At least 200 million girls and women alive today living in 30 countries have undergone FGM

This guidance has referenced various other sources and in particular the Kingston and Richmond K&RSCP would like to extend our appreciation to Wandsworth & Bromley LSCB for allowing us to adopt this policy.
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**Introduction**

FGM is an illegal, extremely harmful practice and a form of child abuse and violence against women and girls, and therefore should be dealt with as part of existing child and adult safeguarding / protection structures, policies and procedures. The safety and welfare of the child is paramount; All agencies will act in the interest of the Rights of the Child as stated in the UN Convention (1989);

“Any act of gender-based violence that results in, or is likely to result in physical, sexual, psychological harm or suffering to women including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.” United Nations Declaration on the Elimination of Violence Against Women (1993)

**Background, Context & Purpose**

This policy is to provide guidance & sets out multi-agency response to FGM and aims to assist all professionals and managers in the prevention and detection of FGM. The guidance sets out processes for identification, referral and follow up support to provide these vulnerable groups with an appropriate joined up response. It also includes guidance on how to undertake a risk assessment.

Specifically, this guidance will aim to support frontline professionals and practitioners to:

- Identify and prevent FGM;
- Appropriately share and record FGM information;
- Ensure that survivors and potential victims receive appropriate responses;
  - Provide practical guidance for professionals about working with women or girls who are victims & potential victims of FGM.
  - Report to the police if they are informed by a girl under the age of 18 that an act of Female Genital Mutilation (FGM) has taken place or observe physical signs that an act of FGM may have been carried out on a girl under the age of 18. This is a mandatory requirement.

**Definition of FGM**

The World Health Organisation (WHO) defines female genital mutilation (FGM) as: "all procedures (not operations) which involve partial or total removal of the external female genitalia or injury to the female genital organs whether for cultural or other non-therapeutic reasons" (WHO, 1996, updated 2017).

**FGM has been classified by the WHO into four types:**

- **Type 1:** Circumcision - Excision of the prepuce with or without excision of part or all of the clitoris
- **Type 2:** Excision (Clitoridectomy) - Excision of the clitoris with partial or total excision of the labia minora. After the healing process has taken place, scar tissue forms to cover the upper part of the vulva region
- **Type 3:** Infibulation (also called Pharaonic Circumcision) - This is the most severe 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
- **Type 4:** Unclassified - This includes all other procedures on the female genitalia, and any other procedure that falls under the definition of female genital mutilation given above. It includes prickings, genital piercings and tattoos, as well as cosmetic procedures to female genitalia.
Pictorial information of all types

For more information on WHO’s classification of FGM refer to Appendix 1 & https://www.who.int/reproductivehealth/topics/fgm/en/ for further detail.

Percentage distribution of ages at which girls have undergone FGM (as reported by their mothers)
Source: UNICEF, 2013
Countries where FGM is practised

FGM is concentrated in a swathe of countries from the Atlantic coast to the Horn of Africa and parts of the Middle East as the map shows.


FGM is a deeply rooted practice, widely carried out mainly among specific ethnic populations in Africa and parts of the Middle East and Asia. It serves as a complex form of social control of women’s sexual and reproductive rights. The exact number of girls and women alive today who have undergone FGM is unknown, however, UNICEF estimates that over 200 million girls and women worldwide have undergone FGM10.

While FGM is concentrated in countries around the Atlantic coast to the Horn of Africa, and areas of the Middle East like Iraq and Yemen, it has also been documented in communities in:

- Colombia;
- Iran;
- Israel (within the Bedouin community and within the immigrant Ethiopian Jewish community in its country of origin);
- Oman;
- The United Arab Emirates;
- The Occupied Palestinian Territories;
- India;
- Indonesia;
- Malaysia;
• Pakistan; and
• Saudi Arabia.
It has also been identified in parts of Europe, North America and Australia.

Notes: In Liberia, girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM since it is performed during initiation into the society. Data for Indonesia refer to girls aged 0 to 11 years since prevalence data on FGM among girls and women aged 15 to 49 years is not available.


Health Impact
The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. FGM has NO health benefits, and causes harm in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls and women’s bodies. Many women appear to be unaware of the relationship between FGM and its health consequences; in particular the complications affecting sexual intercourse and childbirth which can occur many years after the mutilation has taken place.

FGM is typically performed on girls aged between 4 and 13, but in some cases it is performed on new-born infants or on young women before marriage or pregnancy.

Point of Practice It is important to bear in mind however, that this practice can also affect children from a mixed ethnic background who may have a Caucasian mother or father.

Why FGM continues to be practiced
WHO cites a number of reasons for the continuation of FGM, such as:
- Custom and tradition
- A mistaken belief that FGM is a religious requirement
- Preservation of virginity/chastity
- Social acceptance, especially for marriage
- Hygiene and cleanliness
- Increasing sexual pleasure for the male
- Family honour
- A sense of belonging to the group and conversely the fear of social exclusion
- Enhancing fertility
- Local structures of power and authority, such as community leaders or circumcisers

In its interagency statement on Eliminating FGM (2008), WHO states that in every society where it is practised, FGM is the manifestation of gender inequality that is entrenched in social, economic and political structures. FGM is a form of violence against women and girls.
Scope
This guidance is meant for all frontline professionals and volunteers within agencies that work with children, young people & adults.
This includes, but is not limited to, health and social care professionals, police officers, teachers and other educational professionals.
Health professionals, particularly GPs, Midwives, Practice Nurses, School Nurses, Sexual Health nurses, Staff nurses working in vaccination clinics and Gynaecologists, are in a key position to identify female children in a family where women or girls have already undergone FGM.
FGM is considered child abuse in the UK and a grave violation of the human rights of girls and women. In all circumstances where FGM is practised on a child it is a violation of the child’s right to life, their right to their bodily integrity, as well as their right to health. The UK Government has signed a number of international human rights laws against FGM, including the Convention on the Rights of the Child.

For child protection purposes a child is anyone who has not yet reached their 18th birthday.

FGM and the Law -Legal framework

FGM has been illegal in the UK since the Prohibition of Female Circumcision Act 1985 was passed 1985. The Female Genital Mutilation Act 2003 replaced the 1985 Act. Making it an offence for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal. The law imposes a penalty of up to 14 years in prison and, or, a fine.

In England, it is a criminal offence for any person to:
- Perform FGM in England
- Assist a girl to carry out FGM on herself in England
- Assist (from England) a non-UK person to carry out FGM outside the UK on a UK national/resident

It is also a criminal offence for any UK national or resident to:
- Perform FGM abroad
- Assist a girl to carry out FGM on herself abroad
- Assist (from abroad) a non-UK person to carry out FGM outside the UK on a UK national/resident

Under UK law in England, an FGM protection order may be submitted to protect actual or potential victims.

For more information on FGM Protection Order please refer Appendix 2 & leaflet below.

A mandatory reporting duty for FGM in under 18 year olds was introduced via the Serious Crime Act 2015. The duty (as of October 2015) states that regulated health or social care professionals and teachers in England and Wales must report to the police if they either:
- are informed by a girl under the age of 18 that an act of FGM has been carried out on her, or
- observe or become aware of physical signs which appear to show that FGM has been carried out on a girl under 18.
It is the **personal duty** of that professional; the duty to report to police cannot be passed on or delegated to another professional.

In 2016, the Home Office **Violence against Women and Girls Strategy 2016-2020** was released to combat FGM and wider issues of VAWG.

They committed to continuing outreach work to educate and raise awareness of FGM. A **National FGM Prevention Programme (£3m)** was launched in partnership with NHSE to improve the response of healthcare workers to FGM and support prevention.

**Point of practice**- If FGM is confirmed in a girl under 18 years of age reporting to the police and Children’s Social Care is mandatory (Serious Crime Act 2015)

See Appendix 3 for full list of Regulated Bodies included in the mandatory reporting duty.

**National Policy Guidance for Professionals**

Please visit

- **Mandatory Reporting of Female Genital Mutilation – procedural information**

- **Multi-Agency Statutory Guidance on Female Genital Mutilation**

- **Working Together to Safeguard Children, Department for Education 2018**

- **London Child Protection Procedures: Safeguarding children at risk of abuse through female genital mutilation (FGM)**
  http://www.londoncp.co.uk/chapters/sg_ch_risk_fgm.html?zoom_highlight=fgm

- **Female Genital Mutilation Risk and Safeguarding Guidance for professionals: Department of Health**

- **HM Government -Ending Violence against Women and Girls 2016-20**

- **DFE - Statutory guidance for governing bodies, proprietors, head teachers, principals, senior leadership teams, teachers; Relationships Education, Relationships and Sex Education (RSE) and Health Education**
  (The guidance will come into effect in September 2020, but schools can start using it from September 2019.)
Internationally FGM is recognised as the violation of the human rights of girls and women. The United Kingdom (UK) is a signatory to two key international Conventions: the UN Convention on the Rights of the Child (CRC) and the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Article 24 of the CRC calls for the prohibition of all traditional practices that are prejudicial to the health and wellbeing of children across the globe.

**Consequences of FGM**
Depending on the degree of mutilation, FGM can have a number of short-term health implications:
1. Severe pain and shock
2. Infection
3. Urine retention
4. Injury to adjacent tissues
5. Immediate fatal haemorrhaging

**Long-term implications can entail:**
1. Extensive damage of the external reproductive system
2. Uterus, vaginal and pelvic infections
3. Cysts and neuromas
4. Increased risk of Vesico Vaginal Fistula
5. Complications in pregnancy and child birth
6. Psychological damage
7. Sexual dysfunction
8. Difficulties in menstruation

In addition to these health consequences there are considerable psycho-sexual, self-esteem and social consequences of FGM where additional support may need to be provided.

FGM is considered to be a form of child abuse (Physical and Emotional abuse) it is also an abuse of female adults categorised under Honour Based Violence and Domestic Abuse definitions.
**RISK ASSESSMENT AND IDENTIFICATION**

**Person Centred Approach:** Whatever someone’s circumstances, they have rights that should always be respected such as personal safety and accurate information about their rights and choices. Practitioners should listen to the victim and respect their wishes whenever possible. However, there may be times when a victim wants to take a course of action that may put them at risk – on these occasions, practitioners should explain all the risks to the victim and follow the necessary child or adult protection procedures.

**Signs that a child may be at risk of FGM**

There are a number of factors in addition to a girl’s or woman’s community that could increase the risk that she will be subjected to FGM: The following factors are intended to provide guidance to professionals and practitioners, in order to raise their indices of suspicion if one or more of these factors come to their attention when they have any contact with the child and family from countries, that are categorised as ‘high risk’ communities.

**Female Genital Mutilation (FGM) Safeguarding Risk Assessment Guidance**


Additional information for Health Care Professionals in England is available at:


**Factors suggesting a child is at risk of FGM:**

<table>
<thead>
<tr>
<th>From the “high risk” communities (MAP page 4) and:</th>
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<tbody>
<tr>
<td>1. Aged 0 - 14 years old;</td>
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<tr>
<td>2. Withdrawn from Personal, Social, Health and Economic Education (PSHE) lesson by parents;</td>
</tr>
<tr>
<td>3. Parent or female child states the girl will be taken out of the country for an extended holiday;</td>
</tr>
<tr>
<td>4. Mother had FGM /other female children in extended family</td>
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</tbody>
</table>

- 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 *.
- An older sister had FGM *.
- A mother who had FGM requesting re-infibulation after de-infibulation*.
- Talking about a long holiday to country of origin or another country where the practice is prevalent.
- A professional hears reference to FGM.
- It is possible that families will practise FGM in the UK when a female family elder is around, particularly when she is visiting from a country of origin.
- The position of the family and the level of integration within UK society. It is believed that communities less integrated into British society are more likely to carry out FGM.
* Note: Occurrence of any one of these factors should prompt immediate action

**Point of Practice**
Health professionals have the opportunity to check FGM IS on the National NHS Spine, results will inform & assist assessment. (See Appendix 4)

Indicators that a girl or woman has already been subjected to FGM:

<table>
<thead>
<tr>
<th>Factors suggesting a girl or woman has undergone FGM:</th>
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<td>Prolonged absence from school without a medical indication and on return to school:</td>
</tr>
<tr>
<td>1. Has difficulty in walking, sitting or standing;</td>
</tr>
<tr>
<td>2. Has noticeable behaviour changes;</td>
</tr>
<tr>
<td>3. Requests to be excused from physical exercise lessons.</td>
</tr>
<tr>
<td>Confiding in a professional that FGM has taken place <em>.</em></td>
</tr>
<tr>
<td>Requesting help to manage any of the complications Associated with the practice <em>.</em></td>
</tr>
<tr>
<td>Spending longer than normal in the toilet due to difficulties urinating.</td>
</tr>
<tr>
<td>Frequent urinary tract infections or menstrual problems.</td>
</tr>
<tr>
<td>Recent onset of signs of emotional and psychological trauma (e.g. withdrawal, depression and/or anger).</td>
</tr>
<tr>
<td>Reluctance to undergo normal medical examinations. (e.g. cervical smears)</td>
</tr>
</tbody>
</table>

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

**Point of Practice**
Health professionals have the opportunity to check FGM IS on the National NHS Spine, results will inform assist assessment. (See Appendix 4)

The risk of FGM should be considered in a family when it is known that the family comes from a community that is known to practise FGM and/or if there is information that a female family member has undergone the procedure herself. This is particularly important if the community is believed to be less integrated into British society. Furthermore, if there is any consideration that a girl has undergone or is at serious risk of FGM, this should lead to a wider consideration about the welfare of other girls, who belong to the immediate or extended family.

Female Genital Mutilation (FGM) Safeguarding Risk Assessment Guidance


Further considerations
Transferring in from another area, GP, new to the country.
Antenatal – midwifery
New birth contacts
Sexual, contraception health clinics- practice nurses.
Holiday vaccine clinics

Point of Practice
Health professionals have the opportunity to check FGM IS on the National NHS Spine, results will inform assist assessment. (See Appendix 4)

Professional Response
There are three circumstances relating to FGM which require identification, assessment and possible intervention.

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

Professionals and volunteers in most agencies have little or no experience of dealing with female genital mutilation. 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.

The appropriate response to FGM is to follow usual child protection procedures to ensure:

- Immediate protection and support for the child/ren;

Professionals who come into contact with a girl or woman, who has undergone the FGM procedure should be attentive to the risk posed in relation to:

- Sisters of the affected girl;
- Daughters of an affected mother has or may have in the future;
- Extended family members.

Guide to asking a girl or woman about FGM
Front line professionals should be trained and competent in holding sensitive conversations regarding FGM & know the policies & procedures within their own organisations should FGM be identified.

Point of Practice
Health professionals have the opportunity to check FGM IS on the National NHS Spine, results will inform assist assessment. (See Appendix 4)

Female Genital Mutilation (FGM) Safeguarding Risk Assessment Guidance

It is mandatory for midwives to ask women of all cultures regarding FGM, rather than women from particular communities.

**Point of Practice**
The following points should be considered when talking to a woman or child about FGM.

Asking the right questions in a simple, straightforward and sensitive way is key to establishing the understanding, information exchange and relationship needed to plan for the girl or woman’s wellbeing and the welfare of any daughters she may have, or girls she may have access to.

- Different terminology will be culturally appropriate to the different cultures. Alternative approaches are to ask a woman whether she has undergone FGM by saying: ‘I’m aware that in some communities women and girls undergo some traditional operation in their genital area. Have you had FGM or have you been cut/circumcised?’
- To ask about infibulation professionals can use the question: “are you closed or open?” This may lead to the woman providing the terminology appropriate to her language/culture.
- When asking a child, a professional can simplify the language by asking, “Has anything been done to you ‘down there’ or on your bottom?”
- Ask if they want to talk to someone who will understand them better.
- Ask if they need support in contacting other agencies for help or advice.

See Appendix 5- Glossary & local terms used for FGM.

**Point of Practice:**
- They may wish to be interviewed by a practitioner of the same gender.
- They may not want to be seen by a practitioner from their own community.
- The practitioner should meet the woman in a place that she feels is safe/private.

If they insist on being accompanied during the interview with a teacher or advocate, ensure that the accompanying person understands the full importance of confidentiality, especially if the accompanying person is a member of their community.

**Point of Practice:**
For some, an interview will require an authorised accredited interpreter who speaks their dialect. **Never use** family members, friends, neighbours or those with influence in the community as interpreters. People may feel embarrassed to discuss personal issues in front of them and sensitive information may be passed on to others and place the person at risk of FGM in further danger. Furthermore, such an interpreter may deliberately mislead practitioners and or encourage the person to drop the complaint and submit to their family’s wishes. **It is not appropriate to use a child as an interpreter.**

Leaflets in a multiplicity of languages are available for professionals to give to women and their partners and can be downloaded from the NHS Choices Website [https://www.nhs.uk/conditions/female-genital-mutilation-fgm/](https://www.nhs.uk/conditions/female-genital-mutilation-fgm/)
**Holiday Plans**

Professionals, particularly teachers, can ask children to tell them about their holiday plans. Sensitively and informally ask the child about planned extended holiday ask questions like such as:

- Where are you going?
- Who is going on the holiday with you?
- Have you been told what you will be doing during the holiday?
- How long do you plan to go for, and is there a special occasion planned?
- Do you have any concerns, fears, or anxieties about the holiday?

**Questions for the parents include:**

- Are they aware that the school cannot keep their child on roll if they are away for a long period?
- Are they aware that FGM including Sunna is illegal in the U.K even if performed abroad?

**Physical Examinations**

The mandatory reporting duty applies to cases you discover in the course of your professional work. If you do not currently undertake genital examinations in the course of delivering your job then the duty does not change this. Most professionals will only visually identify FGM as a secondary result of undertaking another action.

For *Healthcare Professionals*, if in the course of your work, you see physical signs which you think appear to show that a child has had FGM, this is the point at which the **duty applies** – the duty does not require there to be a full clinical diagnosis confirming FGM before a report is made, and one should not be carried out unless you identify the case as part of an examination already underway and are able to ascertain this as part of that.

Unless you are already delivering care which includes a genital examination, you should not carry one out.


For *Qualified Teachers and Social workers*, there are no circumstances in which you should be examining a girl. It is possible that a teacher or early years practitioner, for example, examination of the child perhaps assisting a young child in the toilet or changing a nappy, may see something which appears to show that FGM may have taken place. In such circumstances, the staff member must make a report under the duty, but should not conduct any further examinations.

Any examination of a child or young person should be in strict **accordance with safeguarding children procedures** and should (normally) be carried out by a consultant paediatrician, with experience of dealing with cases of FGM.

It is important any medical exam undertaken employs a **holistic approach** which explores any other medical, support and safeguarding needs of the girl or young woman, and that appropriate referrals are made as necessary.
Multi-agency referral procedure:

**Child or young person**
- Where a child has undergone FGM
- Where a child is at risk of FGM

**Women**
- When an expectant mother has undergone FGM
- When an adult woman has undergone FGM

FGM should be dealt with as part of existing child and adult protection procedures i.e. through local authority safeguarding structures, with the additional mandatory reporting duty to police for confirmed FGM in children under 18.

Although the duty of care for Children’s Social Care extends to 21 for looked after children and to 25 for children with special needs, for the purposes of FGM Mandatory Reporting, ‘child’ refers to under 18 years. Children and Adults Services should work together in the usual way with regard to looked after children and children with special needs.

**All referrals** to Kingston & Richmond’s Children’s Social Care/ Single Point of Access (SPA) are made through its ‘front door’. This is called the Multi Agency Safeguarding Hub (MASH), with colleagues from the police and health co-located with local authority staff at the Guild Hall complex in Kingston. This provides more cohesive decision making and sharing of appropriate information.

**Contact information**

| Richmond & Kingston Single Point of Access (SPA): Tel: 020 8547 5008 8am-5.15pm Mon to Thursday & 9-5pm on Fridays |
| Out of Hours: If you need to speak to someone urgently outside of office hours, please ring the Duty Social Worker on 020 8770 5000 |

Kingston and Richmond Child Protection Procedures can be found on Kingston and Richmond Safeguarding Children Board website: https://kingstonandrichmondlscb.org.uk/

**Confidentiality**

Professionals and volunteers should not promise complete confidentiality to the victim (blanket confidentiality cannot be given to the individual as FGM is both a crime and child abuse that must be reported).

It is expected that individuals that make a referral to the police / SPA will not normally be able to remain anonymous.

However, given the heightened sensitivity within communities that practise FGM and potential risk to those individuals, referrals made by members of the community who are working with a voluntary sector organisation can reasonably expect not to have this information passed to the family involved. They should still give their details and organisation contact information when making a referral but
can request that they remain 'anonymous' with regard to the family or child who is the subject of the referral.

**Referral: where a child under 18 years has undergone FGM**
Where a child has undergone FGM, professionals should report to the both the Police and the SPA.

**Mandatory Reporting Duty applies**
If a child under 18 years old discloses to a professional that they have undergone FGM or where physical signs indicate FGM has been carried out, there is a mandatory duty on that professional to report to the police.

<table>
<thead>
<tr>
<th>Report to the police by calling ‘101’, the non-emergency number, within 48 hours.</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is the personal duty of that professional; the duty to report to police cannot be passed on or delegated to another professional</td>
</tr>
<tr>
<td>Tell them;</td>
</tr>
<tr>
<td>Explain that you are making a report under the FGM mandatory reporting duty</td>
</tr>
<tr>
<td>Give them your details: name, contact details (work telephone number and e-mail address) &amp; times when you will be available to be called back,</td>
</tr>
<tr>
<td>Your role and place of work</td>
</tr>
<tr>
<td>Give them the girl’s details: name, age/date of birth, address,</td>
</tr>
<tr>
<td>Confirm that you have undertaken, or will undertake, safeguarding actions such as a referral to Children’s Social Care.</td>
</tr>
<tr>
<td>Ensure you are given a reference number.</td>
</tr>
</tbody>
</table>

**Richmond & Kingston Single Point of Access (SPA): Tel: 020 8547 5008 8am-5.15pm Mon to Thursday & 8am – 5pm on Fridays**

**Out of Hours: If you need to speak to someone urgently outside of office hours, please ring the Duty Social Worker on 020 8770 5000**

**The duty applies to:**
Health or social care professionals regulated by a body which is overseen by the Professional Standards Authority for Health and Social Care- i.e. General Chiropractic Council; General Dental Council; General Medical Council; Health and Care Professions Council; Nursing and Midwifery Council, etc.
Teachers (Qualified or other persons employed or engaged to carry out teaching work). See Appendix 3

**Full details of the mandatory reporting duty can be found in the Home Office and Department for Education document:** [https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information](https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information)
Multi Agency Statutory Guidance on FGM


Health Professionals please see link below for flowchart.


Referral to Kingston & Richmond Single Point of Access - SPA (Children’s social Care)

Professional should call the SPA team **without delay**, in order to initiate a strategy meeting between professionals to assess support needed and wider safeguarding implications.

The referring agency **should attempt to gather the relevant information** before calling SPA:

**Point of Practice**

Health professionals have the opportunity to check FGM IS on the National NHS Spine, results will inform assist assessment. (See Appendix 4)

Confirmation that the family has been informed of the referral (**unless this places child at immediate/further risk of harm**)

Full details of parents/relatives and all children in the family (including unborn with E.D.D)

Information regarding extended family members who may have a significant Influence

Indicators/evidence that a girl or woman has already been subjected to FGM

Confirmation whether appropriate advice and information to the family has already been provided regarding the law and harmful consequences of FGM and information as to the family’s response

Parental/carer attitudes and understanding about the practice and where appropriate child/young person’s knowledge, understanding and views on the issue

Any information as to whether previous children’s social care assessments (in regards to other children of family) relating to concerns regarding FGM have been completed and by whom.

**See appendix 6 (page31) Flow Chart**
**Referral: Where a child under 18 is at risk of FGM**

The risk assessment and indicators set out in previously may lead a professional to believe a child is at risk of FGM, for instance if sisters have already undergone FGM or the professional has heard reference to a ‘special procedure’.

Where a child is thought to be at risk of FGM, practitioners should be alert to the **need to act quickly**, before the child is abused through the FGM procedure in the UK or taken abroad to undergo the procedure.

Every attempt should be made to work with parents on a voluntary basis to prevent the abuse. 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 and / or community leaders to facilitate the work with parents / family. However, the best **interest of the child is always paramount**.

All agencies are expected to consider the risk and gather relevant information prior to making a **formal referral** to SPA.

However, if the matter is urgent and you think there is an imminent risk, ring the police on 999 & SPA team without delay.

Where concerns are raised about a child, consideration should be given to whether siblings are at a similar risk.

The referring agency should attempt to **gather the relevant information** before calling SPA

Confirmation that the family has been informed of the referral (unless this places child at immediate/further risk of harm)

Full details of parents and all children in the family (including unborn with E.D.D)

Information regarding extended family members who may have a significant influence, (Geonogram)

Specific factors which may heighten a girl’s or woman’s risk of being affected by FGM

Any information / signs that may suggest that FGM may be about to take place soon

Confirmation whether appropriate advice and information to the family has already been provided regarding the law and harmful consequences of FGM and information as to the family’s response

Parental/carer attitudes and understanding about the practice and where appropriate child/young person’s knowledge, understanding and views on the issue

Any information as to whether previous children’s social care assessments (in regards to other children of family) relating to concerns re FGM have been completed, when and by whom.

**Referral: Where an expectant adult woman has undergone FGM**

When a woman becomes pregnant, the midwife **must** complete an FGM maternity risk assessment. **Questions include:**

Is the husband/partner from a community known to practice FGM?
Does the woman regard FGM as integral to her cultural or religious identity?
Does the woman/husband have limited/no understanding of the harm caused by FGM or of the UK law?  
Have the woman’s daughters/siblings/nieces undergone FGM?

Female Genital Mutilation (FGM) Safeguarding Risk Assessment Guidance  

If the FGM maternity risk assessment indicates that the unborn child may be at risk of significant harm (i.e. signs that the parents intend to subject child to FGM once born, or any other safeguarding concerns), a referral should be made to SPA.

If the pregnant woman is under 18, the professional must report to the police as well as refer to SPA, as per the Mandatory Reporting Duty

**Point of Practice**

Midwives should offer pregnant women a referral to the Consultant led specialist clinic to discuss any health concerns they may have as a result of FGM

**Referral: where an adult woman has undergone FGM**

The wishes of the woman must be respected at all times. There is no requirement for automatic referral of adult women with FGM to adult social services or the police- unless the women is an ‘adult at risk’ under Safeguarding Adults regulations (and therefore is considered to be unable to protect herself from harm). For example, an adult may have a physical or learning disability and therefore the issues of mental capacity and ability to consent need to be formally investigated. Safeguarding adult’s procedures would seek to provide a protection plan for and with that adult at risk who might otherwise be entirely vulnerable to harm.

**Point of Practice**

Health professionals have the opportunity to check FGM IS on the National NHS Spine, results will inform assist assessment. (See Appendix 4)

**Point of Practice**

All professionals should be aware that any disclosure may be the first time that a woman has ever discussed FGM with anyone approach the case with sensitivity at all times.

Referral to the police must not be introduced as an automatic response when identifying adult women with FGM, and each case must continue to be individually assessed.

**Point of Practice**

If a woman discloses she has adult daughter(s) over 18 who have already undergone FGM, even if the daughter does not want to take her case to the police, it is likely to be important to establish when and where this took place. This should lead to enquiries about other daughters, cousins or girls in the wider family context.

**Training**

All professionals should make sure that they and their staff have undergone up-to-date safeguarding training (inclusive of FGM). This is to ensure that staff have the skills and knowledge of what their responsibilities are, and how they can handle cases appropriately where a woman/child with or is at risk of FGM.

**Home office** - This FREE course is useful for anyone who is interested in gaining an overview of FGM, particularly frontline staff in healthcare, police, border force and children’s social care.
The National FGM Centre has developed a toolkit to help social workers carry out direct work with families and girls at risk of female genital mutilation (FGM), or who have undergone FGM. The toolkit provides plans for sessions aimed at children aged seven and older with separate activities for parents, carers and young people. Source: National FGM Centre - February 2019

Further information: FGM direct work toolkit (PDF)

**Early Years & Education settings.**

All education settings are in an important position to identify girls being at risk of FGM or to receive disclosures concerning FGM. All may become aware that a child is at risk of FGM through a child/other children, or parent/other adult disclosing information that the procedure is planned or any of the risks factors are present

*If this does occur, all should refer this to their Designated Safeguarding Lead (DSL) & follow the settings safeguarding policy.*

Many such procedures are carried out abroad and staff will be particularly alert to suspicions or concerns expressed by a female child/children about going on a long holiday during the summer holiday period. Staff are aware that it is also possible for these procedures to be undertaken in the UK.

All educational settings have the responsibility to raise awareness about FGM amongst pupils and parents; Raising awareness about FGM can be undertaken in a variety of ways, for example through Personal, Social, Health and Education (PSHE)& Relationships Education Relationships & Sex Education(RESE) lessons, posters, leaflets, assemblies or parents evening. Teachers and School Nurses play a fundamental role in educating children on the law and health consequences surrounding FGM, children’s Human Rights and support services available to children and young people. *However they also need to ensure that the adequate support is available to girls and/or parents, who then may seek advice or support*

**DFE - Statutory guidance for governing bodies, proprietors, head teachers, principals, senior leadership teams, teachers; Relationships Education, Relationships and Sex Education (RSE) and Health Education** (The guidance will come into effect in September 2020, but schools can start using it from September 2019.)


**Health Professionals**

All health professionals (such as but not restricted to midwives, GPs and Practice Nurses) should ask all pregnant women despite country of origin, in addition to all women and new registrations from the “high risk “countries the question of “have you been cut?” or “are you closed or open?” in consultation, and to record the response taking necessary action to safeguard the unborn child. *It is encouraged that these questions are asked to the woman alone or with an interpreter and that a relative is not present during a consultation.*

This allows the health professional to be in a good position to inform the woman of the law and health consequences of FGM, Human Rights of children and support services that are available. The
information gathered on the mother regarding FGM should be flagged, recorded & shared with other agencies to ensure that girls within the family are safeguarded against FGM occurring - (think FGM information system on NHS spine).

**Point of Practice**

As part of FGM Enhanced Data Collection, it is also now mandatory for any NHS healthcare professional to record within a patient’s clinical record if they identify through the delivery of healthcare services that a woman or girl has had FGM. It is also now mandatory for all Acute Trusts, Mental Health Trusts and General Practitioners to submit details about the number of patients treated who have had FGM to the Department of Health every month.

Maternity services and Health Visitors should record if a woman presents with FGM, and ensure that this information is appropriately passed on to other relevant services (e.g. GPs, Kingston and Richmond SPA)

GP Practices are encouraged to upload the information on their discharge summary regarding the mother’s status of FGM onto the relevant patient electronic system in both the mother and the child’s (regardless of gender) health records with the appropriate code. If the family decide to move, the information uploaded onto the system will follow the child, and safeguard any/future daughter from FGM.

**The Police**

FGM is regarded by the Metropolitan Police to be an extremely severe form of child abuse and they recognise the immediate and long term pain and health risks associated with the procedure/practice.

If officers or members of police staff believe that a girl may be at risk of undergoing FGM, an immediate referral should be made to their local Child Abuse Investigation Team (CAIT). They are committed to eradicating FGM and will work in partnership with health and (SPA) to investigate and prosecute perpetrators of FGM.

If any officer believes that the girl could be at immediate risk of significant harm, they should consider the use of a Female Genital Mutilation Protection Order (FGMPO) or police protection powers under section 46 of the Children Act 1989 and remove the girl to a place of safety.

In addition, children social Care (SPA) should consider the use of a Prohibitive Steps Order or Emergency Protection Order. The welfare of other children within the family, in particular female siblings, should be reviewed.

If it is believed or known that a girl has undergone FGM, a strategy meeting must be held as soon as practicable (and in line with statutory guidance) to discuss the implications for the child and the coordination of the criminal investigation.

In collaboration with Project Azure and the local CAIT team, the pathway for local police to follow on notification of a concern that FGM has occurred, or is at risk of occurring, has been accepted and is to be embedded.

**Project Azure**

The project is made up of four strands: Prevention, Protection, Partnership and Prosecution. 

Local Authority Children’s Social Care- Single Point of Access (SPA)

There is a concern or suspicion that a girl below the age of 18 is at risk of FGM (this can include risk to unborn children). This may be an imminent risk or information that would indicate future risk.

Where a child is thought to be at risk of FGM, practitioners should be alert to the need to act quickly - before the child is abused through the FGM procedure in the UK or taken abroad to undergo the procedure.

When Kingston or Richmond Single point of Access (SPA) receives a referral that a child in a family is at risk of significant harm, appropriate child protection procedures should be followed and all children within that family should be assessed alongside working with the Police, GPs, Health Visitors and support services to advise the family and protect the child/ren.

SPA will review the referral within 24 hours or in the case of imminent risk immediately. All professional are required to make a detailed online referral to SPA, however if the child is at immediate risk and requires immediate protection this should be done in parallel with a phone call to the (police 999). (See K&RSCP FGM Multi Agency Referral Pathway -Appendix 6- page 31)

*While all referral to SPA need to be made online, SPA offer telephone consultation and in urgent cases this is advised.*

As with all referrals, SPA will review the referral in line with AFC's Threshold Guidance, Pan London CP Procedure, Children’s Act 1989 and relevant national and local guidance.

In cases where there is a suspicion that a girl or unborn child may be at risk of FGM, however the professional making the referral is not in a position to provide sufficient information to make a threshold decision. SPA will consider a MASH inquiry to gather information to inform the safeguarding decision. SPA will consider consent and MASH time scales, based on the urgency of the presenting risk.

In cases where SPA has identified risk of FGM and threshold is met for Section 17 or Section 47 intervention. The SPA will progress to the appropriate Social Work Team, who will allocate a Social Worker within 24 hours of the original referral.

Where there is likelihood that a child has or is at risk of suffering significant harm and FGM is significant harm. The Social Work Team will invite the police, health, education and any other professionals working with the family to a Strategy meeting. At the Strategy meeting a multi-agency decision will made in accordance with Section 47 Children Act 1989.

Within the strategy meeting, it should be first established whether the parents or child has had access to information regarding the harmful consequences FGM and the law in the UK. If this is not the case, the parent/child should be given appropriate information on the harmful consequences of FGM and the law. During the interviews with the family and child, a female interpreter (who is not the family) should be used or if it is possible a person who is appropriately trained in all aspects of FGM should also be involved.

Child has already undergone FGM

A strategy meeting/discussion should take place. The strategy meeting/discussion will need to consider carefully whether to continue enquiries health needs of the child or whether to assess the need for support services. If any legal action is being considered, legal advice must be sought.
A child protection conference should only be considered necessary if there are unresolved child protection issues, once the initial investigation and assessment have been completed. Where FGM has been practised, the police child abuse investigation team (CAIT) will take a lead role in the investigation of this serious crime, working to common joint investigative practices and in line with strategy agreements.

Where FGM has been practiced, the police Child abuse investigation team (CAIT) will take a lead role in the investigation of this serious crime, working to common joint investigative practices and in line with strategy agreements.

**Strategy Meeting Considerations**

The following issues should be part of the agenda in any strategy discussion regarding FGM:

- Use of an accredited interpreter in all dealings with the family
- Provision of appropriate advice and information to the family where this has not already occurred, regarding the law and harmful consequences of FGM
- Where FGM has already occurred the Strategy Discussion should discuss how, where and when the procedure was performed and the implication of this
- The provision of counselling and support services to the child/young person
- Risk to siblings and other children in the community
- Any intelligence on who has or is to perform the mutilation
- The immediate health needs of the child
- The possibility for prosecution

**Follow-up to expectant mothers who have already undergone FGM**

If SPA accepts the referral of a pregnant woman because of indications of future harm to the unborn child (FGM or other safeguarding concerns), SPA will record the information and continue to assess risk. Local safeguarding procedures will be initiated as and when appropriate.

**Information Sharing and FGM monitoring among agencies**

It is now mandatory for any NHS healthcare professional to record within a patient’s clinical record if they identify through the delivery of healthcare services that a woman or girl has had FGM.

The statutory guidance on Section 11 of the Children Act 2004 states that in order to safeguard and promote children’s welfare, the agencies covered by Section 11 should make arrangements to ensure that:

- All professionals in contact with children understand what to do and the most effective ways of sharing information if they believe that a child and family may require particular services in order to achieve positive outcomes;
- All professionals in contact with children understand what to do and when to share information, if they believe that a child may be a child in need, including those children suffering or at risk of suffering harm;
The statutory guidance in Section 10 of the Children Act 2004 makes it clear that effective information sharing supports the duty to co-operate to improve the well-being of children. Professionals in all agencies need to be confident and competent in sharing information appropriately, both to safeguard children against having FGM and to enable children and women who have had FGM to receive physical, emotional and psychological help.

HM Government- Information Sharing Advice (2018) for practitioners providing safeguarding services to children, young people, parents and carers
Appendices

Appendix 1: Detailed WHO classification of FGM

- **Type 1** — Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
  - When it is important to distinguish between the major variations of Type I mutilation, the following subdivisions are proposed:
    - Type I (a), removal of the clitoral hood or prepuce only;
    - Type I (b), removal of the clitoris with the prepuce.

- **Type 2** — Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
  - When it is important to distinguish between the major variations that have been documented, the following subdivisions are proposed:
    - Type II (a), removal of the labia minora only
    - Type II (b), partial or total removal of the clitoris and the labia minora
    - Type II (c), partial or total removal of the clitoris, the labia minora and the labia majora.

- **Type 3** — Narrowing of the vaginal orifice with creation of a covering seal by cutting and positioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
  - Type III (a), removal and apposition of the labia minora
  - Type III (b), removal and apposition of the labia majora.

- **Type 4** — All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

[Potential health consequences of FGM: infographic (PDF)]
Appendix 2

FGM Protection Orders (FGMPO)

An FGMPO is a civil order which may be made for the purposes of protecting a girl against the commission of an FGM offence – that is, protecting a girl at risk of FGM - or protecting a girl against whom an FGM offence has been committed. In deciding whether to make an order a court must have regard to all the circumstances of a case including the need to secure the health, safety and well-being of the potential or actual victim. The court can make an order which prohibits, requires, restricts or includes any other such other terms as it considers appropriate to stop or change the behaviour or conduct of those who would seek to subject a girl to FGM or have already arranged for, or committed, FGM. Examples of the types of orders the court might make are:

• to protect a victim or potential victim at risk of FGM from being taken abroad;

• to order the surrender of passports or any other travel documents, including the passport/travel documentation of the girl to be protected;

• to prohibit specified persons (`respondents’) from entering into any arrangements in the UK or overseas for FGM to be performed on the person to be protected;

• to include terms which relate to the conduct of the individuals named in the order both inside and outside of England and Wales; and

• to include terms which cover individuals who are, or may become involved in other respects (or instead of the original respondents) and who may commit or attempt to commit FGM against a girl. Orders may also be made against people, who are not named in the application. This is in recognition of the complexity of the issues and the numbers of people who might be involved in the wider community

Legal Interventions

Key points

• Where a girl or woman is at risk, legal interventions should be considered.

• Interventions may include police protection, an Emergency Protection Order, an FGM Protection Order (FGMPO) and/or other orders or applications.

• The relevant agencies should consider what is appropriate on a fact-specific basis. In some cases it may be considered that an FGMPO is sufficient to protect a girl at risk. In other cases it may be more appropriate for a combination of orders to be sought, for example, an FGMPO and making a girl a ward of court.

• Referral to an accredited family law practitioner to deal with wider issues of private or public family law may be equally important to meet the girl’s needs.

• Where an application has been made to the family court to protect a girl who may be at risk of harm (for example, for a care order) and it is subsequently recognised that there is a risk of FGM but no application for an FGMPO has been made, the applicant can request the court to consider making such an order. A court can also make an FGMPO of its own volition where it considers it necessary to protect a girl from FGM during the course of other court proceedings.
Appendix 3: List of Regulated Bodies Included in Mandatory Reporting Duty

The duty applies to all regulated professionals (as defined in section 5B(2)(a), (11) and (12) of the 2003 Act) working within health or social care, and teachers.

It therefore covers:
Health and social care professionals regulated by a body which is overseen by the Professional Standards Authority for Health and Social Care (with the exception of the Pharmaceutical Society of Northern Ireland). This includes those regulated by the:

- General Chiropractic Council
- General Dental Council
- General Medical Council
- General Optical Council
- General Osteopathic Council
- General Pharmaceutical Council
- Health and Care Professions Council (whose role includes the regulation of social workers in England)
- Nursing and Midwifery Council
- Teachers - this includes qualified teachers or persons who are employed or engaged to carry out teaching work in schools and other institutions, and, in Wales, education practitioners regulated by the Education Workforce Council;
- Social care workers in Wales.

The legislation requires regulated health and social care professionals and teachers in England and Wales to make a report to the police where, in the course of their professional duties, they either:

- are informed by a girl under 18 that an act of FGM has been carried out on her; or
- observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl’s physical or mental health or for purposes connected with labour or birth.

Reports under the duty should be made as soon as possible after a case is discovered, and best practice is for reports to be made by the close of the next working day.

In order to allow for exceptional cases, a maximum timeframe of one month from when the discovery is made applies for making reports. However, the expectation is that reports will be made much sooner than this.
A longer timeframe than the next working day may be appropriate in exceptional cases where, for example, a professional has concerns that a report to the police is likely to result in an immediate safeguarding risk to the child (or another child, e.g. a sibling) and considers that consultation with colleagues or other agencies is necessary prior to the report being made.

Cases of failure to comply with the duty will be dealt with in accordance with the existing performance procedures in place for each profession.

FGM is child abuse, and employers and the professional regulators are expected to pay due regard to the seriousness of breaches of the duty.
Appendix 4

Female Genital Mutilation – Information Sharing (FGM-IS) System

Understanding the FGM-IS System

The FGM Information Sharing or FGM-IS system is a national safeguarding system to share information which:

- Enables a medical professional to record when a girl under 18 has a family history of FGM
- Shares that information with other professionals who treat her as she grows up
- Prompts the clinicians to consider if they need to take safeguarding/other action.
- The FGM-IS tab is accessible on the Summary Care Record application (SCRa) on the NHS Spine Portal for girls under the age of 18.

FGM-IS allows information to be shared so that when a professional sees the FGM-IS indicator, they know a family history of FGM has been identified and they can treat the child accordingly. It supports safeguarding and should be used alongside existing local and national safeguarding frameworks and processes. It does not change, replace or reduce professionals safeguarding responsibilities.

The following NHS England videos can support your discussion with the family/girl and wider safeguarding policies and procedures

When the FGM-IS indication might lead to reporting under the FGM Mandatory Reporting Duty. [https://www.youtube.com/watch?v=94JaYHXNlsg&feature=youtu.be](https://www.youtube.com/watch?v=94JaYHXNlsg&feature=youtu.be)
## Appendix 5: Glossary of local Terms used for FGM

### Terms used for FGM in various languages

<table>
<thead>
<tr>
<th>Country</th>
<th>Term used for FGM</th>
<th>Language</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egypt</td>
<td>Thara</td>
<td>Arabic</td>
<td>Deriving from the Arabic word 'tahar' meaning to clean / purify</td>
</tr>
<tr>
<td></td>
<td>Khitan</td>
<td>Arabic</td>
<td>Circumcision - used for both FGM and male circumcision</td>
</tr>
<tr>
<td></td>
<td>Khifad</td>
<td>Arabic</td>
<td>Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Megrez</td>
<td>Amharic</td>
<td>Circumcision / cutting</td>
</tr>
<tr>
<td></td>
<td>Absum</td>
<td>Harrari</td>
<td>Name giving ritual</td>
</tr>
<tr>
<td>Eritrea</td>
<td>Mekhnishab</td>
<td>Tigregna</td>
<td>Circumcision / cutting</td>
</tr>
<tr>
<td>Kenya</td>
<td>Kutairi</td>
<td>Swahili</td>
<td>Circumcision - used for both FGM and male circumcision</td>
</tr>
<tr>
<td></td>
<td>Kutairi was ichana</td>
<td>Swahili</td>
<td>Circumcision of girls</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Ibi / Ugwu</td>
<td>Igbo</td>
<td>The act of cutting - used for both FGM and male circumcision</td>
</tr>
<tr>
<td></td>
<td>Sunna</td>
<td>Mandingo</td>
<td>Religious tradition / obligation - for Muslims</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>Sunna</td>
<td>Soussou</td>
<td>Religious tradition/ obligation - for Muslims</td>
</tr>
<tr>
<td></td>
<td>Bondo</td>
<td>Temenee/</td>
<td>Integral part of an initiation rite into adulthood - for non Muslims</td>
</tr>
<tr>
<td></td>
<td>Bondo / Sonde</td>
<td>Mendee</td>
<td>Integral part of an initiation rite into adulthood - for non Muslims</td>
</tr>
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<td>Somalia</td>
<td>Gudiniin</td>
<td>Somali</td>
<td>Stitching/tightening/sewing refers to infibulation</td>
</tr>
<tr>
<td></td>
<td>Halalays</td>
<td>Somali</td>
<td>Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)</td>
</tr>
<tr>
<td></td>
<td>Qodiin</td>
<td>Somali</td>
<td>Deriving from the Arabic word 'tahar' meaning to purify</td>
</tr>
<tr>
<td>Sudan</td>
<td>Khifad</td>
<td>Arabic</td>
<td>Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)</td>
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<td>Tahoor</td>
<td>Arabic</td>
<td>Deriving from the Arabic word 'tahar'</td>
</tr>
<tr>
<td>Location</td>
<td>Term</td>
<td>Description</td>
<td></td>
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<tr>
<td>CHAD – the Ngama</td>
<td>Bagne</td>
<td>Used by the Sara Madjingaye</td>
<td></td>
</tr>
<tr>
<td>Sahara subgroup</td>
<td>Gadja</td>
<td>Adapted from ‘ganza’ used in the Central African Republic</td>
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<tr>
<td>Guinea-Bissau</td>
<td>Fanadu di Mindjer</td>
<td>‘Circumcision of girls’</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fanadu di Omi</td>
<td>‘Circumcision of boys’</td>
<td></td>
</tr>
<tr>
<td>Gambia</td>
<td>Niaka</td>
<td>Mandinka Literally to ‘cut /weed clean’</td>
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</tr>
<tr>
<td></td>
<td>Kuyango</td>
<td>Mandinka Meaning 'the affair' but also the name for the shed built for initiates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Musolula Karoola</td>
<td>Mandinka Meaning 'the women's side’ / 'that which concerns women'</td>
<td></td>
</tr>
</tbody>
</table>

Appendix 6: Kingston & Richmond Multi Agency Referral Pathway

This referral pathway can be used by all professionals’ school, health, and local authority, faith & voluntary sector.

Practice Point – Health Professionals have the opportunity to check the FGM Information Sharing system(IS) on the National NHS Spine.

Practice Point – Agencies safeguarding leads should be informed.

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ASSESSMENT OF CASE
Assessment of the case will take place in line with local safeguarding procedures. Outcome of the assessment can include any of the following depending on the level of risk.

Social Care:
- Multi-agency safeguarding meeting / strategy Meeting (Police, social care and health)
- Measures to protect the girl (Child in Need, Section 47 enquiry, Child Protection Plan, Emergency Protection Order)

Police:
- Criminal Investigation
- FGM Protection Order

Health
- Health and Wellbeing Requirements, Including how care is delivered.
Appendix 7: List of FGM Specialist Services in London

1. St George’s FGM Services
   Tel: 0208 725 5949
   Open: 2 Fridays each month 2 – 5pm
   Contact: Denise Henry, Specialist Perineal Midwife

2. Acton African Well Women Centre
   Acton Health Centre 35 – 61 Church Road London, W3 8QE
   Tel: 0208 383 8716; 0208 383 8712; 07730 970738
   Open: Mon, Tue, Thurs: 8:30am - 6:30pm Wed: 8:30am - 4:00pm Fri: 8:30am - 8:00pm
   Contact: Juliet Albert: Juliet.albert@nhs.net Hayat Arteh: Hayat.ar teh@nhs.net

3. African Well Women’s Clinic
   Guy’s & St. Thomas’s Hospital 8th Floor – c/o Antenatal Clinic Lambeth Palace Rd. London, SE1 7EH
   Tel: 0207 188 6872
   Mobile: 07956 542 576
   Open: Monday – Friday, 9am – 4pm
   Contact: Comfort Momoh MBE comfort.momoh@gstt.nhs.uk

4. African Women’s Clinic
   University College Hospital Clinic 3; Elizabeth Garrett Anderson Wing Euston Road, London, NW1 2BU
   Tel: 0845 155 5000
   Open: Monday afternoon 2 - 5 pm
   Contact: Maligaye Biko maligaye.bikoo@uclh.nhs.uk

5. Gynaecology & Midwifery Department
   St. Mary’s Hospital Praed St. London, W1 1NY
   Tel: 0207 886 6691 or 0207 886 1443
   Helpline: 0203 312 6135
   Open: 9 am – 5 pm
   Contact: Judith Robbins or Sister Hany foong.han@imperial.nhs.uk

6. Women’s & Young People’s Services
   African Well Women’s Clinic - Antenatal Clinic Central Middlesex Hospital Acton Lane, Park Royal
   London, NW10 7NS
   Tel: 0208 963 7177; 0208 965 5733
   Open: Friday, 9am – 12pm
   Contact: Kamal Shehata Iskander: kamal.shehataiskander@nwlh.nhs.uk
   Jacky Deehan: Jacqueline.deehan@nwlh.nhs.uk

7. African Well Women’s Clinic
   Whittington Hospital Level 5 Highgate Hill London, N19 5NF
   Tel: 0207 288 3482 ext. 5954
   Mobile: 0795 625 7992
   Open: Last Wed of every month, 9am – 5pm
   Contact: Joy Clarke or Shamsa Ahmed: joy.clarke@whittington.nhs.uk
8. Sylvia Pankhurst Health Centre
Mile End Hospital, 3rd floor Bancroft Rd, London, E1 4DG
Tel: 0207 377 7898 or 0207 377 7870 0208 223 8322
Open: Monday – Thursday 12pm-8pm; Friday, 9:30am - 5:30 pm
Contact: Dr. Geetha Subramanian geetha.subramanian@thpct.nhs.uk

9. West London African Women’s Community Clinic
West London Centre for Sexual Health Charing Cross Hospital (south Wing) Fulham Palace Road
London, W6 8RF
Tel: 0208 383 0827; 07920 450045
Contact: Lazara Garcia Dominguez Lazara.DominguezGarcia@chelwest.nhs.uk

10. Woodfield Medical Centre
Antenatal Clinic 7e Woodfield Road London, W9 3XZ
Tel: 0207 266 8822
Open: Tues morning
Contact: Miss Katy Clifford

11. West London African Women’s Hospital Clinic
Gynaecology and Antenatal Clinics Chelsea and Westminster Hospital 369 Fulham Road, London,
SW10 9NH
Tel: 0203 315 3344
Contact: caw-tr.fgmgwestlondon@nhs.net

12. ACCM (UK)
Non-Government Organisation working to Reaching Communities to improve the health, social and
economic position of BME, asylum seekers, migrant and vulnerable communities
King’s House, 245 Ampthill Road, Bedford MK42 9AZ
Tel: 0044 (0) 77 1248 2568
Mobile: 0044 (0) 1234 356 910
Website: http://www.accmuk.com

13. Daughters of Eve (DoE)
A non-profit organisation that works to advance and protect the physical, mental, sexual and
reproductive health rights of young people from FGM practising communities
Tel: 07983030488
Website: http://www.dofeve.org

14. The Green House
Counselling for girls aged 5 and upwards who have had FGM
Tel: 0117 9351707
Website: http://www.the-green-house.org.uk/
E-mail: info@the-green-house.org.uk

16. NHS list of services in London
http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Documents/List%20of%20FGM%20Clinics%20Mar%202014%20FINAL.pdf
17. Foundation for Women’s Research and Development (FORWARD) Tel: 0208 960 4000 Email: forward@forwarduk.org.uk

18. National FGM Centre Tel: 0208 498 7137
Website: www.nationalfgmcentre.org.uk
Email: info@nationalfgmcentre.org.uk

Tel: 0800 028 3550

20. ChildLine
24 hour helpline for children
Tel: 0800 1111

Patient Information Resources
Department of Health: More information about FGM

NHS: More information about FGM
**Appendix 8**

**Contact details for Local Safeguarding Leads in Kingston and Richmond as of April 2019**

<table>
<thead>
<tr>
<th><strong>Kingston</strong></th>
<th><strong>Richmond</strong></th>
</tr>
</thead>
</table>
| **Kingston CCG Designated Nurse Safeguarding Children** Andrea Knock | **Richmond CCG Designated Nurse Safeguarding Children** Sian Thomas  
Tel 020 3968 2370  Main Switchboard 020 3941 9900  
Sian.Thomas@swlondon.nhs.uk |
| Tel 07974 941176  
Andrea.Knock@swlondon.nhs.uk |  |
| **Designated Doctor Safeguarding Children** Dr Suzanne Luck  
Tel 0208 934 6403/3740  
suzanne.luck@nhs.net | **Richmond CCG Designated Doctor Safeguarding Children** Dr Vanessa Impey  
Tel 0203 771 6100  vanessa.impey@nhs.net |
|  |  |
| **Named Doctor Safeguarding Children Kingston Hospital** Dr Dwight Lindo  
dliindo@nhs.net  
Tel 0208-934-2401/0208 934 6403 |  |
| **Named Doctor Safeguarding Children** Dr Dwight Lindo  
dliindo@nhs.net  
Tel 0208-934-2401/0208 934 6403 | **Richmond CCG Designated Doctor Safeguarding Children** Dr Vanessa Impey  
Tel 0203 771 6100  vanessa.impey@nhs.net |
|  |  |
| **Named Midwife Kingston Hospital** Jackie Latimer  
jackielatimer@nhs.net  
Tel 020 8546 7711 X6149 | **Interim Named Nurse Safeguarding Children** Central London Community Healthcare Tony Bowen  
Tel: 020 8973 3079  
/ 07930352168  anthony.bowen@nhs.net |
| **Named Midwife Kingston Hospital** Jackie Latimer  
jackielatimer@nhs.net  
Tel 020 8546 7711 X6149 | **Consultant Midwife for Public Health and Safeguarding and Named Midwife**  |
| **Named Nurse Safeguarding Children Kingston Hospital** (Commencing in post 1st April 2019) Julie Findlater Tel 020 893 43401  Mobile:-07736 632 927  Bleep: 0208-546-7711  bleep no: 494 | **Named Nurse West Middlesex University Hospital** Daisy Dholoo  
Tel 0208 321 5361  daisy.dholoo@nhs.net |
| **Named Nurse Safeguarding Children Kingston Hospital** (Commencing in post 1st April 2019) Julie Findlater Tel 020 893 43401  Mobile:-07736 632 927  Bleep: 0208-546-7711  bleep no: 494 |  |
Ext:18038 Mobile 07974 770148  
suzanne.cardillo-zallo@nhs.net | **Named Nurse West Middlesex University Hospital** Daisy Dholoo  
Tel 0208 321 5361  daisy.dholoo@nhs.net |
|  | **Consultant Midwife for Public Health and Safeguarding and Named Midwife**  |
Ext:18038 Mobile 07974 770148  
suzanne.cardillo-zallo@nhs.net | **Named Nurse West Middlesex University Hospital** Daisy Dholoo  
Tel 0208 321 5361  daisy.dholoo@nhs.net  
consultant midwife for public health and safeguarding and named midwife  |
| **Named Nurse SW London and St Georges Mental Health Trust** Frankie Campbell  
020 3513 6848  Mob: 07595 413718  
Frankie.Campbell@swlstg.nhs.uk | **Named Nurse SW London and St Georges Mental Health Trust** Frankie Campbell 020 3513 6848  Mob: 07595 413718  
Frankie.Campbell@swlstg.nhs.uk |
| **Named Nurse SW London and St Georges Mental Health Trust** Frankie Campbell 020 3513 6848  Mob: 07595 413718  
Frankie.Campbell@swlstg.nhs.uk |  |
<p>| <strong>Named GP for Kingston &amp; Richmond</strong> Vacant | <strong>Named GP for Kingston &amp; Richmond</strong> Vacant |</p>
<table>
<thead>
<tr>
<th>Official Children Looked After Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Designated Doctor/Medical Advisor for Children Looked After – Kingston (Kingston Hospital)</strong></td>
</tr>
<tr>
<td>Sandy Kenyon</td>
</tr>
<tr>
<td><strong>Working Days:</strong> Thursday</td>
</tr>
<tr>
<td><strong>T:</strong> 020 8547 5229</td>
</tr>
<tr>
<td><strong>e-mail:</strong> <a href="mailto:sandhya.kenyon@achievingforchildren.org.uk">sandhya.kenyon@achievingforchildren.org.uk</a></td>
</tr>
<tr>
<td><strong>Designated Doctor for Children Looked After – Richmond CCG</strong></td>
</tr>
<tr>
<td>Daniela Lessing (Interim 1 day per month)</td>
</tr>
<tr>
<td><strong>Working days:</strong> various</td>
</tr>
<tr>
<td><strong>e-mail:</strong> <a href="mailto:daniela.lessing@nhs.net">daniela.lessing@nhs.net</a></td>
</tr>
<tr>
<td><strong>Named Doctor for Children Looked After – Kingston (Kingston Hospital)</strong></td>
</tr>
<tr>
<td>Augusto Palombi</td>
</tr>
<tr>
<td><strong>Working Days:</strong> Thursday all day and Friday morning</td>
</tr>
<tr>
<td><strong>T:</strong> 020 8547 5229</td>
</tr>
<tr>
<td><strong>e-mail:</strong> <a href="mailto:augusto.palombi@achievingforchildren.org.uk">augusto.palombi@achievingforchildren.org.uk</a></td>
</tr>
<tr>
<td><strong>Named Doctor/Medical Advisor for Children Looked After – Richmond (Hounslow and Richmond Community Healthcare)</strong></td>
</tr>
<tr>
<td>Katalin Schneider</td>
</tr>
<tr>
<td><strong>Working Days:</strong> Thursday.</td>
</tr>
<tr>
<td><strong>T:</strong> 020 8891 8130</td>
</tr>
<tr>
<td><strong>Secure email:</strong> <a href="mailto:katalin.schneider@nhs.net">katalin.schneider@nhs.net</a></td>
</tr>
<tr>
<td><strong>Designated Nurse for Children Looked After - Kingston and Richmond CCG</strong></td>
</tr>
<tr>
<td>Vicky Fraser (1 WTE)</td>
</tr>
<tr>
<td><strong>Working days:</strong> Monday – Friday 9-5.</td>
</tr>
<tr>
<td><strong>T:</strong> 020 3968 2371</td>
</tr>
<tr>
<td><strong>M:</strong> 07384 877047</td>
</tr>
<tr>
<td><strong>e-mail:</strong> <a href="mailto:vicky.fraser@swlondon.nhs.uk">vicky.fraser@swlondon.nhs.uk</a>  <a href="mailto:vicky.fraser@achievingforchildren.org.uk">vicky.fraser@achievingforchildren.org.uk</a></td>
</tr>
<tr>
<td><strong>Secure email:</strong> <a href="mailto:vicky.fraser@nhs.net">vicky.fraser@nhs.net</a></td>
</tr>
<tr>
<td>Role</td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Named Nurse for Children Looked After Kingston and Richmond</td>
</tr>
<tr>
<td>Specialist Nurse Children Looked After – Kingston (Your Healthcare)</td>
</tr>
<tr>
<td>Specialist Nurse Children Looked After - Richmond (Hounslow &amp; Richmond Community Healthcare)</td>
</tr>
</tbody>
</table>

Policy reviewed June 2019
Due for Review May 2020