Female Genital Mutilation

Office of the Children’s Commissioner’s response to the Home Office consultation: Introducing Mandatory Reporting for Female Genital Mutilation

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The Office of the Children’s Commissioner (OCC) is a national organisation led by the Children’s Commissioner for England, Dr Maggie Atkinson. The post of Children’s Commissioner for England was established by the Children Act 2004. The United Nations Convention on the Rights of the Child (UNCRC) underpins and frames all of our work.

The Children’s Commissioner has a duty to promote the views and interests of all children in England, in particular those whose voices are least likely to be heard, to the people who make decisions about their lives. She also has a duty to speak on behalf of all children in the UK on non-devolved issues which include immigration, for the whole of the UK, and youth justice, for England and Wales. One of the Children's Commissioner’s key functions is encouraging organisations that provide services for children always to operate from the child’s perspective.

Under the Children Act 2004 the Children’s Commissioner is required both to publish what she finds from talking and listening to children and young people, and to draw national policymakers’ and agencies’ attention to the particular circumstances of a child or small group of children which should inform both policy and practice.

The Office of the Children’s Commissioner has a statutory duty to highlight where we believe vulnerable children are not being treated appropriately in accordance with duties established under international and domestic legislation.

Our vision

A society where children and young people’s rights are realised, where their views shape decisions made about their lives and they respect the rights of others.

Our mission

We will promote and protect the rights of children in England. We will do this by involving children and young people in our work and ensuring their voices are heard. We will use our statutory powers to undertake inquiries, and our position to engage, advise and influence those making decisions that affect children and young people.

The United Nations Convention on the Rights of the Child
The UK Government ratified the United Nations Convention on the Rights of the Child (UNCRC) in 1991.1 This is the most widely ratified international human rights treaty, setting out what all children and young people need to be happy and healthy. While the Convention is not incorporated into national law, it still has the status of a binding international treaty. By agreeing to the UNCRC the Government has committed itself to promoting and protecting children’s rights by all means available to it.

The legislation governing the operation of the Office of the Children’s Commissioner requires us to have regard to the Convention in all our activities. Following an independent review of our office in 2010 we are working to promote and protect children’s rights in the spirit of the recommendations made in the Dunford report and accepted by the Secretary of State.

In relation to the current consultation, the articles of the Convention which are most relevant to this area of policy are:

**Article 2:** Children’s rights shall be respected and ensured without discrimination of any kind, and children shall be protected against all forms of discrimination on the basis of the status, activities, opinions or beliefs of their parents, guardians or family members.

**Article 3:** The best interests of the child must be a top priority

**Article 4:** The government must take all appropriate measures to implement the Convention rights.

**Article 9:** Children must not be separated from their parents unless it is in the best interests of the child. A child must be given a chance to express their views when decisions about parental responsibility are being made. Every child has the right to stay in contact with both parents unless they might harm them.

**Article 6:** Every child has the right to life. Government must do all they can to ensure that children survive and grow up healthy.

**Article 11:** Governments must take steps to prevent children being taken out of their own country illegally and prevented from returning

**Article 12:** Every child has the right to say what they think in all matters affecting them, and to have their views taken seriously.

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Article 16: Every child has the right to privacy. The law should protect the child’s private, family and home life.

Article 19: Government must do all they can to ensure that children are protected from all forms of violence, abuse, neglect and mistreatment by their parents or anyone else that looks after them.

Article 24: Every child has the right to the best possible health. Governments must provide good quality health care, clean water, nutritious food and a clean environment so that children can stay healthy. Richer countries must help poorer countries achieve this.

Article 39: Children neglected, abused, exploited, tortured, or who are victims of war must receive help to help them recover their health, dignity and self-respect.

In addition, the Istanbul Convention states:

Article 27: Parties shall take the necessary measures to encourage any person witness to the commission of acts of violence covered by the scope of this Convention or who has reasonable grounds to believe that such an act maybe committed, or that further acts of violence are to be expected, to report this to the competent organisations or authorities.

Article 28: Parties shall take the necessary measures to ensure that the confidentiality rules imposed by internal law on certain professionals do not constitute an obstacle to the possibility, under appropriate conditions, of their reporting to the competent organisations or authorities if they have reasonable grounds to believe that a serious act of violence covered by the scope of this Convention, has been committed and further serious acts of violence are to be expected.

Article 38: Parties shall take the necessary legislative or other measures to ensure that the following intentional conducts are criminalised:
   a. excising, infibulating or performing any other mutilation to the whole or any part of a woman’s labia majora, labia minora or clitoris;
   b. coercing or procuring a woman to undergo any of the acts listed in point a;
   c. inciting, coercing or procuring a girl to undergo any of the acts listed in point a.
The response below has therefore been drafted with these articles in mind. We do not propose to respond separately to every consultation question. Rather, we will respond where we feel the UNCRC gives us a locus to do so, and where our existing evidence base gives us a perspective.
Office of the Children's Commissioner response to the Home Office consultation on introducing mandatory reporting for female genital mutilation

1. The Office of the Children’s Commissioner (OCC) welcomes the Home Office’s commitment to tackling FGM as a form of child abuse and of violence against women and girls.

2. The OCC considers FGM a harmful practice and should be considered criminal and recommends that steps should be taken not only to prevent these procedures from happening, but also to provide the appropriate support for those who have undergone FGM.

3. The recent CEDAW/CRC General Comment on harmful practices calls for a holistic strategy to tackle these practices. Paras 48 and 54(j) call for mandatory reporting (MR) for professionals while protecting the privacy and confidentiality of the victim. The OCC is concerned about the extent to which these two things can be fully reconciled in practice.

4. The OCC considers that at present there is not the evidence to justify the implementation of MR for child abuse more broadly in the UK. Such a decision would require an analysis of international evidence with a view to reflecting upon what might constitute an appropriate approach in the UK context and would address the concerns so far identified in research in other countries. Even with such an analysis, we do not consider that MR on its own will provide a solution to concerns about FGM and the child protection system.

5. The Children Act 2004, sections 11 and 12, places a statutory duty on agencies to co-operate to safeguard and promote the welfare of children. Professionals are expected to follow the statutory guidance in Working Together to Safeguard Children (DfE, 2013), which has status under section 7 of the Local Authority Social Services Act 1970. This lays out the responsibilities on all professionals to share information about concerns about risk of harm to children and to co-operate with each other. There are additional professional guidelines which include expectations concerning sharing information and the management of consent and confidentiality. There are also the FGM multi-agency guidelines and overall government guidelines on how to work together and share information. Finally, there can be professional disciplinary consequences for non-reporting as well as identification of professionals in Serious Case Reviews.

6. The true prevalence of FGM is far from being known and understood. How this issue is being identified and addressed is far from being adequate and sufficient. The OCC recognises the value of introducing MR for FGM in bringing known cases to the fore. However, FGM is a form of child abuse, and like other forms of child...
abuse, we maintain the reservations we have highlighted above regarding MR. In addition, we have additional concerns regarding its applicability to known cases of FGM.

7. MR is not a legal requirement for other forms of child abuse. This means that FGM will be treated differently to other forms of child abuse in the child protection system which may lead to siloed approaches to rather than integrated approaches.

8. One argument against MR is that services would be overwhelmed because of the volume of referrals, making it impossible for them to cope. This is a serious concern as there is a related risk that high risk cases may be missed. MR is a reporting system, and does not ensure intervention.

9. The OCC has been informed of cases of FGM that have been referred to statutory services and not been adequately addressed. In spite of the increased awareness and guidance, these cases failed to be addressed by statutory services due to a lack of capacity and expertise. If MR comes into action, this will lead to an increase in cases identified and referred to statutory services. The OCC is concerned that with this increase, the needs and welfare of victims will fail to be adequately addressed once their cases have come to light. This includes therapeutic support.

10. It is imperative that all children at risk of or who have experienced FGM should be able to access help and protection. If there are many more children in need of help than are receiving it, it is essential that there is the infrastructure to respond to these children. In order to achieve this, there is a need to fully understand how existing demands on services are being managed where there are financial constraints.

11. On the basis of the work we have undertaken concerning child abuse, child protection, and FGM, we believe that there are many underpinning features essential to effective safeguarding and child protection. These include a culture and context within which children recognise risk, feel able to ask for help; know where to go for help; and are believed and confident that their needs and views will be addressed.

12. MR for ‘known’ cases of FGM would require professionals to report on confirmed cases and disclosures, or risk criminal sanctions. As has been said above, there are existing requirements to act on all cases of abuse or suspected abuse in the Working Together Guidance on child protection. Article 12 states that children have a right to express their opinion on all matters that affect them and to have their views taken seriously. This therefore places an obligation on practitioners to engage with children who are victims of FGM about any plans for their protection. Furthermore, Article 16 states that a child has a right to privacy. The relationship
between confidentiality, respect for the child’s views and the Fraser guidelines needs to be determined in this process.

13. The potential impact of fear of MR on access to healthcare for girls also needs to be considered, as this could result in other health complications relating to the detrimental impact of FGM on obstetric needs and childbirth for girls and women, as well as other health needs, e.g. attendance for cervical cancer screening.

14. Fundamental to this is an understanding of why children and young people may find it hard to tell others or making allegations against the perpetrators/family members. We consider that awareness raising, prevention and early intervention with children and families face is essential – both as they emerge and early in the child’s life. An effective response of protection and help is vital. The Munro review of child protection made substantial proposals for improvement and must be given time to develop and embed.

15. The intention of those supporting MR is to increase the potential for protection and to emphasise adults’ responsibility to protect. However, there is not yet enough evidence to suggest that MR would achieve greater protection. Experts who have studied the situation in countries where MR is in place have stated that there is as yet no empirical evidence linking MR with reduction of either child maltreatment or child deaths. The potential problems which have been identified by the NSPCC in their overview of the evidence appear to outweigh the benefits.

16. Given the particular vulnerability of children and young people in institutional settings, the OCC considers that there is a case for MR in institutional settings, where children do not have their usual sources of support.

17. FGM is being defined as occurring in predominantly BME communities. Research has highlighted that some surgical procedures involved in Female Genital Cosmetic Surgery (FGCS) procedures are equivalent to Type I and II FGM (see RCOG, 2013). These procedures, although potentially harmful if performed on children under 18, are not considered illegal on the grounds of mental and/or physical health. This means that procedures involved in FGM are only considered illegal on the grounds of custom and ritual practiced by particular BME communities. It is important to ensure that in focusing on certain cases, others are not being missed.

18. The OCC considers that FGM, including surgical procedures equivalent to Types I and II FGM, should be considered illegal for children under 18 even on the grounds of mental health. Instead, first and foremost mental health provisions should be put into place to address the needs and concerns of individuals wanting this procedure. In addition, the grounds for physical health should be clarified and if there are
alternative and less ‘risky’ solutions, then these should be explored further and implemented.

19. Finally, ‘known’ cases of FGM are by definition cases where the FGM has already happened and where the need of the child is for help and support. Significant more efforts are needed to prevent FGM from happening. The OCC has been informed of instances where young people might seek help to protect themselves and others. Further efforts are needed to support these young people in recognising FGM, seeking help, and accessing support in a safe environment.

20. Our position rests on analyses which have been undertaken so far, referenced below, concerning the broader application of MR and we are not convinced that the specific instance of FGM overrides these. These indicate that:
A. there is no empirical evidence linking MR with reduction of either child maltreatment or child deaths
B. there are indications that MR can be counterproductive, using limited resources on investigation and so diverting resources from giving help to those who need it, and
C. MR has not prevented cover-ups of abuse.

21. In not supporting MR in all settings, we are not saying that there is no responsibility on everyone to act when they suspect or discover abuse. Our position is that we are not convinced that the additional feature of having a criminal sanction adds to children’s safety.

22. We have mentioned above the guidance in Working Together (2013) on the individual and organisational responsibility to protect children and the additional guidance for specific professionals, who are also held to account through disciplinary processes.

23. There is always a need for training and for the promotion of good practice cultures so that risk and harm are better identified and professionals are clear on how to act together to address FGM and cases of risk.

24. PSHE needs to be made compulsory. FGM needs to be part of that curriculum in order to enable children and young people to identify risk and recognise the need for help and how to get it.

25. The public need to be better advised about FGM and what can be done to protect children. Public information campaigns do support this and there are advice and helplines which can provide assistance. MR by itself would not obviate the need for these.
26. The OCC would like to stress that it is opposed to forced examinations of children and young people to determine if they have undergone FGM.