Coventry Female Genital Mutilation (FGM) Safeguarding Risk Assessment Guidance

FGM Safeguarding and Risk Assessment Tool

Introduction

The aim is to help make an initial assessment of risk, and then support the on-going assessment of women and children who come from FGM practising communities (using parts 1 to 3). For a list of communities where FGM is prevalent please see part 8.

INTRODUCTORY QUESTIONS (for further guidance on talking about FGM please see part 6): –

(1) Do you or your partner come from a community where cutting or circumcision is practised? (See part 8 for map. Please remember you might need to consider that this relates to their parent's country of origin)

(2) Have you been cut? It may be appropriate to use other terms or phrases (see part 7 for local terms).

*If they answer YES to questions (1) or (2) please complete one of the risk templates.

PART ONE: – For an adult woman (18 years or over)

(a) **PREGNANT WOMAN** – ask the introductory questions.

If the answer is YES to either question, use part 1(a) to support your discussions.

(b) **NON-PREGNANT WOMAN** where you suspect FGM; for example, if a woman presents with physical symptoms or emotional behaviour that triggers a concern (e.g. frequent urinary tract infections, severe menstrual pain, infertility, symptoms of PTSD such as depression, anxiety, flashbacks or reluctance to have genital examination etc); or if FGM is discovered through the standard delivery of care (e.g. when placing a urinary catheter, carrying out a smear test, discussions during social care assessments etc.), ask the introduction questions.

If the answer is YES to either question, use part 1(b) to support your discussions.

PART TWO: – For a CHILD (under 18 years)

Ask the introductory questions (see above) to either the child directly or the parent or legal guardian depending upon the situation.

If the answer to either question is yes OR you suspect that the child might be at risk of FGM, use part 2 to support your discussions.

PART THREE: – For a CHILD (under 18 years)

Ask the introductory questions (see above) to either the child directly or the parent or legal guardian depending upon the situation.

If the answer to either question is yes OR you suspect that the child has had FGM (see part 4), use part 3 to support your discussions.

In all circumstances:

- The woman and family must be informed of the law in the UK and the health consequences of practising FGM.

- Ensure all discussions are approached with due sensitivity and are non-judgemental.
- Any action must meet all statutory and professional responsibilities in relation to safeguarding and be in line with local processes and arrangements.
- Using this guidance does not replace the need for professional judgement in relation to the circumstances presented.
- Signpost the woman and her family to local support services that focus on prevention of FGM through education and effective engagement such as the Ending FGM in Coventry Service.
    - e-mail: referrals@coventryhaven.co.uk
    - tel: 02476 444077
    - website: www.coventryhaven.co.uk
- Ensure all discussions are approached with due sensitivity and are non-judgemental.
- Any action must meet all statutory and professionals' responsibilities in relation to safeguarding and be in line with local processes and arrangements.
- Using this guidance does not replace the need for professional judgement in relation to the circumstances presented.

GUIDANCE

The framework is designed to support professionals to identify and consider risks relating to female genital mutilation, and to support the discussion with the patient and family members. It should be used to help assess whether the client you are working with is either at risk of harm in relation to FGM or has had FGM, and whether she has children who are potentially at risk of FGM, or if there are other children in the family/close friends who might be at risk.

If when asking questions based on this guide, any answer gives you cause for concern, you should continue the discussion in this area, and consider asking other related questions to further explore this concern. Please remember either the assessment or the information obtained must be recorded within the patient's record. The templates also require that you record when and by whom it and at what point in the patient's pathway this has been completed.

Having used the guide, you will need to decide:

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

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

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

In urgent cases, Children's Social Care and the Police will consider what action to take. One option is to take out an Emergency Child Protection Order. If required, an EPO is an order made under Section 44 of the Children Act 1989 enabling a child to be removed to a place of safety where there is evidence that the child is in "imminent danger".

As of 31 October 2015, there is a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s which they identify in the course of their professional work to the police. 'Known' cases are those where either a girl informs the person that an act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was, or was part of, a surgical operation.

Part One (a): PREGNANT WOMEN

Date _____ Completed by_____
Initial / On-going Assessment (please delete as necessary)
Outcome/referred to: _____

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

Indicator	Yes	No	Details
CONSIDER RISK			
Woman originates from a community known to practice FGM			
Woman has undergone FGM herself			
Husband/partner comes from a community known to practice FGM			
A female family elder is involved/will be involved in care of children/unborn child or is influential in the family			
Woman/family has limited integration in UK community			
Woman and/or husband/partner have limited/no understanding of harm of FGM or UK law			
Woman's nieces of siblings and/or in-laws have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic / FGM related appointment (if known)			
Woman's husband/partner/other family member are very dominant in the family and have been present /involved virtually during consultations with the woman			
Woman is reluctant to undergo genital examination (healthcare setting only)			

SIGNIFICANT OR IMMEDIATE RISK	Yes	No	Details
Woman already has daughters have undergone FGM			
Woman requesting reinfibulation following childbirth			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have FGM			
Woman says that FGM is integral to cultural or religious identity			
Family are already known to social care services – if known, and you have identified FGM within a family, you must share this information with social services			

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/Police/MASH, in accordance with your local safeguarding procedures.
If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Date _____ Completed by_____
Initial / On-going Assessment (please delete as necessary)
Outcome/referred to: _____

Part One (b): NON PREGNANT ADULT WOMEN (over 18)

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

Indicator	Yes	No	Details
CONSIDER RISK			
Woman originates from a community known to practice FGM			
Woman already has daughters who have undergone FGM – who are over 18 years of age			
Husband/partner comes from a community known to practice FGM			
Grandmother (maternal or paternal) is influential in family or female family elder is involved in care of children			
Woman and family have limited integration in UK community			
Woman's husband/partner/other family member may be very dominant in the family and have been present during consultations with the woman			
Woman/family have limited/no understanding of harm of FGM or UK law			
Woman's nieces (by sibling or in-laws) have undergone FGM. (Please note:– if they are under 18 years you have a professional duty of care to refer to social care)			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment (if known)			
Family are already known to social services – if known, and you have identified FGM			

SIGNIFICANT OR IMMEDIATE RISK	Yes	No	Details
Woman already has daughters who have undergone FGM – who are under 18 years of age			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be triggered if she is found to have FGM			
Woman/family believe FGM is integral to cultural or religious identity			

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/Police/MASH, in accordance with your local safeguarding procedures.
If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Part 2: CHILD/YOUNG ADULT (under 18 years old)

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

Date _____ Completed by_____
Initial / On-going Assessment (please delete as necessary)
Outcome/referred to: _____

Indicator	Yes	No	Details
CONSIDER RISK			
Childs mother has undergone FGM			
Other female family members have had FGM			
Father comes from a community known to practice FGM			
A Family Elder such as Grandmother is very influential within the family and is/will be involved in the care of the girl			
Mother/Family have limited contact with people outside of her family			
Parents have poor access to information about FGM and do not know about the harmful effects of FGM or UK laww			
Parents say that they or a relative will be taking the girl abroad for a prolonged period – this may not only be to a country with high prevalence, but this would more likely lead to a concern			
Girl has spoken about a long holiday to her country of origin/another country where the practice is prevalent			
Girl has attended a travel clinic or equivalent for vaccinations/anti-malarial medication			
FGM is referred to in conversation by the child, family or close friends of the child (see part 7 for traditional and local terms) – the context of the discussion will be important			
Sections missing from the Red book. Consider if the child has received immunisations, do they attend clinics etc (health professionals)			
Girl withdrawn from PHSE lessons or from learning about FGM – Teacher or School Nurse should have conversation with child			
Girl talking about a special procedure or ceremony that is going to take place or that she is going to become a woman			
Family not engaging with professionals (health, school, or other)			
Any other safeguarding alert already associated with the family (Always check whether family are already known to social care			

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.
In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

SIGNIFICANT OR IMMEDIATE RISK	Yes	No	Details
A child or sibling asks for help			
A parent or family member expresses concern that FGM may be carried out on the child			
Girl has confided in another that she is to have a 'special procedure' or to attend a 'special occasion'. Girl has talked about going away 'to become a woman' or 'to become like my mum and sister'			
Girl has a sister or other female child relative who has already undergone FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

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

Part 3: CHILD/YOUNG ADULT (under 18 years old)

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

Date _____ Completed by_____
Initial / On-going Assessment (please delete as necessary)
Outcome/referred to: _____

Indicator	Yes	No	Details
CONSIDER RISK			
Girl is reluctant to undergo any medical examination			
Girl has difficulty walking, sitting or standing or looks uncomfortable			
Girl finds it hard to sit still for long periods of time, which was not a problem previously			
Girl presents with frequent urine, menstrual or stomach problems			
Girls shows increased emotional and psychological needs e.g. withdrawal, depression, or significant change in behaviour			
Girl avoiding physical exercise or requiring to be excused from PE lessons without a GP's letter			
Girl has spoken about having been on a long holiday to her country of origin/another country where the practice is prevalent			
Girl spends a long time in the bathroom/toilet/long periods of time away from the classroom			
Girl talks about pain or discomfort between her legs			
Girl talks of something somebody did to her that they are not allowed to talk about			

SIGNIFICANT OR IMMEDIATE RISK	Yes	No	Details
Girl asks for help			
Girl confides in a professional that FGM has taken place			
Mother/family member discloses that female child has had FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

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

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

PART 4. What are the signs that a girl may be at risk of FGM or has undergone FGM?

Girl is at Risk of FGM…

Suspicions may arise in a number of ways that a child is being prepared for FGM to take place abroad. These include;

- ✓ Knowing that the family belongs to a community in which FGM is practised
- ✓ Knowing the family is making preparations for the child to take a holiday, arranging vaccinations or planning absence from school.
- ✓ The child may talk about a special procedure/ceremony that is going to take place or becoming a woman

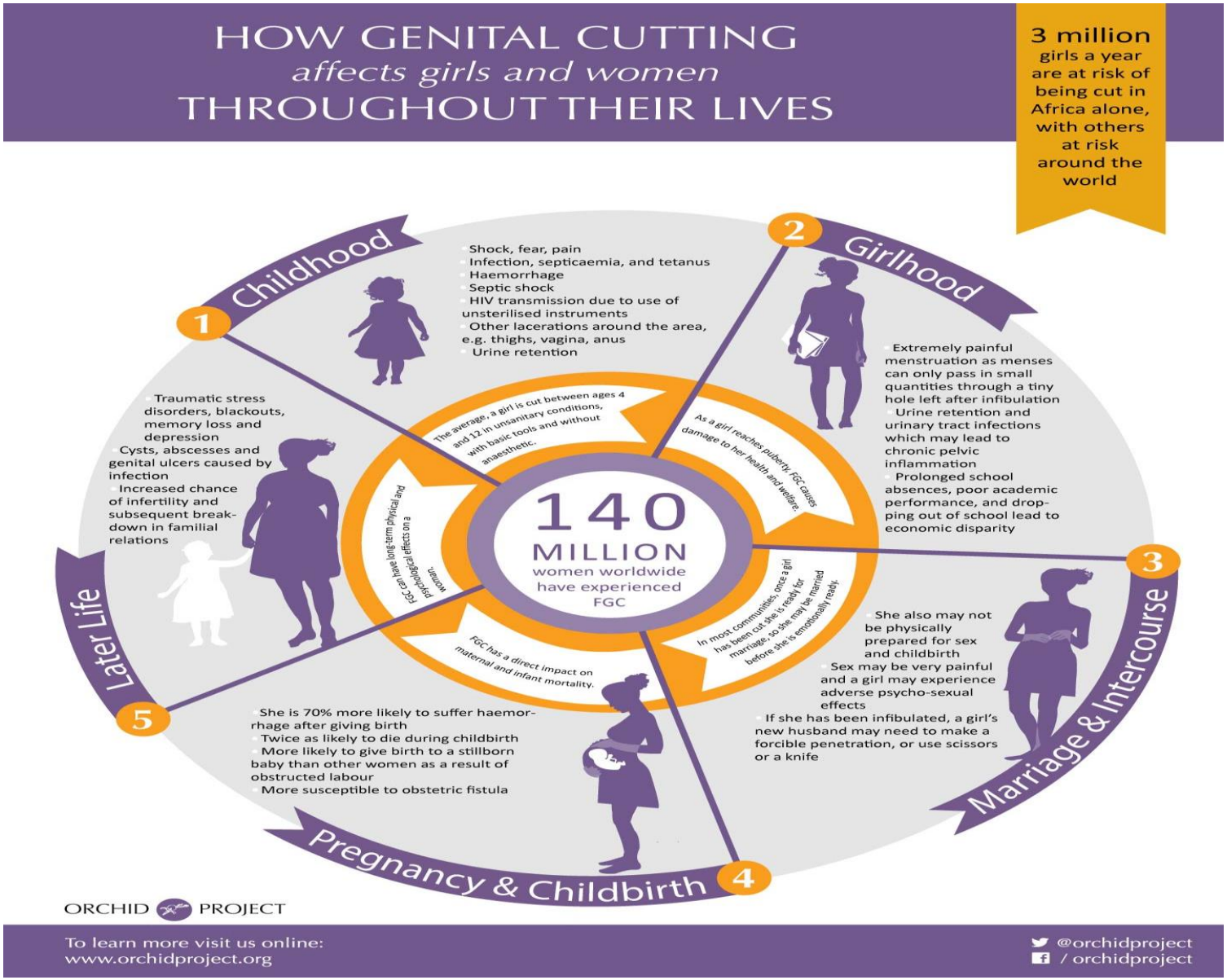
FGM has taken place…

Indicators that FGM may already have occurred include;

- ✓ prolonged absence from school or other activities
- ✓ noticeable behaviour change on return from absence
- ✓ bladder or menstrual problems
- ✓ difficulty sitting still
- ✓ looking uncomfortable
- ✓ complain about pain between their legs
- ✓ talk of something somebody did to them that they are not allowed to talk about

(FGM factsheet, Home Office)

PART 5. CONSEQUENCES OF FGM



(http://orchidproject.org/category/about-fgc/infographics/)

PART 6. Talking about FGM

FGM is a complex and sensitive issue that requires professionals to approach the subject carefully. When talking about FGM, professionals should:

- ✓ Ensure that a female professional is available to speak to if the girl or woman would prefer this.
- ✓ Make no assumptions.
- ✓ Give the individual time to talk and be willing to listen.
- ✓ Create an opportunity for the individual to disclose, seeing the individual 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.
- ✓ Be non-judgemental (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.
- ✓ Take detailed notes.
- ✓ Record FGM in the patient's healthcare record, as well as details of any conversations.
- ✓ Use simple language and ask straight forward questions such as:

  "In some countries, there is a practice in which a girl may have part of her genitals cut. Have you ever heard about this practice?"
  "Have you been closed?"
  "Were you circumcised?"
  "Have you been cut down there?"
  "Have you yourself ever been circumcised/had your genitals cut?"
  "What do you call this practice (that you had)?"
  "Do you think female circumcision should continue?"
  "Does your husband and his family think that female circumcision should be continued?"
  "Do your female relatives think that female circumcision should be continued?"

- ✓ Be direct, as 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 leading questions such as:

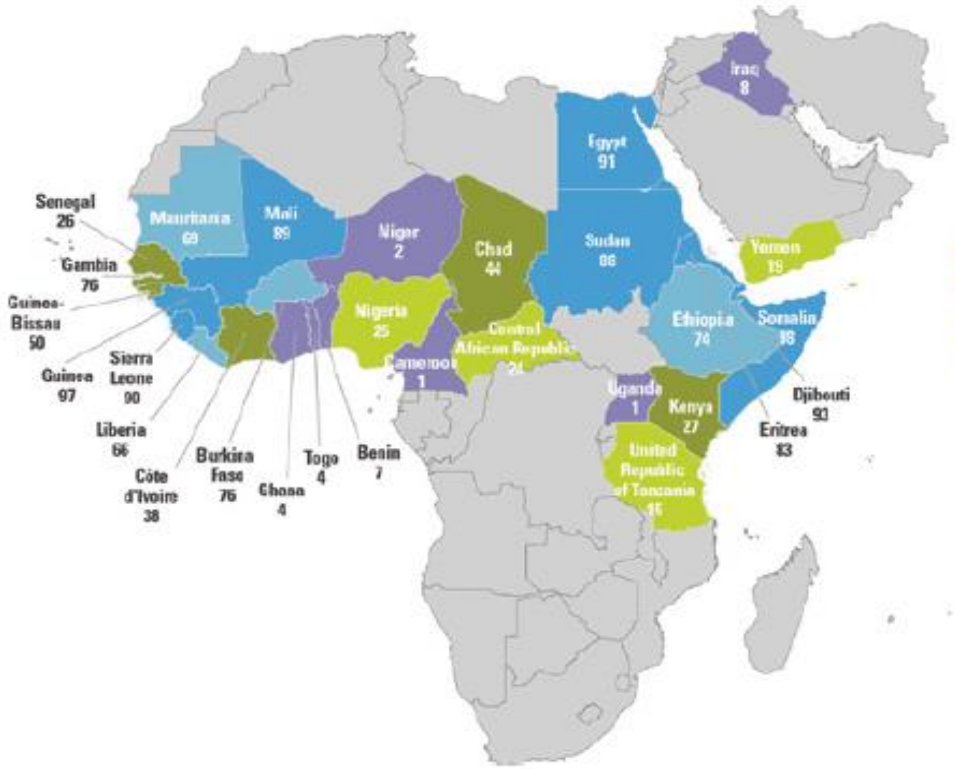
  "Do you experience any pains or difficulties during intercourse?"
  "Do you have any problems passing urine?"
  "How long does it take to pass urine?"
  "Do you have any pelvic pain or menstrual difficulties?"
  "Have you had any difficulties in childbirth?"

PART 7. Traditional and local terms for FGM

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 & 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'

PART 8. Countries that practice FGM

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



FGM has also been documented in communities including:

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

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

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

Source: UNICEF global databases, 2014, based on DHS, MICS and other nationally representative surveys, 2004-2013.
http://www.data.unicef.org/child-protection/fgmc