University Hospitals of Derby and Burton NHS Foundation Trust

TRUST POLICY AND PROCEDURES FOR FEMALE GENITAL MUTILATION (FGM)

Reference Number POL-CL/2016/069	**Version:** V5		**Status** Final	**Author:** Jane O'Daly-Miller **Job Title:** Head of Safeguarding & Vulnerable People Team
Version / Amendment History	**Version**	**Date**	**Author**	**Reason**
	V1	Jan 2016	Jane O'Daly-Miller Trust Safeguarding Lead	Serious Crime Act 2015
	V2	Mar 2019	Pamela Herod Trust Named Midwife Safeguarding	Introduction of FGM-IS (NHS England)
	V3	June 2020	Pamela Herod Trust Named Midwife Safeguarding	Harmonisation of FGM Policies cross-site.
	V4	Nov 2022	Pamela Herod Trust Named Midwife Safeguarding	Amended due to the introduction of Integrated Care Boards (ICB)
	V5	Aug 2023	Pamela Herod Trust Named Midwife Safeguarding	1.Review following Health and Care Act 2022 and change of practice in relation to assessment and referral to Children's social care .
Intended Recipients: All clinical patient facing staff				
Training and Dissemination: Dissemination via the Intranet-training via safeguarding level 3				
To be read in conjunction with: Trust Policy for Safeguarding Children				
In consultation with and Date: Safeguarding Committee				
EIRA stage One Completed Stage Two Completed	Yes No			
Approving Body and Date	Trust Delivery Group - December 2023			

Date of Issue	December 2023
Review Date and Frequency	August 2026 and then three yearly
Contact for Review	Trust Safeguarding Lead
Executive Lead Signature	 Garry Marsh, Executive Chief Nurse

Contents

1. Introduction

FGM is a form of child abuse and violence against girls and women, a serious public health hazard and a human rights issue. The practice of FGM dates back over 2000 years and is performed for a variety of complex reasons. FGM is carried out for various cultural, religious and social reasons within families and communities in the mistaken belief that it will benefit the girl in some way (for example, as a preparation for marriage or to preserve her virginity).FGM usually happens to girls whose mothers, grandmothers or extended female family members have had FGM themselves, or if their father comes from a community where it's carried out.

It is medically unnecessary, extremely painful, the experience terrifying and it has potentially life-threatening consequences (including extreme pain, shock, infection, haemorrhage, infertility, incontinence, HIV, urinary tract infections, menstrual obstruction, and death).and serious psychological health consequences at the time the procedure is carried out, and afterwards, continuing into later life.

There are no health benefits to FGM. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of women's bodies for the rest of their lives.

Prevalence of FGM in the UK is difficult to estimate because of its hidden nature. A recent study suggested that over 22,000 girls under the age of 15 could be at high risk of FGM in England and Wales each year and nearly 66,000 women in England and Wales are living with the consequences of FGM.

FGM is likely to be significantly more prevalent than figures suggest with uneven distribution of cases, with more occurring in those areas of the UK with larger communities from the practising countries. It is believed FGM happens to British girls in the UK as well as overseas, often but not always in the family's country of origin. Children are often unaware that FGM is going to take place. Girls are sometimes taken abroad for FGM, but they may not be aware this is the reason for their travel.

Girls are more at risk of FGM being carried out during the summer holidays, as this allows more time for them to "heal" before they return to school. Unfortunately this means there may be few warning signs before it happens. But sometimes they can suspect, fear or be aware of it which can lead to a change of behaviour such as seeking advice or help.

Communities that perform FGM are found in many parts of Africa, the Middle East and Asia. Girls who were born in the UK or are resident here but whose families originate from an FGM-practising community are at greater risk of FGM happening to them.

Communities at particular risk of FGM in the UK originate from:

- Egypt
- Eritrea
- Ethiopia
- Gambia
- Guinea
- Indonesia
- Ivory Coast
- Kenya
- Liberia
- Malaysia
- Mali

- Nigeria
- Sierra Leone
- Somalia
- Sudan
- Yemen

Practitioners in all areas must be aware of and actively prevent and tackle FGM.

- It is illegal in the UK to subject a girl or woman to female genital mutilation (FGM) or to take a child abroad to undergo FGM. Re-infibulation is also illegal.
- With effect from April 2014, all acute trusts are required to record all incidence of FGM and from September 2014 all acute trusts are required to report figures of identified cases to the Department of Health (DH)
- In October 2015, the Serious Crime Act 2015 introduced a duty requiring regulated health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18-year-olds to the police.

From 1st April 2019, NHS England Female Genital Mutilation Information Sharing System (FGM-IS) was initiated across University Hospitals Derby and Burton (UHDB). FGM-IS shares information about immediate family history with healthcare professionals who come into contact with a girl as she grows up, reducing the chance that health services may overlook a family history of FGM when providing treatment.

Additionally, following the Health and Care Act 2022 it is illegal to carry out, offer or support virginity testing or hymenoplasty in any part of the UK. It is also illegal for UK nationals and residents to support this outside of the UK.
Virginity testing and hymenoplasty are illegal and therefore women and girls are not able to consent to the procedures. Women and girls may request the procedures, but due to the harm they cause and them being precursors to other forms of so called 'honour-based' abuse, the procedures have been banned. As such, there are no circumstances under which a woman or girl should be subjected to a virginity test or hymenoplasty.
Virginity testing and hymenoplasty are forms of violence against women and girls and are part of the cycle of so called 'honour-based' violence.

2. Purpose and Outcomes

This policy is designed for all frontline practitioners and clinicians and applies to all women or girls with known or suspected FGM, presenting within UHDB. It provides information to support identification of FGM, the legal position with regard to FGM, virginity testing, hymenoplasty and reinfibulation and it explains the process to be followed with regard to reporting crime and supporting the woman or child, as well as enabling practitioners to ensure effective reporting of data compliant with Department of Health requirements.

3. Definitions Used

FGM: The World Health Organisation (WHO) defines female genital mutilation 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" (1996). FGM is classified into four main types:

Type 1: Clitoridectomy partial or total removal of the clitoris or clitoral hood
Type 2: Excision partial or total removal of the clitoris and the labia minor
Type 3: Infibulation (also called Pharaonic Circumcision)narrowing of the vaginal opening by creating a covering seal, formed by cutting and sewing over the outer labia
Type 4: Unclassified: all other harmful procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping, stretching or cauterising the genital area

De-infibulation; the name for opening the entry to the vagina following FGM.
Reinfibulation: Reinfibulation is defined as postpartum reclosing of (most of) the vaginal introitus in women with FGM who have been deinfibulated to allow for a vaginal birth and is illegal in the UK under the Female Genital Mutilation Act 2003
Virginity testing; the examination of female genitalia, with or without consent, for the purpose (or purported purpose) of determining virginity.(Illegal
Hymenoplasty: the reconstruction of the hymen (with or without consent)
Safeguarding: The action we take to promote the welfare of children / vulnerable adults to ensure we protect them from harm and is further defined for the purposes of this guidance as:

- protecting from maltreatment;
- preventing impairment of health or development;
- ensuring that vulnerable children and adults are living in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all to have the best outcomes.

Child Protection Concerns: Suspicion that a child is at risk of, or has experienced, significant harm, neglect or abuse.
Adult Protection Concerns: Suspicion that an adult is at risk of, or has experienced, significant harm, neglect or abuse.
Children and Young People: Defined in the Children Acts (1989 and 2004), a child or young person is anyone who has not yet reached their 18th Birthday, or 21yrs if in Local Authority Care (LAC), or 25 if is disabled. Issues of neglect as defined in Working Together 2013 can apply to the unborn baby.
Children's Social Care (CSC): The relevant CSC is the one covering the area in which they are normally resident
Adult Social Care (ASC): The relevant ASC is the one covering the area in which they are normally resident

4. Key Responsibilities/Duties

4.1 <u>Safeguarding Children Partnerships (SCP) / Safeguarding Adult Partnerships or Boards (SAB/Ps)</u>

SCPs and SAB/Ps are required to lead, monitor and coordinate safeguarding arrangements across their locality; oversee and coordinate the effectiveness of the safeguarding work of its members and partner agencies. The Trust is required, as a partner agency, to attend the Partnership meetings and their sub-groups, participate in the work of the partnership to achieve their aims and submit the findings of the Safeguarding Adult Assurance Framework

(SAAF), s11 (Children Act 2004) audits to the relevant forum at the SAB / SCP in Staffordshire / Stoke-on-Trent / Derby and Derbyshire

4.2 Integrated Care Boards (ICB); Derby & Derbyshire / Stoke & Staffordshire

The ICB monitor Trust safeguarding performance in regular meetings with the Trust. The Designated Safeguarding Professionals situated within the ICB receive regular reporting on performance, and provide supervision to the Named Nurses, Named Midwives & Named Doctors

4.3 Director of Patient Experience & Executive Chief Nurse

The Executive Lead accountable to the Trust Board for ensuring compliance with this policy in all parts of the Trust. The Executive Lead, or their nominated deputy, is also a member of the Partnership Boards.

4.4 Head of Safeguarding & Vulnerable People

The post-holder is responsible for alerting the Trust Safeguarding Committee and Lead Executive to any concerns or shortfalls in safeguarding practice within the Trust, advising with regard to the impact of relevant policy, enquiries or legislation; development or review of safeguarding training, and Trust policy and procedures for safeguarding. The post-holder is also responsible for overall management of the Safeguarding and Vulnerable People Team

4.5 Trust Safeguarding & Vulnerable People Team

The Trust Safeguarding Team is responsible for providing advice to Trust staff, for facilitating liaison with the appropriate Local Authority Social Care Department, provision of training and for maintaining records of the number and nature of alerts raised and the quality of advice in such cases. The Named Midwife for Safeguarding will be responsible for reporting details of cases of FGM to the Trust DH Dataset manager

4.6 Trust Safeguarding & Vulnerable People Committee

Identify issues for escalation through the Trust governance structure and for assisting with compilation of evidence necessary to ensure compliance for registration with the Care Quality Commission.

4.7 Business Units, Ward Sisters/Charge Nurses, Nursing and medical staff, On-call Managers

Will ensure that they are aware of the relevant policies and processes,
escalate and communicate concerns to the Trust Safeguarding Team and appropriate adult / children social care services.
They must enter any safeguarding incident where it is alleged that it has been caused by hospital employees / processes into the Datix Incident reporting system.
They have a responsibility to respond sensitively to a disclosure of abuse and act in a professional manner and take appropriate action.
They will ensure that concerns about individual cases are escalated where appropriate to the safeguarding team.

4.8 All Trust Staff including volunteers

All staff / volunteers must raise concerns about the safety of any adult / child at risk of abuse and neglect with whom they are directly or indirectly involved with and to work within the

safeguarding policy. Additionally all staff are expected to use the Trust Freedom to Speak Up policy where necessary. All health professionals are required to report to the police any case where a child under the age of 18years has undergone FGM and additionally report any case of FGM to the Named Midwife for Safeguarding who will enter details onto the Trust dataset for reporting to the DH.

5. Policy Implementation

5.1 Any professional identifying that FGM has taken place should notify the safeguarding team via uhdb.safeguarding@nhs.net with details of the case using the form at Appendix 3. The professional should follow the flowchart at appendix 1 with regard to any children in the family and for support of the woman herself.

If the woman is pregnant the flowchart at Appendix 2 should be followed and relevant maternity guidelines consulted.

Where FGM has been carried out on a child under the age of 18 years the individual clinician who has identified that, is responsible for reporting and sharing information with the police, making a referral to children's social care and informing the Trust Safeguarding Team.

5.2 No Trust professional should undertake or participate in the process of virginity testing , hymenoplasty or reinfibulation and any professional identifying that these processes have taken place must report this to the police via 101, (or 999 if imminently to be performed), refer to children's social care / adult social care as indicated and notify the safeguarding team via uhdb.safeguarding@nhs.net.

5.3 **Antenatal care** - Role of midwife

When a woman has presented for antenatal care and is identified as having undergone FGM

5.2.1. Discuss with woman and family in relation to illegalities of FGM and provide an information leaflet (own language where possible)

5.2.2. Refer for consultant led care in pregnancy.

5.2.3. Take full history of family composition and identify other female children within the family and complete FGM Risk Assessment matrix / risk assessment questions noted in Appendices 5 & 6.

a) If deemed **low risk** of undertaking FGM on expected child / current child(ren), referral to Children's social care not required. Rationale for not referring to social care should be documented by midwife on Lorenzo safeguarding page.

b) If deemed **high risk** of undertaking FGM on expected child/current child(ren) referral to children's social care MUST be undertaken.

c) In all cases, all responses to risk assessment questions MUST be noted on Lorenzo safeguarding information page.

5.2.4. If referral to children's social care required, this should be discussed with the woman and her family.

5.2.5. Midwife to ensure that country of origin and birth, for both parents is obtained and documented.

5.2.6. Midwife to create safeguarding alert regarding FGM on respective electronic patient information system. (Meditech / Lorenzo)

5.2.7. If English is not the woman's first language an independent interpreter must be used. The interpreter should be made aware before the appointment that the conversation will include questions around FGM. Ideally, interpreters views around FGM should be sought prior to consultation, as this may impact on subsequent discussion with the woman.

5.2.8 If under 18 referral to police is required under mandatory reporting procedures on 101.

5.3 Review by consultant.

5.3.1. FGM discussed and physical examination undertaken with consent.

5.3.2. Examination is recommended to ascertain type of FGM, which will assist in planning of antenatal, intrapartum and postnatal care.

5.3.3. Plan of care made in collaboration with the woman and documented in respective patient information system (Meditech/Lorenzo)

5.3.4. Complete FGM Obstetric Management plan (appendix 4) and file in records.

5.4 **Postnatal**

If the infant is female,

the Midwife at delivery must document that genitalia appear to be normal, and create an alert on the baby's records in relation to the risk of FGM.

- Midwife to inform Named Midwives for Safeguarding of gender of baby, as required to update FGM-IS and DH systems.
- Midwife to inform Children's Social Care of gender of baby via online referral, if referral to social care completed antenatally. Decision to hold strategy meeting will then be made by children's social care (if not undertaken antenatally)
- If deemed at low risk of undertaking FGM antenatally, but concerns raised or views shared by parents that they intend to subject child to FGM, online referral to children's social care nust be completed.
- The midwife must also inform the safeguarding team by email uhdb.safeguarding@nhs.net

If the Infant is male

- Midwife at delivery to inform Named Midwives for Safeguarding, of gender of baby,
- Midwife to inform children's social care of gender of baby via online referral (if children's referral completed antenatally)

6. Monitoring Compliance and Effectiveness

Monitoring Requirement :	Dataset reporting to DH quarterly Reporting to TS&VP committee quarterly Multi-agency audit via Safeguarding Children Partnerships as and when required Annual In-house case file audit

Monitoring Method:	Quarterly figures sent to DH secure site Case file audit with sample identified from referrals
Reports Prepared by:	Trust Named Midwife for Safeguarding
Report presented to:	Trust Safeguarding Committee
Frequency of Report	Yearly

7. Reference

Serious Crime Act 2015. (Part 5) Protection of Children and others.

Derby & Derbyshire Safeguarding Children Partnership. Safeguarding Children at Risk of abuse through Female Genital Mutilation (2020)

Staffordshire Safeguarding Children's Board procedures (2017)

RCOG Green top guideline, No 53. (2015) Female genital mutilation and its management,

British Medical Association (2011) Female Genital Mutilation – caring for patients and child protection BMA

Department of Health (2016) Female Genital Mutilation. Risk and Safeguarding Guidance for Professionals.

HM Government. Mult-agency Statutory guidance on Female Genital Mutilation. (2020)

HM Government. Multi-agency guidance on Virginity testing and hymenoplasty. (2023)

NHS England. Female Genital Mutilation Information Sharing System – FGM-IS (2018)

National FGM Centre – info@nationalfgmcentre.org.uk
www.nationalfgmcentre.org.uk

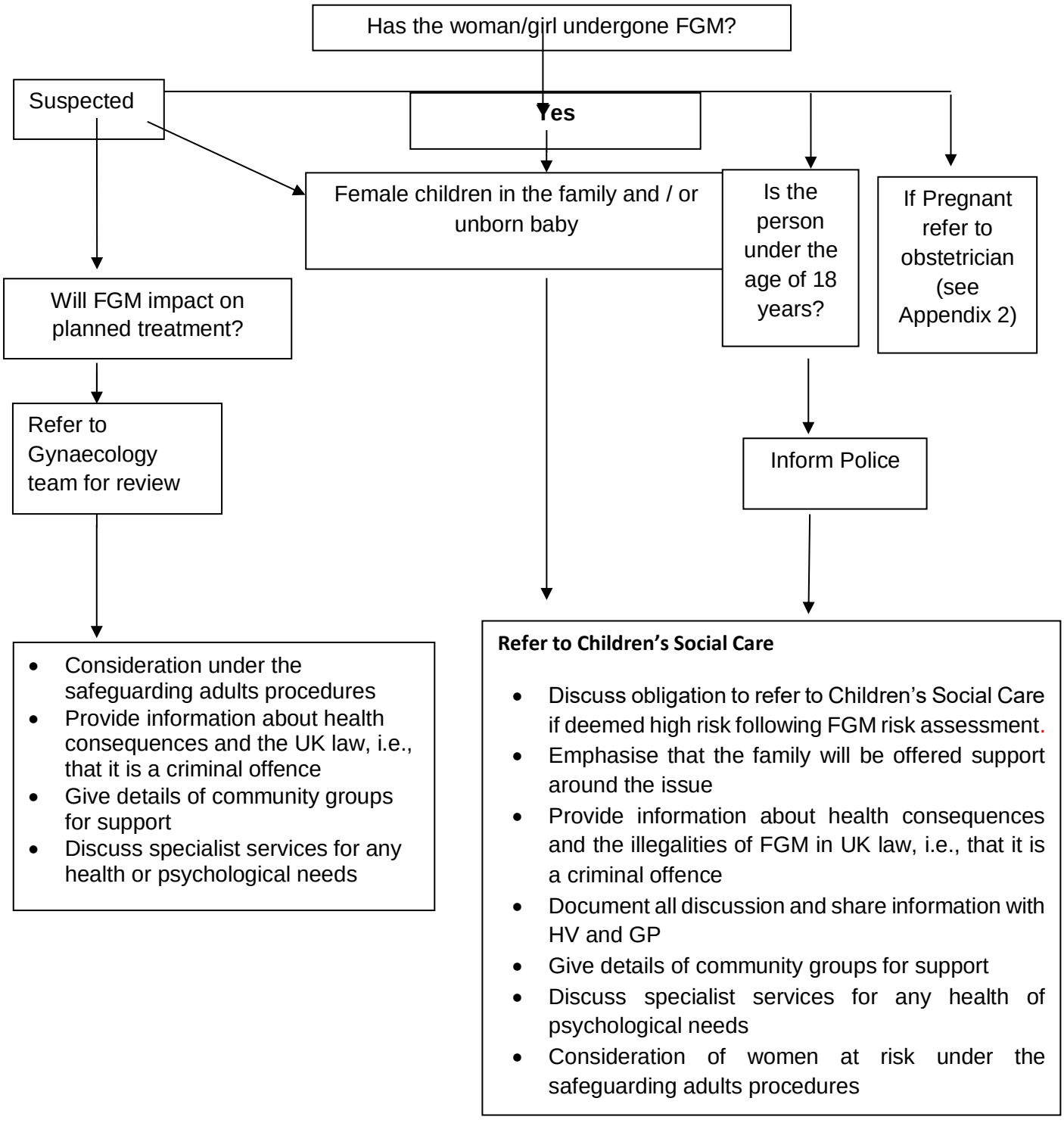
NSPCC FGM Helpline – **0800 028 3550**

Statements against FGM –
www.gov.uk/government/publications/statement-opposing-female-genital-mutilation .
(available in: English, Welsh, Turkish, Urdu, Farsi, French, Somali, Swahili, Arabic, Amharic and Tigrinya)

Health and Care Act 2022

Appendix 1

WORKING WITH WOMEN WHO HAVE BEEN SUBJECT TO FGM

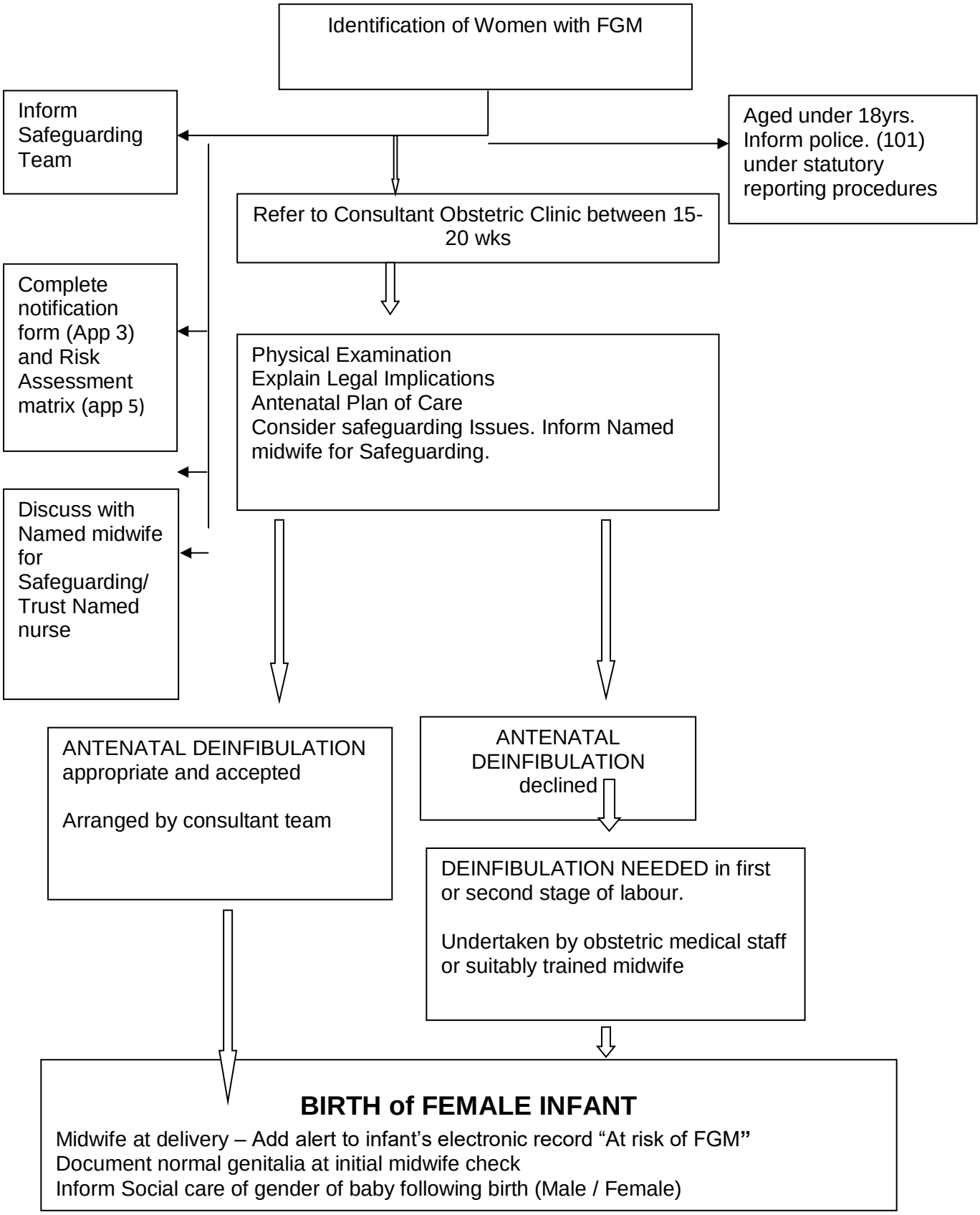


Anyone worried about a child being, or has been a victim of FGM, can contact the helpline on 0800 028 3550 or

Email: fgmhelp@nspcc.org.uk / info@nationalfgmcentre.org.uk

Appendix 2

OBSTETRIC ANTENATAL MANAGEMENT OF WOMEN IDENTIFIED WITH FEMALE GENITAL MUTILATION (Obstetrics)



Appendix 3

Information Sharing Form for women with known FGM

To be forwarded to the Trust Safeguarding Team via email. uhdb.safeguarding@nhs.net

Woman's name	Hospital Number	NHS Number	Type of FGM i- ii- iii- iv	Age when FGM performed	Country of origin

Does this woman have any female children? Yes / No

Name						
Date of Birth						
Country of Birth						
Circumcised? Y / N						
If yes, age & location when circumcision was completed						

Any further referrals required at present time regarding information sharing / safeguarding concerns? Yes / No (if yes, please state below)

Name of person reporting: _____

Designation: _____

Department: _____

Contact number: _____

Date: _____

	Yes	No	N/A
UHDB Safeguarding team informed via email	☐	☐	☐
Social care referral made	☐	☐	☐
Police informed (under 18 years of age	☐	☐	☐

Appendix 4

FGM Assessment and Management Plan (Obstetrics)

Patient Label or

NAME:

……

Contact Number ……..

Country / Region of Origin ……
Languages Spoken ……..
Interpreter required & in what language ……..
Symptoms (please circle as appropriate)

Urinary: Recurrent urinary tract infections …….. Yes / No

Menstrual: Dysmenorrhoea ……..Yes / No
Menorrhagia ……..Yes / No

Sexual: Dyspareunia ……..Yes / No
Psychological: Flashbacks/Depression/ Other ……Yes / No
Other: Keloid scarring/recurrent abscess/cysts /chronic genital pain

Examination Findings on Initial Assessment:

Type 1: Prepuce removal only or partial or total removal of the clitoris.

Type 2: Removal of the clitoris plus part or all of the labia minora
Comments:

Type 3: Removal of part or all of the labia minora with the labia majora sewn together covering the urethra and vagina leaving only a small opening for urine and menstrual fluid

Deinfibulated: Yes No
If yes, when and where?
Comments:

Type 4: Pricking, piercing or incising the clitoris and/or labia, stretching the clitoris and/or labia, cauterising the clitoris or surrounding tissues or any other procedure not classified as above.

Comments:

MANAGEMENT (Circle as appropriate)

Counselled patient about type of FGM found Yes / No

For women with type 3 (who have not had deinfibulation previously)

Counselled patient about advantages and implications of deinfibulation Yes/ No
Informed about inability to re-infibulate following deinfibulation Yes/No
Deinfibulation: Not wished / Gynae / Antenatal / 1st Stage Labour
Date for Deinfibulation if Gynae / Antenatal ……. Anaesthetic
Preference: Local / GA Where: ……..

Comments:

Discussion with male partner, if present, regarding the above: Yes / No
Pregnancy & Labour Recommendations:
Suitable for Midwifery-led Care / Delivery on Delivery Suite Yes / No
Reason for decision: Type 1 / Type 3 and previous NVD after deinfibulation.
Seen and agreed by: …… Designation:
……

Manage labour as normal Yes / No

Counselled patient regarding childbirth and episiotomy if required Yes / No
Medio-lateral episiotomy suggested Yes / No
Deinfibulation in labour Yes / No

Inform SpR when in labour Yes / No

Appendix 5

Date: _____ Completed by: _____

Assessment: Initial/On-going

Part One (a): PREGNANT WOMEN (OR HAS RECENTLY GIVEN BIRTH)

Indicator	Yes	No	Details
CONSIDER RISK			
Woman comes from a community known to practice FGM			
Woman has undergone FGM herself			
Husband/partner comes from a community known to practice FGM			
A female family elder is involved/will be involved in care of children/unborn child or is influential in the family			
Woman/family has limited integration in UK community			
Woman and/or husband/partner have limited/no understanding of harm of FGM or UK law			
Woman's nieces, siblings and/or in-laws have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment			
Woman's husband/partner/other family member are very dominant in the family and have not been present during consultations with the woman			
Woman is reluctant to undergo genital examination			

SIGNIFICANT OR IMMEDIATE RISK			
Woman already has daughters who have undergone FGM			
Woman or woman's partner/family requesting reinfibulation following childbirth			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have FGM			
Woman says that FGM is integral to cultural or religious identity			
Family are already known to social care services – if known, and you have identified FGM within a family, you must share this information with social services			

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

This is to help you make a decision as to whether the unborn child (or other female children in the family) is at risk of FGM or whether the woman herself is at risk of further harm in relation to her FGM

Appendix 6

FGM (responses required for referral to Children's Social care.)

1. If the parent has had FGM, what type is this?
2. Are there any language or communication barriers?
3. Which country of origin is the woman and other family members from?
4. Are they from communities known to practice FGM?
5. What – if any – discussions have taken place about the views of the family regarding FGM?
6. Have discussions been held about the health complications of FGM and the UK law?
7. Details of immigration history
8. Details about the mother and fathers views/understanding of FGM and UK Law? Are they the same father?
9. Has the woman undergone FGM herself? What was this identified? What discussions took place about this?
10. Clarify any other children, their gender and age.
11. Are there any extended family members who may be involved in the care of the child? Female family elders are important to identify. Explore what role they currently play.
12. Establish the degree of integration the family has within the community in the UK? Do the family access universal services?
13. Is there any indication of other family members having undergone FGM or been at risk of this previously?
14. Has the woman failed to attend any intimate appointments or FGM clinic appointments? Has the woman been reluctant to undergo genital examination?
15. Have the relationship dynamics between people within the family been observed? What does this look like? Any concerns around dominance of the male?
16. Has the woman or other relative requested re-infibulation following childbirth?
17. Have there been any concerns about the capacity or cognition of either parent?
18. Have the local authority followed up on FGM concerns previously? If so, what was the outcome and rationale?
19. Has the referrer informed the GP?
20. What are the families strengths/protective factor