

EQUALITIES AND HUMAN RIGHTS COMMITTEE

FEMALE GENITAL MUTILATION (PROTECTION AND GUIDANCE) (SCOTLAND) BILL SUBMISSION FROM ROYAL COLLEGE OF PAEDIATRICS AND CHILD HEALTH SCOTLAND

The Royal College of Paediatrics and Child Health (RCPCH) is responsible for training and examining paediatricians. The College has over 19,500 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.

1. Will protection orders and statutory guidance be more effective in preventing FGM and safeguarding those at risk of FGM than the current approach? Please explain your reasons.

FGM protection orders 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 general Child Protection Order, however we support the introduction of a specific FGM order to add further clarity and improve care for children.

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 and we look forward to their introduction in Scotland.

One concern we would like to raise is with regards to the introduction of the “failure to protect a girl at risk of FGM” order. If this is not sought for a case where it is in fact applicable, then this could be interpreted as mitigation for the perpetrator if a child was in fact taken abroad for FGM.

2. What more could the Scottish Government and public services do to strengthen FGM prevention and protection, for example on:

Anonymity of victims

We are aware that anonymity is often championed by victims of FGM to ensure protection from community or media interest. Although anonymity may seem a sensible addition to the legislation, we feel that existing legislature already covers this situation to a satisfactory degree, and there is unlikely to be a benefit from introducing additional laws. Adding an anonymity option in to this legislation could make the procedure more complicated, particularly if anonymity was not sought, as this could lead to a false understanding that it was acceptable for the media to release the alleged victim’s name.

To strengthen the existing media coverage convention for sexual assault cases, which includes FGM cases, we would recommend that appropriate sanctions, for example a fine, are imposed for websites or newspapers that continue to publish the names of victims of FGM.

Failure to protect a girl at risk of FGM

The introduction of an offence of failure to protect a girl at risk of FGM might provide further deterrent for perpetrators of FGM, which would be welcome. 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. However, 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.

Although we support the introduction of this offence, it is important to note that we should continue to prioritise pursuing the people who are actively committing or facilitating the FGM,, and not focus too heavily on the family members, who are probably less powerful within the family.

Duty to notify the police of FGM

We do not recommend a duty to report to the police of FGM in all circumstances. Instead there should be an overall duty on all professionals to follow child protection procedures where a girl is considered at risk of FGM, and an appropriate response should be in place locally. For example, 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, 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. Until issues are explored and the parents are asked if their families practise FGM, you cannot establish this.

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. Therefore, if the agreed threshold for triggering an IRD is not reached, then there should not be a duty to notify the police. The danger of introducing a duty to notify the police is that there would have to be an IRD for every girl from most of Africa and much of Asia.

Experience in Lothian has shown that the majority of families are protective and appropriate towards their daughters and with support from healthcare and social work staff engagement, 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 required¹.

Despite this under specific circumstances a duty to report to the police should apply. Where it is known that 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. .

Consistency and clarity in practice can be achieved through good statutory procedures, and there should be an agreed threshold for triggering an IRD. If the agreed threshold for triggering an IRD is not reached, then there should not be a duty to notify the police. This method of response is aligned with community views, and limits the risk of alienating already vulnerable women.

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

Additional protections

Members of the RCPCH Child Protection Committee have limited clinical experience of vaginal elongation or breast ironing. However, these practices

should be considered child abuse as they can cause significant pain and discomfort. Existing legislation should already cover all types of abuse and assault on a person, including the above.

All methods of harm to women and children do not need to be named in legislation relating to FGM. Recently, the Crown Prosecution Service in England and Wales issued new legal guidance making it clear that, although it is not named as a specific offence, breast ironing is a crime that can be charged under existing law. We recommend that similar guidance is issued alongside new FGM legislation to make similar clarifications, reassure victims and give warning to perpetrators.

Piercing the skin of genitalia as part of FGM should be seen as FGM. 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. We recommend that it would be more practical to say that genital piercing should not be legally permitted until the age of legal consent for sexual activity is reached.

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.

Communicating with communities

Paediatricians play a key role in communicating with immediate family and carers in FGM cases. We therefore support the introduction of statutory guidance to support families in understanding that professionals have a duty to act.

3. How will the Bill impact on you, your community or organisation?

Previously, the difficulty has been that statutory guidance does not specifically address FGM risk and FGM 'does not fit' into the conventional models of child abuse. Ensuring that information is shared within and across agencies is challenging. Ensuring that staff are empowered and confident to address such a sensitive subject necessitates detailed direction and responsibility, specific to FGM. Experience shows us that unless this is explicit, professionals fail to appropriately risk assess and protect girls. The introduction of this bill should

address these issues.

4. Please highlight any relevant equalities and human rights issues you would like the Committee to consider, in particular any potential barriers to accessing the provisions of the Bill or any rights which might be advanced or adversely impacted.

RCPCH support the principles of taking a children's rights approach to all policies, which should ensure:

- Children's best interests are always central
- The voice of the child is at the centre
- Children's views are taken into account and given due weight
- A holistic approach which looks at the whole child and not just their status e.g. a disabled child

Under article 24 all children have the right to be as healthy as they can be and to access health services. This right needs to be embedded in all health services for infants, children and young people, including the FGM assessment. Children have the right to be involved in decisions that affect them in an appropriate way and health professionals must ensure their views are included in decisions about their care (following the principals of article 12).

RCPCH has a policy to reference the relevant UNCRC articles in all communications to increase awareness both with children and those who care for children, focusing particularly on the following 5 articles as identified by children and young people from the RCPCH &Us network:

- **Article 12** – right to be involved in decisions that affect you, from individual care decisions through to shaping health services that you might use
- **Article 23** – infants, children and young people with disabilities have the right to be involved, which includes having appropriate communication support within health care appointments and engagement work
- **Article 24** – the right to best health care possible, thinking here about child and youth friendly health services
- **Article 28** – the right to education, including as in inpatient, structuring services to avoid missing school due to medical appointments, engagement sessions in evening and weekends/school holidays
- **Article 31** – the right to rest, relax and play to include support for parents of children with complex health needs to think about how to engage in social activities, and to provide services that support socialising with their peers (clinic times).