

January 2015

PART A: WHAT SHOULD BE IN SCOPE OF THE MANDATORY REPORTING DUTY?

- 1. Do you agree with the government's proposal that the mandatory reporting duty of FGM should apply to cases of 'known' abuse?**
 - 1.1. The RCPCH firmly believes that the same principles and duties for safeguarding children and young people, and the reporting of child protection concerns must be consistent regardless of the type of abuse, with FGM fully integrated into existing child protection procedures and does not believe that mandatory reporting by medical professionals should be introduced.
 - 1.2. The RCPCH is particularly concerned with the language used in the document, referring to FGM as an 'extremely harmful form of child abuse' (p.8) and subsequent implications of suggesting that one form of child abuse is more serious than another, unhelpfully reinforcing a hierarchy of abuse, and potentially leading to a variation in response and care received by vulnerable children and young people.
 - 1.3. Recent government efforts through the Department of Health's FGM Prevention Programme to increase awareness and ensure health professionals are confident and competent to adequately recognise and respond to FGM are welcomed. The RCPCH has also developed several resources to raise awareness of FGM and provide support to members, including a series of video modules for paediatricians outlining the clinical features of FGM, legal implications for FGM in the UK, and the role of paediatricians working with children and families from practicing communities. The RCPCH has also supported the development of the e-Learning for Healthcare modules on FGM.
 - 1.4. Given this increased recent effort it is concerning that there has not been adequate time given for these newer initiatives to become embedded within the system prior to the introduction of mandatory reporting; a blunt legislative instrument that could undermine the cultural approach of risk and responsibility in the current child protection system.
 - 1.5. The consultation document highlights several potential risks with the introduction of mandatory reporting for FGM, and the RCPCH does not believe that these risks would be alleviated through limiting the reporting requirement to only 'known' cases. The introduction of mandatory reporting could result in a significant deterrent for young girls accessing health services; a particular risk given that

girls who have undergone FGM are likely to need a range of physical and psychosocial support, and would benefit greatly for early identification and intervention.

- 1.6. A recent interaction by one of our members with a parent of a child who had undergone FGM in their country of origin raises particular concerns. Since moving to the UK this family had been made aware of the harmful consequences of FGM and as a result had been wishing to seek health assistance for their daughter to reduce the risk of complications following the procedure. This mother of the girl expressed specific concerns about accessing health services for fear of police intervention, in light of recent media attention and the possible introduction of mandatory reporting. Therefore, the RCPCH would like to see further research undertaken into the possible consequences of this legislation on the health seeking behaviours of young girls and their families.
2. **Do you agree with the government's definition of 'known' abuse, as something which is visually confirmed and/ or disclosed by the victim?**
 - 2.1. The WHO definition of Type IV FGM includes all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization¹.
 - 2.2. The consultation document rightly points out that some forms of FGM, mainly those classified under Type IV, can be 'very difficult for even expert clinicians to confirm following a physical examination' (p.13). A retrospective analysis of FGM referrals from 2006 to 2013 carried out at an inner London safeguarding clinic found that of the 15 girls examined with FGM, 10 girls (60 per cent), were found to have a normal or near normal examination, highlighting that the physical signs of FGM may be subtle and difficult to detect without disclosure and the use of an appropriate light source and magnification².
 - 2.3. A girl's social or cognitive development may have been equally compromised in the absence of 'visually confirmable' physical signs compared with other types of FGM. The RCPCH therefore has serious concerns that excluding or reducing the emphasis placed on these types of FGM further reinforces a hierarchy of abuse, where some types of FGM are seen as more harmful than others and as a consequence treated differently.
 - 2.4. Furthermore, there are additional challenges in identifying FGM in the case of genital piercing, with professional judgement having an important role. For example, one clinician may consider a genital ring in a 17 year old girl a case of FGM while another may not; contrary to the WHO definition of FGM which clearly states that a genital piercing is a form of FGM.

¹ <http://www.who.int/reproductivehealth/topics/fgm/overview/en/>

² Hodes D, Armitage A, Dykes A. Symposium – Child Protection Special Interest Group. G165 Female genital mutilation in London and the UNICEF report; a local perspective on worldwide statistics. Arch Dis Child 2014;99:A73 doi:10.1136/archdischild-2014-306237.173

3. Do you agree with the government's proposal that the duty be limited to FGM in under 18s?

- 3.1. The RCPCH acknowledges the rationale for reducing the age limit to under 18 years, but does not agree with the overall proposal to introduce mandatory reporting.

4. Do you agree with the government's proposal that the duty should be placed on health care professionals, teachers and social care professionals?

- 4.1. All paediatricians have a responsibility to take appropriate action when they believe that a child or young person is suffering, or may be likely to suffer, significant harm. There are existing legislative and statutory requirements for all NHS bodies and all health professionals to have a duty to safeguard children and young people³. This duty of care requires them to act in the best interests of children and young people and for their welfare to be the paramount consideration. The duty also extends to cooperating with other agencies in safeguarding children and young people⁴.
- 4.2. There are duties upon professionals to be competent, reasonable, and proportionate and to act in good faith. This means exercising care, skill and professional judgement. Professionals use guiding principles such as proper reasoning, evidence-based practice, consideration of all relevant factors, effective risk assessment, consideration of all options, keeping an open mind, acting in accordance with the law, knowing and applying procedures, considering relevant guidance, consulting others, acknowledging lack of expertise and information, and fully and accurately recording concerns.
- 4.3. The current statutory guidance in England, *Working Together to Safeguard Children* (2013), states that "*if somebody believes or suspects that a child or young person may be suffering, or is likely to suffer, significant harm then s/he should always refer his or her concerns to the local authority children's social care services*"⁵.
- 4.4. The General Medical Council (GMC), as a regulatory body, has also published guidance stating that "*all doctors must act on any concerns they have about safety or welfare of a child or young person*" and "*it is vital that all doctors have the confidence to act if they believe that a child or young person may be being abused or neglected*"⁶. The GMC also reinforce that protection is afforded to those who hold an honestly and reasonably held concern.
- 4.5. The GMC have also stated that professionals "*must tell an appropriate agency, such as your local authority children's services, the NSPCC or the police, promptly if you are concerned that a child or young person is at risk of, or is suffering, abuse or neglect unless it is not in their best interests to do so. You do not need to be certain that the child or young person is at risk of significant harm to take*

³ British Parliament (2004) Children Act 2004, Section 11. <http://www.legislation.gov.uk/ukpga/2004/31/section/11>

⁴ British Parliament (2004) Children Act 2004, Section 10. <http://www.legislation.gov.uk/ukpga/2004/31/section/10>

⁵ HM Government (2013) Working Together to Safeguard Children.

<https://www.education.gov.uk/publications/eOrderingDownload/Working%20Together%202013.pdf>

⁶ General Medical Council (2012) Protecting children and young people: The responsibilities of all doctors. http://www.gmc-uk.org/static/documents/content/Child_protection_-_English_0712.pdf

*this step. If a child or young person is at risk of, or is suffering, abuse or neglect, the possible consequences of not sharing relevant information will, in the overwhelming majority of cases, outweigh any harm that sharing your concerns with an appropriate agency might cause*⁷.

- 4.6. Furthermore, the recently updated intercollegiate guidance *Safeguarding children and young people: roles and competences for health care staff (3rd Ed)* specifies that paediatricians must be able to recognise potential indicators of child maltreatment, including FGM, and be competent at Level 3.
- 4.7. Given these existing statutory and non-statutory requirements and guidance the RCPCH does not believe that an additional duty is required for health professionals.
- 4.8. However, RCPCH members have reported that a significant number of families cite concerns about FGM in their asylum claims and the duty to report concerns about FGM must be extended to home office staff and their contracted staff. Reporting by the immigration authorities should be to the Designated Doctor for Safeguarding Children, as well as to the local authorities. The Home Office must also collect data on asylum claims where FGM is cited and ensure that all such cases have a child health referral made.

5. Do you have views on any necessary differentiation between different professional groups on whether the duty should cover disclosure and/or visual identification?

- 5.1. Only clinicians who have the relevant skills and competence in the identification of FGM, in line with what is specified in the RCPCH Child Protection Companion⁸, should undertake assessment to 'visually confirm' FGM.

6. How do you think mandatory reporting of FGM should apply in the early years sector?

- 6.1. No comment

7. Do you agree with the government's proposal that all reports should be made to the police?

- 7.1. Reporting arrangements for suspected FGM should remain consistent with all forms of child abuse as outlined in *Working Together* and be consistent with those made for other types of acute injury as a result of physical abuse. All suspicions of FGM should be followed up with a multi-agency strategy discussion and referral made to a paediatrician with the necessary skills to conduct an examination.

⁷ GMC. *Protecting children and young people: The responsibilities of all doctors* (2012) www.gmc-uk.org/guidance/ethical_guidance/13257.asp

www.gmc-uk.org/guidance/ethical_guidance/13257.asp

⁸ <http://www.rcpch.ac.uk/child-protection-publications>

8. Do you agree that reports should be made at the point of initial disclosure/ identification?

8.1. Reporting should be undertaken in a timely manner, as is the case with other forms of physical abuse, working in partnership with other agencies.

9. If an individual is in contact with multiple organisations, should they be reported once, once from within a sector, or repeatedly throughout life?

9.1. An individual should only be reported once, but information related to the referral should be documented in the child's health records.

PART B: SANCTIONS FOR FAILURE TO REPORT

10. By what mechanism do you think sanctions should be placed upon individuals who fail to report FGM under the new duty?

10.1. There are already existing sanctions for failing to adequately respond to child protection concerns.

11. What level of sanction do you think should be placed upon individuals who fail to report FGM upon the new duty?

11.1. As per 10.1, there are existing sanctions in place.

PART C: STATUTORY GUIDELINES

12. Do you agree that all persons exercising public functions in relation to tackling FGM should be under a duty to have regard to the statutory guidance?'

12.1. Guidance for the management of FGM should be consistent with all other forms of child abuse.

13. Are there substantive amendments which could be made to the guidelines, which would help to prevent FGM and protect and support victims?

13.1. Reference to documenting the presence or absence of FGM in a personal child health record, or red book, should be explicitly mentioned.

13.2. The document should set out clearly the difference between mandatory reporting and mandatory recording.

ADDITIONAL QUESTIONS

14. What evidence or information do you have on the expected increase in reports to the police or social services from introducing mandatory reporting of FGM and how do you think they will vary with the different proposals?

14.1. No comment

15. What evidence or information do you have on the cost of referring FGM to the police or social services? For example, information on the length of time it takes to file a report or the length of time the police spend investigating a case will enable us to better establish the cost of the policy.

15.1. We envisage the cost would be similar to the cost of investigating a case of suspected child sexual abuse with paediatric sexual offence examination. It is estimated that investigation of each case costs approximately £3,500 as minimum.

16. What do you think the expected impact of mandatory reporting of FGM would be on the prevalence of FGM and would this change with the different proposals?

16.1. It is unlikely that the introduction of mandatory reporting of FGM would lead to a decrease in the number of girls being exposed to the procedure. Ultimately there is no credible or conclusive evidence that mandatory reporting better protects children at risk of harm, and its introduction would undermine the cultural approach working together, sharing of risk and responsibility that has been developed in the current system.

16.2. The unintended consequences of the introduction of such a policy must also be considered and evidence from other countries where mandatory reporting has been introduced indicate the following risks⁹:

- Children are discouraged from reporting abuse because of concerns about being catapulted into criminal investigation
- Heightened reporting levels overwhelm the child protection system, diverting resources and focus away from service delivery into assessment and investigation; leaving it less able to respond to meet the needs of children

⁹ <https://www.nspcc.org.uk/globalassets/documents/information-service/policy-briefing-strengthening-duties-professionals-report-child-abuse>

- Heightened reporting levels do not lead to an increase in the capacity of services to respond to need. In fact it has been shown in some cases to undermine capacity to respond
- Reporting driven by the process rather than focusing on the needs of the child
- Failing to address the underlying reasons why individuals do not report abuse.

16.3. Based on the available evidence, the RCPCH supports a system of reporting based on statutory duties and duties of care; strengthened by interagency protocols and guidance and accompanied by professional training and public education and awareness raising.

About the RCPCH

The College is a UK organisation which comprises over 15,000 members who live in the UK, Ireland and abroad and plays a major role in postgraduate medical education, as well as professional standards.

The College's responsibilities include:

- setting syllabuses for postgraduate training in paediatrics
- overseeing postgraduate training in paediatrics
- running postgraduate examinations in paediatrics
- organising courses and conferences on paediatrics
- issuing guidance on paediatrics
- conducting research on paediatrics
- developing policy messages and recommendations to promote better child health outcomes
- service delivery models to ensure better treatment and care for children and young people

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