Dundee and Angus

MULTI-AGENCY PROTOCOL

FOR

FEMALE GENITAL MUTILATION

Dundee and Angus Multi-Agency Protocol for Female Genital Mutilation

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Is the person an adult or child?

Adult

Offer reassurance and support. Ensure that it is safe to speak to the person.

Gather information from the person. There may be only one chance to do so.

Assess immediate risk to the person's safety using the Risk assessment tool as guide

Is the person in immediate danger?

Yes

Take immediate protective action. Involve Police and/ or Social Work who will need to consider IRD.

Complete Risk Assessment using Risk Assessment Tool and provide a copy to Police and Social Work.

Arrange a Professionals Meeting. Follow Adult Protection Procedures and consider referral for Case Conference.

No

Discuss a safety plan with the person and complete referrals to local support agencies. See Contacts page.

Follow current Adult Support and Protection Procedures.

Complete risk assessment tool.

Multi Agency IRD/Case Conference, if required (Emergency MARAC)

Child

Offer reassurance and support. Ensure it is safe to speak to the child and if not establish how that can be achieved.

Gather information from the individual. There may be only one chance to do so.

Assess if there is immediate risk to the child's safety (use risk assessment tool as guide)

Is the child in immediate danger?

Yes

Take immediate protective action. Involve police and Social Work (Child Protection Team or Out of Hours Team who will need to consider IRD)

No

Follow Local Child Protection Procedures. Contact Child Protection Team/ Out of Hours Team.

Complete Risk Assessment and along with any other relevant documents pass to Child Protection/Out of Hours Team.

Child Protection Team and/or Out of Hours Team further will further assess and liaise with people and other agencies as needed. Follow all relevant Operational Instructions for Child Protection and specifically for FGM.

If FGM,Forced Marriage and/or Honour Based Violence is suspected DO NOT MAKE ATTEMPTS TO CONTACT THE FAMILY, COMMUNITY MEMBERS – THIS INCREASES RISK AS THEY MAY BE COLLUDING WITH THE ABUSE.

DUNDEE AND ANGUS MULTI-AGENCY PROTOCOL ON FEMALE GENITAL MUTILATION

CONTEXT

Three protocols, on Female Genital Mutilation, Honour Based Violence and Forced Marriage, have been developed by the Tayside Harmful Practices Multi-agency working group. Each protocol contains a section on Operational Instructions followed by broader Guidance for staff.

OPERATIONAL INSTRUCTIONS

PURPOSE

The implementation of this Protocol is intended to assist professionals, police, social care teams, voluntary sector partners, health and education (hereinafter referred to as practitioners) to effectively, consistently and safely deal with cases of Female Genital Mutilation (FGM) towards any person by:

- The early identification of such cases
- Reducing the risk once these cases are identified
- Initiating proportionate and effective joint short and longer term plans, in order to support the victim and deal effectively with perpetrators of crime
- Maintaining and enhancing public confidence in the partner agencies, to respond safely and proportionately to allegations of FGM.
- Facilitating the effective use of powers, national guidance and best practice, in order to protect those living in Dundee and Angus from harm

The purposes of this protocol are to:

- Provide a partnership approach to the identification and provision of services to individuals who have been affected or are in danger of being affected by Female Genital Mutilation.
- Outline the processes involved in identifying and supporting victims, and how the agencies involved at each stage can best co-ordinate their actions
- Provide a framework for sharing of information
- Balance the rights of the victim with the wider public interest in cases where criminal proceedings are being considered

SCOPE

This protocol refers to the geographical area covered by Angus and Dundee Councils. This geographical area is also the concern of Police Scotland, D Division and NHS Tayside.

This protocol applies to all victims or potential victims of FGM. Any victims of FGM aged less than 16 years of age must be dealt with under multi-agency child protection procedures. Where the age of a victim is uncertain and there are reasons to believe they may be a child, it must be presumed they are a child and be dealt with under child protection arrangements pending verification of their age.

FGM is a violation of human rights. It is a form of violence against women and girls, and child abuse. Where a child is thought to be at risk of significant harm, the primary concern will be for their safety and the planning process must reflect this.

RELEVANT LEGISLATION

The Prohibition of Female Genital Mutilation (Scotland) Act 2005
Domestic Abuse (Scotland) Act 2011
Family Law (Scotland) Act 2006
Forced Marriage (Protection and Jurisdiction) (Scotland) Act 2011
Adult Support and Protection (Scotland) Act 2003
Mental Health (Care and Treatment) (Scotland) Act 2003
Adults with Incapacity (Scotland) Act 2000
The Sexual Offences (Scotland) Act 2009
The Children (Scotland) Act 1995
Protection of Children (Scotland) Act 2003
Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005
Adult Support and Protection (Scotland) Act 2007
Equality Act (2010)
Human Rights Act 1998

UN Convention on the Rights of the Child (UN CRC)
UN Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)

POLICIES

'Tackling FGM in the UK, Intercollegiate recommendations for identifying, recording and reporting' (November 2013)
Equally Safe: Scotland's Strategy for preventing and eradicating violence against women and girls (June 2014)

FEMALE GENITAL MULTILATION (FGM)

Female genital mutilation (FGM) comprises all procedures involving the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons.

The World Health Organisation (WHO) classifies FGM into four major types.

> **Type 1** - 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 2** - Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
>
> **Type 3** - 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 4** - All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Female Genital Mutilation is known by different names including 'cutting', 'female circumcision', and 'initiation'. It is also sometimes referred to as 'sunna'.
FGM predates Christianity and Islam and is **not** approved by any religion.

The motivations for FGM vary between different ethnic groups as does the age at which the practice is carried out - from just after birth, just before marriage or before the birth of a woman's first child. The most common age is between four and ten years, although it appears to be falling[i]. FGM is an extremely high impact crime with girls dying as a direct result of the procedure, from blood loss or infection.

Reasons given for carrying out FGM

In most societies, FGM is considered a cultural tradition and this is often used as an argument for its continuation. The main reason now given for carrying out FGM is social acceptance or, conversely, fear of exclusion. Amongst ethnic groups and communities where FGM has become the social norm, parents are likely to regard having their daughters cut as part of their duty as parents. Whatever the origins of practice, or the stated reasons for continuing it, FGM serves to control women's bodies and sexuality.

- Where FGM is a social convention, the social pressure to conform to what others do and have been doing is a strong motivation to perpetuate the practice
- FGM is often considered a necessary part of raising a girl properly, and a way to prepare her for adulthood and marriage
- FGM is often motivated by beliefs about what is considered proper sexual behaviour. FGM is in many communities believed to reduce a woman's libido.
- FGM is associated with cultural ideals of femininity and modesty, which includes the notion that girls are 'clean' and 'beautiful' after removal of body parts that are considered 'male' or 'unclean'
- FGM is not approved by any religion but practitioners often believe the practice has religious support.
- Religious leaders take varying positions with regard to the practice, some promote it, some consider it irrelevant to religion, and others contribute to its elimination.
- Local structures of power and authority, such as community leaders, religious leaders and even some medical personnel can contribute to upholding the practice.

Communities at risk

The majority of cases of FGM are carried out in 29 countries in Africa and the Middle East. FGM is a deeply rooted tradition, widely practised mainly among specific ethnic populations in Africa and in other parts of the world including Bahrain, Iran, Iraq, Jordan, Kuwait, Oman, Palestinian territories, Qatar, Saudi-Arabia, Syria, Turkey, United Arab Emirates, Yemen, Afghanistan, Maldives, Pakistan, India, Malaysia, Indonesia, Philippines, Tajikistan, which serves as a complex form of social control of women's sexual and reproductive rights. Practitioners should be aware that this list is not exhaustive, and that not every community or family within these countries practice FGM.

It is known that the number of potentially affected communities is growing and with increased migration from the countries where FGM is practised, more girls in the UK are at risk of FGM. It is more accurate to view FGM as being practised by specific ethnic groups, rather than a whole country.

No reliable estimate of the prevalence of FGM in Scotland is available. Tackling Female Genital Mutilation in Scotland – A Scottish Model of intervention scoping study identified potentially affected communities living in every local authority area in Scotland, with the largest in Glasgow, Aberdeen, Edinburgh and Dundee respectively.

All information is taken from the Scottish FGM Aware website.

FGM has been unlawful in Scotland since 1985 by virtue of the Prohibition of Female Circumcision Act 1985. The Prohibition of Female Genital Mutilation (Scotland) Act 2005 Act re-enacts the existing offences in the 1985 Act, and extends protection by giving those offences extra-territorial effect in order to protect those being sent abroad to have FGM carried out. The Act also increases the penalty on conviction from indictment to 5-14 years imprisonment.

Under the terms of the Act it is criminal to:

- Excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person;
- Aid, abet, counsel or procure a girl to mutilate her own genitalia; or,
- Aid, abet, counsel of procure another person who is not a UK national to mutilate a girl's genitalia outside the UK.

Violation of Human Rights - FGM in all its types violates a number of human rights principles, including the principle of equality and non-discrimination on the basis of sex. It is important to note that the right to participate in cultural life and freedom of religion are protected by international law. However, international law also stipulates that freedom to manifest one's religion or beliefs must be subject to limitations necessary to protect the fundamental rights and freedoms of others. Therefore social and cultural claims cannot be evoked to justify FGM.

The UN CRC states that children have a right to:

- Protection from all forms of violence, including abuse committed by parents (article 19);
- The right to health (article 24); and,
- Non-discrimination: no child should be treated unfairly, including being able to access protective measures.

Article 24 of the CRC calls for the prohibition of all traditional practices that are prejudicial to the health and wellbeing of children.

CEDAW General Recommendation 14 states that women have the right to:

- Protection from all forms of violence, including FGM; and,
- The right to re-dress for the harm caused by FGM.

The UN has recognised FGM as torture and calls for its elimination as a form of cruel, inhumane and degrading treatment of girls and women.

BASIC DOS AND DON'TS

You should not feel worried about appearing culturally insensitive. Remember, you may be the woman or girl's only chance to get help. FGM harms girls and women, it is child abuse and a violation of human rights.

If further areas of concern are present, for example, Forced Marriage and/or Honour Based Violence please see relevant protocols and refer to the Risk Assessment (Appendix B).

THE ONE CHANCE RULE – (See Appendix A for One Chance Checklist)

All practitioners working with girls and women at risk of, or who have been subject to, FGM need to be aware of the "one chance rule". This means that they may only get one chance to speak to a potential victim and thus they may only have once chance to save a life. Therefore all practitioners working within all agencies need to be aware of their responsibilities and obligations when they come across anyone suspected of being a victim or potential victim of FGM. If the victim is allowed to walk out of the door without support being offered, that one chance might be wasted.

What you should do:

- Know what to look for: Be aware of the FGM risk indicators
- Listen to and believe what the girl or woman is saying.
- Seek advice from specialist organizations like NSPCC FGM telephone helpline, SAHELIYA (see Useful Contacts)
- If dealing with a girl under the age of 18 refer to child protection procedures
- Reassure the victim about confidentiality
- Arrange a way for you to contact the victim discreetly.

What you should NOT do:

- Do not make assumptions. Not every woman from a country where there is FGM is affected.
- Do not be shocked, be sensitive and remember many families believe they are doing their best for their daughters.
- If you suspect FGM, Forced Marriage/Honour Based Violence do not contact the family or attempt mediation
- Do not send the woman or girl back to her family
- Don't assume the members of her family, including female members will protect the victim as family members may be colluding and/or under pressure to conform
- Do not use a family or community member as an interpreter – always use an independent and impartial interpreter

- Do not turn the woman or girl away as you may be her only chance to get help.

RECORD KEEPING

Accurate record keeping in all cases of violence or abuse is essential. Records should:

- Be accurate, detailed, clear and include the date
- Use the child or adult's own words in quotation marks
- Document any injuries – include photographs, body maps or pictures of their injuries
- Only be available to those directly involved in the person's case

CHILD/ADULT PROTECTION

A victim or someone at risk of FGM is "a child or adult at risk" under the terms of the relevant legislation.

All staff employed by a local authority, the police or the NHS are legally obliged to make a referral to the local authority if they know or suspect someone is "a child or adult at risk". Anyone in any doubt as to whether a case involving FGM is a child or adult at risk should contact the appropriate team manager.

SPECIFIC GUIDANCE FOR HEALTH STAFF

In addition to the multi-agency guidance, there are a number of areas in which staff based within health settings are encouraged to consider specific responses appropriate to health services.

Wherever possible women and girls should have the option to be seen and treated by a clinician of the same gender.

GPs and practice nurses are encouraged to consider a number of areas:

- Enquiry regarding FGM should be made when a routine patient history is being taken from girls and women from communities that traditionally practise FGM;
- Information about FGM should be made available as part of any 'welcome pack' given to practice's new patients; and,
- The risk of FGM should be considered where girls and young women request vaccinations for an extended holiday.

A number of practical actions should be considered by midwives and other health staff involved in maternity care:

- At the antenatal booking, the process of history taking should identify women who have undergone FGM;

- There should be an appropriate care pathway during pregnancy, delivery and postnatal care for women affected;
- The possibility of FGM should be considered even if the woman has had previous vaginal births. This should be addressed as early as possible during pregnancy or, if a woman is admitted who is already in labour, it is important to check for re-suturing;
- The type of FGM should be clearly recorded on the women' medical records, including a detailed description of the genitals, identifying the presence/absence and condition of each structure;
- FGM should be documented in the antenatal notes but if for any reason this is not the case, it should be done postnatally before the transfer home after delivery; and,
- The women's health visitor and GP should be informed that she has undergone FGM so they can ensure that she receives any physical and mental health support needed, reinforce the messages about the practice's illegality, and protect any female children.

All women who have undergone Type 3 (infibulation) should be informed that deinfibulation is an option and be informed about the benefits of this.

Re-suturing, often know as reinfibulation or closing, should never be performed because it is illegal for any professional to do this in the UK. This may mean that careful discussions have to be held with the woman, her partner and family to explain the law and why reinfibulation has been refused. For women who have undergone deinfibulation, health professionals should communicate equally the disadvantages of infibulation and the benefits of not being reinfibulated after childbirth.

IDENTIFYING FEMALE GENITAL MUTILATION

When identifying those at risk of FGM it is important that practitioners focus on country of origin and cultural identity, rather than on religious identity.

It is also important that practitioners do not assume that all families from practising communities will want their girls and women to undergo FGM. Assessment of risk must be undertaken on a case-by-case basis utilising all of the available information.

Professionals in all agencies, and individuals and groups in relevant communities, need to be alert to the possibility of a girl or woman being at risk of FGM, or already having undergone FGM. There are a range of potential indicators that a child or young person may be at risk of FGM.

Indicators of Risk which need consideration:

- One or both parents come from an ethnic group that traditionally practices FGM
- Any girl 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.

BUT do not assume that all women who have experienced FGM, or all men from practicing communities, will support the practice.

A girl should be viewed as at increased risk if:

- Any girl 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.
- Female cousins of a similar age have undergone FGM
- The mother (and/or father) has requested re-infibulation following delivery.
- The parents express views which show that they value the practice
- A girl is withdrawn from Personal, Social and Health Education (PSHE) may be at risk as a result of her parents/carers/guardians wishing to keep her uninformed about her body and rights.
- The level of integration within UK society is also significant. It is believed that communities less integrated into British Society are more likely to carry out FGM[ii]. FGM Multi-Agency Practice Handook (FCO, HM Government 2011)

Possible signs of imminent risk:

- A girl is withdrawn from school to allow for an extended holiday, or a girl talks about a long trip planned during the school summer holidays.
- It may be possible that families will practise FGM in the UK when a female family elder is around, particularly when she is visiting from a country of origin.

- A professional may hear reference to FGM in conversation, for example a girl may tell other children about it: words used may include 'cut', 'cutting', 'circumcised', 'closed'.
- A girl may talk about "something special happening", or that there will be "a big party" or "she is going to be a woman soon".
- A girl may talk about a long holiday to her country of origin or another country where the practice is prevalent. Parents state that they or a relative will take the child out of the country for a prolonged period.
- If Forced Marriage is suspected or known then risk of FGM should also be addressed where the girl comes from a group that traditionally practices FGM.
- A girl may request help from a teacher or another adult if she is aware or suspects that she is at immediate risk.

Different ethnic groups carry out FGM for different reasons, and at different ages. Parents in communities affected by FGM will believe that it is the right thing to do and that it is part of being a responsible parent. In working to protect girls it is very important to find out the reasons why FGM is carried out in her community/ethnic group, and the age at which it is arranged. If a girl is viewed as potentially at risk then there should be increased monitoring and support around the age at which FGM is traditionally carried out in her family/ethnic group. Practitioners should aim to support parents in resisting any pressure from their family or wider community.

Even where the parents oppose FGM, there are still risks if the girls and young women are visiting the country of origin or being visited by extended family, or are living in a community which supports FGM, especially if this is supported by the Community Leaders. A Scottish Government statement, opposing FGM, supported by Scottish Ministers, the Lord Advocate and Police Scotland is available to download from www.fgmaware.org and is intended to be used to support parents when visiting family/community.

There are a number of indications that a girl or woman has already been subjected to FGM:

- A girl or woman may have difficulty walking, sitting or standing.
- A girl or woman may spend longer than normal in the bathroom or toilet due to difficulties urinating.
- A girl may spend long periods of time away from a classroom during the day with bladder or menstrual problems.
- A girl or woman may have frequent urinary or menstrual problems.
- There may be prolonged or repeated absences from school or college.
- A prolonged absence from school or college with noticeable behaviour changes (e.g. withdrawal or depression) on the girl's return could be an indication that a girl has recently undergone FGM.

- A girl or woman may be particularly reluctant to undergo normal medical examinations.
- A girl or woman may confide in a professional.
- A girl or woman may ask for help, but may not be explicit about the problem due to embarrassment or fear.
- Female genital mutilation differs from other forms of child abuse in two important respects:

    1. despite the very severe health consequences, parents and others who have this done to their children may genuinely believe that it is in the child's best interest to conform with their prevailing custom. They believe it makes the child socially acceptable and do not intend it as an act of abuse; and
    2. there is no element of repetition for the individual affected - it is a one-off act of abuse (although younger female siblings of any child found to have been mutilated may be at risk).

It is acknowledged that some FGM-practising families do not see it as an act of abuse, however FGM has severe significant physical and mental health consequences both in the short and long-term and must not be excused, accepted or condoned.

RESPONDING TO FEMALE GENITAL MUTILATION

It has been recognised that professionals' concerns about rights to confidentiality may be acting as a barrier to effective information sharing between agencies. Practitioners must discuss each case with their manager to ensure that confidentiality is not a barrier to protecting children and adults at risk.

Key principles that must inform standards within local practice are:

- Treat it as a child protection issue, and adults support and protection issue where relevant criteria are met, the safety and welfare of the child and/or adult is paramount;
- Document and collect information;
- Share the information systematically;
- Identify girls at risk and refer them as part of multi-agency child protection obligations;
- Empower and support affected girls and women (both those at risk and survivors);
- FGM is not a matter that can be left to be decided by personal preference, professionals should not let fears of being branded 'racist' or 'discriminatory' weaken protection required by vulnerable girls and women; and,
- Accessible, acceptable and sensitive health, education, police, social care and voluntary sector services must underpin interventions for FGM.

Whilst practitioners in all agencies must be alert to the risk of FGM, some key groups of staff are more likely than others to come into contact with women and girls at risk of or who have experienced FGM:

- GPs;
- Paediatricians;
- Midwives;
- Health visitors;
- School nurses;
- A&E staff;
- Women's Community Groups (especially BME);
- Mental health Services;
- Staff based in sexual health clinics;
- Forensic Medical Examiners (FMEs);
- Staff based in community contraception services;
- Teachers; and,
- Staff based in nursery and early years services.

These staff must be actively alert to risk of FGM and may wish to access additional learning and workforce development opportunities that are specific to their role.

Tackling FGM in the UK : Intercollegiate Recommendations for Tackling FGM in UK (November 2013)

GIRLS AT RISK OF HAVING FGM (and other children including baby girls born to a mother who has undergone FGM, any female child whose older sibling has undergone FGM and other children in the household)

Any child (aged less than 16 years, or less than 21 years in the case of a looked after child) considered to be at risk of FGM must be dealt with under local Child Protection Procedures.

Adult support and protection structure, policies and procedures may also require to be utilised depending on the age of any young person involved and / or the needs of wider family members.

In addition, if a teacher or other staff member suspects that a student has been removed from, or prevented from, attending education as a result of FGM, procedures regarding Children Missing from Education should be followed.

At the point of referral you must clearly state that the child is at risk of FGM and that a child protection response is required. Where the risk is imminent legal advice regarding available legal interventions to secure the child's immediate safety must be sought.

An IRD must always be held where there are credible concerns that a child is at risk of FGM. The IRD must consider the risk of FGM as well as the wider care and welfare

needs of the child. It must also seek advice regarding available legal interventions that can secure the child's immediate and longer-term safety.
Practitioners must, in conjunction with the referring practitioner / agency, consider the risk to other female children within the household and wider family at the earliest possible opportunity. Where any other child at risk is identified a separate referral must be initiated for each child at risk.

Throughout the child protection process practitioners must remain alert to the risks and needs of any adults involved and implement their duties under adult support and protection procedures as required. Where an adult victim of FGM is identified the guidance should be followed concurrent the child protection processes.

Criminal investigations should follow police standard operating procedures, and those for child protection investigations.

GIRLS AND WOMEN WHO HAVE UNDERGONE FGM

If the girl is under the age of 16 and there are any other care and welfare needs that meet the threshold for child protection intervention normal child protection procedures should be followed. Interventions to address the impact of FGM should form part of any wider child protection response.

If the girl is under the age of 16 and there are no ongoing care and welfare needs that meet the threshold for child protection, intervention procedures should be followed to ensure a Level 3, Team around the Child response is instigated to address health and wellbeing issues.

If the woman is aged 16 years or over and there are ongoing care and welfare concerns consideration should be given as to whether the individual meets the criteria for referral to adult support and protection procedures. If there are no additional care and welfare concerns and/or the woman does not meet adult support and protection criteria the identifying agency should follow their single agency care planning process, involving partner agencies as necessary.

Where the woman is 16 years or over the police should only be contacted where the victim has given their consent for this. Exceptions may apply where the woman herself or a third party is considered to be at immediate risk of significant harm.

If the woman is 16 years or over, there must be sensitive pro-active enquiry about relevant children in the household or wider family who may be at risk. Where any child or young person at risk is identified the previous guidance should be followed for each child.

The practitioner will:

- Develop care and support plans in response to FGM alongside wider care and welfare needs;
- Offer appropriate referral to counselling services; and,
- Ensure that an appropriate health assessment is conducted, including onward referral to health services where required.

Counselling

All girls or women who have undergone FGM should be offered counselling. Boyfriends, partners and husbands should also be offered counselling.

When a woman who has undergone FGM gives birth to a daughter, she should be provided with clear information that FGM is illegal in the UK and should not be performed on her daughter. It is important that this is done in a sensitive manner and that consideration is given to the possibility that the women has been a victim of enforced FGM and may be distressed at the suggestion she would wish to have FGM performed on her daughter. In each case an individual assessment should be made regarding who (i.e. which practitioner or practitioners) should provide this information and at what time (for example, it is not appropriate to do so immediately following birth whilst the woman is receiving post-natal care).

For both groups, those at risk and those who have already undergone FGM, the following guidance should be followed, within the Child/Adult Protection Procedures.

Medical Examinations

Medical examinations may be required in two main circumstances:

- To assess and agree appropriate treatment for emotional or physical health needs, including possible reconstructive surgery; and / or
- To document injuries for evidential purposes.

In all cases is it advisable to encourage the woman or girl to have injuries documented for future reference.

Where there is suspicion that a girl has undergone FGM and that siblings may have undergone FGM, a medical examination should be conducted as part of a whole health assessment. This can be important in establishing a base line in cases where further suspicions arise at a later date.

The examination of a child or young person should always be in accordance with multi-agency child protection procedures.

Recording of Information

In addition to single and multi-agency recording requirements, additional information that must be recorded when FGM is identified are:

- What type of FGM has been conducted (by relevant health staff, using WHO ICD codes);
- County of origin;
- On-going cultural links to the country of origin;
- When FGM was performed;
- Where FGM was performed;
- Any brief interventions undertaken (for instance, information given); and,
- Referrals to appropriate specialist interventions services.

For children and young people, this information should be recorded as part of the child's assessment and/or care plan.

For adult women, this information should be recorded as appropriate, normally by the lead agency/professional in the case (See Appendix B for Risk assessment format).

In deciding the most appropriate location for the recording of information practitioners should take into account issues relating to confidentiality and the potential for disclosure of records to family members which may place a girl or women at increased risk.
For NHS FGM codes, please see Scottish Government letter to NHS Boards in Further contacts and information.

TALKING ABOUT FGM

Professionals should be aware that girls and women at risk of FGM may not be aware of the practice or that it may be conducted on them, so sensitivity should always be shown when approaching the subject.

If the girl or woman insists on being accompanied during an interview/support session e.g. by a teacher or advocate, ensure that the accompanying person understands the full implications of confidentiality, especially with regard to the person's family.

Remember that individuals may wish to be interviewed by a professional of the same gender. They may not want to be seen by a professional from their own community.

When talking about FGM, practitioners should:

- Make no assumptions;
- Give the individual time to talk and be willing to listen;

- Create an opportunity for the individual to disclose, seeing the individual on their own in private;
- Be sensitive to the intimate nature of the subject;
- Be sensitive to the fact that the individual may be loyal to their parents/family/wider/community;
- Be non-judgemental (pointing out the illegality and health risks of the practice, but not blaming the girl or woman);
- Get accurate information about the urgency of the situation if the individual is at risk of being subjected to the procedure;
- Take detailed notes;
- Use simple language and ask straightforward questions;
- Use terminology that the individual will understand e.g. the individual is unlikely to view the procedure as 'abusive'; ask 'have you been cut'.
- Avoid loaded or offensive terminology such as 'mutilation';
- Use value-neutral terms understandable to the woman, such as 'have you been closed?', 'were you circumcised?';
- Be direct as indirect questions can be confusing and may only serve to reveal any underlying embarrassment or discomfort that you or the woman may have;
- Give the message that the individual can come back to you if they wish;
- 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 daughters; and,
- Give a clear explanation of the health impacts of FGM with a view to encouraging the woman or girl to seek and accept medical assistance.

USE OF INTERPRETERS

Any interpreter should be appropriately trained in relation to FGM and should not be a family member, not be known to the individual, and not be an individual with influence in the individual's community. Other steps that should be taken when working with an interpreter include:

- Checking the dialect spoken before arranging an interpreter;
- Having a briefing meeting with the interpreter prior to the discussion with the victim;
- If the victim wishes to be accompanied during the discussion, checking that the victim understands the full extent of the discussion and the impact of having someone with them. If the victim insists, have a brief meeting with the accompanying person and establish the rules of confidentiality;
- Explaining the role of the interpreter at the beginning of the discussion; and,
- Ensuring that the interpreter does not add their own information or opinion.

INVOLVEMENT OF FAMILY MEMBERS

Relatives, including female relatives, may conspire, aid or participate in FGM. On many occasions the wider community may also play an active role in encouraging FGM and protecting those who perpetrate it.

In cases of FGM it is not appropriate to involved family members without prior careful consideration of the risks of doing so, particularly in cases where a girl is thought to be at risk of FGM. Contact with family members should be carefully planned and the impact of this contact monitored on an ongoing basis.

It is important that staff never:

- Approach members of the victim's family or community unless this has been fully considered, risk assessed and planned, preferably on a multi-agency basis; or,
- Attempt to act as a mediator between the girl or woman and her family or community.

In most instances enquiries with the family should be undertaken by police, with appropriate assistance from social work staff. In the early stages of a case where, for example, FGM is suspected as a girl has been missing from education for a prolonged period it can be appropriate for other professionals to make informal enquiries before referring to the MASH. In these circumstances it is important that professionals do not reveal that enquiries are related to FGM either to family and community members, or to other professionals who are not fully aware of the need to handle information appropriately.

Parents may ask for contact with the child or young person during the enquiry process but this does not have to be granted if it is not in the best interests of the child.

PERPETRATION AT HOME OR ABROAD

Provided that FGM takes place in the UK, the nationality or residence status of the victim is irrelevant and the guidance above should be followed.

Where FGM has taken place abroad a British national may seek assistance at a British Embassy or High Commission overseas and wishes to return to the UK, the Foreign and Commonwealth Office (FCO) will do what it can to assist or repatriate the individual. The FCO may ask the police or social work for assistance when a British national is being repatriated to the UK from overseas. Given the potential urgency of the situation the FCO may not be able to give notice of the need for assistance.

The types of assistance commonly sought by the FCO from police and social work are:

- Funding for the cost of repatriation; and,
- Meeting the individual immediately on their arrival to the UK.

Staff should co-operate with requests from the FCO for assistance wherever possible and treat this as a priority.

INDIVIDUALS AND FAMILIES WITH 'NO RECOURSE TO PUBLIC FUNDS

An investigation of the immigration status of any individual must not impede police enquiries into an offence that may have been committed against a woman or girl.

If the girl or women is not a British Citizen or does not have indefinite leave to remain in the UK professionals should refer to procedures for:

- Support for Adults with Care Needs and Families who have No Recourse to Public Funds;
- Guidance for Working with Unaccompanied Asylum Seeking Children; and,
- Guidance for Working with People Experiencing Domestic Abuse who have no Recourse to Public Funds.

These procedures should be followed concurrently with the guidance laid out in this document.

USEFUL CONTACTS AND INFORMATION

National Contacts and Information

NSPCC FGM helpline launched	NSPCC operates a dedicated helpline on FGM. Telephone: **0800 028 3550** Emails to fgmhelp@nspcc.org.uk Further information. NSPCC FGM website.
FGM in Scotland website	**www.fgmaware.org** A website with a range of guidance and resources was launched on 6th February (UN Day for zero tolerance to FGM) 2015. A short animated film about FGM can be viewed on the website which also provides a range of information, resources - FGM & Health, Child Protection, FGM and the law and links to further resources/information. The film 'Sara's Story (available as a download and/or DVD with facilitators notes) is intended for use across Scotland as part of Violence Against Women, Child Protection, Adult Support and Protection training.
NHS Scotland	The Scottish Government issued a letter to NHS Boards in 2014.  Female-Genital-Mutilation-Letter-from-Scc A range of resources to support Routine Enquiry of Gender Based Violence in Scotland are available via: **www.gbv.scot.nhs.uk** **Harmful Traditional Practices- what health workers need to know** **NHS Choices FGM Information Pages**
Information for schools in Scotland	**Schools:** The Scottish Government wrote to all Head Teachers in Scotland in February 2014 outlining the role schools play in relation to FGM and highlighting National Guidance for Child Protection, links to the UK Home Office leaflet and the Women's Support Project who have been funded by the Scottish Government to develop resources for use in training and education.  education letter.pdf **Education Scotland** working with partners and Education Authority staff produced a short supported PowerPoint presentation, which

	authorities and head teachers can use to raise awareness of Female Genital Mutilation (FGM) in schools and early years settings. www.educationscotland.gov.uk/resources/f/fgm **Teach, Educate, Share** website provides a range of materials including a comprehensive and adaptable lesson plan including guidelines and preparation information for teachers who are teaching the lesson. It also includes detailed notes for how to teach the lesson. The interactive lesson consists of various age appropriate activities. Access it here: https://www.tes.co.uk/teaching-resource/FGM-Lesson-Plan-6408349/
FORWARD	FORWARD is a UK wide organisation campaigning against FGM. http://www.forwarduk.org.uk/ Forward's Young People Speak Out program which aims to engage with young people on FGM. http://www.forwarduk.org.uk/programmes/uk-programmes/youth
Dignity Alert Research Forum (DARF)	DARF is an organisation working to end violence against women and children in Scotland. Their current focus is on FGM and child marriage. www.darf.org.uk
Equality Now	Equality Now advocates for the human rights of women and girls around the world. One of there areas of focus is FGM. www.equalitynow.org
Karma Nirvana	Karma Nirvana provides specialist support to Asian women and children and advice to other agencies. They can also access refuge accommodation. Website: www.karmanirvana.org.uk
Shakti Women's Aid	Shakti offers support and information to all black minority ethnic women, children and young people who are experiencing or fleeing domestic abuse, forced marriage and other honour based violence issues. They also have refuge accommodation. Tel: 0131 475 2399 Website: www.shaktiedinburgh.co.uk
Saheliya	Saheliya is an organisation, which provides a safe and confidential service that supports the mental health and well being of Black and Minority Ethnic women in Edinburgh. Services include counselling, support, befriending and advocacy. www.saheliya.org.uk
ROSHNI	Roshni aims to raise awareness and ensure the safety of children, young people and adults within minority ethnic communities. Email: info@roshni.org.uk Website: www.roshni.org.uk

Amina Muslim Women's Resource Centre	Amina works with mainstream agencies to establish the barriers that prevent Muslim women from accessing services and participating in society. They provide direct helping services and community development to Muslim women. **Free phone helpline number: 0808 801 0301** Dundee: 01382 224 687 Glasgow: 0141 585 8026 www.mwrc.org.uk
Beyond the Veil	Beyond the Veil educate and inform the public to clear misconceptions and myths surrounding Islam. Address: c/o 1 House O'Hill Road, Edinburgh, EH4 2AJ Email: nasim.azad69@yahoo.co.uk
The FGM National Clinical Group	Advocates for the end of the Female Genital Mutilation practice as well as championing education and support for healthcare specialists and advisors throughout the National Health Service and the wider community. The FGM Resource is targeted at specialists, practitioners and educators based in the UK and abroad, with the intentions to provide an overall context of FGM and its current standing within healthcare and political arenas. **http://www.fgmresource.com/**
Zero Tolerance	Zero Tolerance briefing paper which provides links to further FGM information and resources. www.zerotolerance.org.uk
Orchid Project	Information and awareness raising of FGM www.orchidproject.org.uk
Foreign & Commonwealth Office Forced Marriage Unit	The Forced Marriage Unit is a single point of confidential advice and assistance for those at risk of being forced into marriage overseas. Telephone: 020 7008 0151 From overseas: +44 (0)20 7008 0151 Monday to Friday, 9am to 5pm Out of hours: 020 7008 1500 (ask for the Global Response Centre) Email: fmu@fco.gov.uk Website: www.fco.gov.uk/forcedmarriage
National Domestic Abuse Help Line	Tel 0800 0271234 Support is available 24/7
Stonewall Scotland	Campaign for equality and justice for gay, lesbian, bisexual and transgender (LGBT) people living in Scotland. Telephone 0131 474 8019 Email: info@stonewallscotland.org.uk

LGBT centre for Health and Wellbeing	The LGBT centre provides a varied programme of services, events, courses and groups for LGBT people. 9 Howe Street Edinburgh EH3 6TE Telephone: 0131 523 1100 9 and 5, Monday to Friday Email: admin@lgbthealth.org.uk LGBT Helpline Scotland Tel: 0300 123 2523 Tuesdays and Wednesdays 12-9pm.
UK Wide Human Trafficking Website **UK Human Trafficking Centre**	www.moderndayslavery.co.uk Telephone Helpline 0800 0121 700 UK Human Trafficking Centre
Iranian & Kurdish Women's Rights Organisation	The Iranian and Kurdish Women's Rights Organisation provide advice, support, advocacy and referral in Arabic, Kurdish and Farsi to help women, girls and men escape the dangers of "honour" killing, forced marriage and domestic abuse. Tel: 0207 920 6460 09:30 and 17:30 Monday to Friday Email: ikwro@yahoo.co.uk
Scottish Women's Aid	Scottish Women's Aid does not offer direct services for Women. Services for women and children are provided by Angus Women's Aid, Dundee Women's Aid and Perth and Kinross Women's Aid. Scottish Women's Aid is a good resource for workers. Scottish Women's Aid, 2nd Floor, 132 Rose Street, Edinburgh, EH2 3JD Tel: 0131 226 6609 Fax: 0131 226 2996 Email: contact@scottishwomensaid.org.uk
Hemat Gryffe Women's Aid (Glasgow based)	Hemat Gryffe provides support, advice and temporary accommodation to women and children from the BME community who experience domestic abuse or forced marriage. Tel: 0141 353 0859 9-5 Mon - Fri Email: hemat.gryffe@ntlbusiness.com

Rape Crisis (Scotland)	Rape Crisis Scotland (RCS) is the national office for the rape crisis movement in Scotland. 46 Bath Street, Glasgow, G2 1hG Tel: 0141 331 4180 Fax and Minicom: 0141 332 2168 Email: info@rapecrisisscotland.org.uk The Rape Crisis Scotland National Helpline provides crisis support for anyone in Scotland affected by sexual violence at any time in their lives. Rape Crisis Scotland Helpline: 08088 01 03 02 (free number) everyday, 6pm to midnight.
Archway	Archway Glasgow is Scotland's first Sexual Assault Referral Centre, providing forensic and medical assistance, as well as support and counselling for anyone who has recently been raped or sexually assaulted. Telephone: 0141 211 8175 Open 24 hours a day, 7 days a week.

Angus, Dundee, Perth and Kinross Contacts

Perthshire Women's Aid	49 York Place, Perth PH2 8EH Telephone: 01738 639043 Available 9.30am – 4pm Monday to Friday
Dundee Women's Aid	Top Floor, Enterprise House 45 North Lindsay Street Dundee DD1 1DW Telephone: 01382 207099 Mon to Fri 9.30 -12.30 & 1.30 - 4.30pm except Thurs 9.30 - 12.30 Fax: 01382 646520
Angus Women's Aid	Lindsay Street Arbroath DD11 1RP Telephone: 01241 439437 info@anguswomensaid.co.uk
Barnardo's	Angus Domestic Abuse Officer Tel: 01241 435747 Mon – Fri 08.45- 5.00 Dundee Domestic Abuse Officer

	Tel: 01382 596686 Mon – Fri 08.45- 5.00 Perth Domestic Abuse Officer Tel: 01738 892516 Mon – Fri 08.45- 5.00
Domestic Abuse Liaison Unit	TaysideDAIU@scotland.pnn.police.uk. The on duty DS can be contacted on 01382 591891 or 96
Shakti Women's Aid (Dundee)	Shakti offers support and information to all black minority ethnic women, children and young people who are experiencing or fleeing domestic abuse, forced marriage and other honour based violence issues. Enterprise House, 45 North Lindsay Street, Dundee, DD1 1PW Tel 01382 207095 Email – Tshakti@dundeewomansaid.co.uk
Amina Muslim Women's Resource Centre	Amina works with mainstream agencies to establish the barriers that prevent Muslim women from accessing services and participating in society. They provide direct helping services and community development to Muslim women. Free phone helpline number: 0808 801 0301 Dundee: 01382 224 687 opening hours 9.30am to 5pm Glasgow: 0141 585 8026 Email: www.mwrc.org.uk
Victim Support Scotland	Angus 82 High Street Arbroath DD11 1HL Tel 01241870096 Dundee 10 Constitution Road Dundee DD1 1LL 01382 305707 Perth The Gateway Centre, N Methven St, Perth PH1 5PP 01738 567171 Helpline – 0845 603 9213 Practical and emotional support for Victims of Crime. Also support at court for victims and witnesses

Rape and Sexual Abuse Centre (RASAC) Perth and Kinross	18 King Street, Perth, PH2 8JA Business line – 01738 626290 Helpline – 01738 630965 Or email rasacpk@gmail.com
Women's Rape and Sexual Abuse Centre (WRASAC)	WRASAC – Dundee & Angus 2 Dudhope Street, Dundee, DD1 1JU. Phone 01382 205556 email support@wrasac.org.uk
Dundee International Women's Centre	Dundee International Women's Centre (DIWC) works to address the needs of women, with an emphasis on those from Black and Minority Ethnic communities. We have 45 years of experience in providing a safe, friendly, culturally sensitive support service for women from diverse communities facing a wide range of issues; services include advice and support, a listening- ear, advocacy, language support, adult learning, training and sign-posting. Tel: 01382 462068 Email: mail@diwc.co.uk

Appendix A

ONE CHANCE CHECKLIST

You may only have one chance to speak to a potential victim and, therefore, only one chance to intervene.

- See the victim on her own – even if they are accompanied by others;
- See the victim immediately in a secure and private place where you will not be overheard;
- Reassure the victim about confidentiality and explain that you will not give information to family, friends or the community.
- Accept what is said;
- Explain all the options to the victim and possible outcomes;
- Recognise and respect her wishes;
- Assess the risk faced by conducting an appropriate and thorough risk assessment.
- Contact, as soon as possible, the lead worker responsible for female genital mutilation (if the potential victim is under 16, refer to child protection inter-agency guidance; if an adult at risk, discuss with your adult support and protection lead and refer to inter-agency guidance);
- Agree a way to make contact safely (for example agree a code word);
- Obtain full details to pass on to the lead worker and record these safely;
- Provide contact details or help the victim to memorise your contact details and/or those of a support agency such as Women's Aid.
- Consider the need for immediate police involvement, protection and placement away from the family and arrange this is necessary; this includes any action to stop the victim from being removed from the UK;
- Do everything possible you can to keep the victim safe; and
- Get immediate advice if you are not sure what to do.

Appendix B

Risk Assessment Tool & Guidance

VICTIM DETAILS		
Photograph Date/Time Taken		
First Name		
Surname / Last Name		
Date of Birth and Age		
Place of birth		
Self defined ethnicity		
Religion		
Gender		
School or Occupation		
Address		
Safe Contact Number		
Dependent Children	**Yes**	**No**
Current Whereabouts		
Relationship to Perpetrator(s)		

PERPETRATOR(S) DETAILS

Person 1

First Name	
Surname / Last Name	
Date of Birth and Age	
Place of birth	
Self defined ethnicity	
Religion	
Gender	
School or occupation	
Address	
Relationship to Victim	

Person 2

First Name	
Surname / Last Name	
Date of Birth and Age	
Place of birth	
Self defined ethnicity	
Religion	
Gender	
School or occupation	
Address	
Relationship to Victim	

OTHER FAMILY MEMBERS (WHO MAY BE AT RISK)

Person 1

First Name	
Surname / Last Name	
Date of Birth and Age	
Gender	
Address	
Relationship to Victim	

Person 2

OTHER FAMILY MEMBERS	
First Name	
Surname / Last Name	
Date of Birth and Age	
Gender	
Address	
Relationship to Victim	

INCIDENT DETAILS
Description of incident: (include details of previous incidents, reported or unreported)

RISK FACTORS – DOMESTIC ABUSE,STALKING AND HARRASSMENT & HONOUR BASED VIOLENCE (DAQ)	
All practitioners, as a matter of routine, should complete the Domestic Abuse, Stalking and Harassment and Honour Based Violence (DAQ) checklist and consider the existence of the established 15 high risk factors when dealing with potential incidents to inform their judgement and form an accurate risk assessment	
Q1. Has the current incident resulted in injury?	
Q2. Are you very frightened?	
Q3. What are you afraid of? Is it further injury or violence?	
Q4. Do you feel isolated from family/friends i.e. does (name of abuser(s)) try to stop you seeing friends/family/doctor or others?	
Q5. Are you feeling depressed or having suicidal thoughts?	
Q6. Have you separated or tried to separate from (name of abuser…) within the past year?	
Q7. Is there conflict over child contact?	
Q8. Does (…) constantly text, call, contact, follow, stalk or harass you?	
Q9. Are you pregnant or have you recently had a baby (in the past 18 months)?	
Q10. Are there any children, stepchildren, that aren't (…)'s in the household? Or are there other dependents in the household (i.e. older relatives)?	
Q11. Has (…) ever hurt the child(ren)?	
Q12. Has (…) ever threatened to hurt or kill the child(ren)?	
Q13. Is the abuse happening more often?	
Q14. Is the abuse getting worse?	
Q15. Does (….) try to control everything you do and/or are they excessively jealous?	

Q16. Has (….) ever used weapons or objects to hurt you?	
Q17. Has (….) ever threatened to kill you or someone else and do you believe them?	
Q18. Has (….) ever attempted to strangle / choke / suffocate /drown you?	
Q19. Does (….) do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else?	
Q20. Is there any other person who has threatened you or who you are afraid of?	
Q21. Do you know if (….) has hurt anyone else?	
Q22. Has (….) ever mistreated an animal or the family pet?	
Q23. Are there any financial duties? For example, are you dependent on (…) for money/ have they recently lost their job/ other financial issues?	
Q24. Has (….) had problems in the past year with drugs (prescription or other) alcohol or mental health leading to problems in leading a normal life?	
Q25. Has (….) ever threatened or attempted suicide?	
Q26. Has (….) ever breached bail/an Order and/or agreement for when they can see you and/or the children?	
Q27. Do you know if (….) has ever been in trouble with the police or has a criminal history?	
Risk Factors for HBV	
Truanting – Is the victim truanting from school or are they being prevented from attending school?	
Self-Harm – Has the victim been self-harmed in any	

way? Does the victim feel suicidal?	
House arrest and being "Policed" at home – Has the victim been subject to house arrest or the threat of house arrest?	
Fear of being forced into an engagement/marriage – Does the victim fear a forced marriage?	
Pressure to go abroad – Has the victim been pressured to go abroad/ to visit country of origin?	
Isolation – Do you feel isolated and live in fear of being tracked down by family who may solicit the help of others?	
Attempts to separate or divorce (child contact issues)	
Threats that they will never see the children again	
A Pre-marital relationship or extra marital affairs – Does the victim have a boyfriend/girlfriend?	
Threats to Kill – Has the victim been subject of threats to kill or inflict serious harm?	
How does the victim perceive the risk to themselves? Has the victim or any other member of their family been subjected to Female Genital Mutilation?	
Does the victim know or suspect the trigger for the reported incident? E.g. rumours, sexuality, westernisation	
Are there any other agencies involved in the family? E.g. Social services, health workers, education. Are there any children on CPR?	
Have any other agencies been notified of current incident?	
Is the victim part of a close extended family/community network?	
Has the victim been subject of any abuse from the extended family/community?	

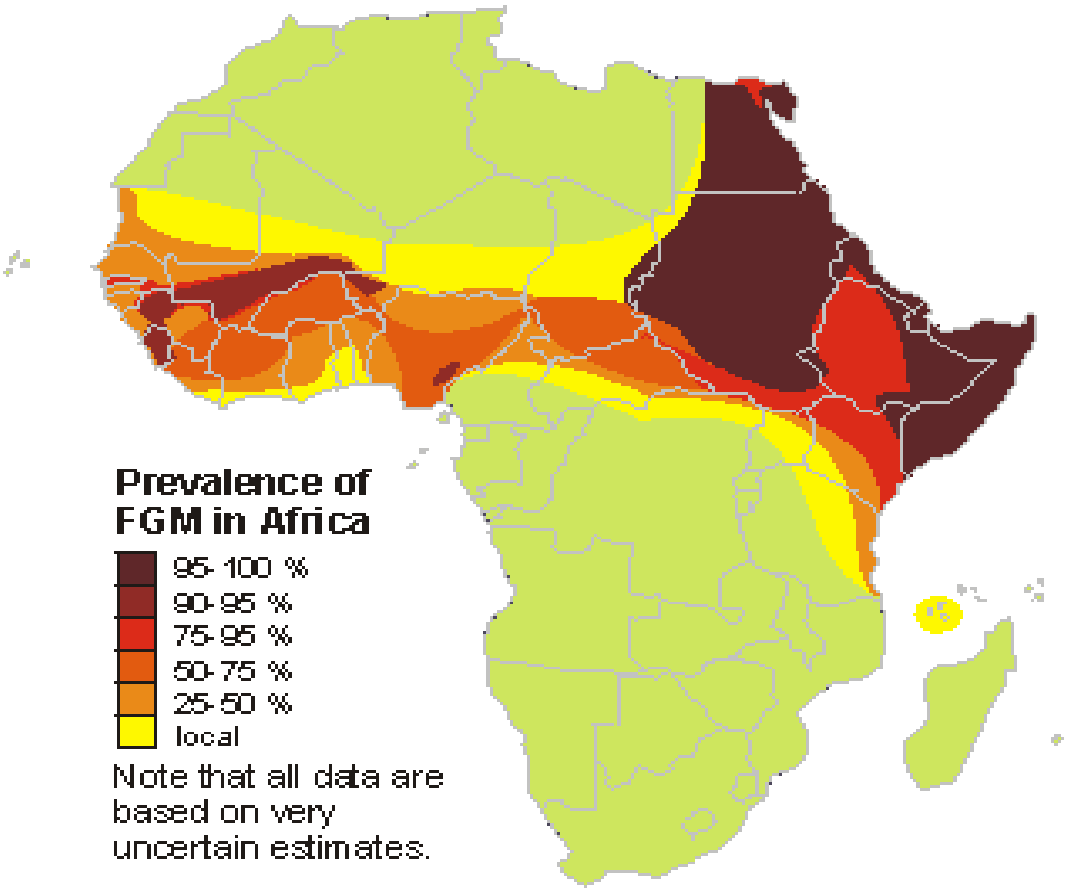
15 HIGH RISK FACTORS OF SERIOUS HARM AND HOMICIDE IN DOMESTIC ABUSE CASES	
1	**Victim's perception of risk of harm.** Victims of domestic abuse often tend to underestimate their risk of harm from perpetrators of domestic violence. However, if they say they fear further harm to themselves, their child(ren) or someone else this should be taken seriously when assessing future risk of harm
2	**Separation (Child contact):** Victims who attempt to end a violent relationship are strongly linked to intimate partner homicide. Many incidents happen as a result of child contact or disputes over custody.
3	**Pregnancy/new birth (Under 18 months old):** Domestic abuse can start or get worse in pregnancy. Victims who are assaulted whilst pregnant, when they have recently given birth or who have young children should be considered as high risk. This is in terms of future harm to them and to the unborn/young child.
4	**Escalation:** Repeat victimisation and escalation must be identified. DA victims are more likely to become repeat victims than any other type of crime; as violence is repeated it gets more serious.
5	**Community Issues/Isolation:** needs may differ amongst ethic minority victims, newly arrived communities, asylum seekers, older people, people with disabilities, as well as travelling or gay, lesbian, bisexual or transgender people. This might be in terms of perceived racism, language, culture, insecure immigrations status and/or accessing relevant support services. Be aware of forced marriage and honour based violence whereby family/community tries to restore their mistaken sense of honour and respect. Victims may be particularly isolated and/or vulnerable. Take their concerns seriously.
6	**Stalking:** Persistent and consistent calling, texting, sending letters, following. DA stalkers are the most dangerous. Stalking and physical assault, are significantly associated with murder and attempted murder. This is not just about physical violence but coercive control and jealous surveillance. Consider the perpetrator's behaviour and whether victim believes it is being done to deliberately intimidate.
7	**Sexual Assault:** Those who are sexually assaulted are subjected to more serious injury. Those who report a domestic sexual assault tend to have a history of domestic abuse whether or not it has been reported previously. Many domestic sexual offenders are high risk and potentially dangerous offenders. Be aware of the link between domestic and stranger rape.
8	**Strangulation (choking/suffocating/drowning):** Escalating violence, including the use of weapons and attempts at strangulation must be recorded when identifying and assessing risk. This includes all attempts at blocking someone's airway.
9	**Credible Threats to kill:** A credible threat of violent death can very effectively control people and some may carry out this threat.
10	**Use of weapons:** Abusers who have used a weapon, or have threatened to use a weapon, are at increased risk of violent recidivism.
11	**Controlling and/or Excessive Jealous Behaviour:** Complete control of the victim's activities and extreme jealousy are associated with serious violence and homicide. Consider honour based violence – the victim may not have the freedom of choice. Examples may include fear of or actual

	forced marriage, controlling sexual activity, DA, child abuse, rape, kidnapping, false imprisonment, threats to kill, assault, harassment, forced abortion The perpetrator may well try and control professionals as well.
12	**Child Abuse:** Evidence shows that both DA and child abuse can occur in the same family. Child abuse can act as an indicator of DA in the family and vice versa – please note if the child(ren) witness or hear the abuse.
13	**Animal/Pets Abuse:** There is a link between cruelty to animals, child abuse and DA. The use or threat of abuse against pets is often used to control others in the family. Abuse of animals may also indicate a risk of future harm.
14	**Alcohol/Drugs/Mental Health:** The abuser's use of drugs and alcohol are not the cause of the abuse, as with all violent crime they might be a risk of further harm. Physical and mental ill health does appear to increase the risk of DA.
15	**Suicide-Homicide:** Threats from an offender to commit suicide have been highlighted as a Factor in domestic homicide. A person who is suicidal should also be considered homicidal.

RISK MANAGEMENT ACTIONS	
Establish Regular Safe Contact	Provision of mobile phone to maintain 24/7 contact in early stage, using covert methods to establish regular contact with the victim, non-police e-mail and/or provide victim with a 'pay as you go' mobile phone. Establish a code word for use by the victim during telephone calls. Be conscious when using the telephone that individuals may not be who they purport to be or may be being threatened by their family as they speak. Ask victim to contact practitioner at least two/three days in advance if they decide to make any significant changes or decisions or decide to leave or return home.
Accommodation	If considering refuge accommodation it may be appropriate to approach a Women's Aid Organisation out with your area. Put contingency in place for relocation to another area if current location is found (work is ongoing to establish local arrangements for persons with no recourse to public funds)
Personal Safety Plan	Nominated safe contact, access to funds, passport, identification transport (spare car keys), and change of clothes. Open a bank/savings account in their name, leave copies of important documents such as passport, national insurance number and birth certificate with police, social services or a trusted friend. Set up local agreements with housing, local government. Children need to be included in safety plan & alternative escape plan for them may be found necessary. General safety advice for victims can be found at www.crimereduction.gov.uk/personalsafety
Victim Log	Advise victim to record details of all interactions that take place between themselves and the offender
Travel/Abduction precautions	At an early stage seek specialist advice from other units such as the Foreign and Commonwealth Office Forced Marriage Unit and Karma Nirvana. Consider application for a Forced Marriage Protection order under Forced Marriage etc. (Protection and Jurisdiction) (Scotland) Act 2011. A FMPO may, among other things, require a person to refrain from taking a protected person from, or to, such a place as the court may specify and submit to the court documents which the court may specify including passports and travel documents. If a FMPO is not granted or appropriate consider removal and retention of Passport. Check whether victim is on parent(s) passport or has dual nationality as may have two passports. Could flag their passports at Passport Office in case applications are made for new ones. Advise them to travel on their British passport if going abroad as easier to repatriate. Alert airports of possible travel and safety planning advice should be given to victim if they believe they will be taken overseas.

	Where travel is inevitable, obtain details of the itinerary and details of when they are going to return. Arrange for contact to be made on return. Obtain a statement saying the victim would like the authorities to take action to ensure his/her safety should they not return as arranged. If they are going overseas victim should be advised to take: • Contact details of Embassy/High Commission/trusted third party or Forced Marriage Unit at the FCO; • Secret stash of money, mobile telephone; • Copies of passport and tickets for themselves.
Referral to other Agencies	Inform victim of services available from Women's Aid, Barnardo's and local authorities and other relevant agencies.
Child Protection	Where children are involved refer to local child protection procedures/guidelines.
Vulnerable Adult	Where the victim is identified as a vulnerable adult refer to local procedures.
Move to another Local Authority area	Where a victim moves to another Local Authority area ensure that the new force is notified of the circumstances.
Vehicles	Record full details of all vehicles belonging to perpetrators

Appendix C – Prevalence of FGM in Africa



[i] http://www.forwarduk.org.uk/key-issues/fgm/

[ii] **FGM Multi-agency practice guidelines** *(FCO, HM Government, 2011)*