Home Office consultation on statutory multi-agency guidance on Female Genital Mutilation

Consultation response submitted by the Royal College of Paediatrics and Child Health

September 2015

INTRODUCTION

The RCPCH welcomes the opportunity to respond to this consultation regarding the statutory multi-agency guidance on Female Genital Mutilation.

We understand that separate procedural guidance is being developed to support the introduction of a mandatory reporting duty for FGM. We strongly advise that given the plethora of existing guidance documents for FGM, that this procedural guidance for mandatory reporting, once finalised, be encompassed within the multi-agency guidance for ease of use.

Please note that we have not provided direct feedback on Section 4.1, as the RCPCH has provided extensive feedback on the mandatory reporting processes through the Department of Health Prevention Programme and as part of the cross-government working group - a copy of this feedback has been sent alongside this consultation response.

CONSULTATION QUESTIONS

1. *Do you agree that the draft statutory guidance provides frontline professionals with the information they need on the prevalence of FGM and the issues around it? If not, where and how could the guidance be changed?*

   1.1. No, see specific comments later in the response.

2. *Do you agree that the draft statutory guidance provides service delivery organisations with the information they need on the prevalence of FGM and the issues around it? If not, where and how could the guidance be changed?*

   2.1. No, see specific comments later in the response.

3. *Do you agree that the draft statutory guidance adequately captures FGM risk factors?*

   3.1. Yes. We also note that the Department of Health guidance, *Female Genital Mutilation Risk and Safeguarding; Guidance for professionals* is referenced.

4. *Do you agree that the draft statutory guidance captures the full range of legal tools and interventions to enable professionals and public sector organisations to safeguard and protect women and girls at risk of FGM?*

   4.1. Yes

5. *Do you agree that the draft statutory guidance promotes an individual-centred approach, ensuring that a woman or girl's individual circumstances drive the decision making process at all times? If not, what additions do you consider could be made to the guidance?*

5.1. No, see specific comments later in the response.

6. *Do you agree that the draft statutory guidance provides sufficient - and clear information for a) health care providers b) police c) children's social care and d) schools and colleges?*

6.1. Somewhat - see specific comments later in the response.

7. *Do you agree that the draft statutory guidance captures how professionals and public sector organisations can work with communities to prevent FGM?*

7.1. To some extent, see specific comments later in the response.

8. *Do you agree that the draft statutory guidance describes a multi-disciplinary approach which will allow for the voice of the child to be heard and respected whilst working to protect and support her? If not, where and how could it be improved?*

8.1. To some extent, see specific comments later in the response.

SPECIFIC FEEDBACK

Section 2.2

The final paragraph should state that almost all FGM takes place in childhood. The UNICEF report of 2013 confirms this. It is very unusual for FGM to occur for the first time at marriage or pregnancy. 50% of FGM is performed between 0 and 5 years and the rest under 15years.[1]

Section 2.3

Figure 1 should include Asia. There are increasing numbers of girls from Malaysia with type 4 FGM presented to UK clinics and professionals must be aware of this group.

Section 2.6

It must be made clear in this section that while "newly identified" cases of FGM may be new to the health service they are not new cases of FGM performed in the UK.

Section 2.10.1

Testing for blood-borne infections in FGM survivors is advised; however it is useful to note that there is no scientific evidence that FGM increases the risk of HIV or Hepatitis B and C. Although the circumstances in which FGM is sometimes performed make this possible, this has not been scientifically confirmed.

There is no anecdotal or scientific evidence of fractures being caused due to restraint.

[1] http://www.unicef.org/publications/index_69875.html

Section 2.10.2

This section would benefit from a more robust review of the evidence base, and should align with the RCOG FGM Green Top Guidelines[2] which is based on scientific review. The following should be specifically noted:

- There is some evidence on the specific nature of obstetric sequelae and you could specify this rather than just putting "complications of pregnancy".
- There is no evidence that FGM increases infertility, obstetric fistulae, HIV or renal failure.

Section 2.11

Line 1 should say "is an extremely traumatic experience for girls and women, with the possible exception of Type 4, which stays with them for the rest of their lives". Anecdotal feedback from clinicians suggests that many girls with type 4 FGM have minimal or no recollection and no psychological consequences.

It is clear that FGM contributes to psychological and psychosexual harm however there is little good evidence on the magnitude of this. There is no evidence on successful treatment modalities. The study quoted on PTSD by Behrendt is a small study of only 23 women. It is the only study in the world and has not been repeated. Whilst PTSD is important, there is no reason to suggest that the majority of women with FGM would need psychiatric referral for PTSD.

Section 4.3

These phrases used when talking about FGM must use language which will be understood by a lay person. For example:

- "intercourse" should be replaced with "sex"
- "menstrual difficulties " should be replaced with "period problems"

Section 4.5

Medical examinations must be carried out by a doctor familiar with the different types of FGM. Even those paediatricians experienced in genital examination of children for sexual abuse may not be familiar with the physical appearance of Type 4 FGM. It is often assumed that the detection of FGM on genital appearance will be very obvious. This is not the case. Type 4 FGM may leave no visible trace or only a small scar which must be distinguished from congenital variations and irregularities.

Children with suspected FGM are currently managed in the same way as all other suspected child maltreatment cases. This usually means a strategy meeting with social services and the police and a subsequent referral onwards for medical examination. Anecdotal feedback from the UCLH FGM clinic indicates that half of the children referred do not have FGM and there are no other issues of concern within the family. We suggest that in the case of suspected FGM, a doctor with expertise to undertake the examination be present or be able to contribute directly to the initial strategy meeting so that a decision can be made as to who, when and where the examination should take place, with the medical examination arranged at the earliest opportunity before the family has been assessed. If the child does not have FGM then the process can be halted immediately. This will cause less distress to families and reduce costs and delays associated with this work.

[2] https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf

Section 6.1

The first sentence should say 'women **and girls**'.

There should be a reference to the new RCOG Green Top Guidelines[3].

The following addition is suggested:

- "As well as specific services offered, it is essential that the designated doctor and nurse in all local areas ensure their LSCB has FGM on their annual work plan. In areas of high prevalence there should be a whole borough plan with the voluntary sector leading the prevention campaign. LSCBs should also consider convening a FGM sub-group that reports to them." This approach has been adopted by the Birmingham Children Safeguarding Board.

Section 6.2

The following changes are suggested for paragraph 4:

- "A women or girl may present at many different care settings. After an initial discussion and having met any urgent health needs, she should be offered a referral to an FGM service. For girls under 18 years of age this referral should form part of the routine multiagency assessment and should involve a paediatrician with appropriate skills and competencies, with knowledge and responsibility for safeguarding. For women over 18 years of age, the woman can decide if they wish to accept the referral. The referral may be to a dedicated FGM clinic or to another outpatient clinic where an appropriately trained professional is able to provide treatment."

The following changes are suggested to paragraph 5:

- "Recent studies have shown that the majority of girls referred in the UK have had type 4 FGM with a few cases of Type 1,2 and 3 also referred."
- "Most women **and girls** with Type 3 FGM where the vagina…"

Section 6.3

The following addition is suggested:

- "A recent cohort study in London (submitted for publication BJOG 2015) suggests that the trauma of the referral to safeguarding service is considerable and it is advisable that the girl and their family be offered a debriefing session with a psychotherapist/psychologist/other trained professional at the consultation with the paediatrician/gynaecologist."

Section 6.4

The following changes are suggested to paragraph 3:

- "FGM is not an issue that can be decided on by personal preference – it is an illegal sometimes extremely harmful practice, as well as violence against women and girls and so falls into the category of child abuse."

The following changes are suggested to paragraph 4:

- "Each NHS organisation will have local safeguarding protocols and procedures for helping children and young people who are at risk of, or facing abuse, in line with Working Together 2015."

[3] https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf

The following additions are suggested for paragraph 5:

- "FGM is a one off event that takes place at a specific time depending on a girl's background and the practise, although there is evidence that it is now being done at a younger age and in medical premises or by 'medical practitioners'. Child abuse and neglect on the other hand is usually a chronic condition that takes many forms and is often very complex. This difference should be recognised when putting in place policies and procedures to protect against FGM."
- "It is important to do a full risk assessment of the child, as it is recognised that many women and their families living in the UK do not believe in the practice. These families need to be protected when travelling to their country of origin against relatives taking their child (without their permission) to have FGM performed. Having the knowledge that it is illegal and that they will still be prosecuted even if they didn't know it was going to happen can be a powerful tool in supporting these families. The Home Office 'passport' is a useful tool for communicating this."

The following addition is suggested for paragraph 5:

- "Examinations should be undertaken by paediatricians with expertise in examining children who have been sexually assaulted or allege sexual abuse with have the skills and competencies to examine the genitalia and take a DVD recording. If there is doubt, they can then they should request a second opinion from a more experienced clinician and speaking with their named or designated professional for safeguarding."

Section 6.5

The following addition is suggested for paragraph 3:

- "If a woman or child is accompanied by a partner or parent/relative/guardian respectively, the health and social care professional must be vigilant. They must be prepared to talk to the woman and/or girl alone, using the independent interpreting service, and they should also be aware of the signs coercion and control as detailed by the Crown Prosecution Service[4]."

Section 6.7

It must be made clear that women over 18 must be asked for their consent to share their data with the DH for the enhanced FGM data set.

The following addition is suggested for paragraph 1:

- "Any concerns should be recorded within the patient's records by the healthcare professional who has obtained the information, including details of action taken. This includes all records and the red book – personal child health record."

The following change is suggested for paragraph 4:

- "On completion of an initial assessment, the outcome, as with all other conditions, must be shared with the GP and health visitor / school nurse."

The following addition is suggested for paragraph 7:

- "It may commonly present in GUM clinic and also in A&E and ITU when the patient may need catheterisation."

[4] https://www.cps.gov.uk/publications/equality/vaw/vaw_strategy.html

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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