Strengthening protection from Female Genital Mutilation (FGM)

Response to Consultation from the
Royal College of Paediatrics and Child Health Scotland Child Protection Committee

January 2019

About the RCPCH

The Royal College of Paediatrics and Child Health (RCPCH) is responsible for training and examining paediatricians. The College has over 18,000 members in the UK and internationally and sets standards for professional and postgraduate education. We work to transform child health through knowledge, research and expertise, to improve the health and wellbeing of infants, children and young people across the world.

QUESTION 1: do you believe that a provision for anonymity for victims of FGM should be introduced? Please explain your answer.

This would seem a sensible addition to the legislation and may have been championed by victims of FGM to ensure some protection from community or media interest. However, it appears that the existing legislature covers this situation to a satisfactory degree, and there is therefore unlikely to be a benefit from introducing additional laws. It could even be counterproductive by making the procedure more complicated and leading to a false understanding that it was acceptable for the media to release the alleged victim's name if no specific anonymity order had been sought.

QUESTION 2: If anonymity is not introduced and having regard to existing convention and powers of the courts, what further steps do you consider could be taken to ensure protection of victims and complainers of FGM in the Justice system?

It would appear that the existing media coverage convention in relation to sexual assault cases is sufficient and should cover FGM cases. However, there may be a case for imposing a fine or penalty for websites or newspapers etc. for publishing the names of victims of FGM.

QUESTION 3: Do you think that Scotland should introduce an offence so that individuals can be prosecuted if they fail to protect a person they have caring responsibilities for being subjected to FGM? Please explain your answer.

Introduction of an offence might provide further deterrent alongside the current legislation. Paediatricians have experience of cases where families had stated 'it will be out of their hands when they return home', which is an unacceptable excuse. This scenario should be viewed as a parent or carer failing to protect a child from child sexual abuse or physical abuse. Proving this would remain a challenge for the Courts. The current legislation states it is an offence for a person to 'aid, abet, counsel, procure or incite'....but we propose that it should include 'failure to protect'.

If a parent knowingly travels with the understanding that FGM is the likely result of the trip, they have failed to protect their child. Some parents living with coercive or controlling partners may have little

choice but to 'go along' with the decision of the dominant parent. In this case, where for example, a mother can demonstrate she was the victim of domestic abuse and therefore had no control over the decision, we do not think it would be fair to penalise her for it. However, in general, we are in support of the offence of failing to protect a daughter because it does fit with the requirement of the parents' duty to protect their children and a child rights approach.

As there have been no FGM cases that have proceeded to court in Scotland, we are also concerned that the attempt to prosecute people for an act of omission will make the chances of successful prosecution even lower. If there was a strong sense that someone with parental responsibility allowed harm to come to the child, they could be prosecuted under existing rules relating to child protection offences. We should pursue the people who are actively committing or facilitating the FGM instead, not the family members who are probably less powerful within the family.

QUESTION 5: Do you think that the Scottish Government should introduce Female Genital Mutilation Protection Orders? Please explain your answer

Yes. This will allow agencies to protect children and young people by preventing their departure abroad for FGM when the risk is high. At present this is pursued under a Child Protection Order but a specific FGM order may clarify any event.

We believe this will allow robust measures of protection for these girls and will keep us aligned with the rest of the UK. There is evidence that these orders have worked well in England, we should introduce them in Scotland. Our only concern would be that the absence of such an order would somehow be interpreted as mitigation for the perpetrator if a child was taken abroad for FGM.

QUESTION 6: What do you think the penalty should be for breach of a FGMPO?

As paediatricians not from a legal background, we would prefer not to comment on appropriate penalties for the offence.

QUESTION 7: Do you think the Scottish Government should introduce a duty to notify Police of FGM? Please explain your answer.

The document states 'We are mindful of the importance of not inadvertently placing barriers in the way of those who would seek to access support services but be dissuaded from doing do in the knowledge those services have a duty to report to the Police.'

Rather than a duty to report to the police, there should be a duty to follow child protection procedures where a girl is considered at risk of FGM. Extensive work between agencies in Lothian has led to an agreed response to 'girls who may be at risk of FGM'. The crux of the issue here is that it is not usually obvious to 'whoever may be expected to report', just how 'at risk' a girl is. For example, while a girl from Nigeria sitting in a classroom can rightly be considered at risk of FGM, only certain ethnic groups from Nigeria practice FGM. Until issues are explored and the parents are asked if their families practise FGM, you cannot establish this. In fact, less than a third of Nigerians practice FGM, so it is more likely than not that in fact this girl is not at risk at all. Perhaps her mother is the chair of the anti FGM local group? We take the

view that it is not practical, right or justifiable to have an Inter-agency Referral Discussion (IRD) for every girl from a family that originates from a country that happens to have ethnic groups who practice FGM. Going by what is written here, you are in danger of writing a guideline that would have an IRD for every girl from most of Africa and much of Asia. Experience in Lothian has shown that in most cases, with support from healthcare and social work staff engagement, families are protective and appropriate. Only a small proportion of definite cases of FGM identified by maternity and gynaecology services in Lothian reach threshold for IRD for daughters. This does not mean that girls are not risk assessed; they are, and professionals get to know the families well, but the police are NOT informed until there are reasonable grounds to believe that the girl is at risk of harm and intervention is required.

Views were also expressed that under certain circumstances, a duty to report to the police should apply. For example, healthcare staff should report cases that affect all girls under 18 years where a concern is identified regarding FGM or risk of FGM. Where women have had FGM themselves and they have female children there may a duty to report. The reporting should be a Child Protection response, with an Interagency Referral Discussion and assessment of whether or not any child under 18 is currently at risk of FGM.

For women who have had FGM and there are no children, mandatory reporting to the police would not be helpful. It should be left to the woman to decide for herself, considering each situation and preferences.

Support can still be offered and accessed although evidence from community groups would suggest otherwise. Consistency and clarity in practice can be achieved through good statutory procedures, and an agreed threshold for triggering an IRD. Again, this is in keeping with community views. All our work will be at risk if we alienate already vulnerable women in this way, and if we do not listen to the people affected.

In Lothian, guidelines have been written where a regional multiagency FGM review group meets, with police attendance, to allow key information such as clusters of at risk families, trends in ethnicity affected etc to be fed into police intelligence, without the need to disclose individual sensitive highly personal health information. While the REASONS for mandatory reporting are sound, the NEED can be met via other routes which do not breach confidentiality.

All other cases should only be recorded for the interests of public health information, such as recording of HIV, TB etc and should be anonymous and submitted via health boards. This reporting can only take place where statutory requirements exist, as in England.

QUESTION 8: Do you agree that the Scottish Government should issue statutory guidance for professionals in relation to female genital mutilation? Please explain your answer.

Yes. Statutory guidance will be helpful to practitioners and will mean families understand that professionals have a duty to act, due to statutory guidance. The guidance should provide a framework for professionals in relation to a duty to share information.

QUESTION 9: Using existing non-statutory guidance as a basis, what should be covered by statutory guidance?

We suggest the following:

- Lead for FGM identified in Health, Education, Police and Social Work for each area covered by a Health Board.

- Nationally agreed thresholds / triggers for Interagency Referral Discussion / Child Protection Referral if child at risk of FGM

- Healthcare workers MUST routinely share information about any significant concerns with other main professionals in a girl's life. In practice, this means the girl's health visitor or head teacher / guidance teacher depending on the girl's age, the GP and school nurse (as appropriate).

- Use GIRFEC as basis for deciding how any relevant information is shared.

All of the above are written into procedures in Lothian; the difficulty is that existing statutory guidance does not specifically address FGM risk; FGM 'does not fit' into our current 'models' of child abuse. The resulting guidance is comprehensive and detailed but needs to be. Our systems are complex and ensuring that information is shared within and across agencies is challenging. Ensuring that staff are empowered and confident to address such a sensitive and 'new' subject (for many) necessitates detailed direction AND RESPONSIBILITY, specific to FGM. Experience shows us that unless this is explicit, professionals 'dodge' the issue and fail to risk assess and protect girls.

QUESTION 10: Do you consider that additional protections need to be introduced in Scotland in respect of the practice of vaginal elongation? Please explain your answer.

Members of the Child Protection Committee have no experience of vaginal elongation. This should be encapsulated in the definition of FGM.

If this was practised in children, we would consider the practice harmful and abusive. Existing legislation should cover any type of assault on a person, including this.

QUESTION 11: Do you have any evidence to suggest that individuals in Scotland have been subject to the practice of vaginal elongation?

As above.

QUESTION 12: Do you consider that additional protections need to be introduced in Scotland in respect of the practice of breast ironing? Please explain your answer.

Again, paediatricians in Scotland have little experience of this practice but it sounds as though this would be painful and cause injury and harm. We would therefore consider the practice of breast ironing abusive.

However, all types of ways of harming children and women and girls in particular DO NOT need to be named in legislation, or that these other practices need to be specifically associated with FGM legislation. FGM is a form of child sexual abuse and there is no consensus that we know of that classifies breast ironing as such, although it appears to be a form of gender-based violence.

QUESTION 13: Do you have any evidence to suggest that individuals in Scotland have been subject to the practice of breast ironing

Paediatricians in Scotland have no experience of this practice in the paediatric population.

QUESTION 14: Do you have views in relation to the place of cosmetic genital piercings in relation to protections and guidance?

Piercing the skin of genitalia as part of FGM should be seen as FGM. In our opinion, a child should be of sufficient maturity and have the legal capacity to give informed consent before they can have genital piercings for cosmetic purposes. However, genital piercing is abusive and should be considered as part of FGM guidance. It might be more practical to say that it should not be legally permitted before children are old enough to have sex legally.

Under the Sexual Offences (Scotland) Act 2009, children under 13 are presumed not to have the capacity to consent. The case must be referred as a Child Protection concern through the Inter-agency Referral Discussion (IRD) process. For older children aged 13-16 years, an individual assessment must be made, considering the GIRFEC principles and procedures.

A woman of any background, who makes the independent decision to undergo cosmetic piercing, has a different motivation and if the decision is hers alone and she has capacity and is an adult or over 16, we would not dispute her right to it and the right to make that decision for herself.

QUESTION 15: In relation to the issues covered within this consultation, are there any other points you would wish to make that are not already included under other answers?

RCPCH have developed a position statement on mandatory reporting that is available on request if you would find it useful.

For further information about any aspect of this consultation response, please contact Louise Slorance, RCPCH Scotland at louise.slorance@rcpch.ac.uk