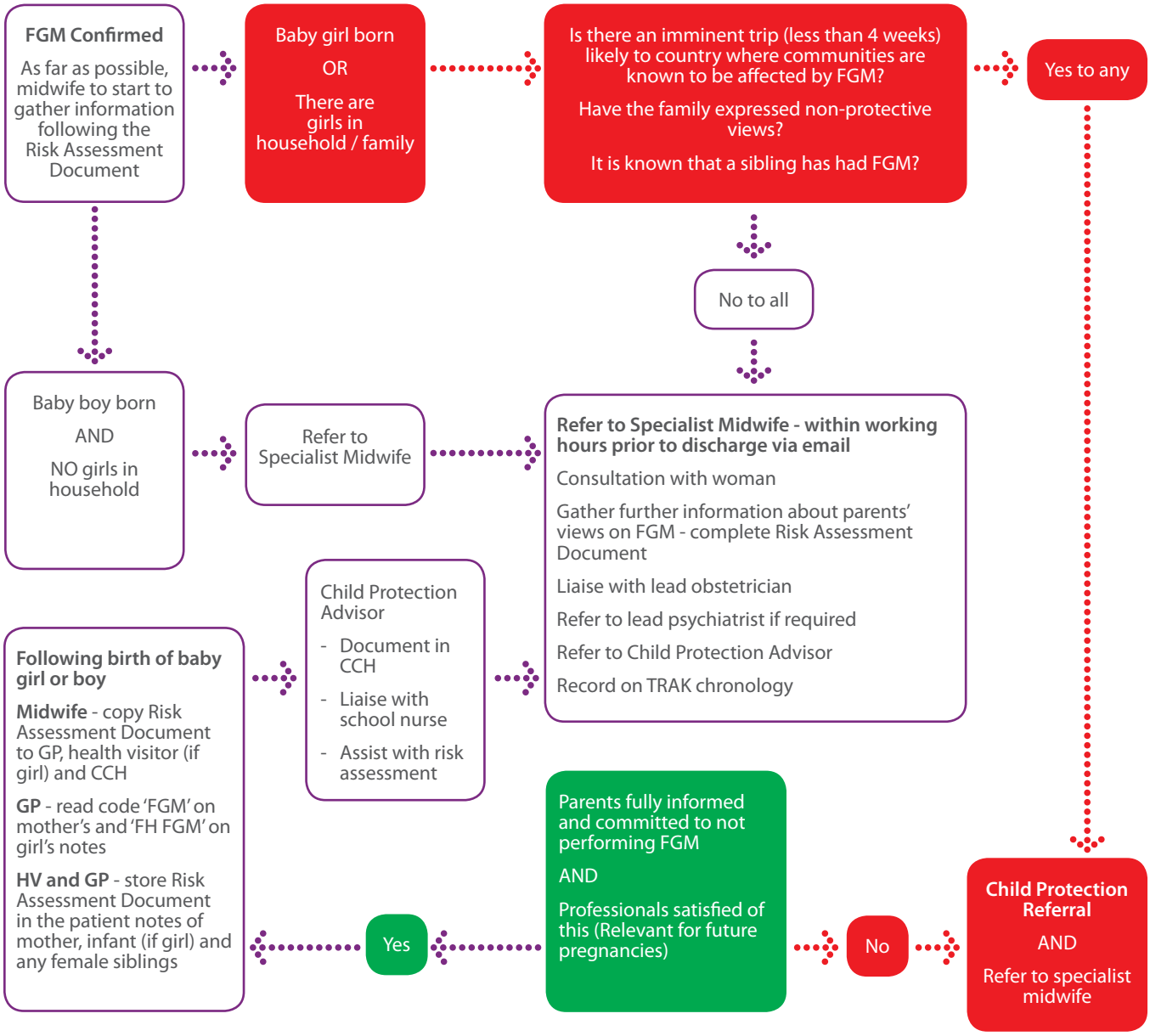
Flowchart 6 - Guidance for Child Protection Professionals Receiving Child Protection Referrals

Flowchart 1 | Pregnant Woman from a Country with Communities Known to be Affected by FGM

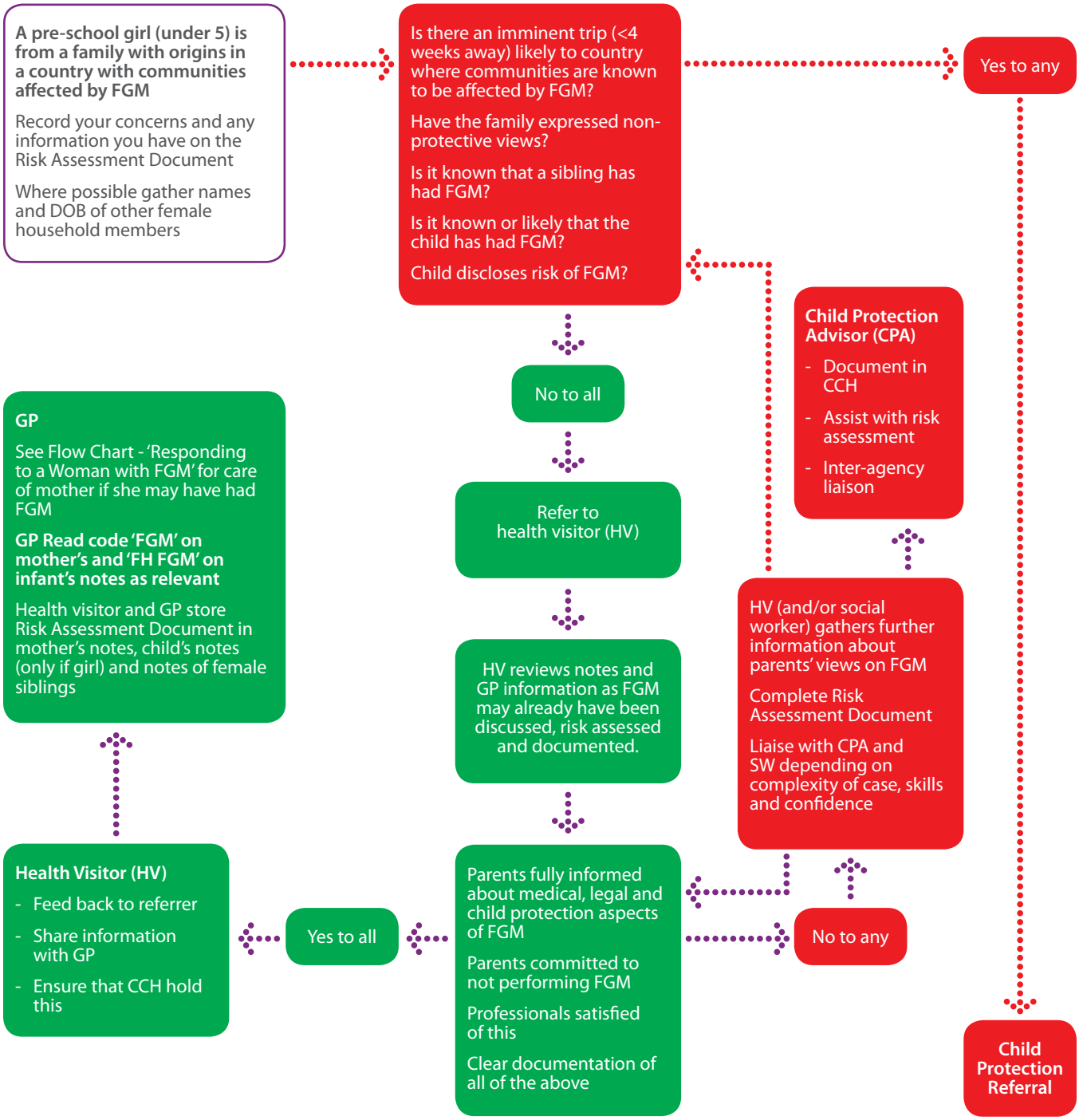
(Appendix A - Prevalence Map)



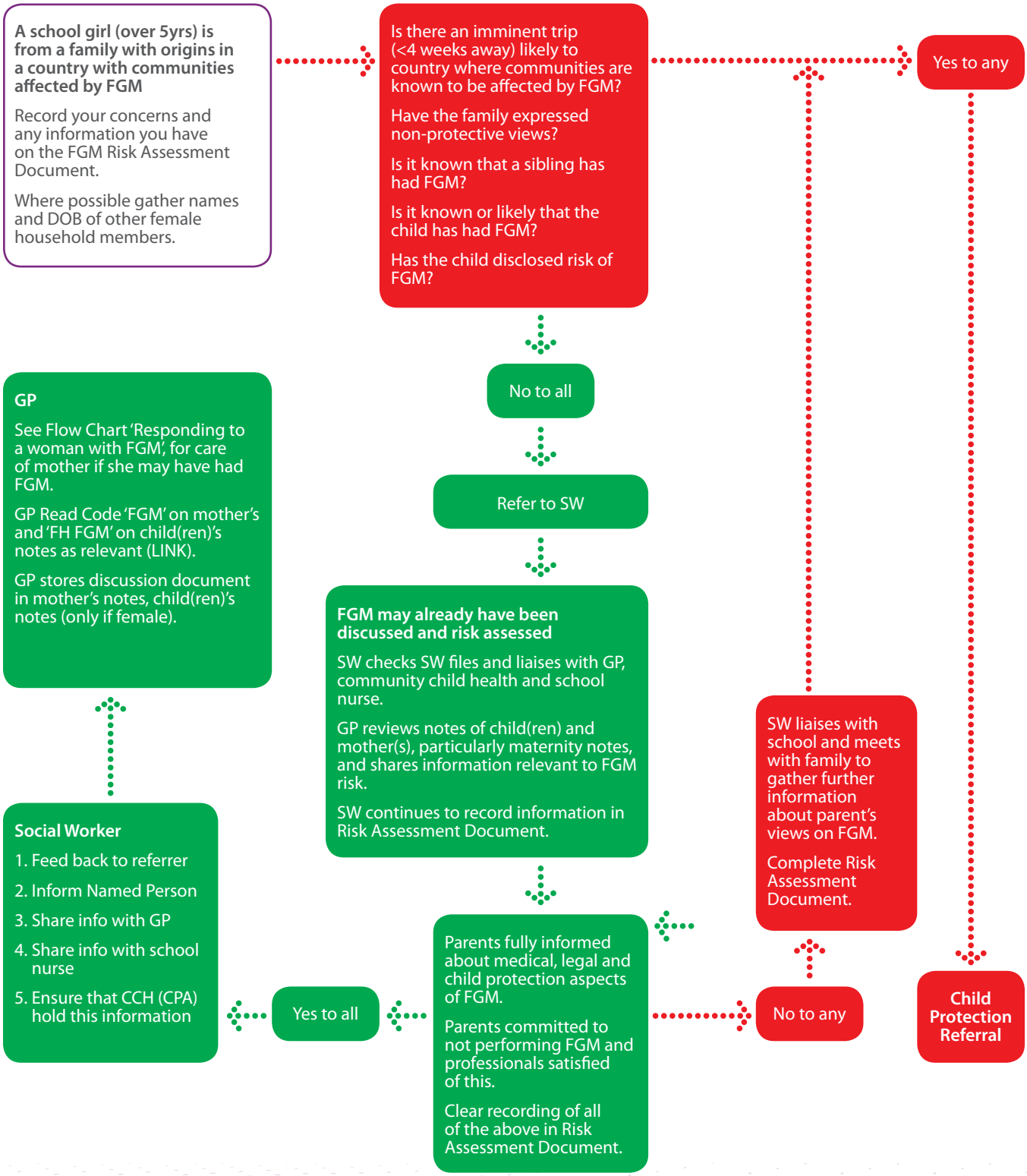
Flowchart 2 | Baby Born to Woman who has had FGM - Not Previously Known to Health Services or Not Recognised Until Labour



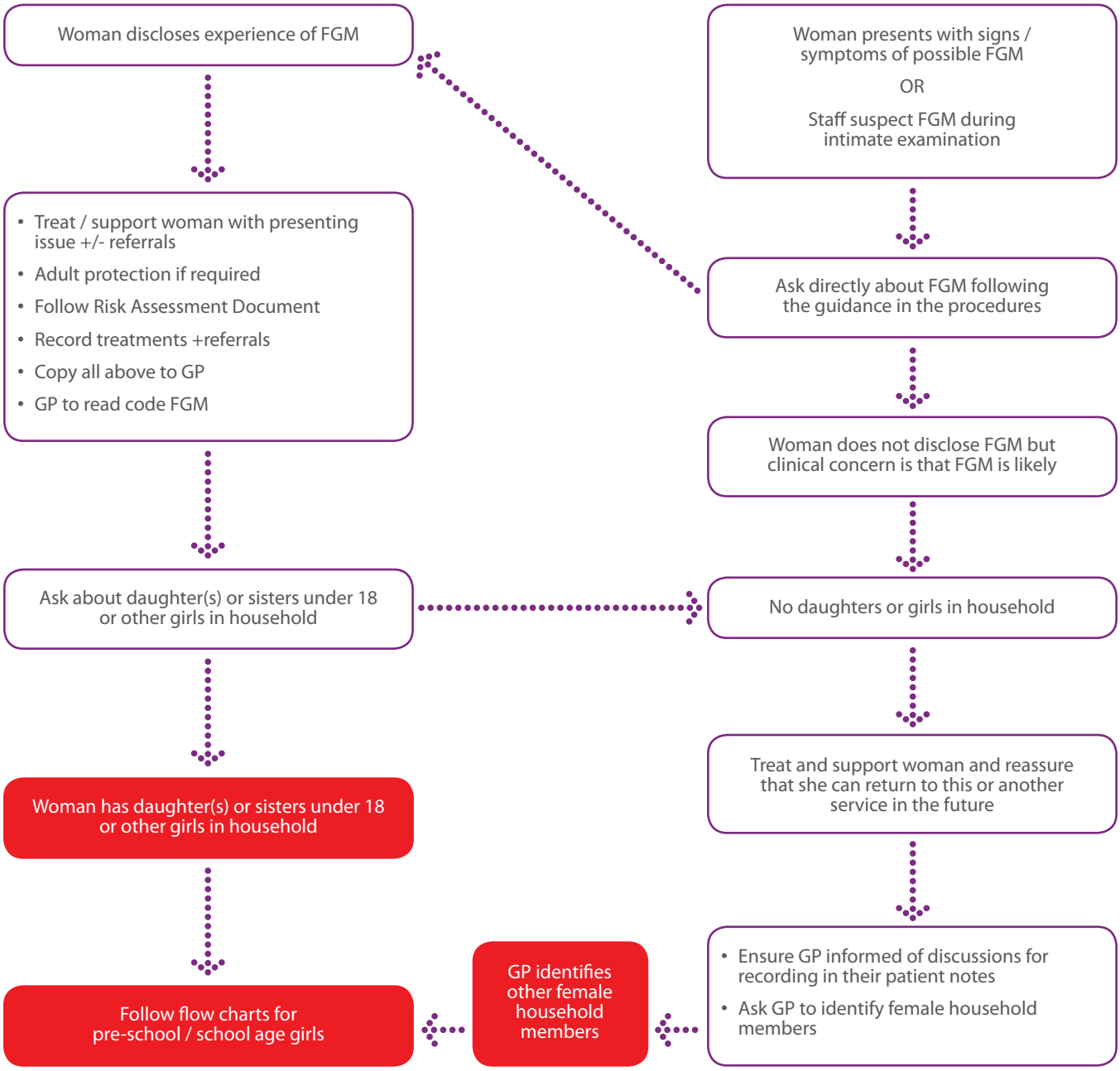
Flowchart 3 | Concerns about Pre-school Girl Who May be at Risk of FGM



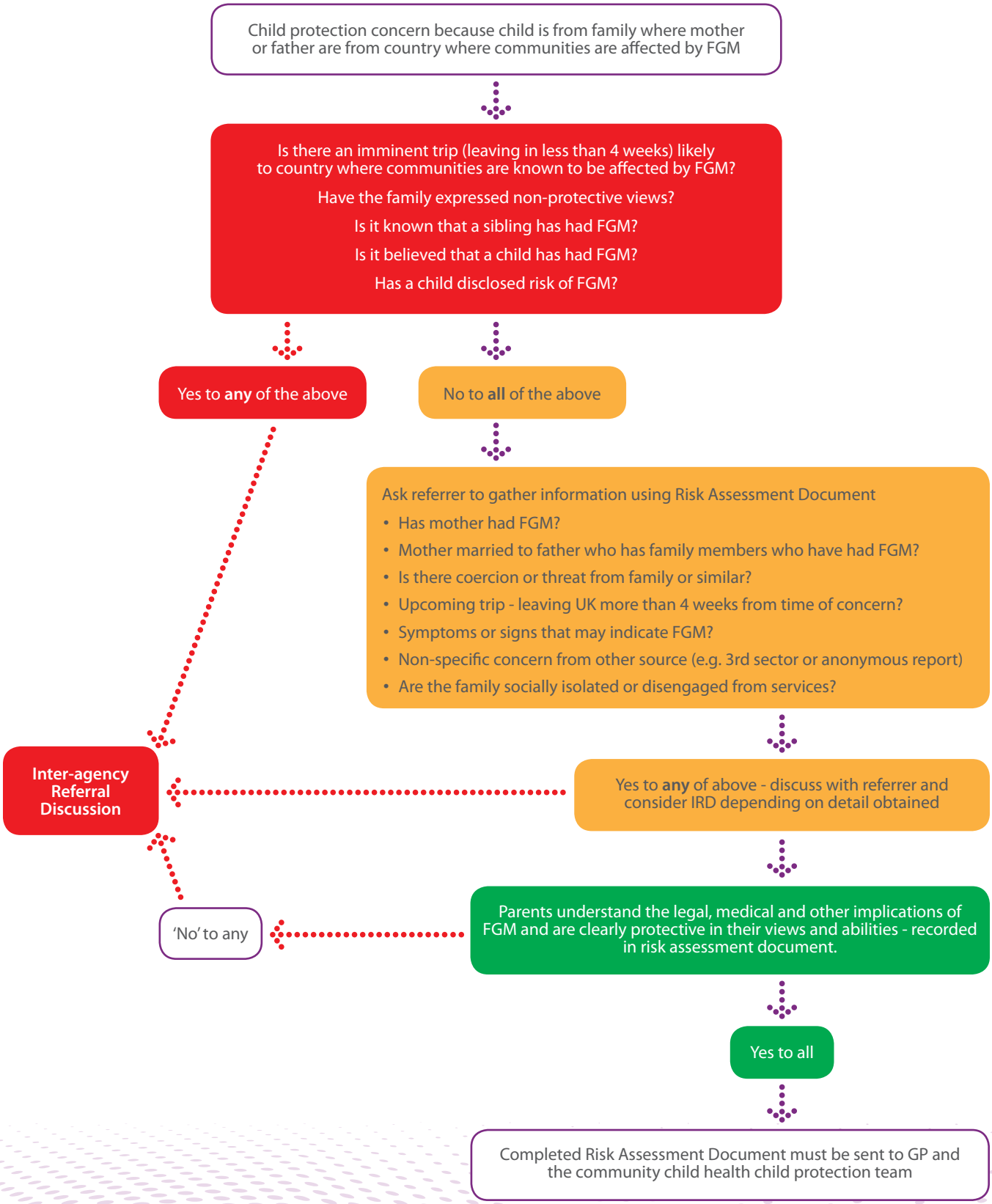
Flowchart 4 | Concerns about School Age Girl Who May be at Risk of FGM



Flowchart 5 | Responding to a Woman in a Clinical Setting with (possible) FGM



Flowchart 6 | Guidance for Child Protection Professionals Receiving Child Protection Referrals



NHS Lothian

NHS Lothian Procedures for the Protection of Girls and Women at Risk from Female Genital Mutilation (FGM)

Contents | NHS Lothian Procedures

Section 1 | Introduction

Women and girls with or at risk of female genital mutilation may present in many ways to health services e.g. obstetric and midwifery services, cervical smear screening, family planning / genito urinary clinics, travel clinics, paediatrics, urology, gynaecology, mental health, AandE, Scottish Ambulance Service and general practice.

"Protecting girls at risk of harm through FGM poses specific challenges because the families may give no other cause for concern. There may be an intergenerational element, or husband and wife may have differing views about daughters. The wish to carry out FGM is also not confined to individuals within particular levels of education or social class. The pressure to undertake this procedure maybe embedded in family structures. At all times however, it is important to think the unthinkable, and act with respectful uncertainty"(Department of Health, 2003).

All healthcare workers including all nurses, midwives and doctors have a duty of care to girls and women who are at risk of having FGM carried out, or who have already been affected by FGM. The Chief Nursing Officer and Chief Medical Officer for the Scottish Government have written to all healthcare professionals highlighting this obligation and the responsibility to understand and act in response to actual and potential FGM. Chief Medical Officer / Chief Nursing Officer Letter FGM 2014

Section 2 | Context

Female genital mutilation is illegal in Scotland (Prohibition of Female Genital Mutilation (Scotland) Act 2005) and the rest of the UK (Female Genital Mutilation Act 2003). It is illegal for anyone in the UK to perform FGM or assist in performing FGM on a girl or woman in and outside of the UK.

FGM is a violation of a child's rights and is a child protection issue. It is considered to be a form of gender based violence against women and girls and is managed in accordance with existing child and adult protection structures, policies and procedures.

Key Points

- Health care professionals have a responsibility to recognise and respond to women and girls at risk of FGM
- Country of origin is the single most important factor in identifying at risk girls and women
- If a woman is married to a man from a community known to be affected by FGM, she and her daughters may also be at risk
- A mother who has had FGM is a key risk factor for girls at risk of FGM.

Section 3 | Response and Actions to Follow in Acute Presentations

If a child or woman is in pain, has impairment (e.g. limping, bleeding, fever, or is generally unwell), where FGM is a concern:

1. Obtain medical help urgently - Accident and Emergency Department or GP

2. Make sure that the medical practitioner who will see the child / woman is aware of your concerns about FGM as soon as you are able, preferably before they are seen. However do not let this delay the process of obtaining medical help

3. In parallel with obtaining medical help, make a child protection referral by phoning health, social work or police, in accordance with the Inter-agency Child Protection Procedures Edinburgh and the Lothians 2015

Section 4 | Roles and Responsibilities all Health Professionals

All health professionals must be alert to at risk girls and women who they come across in their work, and take appropriate action.

- Midwives must enquire and gather information for pregnant women
- Health visitors must enquire and gather information for families from communities affected by FGM, who move to their area
- GPs must read code all FGM that has been carried out, and be aware of at risk women and girls, initiating action where appropriate
- Clinicians who manage adults who may be affected by FGM, have a professional obligation to
  - Be aware of countries affected
  - Be aware of the range of presentations of FGM
  - Follow adult protection procedures
  - Ask about female children (under 18 years) in the household
  - Follow Flowchart 5.

When talking about FGM, practitioners should:

- Make no assumptions
- Give the individual time to talk and be willing to listen
- Create an opportunity for the individual to disclose, seeing them on their own in private
- Be sensitive to the intimate nature of the subject
- Be sensitive to the fact that the individual may be loyal to their parents / family / wider community
- Be non-judgmental pointing out the illegality and health risks of the practice, but not blaming the girl or woman
- Get accurate information about the urgency of the situation if the individual is at risk of being subjected to the procedure
- Use simple language and ask straightforward questions
- Use terminology that the individual will understand e.g. they are unlikely to view the procedure as 'abusive' so ask 'have you been cut?'
- Avoid loaded or offensive terminology such as 'mutilation'
- Use value-neutral terms understandable to the woman, such as 'have you been closed?' or 'were you circumcised?'
- Be direct as indirect questions can be confusing and may only serve to reveal any underlying embarrassment or discomfort that you or the woman may have
- Give the message that the individual can come back to you if they wish
- Give a clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM if/when they have daughters
- Give a clear explanation of the health impacts of FGM with a view to encouraging the woman or girl to seek and accept medical assistance.

All health professionals should:

Be aware of the FGM Risk Assessment Document **(Appendix H)** to:

- See relevant questions
- Record information
- See what information should be given to patients

Follow the guidance on:

- Discussions
- Use of interpreters / translators
- Information sharing

Further information and resources can be found in Appendices A – I

Section 5 | Guidance for Specific Health Professionals

Pre-birth and Maternity Services

Early identification is critical to the delivery of effective maternity care, the implementation of effective preventative strategies and the protection of girls. The booking appointment is the most appropriate time to enquire about FGM and is an integral part of routine history taking - **refer to Flowchart 1**.

Midwives will need to explain that FGM can cause many complications in pregnancy / childbirth and therefore it is important you know if a woman has experienced any form of FGM to ensure safe delivery and effective care to both her and her baby.

If any uncertainty remains, a midwife might ask questions such as:

- Do you experience any pains or difficulties during sexual intercourse?
- Do you have any problems passing urine?
- How long does it take to pass urine?
- Do you have any pelvic pain / menstrual difficulties?
- Have you had any difficulties in childbirth?

The information leaflet FGM - A Statement Opposing Female Genital Mutilation helps explain the legal position and can be used by midwives as part of the discussion. It explains that the law is there to protect children. It is also there to help parents if they come under pressure from relatives or the wider community.

It is important that when using the leaflet, midwives:

- Point out the section stating: 'Any procedures to the genitalia can result in you and the person doing so being arrested and going to prison. This can happen even if it happens in Sudan (or relevant country)'
- Pay attention to the response - did you think that the woman / family understood it?
- Document the response - what was said?

See the flowcharts for patient pathways **(Section 9)**

There is a Specialist Midwife for FGM and referral should be made and advice sought, as outlined in the flowchart.

Ultrasound Scan Department

When a woman attends for an ultrasound scan and this needs to be done vaginally, the sonographer may see that she has had FGM. This may make the scan difficult or impossible, particularly if the vaginal orifice has been closed or obscured by tissue, because of FGM.

If this is the case then the sonographer should get in touch with the referrer as soon as possible. In the case of maternity patients this would be the community midwife and for non-maternity, it should be whoever has sent the woman for the scan, for example, GP or consultant.

If the sonographer has any concerns for the health or safety of a woman, they should consult with lead obstetrician and specialist midwife for FGM **(Appendix E - Key Contacts)**

Health Visitors

Health visitors are in a unique position to recognise girls at risk of FGM, within the community and take protective action. They are often the only professionals in contact with a family with pre-school children and are the Named Person (GIRFEC). A family new to the area, with pre-school children, would usually be contacted and visited by the health visitor and there are usually multiple contacts through routine health surveillance and immunisations.

For pre-school children, initiating discussion about FGM and gathering first information is the responsibility of the health visitor, if there is no record of previous discussions or risk assessment.

What to do when a baby girl is born to an 'at risk' mother:

Maternity services should already have gathered sufficient information for risk assessment of the baby girl. Health visitors should have access to this information including the FGM type, mother's views and assessment of risk to the baby, as well as any other relevant information about the mother's own well-being.

This should be copied to the baby girl's notes and the GP notes. If there are other girls in the family, then this information should also be copied to their GP notes, HV notes etc.

If this information has not been gathered or new information becomes available you may need to gather information as if the family are new to the area - as below. If any of the information is incomplete or you have ongoing concerns that the baby girl is at risk, you should seek advice from the Child Protection Advisors.

What to do when visiting a family new to area:

- Is the family from a 'risk' country? **(Appendix A - Prevalence Map)**
- Look at the other terms used for FGM to identify the terminology used in the particular country of origin **(Appendix B – Terms Used)**
- Print leaflets a) on legal position b) list of supports (in the home language) FGM Aware (Downloads)
- If you are going to see a family from an at risk country, check the notes of the child(ren) and mother (maternity notes in particular) as the issue of FGM may already have been addressed and risk assessed
- Initiate information gathering as outlined in the Risk Assessment Document
- Make child protection referral in accordance with **Flowchart 3** (Pre-school Girls).

School Nurses

School nurses are in a good position to work opportunistically with regards to FGM. They can reinforce information about the related health consequences and the law.

1) The school nurse will be copied in to FGM risk assessments carried out by health professionals and social workers
2) They should receive a copy of the risk assessment document for full background detail
3) They should be vigilant to any health issue such as recurrent urinary tract infection that may indicate FGM has been carried out
4) They are pivotal in information sharing about FGM risk in school age girls.

The school nurse should work closely with the child's Named Person in school, supporting them in any concerns. If a school nurse has been informed about or has taken part in risk assessment and information gathering, they should inform the Named Person using the standard letter at **Appendix F**.

Sharing of information should be relevant and proportionate therefore the entire risk assessment document, with all the health details of any FGM within the family need not be shared.

The Named Person should be advised that a risk assessment for FGM has been carried out and that professionals are aware. The protectiveness of parents and perceived level of risk to a child, along with ongoing work with families should be shared.

If the school nurse becomes aware of a trip abroad or there are other indicators of FGM risk, they should still follow **Flowchart 4**.

Monitoring 'at risk' girls and supporting their families is an ongoing process.

If the school nurse has opportunistic contact with a family who comes from a country where FGM is practised, they should initiate discussion and follow **Flowchart 4**. The Risk Assessment Document should guide discussion and be can be completed if a trusting relationship is established and communication is good **(Appendix H)**.

General Practitioners and Practice Nurses

What is your responsibility?

a) Ask about FGM when indicated and refer to adult and/ or child services if FGM is identified

b) Record FGM information in primary care

c) Hold and share information to facilitate risk assessment by other professionals

Who is at risk of FGM?

As well as families with origins in African countries, the student population (particularly post graduates with young children), including those from Middle Eastern and some Asian countries represent a significant at risk group **(Appendix A - Prevalence Map)**.

When should you ask about FGM?

If the mother/ woman is from a country where there are communities know to be affected by FGM **AND**

1) There are **genitourinary or mental health symptoms** - FGM should be considered in the differential diagnosis (which may become evident at routine cervical smear screening). Refer for specialist assessment if the woman discloses FGM, or you find or suspect this on examination.

2) **A family with girls** presents to a GP practice or travel clinic requesting foreign travel vaccinations - make a child protection referral

3) **Newborn check** - at the routine six week newborn check, particular attention should be paid to the documentation of **normal anatomy** of every girl's genitalia; if there is no communication from maternity services about previous FGM discussion or risk assessment, you should liaise with the health visitor.

Removal of the clitoris in the newborn period is a common form of FGM in some cultures.

If FGM is disclosed, ask if there are girls under 18 years in the household.

Make a child protection referral if there is threat to the child or a trip abroad. Otherwise, further information gathering, discussion and risk assessment will follow your referral to:

- Health visitor - for girls under 5 years
- Social Work - if girls over 5 years

Enquiry and discussion about FGM for women presenting with non-FGM related problems, is considered good opportunistic preventative practice, but is not a required action. To see the context of GP actions, refer to flowcharts, Risk Assessment Document and guidance on having discussions.

Information Holding - National Read Codes

FGM and FGM risk should be recorded appropriately to allow for data gathering at a national level. Chief Medical Officer / Chief Nursing Officer Letter FGM 2014

12b – Family history of female genital mutilation

13VY – At risk of female genital mutilation

K578 – Female genital mutilation

Information and Resources (Scottish Government) are available to download, print and give to patients at FGM Aware - these state the legal position and give sources of information and support.

NHS Lothian Adult Support and Protection Procedures 2015 should be followed if vulnerable adult women are at risk of FGM or honour based violence.

Clinicians who See and Manage Children in Other Settings

These include:

- Hospital and community paediatric staff
- Emergency Department doctors and nurses
- Doctors in general specialties who may see children, for example, dermatology, surgery, plastics etc
- CAMHS
- 'Walk in' centre staff.

Such clinicians need to consider the risks associated with FGM in relation to:

- Awareness of the countries with communities affected by FGM (Appendix A)
- You must ask about FGM directly if the child's family is from an affected country AND presenting symptoms may be caused by FGM (Appendix C)
  - Physical - urogenital symptoms, abdominal pain etc.
  - Psychological - behavioural disturbance, PTSD, anxiety, depression
- You are aware that the child will be travelling out of the UK.

If the child's family is from an affected country and you are assessing for a problem unlikely to be related to or due to FGM, for example a minor injury, then you are not required to take action.

If there is an admission to hospital, then FGM enquiry should be regarded as part of a routine social/ family history. In the same way that a family should routinely be asked about family members' health, ages and occupations, social work support, consanguinity and so on, FGM should also routinely be addressed.

You should be matter of fact, non-judgemental, clear and explain that the reason you are asking is to ensure that a child's health needs are considered and met. See also guidance in **Appendix D - Talking about FGM**.

Section 6 | Family Involvement and Translation Services

Relatives both male and female may coerce family members or perpetrate FGM. On occasions, the wider community may also play an active role in encouraging FGM and protecting those who perpetrate it.

It is therefore not appropriate to involve family members in initial discussions **without prior careful consideration of the risks of doing so**, particularly in cases where a girl is thought to be at risk of FGM. Contact with family members should be carefully planned and the impact of this contact monitored on an ongoing basis.

It is important that staff never:

- Approach members of the victim's family or community unless this has been fully considered, risk assessed and planned, preferably on a multi-agency basis
- Attempt to act as a mediator between the girl or woman and her family or community.

In most instances enquiries with the family should be undertaken by police or social work staff. In the early stages of a case (e.g. FGM is suspected as a girl has been missing from education for a prolonged period), it can be appropriate for other professionals to make informal enquiries before making a child protection referral. In these circumstances it is important that professionals do not reveal that enquiries are related to FGM, either to family / community members or to other professionals who are not fully aware of the need to handle information appropriately.

Use of Interpreters

Use of any interpreter or translator should only be through approved services such as NHS Lothian ITS - Interpretation and Translation Services.

They should **not** be:

- A family member
- Known to the individual
- Someone with influence in the individual's community.

Other steps that should be taken when working with an interpreter include:

- Checking the dialect spoken before making arrangements
- Having a briefing meeting with the interpreter, prior to the discussion with the woman
- If the woman wishes to be accompanied during the discussion, check that she understands the full extent of the discussion and the impact of having someone with her. If she insists, have a brief meeting with the accompanying person and establish the rules of confidentiality
- Explain the role of the interpreter at the beginning of the discussion
- Ensure that the interpreter does not add their own information or opinion.

Section 7 | Risk Assessment and Information Gathering

Risk is a 'dynamic continuum' and FGM risk assessment and monitoring for a girl is 'an ongoing conversation for her whole childhood'.

It is important to understand that even when a child, family and situation seem stable and safe, this is true for that point in time only. Changes in circumstances may increase risk of FGM to a girl significantly, even when parents themselves are entirely protective in their views. Such circumstances could include a visit from family members from a country known to be affected by FGM, or a trip to a country known to be affected by FGM. A protective parent may leave the nuclear family after relationship breakdown, and new partners may have less protective views with regards to FGM.

Many healthcare professionals have never seen or managed a woman with FGM but with ongoing training and awareness, this will evolve. A detailed discussion about FGM may therefore be best carried out by an appropriately trained health professional or more experienced social workers and/or public protection police officers, following the flowcharts.

Initiating Enquiry

You may find yourself in an opportunistic situation, you may have immediate concerns, or it may be your responsibility to initiate information gathering and communication about FGM. If this is the case, the FGM Risk Assessment Document **(Appendix H)** is designed to help you gather, as far as possible, the most important initial information that the child protection team will need to look at.

Language

If you feel that there is not sufficient understanding of English language, arrangements should be made for an appropriate interpreter or translator – **refer to Section 6**.

If this is being arranged, then discussion with the Child Protection Advisor about an IRD should take place early. Consider an opportunity at the outset for an interpreter / translator facilitated discussion, to address all the areas in the FGM Risk Assessment Document, depending on urgency and other factors. This decision would be in discussion with the child protection team.

FGM Risk Assessment Document (Appendix H)

If communication is good, language is not a barrier and you are confident with your knowledge and skills, you may be the best person to gather further information to help with inter-agency risk assessment. If this is the case, then you should document your discussion and all the information gathered on this document and share it with the child protection team.

Where possible FGM discussion should include:

- Review records to see if FGM risk assessment or information is already available
- Clarify all the female members of the extended family and household
- Ask if the family plan any trips to the country of origin.

Focus of Discussion

Depending on your role and setting there will be different emphasis on the three main areas:

1. Risk to child / children
2. Care of woman who has undergone FGM
3. Adult support and protection.

Child Protection

The aim is to try to clarify risks to the child / children in order to inform subsequent risk assessment.

Key points are:

- Has the woman undergone FGM? - a significant risk factor for daughters
- What are her views on FGM?
  - Protective - may be opposed to FGM and determined daughter will not have it
  - Non protective - may not realise health, legal, child protection issues and believe her daughter should have FGM
  - Undetermined
- Is there an up-coming trip to the country of origin? - this increases risk significantly therefore **make a child protection referral**
- Are there other associated girls at risk?
- Are there other people e.g. husbands, grandmothers who may wish the girl to have FGM?

If The Woman Discloses FGM

You may be the first person that the woman has discussed FGM with. This subject can be extremely complex and women may deny that they have had the procedure when they have, through fear or shame or sometimes say that they have had it when they haven't because the community regards it as a positive sign for example of 'purity' or 'cleanliness'.

Here are the suggested areas to cover following a disclosure:

Ask if she has seen a doctor and acknowledge that women who have been cut / circumcised can have physical difficulties e.g. pain, urine problems, as well as emotional difficulties. Let her know that there are people who can help and offer your help to get her support e.g. if she would like to make an appointment with a GP.

Explain that while it is now illegal for FGM (cutting / circumcision) to be carried out on children and women, reassure her that she does not need to be afraid of the police. If it happened in her country and maybe a long time ago, it does not mean there will be legal or police involvement.

Whether or not the woman has disclosed FGM, it is important to 'leave the door open':

- Reassure her that she can come back for support
- Offer the information leaflet and point out the key contacts
- Offer your help to contact support agencies or help with referrals

For more information on talking about FGM refer to **Appendix D**.

If you are not able to progress with the woman's welfare issues as outlined above:

- You must communicate with her GP
- You must be aware of Adult Support and Protection Procedures - some situations regarding FGM can put women at risk

You must explain that because FGM is a child protection concern in Scotland:

- You have a duty to follow child protection procedures and that this is routine practice
- Be clear about your duty to share information
- Reassure that this will only be with professionals who need to know, not people in the wider community.

Sharing Information

All health professionals have a responsibility to share information if there are concerns about the wellbeing or safety of a child or young person. The Caldicott Guardian for NHS Lothian has provided additional specific guidance on the sharing of health information in relation to FGM, as follows:

"FGM is a crime in Scotland and has been for some time Prohibition of Female Genital Mutilation (Scotland) Act 2005. It is considered as one of the 'offences against children under 17 to which special provisions apply'.

All of the guidance is very clear that FGM is a form of abuse and gender based violence that has serious short and long term physical and psychological consequences. It is necessary therefore to identify children at high risk. Since the risk of FGM varies by country of origin, it is essential that we gather the information necessary to assess risk and to take action. This includes identifying and sharing intelligence in preparation for an IRD when the only information we have initially is country of birth or country of origin".

Health information shared with other agencies should be relevant and proportionate, in accordance with GMC Guidance (0-18) and local and national policy and procedures.

Once information has been gathered and shared to inform assessment of risk, a proportionate response can be progressed.

Section 8 | Medical Assessment of Children

1. **Acute symptoms:** If a child or woman presents with acute symptoms, she should be examined in the usual way by Accident and Emergency Department or GP professionals, for assessment of need for urgent intervention.

2. **Non-acute situation:** If there is a non-acute indication for examination, then the situation needs to be weighed up carefully, with an experienced paediatrician involved with decision making. This should be done if it is in the best interests of the child, for example if she has symptoms. It should be done by an experienced paediatrician, in a planned and supportive way, usually in the 'SCAN' clinic by the child protection team. Not all girls who have undergone FGM need to be examined.

3. **Unnecessary repeated examinations** by inexperienced staff should be avoided by careful consideration, discussion and planning.

4. **Women with complications of FGM** may be seen in the specialist service for women who have had FGM - referral via SCI Gateway F.A.O. Consultant with Special Interest in FGM.

5. **Blood Borne Viruses** because FGM is usually carried out in a non-clinical setting, using instruments that have not been sterilised, and which may have been used repeatedly for FGM procedures on other girls, the transmission of Hepatitis B, C and HIV is an appreciable risk. Even if there is lack of clarity about whether to carry out an examination, there should be consideration of a holistic and supportive medical assessment to include blood borne virus screening, exploration of symptoms, and the offer of a supportive examination and evaluation if indicated.

6. **Forensic evidence:** If you believe that a criminal offence has been committed and FGM carried out, there may be a need for corroborating evidence in the form of a joint paediatric forensic examination. This must be discussed with child protection paediatricians and police, as part of an Inter-agency Referral Discussion (IRD)

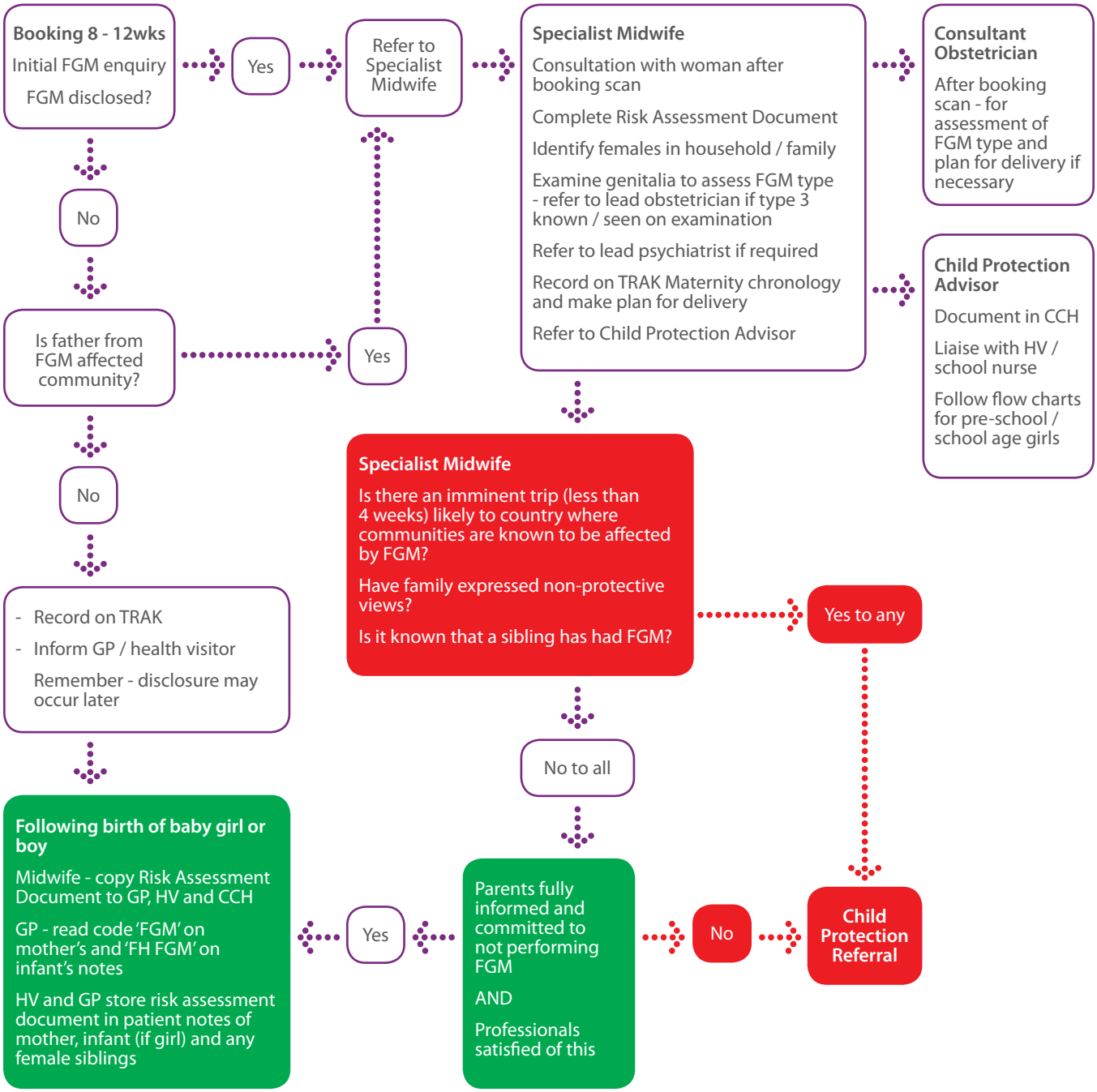
7. **A holistic assessment** which explores any other medical, support and protection needs of the girl or young woman is offered and appropriate referrals, including mental health, should be made as necessary.

8. **Visible evidence of FGM** particularly type 4, may be difficult to discern on 'standard' or 'naked eye' inspection, so specialist examination should always be discussed with the child protection team where there is a concern that FGM has been performed.

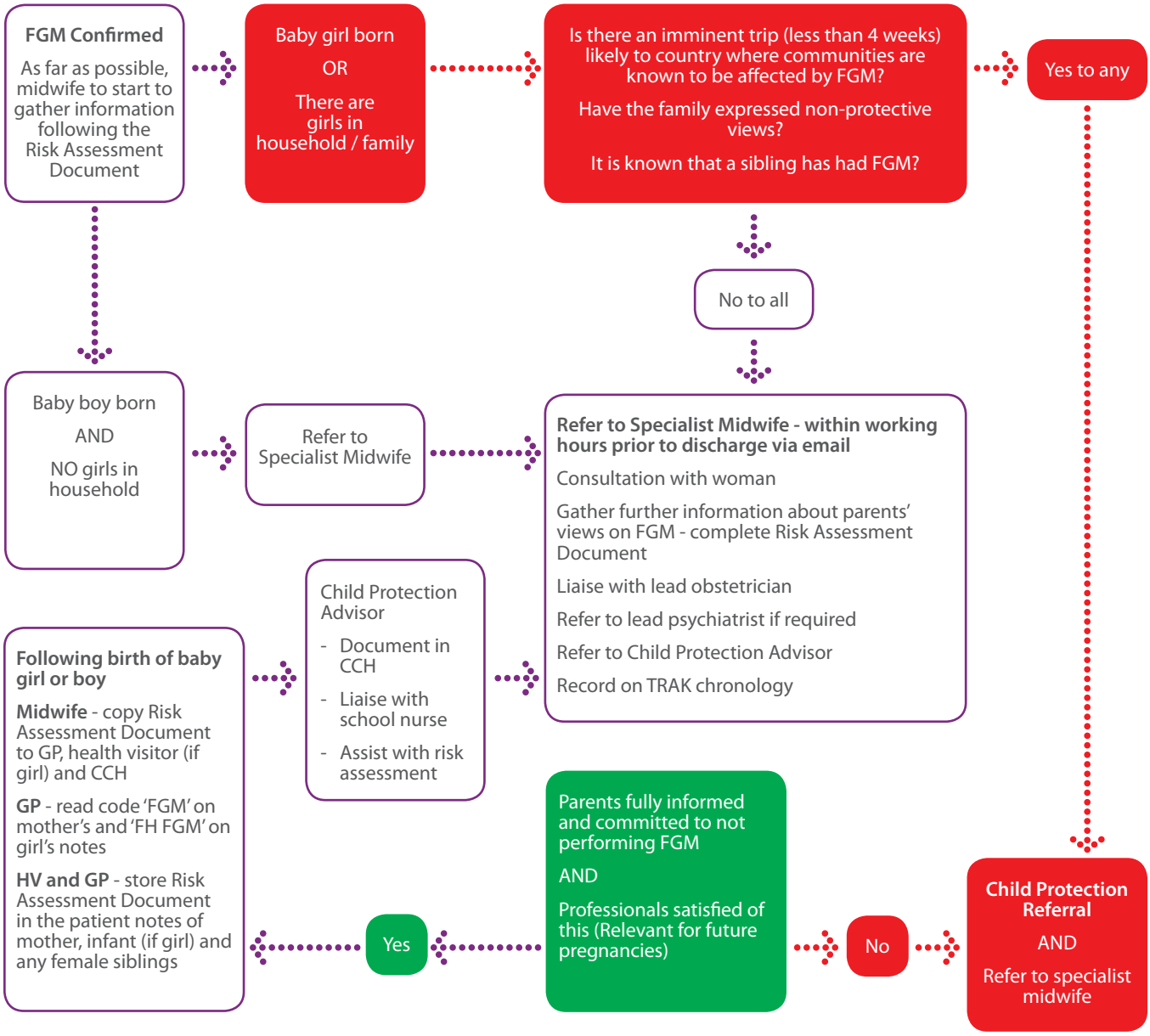
Section 9 | Flowcharts

Flowchart 1 | Pregnant Woman from a Country with Communities Known to be Affected by FGM

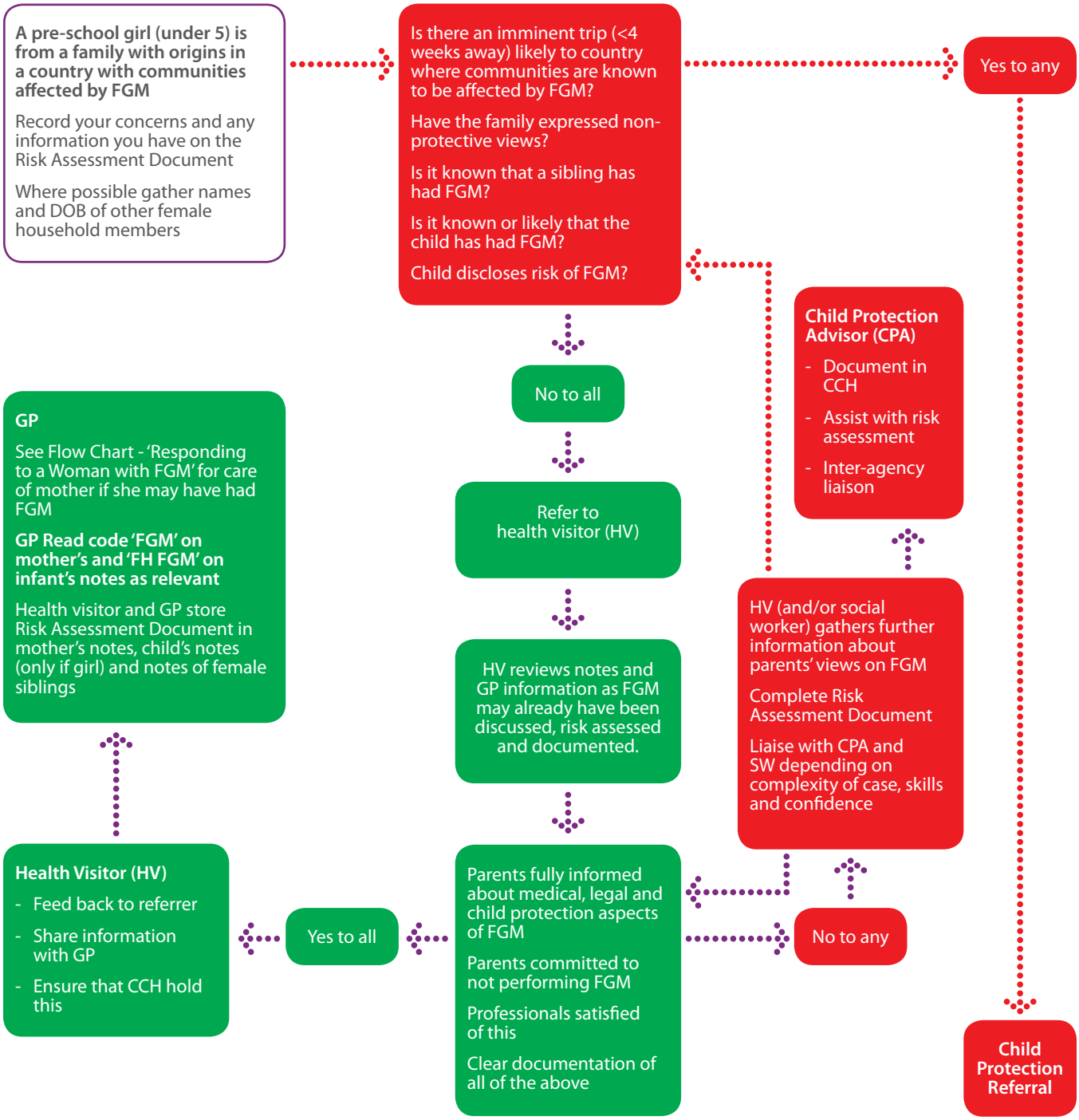
(Appendix A - Prevalence Map)



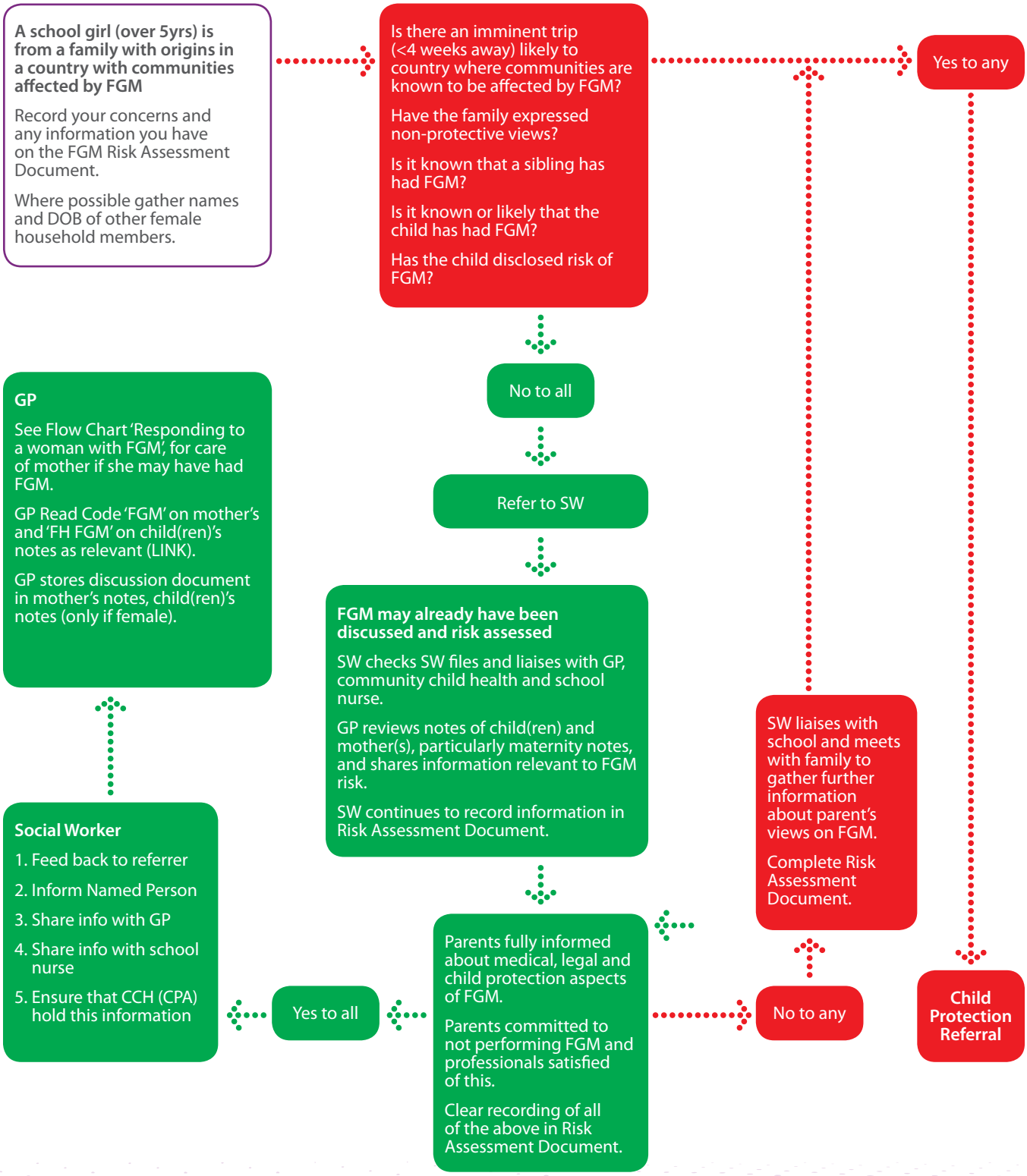
Flowchart 2 | Baby Born to Woman who has had FGM - Not Previously Known to Health Services or Not Recognised Until Labour



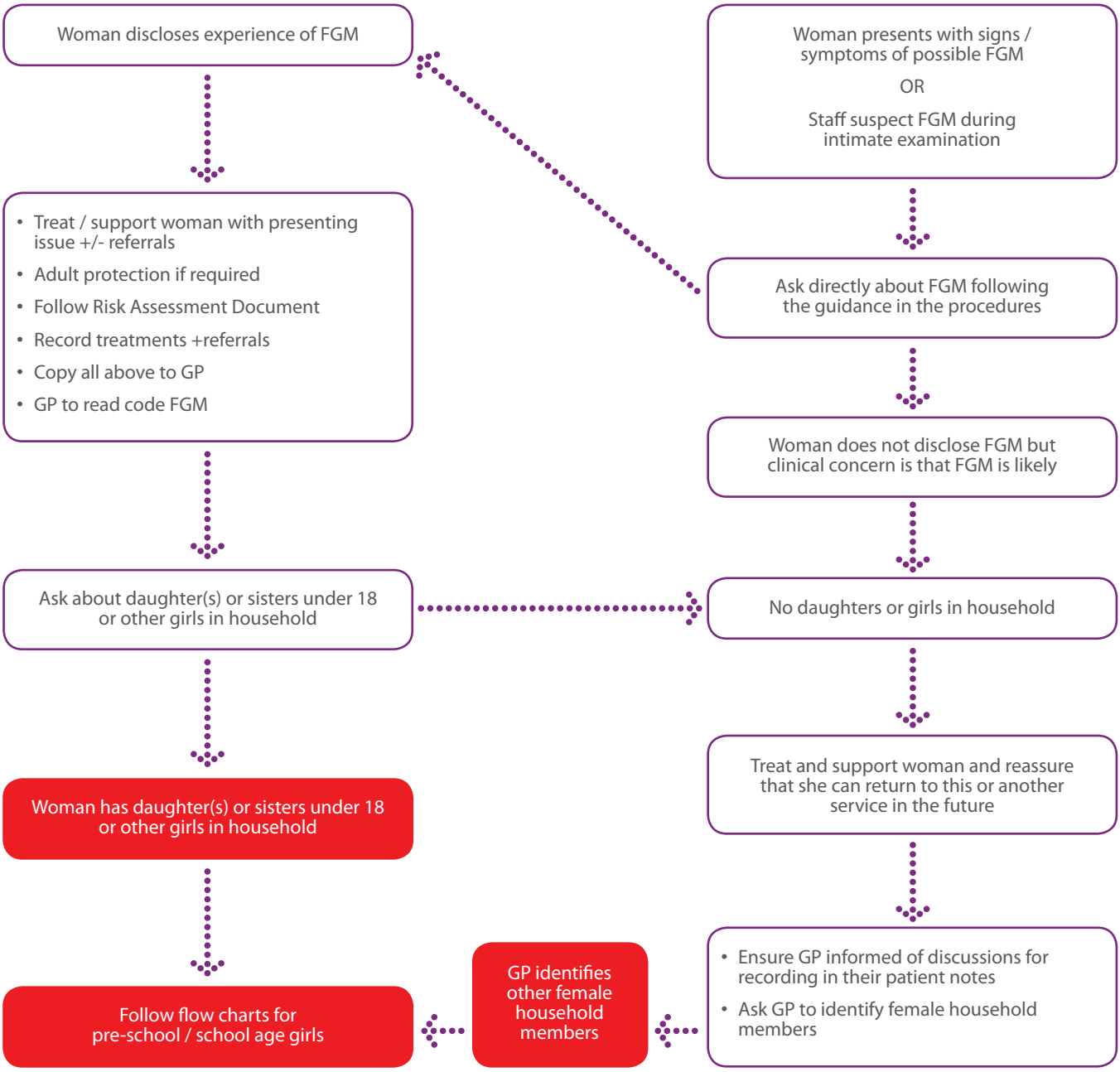
Flowchart 3 | Concerns about Pre-school Girl Who May be at Risk of FGM



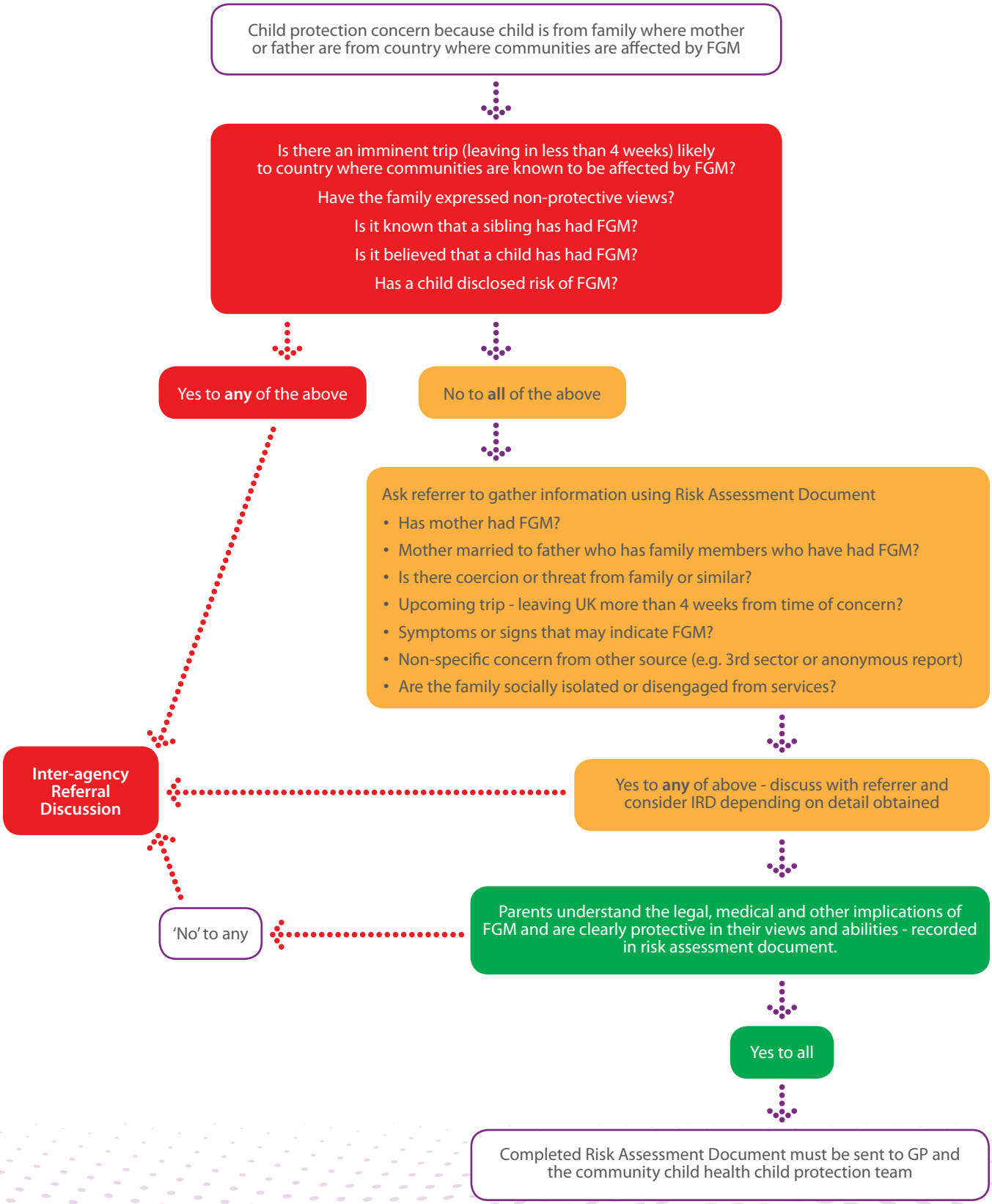
Flowchart 4 | Concerns about School Age Girl Who May be at Risk of FGM



Flowchart 5 | Responding to a Woman in a Clinical Setting with (possible) FGM

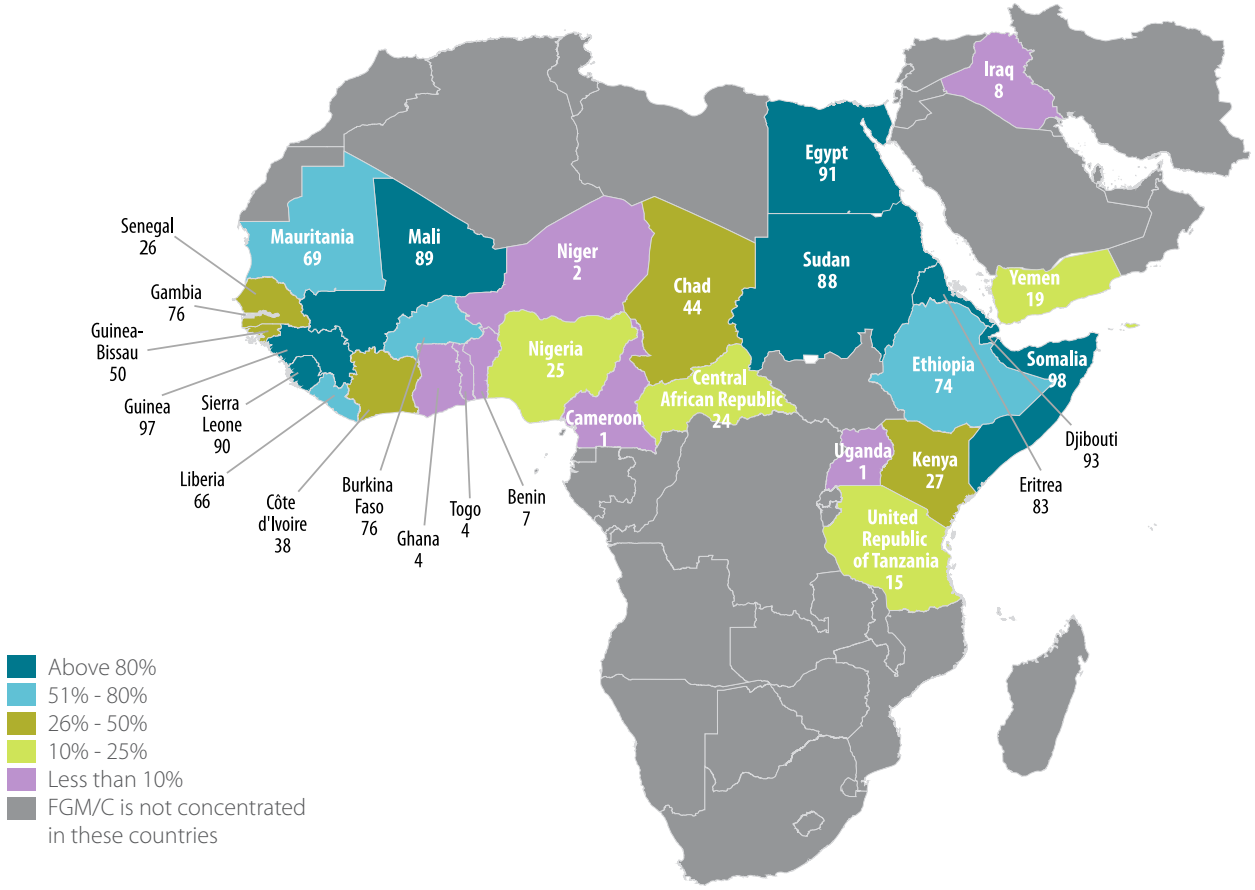


Flowchart 6 | Guidance for Child Protection Professionals Receiving Child Protection Referrals



Appendix A | Countries that Practice FGM

FGM/C is concentrated in a swathe of countries from the Atlantic coast to the Horn of Africa.



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

FGM has also been documented in communities including:

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

Appendix B | FGM Terms Used in Practicing Countries

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 circumcision
	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
ETHIOPIA	Megrez	Amharic	Circumcision/cutting
	Absum	Harrari	Name giving ritual
ERITREA	Mekhnishab	Tigregna	Circumcision/cutting
KENYA	Kutairi	Swahili	Circumcision – used for both FGM and male circumcision
	Kutairi was ichana	Swahili	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 an initiation rite into adulthood – for non-Muslims
	Bondo/Sonde	Mendee	Integral part of an initiation rite into adulthood – for non-Muslims
SOMALIA	Gudiniin	Somali	Circumcision used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word 'halal' ie. ' sanctioned' – implies purity. Used by Northern and 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 word '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	Mandinka	Meaning 'the affair' but also the name for the shed built for initiates
	Musolula Karoola	Mandinka	Meaning 'the women's side'/'that which concerns women'

Appendix C | Signs, Symptoms and Indicators that a Girl may have had FGM and Medical / Health Complications for Women

- Girl is reluctant to undergo any medical examination
- Girl has difficulty walking, sitting or standing or looks uncomfortable
- Girl finds it hard to sit still for long periods of time, which was not a problem previously
- Girl presents to GP or A and E with frequent urine, menstrual or stomach problems
- Increased emotional and psychological needs e.g. withdrawal, depression, or significant change in behaviour
- Girl avoiding physical exercise or requiring to be excused from PE lessons without a GP's letter
- Girl has spoken about having been on a long holiday to her country of origin or another country, where the practice is prevalent
- Girl spends a long time in the bathroom / toilet or long periods of time away from the classroom
- Girl talks about pain or discomfort between her legs.

Medical and health complications for women include:

- Constant pain
- Pain and/or difficulty having sex
- Repeated infections, which can lead to infertility
- Bleeding, cysts and abscesses
- Problems passing urine or incontinence
- Depression, anxiety, flashbacks and self-harm
- Nightmares and other sleep problems
- Problems during labour and childbirth, which can be life-threatening for mother and baby.

Appendix D | Talking about FGM

FGM is a complex and sensitive issue that requires professionals to approach the subject carefully. Asking the right questions in a straightforward and sensitive way is key to establishing the understanding, information exchange and relationship needed to ensure that the girl or woman, and her family members, are given the care, protection and safeguarding they need.

Use simple language, be direct and ask straight forward questions such as:

"Have you been cut or closed?"

"Were you circumcised?"

"Have you been cut down there?"

Indirect questions can be confusing and may only serve to compound any underlying embarrassment or discomfort that you or the patient may have. If any confusion remains, ask questions such as:

"Do you experience any pains or difficulties during intercourse?"

"Do you have any problems passing urine?""How long does it take to pass urine?"

"Do you have any pelvic pain or menstrual difficulties?"

"Have you had any difficulties in childbirth?"

(FGM Multi-Agency Practice Guidelines (section 4.2) Home Office 2014)

Other examples of the vocabulary that you might helpful to use to start discussion:

"Because you / your family / husband are from Sudan (or other country) I want to show you this" FGM - Information to Help

"I understand that traditional practices (or local word for FGM) are sometimes carried out in some communities in Sudan (or other country). This leaflet explains that FGM is taken very seriously in Scotland and is against the law."

There are obviously many possible responses to this 'opener'. It may prompt the mother to give information, either volunteering that she has had FGM or that she has not. She may say nothing, or say something unclear. You should then use your judgement on how to take the conversation forward such as:

"It can be difficult to talk about this, but is this something that you have experienced? Have you been cut or closed, or had anything done 'down there' (indicate area of body depending on understanding of English language).

If you know the country of origin, then you can add the term from the country here but bear in mind that many different terms are used within communities - "What is the name for this where you come from?"

Appendix E | Key Contacts

Lead Professionals for FGM in NHS Lothian

Service	Obstetrics
Lead Professional	Dr. Anne Armstrong, Consultant Obstetrician and Gynaecologist
Telephone	01506 523 979
Email	Anne.Armstrong@nhslothian.scot.nhs.uk

Service	Gynaecology
Lead Professional	Dr. Alison Scott, Consultant, Family Planning and Well Woman Services
Telephone	0131 536 1527 (61527)
Email	Alison.M.Scott@nhslothian.scot.nhs.uk

Service	Midwifery
Lead Professional	Vicki Davitt, Gender Based Violence Midwife
Telephone	07765 2331789
Email	vicki.davitt@nhslothian.scot.nhs.uk vicki.davitt@nhs.net

Service	Paediatrics
Lead Professional	Dr. Susan Kidd, Consultant Paediatrician
Telephone	01506 524406
Email	susan.kidd@nhslothian.scot.nhs.uk

Service	Child Protection
Lead Professional	Breda Wilson, Child Protection Advisor
Telephone	0131 536 0170 (20170)
Email	Breda.Wilson@nhslothian.scot.nhs.uk

Service	General Practice
Lead Professional	Dr. Kim Henry
Telephone	0131 554 4853
Email	kim.c.henry@nhslothian.scot.nhs.uk

Service	Psychological Support for Adults
Lead Professional	Dr. Sarah M Kennedy, Consultant Psychiatrist
Telephone	0131 242 1398 (21398)
Email	Sarah.M.Kennedy@nhslothian.scot.nhs.uk

Service	Psychological Support for Children
Lead Professional	Via Meadows Child and Adolescent Sexual Trauma Service
Telephone	0131 536 0519 (20519)

Appendix F | Threshold for Inter-agency Referral Discussion (IRD): Guidance for the Core Agencies on Receipt of FGM Child Protection Referral

Proceed to Inter-agency Referral Discussion if:

Girl is known to come from a community affected by FGM **(Appendix A – Prevalence Map)**

AND any of the following:

1. Indication of imminent (less than one month) trip to country where communities are known to be affected by FGM
2. The family have expressed non-protective views
3. Sibling has had FGM
4. Child has had FGM
5. Child discloses risk of FGM

If the referrer is not in a position to directly gather the information outlined above, for pre-school girls, this can be done via the health visitor, for school girls, refer to social work following Flowchart 4.

If none of the above known ask the referrer to gather additional information:

1-5 above AND where possible, if:

6. Mother has had FGM (significant risk factor for daughters)
7. Mother married to father who has family members who have had FGM
8. Coercion or threat from family or similar
9. Upcoming trip abroad, over a month away
10. Symptoms or signs that may indicate FGM
11. Non-specific concern from other source (e.g. 3rd sector or anonymous report).

If the referrer is not in a position to directly gather the information outlined above:

- For pre-school girls, this can be done via the health visitor
- For school age girls, refer to social work flowcharts in Inter-agency FGM Procedures Edinburgh and the Lothians.

Appendix G | Standard Letter from Health Visitor to Head Teacher (Named Person to Named Person, under GIRFEC Principles)

Date

Referrer Name

Address

Contact email

Contact phone no

To:

Head Teacher / Other Named Person

School

Address

Child's Name / DOB

Address

Contact phone

Dear Colleague,

Re: FGM Risk Assessment

This girl's family is from a country where communities are known to be affected by FGM.

FGM has been fully discussed with the family and a risk assessment has taken place, in accordance with the Lothian Inter-agency FGM Child Protection Procedures. Should you require any further information, please discuss with myself or the school nurse, who holds a copy of the relevant background document.

There are no child protection procedures in place for this child in relation to FGM.

Monitoring girls who may be at risk of FGM and supporting their families, is a continuous process. Although there is not believed to be a significant risk to this girl at present, if new information should emerge such as a trip abroad, plans for a ceremony, or specific information about FGM, then the Lothian Inter-agency FGM Child Protection Procedures should be followed.

Yours sincerely,

NAME

Appendix H | FGM Risk Assessment Document

This is a sensitive child protection document. No details of this report should be disclosed unless the information is relevant and proportionate for a child protection concern.

Use this to guide gathering of information and document discussions with family and between professionals

You may be the first person to broach the subject of FGM with a woman or at risk child (health visitor, GP, midwife, obstetrician, paediatrician, school nurse, other healthcare worker, social worker, teacher, police officer or volunteer). You may be the IRD participant and carrying out the risk assessment discussion with the carer(s).

Work to the relevant flowcharts, guidance about having discussions, map of affected communities and symptoms within the procedures.

There are likely to be several discussions about FGM in relation to a child / family at risk. You do not have to have discussed FGM directly but if you are aware that FGM is a risk, then gathering information and documenting it will allow clear and proportionate actions and decisions to be made now and in the future.

You don't have to ask all of the questions listed but if you have discussed any of the areas then you must document that you have.

You must then share this document with those professionals continuing to work with the family about FGM.

Complete the table on page 9 stating who completed each part. This may be more than one person in which case the name of each should be documented.

If at any stage you think there is imminent risk of harm, take action and make an immediate child protection referral.

Part 1

a) Initial information

b) When a woman or child has had FGM

Part 2

a) Risk Assessment – direct discussion with parent/s / family

b) Legal aspects

c) Medical aspects

d) View of parent/s / family and outcome of discussion

e) Information sharing and communication

Part 1a Initial Information

Name (child or woman)
DOB
Address
Contact phone number
Name of parents or other family members present
Relationship to child
DOB
Address
Contact phone number
Date discussion initiated
Place / location / setting
Who started the discussion / information gathering?
Which agency or organisation does this person belong to?
What is the subject's / family's country of origin?
What links do they have with the country of origin?
Are there any plans for a trip to country of origin or other country where FGM is practiced? (make child protection referral)

What visa / passport do they have?
What is the subject's first language?
What level of English language is used if any?
What other languages are spoken?
Did you use a translator?
Language used
Organisation
Translator's full name
Contact number
Notes

Part 1b Woman or Child as had FGM Performed

(If more than one family or household member has had FGM, complete a separate page for each person)

*** Remove or block out this section prior to copying to child's notes**

What terminology / word is used to describe the FGM?
Which country (including region or tribe) was it carried out in?
When was FGM carried out? / How old was she?
By whom?
Does she still have contact with this person? Other circumstances?
What type of FGM (if known or clear - it may not be)?
Any medical symptoms or complications? *
Any treatment received since FGM? *
Do you need to discuss or offer facilitating referral for (further) medical assessment and treatment, including psychological support? *
Does the subject's GP or other health professional know about the FGM?

Who else knows about the FGM? *
What are the woman's views about the FGM or the parents' views if the subject is a child?
Were you able to gain a realistic impression of their views?
Do they appear to see FGM as acceptable and 'normal'?
Has the woman expressed a desire to have the procedure carried out on their / a child? (you must make a child protection referral if not already done)
What are the child's father's / woman's partner's views about the FGM?
Were you able to gain a realistic impression of their views?
Do they appear to see FGM as acceptable and 'normal'?
Have they expressed a desire to have the procedure carried out on their / a child? (you must make a child protection referral if not already done)

What support services have been accessed, for example – health, Shakti, Saheliya, Bright Choices, church/ faith groups) (Offer information or help to contact if appropriate)
Does the woman feel threatened, afraid or intimidated by anyone regarding FGM? If yes from whom?
Are there any active associated issues such as forced marriage, honour based crime, domestic violence?
Have you or do you need to consider adult protection procedures for the adult who has had FGM or the parent?
Does the person have a social worker?
If a child, does the Named Person know about FGM risk?
Has there been a clinical assessment of the type of FGM? If so, by whom?

Date of examination
Outcome 'Any further clinical information? (include EDD if pregnant)
Offered deinfibulation?
If a professional is working with a family over several visits, or there is an IRD, there may be a large amount of information gathered to inform the risk assessment, identify protective factors, safety planning, etc. This should be referred to, attached or summarised here:

Part 2a) Direct Discussion with Parents / Family

Record Details of: child at risk, those present and professional leading the discussion

NAME AND D.O.B. OF AT RISK CHILD / CHILDREN

Name.....

Address.....

DOB.....

Tel no.....

Name.....

Address.....

DOB.....

Tel no.....

Name.....

Address.....

DOB.....

Tel no.....

Name.....

Address.....

DOB.....

Tel no.....

NAME, D.O.B. OF PARENTS / FAMILY MEMBERS PRESENT (including relationship to child)

Name.....

Address.....

DOB.....

Tel no.....

Relationship to Child.....

Name.....

Address.....

DOB.....

Tel no.....

Relationship to Child.....

Name.....

Address.....

DOB.....

Tel no.....

Relationship to Child.....

Name.....

Address.....

DOB.....

Tel no.....

Relationship to Child.....

Part 2b) Legal Aspect

LEGAL ASPECTS Have you explained that:	Tick when discussed Yes	No	Notes
FGM is illegal in the UK?			
It is illegal to take a child out of the country to have FGM performed, even if it is legal in that country?			
Anyone who carries out, facilitates, or encourages FGM faces prosecution and imprisonment?			
Is treated as child abuse by the UK authorities?			
Have you given the information leaflets that include all of the above points? (Appendix I)			
If yes, which document did you give?			
Who did you give it to?			
What language was this in?			
Are you confident that the subject fully understands the content of the LEGAL ISSUES above?			

Part 2c) Medical Aspects

MEDICAL ASPECTS Have you discussed that:	Tick when discussed Yes	No	Notes
FGM is associated with many serious medical complications?			
Can cause death in some cases?			
If relevant, have you asked if the person suffers from these symptoms?			
If yes to above, have you offered to refer for assessment and if possible medical treatment?			

Part 2d) Views of Parent/s / Family and Outcome of Discussion

CHILD PROTECTION	**Tick when discussed** Yes	No	**Notes**
Did the child's parents / carers ALL overtly commit to protecting their child / children from FGM?			
Are you and they clear that there are no other individuals who might carry out or facilitate FGM on the child / children?			
Outcome There was good communication in an appropriately supported environment and I / we as the professional/s are clear that the above points have been addressed completely and there are no outstanding child protection concerns.			
There were difficulties with communication or an incomplete picture was obtained that means further work and engagement with the family will be needed. Significant uncertainty and concerns remain? **Make a child protection referral.**			
Action Taken			

Part 2e) Information Sharing and Communication

IRD has been initiated **Yes** ☐ **No** ☐

If an IRD been carried out for this child

Date initiated.....

eIRD number? (if applicable).....

Outcome of IRD.....

CPCC / NO FURTHER ACTION / OTHER (state).....

.....

Notes.....

.....

.....

.....

Sharing Document with GP
GP's are pivotal to information holding and continuity through a child's life. It is ESSENTIAL that this document is shared with the GP.

This is the responsibility of the IRD health participant (if IRD held); the midwife if maternity case; health visitor for pre-school child; social worker if school aged child.

Remember to remove marked sections on page 2 before copying to child's notes.

Sent to GP by (PRINT):.....

Designation:.....

Date:.....

Share with Child Protection Advisor
Send copy to Child Protection Advisor, Community Child Health

Sent to CPA by (PRINT):.....

Designation:.....

Date:.....

GP Actions
1. 'Read Code'
2. Ensure that a copy of this entire document is in the **GP notes of the woman** with FGM **and all female children**; should be shared with maternity services at booking of any subsequent pregnancies
3. Ensure that a copy of the document is in the **health visitor notes** of all female children

Part 1 Completed by

Name:.....

Designation:.....

Tel no.:.....

Date:.....

Part 2 Completed by

Name:.....

Designation:.....

Tel no.:.....

Date:.....

Appendix I | References

Further guidance for health professionals:

NHS Lothian Child Protection Procedures 2016

NHS Lothian Adult Support and Protection Procedures 2015

Child Protection Guidance for Health Professionals (Scottish Government, 2013)

Female Genital Mutilation: Caring for patients and safeguarding children
(Guidance from the British Medical Association, July 2011)

Royal College of Obstetrics and Gynaecology FGM Guidelines Intercollegiate Guidelines

Chief Medical Officer / Chief Nursing Officer Letter FGM 2014 - raises awareness of the condition and the services most likely to come across it; encourages healthcare professionals in NHS Scotland to record diagnosis / types of FGM, together with any corrective procedures, in the relevant clinical records.

Chief Medical Officer / Chief Nursing Officer Letter FGM 2015 - informs health professionals in Scotland of the additional resources available to support the delivery of services to people who have had FGM or at risk of FGM. Also provides a reminder to be alert to young girls being taken out of Scotland to have FGM performed.

GMC Guidance on FGM 2015

Further information and resources:

FGM - Information to Help - leaflet suitable for community use, outlining how Health services can help; the law on FGM; what to do if concerned about a girl at risk; organisations to help.

FGM - A Statement Opposing Female Genital Mutilation - Scottish Government statement opposing FGM, outlining the law and where to get help in Scotland or whilst abroad. Helpful for parents under pressure from family or community members to arrange FGM for their daughter.

Royal College of Nursing - FGM educational resource 2015

FGM Aware - Resources and Information to Help Tackle FGM in Scotland