Female Genital Mutilation

Classification:	Guideline
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Authors Job Title:	Named Midwife for Safeguarding
Authors Division:	Women & Children's
Departments/Group this Document applies to:	All Departments

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Guideline to be followed by (target staff): For use by all clinical staff on identification of Female Genital Mutilation (FGM)

To be read in conjunction with the following documents:

Milton Keynes University Hospital NHS Foundation Trust (2019). *Safeguarding children, ORG/GL/25, Version 11.* [Online]. Available from: https://mkuhcloud.sharepoint.com/:b:/r/sites/TrustDocumentation/Trust%20Documentation%20%20policies%20guideslines%20patient/Safeguarding/Safeguarding%20Children%20Policy%20.pdf?csf=1&web=1&e=TdPNBu. [Accessed 14th September 2022].

Are there any eCARE implications? No

CQC Fundamental standards:

Regulation 9 – person centred care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 16 – Receiving and acting on complaints
Regulation 17 – Good governance Regulation 18 – Staffing Regulation 19 – Fit and proper

Disclaimer -

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

This policy has been written in response to changes in the Female Genital Mutilation Act 2003 in England, Wales and Northern Ireland, and Sections 70-75 of Serious Crime Act 2015. All clinicians need to know how to manage and record into clinical notes when a patient with FGM is identified, and the type. If a girl under the age of 18yrs of age is suspected of being at risk or has undergone FGM then this must be reported to the Police non-emergency number (101) and Children's Social Care.

Executive Summary

The purpose of this policy is to ensure that all clinical staff are aware of Female Genital Mutilation (FGM) and the management of service users with FGM and those considered to be at risk and should be used in conjunction with the Trust Safeguarding policies and procedures. It covers the clinical care as well as the legal and regulatory responsibilities of health professionals.

FGM is an extremely harmful practice and responding to it cannot be left to personal choice. FGM is a human rights violation and a form of child abuse, breaching the United Nations Convention on the Rights of the Child (1989) and is a severe form of violence against women and girls and has severe short-term and long-term physical and psychological consequences.

FGM refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. It is an act perpetrated by parents and extended family members upon young girls entrusted to their care.

FGM is prevalent in 30 countries. These are concentrated in countries around the Atlantic coast to the Horn of Africa, in areas of the Middle East and in some countries in Asia. It has also been documented in communities in Colombia: Iran; Israel; Oman; The United Arab Emirate; The Occupied Palestinian Territories; India; Indonesia; Malaysia; Pakistan and Saudi Arabia. It has also, been identified in parts of Europe, North America and Australia.

UNICEF estimate that 200 million girls and women worldwide have undergone FGM with a further 3 million at risk of FGM per year. In England & Wales it is estimated that 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over from FGM practicing countries are living with the consequences of FGM. In addition, approximately 10,000 under the age of 15 years who have migrated to England and Wales are likely to have undergone FGM. Approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM. A 2015 study reported that no local authority in England and Wales is likely to be free from FGM entirely.

The type of FGM varies between countries and is almost always carried out on girls between infancy and the age of 15yrs. If FGM is not undergone in childhood, then women can be subjected to FGM at time of marriage, first pregnancy or shortly after giving birth. Some women may have FGM resutured after childbirth (reinfibulation).

Adult is defined as a person aged 18 years or over.

Child/Girl/Young Person is defined as a person under the age of 18 years. This includes young people aged 16 and 17 who are living independently.

All Agencies should act in the interests if the rights of the child, as stated in the UN Convention on Rights of Child.

FGM is illegal in England and Wales under the Female Genital Mutilation Act 2003. As amended by the Serious Crime Act 2015, the FGM 2003 act includes

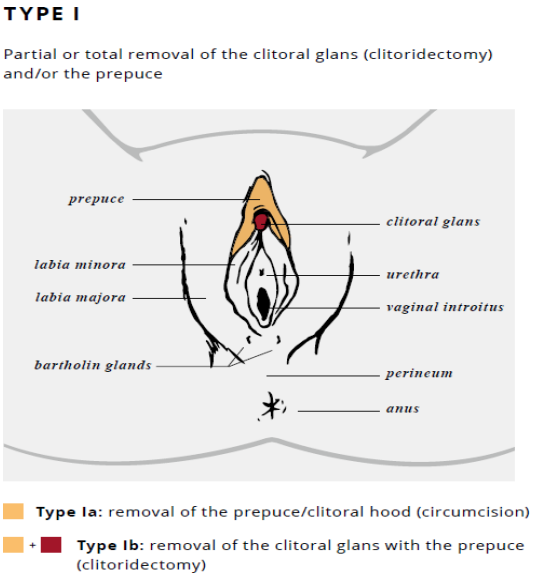
- An offence of failing to protect a girl from the risk of FGM
- Extra-territorial jurisdiction over offences of FGM committed abroad by UK nationals and those habitually (as well as permanently) resident in the UK
- Lifelong anonymity for victims of FGM
- FGM Protection Orders (FGMPO) which can be used to protect girls at risk

Definitions

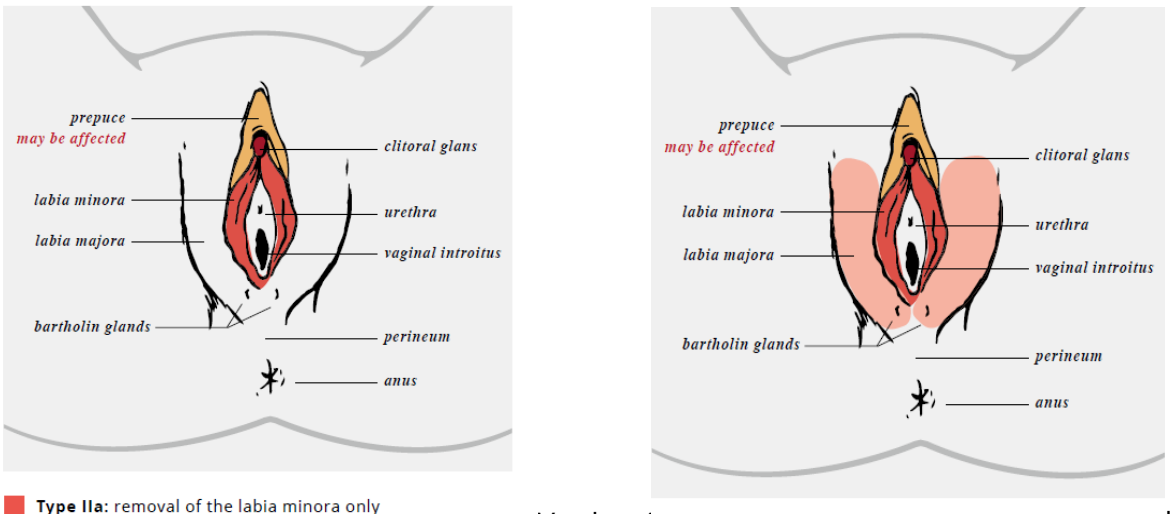
FGM Female Genital Mutilation
FGM-IS Female Genital Mutilation – Information Sharing
FGMO FGM Protection Orders
MARF Multi-Agency Referral Form
MKCSB Milton Keynes Safeguarding Children's Board
PCHR Personal Child Health Record (also known as the Red Book)
SABR1 Safeguarding Adult Alert (Previously known as a SABR1)
WHO World Health Organisation

Female Genital Mutilation as defined by World Health Organisation (WHO 2007):

- **Type I** — Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris)



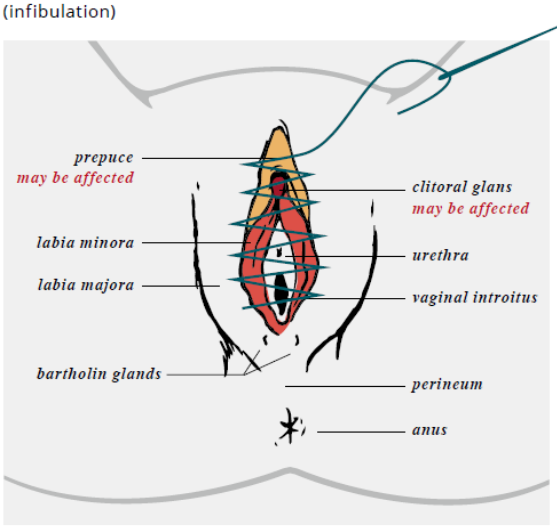
- **Type II** — Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision) (the labia minora are the 'lips' that surround the vagina)



- **Type III** — Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris

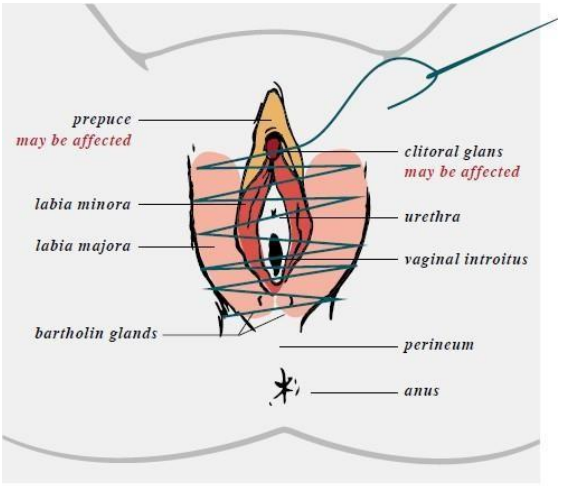
TYPE III

Narrowing of the vaginal opening with the creation of a covering seal by cutting and appositioning the labia minora or labia majora with or without excision of the clitoral prepuce and glans (infibulation)



Type IIIa:

+ + + appositioning of the labia minora



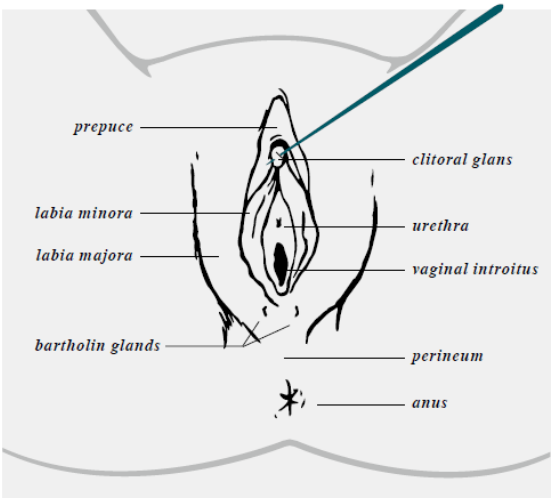
Type IIIb:

+ + + + appositioning of the labia majora

- **Type IV** — Other: all other harmful procedures to the female genitalia for non-medical purposes e.g. pricking, piercing, incising, scraping and cauterising the genital area

TYPE IV

All other harmful procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping and cauterization



The term FGM may be understood and accepted by some people, other terms used include: cut, closed or circumcised. See Appendix 1 for a list of local/traditional terms for FGM

Adults**: It is important to note that as with domestic violence and rape, if an adult has had FGM and this is identified through the delivery of NHS healthcare, the patient's right to patient confidentiality MUST be respected if they do not wish any action to be taken. No reports to social services or the police should be made in these cases. (Appendix 2)**

1.0 Roles and Responsibilities:

All staff

- Health care professionals should be sensitive to the fact that service users and families may have been under intense cultural /social pressure from within their country of origin to practice FGM
- In discussions with the service user and/or family the health care professional should be direct but non-judgmental and the illegality of FGM in the UK and the health care risks should be explained (Appendix 5)
- If the service user is under 18yrs of age and either discloses that they have had FGM or the professional observes physical signs of FGM then police should notify on their non-emergency number 101 and Children's Social Care must be informed by completing a Multi-Agency Referral Form (MARF)
- When a service user with FGM is identified the health professional should record the information in the health care records, and if known type of FGM A RADAR and a Milton Keynes Safeguarding Board FGM screening tool (Appendix 4) must be completed when FGM identified. Female Infants born to a mother who has experienced FGM will have an Female Genital Mutilation – Information Sharing) FGM-IS) Indicator added to their Summary Care Record – this will be discussed within this guideline

2.0 Implementation and dissemination of document

The policy should be available on the Trust Intranet

3.0 Processes and procedures

3.1 Identification

- Healthcare professionals should be vigilant and aware of the clinical signs of recent FGM, which include pain, haemorrhage, infection and urinary retention
    - Identification may be incidental during medical examination, treatment or they may self-disclose. An examination should not be carried out unless the case is identified as part of an examination already underway by the appropriate professional

- If necessary, an authorised accredited interpreter should be arranged (not a family member)
- When treating an individual affected by FGM, deal with the FGM in a sensitive and professional manner. Ensure that psychological health issues are also considered when supporting service users with FGM and if necessary, offer referral to psychological services through Talk for Change.
- Consider whether testing for HIV, Hepatitis B and C is indicated
- Where appropriate or if a service user is experiencing symptoms directly attributable to their FGM then a referral should be made to a Gynaecologist
- In children under 18 years where FGM is confirmed (on examination or if the patient or parent says it has been done) then report to Children's Social Care and the Police non-emergency number (101)
- In children under 18 years where FGM is suspected (but not confirmed) or the female is at risk (but has not had FGM) refer to Children's Social Care and/or the Police non-emergency number There is no requirement for automatic referral for an adult service user with FGM to Social Services or Police. This may be the first time the service user has discussed her FGM with anyone. It is important to note that as with domestic violence and rape, if an adult service user has had FGM and this is identified through the delivery of NHS healthcare, the patient's right to patient confidentiality MUST be respected if they do not wish any action to be taken. No reports to social services or the police should be made in these cases. (Appendix 3)
- If a service user discloses that they have a daughter/s over the age of 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 other enquiries about other daughters/cousins or females in the wider family context
- If a decision has been taken within the family not to carry out FGM on a UK born female child this can allow for a useful conversation to ascertain whether this was as a result of a change in attitude, a fear of prosecution or due to a lack of opportunity or other motivations
- Risk can only be considered at a particular moment in time. Healthcare Professionals should take the opportunity to continue their discussions around FGM throughout the standard delivery of health care
- If you suspect a child or vulnerable adult may have FGM or is at serious or imminent risk of FGM having considered their family history or other relevant factors, then complete a Multi-Agency Referral Form (MARF) or Safeguarding Adult Alert (Previously known as a SABR1)
- If you identify that a child (or vulnerable adult) has a family history or details which means they may be at risk of FGM, but you do not have information to suggest that the risk is imminent or you would not describe it as serious, you should follow local policies and procedures, discuss with the safeguarding team and complete a MARF/SABR1
- Consider other females in the family or household who may also be at risk of FGM and identify if any are under the age of 18 years and notify the GP so they can add the FGM-IS Indicator to the records of those in their care
- For females under the age of 5 years notify the Health Visitor, or over 5 years the School Nurse Document the identification of FGM (and type if known) in medical records (even if it is not the reason for presentation)
- Complete a Milton Keynes Safeguarding Children's Board FGM Screening Tool and a RADAR
- Offer the leaflet "Statement Opposing Female Genital Mutilation" DH (copies can be obtained from Department of Health order line Statement opposing female genital mutilation - GOV.UK (www.gov.uk) or an on-line PDF version is available on the NHS website)

- The NSPCC FGM helpline number 0800 028 3550 can support both professionals of family members concerned that a child is at risk of or has had FGM
- THE FGM-IS SYSTEM - The FGM-IS system shares information in a females healthcare record when they has a family history of FGM. This is shared to help professionals be aware of the family history whilst they treat her, so that they are alert to any associated safeguarding concerns. This information is shared confidentially with authorised healthcare professionals across all healthcare settings in England until a female is 18 years old.

3.2 Management by Gynaecologist

- Gynaecologists should ask all service users from communities that traditionally practice FGM whether they have had the procedure
- Examination should include inspection of the vulva to determine the type of FGM and whether de-infibulation is indicated, as well as to identify any other FGM related morbidities e.g. epidermoid inclusion cysts.
- De-infibulation is recommended if the introitus is not sufficiently open to permit normal urinary and menstrual flow, vaginal examination, comfortable sexual intercourse and safe vaginal birth. It may also be necessary to permit cervical smears
- Service users that are likely to benefit from de-infibulation should be counselled and ideally offered the procedure before pregnancy or first sexual intercourse. It is usually required for service users with type 3 FGM
- De-infibulation can be performed under local anaesthetic in an appropriately equipped room for minor procedures or a birthing room
- Occasionally a spinal or general anaesthetic is required
- They should be offered counselling to address any psychological or emotional problems they may have as a result of having FGM, and how things will be different for them afterwards if the service user has had a deinfibulation procedure. Boyfriends, partners and husbands should also be offered counselling

NB: The 2003 Act contains **no specific exemption for 'cosmetic' surgery or female genital cosmetic surgery (FGCS)**. If a procedure involving any of the acts prohibited by section 1 of the 2003 Act is not necessary for physical or mental health or is not carried out for purposes connected with childbirth, then it is an offence (even if the service user on whom the procedure is carried out consented).

The Royal College of Obstetricians and Gynaecologists is clear in its guideline ("*Female Genital Mutilation and its Management (Green-top Guideline No. 53)*", published on 10 July 2015) that "All surgeons who undertake FGCS must take appropriate measures to ensure compliance with the FGM Act".

3.3 Management in pregnancy

- All service users irrespective of country of origin should be asked for whether they have undergone FGM at the pregnancy booking visit and the response documented inFGM Section of the Booking within eCare. It is important to consider that some service users may not know if they have been exposed to FGM

- If identified a Confidential Communique should be completed and shared with the Health Visitor, a Milton Keynes Safeguarding Children's Board FGM Screening Tool and a RADAR completed.
- If necessary, an interpreter should be arranged and not use a member of the family
- Screening for Hepatitis C should be offered in addition to routine antenatal screening for HIV, Hep B and syphilis
- Service users identified as having FGM should be referred to a Consultant Obstetrician
- De-infibulation may be performed antenatally, in the first stage of labour or at any time of delivery and can usually be performed under local anaesthetic
- For service users with type 3 FGM, where adequate vaginal assessment in labour is unlikely to be possible, de-infibulation should be recommended antenatally, usually in the second trimester at around 20 weeks gestation.

3.4 Management at Birth

- De-infibulation during first stage of labour should be performed or supervised by an Obstetrician trained in de-infibulation
- De-infibulation at birth should be completed with scissors rather than a scalpel just before crowing of the head. Lidocaine (without adrenaline) should be used. Once performed the need for an episiotomy should be assessed; this is commonly required (irrespective of FGM type) due to scarring and reduced skin elasticity of the introitus
- If FGM is diagnosed during labour then the impact of FGM and birth should be sensitively discussed, and a plan of care agreed. If vaginal examination, intrapartum procedures or urinary catheterisation are not feasible then de-infibulation in the first stage of labour should be recommended. A confidential Communique should be completed and shared with the Health Visitor, a Milton Keynes Safeguarding Children's Board FGM Screening Tool and a RADAR.
- If service users do not have de-infibulation during pregnancy or birth because of caesarean section, then they should be given a follow-up gynaecology appointment so that de- infibulation can be offered before a subsequent pregnancy
- All discharge information sent to the GP and HV must include all relevant FGM information, where appropriate and when FGM or a family history of FGM has been identified, prior to, during or after the birth of the baby.

3.5 Management following birth

As part of the midwife's record keeping following the birth of a female infant a FGM-IS should be added to the infants NHS Summary Care Record (see SOP on adding indicator)
– consent is not required but a conversation with the family should take place in a sensitive and professional manner.
The FGM IS contains: an indicator that a female has a family history of FGM and the date that the FGM indicator was added on to the system
Document maternal history of FGM in the Personal Child Health Record ('Red Book') prior to discharge from hospital.
Objection to the FGM IS indicator.

Though you will not seek consent when deciding to add the FGM-IS indicator to a child's record, there will be circumstances where a parent or the child does not want this to happen and raises an objection. In most circumstances, you will need to discuss further with the patient and/or family, but all such instances are unique. It may be helpful to remember that the information is being shared as part of safeguarding procedures. If the family still wish for the indicator to be removed then please complete Appendix 6
Also, document conversation in Baby's record and ensure that included in the Postnatal Discharge Summary.

3.6 Children under 18 years of age (see Appendix 2)

- If any child under 18 years discloses that they have had FGM or if a professional observes that they has had FGM then it must be reported to the Police, using the non-emergency number (101) and to Children's Social Care with a MARF.
- In children under 18 years where FGM is suspected (but not confirmed) or the female is at risk (but has not had FGM) refer to Children's Social Care and/or the Police
- If the health care professional identifies that there are children in the household or family that are under the age of 18 years then to notify the GP, if under 5 years the Health Visitor and School Nurse if over 5 years of age.
- Following birth document maternal history of FGM in the Personal Child Health Record ('Red Book') prior to discharge from hospital.
- 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, preferably with experience of dealing with cases of FGM.
- The GMC has issued ethical guidance on child protection which outlines how to identify risk, considerations around confidentiality and procedures to follow. The guidance can be accessed at: https://www.gmc-uk.org/ethical-guidance (checked August 2022)

3.7 Documentation

- Record FGM, and any signs or symptoms in the clinical records, documenting type where known
- Discharge information sent to the GP should include FGM and type (where known) in addition to any other clinical findings as part of the provision of care
- Complete MKCSB FGM screening tool see Appendix 4
- Complete RADAR
- Following the birth of a female infant born to a mother who has experienced FGM add a FGM-IS indicator to the infants NHS Summary Care Record
- If FGM is identified in a female under the age of 18 years, or they is considered at risk of FGM complete Multi-Agency Referral Form (MARF)
- If a vulnerable adult is identified or considered to be at risk of FGM then complete a SABR1
- Following birth, document maternal history of FGM in the Personal Child Health Record ('Red Book') I the following section "Are there any other particular illnesses or condition s in the mothers of father family that you feel are important" to reflect that FGM has been identified in the mother.

3.8 Reporting

- It is mandatory to report cases of FGM in under service users under 18yrs to the Police and engage with the agreed local MKSCB safeguarding and reporting processes for FGM
- MKUH will maintain its own records of service users who have undergone FGM and ensure that with the service user's consent the information is shared with the relevant health care providers i.e. GP's.
- MKUH will provide non-identifiable data to the local CCG on a quarterly basis, including any actions taken to support local planning

3.9 On-line training

On-line training is available on all aspects of FGM and standard care provision principles though

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4.0 Statement of evidence/references

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5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
4	Aug 2022	Lucy Napthine	Review and updated

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Janice Styles	Consultant Midwife	August 2022	Aug 2022	No comments	N/A
Melissa Davis	Head of Midwifery	August 2022	Aug 2022	Wording	Yes
Carrie Tyas and Caroline Kintu	Named Midwife for Safeguarding	March 2019	March 2019	Included information regarding FGM-IS Revised working/formatting Revised actions for other young females in family	
Julie Cooper	Head of Midwifery	March 2019	March 2019	Wording and formatting	Yes
Katherine Bulbeck	Clinical Governance lead for medicine	March 2019	March 2019	Inclusion of pictorial diagrams to Classification of FGM	Yes
Jacqueline Mcainsh	Midwife	March 2019	March 2019	Formatting/Wording	Yes

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Number service users referred to Gynaecologist for FGM		Safeguarding Team	Annually	Safeguarding Committee
Number of referrals made to Social Services and/or Police		Safeguarding Team	Annually	Safeguarding Committee
Number of service users identified with FGM and departments reporting		Safeguarding Team		Safeguarding Committee

5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women's and Children's Health	Department	Maternity
Person completing the EqIA	Lucy Napthine	Contact No.	86402
Others involved:		Date of assessment:	17.08.22
Existing policy/service	Yes	New policy/service	No

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	Womens and children's staffing groups

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	YES	
Race	YES	
Religion or belief	YES	
Sex	YES	
Sexual orientation	NO	

What consultation method(s) have you carried out?
Via email to all O&G consultants and junior doctors, midwives, ED senior staff, pediatric consultants, urology team, gynae nurses. Discussed at guideline review group meeting.
How are the changes/amendments to the policies/services communicated?
Email and meetings
What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA	Aug 2025		

Appendix 1: Traditional and local terms for FGM

Country	Term used for FGM	Language	Meaning
Egypt	Thara	Arabic	Deriving from the Arabic word 'tahar' meaning to purify
	Khitan	Arabic	Circumcision used for both FGM and male circumcision
	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
Ethiopia	Megrez	Amharic	Circumcision/cutting
	Absum	Harrari	Name giving ritual
Eritrea	Mekhnishab	Tigregna	Circumcision/cutting
Kenya	Kutairi	Swahili	Circumcision used for both FGM and male circumcision
	Kutairi was ichana	Swahili	Circumcision of girls
Nigeria	Ibi/Ugwu	Igbo	The act of cutting - used for both FGM and male circumcision
	Sunna	Mandingo	Religious tradition/obligation for Muslims
Sierra Leone	Sunna	Soussou	Religious tradition/obligation for Muslims
	Bondo	Temenee/Mandingo/Limba	Integral part of an initiation rite into adulthood for non-Muslims
	Bondo/Sonde	Mendee	Integral part of an initiation rite into adulthood for non-Muslims
Somalia	Gudiniin	Somalia	Circumcision used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word 'halal' i.e. 'sanctioned' – implies purity. Used by Northern and Arabic speaking Somalis
	Qodiin	Somali	Stitching/tightening/sewing - refers to infibulation
Sudan	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
	Tahoor	Arabic	Deriving from the Arabic word 'tahar' meaning to purify
Chad – the Ngama	Bagne		Used by the Sara Madjingaye
Sara subgroup	Gadja		Adapted from 'ganza' used in the Central African Republic
Guinea-Bissau	Fanadu di Mindjer	Kriolu	'Circumcision of girls'
Gambia	Niaka	Mandinka	Literally to 'cut/weed clean'

	Kuyango	Mandinka	Meaning 'the affair' but also the name for the shed built for initiates
	Musolula Karoola	Mandinka	Meaning 'the women's side' / 'that which concerns women'

Appendix 2: Female Genital Mutilation: Children

Female Genital Mutilation: Children

You suspect that a child / person under 18 years old is at risk of, or a victim of Female Genital Mutilation (FGM)

If they are at immediate risk dial 999 and contact Police.

Contact	Police in Hours (01908 276140) or Non Urgent Police out of hours 101.
AND	Contact Social Services via MASH Tel: 01908 253169 In Hours
	Or Duty SW Team: 01908 265545 Out of Hours
AND	Complete a MARF. (Available Hospital Intra net)

Ensure the MARF has been received by MASH Tel 01908 253169
If identified by a midwife complete a Confidential Communique

Complete the FGM Toolkit found via the FGM Tab on the MKUH Workspacet

and email also send a copy to MKCCG.fgm@nhs.net and MKUH Safeguarding Administrators as **urgent** documentation

Either hard copy to Safeguarding Admin, Oak house, MKUH or email to safeguarding.referrals@mkuh.nhs.uk

Provide Family and if appropriate Young Person with information leaflets on FGM.

- .https://www.gov.uk/government/publications/female-genital-mutilation-leaflet (Checked May 2019)

Ensure a RADAR is also completed

Category is Safeguarding and Sub Category is FGM.

NB: Don't forget to record information in the patients' Medical Records (and PCHR Red Book for children)

Support can be gained from the: -

Lead Nurse Safeguarding Children (01908 995111)
Named Midwife Safeguarding (07917 815142)
Named Doctor Safeguarding Children (01908 996507)

Appendix 3: Female Genital Mutilation: Adult Female

You have a disclosure/ identification of Female Genital Mutilation in adult

If they are at immediate risk dial 999 and

Complete the FGM toolkit and send a copy to
http://mkscb.proceduresonline.com/chapters/p_fem_gen.html and MKUH Safeguarding Administrators as **urgent** documentation
Either hard copy to Safeguarding Admin, Education Centre, MKUH or email to

If there are female children/ young people in the home:

- Ensure GP and if under 5's HV are made aware
- A MARF is only required if any other safeguarding concerns are identified or on completing the tool kit there are immediate concerns

Sign post the service users to appropriate support services (available from MKSCB website) and advise the patient that their GP will be informed by letter **unless** they explicitly deny consent

If there are Safeguarding Adult concerns:

- Complete a Safeguarding Adult referral form (SABR1) Available on the Intranet

Provide patient and if appropriate the family with information leaflets on FGM.

- .https://www.gov.uk/government/publications/female-genital-mutilation-leaflet

Ensure a RADAR is completed

NB: Don't forget to record information in the patients' Medical Records and on discharge summary
If pregnant complete a Confidential Communique and if a female infant is born to a mother add the FGM-IS Indicator

Support can be gained from the: -
Lead Nurse Safeguarding Adults (01908 995091)
Named Midwife Safeguarding (07917 815142)
Lead Nurse Safeguarding Children (01908 995111)
Named Doctor Safeguarding Children (01908 996507)

Appendix 4: Milton Keynes Safeguarding Board FGM Screening Tool

FGM Screening Tool.docx

Appendix 5 Consequences of FGM

Many people in practicing communities can be unaware of the relationship between FGM and its harmful health and welfare consequences as set out below, in particular the longer- term complication affecting sexual intercourse and childbirth.

1 Short term implications for a child's health and welfare. The short-term consequences following a child undergoing FGM can include:

- Severe pain
- Emotional and psychological shock (exacerbated by having to reconcile being subjected to the trauma by loving parents, extended family and friends)
- Haemorrhage
- Wound infections, including tetanus and blood borne viruses (including HIV and Hepatitis B and C)
- Urinary retention
- Injury to adjacent tissues
- Fracture or dislocation as a result of restraint
- Damage to other organs
- Death

2 Long term implications for a service user's health and welfare. The longer-term implications for service users who have had FGM. Types 1 and 2 are likely to be related to the trauma of the actual procedure, while health problems caused by FGM Type 3 are more severe and long lasting.
However, all types of FGM are extremely harmful and cause severe damage to health and wellbeing. World Health Organisation research has shown that service users who have undergone FGM of all types, but particularly Type 3, are more likely to have complications during childbirth. The long-term health implications of FGM include:

- Difficulties with menstruation
- Difficulties in passing urine and chronic urine infections
- Renal impairment and possible renal failure
- Damage to the reproductive system, including infertility, infibulation cysts, neuromas and keloid scar formation
- Obstetric fistula
- Complications in pregnancy and delay in the second stage of childbirth
- Pain during sex and lack of pleasurable sensation
- 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
- Death of mother and child during childbirth

Appendix 6: Family Opposing to a FGM Indicator

Family Opposing to an FGM Indicator

Email to: MKCCG.fgm@nhs.net
And
safeguarding.referrals@mkuh.nhs.uk

Please affix a baby sticker here

We are writing to notify you of a family who are objecting to the FGM-IS Indicator being applied to their daughters SCRa Record

Name of Maternal Mother	
NHS Number	
Address	
Contact Number	
GP Surgery	

Please provided information regarding the conversation that took place with the family opposing the FGM-IS Indicator:

Name of Midwife completing	
Contact details(email/number):	
Date:	

Appendix 7 FGM-IS SCRa Quick Reference Guide

Female Genital Mutilation - Information Sharing - NHS Digital