Sutton

Sutton LSCB
Local Safeguarding
Children Board

SSAB
Sutton Safeguarding Adults Board

SUTTON FGM RISK ASSESSMENT TOOL AND GUIDANCE

i. INTRODUCTION

This risk assessment tool and guidance has been developed to ensure that all practitioners across Sutton respond to the risk of or disclosure of female genital mutilation (FGM) in the same way, and that there is effective coordination of partnership responses in Sutton.

1. GUIDANCE

FGM guidance for all professionals (social workers, health professionals etc.) can be accessed here: nationalfgmcentre.org.uk/fgm/fgm-resources

2. HOW TO USE THIS TOOL

This tool is to help professionals working in health services, hospitals, schools, education, police, and children's services to identify and assess the risk of FGM.

The tool is divided into three parts:

Part One	Children at risk of being abused through FGM
Part Two	Children who may have been subjected to FGM and suffering physical and emotional harm
Part Three	Women with FGM presenting to GP/ maternity/ gynaecology/ urology/ sexual health services

Professionals need only complete the part that applies to the child/ adult they are working with.

Use the tool to identify the relevant indicators, being careful to record whether each indicator is known to be present, definitely not present, or suspected to be present; and make a brief note of your evidence. Ensure that this is saved in the appropriate place within your service.

2.1 WHAT TO DO NEXT?

When completing this risk assessment tool you need to consider the following:

How do I approach talking about FGM?

Consider using the 4 Cs to being conversations about FGM and to assist completion of the risk assessment tool.

1.	**Do you come from a community that practices cutting?**
2.	**Have you or any member of your family been cut?**

3.	**Does anyone intend to cut you or anyone you know?**
4.	**For patients who are pregnant or mothers of daughters ask: do you or anyone you know intend to have your daughter(s) cut?**

Does this case need to be reported via the FGM Mandatory Reporting Duty?

The duty requires regulated health and social care professionals and teachers in England and Wales to report 'known' (visually identified or verbally disclosed) cases of FGM in under 18s to the police via police 101 number. The duty does not apply in relation to at risk or suspected cases or in cases where the woman is over 18. In these cases, professionals should follow existing local safeguarding procedures. Cases that were identified pre 31 October 2015 will not need to be reported under the duty, only known cases identified from 1 November 2015 regardless of when the cutting occurred.

What to do?

Phone the police non-emergency crime number, 101, **and** send an email notification to Sutton MASH that the report has been made, if a girl under 18 tells you she has had FGM and/or has signs which appear to show she has had FGM *(see Appendix 3)*.

When?

As soon as possible; normally by close of the next working day. Longer timeframes are allowed under exceptional circumstances but always discuss with your safeguarding lead.

Can someone else do this?

No, this is a personal duty; the professional who identifies FGM or receives the disclosure must report it.

What if I don't do this?

If you do not comply, your professional regulator may consider the circumstances under the existing 'fitness to practice' proceedings.

Mandatory reporting is only one part of safeguarding against FGM and other abuse, you must always consider safeguarding concerns.

Safeguarding

An assessment of risk should be completed in all cases where FGM has been identified as an actual or potential concern. This will allow you to identify which children/ young people require a referral to MASH.

In instances where the risk of harm to a child is judged to be high i.e. that is it likely that FGM will happen in the near future or has happened and a child is suffering harm, there should be no delay in referring the child to Children's Social Care via Multi-Agency Safeguarding Hub (MASH).

MASH CONTACT DETAILS:
Telephone number: 0208 770 6001 **Out of hours number:** 020 8770 5000
Secure email: mash@sutton.gov.uk.cjsm.net

Always discuss with your safeguarding lead if in doubt.

REMEMBER: If a girl appears to have been recently cut or you believe she is at imminent risk, act immediately – this may include phoning 999.

Support

Always provide information and signposting to services that can be accessed for further advice and support such as, Early Help, and specialist services; see Appendices 5 and 6.

FGM Risk Assessment Tool

The tool will not provide you with a score but will allow you to identify factors/ indicators that will assist you in analysing the level of risk and consider next steps using the referral pathways at the back of this booklet.

What to do next

Check that you have:

- Completed the screening tool, risk indicators, and documented in the appropriate place for your agency;
- Reported via 101 and notified MASH if the mandatory reporting duty on FGM applies – document this clearly in your records;
- Completed a referral to MASH if the risk assessment identifies high risk of harm (send completed risk assessment tool with the referral);
- Informed the designated safeguarding lead in your agency (if this is in line with your internal processes);
- Provided information about ongoing support services (Early Help, specialist services);
- Followed Sutton FGM referral pathway for clarity (see Appendix 5).

3. SUTTON FGM RISK ASSESSMENT TOOL

This tool brings together a range of indicators published in government guidance; by specialist FGM voluntary organisations; and the advice of professionals working in this field.

Professional completing this screening tool

Name . . . . . .

Designation . . . . . .

Agency . . . . . .

Contact number . . . . . .

Email address . . . . . .

Date of completion . . . . . .

Action to be taken following completion of the screening tool . . . . . .

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Please indicate whether the personal data in this screening tool is:

1. Being shared with other agencies with the consent of the subject/ parent(s) of the subject? **Yes / No**

2. Being shared with other agencies under the LSCB information-sharing protocol for reasons of child protection? **Yes / No**

If yes to 1 or 2 above, name and address of subject and family members

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Part One Children at risk of being abused through FGM				
Indicator	**Yes**	**No**	**Suspected**	**Brief Details**
A child seeks help to avoid FGM or the circumstances in which FGM is a risk (e.g. going abroad)				
A parent of family member expresses concern that FGM may be a current risk				
Mother/ female family members comes from a community known to practice FGM *(see Appendix 1)*				
Mother has undergone FGM herself *(see Appendix 2)*				
Father comes from a community known to practice FGM				
Grandmother/ female family elder is very influential within the family and involved in care of child				
Mother/ family have limited contact with people outside of her family				
Parents have poor access to information about FGM and nobody has advised them about the harmful effects of FGM or UK law				
Parents stating that they or a relative will be taking the girl abroad for a prolonged period				
Girl has attended a travel clinic of equivalent for vaccinations/ anti-malarials for her country of origin/ another country where the practice is prevalent				
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 withdrawn from PSHE lessons or from learning about FGM				
FGM is referred to in conversation by the child, family, or close friends of the child *(see Appendix 3 for traditional and local terms)*				
Girl has a sister or other female relative who has already undergone FGM				

Part Two	Children who may have been subjected to FGM and may by suffering physical or emotional harm			
Indicator	**Yes**	**No**	**Suspected**	**Brief Details**
Girl asks for help with symptoms of FGM				
Girl confides in a professional that FGM has been done				
Girl spends long periods away from the classroom with bladder or menstrual problems				
Girls finds it hard to sit still for long periods of time, which was not a problem previously				
Prolonged absence from school				
Noticeable behavioural changes following long summer holiday or prolonged absence from school				
Girl has spoken about having been on a long holiday to her country of origin/ another country where the practice is prevalent				
Increased emotional and psychological needs e.g. withdrawn, depression				
Girl avoiding physical exercise or requiring to be excused from PE lessons with a GP's letter				

Part Three	Pregnant/ non pregnant women/ girls, with FGM, with existing female children, anticipated female child, or with other female children in the household			
Indicator	**Yes**	**No**	**Suspected**	**Brief Details**
Mother comes from a community known to practice FGM *(Appendix 1)*				
Mother has undergone FGM herself *(Appendix 2)*				
Father comes from a community known to practice FGM				
Grandmother/ female family elder (maternal or paternal) is influential in the family				
A female family elder is involved/ will be involved in care of daughter				
Mother has limited integration in UK community				
Woman believes FGM is integral to cultural or religious identity				
Parents have limited/ no understanding of harm of FGM or UK law*				
Mother has been reinfibulated following previous delivery**				
Mother requesting reinfibulation following childbirth*				
Woman's sisters' /brothers' daughters have undergone FGM				
Woman's sister/ brother-in-law's daughters have undergone FGM				
Woman already has daughters who have undergone FGM***				

* It is important to consider the opposite of this as indication of willingness to abandon FGM practice: a woman who herself has ongoing physical, psychological and/or sexual dysfunction that she recognises/acknowledges are a result of her FGM, and/or who is involved or is highly supportive of FGM advocacy work/eradication programmes, is less likely to mutilate her own children.

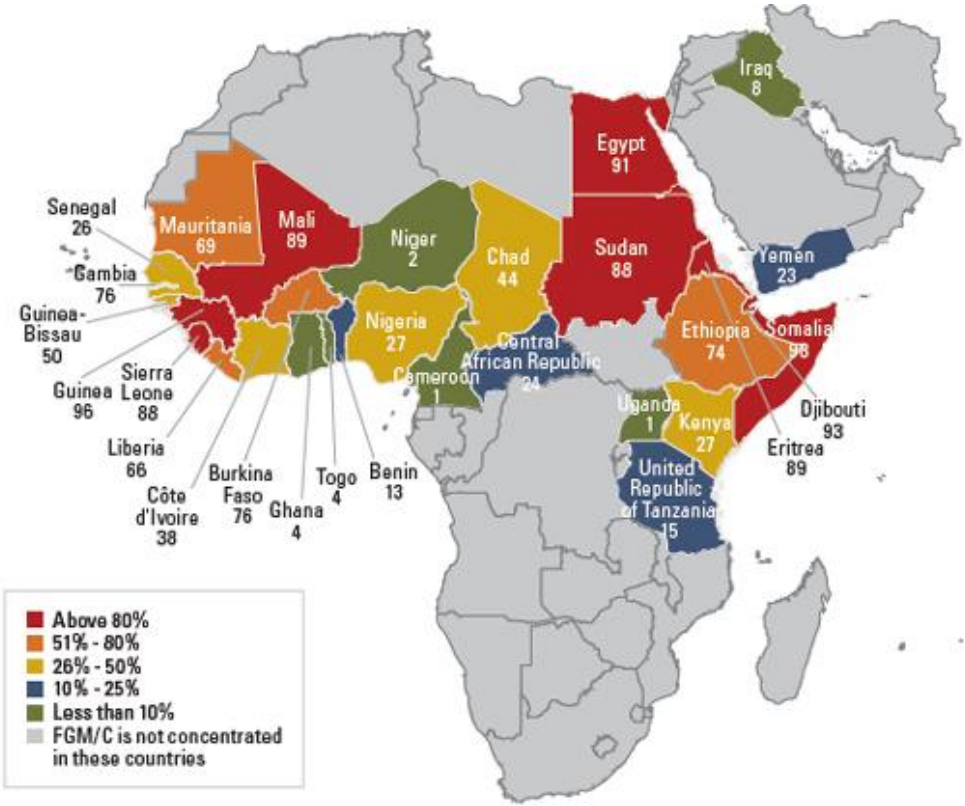
** Reinfibulation following childbirth in Sudan is highly prevalent - not to be closed after birth carries great stigma. Reinfibulation per se does not necessarily indicate ongoing support of FGM by the woman herself. One should enquire how the woman felt about reinfibulation after birth. This is in contrast to a woman giving birth in the UK requesting reinfibulation - this should be considered a significant indicator of risk of FGM for a female child. In addition, a reinfibulated woman requesting elective c/section without medical indication should be explored as it may indicate an awareness regarding the law and a wish to avoid deinfibulation. Enquiry needs to be sensitively made- as potential alternative explanation for maternal request c/section may relate to trauma/PTSD.
Reinfibulation in this country is potentially illegal under the FGM Act 2003 - if a woman has been reinfibulated, it is important to establish which country this took place in and when.

*** If woman discloses she has daughter(s) who have already undergone FGM, it is important to establish when and where this took place and which type of FGM. This is for two reasons: 1) if child was a UK national at time of FGM, a crime has taken place - this should be escalated to Social Care and Police as per introduction/mandatory reporting duty; 2) if child was not a UK national at time of FGM i.e. FGM took place prior to coming to this country, it is important to enquire regarding FGM status of any subsequent daughters born in the UK. If no FGM has been carried out on UK-born female child, one should establish why this is the case (e.g. •change in attitude or •fear of prosecution •lack of opportunity, •child too young). This is a complex area - many women have greater agency in decision-making regarding FGM when outside their country of origin and may elect not to continue FGM practice. This is an important indicator of positive attitudinal change and should be taken into consideration in risk assessment of any siblings.

APPENDIX 1: COUNTRIES THAT PRACTICE FGM

When assessing for risk of FGM and country of origin it is important to consider the following; increased migration around the world, mixed nationality/heritage families and countries where FGM is practiced yet unreported.

Prevalence of FGM in Africa and parts of Asia (women aged 15-49 years), UNICEF 2013.



Somalia	98%	Guinea Bissau	50%
Guinea	96%	Chad	44%
Djibouti	93%	Cote d'Ivoire	36%
Egypt	91%	Nigeria/ Kenya	27%
Eritrea	89%	Senegal	26%
Mali	89%	Central African Republic	24%
Sierra Leone/ Sudan	88%	Yemen	23%
Burkina Faso/ Gambia	76%	Tanzania	15%
Ethiopia	74%	Benin	13%
Mauritania	69%	Iraq	8%
Liberia	66%	Ghana/ Togo	4%

APPENDIX 2: TYPES OF FEMALE GENITAL MUTILATION

Type I involves the excision of the prepuce with or without excision of part or all of the clitoris.

Type II excision of the prepuce and clitoris together with partial or total excision of the labia minora.

Type III excision of part or all of the external genitalia and stitching or narrowing of the vaginal opening, also known as infibulation. This is the most extreme form and constitutes 15 per cent of all cases. It involves the use of thorns, silk or catgut to stitch the two sides of the vulva. A bridge of scar tissue then forms over the vagina, which leaves only a small opening (from the size of a matchstick head) for the passage of urine and menstrual blood.

Type IV includes pricking, piercing or incision of the clitoris and/or the labia; stretching of the clitoris and or the labia; cauterisation or burning of the clitoris and surrounding tissues, scraping of the vaginal orifice or cutting (Gishiri cuts) of the vagina and introduction of corrosive substances or herbs into the vagina.

APPENDIX 3: FGM RISK IDENTIFICATION

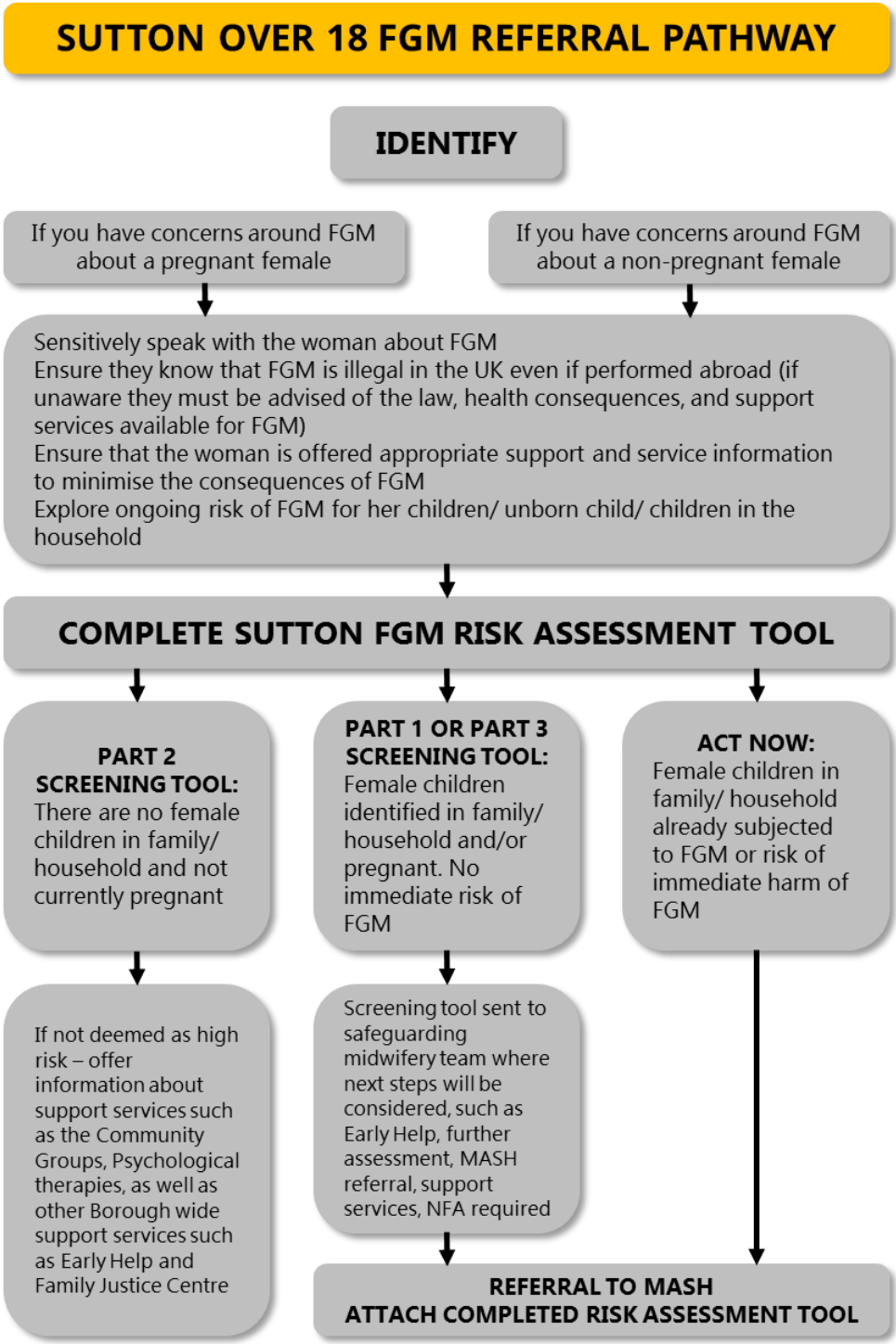
Factors suggesting a girl has undergone FGM:	**Factors suggesting a girl is at risk of FGM:**
Prolonged absence from school without a medical indication and on return to school:	From 'high risk' background (see chart) and:
1. Has difficulty in walking, sitting, or standing;	1. Aged 0-15 years old
2. Has noticeable behaviour changes;	2. Withdrawn from Personal, Social, Health, and Economic Education (PSHE) lessons by parents
3. Requests to be excused from physical exercise lessons.	3. Parent or female child states the girl will be taken out of the country for an extended holiday
Confiding in a professional that FGM has taken place*****	4. Mother had FGM, confiding in a professional about an impending 'special procedure' or special holiday or ceremony*****
Requesting help to manager any of the complications associated with the practice*****	Requesting help from a teacher of another professional or adult to avoid FGM*****
Spending longer than normal in the toilet due to difficulties urinating	Older sister had FGM*****
Frequent urinary tract infections or menstrual problems	A mother who had FGM requesting reinfibulation after deinfibulation*****
Recent onset of signs of emotional and psychological trauma (e.g. withdrawal, depression, and/or anger)	Talks about a long holiday to country of origin or another country where the practice is prevalent
Reluctance to undergo normal medical examination (e.g. smears)	A professional hears reference to FGM

***Note:** Occurrence of any one of these factors should prompt **immediate** action

APPENDIX 4: TRADITIONAL AND LOCAL TERMS FOR FGM

Country	Term used for FGM	Language	Meaning
Chad – the Ngama Sara subgroup	Bagne		
	Gadja		
Gambia	Niaka	Mandinka	
	Kuyungo		
	Musolula		
Guinea-Bissau	Fanadu di Mindjer	Kriolu	
Egypt	Thara	Arabic	Deriving from the Arabic word 'tahar' meaning to clean/ purify
	Khitan		Circumcision – used for both FGM and male circumcision
	Khifad (rarely used)		Deriving from the Arabic word 'Khafad' meaning to lower
Ethiopia	Megrez	Amharic	Circumcision/ cutting
	Absum	Harrari	Name giving ritual
Eritrea	Mekhnishab	Tigregna	Circumcision/ cutting
Iran	Xatna	Farsi	
Kenya	Kutairi	Swahili	Circumcision used for both FGM and male circumcision
	Kutairi was ichana		Circumcision of girls
Nigeria	Ibi/ Ugwu	Igbo	The act of cutting – used for both FGM and male circumcision
	Didabe fun omobirin/ ila kiko fun omobirin	Yoruba	
Sierra Leone	Sunna	Soussou	Religious tradition/ obligation for Muslims
	Bondo	Temenee	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
	Bondo	Mandinka	
	Bondo	Limba	Integral part of an initiation rite into adulthood for non-Muslims
Somalia	Gudniin	Somali	Circumcision used for both FGM and male circumcision
	Halalays		
	Qodiin		
Sudan	Khifad	Arabic	
	Tahoor		
Turkey	Kadin Sunneti	Turkish	

APPENDIX 5: FGM REFERRAL PATHWAYS



SUTTON UNDER 18 FGM REFERRAL PATHWAY

IDENTIFY

If you are concerned a female child is at risk of FGM

If you are concerned a female child has undergone FGM

Consider risk – if it safe to speak with the child and parent then sensitively speak with the child/ family about FGM

- Ensure the parents know that FGM is illegal in the UK, even if performed abroad (if unaware they must be advised of the law, health consequences, and support services available for FGM)
- Ensure that the child is offered appropriate support and service information to minimise the consequences of FGM

If it is not safe to speak with the parents then contact Sutton MASH and/or police explaining why it is not safe

COMPLETE SUTTON FGM RISK ASSESSMENT TOOL

COMPLETE SUTTON FGM RISK ASSESSMENT TOOL

FGM HAS TAKEN PLACE

MANDATORY REPORTING OF FGM

If a girl under 18 tells you she has had FGM and/or has signs which appear to show she has had FGM, report to the police via police **101** or contact Children's Services via MASH:
Telephone: 0208 770 6001 Out of hours: 0208 770 5000
Secure email: mash@sutton.gov.uk.cjsm.net
As with other areas of safeguarding, wherever possible you should explain why the report is being made and what it means. If you believe reporting would lead to risk of serious harm to the child or anyone else, do not discuss it, but instead contact your local designated safeguarding lead for advice

RECORD AND REFER - SAFEGUARDING

Consent – do obtain consent if appropriate. If not appropriate to obtain consent, clearly explain why consent is overridden and document clearly in your records
Where the risk assessment has indicated risk of harm to a child/ young person to be high or likely there should be no delay in referring the child to Children's Services via MASH (contact details above). A completed copy of the Sutton FGM Risk Assessment Tool should be sent with all referrals into MASH for FGM
Inform designated safeguarding lead in your agency
Accurately record all interventions, noting date, full name, and role of person making the recording, and sign
Collate this information and liaise with the health visitor and GP of the child

SUPPORT

Ensure that ongoing support needs are considering, including:

- The provision of counselling and support services to the child/ young person
- Risk to siblings and other children in the community
- The possibility of prosecution
- The immediate health needs of the child
- Access to community support

IF THERE IS EVIDENCE THAT THIS CHILD OR YOUNG PERSON NEEDS IMMEDIATE PROTECTION, CONTACT MASH IMMEDIATELY ON: 0208 770 6001/ OOH: 0208 770 5000

APPENDIX 6: FURTHER INFORMATION

For more information on FGM please refer to the following resources:
NSPCC FGM 24 hour helpline: 0800 028 3550
www.nationalfgmcentre.org.uk
www.IKWRO.org.uk
www.forwarduk.org.uk
www.aydacentre.org
www.suttonlscb.org.uk

Owner: Sutton LSCB
Date: January 2019
Contact: suttonlscb@sutton.gov.uk