Northern Devon Healthcare NHS Trust

Document Control

Title			
Female Genital Mutilation (FGM) Policy			
Author		**Author's job title** Named Nurse Safeguarding Children and Young People Specialist Midwife in Complex Care	
Directorate Women's, Children's and Mental Health Interface		**Department** Integrated Safeguarding Team	
Version	**Date Issued**	**Status**	**Comment / Changes / Approval**
1.0	July 2017	Final	Approved by Safeguarding Children Board July 2017
1.1	Sept 2020		Integrated Safeguarding Committee Minor wording changes only
Main Contact Nurse Consultant Safeguarding Lead Named Nurse Children and Young People Northern Devon Healthcare NHS Trust Raleigh Park Barnstaple, EX31 4JB		**Tel: Direct Dial** – **Email**:	
Lead Director Chief Nurse/Executive Director of Safeguarding			
Superseded Documents None			
Issue Date September 2020	**Review Date** July 2023	**Review Cycle** Three Years	
Consulted with the following stakeholders: • NDHT Integrated Safeguarding Committee • NDHT Safeguarding Children Operational Group • NDHT Safeguarding Adult Operational Group • Director of HR and Personnel Development • Divisional General Manager – Strategic Delivery • Named Doctor • Named Midwife • Lead Consultant for Obstetrics and Gynaecology • Lead Consultant for Sexual Health • Safeguarding Children and Adults Link Practitioners • Bladder and Bowel Specialist Team • Integrated Safeguarding Team Members			
Approval and Review Process • NDHT Integrated Safeguarding Committee			
Local Archive Reference G:\Compliance Team\Published Policies\Children Safeguarding **Local Path** Safeguarding children\folder **Filename** Female Genital Mutilation (FGM) Policy v1.0			

Policy categories for Trust's internal website (Bob)	Tags for Trust's internal website (Bob)
All Staff, Child Protection, Safeguarding, Paediatrics	Safeguarding Children, Child Protection, Female Genital Mutilation, FGM

CONTENTS

1. Purpose

1.1. The purpose of this document is to inform all health professionals regarding Female Genital Mutilation (FGM). It provides guidance on how to identify and address this issue with women, how to proceed when someone is identified as having undergone FGM and how to safeguard girls from the practice of FGM within Northern Devon Healthcare Trust.

Within the maternity setting it also supports the policy of asking all women whether they have experienced any form of surgery to their genitals including FGM.

Northern Devon Healthcare Trust is required to record and report this data centrally to the Department of Health (DOH) on a quarterly basis;

1.1.1. If a patient has had FGM

1.1.2. If there is a family history of FGM

1.1.3. If an FGM related procedure has been carried out on a women e.g. deinfibulation

1.2. FGM has been a criminal offence in the UK since the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003 replaced the 1985 Act and made it an offence for UK Nationals, permanent or habitual 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.

1.3. The policy applies to all Trust staff.

1.4. Implementation of this policy will ensure that the duty for all professionals to act to safeguard girls at risk of FGM with four key considerations;

- An illegal act being performed on a female regardless of her age
- The need to safeguard girls and young women at risk of FGM
- The risk to girls and young women where a relative has undergone FGM
- Situations where a girl or young woman may be removed from the country to undergo FGM

2. Definition

Female Genital Mutilation (FGM) has been defined as “any procedure involving partial or total removal of the external female genitalia and/or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons” (WHO, 2000).

The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time the mutilation is carried out and in later life. The procedure is typically performed on girls between ages two and 13, but in some cases to new born infants or young women before marriage or pregnancy.

FGM is a form of violence against women and girls, is an abuse of human rights and is a form of child abuse. It can be referred to by a number of names such as female circumcision, female genital cutting, pharionic circumcision or sunna, there are also local names.

3. Responsibilities

3.1. Role of Managers

Managers are responsible for:

3.1.1. Ensuring that staff are competent to perform their delegated roles

3.1.2. Ensuring that staff have protected time identified to access appropriate training. However if there is urgent care required for a patient then this would need to be prioritised.

3.1.3. Ensuring that staff have undertaken mandatory safeguarding training at the level identified in the Intercollegiate Document (2014).

3.2. Role of Named Nurse/Named Doctor/Named Midwife

The Named Professionals are responsible for:

3.2.1. Overseeing the process of safeguarding children at risk or for whom FGM has been perpetrated

3.2.2. Providing assurance of compliance with standards across the organisation

3.2.3. Monitoring provision for safeguarding children at risk of FGM

3.2.4. Ensuring staff have undertaken their statutory requirements for reporting FGM

3.2.5. Providing appropriate training and support to staff which enables them to identify women and children at risk of, or who have undergone FGM

3.2.6. Reporting all cases of FGM to NHS England/Department of Health

3.3. Role of Employee(s)

The employee(s) are responsible for:

3.3.1. All staff have an individual “mandatory duty to report” known cases of FGM in under 18 year old girls.[1]

3.3.2. Actively accessing mandatory safeguarding training at the level identified in the Intercollegiate Document (2014).

3.3.3. Midwives, Gynaecologists and Obstetricians should further develop and enhance knowledge and skills as per policy to ensure they can use the appropriate language to ask questions and identify those women that have had FGM.

3.3.4. All staff need to be alert to the possibility of a child being at risk of, or having experienced FGM.

4. Female Genital Mutilation (FGM)

4.1. The World Health Organisation (WHO) describe four classifications of FGM;

4.1.1. Type One – Excision of the prepuce, with or without excision of part or the entire clitoris

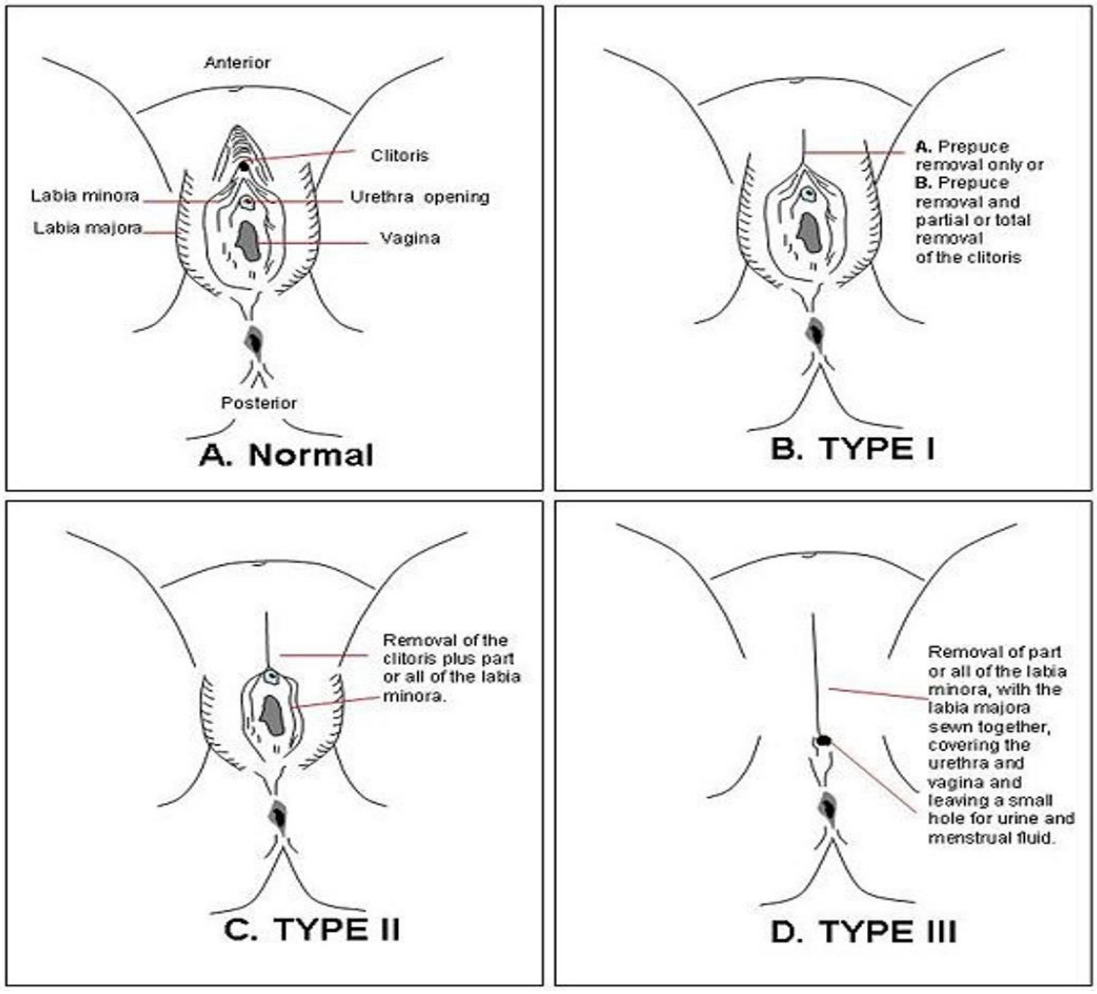
[1] Known cases are those where either a girl informs the person that an act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show an act of FGM has been carried out and the person has no reason to believe the act was, or was part of, a surgical operation with Section One (2) (a) or (b) of the FGM Act 2003.

4.1.2. Type Two – Excision of the clitoris with partial or total excision of the labia minora

4.1.3. Type Three – Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening. Otherwise known as “infibulation”. This type is most common in Somalia and Sudan

4.1.4. Type Four – Unclassified; pricking, piercing, incising, stretching, burning or cauterising of the clitoris or surrounding tissue. Scraping of the vaginal orifice or the introduction of corrosives or herbs in to the orifice, to cause bleeding or for the purpose of tightening or narrowing it (See Figure 1).

Figure 1



5. Indicators

5.1. Identifying a child who has been subject to FGM or who is at risk of being abused through FGM

5.1.1. Professionals in all agencies, and individuals and groups in the community, need to be alert to the possibility of a child being at risk of or having experienced FGM. There are a range of potential indicators that a child may be at risk of FGM which individually may not indicate risk but if there are two or more present this could signal risk to the child.

5.2. Indications that a child may be at risk of FGM:

5.2.1. The family comes from a community that is known to practice FGM e.g. Somalia, Sudan and other African countries. It may be possible that they will practice FGM if a female family elder is around.

5.2.2. Parents state that they or a relative will take the child out of the country for a prolonged period

5.2.3. A child may talk about a long holiday to her country of origin or another country where the practice is prevalent, including African countries and the Middle East

5.2.4. A child may confide to a professional that she is to have a 'special procedure' or to attend a special occasion

5.2.5. A professional hears reference to FGM in conversation, for example a child may tell other children about it

5.2.6. A child may request help from a teacher or another adult

5.2.7. Unaccompanied asylum seeking children, refugee families

5.2.8. Any female child born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family

5.2.9. Any female child who has a sister who has already undergone FGM must be considered to be at risk, as must other female children in the extended family

5.3. Indications that FGM may have already taken place include:

5.3.1. A child may spend long periods of time away from the classroom during the day with bladder or menstrual problems

5.3.2. There may be prolonged absences from school

5.3.3. A prolonged absence from school with noticeable behaviour changes on the girl’s return

5.3.4. Professionals also need to be vigilant to the emotional and psychological needs of children who may/are suffering the adverse consequence of the practice, e.g. withdrawal, depression etc.

5.3.5. A child may confide in a professional

5.3.6. A child requiring to be excused from physical exercise lessons without the support of her GP

5.3.7. A child may ask for help

6. Consequences

6.1. Short Term Consequences following FGM can include;

6.1.1. Severe pain

6.1.2. Emotional and psychological shock exacerbated by having to reconcile being subjected to the trauma by loving parents, extended family and friends

6.1.3. Haemorrhage

6.1.4. Wound infections, including tetanus and blood-borne viruses including HIV and Hepatitis B and C

6.1.5. Urinary retention

6.1.6. Injury to adjacent tissues

6.1.7. Fracture or dislocation as a result of restraint

6.2. Long Term Health Implications can include;

6.2.1. Chronic vaginal and pelvic infections

6.2.2. Difficulties with menstruation

6.2.3. Difficulties in passing urine and chronic urine infections

6.2.4. Renal impairment and possible renal failure

6.2.5. Damage to the reproductive system, including infertility

6.2.6. Infibulation cysts, neuromas and keloid scar formation

6.2.7. Obstetric fistula

6.2.8. Complications in pregnancy and delay in the second stage of childbirth.

6.2.9. Pain during sex and lack of pleasurable sensation

6.2.10. Psychological damage, including a number of mental health and psychosexual problems such as low libido, depression, anxiety and sexual dysfunction; flashbacks during pregnancy and childbirth; substance misuse and/or self-harm

6.2.11. Increased risk of HIV and other sexually transmitted

7. The Law

In England and Wales, criminal and civil legislation on FGM is contained in the Female Genital Mutilation Act (2003)

The Act;

- Makes it illegal to practice FGM in the UK
- Makes it illegal to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in that country
- Makes it illegal to aid, abet, counsel or procure the carrying out of FGM abroad
- Has a penalty of up to 14 years in prison and/or a fine.

This was amended by the Serious Crime Act 2015, the Female Genital Mutilation Act (2003) now includes:

- New offence of failing to protect a girl from FGM. A person is liable if they are 'responsible' for the girl at the time the offence is committed. This covers someone who has parental responsibility for the child and has 'frequent contact' with her and any adult who has assumed responsibility for caring for the child in the manner of a parent. i.e. a family member, with whom she is staying during the school holidays.
- Female Genital Mutilation Protection Orders (FGMPO) - The terms of the order are flexible and the court can include whatever terms it considers necessary to protect the girl or young women.
- Allowing for lifelong anonymity of victims of FGM - prohibiting the publication of any information that could lead to the identification of the victim. Including all aspects of the media and social media
- Extended the extra-territorial reach of FGM offences to include "habitual residents" of the UK
- Creating a new duty of Mandatory Reporting of Female Genital Mutilation for regulated professionals in health and social care professions and teachers in England and Wales (came into force 31.10.15)

8. NHS Actions

Since April 2014 NHS hospitals have been required to record:

8.1.1. If a patient has had Female Genital Mutilation;

8.1.2. If there is a family history of Female Genital Mutilation;

8.1.3. If a Female Genital Mutilation-related procedure has been carried out on a patient.

Since September 2014 all acute hospitals have been required to report this data centrally to the Department of Health on a regular basis. This was the first stage of a wider ranging programme of work in development to improve the way in which the NHS will respond to the health needs of girls and women who have suffered Female Genital Mutilation and actively support prevention.

A midwife/obstetrician/gynaecologist/general practitioner may become aware that Female Genital Mutilation has occurred when treating a female patient. This should trigger concern for other females in the household.

For further information, see **Information Standards Board for Health and Social Care, Female Genital Mutilation Prevalence Dataset Standard Specification.**

9. Protection and Actions to be taken for Children

There are three circumstances relating to FGM which require identification and intervention:

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

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

- Immediate protection and support for the child or children
- That the practice is not perpetuated

9.1. **An appropriate response to a child suspected of having undergone FGM as well as a child at risk of undergoing FGM could include:**

9.1.1. Arranging for an interpreter if this is necessary and appropriate

9.1.2. Creating an opportunity for the child to disclose, seeing the child on their own

9.1.3. Using simple language and asking straightforward questions

9.1.4. Using terminology that the child will understand, e.g. the child is unlikely to view the procedure as abusive

9.1.5. Being sensitive to the fact that the child will be loyal to their parents

9.1.6. Giving the child time to talk

9.1.7. Getting accurate information about the urgency of the situation, if the child is at risk of being subjected to the procedure

9.1.8. Giving the message that the child can come back to you again

9.2. **An appropriate response by professionals who encounter a girl or woman who has undergone FGM includes:**

9.2.1. Arranging for a professional interpreter and not agreeing to friends/family members interpreting on their behalf

9.2.2. Being sensitive to the intimate nature of the subject

9.2.3. Making no assumptions

9.2.4. Asking straightforward questions

9.2.5. Being willing to listen

9.2.6. Being non-judgemental (condemning the practice but not blaming the girl/woman)

9.2.7. Understanding how she may feel in terms of language barriers, culture shock, that she, her partner, her family are being judged

9.2.8. Give a clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM/ if/when they have a daughter

10. Mandatory Duty to Report (Children under 18 years)

When a report must be made, refer to Appendix A: FGM Safeguarding Pathway

10.1. Northern Devon Healthcare NHS Trust Professionals' Response (Children under 18 years)

The FGM mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015). 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:

10.1.1. Are informed by a girl under 18 that an act of FGM has been carried out on her; or

10.1.2. 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.

For the purposes of the duty, the relevant age is the girl's age at the time of the disclosure/identification of FGM (i.e. it does not apply where a woman aged 18 or over discloses she had FGM when she was under 18).

Complying with the duty does not breach any confidentiality requirement or other restriction on disclosure which might otherwise apply.

The duty is a personal duty which requires the individual professional who becomes aware of the case to make a report; the responsibility cannot be transferred. The only exception to this is if you know that another individual from your profession has already made a report; there is no requirement to make a second.

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, you should follow local safeguarding procedures. For more information, please see NDHT Safeguarding Children Policy or SWCPP Procedures.

Where there is a risk to life or likelihood of serious immediate harm, professionals should report the case immediately to police, including dialling 999 if appropriate.

Any information or concern that a child is at immediate risk of, or has undergone FGM should result in an **immediate call to the Police using the 101 number**. You must provide:

- Full details of child – name, date of birth, address, school, GP
- Full details of parents – name, date of birth, address

- Your name and professional details
- The name of the Named Nurse for Safeguarding Children at Northern Devon Healthcare Trust (Anna Brimacombe)
- Full details of siblings – name, date of birth, school, address, GP
- Description of concern
- Any background health information available to referrer
- Any additional social information regarding the family i.e. mental health, learning

A MASH enquiry must also be made at the same time following the guidance in the Safeguarding Children Policy.

10.2. Northern Devon Healthcare NHS Trust Professionals' Response (Adults over 18 years)

Staff should:

10.2.1. Email the Safeguarding Children Team at ndht.childprotection@nhs.net with the patient's name and NHS number

10.2.2. Ask if she has female children or siblings at risk of FGM; if this is the case make a MASH enquiry to share information with multi-agency partners and initiate a safeguarding response

10.2.3. Clearly document all decisions and actions with the patient/family in the patients' medical records

10.2.4. Explain FGM is illegal in the United Kingdom

10.2.5. Discuss the adverse health consequences of FGM

10.2.6. Consider is the patient a vulnerable adult?

10.2.7. Consider the need to refer the patient to FGM services to confirm FGM is present, FGM type and/or deinfibulation

10.2.7.1. If long term pain, consider referral to urogynecology specialist clinic

10.2.7.2. If mental health problems, consider referral to counselling/other

10.3. Information regarding the multi-agency response

Where concerns about the welfare and safety of a child or young person have come to light in relation to FGM, a referral to Children's Social Care should be made in accordance with the NDHT Safeguarding Children Policy via a MASH Enquiry.

Children's Social Care will undertake an assessment and jointly with the Police, will undertake a Section 47 Enquiry if they have reason to believe that a child is likely to suffer or has suffered FGM. A strategy discussion/meeting should include the relevant health professionals and, if the child is of school age, the relevant school representative.

Where a child has been identified as having suffered or being likely to suffer, significant harm, it may not always be appropriate to remove the child from an otherwise loving family environment. Parents and carers may genuinely believe that it is in the girl's best interest to conform to their prevailing custom. Professionals should work in a sensitive manner with families to explain the legal position around FGM in the UK. The families will need to understand that FGM and re-infibulation (the process of resealing the vagina after childbirth) is illegal in the UK and that if they are insistent upon carrying out the practice, the health visitor and Children's Social Care must be informed that a female child may be at risk of significant harm. Interpretation services should be used if English is not spoken or well understood and the interpreter should not be an individual who is known to the family.

Where a child appears to be in immediate danger of mutilation, legal advice should be sought and consideration should be given, for example, to seeking a Female Genital Mutilation Protection Order, an Emergency Protection Order or a Prohibited Steps Order, making it clear to the family that they will be breaking the law if they arrange for the child to have the procedure.

The 2003 Female Genital Mutilation Act makes it illegal for any residents of the UK to perform FGM within or outside the UK. The punishment for violating the 2003 Act carries 14 years imprisonment, a fine or both.

10.4. NDHT Reporting Process

Staff should email ndht.childprotection@nhs.net when they identify women who have undergone FGM and there are no children in the household. This should include the women's name and NHS number.

NDHT is required to record and report this data centrally to the Department of Health (DOH) on a quarterly basis. Information from the MASH/SCLF process will be collated by the Safeguarding Children Team to inform this process.

If the patient has female children then a MASH enquiry should be completed and copied to the Safeguarding Children Team as per the NDHT Safeguarding Children Policy.

Information from the MASH will be shared with the patient's GP and Public Health Nursing Team (including Health Visitor) via this process.

10.5. Guidance for staff working with women who are not pregnant including Sexual Health and Bladder and Bowel Specialist Services.

Women seen in Sexual Health and Bladder and Bowel services are routinely asked questions that may lead the clinician to have concerns about FGM affecting the patient in front of them. We are aware FGM is a complex and sensitive issue that requires professionals to approach the subject carefully.

Routine health questions that may lead a clinician to be concerned include questions such as:

- Do you experience any pains or difficulty during intercourse?
- Do you have any problems passing urine?
- Do you have any pelvic pain or menstrual difficulties?

All women are also asked about obstetric history and gynaecological procedures Questions include:

- Have you had any difficulties in childbirth?
- Have you had any genital piercings or genital procedures?

All patients attending health services can request a clinician of the same gender, ensure the woman is aware of this and interpreting services are available if required.

Clinicians who suspect or identify FGM have a duty to report to the Safeguarding lead for discussion and referral.

Examination of the patient who has disclosed FGM should be by a senior clinician and following departmental examination and chaperone policy, but at the clinician's discretion to adapt the examination to suit the individual woman. It is mandatory for health professionals to record in their healthcare record if a patient has FGM whenever it is identified in the course of NHS treatment. Injuries should be carefully documented.

Examination of a child or young person should be in strict accordance with safeguarding children procedures and a consultant paediatrician may need to be present.

Patients should be signposted onto appropriate counselling and support, and offered referral in gynaecological services for discussion of reversal/de-infibulation if appropriate.

Patients should be informed that FGM is an illegal act performed on a female, regardless of her age. The Female Genital Mutilation Act 2003 made it illegal for UK residents (in England and Wales) and permanent residents to practice FGM within or outside in the UK (there is different legislation for Scotland). There is no requirement for automatic referral of adult women with FGM to adult social services or the police. Healthcare professionals should be aware that a disclosure may be the first time that a woman has discussed her FGM with anyone. 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. The wishes of the woman must be respected at all times. If the woman is pregnant, the welfare of her unborn child or others in her immediate or extended family must also be considered at this point as they are potentially at risk and action must be taken accordingly.

As previously discussed, consider onward referral into gynaecology services and ask permission to involve the GP. See reporting process at 10.1 and 10.2.

11. Guidance for Midwives

11.1. Psychological

It is important to note that psychological trauma and physical morbidity associated with the original act may lead to fear of childbirth; therefore any discussion needs sensitive and careful handling on the part of medical and midwifery practitioners (Birmingham Heartlands, 2004)

The original act of FGM can be carried out without explanation, analgesia, anaesthesia or qualified medical supervision. It is often performed on young girls who are being held down by female relatives. The psychological effects can be lifelong instilling fear, anxiety and depression. It is not uncommon for women to experience "flash backs" during childbirth. It is therefore imperative that all birth attendants are aware of this and always act in a sensitive manner (Birmingham Heartlands, 2004)

11.2. Antenatal

The aim is to offer and carry out reversal of female genital mutilation in the second trimester to enable easy access to the vaginal orifice and urethra during labour.

11.3. Antenatal Period, Booking Appointment and FGM Enquiry

It is NDHT's maternity guidance that sensitive enquiry at the booking appointment should be made to determine the FGM status of all women.

In addition, it is essential to classify the type and severity of FGM as this will influence maternity and obstetric care.

All women should be asked sensitively about FGM using the following question:

Have you ever had any surgery to your genitals such as: genital piercings, operations or have you been cut or circumcised?

"Have you been circumcised? Are you open or closed?" or "Did you have a cut or operation (on your vagina) as a child?"

If the answer to this is yes the health professional will ask the question:

What type of genital surgery have you had?

- Episiotomy repair
- Episiotomy refashioning
- Repair of 3rd or 4th degree tear?
- Female circumcision/cut/closed?
- Other

For women who come from outside the UK the question – "Do you come from a country in which FGM or genital cutting is practiced?" will allow discussion about whether the woman has experienced FGM. Women may not disclose this information unless actually asked. Once the question has been asked they will often feel comfortable with further discussions.

A skilled non-related interpreter may be required due to language barriers.

If the midwife taking the history does not feel confident to discuss FGM she/he should seek support and training from a colleague who is confident.

If the woman says that she has not had FGM, this should be clearly documented in her notes. No further action is needed.

If the woman discloses that she has undergone FGM, it is important for her to be examined by a competent practitioner (Midwife/Doctor), to identify:

- Whether she has already had 'reversal' of FGM
- The type of FGM
- Whether or not 'reversal' or de-infibulation is necessary.

Clear documentation should be made in the case-notes. A diagram is often helpful.

FGM type I and II do not usually impede labour and it is likely that no further action is necessary.

FGM type III, infibulation or an extensive type II requires de-infibulation. They should see their assigned Consultant for this procedure or should be offered an appointment with a Consultant Obstetrician and Gynaecologist as soon as possible.

All women who have an FGM should be given information on the legal implications of organising or performing on female children.

11.4. Factors to remember for the booking appointment

The woman may be asked at booking if she is on her own or at the woman only appointment at 16 weeks gestation

Where a woman has a hearing impairment, or her first language is not English, arrangements should be made for an interpreter to be present

Wherever possible it should be ascertained from the woman whether the interpreter is suitable. Family members and friends should never be used to interpret interviews of this kind.

11.5. If FGM is disclosed or identified

Record FGM in the patient's healthcare record, as well as details of any conversations, use a diagram or medical photography (with consent).

This aids communication with the patient and other clinicians, and limits repetitive examinations.

Ascertain whether there are any daughters within the family and whether they have also had FGM.

Give a very clear explanation that FGM is illegal in the UK, and also illegal to take a child out of the country to carry out FGM, and that the law can be used to help the family avoid FGM if/when they have daughters

Explain to the patient that you will need to make a referral to MASH and you will need to inform the patient's GP and Health Visitor if there are female children in the family or if the baby is female.

Inform the Named Midwife for Safeguarding and Safeguarding Children team via a SCLF or email ndht.childprotection@nhs.net

Refer the patient to an obstetrician ante natal clinic who will arrange to see and examine the patient and refer to appropriate services.

Assess the psychological impact and referral to a psychologist (via perinatal mental health team) if deemed necessary and agreed upon by the patient.

Following the assessment, if a patient is a primigravida with type III FGM or it is felt that vaginal examination or delivery will be difficult or impossible she should be referred to a Consultant Obstetrician for consideration for antenatal deinfibulation.

11.6. Antenatal Deinfibulation

Deinfibulation (reversal) should be offered if vaginal access is inadequate and to all women with type III FGM. Ideally this is performed antenatally around 20 weeks gestation (reduces risk of miscarriage and allows time for healing before birth). The patient may need to be referred to a specialist unit for this procedure as this may not be available at NDHT.

Often the patient has not been identified antenatally and she presents in labour (see below for intrapartum deinfibulation). In addition, some women would prefer to have the procedure performed during labour (so as to experience only one lot of pain and trauma). This may be normal practice in their country of origin.

11.7. Benefits of Antenatal Deinfibulation

11.7.1. Avoids the need to cut scar tissue in labour

11.7.2. Reduces excessive laceration

11.7.3. Reduces the risk of foetal asphyxia due to delayed crowning at the point of delivery

11.7.4. Reduces the incidence of bacterial vaginosis and associated pre-term labour

11.8. Intrapartum Care

11.8.1. When deinfibulation has been performed antenatally

11.8.2. Aim for vaginal birth

11.8.3. Aim for intact perineum

11.8.4. Episiotomy is recommended if inelastic scar tissue prevents progress

11.8.5. Episiotomy when indicated should be medio-lateral

11.9. When no antenatal deinfibulation (unbooked or elected for intrapartum deinfibulation)

11.9.1. Birth should be in a unit with immediate access to facilities for emergency obstetric care

11.9.2. The Labour Ward Coordinator must be informed. Aim for vaginal birth

11.9.3. Place IV Access; send FBC and Group & Save (risk of PPH)

11.9.4. Provide adequate analgesia to prevent flashbacks to original procedure

11.9.5. Inform Consultant Obstetrician

11.9.6. Epidural should be offered, adequate pain relief is essential as vaginal examinations are poorly tolerated, for anterior episiotomy and deinfibulation, and to psychologically reduce flashbacks

11.9.7. Perform deinfibulation in the first stage of labour

11.9.8. Informed consent is essential prior to deinfibulation

11.9.9. Infiltrate with local anaesthetic or top up epidural for adequate pain relief

11.9.10. Perform an anterior midline incision to expose the urethra and clitoris that are beneath the scar tissue. (If uncertain, stop when the urethral meatus is visible)

11.9.11. If woman presents in the 2nd stage of labour perform the incision at the time of the foetal head crowning

11.9.12. Stretching the fused labia allows a good view of the fusion line and minimises blood loss

11.9.13. Care must be taken to protect the foetal head from laceration

WHO recommends suturing raw edges to prevent re-infibulation

It is illegal to re-infibulate i.e. re-sew or to re-suture the incised skin edges and close the scar tissue and to do so would risk a criminal prosecution.

Staff should not do a medio-lateral episiotomy and leave the infibulation intact.

Figure 2

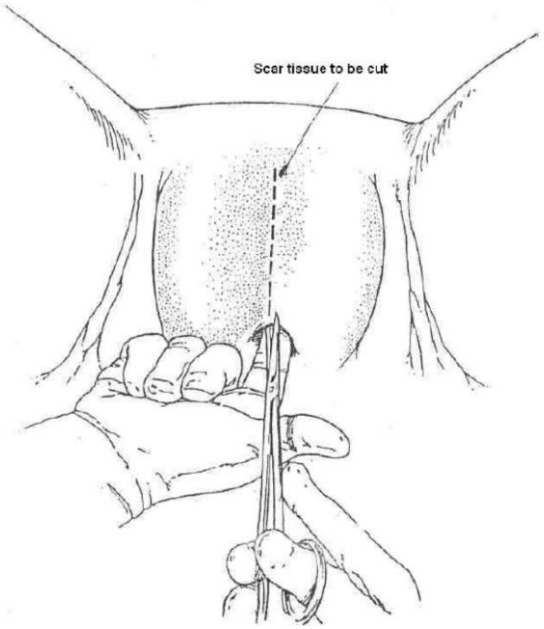
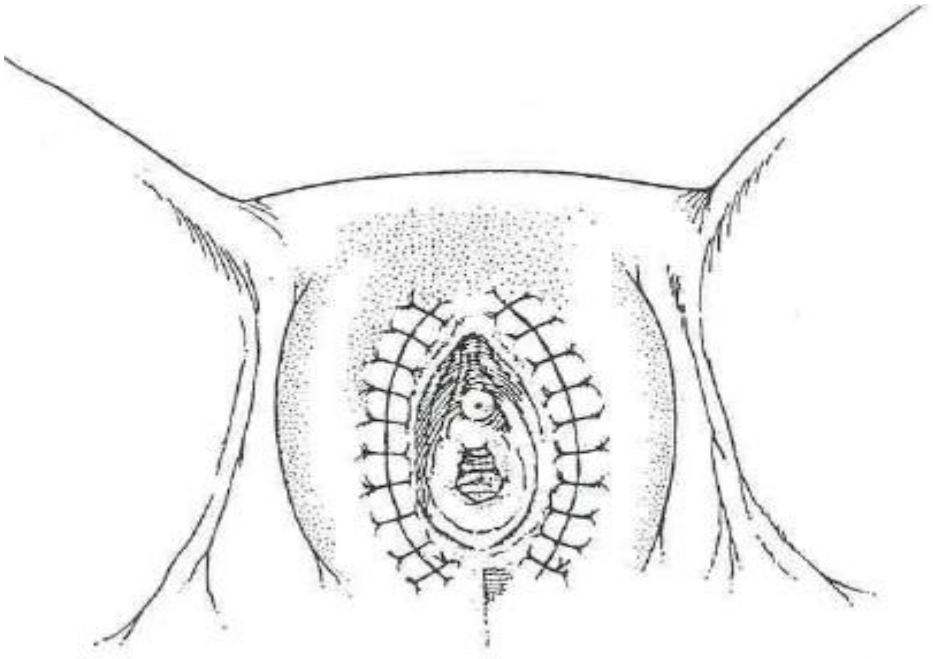


Figure 3



11.10. Postnatal Care

11.10.1. Routine care, inform women that if there were no complications, she is otherwise low risk and the deinfibulation was successful she would be suitable for a community birth in a future pregnancy

11.10.2. Debrief if deinfibulation was carried out during labour

11.10.3. Discuss with woman legal status of FGM in the UK (especially if baby girl or girls in the family) and ensure this is documented.

11.10.4. Inform health visitor and safeguarding team and inform the woman the referral has been made and write 'Family history of FGM' in the baby's red book

11.10.5. Inform woman of the link between FGM, pain and health problems in later life

11.10.6. If deinfibulation was carried out in labour, 4-6 week postnatal follow up recommended to assess healing.

11.10.7. If deinfibulation was carried out in labour, advise to avoid sexual intercourse until healing has occurred and to use lubrication if necessary

11.10.8. Advice/counselling may be required in relation to passing urine, menstruation and sexual health needs

11.10.9. Discuss contraception, IUCD will be a method not previously available

11.10.10. Cervical smear uptake should also be discussed

12. Monitoring Compliance with and the Effectiveness of the Policy

12.1. Standards/ Key Performance Indicators

Key performance indicators comprise:

12.1.1. These are identified on the Children's Performance Report

12.2. Process for Implementation and Monitoring Compliance and Effectiveness

This policy will be implemented across the Trust through the Safeguarding Children Operational Group.

Monitoring compliance with this policy will be the responsibility of the Named Nurse:

12.2.1. Named Nurse responsible for updating and reporting to NDHT Safeguarding Operational Group and the Trust Safeguarding Children Board (NDHT).

12.2.2. Minutes of NDHT received by the Quality Assurance Committee

12.2.3. Quality Assurance minutes received by Trust Board.

13. Equality Impact Assessment

13.1. The author must include the Equality Impact Assessment Table and identify whether the policy has a positive or negative impact on any of the groups listed. The Author must make comment on how the policy makes this impact.

Table 1: Equality impact Assessment

Group	Positive Impact	Negative Impact	No Impact	Comment
Age			x	
Disability			x	
Gender	x			
Gender Reassignment	x			
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment), marriage and civil partnership	x			
Pregnancy	x			
Maternity and Breastfeeding	x			
Race (ethnic origin)	x			
Religion (or belief)	x			
Sexual Orientation	x			

14. References

- Royal College of Nursing (2006) Female Genital Mutilation, An RCN educational resource for nursing and midwifery staff.
- Royal College of Obstetricians and Gynaecologists (2009) Female Genital
- Mutilation. RCOG Green-Top Guideline No 53. London.
- Sosa, G Clarke, J (2004) Female Genital Mutilation. The African Well Women Clinic at the Whittington Hospital NHS Trust. A Whittington Hospital Clinical Management Guideline.
- Toubia, N (1999) Caring for women with circumcision: a technical manual for health care providers.
- World Health Organisation (2001) Management of pregnancy, childbirth and the postpartum period in the presence of female genital mutilation. London.
- Department of Health Taskforce on the Health Aspects of Violence Against FGM

- The Royal College of Obstetricians and Gynaecologist – Felale-genital-mutilations-and-its-management-green-top-53

- Multi-Agency Practice Guidelines: Female Genital Mutilation

15. Associated Documentation

- South West Child Protection Procedures (SWCPP) FGM
- Allegations Regarding Children Against NDHT Employed Staff Policy
- Clinical Record Keeping Policy
- Consent Policy
- Domestic Violence and Abuse Policy
- Healthcare Records Policy
- Information Governance Policy
- Risk Management Training Policy
- Safeguarding Children Supervision Policy
- Safeguarding Adults Policy
- Preventing Terrorism and Radicalisation (Prevent) Policy
- Clinical Guideline for Joint Examinations by Paediatricians and Forensic Medical Examiners or Doctors from SARC (Sexual Abuse Referral Centre) at Northern Devon Healthcare Trust
- Chaperone Policy

16. Support and Information

16.1. Useful Contact Details

16.1.1. FGM Specialist Clinics – list on NHS England Website

16.1.2. UK Government - www.gov.uk/female-genital-mutilation

16.1.3. Revised HMG FGM Multi Agency Guidelines – www.gov.uk/government/publications/female-genital-guidelines

16.1.4. Women affected, who would like further support, can be referred on to a specialist FGM service – www.nhs.uk/fgm

16.2. Helplines

16.2.1. NSPCC FGM Helpline

16.2.2. Black Association of Women Step Out (BAWSO) Childline

16.2.3. The FGM helpline is a free 24 hour service – 0800 028 3550

16.3. Other Organisations

16.3.1. Halo Project – www.haloproject.org.uk

16.3.2. The Maya Centre – www.mayacentre.org.uk

16.3.3. Africans Unite Against Child Abuse – www.afruca.org

17. Appendix A: FGM Safeguarding Pathway

Presentation prompts clinicians to suspect/consider FGM e.g. repeated UTI, vaginal infections, urinary incontinence, dyspareunia, dysmenorrhea etc. Also consider difficulty getting pregnant, presenting for travel health advice or patient disclosure (e.g. young girl from community known to practise FGM that she will soon undergo 'coming of age' ceremony).

INTRODUCTORY QUESTIONS: Do you, your partner or parents come from a community where cutting or circumcision is practised? (It may be appropriate to use other terms or phrases).

No – no further action required

Yes

Do you believe patient has been subject to FGM?

No – but family history

Patient is under 18 or vulnerable adult

If you suspect she may be at risk of FGM:

Use the safeguarding risk assessment guidance to help decide what action to take:

- If child is at imminent risk of harm, initiate urgent safeguarding response.
- Consider if a child social care referral is needed, following your local processes.

Can you identify other female siblings or relatives at risk of FGM?

- Make a **MASH** enquiry to share information with multi-agency partners to initiate safeguarding response

Yes

Patient is under 18

Ring 101 to report basic details of the case to police under:

Mandatory Reporting Duty.

Police will initiate a multi-agency safeguarding response.

Patient is over 18

Does she have any female children or siblings at risk of FGM?

And/or do you consider her to be a vulnerable adult?

Consider safeguarding risk assessment and use guidance to decide whether a social care referral is required.

FOR ALL PATIENTS who have HAD FGM

1. Email NDHT Safeguarding Children Team
2. Consider need to refer patient to FGM service to confirm FGM is present, FGM type and /or for deinfibulation.
   a) If long term pain, consider referral to uro-gynae specialist clinic.
   b) If mental health problems, consider referral to counselling/other.
3. If under 18 refer for a paediatric appointment and physical examination at **SARC**.

Contact details
NDHT Child Protection **Anna Brimacombe**
01271 341533
MASH/OOH – 0345 155 1071
NSPCC FGM Helpline: 0800 028 3550
Detailed FGM risk and safeguarding guidance for professionals from the Department of Health is available **online.**

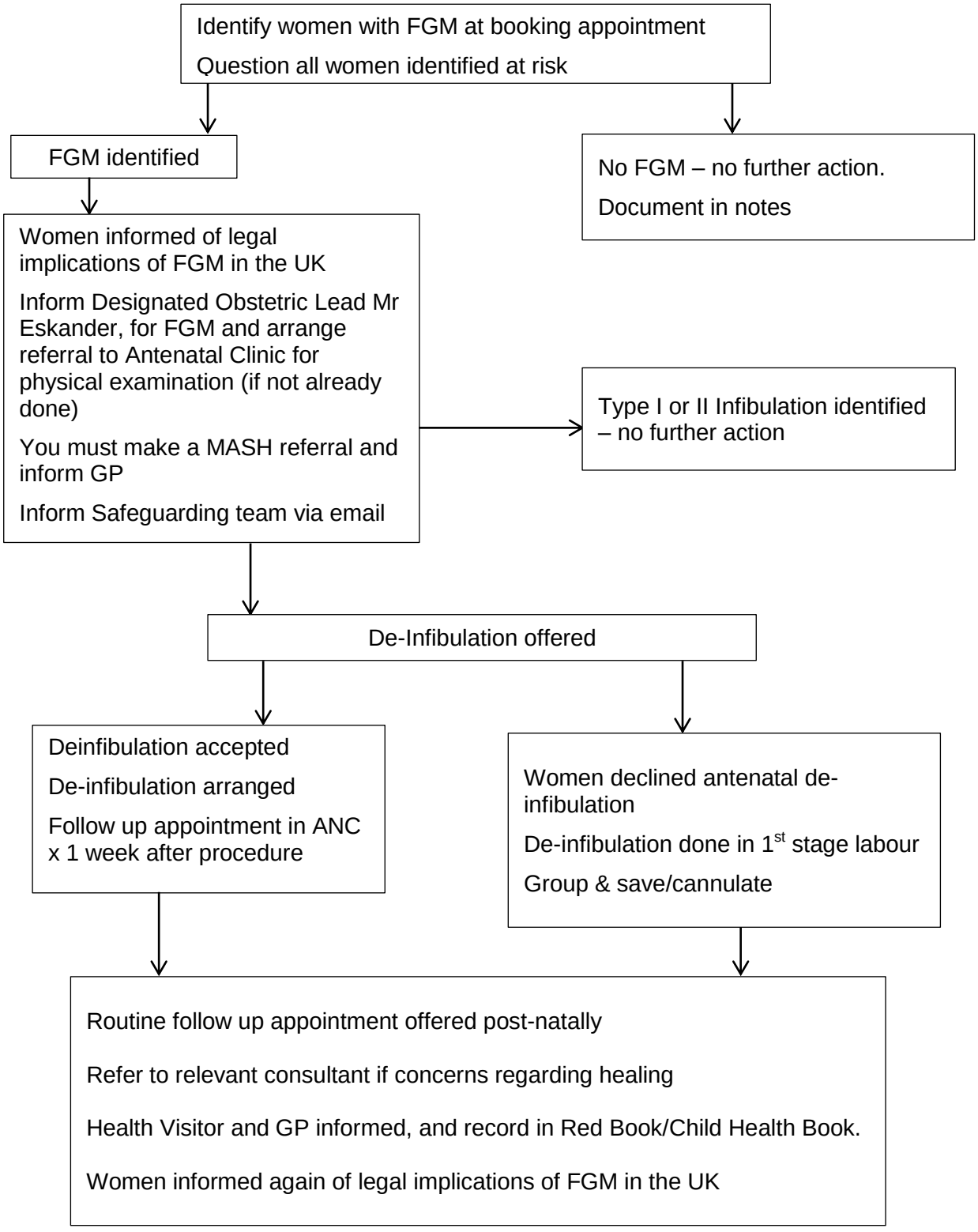
FOR ALL PATIENTS:

1. Clearly document all discussion and actions with patient/family in patient's medical record.
2. Explain FGM is illegal in the UK
3. Discuss the adverse health consequences of FGM

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

REMEMBER: Mandatory reporting is only one part of safeguarding against FGM and other abuse.

18. Appendix B: Obstetric FGM Pathway



19. Appendix C: Actions for Clinicians (includes all regulated professionals i.e. nursing, midwifery, medical and education)

Reporting Procedure

If a child/young person under the age of 18 makes a direct disclosure of female genital mutilation or female genital mutilation is seen at examination, the following must occur:

1. An immediate referral to the police by telephoning 101 (this is covered by the Serious Crime Act).

2. The enhanced data set must be reported to the Health and Social Care Information Centre (covered by the Health and Social Care Act 2012). This process should be started by emailing the Safeguarding Children Team at ndht.childprotection@nhs.net

3. Immediate referral through safeguarding procedures. The referral must be made to:

Devon MASH 0345 155 1071

Out of hours, the referral must be made to:

Emergency Duty Team on 0845 6000 388

There are two exceptions to this reporting structure:

1. For girls under the age of 18 who disclose or have FGM seen at examination in genitourinary medicine or sexual health clinics. A referral to the police and through safeguarding procedures must occur as above, but there is no submission of this standard data set to HSIC as no personal details need be collected in these clinics.

2. If a parent, sibling or other person informs a regulated professional that a child/young person under the age of 18 has had FGM, the police should not be informed, but usual safeguarding processes be followed.

This guidance does not apply where a woman over the age of 18 discloses that she had FGM whilst aged under 18 years. However, consideration of the risk to her children or younger siblings may prompt a referral to Safeguarding Services.

Should it be identified that a child is at risk of or has had FGM, then an immediate referral to Children's Social Care must take place with a strategy meeting being convened to discuss risks to the extended family and to ensure safety of the child. This follows standard safeguarding procedures (see *Trust Child Protection Policy* and *South West Child Protection Policy and Procedures*).

It is important to take detailed notes particularly of the country of origin, type of FGM, the age at which FGM was carried out, who by and in which Country. This must be carefully documented including documenting details of all discussions with the parent/carer.