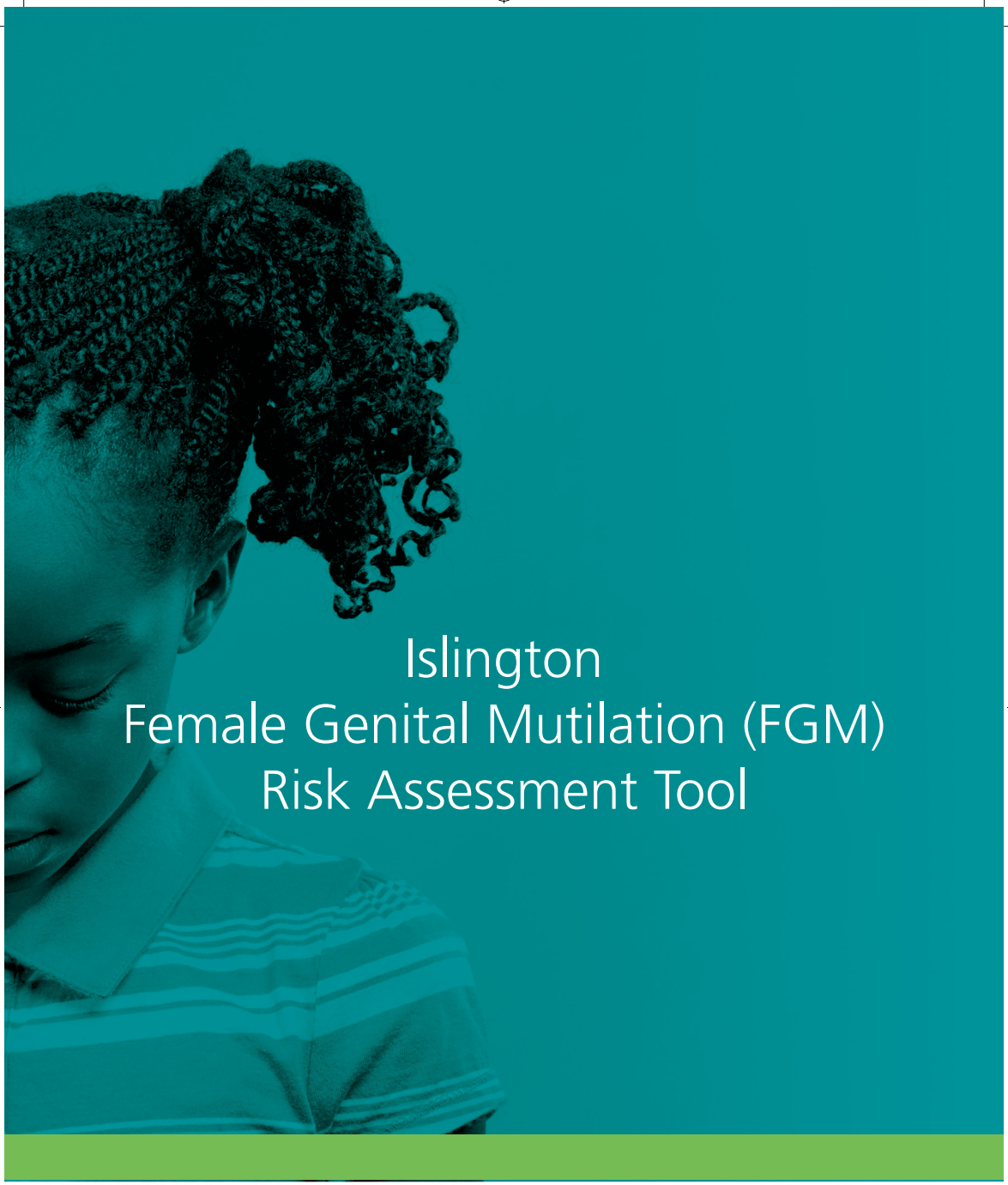


Islington Female Genital Mutilation (FGM) Risk Assessment Tool

Working in partnership

ISLINGTON

NHS

METROPOLITAN POLICE

Providing services to the community since 1913
manorgardens
for health and wellbeing

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 risks 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.

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 C's to begin conversations about FGM and to assist completion of the risk assessment tool.

1. **DO YOU COME FROM A COMMUNITY THAT PRACTISES 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 31st October 2015 will not need to be reported under the duty, which only requires the reporting of cases identified from 1st November 2015 regardless of when the cutting occurred.

What to do?

If a girl under 18:-
Tells you she has had FGM (female genital mutilation) and/or has signs which appear to show she has had FGM *(see Appendix 3)*

Phone the police non-emergency crime number, 101 AND send an email notification to the Children's Services Contact Team (CSCT) that the report has been made.

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 local safeguarding lead.

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

Can someone else do this?

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

What if I don't do this?

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

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 the Children's Services Contact Team (CSCT).

In instances where the risk of harm to a child is judged to be high ie 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.

Please contact the **Children's Services Contact Team on 020 7527 7400, Monday - Fridays 9am - 5pm.** For evening and weekend referrals please contact the **Emergency Duty Team on 020 7226 0992.**

Non-urgent referrals can be made by email:
csctreferrals@islington.gov.uk or **csct@islington.gcsx.gov.uk**

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 info at the back of this booklet.

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 Children's Services Contact Team (CSCT) if the mandatory reporting duty on FGM applies – document this clearly in your records.**
- **Completed a referral to Children's Services Contact Team (CSCT) 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 on-going support services *(Early Help, specialist services).***

Islington FGM Risk Assessment Tool

Please note, this tool is a 'work in progress' subject to review by the Islington Safeguarding Children's Board. It 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

Role

Organisation

Contact tel no

Email address

Date of completion

Action to be taken following completion of the screening tool

This is a mandatory field. Please select either Yes or No to confirm if consent has been given:

☐ **Yes** ☐ **No**

Date consent was requested:

Requested from:

Please indicate whether: ☐ Child ☐ Parent ☐ Carer

If parent/carer (or child/young person) has not consented please state the reason:

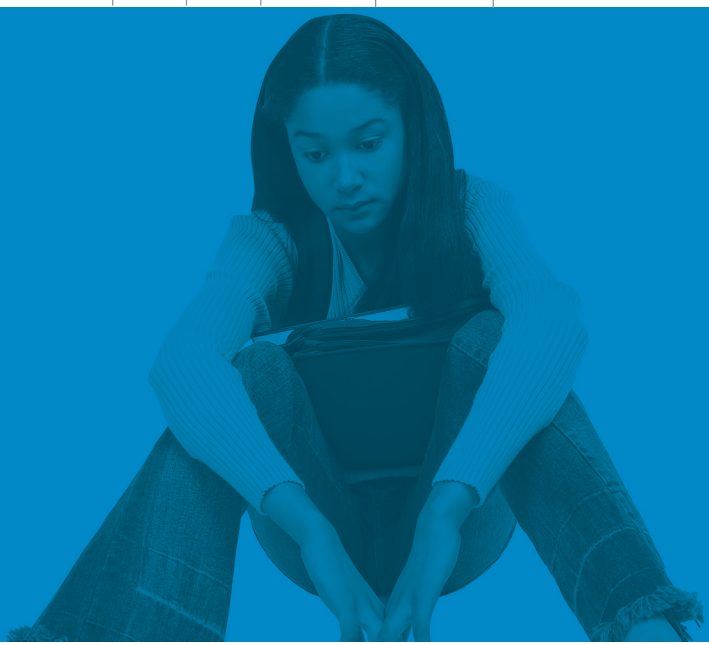
If you have not sought consent from the parent/carer (or child/young person) state why:

Part One: Children At Risk of being abused through FGM

Indicator	Yes	No	Suspected	Unknown	Brief Details
A child seeks help to avoid FGM or the circumstances in which FGM is a risk (eg. going abroad)					
A parent or family member expresses concern that FGM may be a current risk					
Mother/female family members comes from a community known to practise FGM (see Appendix 1)					
Mother has undergone FGM herself (see Appendix 2)					
Father comes from a community known to practise 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 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-malarials for her country of orgin/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 PHSE 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 be suffering physical or emotional harm

Indicator	Yes	No	Suspected	Unknown	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					
Girl 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 holidlay to her country of origin/another country where the practice is prevalent					
Increased emotional and psychological needs eg. 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	Unknown	Brief Details
Mother comes from a community known to practise FGM (Appendix 1)					
Mother has undergone FGM herself (Appendix 2)					
Father comes from a community known to practise FGM					
Grandmother/female family elder (maternal or paternal) is influential in 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***					

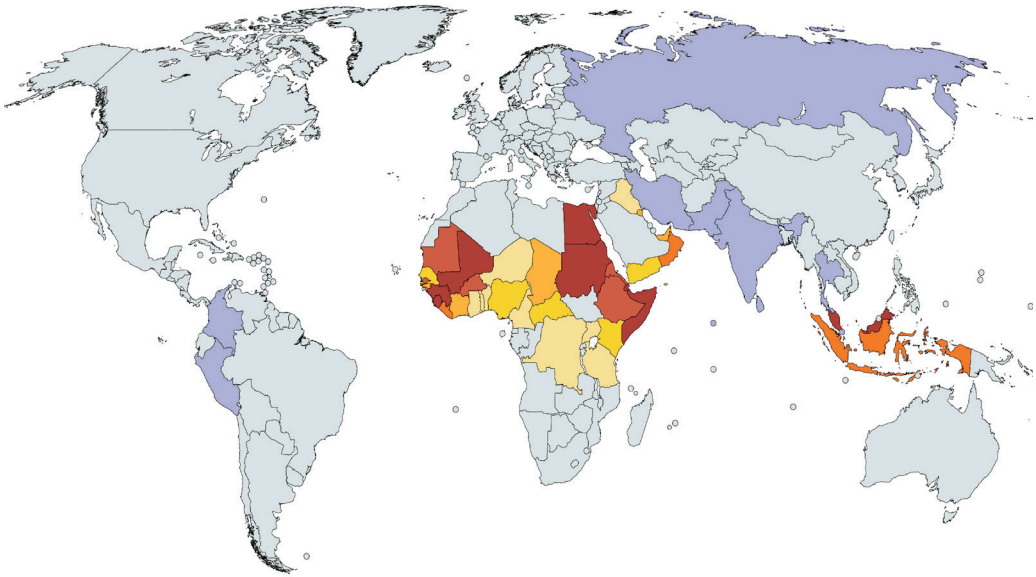
* It is important to consider the opposite of this as indication of willingness to abandon FGM practice: a woman who herself has ongoing physical, psychological and/or sexual dysfunction that she recognises/acknowledges are a result of her FGM, and/or who is involved or is highly supportive of FGM advocacy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

FGM Global Prevalence Map (%)



FGM Prevalence	
0-15%	
16-30%	
31-45%	
46-60%	
61-85%	
85-100%	
Only small scale studies exist/ Prevalence Unknown.	

All data has been sourced from WHO, DHS, MICS or Unicef unless stated otherwise below and represent women 15-49 years old.

Please click here to view an online interactive map with more information.

Malaysia: Muslim Women only (University of Malaya, 2010), Indonesia: 0-14 year olds girls,UAE: Dubai Women's College, 2011.

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:

Prolonged absence from school

without a medical indication and on return to school:

1. *Has difficulty in walking, sitting or standing*
2. *Has noticeable behaviour changes*
3. *Requests to be excused from physical exercise lessons*

Confiding in a professional that FGM has taken place*

Requesting help to manage any of the complications associated with the practice*

Spending longer than normal in the toilet due to difficulties urinating

Frequent urinary tract infections or menstrual problems

Recent onset of signs of emotional and psychological trauma *(e.g. withdrawal, depression and/or anger)*

Reluctance to undergo normal medical examination *(e.g. smears).*

Factors suggesting a girl is at risk of FGM:

From "high risk" background *(see chart)* and:

1. *Aged 0-15 years old*
2. *Withdrawn from Personal, Social, Health and Economic Education (PSHE) lessons by parents*
3. *Parent or female child states the girl will be taken out of the country for an extended holiday*
4. *Mother had FGM Confiding in a professional about an impending 'special procedure' or special holiday or ceremony**

Requesting help from a teacher or another professional or adult to avoid FGM*

Older sister had FGM*

A mother who had FGM requesting re-infibulation after de-infibulation*

Talks about a long holiday to country of origin or another country where the practice is prevalent

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 Kuyungo Musolula Karoola	Mandinka Mandinka Mandinka	
GUINEA-BISSAU	Fanadu di Mindjer	Kriolu	
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)
ETHIOPIA	Megrez Absum	Amharic Harrari	Circumcision/cutting 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	Swahili	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 Bondo	Soussou Temenee	Religious tradition/obligation - for Muslims 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 Bondo	Mandinka 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	Somali Somali	
SUDAN	Khifad Tahoor	Arabic Arabic	
TURKEY	Kadin Sunneti	Turkish	

For more information on FGM please refer to the following resources:

NSPCC FGM 24 hour Helpline **0800 028 3550**

If you think a child is at immediate risk or if you would like advice please contact the **Children's Services Contact Team** on 020 7527 7400
Monday - Fridays 9am - 5pm

For evening and weekend referrals please contact the **Emergency Duty Team** on 020 7226 0992

Non-urgent referrals can be made by email:
csctreferrals@islington.gov.uk or csct@islington.gcsx.gov.uk

African Well Woman Clinic

Whittington Health
Magdala Avenue
London N19 5NF
Contact: Huda Mohamed
Tel: 07825 034665

For specialist FGM health advice, pregnancy and deinfibulation

The FGM Project

Manor Gardens Welfare Trust
6-9 Manor Gardens
London N7 6LA
Contact: Rosalind Jerram
Tel: 020 7281 9478

For advice, support and training on FGM

The Dahlia Project

Manor Gardens Welfare Trust
6-9 Manor Gardens
London N7 6LA
Tel: 020 7281 7694

Specialist support and advice for survivors of FGM

Providing support for BAMER (Black, Asian, Minority Ethnic and Refugee) women who are survivors of domestic and sexual violence and harmful practices.

Monday – Wednesday 0207 354 1359

Wednesday – Friday 0207 275 0321

Wednesday only 0207 263 1027

Email: referral@samiraproject.co.uk

National FGM Centre

www.nationalfgmcentre.org.uk

Useful online resource for FGM resource materials and advice

Islington FGM Risk Assessment Tool

www.islington.gov.uk