



House of Commons  
Home Affairs Committee

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# Female genital mutilation: abuse unchecked

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**Ninth Report of Session 2016–17**

*Report, together with formal minutes  
relating to the report*

*Ordered by the House of Commons to be printed  
6 September 2016*

## Home Affairs Committee

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# 1 Introduction

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## Background to this report

1. Our predecessor Committee published two reports on female genital mutilation (FGM) towards the end of the last Parliament. Its over-riding conclusion in July 2014 was that “FGM is a severe form of gender-based violence, and where it is carried out on a girl, it is an extreme form of child abuse. Everyone who has a responsibility for safeguarding children must view FGM in this way. While welcoming action taken by the Government and the impressive work undertaken by campaigners, the follow-up report, published in March 2015, concluded that insufficient progress had been made in tackling this pernicious problem, particularly in relation to prosecutions.<sup>1</sup> We therefore decided it was right to revisit this issue to assess whether further positive developments had taken place.

2. In July 2016 we hosted a roundtable discussion on FGM that brought together survivors, grassroots organisations, clinicians, representatives from the criminal justice system and educationalists. In recent years the profile of FGM has risen significantly across Parliament, the media and the public, largely as a result of the tireless efforts by campaigners and public servants including those who attended the roundtable.<sup>2</sup> We would like to thank all those who contributed to the discussion as well as those who attended the event as invited guests in the audience. The roundtable informed an evidence session with Karen Bradley MP, the then Minister for Preventing Abuse, Exploitation and Crime, on 12 July 2016.<sup>3</sup>

## The nature, scale and geographical spread of FGM

3. The World Health Organization (WHO) defines female genital mutilation as “all procedures involving the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons”.<sup>4</sup> There are four main types:

- **Type 1** (clitoridectomy), which involves partial or total removal of the clitoris and, in rare cases, only the prepuce;
- **Type 2** (excision), which involves partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora;
- **Type 3** (infibulation), which involves narrowing of the vaginal opening through the creation of a covering seal, which is formed by cutting and repositioning the inner or outer labia, with or without removal of the clitoris; and
- **Type 4** (other), which comprises all other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing or incision of the clitoris and/or the labia; stretching of the clitoris and/or labia; and cauterisation or burning of the clitoris and surrounding tissues.<sup>5</sup>

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1 Second Report of Session 2014–15, [Female genital mutilation: the case for a national action plan](#), HC 201, para 8; and Sixteenth Report of Session 2014–15, [Female genital mutilation: follow-up](#), HC 961

2 Home Affairs Select Committee, [Roundtable Discussion on Female Genital Mutilation](#), 6 July 2016

3 Oral evidence taken on [Female Genital Mutilation](#), 12 July 2016

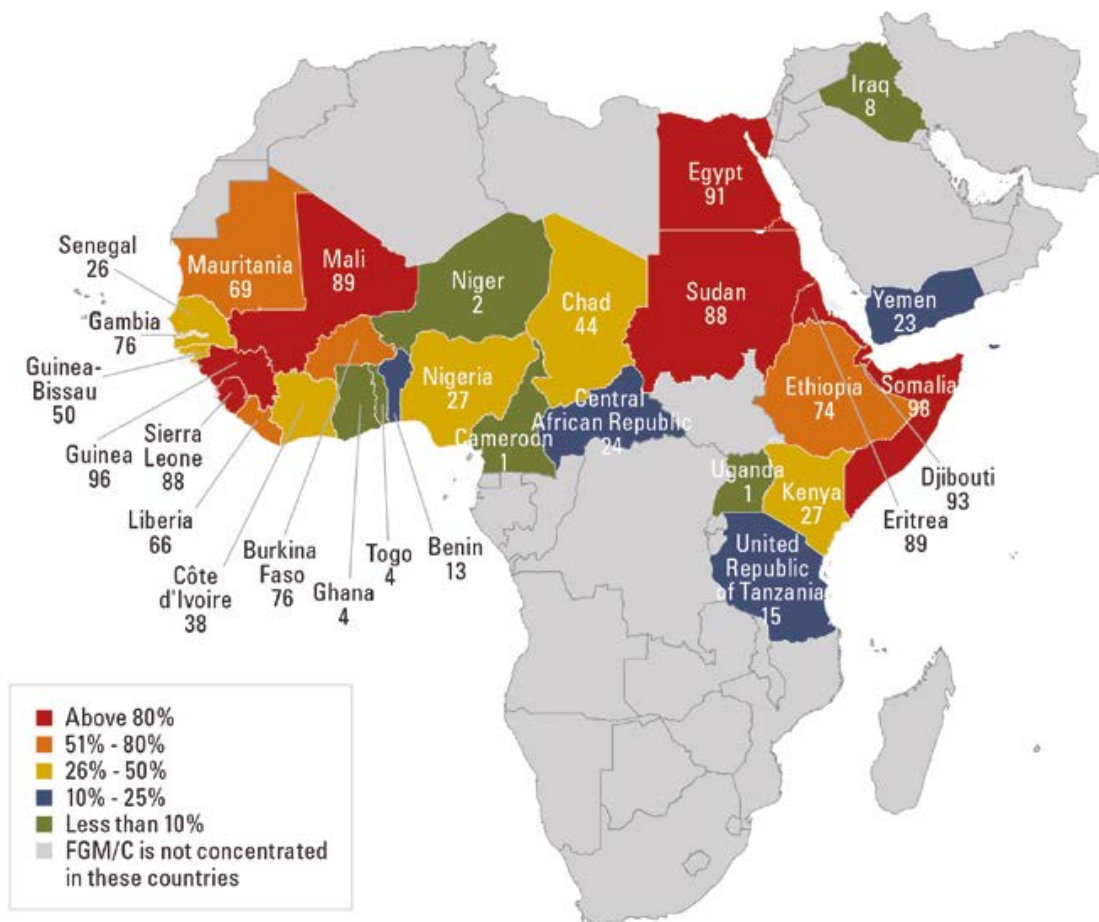
4 World Health Organization, [Female genital mutilation, Factsheet No. 241](#), February 2014

5 [NHS, Female Genital Mutilation \(FGM\)](#)

International bodies such as the United Nations and the WHO are unanimous that FGM has no health benefits and leads to short- and long-term physical and psychological harm. In the short term, FGM can result in severe pain, excessive bleeding, fever, urinary problems and even death. Longer-term effects include menstrual problems, difficulties in childbirth, sexual problems and psychological trauma.<sup>6</sup>

4. FGM is practised in more than 29 African countries and by certain ethnic groups in the southern part of the Arabian Peninsula and along the Persian Gulf. It is concentrated in the Horn of Africa but it is also highly prevalent in other countries in North, East and West Africa.<sup>7</sup> The WHO has also reported FGM in India, Indonesia, Iraq, Kurdistan, Israel, Malaysia and the United Arab Emirates.<sup>8</sup> It has been estimated that more than 200 million women worldwide have been subjected to FGM and three million girls are believed to be at risk each year.<sup>9</sup> The map below shows the percentage of women and girls aged 15 to 49 years who have been subjected to FGM in countries where it is most prevalent.

**Figure 1: Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by country**



Source: Unicef, [Female Genital Mutilation/Cutting: a statistical overview and exploration of the dynamics of change](#), July 2013, page 26

6 World Health Organization, [Female genital mutilation](#), Factsheet No. 241, February 2016

7 Unicef, [FGM/C infographic](#)

8 World Health Organization, [Eliminating female genital mutilation: An interagency statement](#), 2008

9 World Health Organization. [Female genital mutilation](#), Factsheet No. 241, February 2016

5. Worldwide, the incidence of FGM is falling. Girls are a third less likely to be subjected to it today than they were 30 years ago. In part, that is the result of a surge in activity over the last 25 years to eradicate FGM, with efforts to collect more useful data to enhance understanding of the practice and its prevalence.<sup>10</sup> Unfortunately the pace of the decline is not spread evenly. Low prevalence countries have reduced the practice faster than high prevalence countries; in Egypt, Djibouti and Somalia, for example, FGM remains almost universal. Furthermore, the current rate of progress in eliminating FGM is not sufficient. Population growth, particularly in Africa, means that on current trends the number of girls subjected to FGM will grow from 133 million now to 196 million in 2050.<sup>11</sup>

6. The reasons FGM is performed vary from one region to another as well as over time. There is a common assumption that FGM has a basis in religion; that is false. Religious leaders take different positions on the practice—some promote it, some consider it irrelevant to religion, and others contribute to its elimination. In some ethnic groups, FGM can be seen as a rite of passage to adulthood and a prerequisite for marriage. It is often motivated by beliefs about what is considered acceptable sexual behaviour in that sometimes it is done to ensure premarital virginity and marital fidelity. For some African women, marriage and reproduction are the only means of ensuring economic security and social status. Where it is believed that being cut increases the opportunity to marry, it is more likely to be carried out.<sup>12</sup>

7. FGM is usually carried out on girls between infancy and the age of 15, with the majority of cases occurring between the ages of five and eight. In most countries it is carried out by a traditional practitioner with no formal medical training, without anaesthetics or antiseptics. Knives, scissors, scalpels, pieces of glass, or razor blades are used. In some countries FGM is now carried out by health professionals but that does not necessarily reduce risk. Inexperience can lead doctors to cut more severely than traditional practitioners. In Egypt a 17 year old girl died during an FGM operation at a private hospital in May 2016.<sup>13</sup>

## FGM in the UK

8. In the UK, the existence of women and girls living with the effects of FGM is almost wholly the result of migration from practising countries. Some have questioned whether FGM can be eradicated in the UK before it is eradicated in Africa.<sup>14</sup>

9. The practice has been illegal in the UK since 1985 but the covert nature of the crime has made it difficult to prosecute. It took 29 years before the first FGM-related prosecution was brought to trial in the UK. The defendants were found not guilty.

10. The Government has made significant efforts to raise the profile of the dangers of FGM and to identify ways to eradicate it within a generation. In July 2014, the then Prime Minister, Rt Hon David Cameron MP, hosted the UK's first ever Girl Summit. At the Summit, the Government announced a range of measures to help eradicate FGM which

10 UNICEF, [Female Genital Mutilation/Cutting: what might the future hold?](#), 2014

11 UNICEF, [Female Genital Mutilation/Cutting: what might the future hold?](#), 2014

12 WHO, [Female Genital Mutilation factsheet](#), February 2016

13 Guardian, [Egyptian girl dies during banned female genital mutilation operation](#), 31 May 2016. FGM has been illegal in Egypt since 2008 but social norms mean the practice is still endemic.

14 Department for International Development, [The UK announces a range of measures to end Female Genital Mutilation/Cutting](#), 6 February 2014

have now been implemented. Those included lifelong anonymity for survivors, legislation to enable parents to be prosecuted if they failed to prevent their daughter being cut, FGM Prevention Orders and a specialist FGM Unit to identify and respond to FGM.<sup>15</sup>

11. This report provides a further update on the extent to which these measures have been effective in tackling FGM, since our predecessors last reported on this subject in March 2015 and points to the additional action we regard as necessary to combat this criminal activity.

**12. FGM is not a religious or cultural rite of passage that deserves protection. When it is inflicted on a woman, it is a horrific crime. When it is inflicted on a girl, it is violent child abuse. It involves young girls' genitalia being cut with scissors, a razor, a knife or even glass, usually with no anaesthetic or antiseptic. It causes severe physical and psychological pain and leaves survivors with lifelong health consequences. Everyone involved in protecting children needs to be aware of, and prevent, this specific form of abuse. This responsibility also extends to the wider community and to all professionals whose roles bring them into contact with children.**

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<sup>15</sup> Home Office, [New measures to tackle female genital mutilation and forced marriage announced at today's Girl Summit](#), 22 July 2014



## 2 Measuring the problem

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### City University Study

13. Precise data on the prevalence of FGM in the UK remains elusive despite improvements to the quality of research that has been undertaken in recent years. In 2015 the Home Office attempted to enhance its understanding of the scale of FGM in England and Wales by part-funding a study by City University. The study examined data on the incidence of FGM in countries in which it traditionally occurs and then projected incidence rates onto the relevant immigrant communities in England and Wales, the size of which were derived from the 2011 Census. The study estimated that there were approximately 137,000 women and girls subjected to FGM who were permanently resident in England and Wales in 2011.<sup>16</sup>

14. The study also found that almost every local authority area was likely to contain women living with the effects of FGM and provided an indication of where cases of FGM were likely to be concentrated—London had by far the highest prevalence at an estimated 28.2 per 1,000 women aged 15–49.<sup>17</sup>

15. Although it represented a credible starting point for measuring FGM prevalence, the study itself acknowledged some of the limitations, including that it did not take account of migration that had taken place since 2011 and that it was problematic to assume that the prevalence of FGM in practising countries was necessarily mirrored in the diaspora from those countries. It also identified that in some countries there were strong regional or social variances in FGM practices which would mean that women who emigrate might not be representative of a country as a whole. Moreover, attitudes within a diaspora are not fixed; grassroots groups have had a great deal of success in encouraging families to abandon FGM at community level and it was not possible to take account of this kind of attitudinal change in the method used by the study.<sup>18</sup>

16. The study suggested that approximately 60,000 girls aged 0–14 years were born to women who had undergone FGM. Karen Bradley, then Minister for Preventing Abuse, Exploitation and Crime, told us that this figure represented the “sorts of numbers we are talking about who are at potential risk.”<sup>19</sup> However, the City University Report itself was more cautious of making such a claim:

Our earlier report attempted to assess the numbers of girls born in England and Wales who could be described as being ‘at risk’. This is no longer appropriate. On the one hand, qualitative research has shown that attitudes to FGM have changed on migration and in response to community based programmes and many families have abandoned it while on the other, there

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16 City University, [Prevalence of Female Genital Mutilation in England and Wales: National and local estimates](#), July 2015, p5

17 City University, [Prevalence of Female Genital Mutilation in England and Wales: National and local estimates](#), July 2015, p18

18 City University, [Prevalence of Female Genital Mutilation in England and Wales: National and local estimates](#), July 2015, page 14

19 Oral evidence taken on [Female Genital Mutilation](#), 12 July 2016, Q29. Karen Bradley MP was replaced by Sarah Newton MP as the Minister responsible for FGM policy on 17 July 2016

are still reports of girls living in England and Wales being subjected to FGM or threatened with it. In neither case, has the extent been quantified in a way which can be used in numerical estimates at a population level.<sup>20</sup>

17. **Some progress has been made in the collection of data on FGM. However, the Government must adopt a more sophisticated, data-driven approach to eradicating it. It is a hidden crime and the first step towards tackling it effectively is to measure it properly. Only then can resources be allocated accordingly. In the UK, despite the publicity surrounding the Government's Summit on FGM in 2015, there is still a paucity of information on the scale of FGM, on its trends over time and on the number of girls at risk. There have been a small number of statistical analyses and data-gathering exercises but they have been conducted in isolation and without reference to a national strategy. As a result the statistics lack the necessary degree of utility to safeguarding and law enforcement agencies.**

18. **We recommend that the Home Office identify a more reliable methodology for measuring the number of girls at risk of undergoing FGM in the UK. This approach would be best served by engaging directly with women and families affected by FGM, for example through the use of anonymised surveys of a statistically meaningful number of women in families from practising countries. Research should also seek to ascertain attitudes towards FGM, including motivations for continuing to use the procedure, and awareness of the law prohibiting it. It should also be used as an opportunity to learn exactly where in practising countries women had their FGM carried out. Such information would enrich the international intelligence picture, including for UK Border Force staff in their work to prevent girls from being taken abroad to undergo FGM.**

## Mandatory recording

19. In a further effort to gather more information on FGM in the UK, data has been collected across the NHS since April 2015 as part of the Department of Health's prevention programme.<sup>21</sup> It became mandatory for all NHS acute healthcare Trusts to report and submit information to the FGM Enhanced Dataset from 1 July 2015 and for all mental health trusts and GP practices to do this from 1 October 2015.<sup>22</sup> Clinicians across all NHS healthcare settings are required to record when a patient with FGM is identified as part of clinical examination during routine care provision.<sup>23</sup> The data collected are sent to the Health and Social Care Information Centre (HSCIC), where the information is anonymised, analysed and published in aggregate form. The full dataset contains 30 data requirements including patient demographic data, specific FGM information and referral and treatment information. Controversially, healthcare professionals are required to submit patient identifiable data which is then centralised. The Department of Health

20 City University, [Prevalence of Female Genital Mutilation in England and Wales: National and local estimates](#), July 2015, page 26

21 Mandatory recording should not be confused with mandatory reporting which is the requirement to report FGM cases in under 18s to the police and is assessed below.

22 [The Health and Social Care Information Centre \(Female Genital Mutilation\) Directions 2015](#)

23 HSCIC, [Female Genital Mutilation \(FGM\) Enhanced Dataset: April 2015 to March 2016, experimental statistics](#), 21 July 2015, page 6

has stated that personal information is collected only for internal quality assurance and to avoid duplicate counting.<sup>24</sup> Although patient consent does not need to be sought, transparency is required.<sup>25</sup>

20. The HSCIC published the first annual collection of mandatory recording results in July 2016.<sup>26</sup> The table below shows the local authority areas with the highest prevalence of FGM.

**Table 1: Local authority areas with highest FGM prevalence, England, April 2015 to March 2016**

| Local authority | Newly recorded | Local authority | Total attendances |
|-----------------|----------------|-----------------|-------------------|
| Birmingham      | 435            | Brent           | 1250              |
| Bristol         | 385            | Bristol         | 705               |
| Brent           | 325            | Birmingham      | 520               |
| Manchester      | 310            | Harrow          | 460               |
| Southwark       | 290            | Ealing          | 355               |
| Enfield         | 215            | Manchester      | 350               |
| Ealing          | 175            | Southwark       | 320               |
| Lambeth         | 175            | Enfield         | 265               |
| Sheffield       | 165            | Lambeth         | 200               |
| Camden          | 140            | Sheffield       | 185               |
| Greenwich       | 130            | Camden          | 175               |
| Leeds           | 125            | Hillingdon      | 175               |

Source: HSCIC, [Female Genital Mutilation \(FGM\) Enhanced Dataset: April 2015 to March 2016, experimental statistics](#)

**Notes:** Newly Recorded women and girls with FGM are those who have had their FGM information collected in the FGM Enhanced Dataset for the first time. This will include those identified as having FGM and those having treatment for their FGM. 'Newly recorded' does not necessarily mean that the attendance is the woman or girl's first attendance for FGM.

Total Attendances refers to all attendances in the reporting period where FGM was identified or a procedure for FGM was undertaken. Women and girls may have one or more attendances in the reporting period. This category includes both newly recorded and previously identified women and girls.

#### The results identified:

- 5,702 newly recorded cases of FGM and 8,656 total attendances where FGM was identified or a procedure for FGM was undertaken;
- 43 newly recorded cases of FGM involving women and girls born in the UK. Of those with a known FGM type, more than 40% were reported with FGM Type 4—Piercing;
- 18 newly recorded cases of FGM reported to have been undertaken in the UK, including 11 women and girls who were born in the UK. Where the nature of the procedure was known, around 10 were reported with FGM Type 4—Piercing;
- 52% of newly recorded cases and 58% of total attendances related to women and girls from the London NHS Commissioning Region;

24 Department of Health, [FGM prevention programme](#), September 2015, page 3

25 To meet the requirement to provide a 'fair processing' notification to patients, clinicians are required to give the patient the FGM leaflet "[More information about FGM](#)" (2015)

26 HSCIC previously published data on a quarterly basis

- 90% of women and girls with a known country of birth were born in an Eastern, Northern or Western African country; 6% were born in Asia; and
- Types 1 and 2 FGM had the highest rate of incidence, 35% and 31% respectively, where the FGM Type was known.<sup>27</sup>

21. In July 2015, the then Minister said that the data published by HSCIC “will provide more information on where and when FGM took place so we can get a better understanding of the scale of the crime taking place within the UK.”<sup>28</sup> HSCIC’s annual figures show that 177 NHS trusts (73.4%) and 664 GP practices (8.7%) are registered on the FGM Enhanced Dataset collection system. Of those, just 150 organisations submitted one or more attendance records during the reporting period—112 NHS trusts and 38 GP practices.<sup>29</sup> In London, where the majority of FGM cases are believed to be located, just six out of approximately 1,500 GP practices recorded cases.<sup>30</sup>

**Table 2: Number of NHS organisations recording FGM cases, England, April 2015 to March 2016**

|  | London | Midlands and East England | North of England | South of England | Total |
|--|--------|---------------------------|------------------|------------------|-------|
| NHS Trusts                             | 23     | 32                        | 34               | 23               | 112   |
| - Providing mental health services     | 6      | 4                         | 4                | 1                | 15    |
| - Not providing mental health services | 17     | 28                        | 30               | 22               | 97    |
| GP practice                            | 6      | 11                        | 16               | 5                | 38    |
| Total                                  | 29     | 43                        | 50               | 28               | 150   |

Source: HSCIC, [Female Genital Mutilation \(FGM\) Enhanced Dataset: April 2015 to March 2016, experimental statistics](#)

Much of the data submitted is incomplete. For instance, the FGM type was recorded for only 44% of women; the country of birth was recorded for only 38%; and the age when FGM took place was recorded for only 24%. Data relating to other metrics was similarly incomplete.

22. Alison Macfarlane, Professor of Perinatal Health, City University, was reported as saying that the incompleteness of the data “calls into question the usefulness of the statistics for planning services” and recommended using anonymised, sample surveys in future.<sup>31</sup> She noted that many clinicians were uncomfortable with the requirement to record data on women affected by FGM without asking for their consent, “even though it would be feasible to ask them”.<sup>32</sup>

27 HSCIC, [Female Genital Mutilation \(FGM\) Enhanced Dataset: April 2015 to March 2016, experimental statistics](#), 21 July 2015, page 4

28 Home Office, [Government response to the Home Affairs Committee Report, Female Genital Mutilation: follow-up](#), 22 July 2015

29 There were 241 NHS trusts and about 7,600 GP practices active at the start of the reporting period (1 April 2015)

30 HSCIC reported that more women and girls newly recorded with FGM lived in the London NHS Commissioning Region (51.5%) than in any other commissioning region.

31 Guardian, [Caution needed with FGM statistics](#), 27 July 2016. Alison Macfarlane conducted the City University study on FGM prevalence in England and Wales

32 Guardian, [Caution needed with FGM statistics](#), 27 July 2016

23. A letter from clinicians published by the British Medical Journal in September 2015 summarised the concerns. The authors said the commitment not to release patient identifiable data to third parties (such as the police and the Crown Prosecution Service) was “inadequate and not future-proofed”. Furthermore, there was dissatisfaction that frontline clinicians were responsible for explaining to patients that data would be collected. The letter said, “The initiative has no evidence of benefit, wastes precious clinical time, and will profoundly damage trust in health professionals who will either collude or ignore the imperative.”<sup>33</sup>

**24. Since 2015, there has been a requirement on clinicians to record and report FGM cases which they identify as part of clinical examinations. While we agree that they are best placed to help to measure this appalling crime, we are not convinced that the present standard of recording meets the Home Office’s expectation that it will lead to a “better understanding of the scale of the crime taking place”. The most conspicuous weakness in the data is its incompleteness which makes it difficult to use to set benchmarks against which trends can be measured. We are alarmed by reports that some clinicians are ignoring the requirement to record data on the basis that they do not recognise its purpose. We expect NHS employers and the Royal Colleges to take a hard line against such attitudes and call for the Department of Health to write to frontline clinicians to remind them of the duty, and the purpose of mandatory recording, and to reissue guidance. In areas where recording is far below expectations, training on the harm resulting from FGM, the importance of fulfilling the duty to record FGM incidence and dealing with affected women should be commissioned.**

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33 [BMJ, Letters: Mandatory submission of patient identifiable information to third parties: FGM now, what next?](#), 21 September 2015

## 3 Safeguarding girls

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### Prevention policy

25. FGM prevention often requires collaboration between the health, social care, education and law enforcement sectors. However, we heard during our roundtable discussion that there was an absence of joined-up work across those sectors. A number of Government departments operate FGM prevention and safeguarding initiatives, including the Department for Education, the Department of Health and the Home Office, each with their own focus, budgets and expertise. There is evidence of some duplication of effort and that resources are not being used as efficiently as they should be. For example, both the National FGM Centre, a partnership between Barnardo's and the Local Government Association funded by the Department for Education, and the Home Office-funded FGM Unit reach out to communities to change attitudes on FGM through consultancy, training, conferences and workshops.

26. Dr Ann-Marie Wilson, Executive Director of the campaigning organisation 28 Too Many, commented during our roundtable discussion that there were significant gaps between the different safeguarding stakeholders. Vanessa Lodge, Director of Nursing for North Central and East London, praised recent improvements to Department of Health risk assessment tools, but said that collaboration between social care and health in particular needed to be strengthened. Sue Mountstevens, Police and Crime Commissioner for Avon and Somerset, said that the police lacked access to sufficient information from the social care and health sectors to support the safeguarding process. She said the police should have greater access to their risk assessment and safeguarding tools.

**27. The multi-agency approach to tackling FGM has been hampered by the absence of a central authority to co-ordinate expertise, manage resources and adjust strategy when it is found to be failing. We recommend that this is addressed through the FGM Unit, hosted by the Home Office, being given the remit, powers and budget to become the sole source of Government policy for safeguarding at-risk girls and eradicating FGM. The Unit should be a joint enterprise between the Home Office, the Department of Health and the Department for Education in the same way that the Forced Marriage Unit is a joint enterprise between the Home Office and the Foreign and Commonwealth Office. Linking the expertise and resources of those Departments, and ensuring that they liaise fully with responsible authorities in the devolved governments, will ensure the greatest chance of successfully meeting the Government's ambition to eradicate FGM within a generation.**

**28. Without a powerful, central co-ordinator, we are concerned that finite resources to fight FGM will not be as well-targeted or used as efficiently as they should be. A single reporting and safeguarding system would be the best approach to removing some of the institutional barriers that presently prevent effective safeguarding and would be a suitable project for a redefined FGM Unit.**

### The experience in France: routine medical examinations

29. In France, children up to the age of six generally undergo regular medical check-ups which include examination of the genitals. Check-ups are not mandatory, though they

are routine and receipt of social security is dependent on participation. Girls identified to be at risk of FGM are usually examined every year and when they return from abroad. Medical practitioners are expected to set aside patient confidentiality and to report cases of physical abuse against children. Linda Weil-Curiel, a Paris-based lawyer who attended our roundtable discussion, advocated routine medical examinations, believing them to be one of the main drivers behind France's high rate of successful prosecutions for FGM. She conceded that the examinations had led to some unintended consequences, in that the age at which girls undergo FGM had risen as parents seek to avoid detection by healthcare staff. She told us:

In the 1980s, we had a lot of babies who had been cut, and then no more until the 1990s. Then they changed the practice and did it between six years and 11 years. We had training for teachers and school doctors, so that they saw girls who were happy before the holidays and then sad after, and they do report. They stopped cutting between six and 11. There have been some trials. That is our difficulty now. At the end of primary school, they take away the girls to Mali and Senegal, and then, at 11 or 12 years, they cut them.<sup>34</sup>

30. The UK does not have a comparable system of regular medical checks for all children. Neil Moore, Principal Legal Advisor to the Director of Public Prosecutions, saw it as a distinct advantage of the French system and a principal reason for their success in securing prosecutions.<sup>35</sup> However, the Minister was not convinced by the idea of routine examinations; she said, "I just have a nervousness about going down any route where we are forcing young people to have a very intimate examination, when I think we can find other ways to detect this crime."<sup>36</sup>

**31. It is likely that routine medical examinations of children under age six in France have resulted in a large number of successful prosecutions in relation to FGM and contribute to the safeguarding of vulnerable girls. This would be a radical change in practice in the UK and there is a strong case for its implementation in this country. However, it should be noted that it has been shown that the French system has to some extent deferred the problem by encouraging some parents simply to wait for their daughters to get beyond the usual age range for the routine medical examinations before having them cut. We are also concerned that the examination itself could be unnecessarily traumatic for children. Nevertheless, we believe medical examinations can have a role as a last resort in particularly high-risk cases. As improvements to risk assessment methods continue, there may be a stronger case for a system that requires health professionals to carry out regular medical checks when a girl is identified as being at high risk.**

## Tackling FGM at the UK border and in schools

32. Schools have a key role in tackling FGM—first through identifying and reporting potential or actual victims and second by raising awareness about the practice among pupils. The six-week school summer holiday is thought to be a particularly dangerous

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34 Home Affairs Select Committee, [FGM roundtable discussion](#), Q38

35 Home Affairs Select Committee, [FGM roundtable discussion](#), Q41

36 Home Affairs Select Committee, [Female Genital Mutilation](#), Q8

time of the year for girls at risk; it is a convenient time for them to be taken abroad in order for the procedure to be carried out because girls need several weeks to heal before returning to school.

### *Airside operations*

33. It is clear that effective intelligence at the borders, particularly airports, is required to prevent girls being taken out of the UK and sent ‘home’ for FGM to be carried out. During our roundtable discussion, Detective Chief Superintendent Gerry Campbell representing the National Police Chiefs’ Council (NPCC), provided an update on Operation Limelight, an airside operation at airports across the UK that targets inbound and outbound flights to countries where FGM is prevalent. Metropolitan Police officers undertake a combination of educational and enforcement activities, including the provision of training to airport staff, preventative work with passengers on outbound flights to FGM-prevalent countries, and identifying possible offences in order to take action against those responsible.<sup>37</sup> Gerry Campbell said that at Heathrow, 10,000 people had been engaged with, five people had been arrested and four young girls had been taken into police protection to safeguard them.<sup>38</sup> Sarah Newton, Parliamentary Under Secretary of State for Vulnerability, Safeguarding and Countering Extremism, told us in written evidence, following up the oral evidence from her predecessor, that all frontline Border Force staff are expected to undertake an e-learning course on how to identify women and girls at risk of FGM leaving or returning to the UK and that 2,311 Border Force staff have completed that training. New e-learning for Border Force staff on Modern Slavery also includes a module about FGM.<sup>39</sup>

34. Police and Border Force operations that target passengers travelling between the UK and high prevalence countries will not reach all girls at risk of being subjected to FGM overseas as countries that are considered to have moderate or even low levels of FGM incidence can still contain regions where incidence is high. For example, “data from Senegal show that 26 per cent of girls and women aged 15 to 49 have undergone FGM/C. At the regional level, FGM/C prevalence ranges from a low of 1 per cent in Diourbel (the region with the lowest prevalence) to 92 per cent in Kedougou (the region with the highest prevalence).”<sup>40</sup> The map below shows the percentage of girls and women aged 15 to 49 years who have undergone FGM by regions within countries.

37 Gov.uk, [Border Force targets ‘high risk’ flights at Heathrow to stop female genital mutilation](#), 9 May 2014

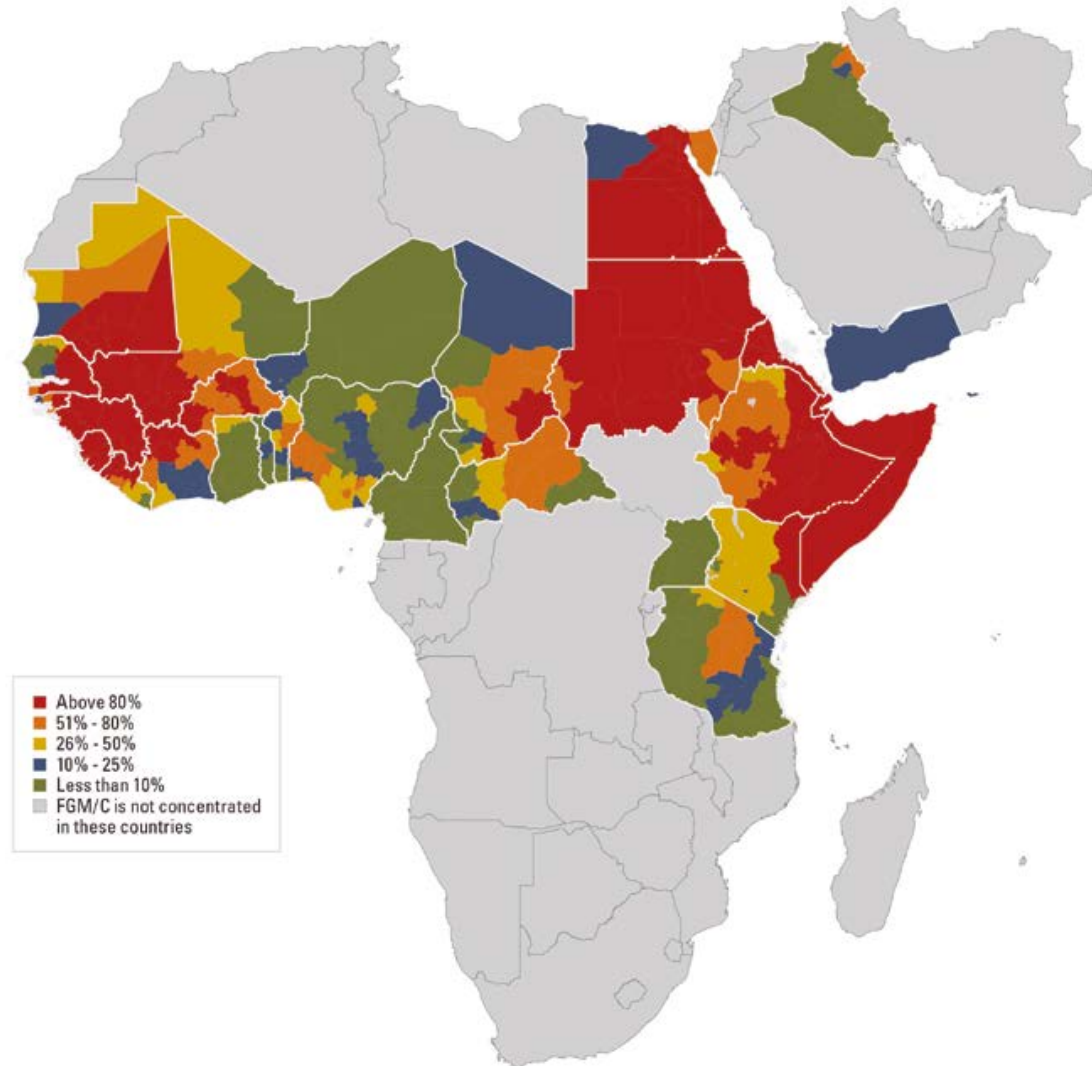
38 Home Affairs Select Committee, [FGM Roundtable discussion](#), Q24

39 Letter from Sarah Newton to the Chair of the Committee, [21 July 2016](#)

40 Unicef, [Female Genital Mutilation/Cutting: a statistical overview and exploration of the dynamics of change](#), July 2013, page 30



Figure 2: Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by regions within countries



Source: Unicef, [Female Genital Mutilation/Cutting: a statistical overview and exploration of the dynamics of change](#), July 2013, p32

35. While the police and Border Force have taken some steps to improve their ability to detect and prevent girls from being taken out of the UK to undergo FGM in their 'home' countries, much more needs to be done. A sophisticated understanding of the regional nature of FGM within practising countries would help the police and Border Force officers to better target and engage with individuals and families who are seen to be at risk of travelling overseas to commit an FGM offence. It would also prevent an overly narrow targeting of flights between the UK and high-prevalence countries which serves to mask the full extent of locations where FGM is practised. We recommend that the FGM Unit immediately form operational links with police and Border Force airside operations, to provide intelligence and guidance on high-risk countries. This intelligence should be informed by the work carried out over the last 25 years by the United Nations, the World Health Organization and NGOs, and information provided by the Department for International Development and Foreign and Commonwealth Office overseas posts.

### **Personal, Social, Health and Economic (PSHE) education**

36. During our roundtable discussion, a number of speakers highlighted the potential of Personal, Social, Health and Economic (PSHE) education to raise awareness about FGM among pupils which in turn would support efforts to safeguard girls and report incidences.<sup>41</sup> Our predecessor Committee recommended that PSHE be made compulsory, including teaching children about FGM in high-prevalence areas. In its response, the Government said:

[ ... ] we do not want to prescribe exactly which issues schools should have to cover in PSHE or other related parts of the curriculum, as we believe it more effective for schools to make their own judgements on this, based on their knowledge of their pupils; school leaders and practitioners have supported this flexible approach. To assist those wishing to teach pupils about FGM, the Department for Education commissioned the PSHE Association to produce briefing about FGM for teachers, and the Association published that briefing in July 2014.<sup>42</sup>

37. Joe Hayman, Chief Executive of the PSHE Association, explained that the opportunity to raise awareness on FGM in schools has ‘gone backwards’ and that the amount of time given to PSHE in schools had gone down by more than 20%. “I would say this is all about school accountability: what is measured and what is not, and what is statutory and what is not.”<sup>43</sup> He called for leadership from the Government because “prevention would be undermined if we are delivering these lessons by untrained teachers or if we do not have these lessons at all”. In January 2016, four select committee Chairs, including the Chair of this Committee, signed a letter to Nicky Morgan, then Secretary of State for Education, to express disappointment with the Government’s response to recommendations from committees on making PSHE a statutory requirement.<sup>44</sup>

**38. Personal, Social, Health and Economic (PSHE) education has a key role to play in helping pupils to keep themselves and others safe but successive Governments have failed to provide sufficient leadership on this. We recommend that PSHE education be made compulsory and that it include tackling violence against women and girls, and teaching children about FGM in particularly high-prevalence areas. Such discussions between teachers and pupils would be likely to contribute to increasing the level of reporting and to safeguarding at-risk girls.**

### **Role of communities**

39. Detective Chief Superintendent Gerry Campbell told our roundtable meeting that the NPCC’s view was that “the solution to eradicating FGM rests within communities”. However, other contributors to the roundtable raised concerns that the ability to tackle FGM effectively in the local areas most affected by it was being hindered by the lack of funding for community groups.<sup>45</sup>

41 Home Affairs Select Committee, [FGM roundtable discussion](#), Q41

42 Home Office: [Female Genital Mutilation: the case for a national action plan](#), December 2014, page 11

43 Home Affairs Select Committee, [FGM Roundtable discussion](#), Q41

44 [Letter from Neil Carmichael, Sarah Wooleston, Keith Vaz and Iain Wright to Nicky Morgan](#), dated 7 January 2016

45 Home Affairs Select Committee, [FGM Roundtable discussion](#), Q31

40. Sarah McCulloch of ACCM UK, an advocacy organisation which works with local communities, argued that “all the resources are in London” and that there were no local services, including in other major cities such as Birmingham and Sheffield. Community groups and NGOs were having to use their own resources and manpower to work on FGM which meant that “we are not achieving anything”. She was very clear that “to reach out to communities, you have to engage, and that needs resources” and that “without funding, we cannot achieve anything”. Alimatu Dimonekene, an FGM survivor and the founder of ProjectACE, a survivor-led organisation based in Enfield, spoke of the importance of survivor organisations in trying to “galvanise communities” and encouraging women and girls to access support. She told us that organisations such as hers “play a crucial role” but agreed that, because they do not receive government support, their work is done “on our own time, our own effort and our own money.”<sup>46</sup>

**41. FGM is a hidden crime, practised in some communities within the UK on a daily basis. There is no doubt about the Government’s willingness to confront this abuse but unless sufficient resources are provided to those groups who work and campaign within the communities where FGM is practised, efforts to prevent it will be in vain.**

## 4 Prosecuting FGM offences

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### Mandatory reporting

42. Since 31 October 2015 healthcare professionals, social care workers and teachers in England and Wales have been required to report cases of FGM in under-18s to the police.<sup>47</sup> Some clinicians have raised concerns that mandatory reporting breaches fundamental principles of patient confidentiality which might result in women being less likely to speak with doctors openly.<sup>48</sup> We heard that some healthcare professionals just did not accept that mandatory reporting should be their responsibility. Janet Fyle, Professional Policy Advisor at the Royal College of Midwives, said that mandatory reporting “had not worked” because some healthcare professionals believed they did not have to do it and had “franchised it out to some community groups”.<sup>49</sup>

43. Our predecessor Committee was concerned that it was unclear what would happen if a professional failed to report a case of FGM to the police and recommended that the Government set out the sanctions that might apply if a professional failed to comply. It suggested that sanctions should range from “compulsory training to a criminal offence for intentional or repeated failures.”<sup>50</sup> In its response to the Committee’s report, the Government rejected the recommendation and said that failure to comply with the mandatory reporting duty would be dealt with in accordance with existing disciplinary procedures.<sup>51</sup>

**44. The police rely on professionals in the education, health and social care sectors to identify signs that FGM has taken place. Prosecutions will not be possible if we wait for daughters to report their parents to the police, which is unlikely to happen. On that basis, we believe the Government was right to introduce mandatory reporting. If a health professional, social worker or teacher saw someone who had been the victim of another crime, they would be expected to report it. In the same way, they must report FGM, which is equally a crime.**

**45. Existing disciplinary procedures for professionals who ignore the duty on mandatory reporting are insufficient and ineffective and it is unacceptable that some clinicians appear to refuse to accept it as their responsibility. The duty to report must not be seen as optional. A decision not to report puts children’s lives at risk and is complicit in a crime being committed. We repeat our predecessor Committee’s recommendation that the Government introduce stronger sanctions for failure to meet the mandatory reporting responsibility, beyond the relevant professions’ own general disciplinary procedures.**

46. Dr Judy Shakespeare, Clinical lead for FGM at the Royal College of GPs, told us that statistics showing the rate of mandatory reporting were not available and that neither the Home Office, the Department of Health nor the Office for National Statistics (ONS)

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47 The Serious Crime Act 2015 amended the Female Genital Mutilation Act 2003 for the purposes of introducing a mandatory reporting responsibility

48 BMJ, Views and Reviews: [Disrespecting confidentiality isn’t the answer to FGM](#), 12 November 2015

49 Home Affairs Select Committee, [FGM Roundtable discussion](#), Q12

50 Home Affairs Select Committee, [Female Genital Mutilation: follow-up](#), July 2015, para 22

51 Home Office, [Government response to the Home Affairs Committee Report, Female Genital Mutilation: follow-up](#), 22 July 2015

were collecting figures.<sup>52</sup> In response to an FOI request for the number of cases of FGM reported to the police between 21 October 2014 and 10 January 2016 sent to the Home Office, Department for Health, NHS England and the ONS, the first three organisations were unable to provide any information. The ONS said that FGM statistics were collected under category ‘8N Assault with injury’ but that category included incidences of other offences so it was not possible to extract data on FGM only. The majority of police forces declined to provide the information.<sup>53</sup>

47. Detective Chief Superintendent Gerry Campbell was able to provide some figures on mandatory reporting. He said that since 31 October 2015 there had been in excess of 152 referrals from regulated professionals, notably from health, education and from children’s social care. However, those figures were not comprehensive as some forces had not yet returned data. He noted that one police force in particular (not named) had received a significant number of reports from professionals which could offer lessons for other force areas in maximising reporting.<sup>54</sup>

48. The then Minister acknowledged that data collection had been a problem but suggested the absence of available statistics was the result of health and social care professionals being unaware of the reporting duty rather than recognising that it was the responsibility of Government to manage the data:

We know that data collection has been a problem. That is why the NHS has started to collect this data. It is disappointing to hear that, because we contacted all GPs—about 8,000 practices across the country—and sent them FGM packs. Health Education England has delivered 22,000 training sessions in an e-learning session. There has been significant work. The Department of Health has put over £4 million into outreach to medical professionals to help them understand what FGM looks like, how to find the signs of it, how to identify it, and the mandatory reporting duty. It is disappointing to hear that, but it is clearly something that we need to look at.<sup>55</sup>

Janet Fyle of the Royal College of Midwives said the absence of feedback from the police on reports might lead some healthcare professionals not to report in future. She suggested that the police should disseminate a report with a breakdown of figures along with an explanation of progress that had been made on cases.<sup>56</sup>

**49. We were surprised and disappointed that there still appears to be no central Government office collating data on the mandatory reporting of FGM. One way to encourage reporting would be to publish readily available statistics so that those reporting can see the results of their diligence as well as that of their colleagues across the health, social care and education sectors. A centralised system for pooling reports of FGM would also be a positive step and would aid data analysis from which examples of best practice could be drawn. We recommend that the FGM Unit publish quarterly reports showing high-level results, progress in police investigations and examples of best practice that should then be disseminated to all professionals with a mandatory**

52 Home Affairs Select Committee, [FGM Roundtable discussion](#), Q12

53 BMJ, Letters: [Failure to evaluate introduction of female genital mutilation mandatory reporting](#), 20 May 2016

54 Home Affairs Select Committee, [FGM roundtable discussion](#), Q21

55 Oral evidence taken on Female Genital Mutilation, 12 July 2016, Q23

56 Home Affairs Select Committee, [FGM roundtable discussion](#), Q12

**duty to report FGM. Ideally those reports should incorporate the data collated by the Health and Social Care Information Centre to encourage the standard of that data also to be improved.**

## Prosecutions

50. FGM has been a crime since 1985 but there has still not been a successful prosecution for the offence. In February 2015, Dr Dhanuson Dharmasena (along with another defendant) was found not guilty of performing FGM on a patient at the Whittington Hospital in north London. He was alleged to have performed reinfibulation on a woman after she had given birth. He performed a single suture to stop postpartum bleeding. The woman herself made no request for the doctor to be prosecuted. The prosecution resulted in acquittal. Campaigners said that the publicity generated from the prosecution sent out a strong message to the practising community that the UK takes FGM seriously, but given it was the only prosecution to date, some felt that the outcome of the case could discourage survivors from coming forward if they thought a conviction was unlikely.

51. There have been no further FGM-related prosecutions since, despite recent legislative changes to expand the range of offences. Since 2010, only 29 cases of FGM offences have been referred to the CPS and a number of those cases are still live.<sup>57</sup> In comparison, there have been 40 FGM-related trials in France, and European Commission figures to January 2012 show that there had been six in Spain; two in Italy and Sweden; and one each in the Netherlands and Denmark.<sup>58</sup>

52. We were told during our roundtable discussion that one of the main barriers to gathering evidence on FGM offences is the difficulty in getting testimony from survivors.<sup>59</sup> FGM is often arranged by close family members, including parents, whom children will rarely want to implicate. A child might have no memory of the act if it took place at a young age, as is common, or they might not know who was responsible. Crucially, a child is unlikely to know that FGM is illegal. It is often practised by families because they believe that it is in the best interests of the child, so even where a child does know that FGM is a crime, there might be an unwillingness to inform on others within a community and to do so might result in being ostracised.<sup>60</sup>

53. The Government has expanded support for survivors and has sought to make FGM more difficult to inflict, particularly since the implementation of the Serious Crime Act 2015. Extra-territorial offences contained in the Female Genital Mutilation Act 2003 have been extended, life-long anonymity has been granted to survivors, and new civil FGM Protection Orders (FGMPOs) have been created. There is also a new offence of failing to protect a girl from FGM. As we have discussed, the Act also introduced a mandatory reporting duty on healthcare professionals, social care workers and teachers.

54. In France, FGM was defined as a crime in 1983 with the threat of 10 years in prison, or up to 20 years for cutting a girl under the age of 15. There have been about 40 trials which have led to approximately 100 convictions since.<sup>61</sup> Unlike in the UK, there is no

57 Letter from Sarah Newton to the Chair of the Committee, [21 July 2016](#)

58 European Commission, [Communication from the Commission to the European Parliament and Council](#), 25 November 2013

59 Home Affairs Select Committee, [FGM roundtable discussion](#), Q28

60 College of Policing, [FGM guidance](#)

61 Home Affairs Select Committee, [FGM roundtable discussion](#), Q34

specific French legislation banning FGM but it is a crime under articles of the Penal Code which deal with mutilation and abuse of minors. Linda Weil-Curiel, a Paris-based lawyer, (who attended our roundtable discussion) has said the French legal system makes it easier to bring FGM trials than in other countries because a young victim does not herself pursue her own parents through the justice system. She can be represented by a person named as her guardian by the judge.<sup>62</sup> Neil Moore, Principal Legal Advisor to the Director of Public Prosecutions, pointed out that the UK has a very different legal tradition and history of case law which would make adopting elements of the French system problematic.<sup>63</sup> However, the expansion of the law to prosecute parents for failing to protect daughters from FGM has gone some way to moving the UK closer to the strict liability approach which operates in France.

**55. France has an excellent record on securing prosecutions for FGM offences but the UK's distinct legal tradition makes the adoption of similar practices unlikely and possibly unworkable. We welcome the introduction under the Serious Crime Act 2015 of the new offence of failing to protect a girl from FGM, which is similar to provisions in French law for prosecuting parents as abettors of the crime. The UK could learn a great deal from identifying the methods used in other countries, particularly France, to support girls who are prepared to give evidence against perpetrators. The Home Office should take steps to investigate additional legislative measures which might be successful in securing more prosecutions and in supporting victims who wish to contribute to legal proceedings, despite the obvious difficulties and conflicts this presents for young women.**

**56. It is beyond belief that there still has not been a successful prosecution for an FGM offence since it was made illegal over 30 years ago. That is a lamentable record and the failure to identify cases, to prosecute and to achieve convictions can only have negative consequences for those who are brave enough to come forward to highlight this crime. In the absence of successful prosecutions, FGM remains a national scandal that is continuing to result in the preventable mutilation of thousands of girls. We welcome the measures that the Government has introduced in recent years to deter parents and others from attempting to inflict FGM on girls and to bring those to justice who succeed in this. When we next review FGM the new laws will have had longer to 'bed in' and we will expect to see a number of successful and ongoing prosecutions, in line with other countries in Europe.**

**57. We recommend that the Government reconvenes its FGM Summit of June 2014 within the next year, to bring together the leaders of other European countries dealing with this problem and those from 'home' countries where girls living in the UK are taken in order for FGM to be carried out. The current Prime Minister took action to tackle FGM when she was the Home Secretary and she should take the opportunity to provide global leadership in tackling this form of child abuse.**

**58. When our predecessors published their report on FGM last year, they were so appalled by the lack of progress that they announced their intention to revisit this matter again. We will continue to draw attention to this horrific crime until prosecutions and convictions are achieved and we are able to turn the tide of violence against girls and women.**

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62 Home Affairs Select Committee, [FGM roundtable discussion](#), Q32

63 Home Affairs Select Committee, [FGM roundtable discussion](#), Q41

# Conclusions and recommendations

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## Introduction

1. FGM is not a religious or cultural rite of passage that deserves protection. When it is inflicted on a woman, it is a horrific crime. When it is inflicted on a girl, it is violent child abuse. It involves young girls' genitalia being cut with scissors, a razor, a knife or even glass, usually with no anaesthetic or antiseptic. It causes severe physical and psychological pain and leaves survivors with lifelong health consequences. Everyone involved in protecting children needs to be aware of, and prevent, this specific form of abuse. This responsibility also extends to the wider community and to all professionals whose roles bring them into contact with children. (Paragraph 12)

## Measuring the problem

2. Some progress has been made in the collection of data on FGM. However, the Government must adopt a more sophisticated, data-driven approach to eradicating it. It is a hidden crime and the first step towards tackling it effectively is to measure it properly. Only then can resources be allocated accordingly. In the UK, despite the publicity surrounding the Government's Summit on FGM in 2015, there is still a paucity of information on the scale of FGM, on its trends over time and on the number of girls at risk. There have been a small number of statistical analyses and data-gathering exercises but they have been conducted in isolation and without reference to a national strategy. As a result the statistics lack the necessary degree of utility to safeguarding and law enforcement agencies. (Paragraph 17)
3. We recommend that the Home Office identify a more reliable methodology for measuring the number of girls at risk of undergoing FGM in the UK. This approach would be best served by engaging directly with women and families affected by FGM, for example through the use of anonymised surveys of a statistically meaningful number of women in families from practising countries. Research should also seek to ascertain attitudes towards FGM, including motivations for continuing to use the procedure, and awareness of the law prohibiting it. It should also be used as an opportunity to learn exactly where in practising countries women had their FGM carried out. Such information would enrich the international intelligence picture, including for UK Border Force staff in their work to prevent girls from being taken abroad to undergo FGM. (Paragraph 18)
4. Since 2015, there has been a requirement on clinicians to record and report FGM cases which they identify as part of clinical examinations. While we agree that they are best placed to help to measure this appalling crime, we are not convinced that the present standard of recording meets the Home Office's expectation that it will lead to a "better understanding of the scale of the crime taking place". The most conspicuous weakness in the data is its incompleteness which makes it difficult to use to set benchmarks against which trends can be measured. We are alarmed by reports that some clinicians are ignoring the requirement to record data on the basis that they do not recognise its purpose. We expect NHS employers and the Royal Colleges to take a hard line against such attitudes and call for the Department of



Health to write to frontline clinicians to remind them of the duty, and the purpose of mandatory recording, and to reissue guidance. In areas where recording is far below expectations, training on the harm resulting from FGM, the importance of fulfilling the duty to record FGM incidence and dealing with affected women should be commissioned. (Paragraph 24)

### Safeguarding girls

5. The multi-agency approach to tackling FGM has been hampered by the absence of a central authority to co-ordinate expertise, manage resources and adjust strategy when it is found to be failing. We recommend that this is addressed through the FGM Unit, hosted by the Home Office, being given the remit, powers and budget to become the sole source of Government policy for safeguarding at-risk girls and eradicating FGM. The Unit should be a joint enterprise between the Home Office, the Department of Health and the Department for Education in the same way that the Forced Marriage Unit is a joint enterprise between the Home Office and the Foreign and Commonwealth Office. Linking the expertise and resources of those Departments, and ensuring that they liaise fully with responsible authorities in the devolved governments, will ensure the greatest chance of successfully meeting the Government's ambition to eradicate FGM within a generation. (Paragraph 27)
6. Without a powerful, central co-ordinator, we are concerned that finite resources to fight FGM will not be as well-targeted or used as efficiently as they should be. A single reporting and safeguarding system would be the best approach to removing some of the institutional barriers that presently prevent effective safeguarding and would be a suitable project for a redefined FGM Unit. (Paragraph 28)
7. It is likely that routine medical examinations of children under age six in France have resulted in a large number of successful prosecutions in relation to FGM and contribute to the safeguarding of vulnerable girls. This would be a radical change in practice in the UK and there is a strong case for its implementation in this country. However, it should be noted that it has been shown that the French system has to some extent deferred the problem by encouraging some parents simply to wait for their daughters to get beyond the usual age range for the routine medical examinations before having them cut. We are also concerned that the examination itself could be unnecessarily traumatic for children. Nevertheless, we believe medical examinations can have a role as a last resort in particularly high-risk cases. As improvements to risk assessment methods continue, there may be a stronger case for a system that requires health professionals to carry out regular medical checks when a girl is identified as being at high risk. (Paragraph 31)
8. While the police and Border Force have taken some steps to improve their ability to detect and prevent girls from being taken out of the UK to undergo FGM in their 'home' countries, much more needs to be done. A sophisticated understanding of the regional nature of FGM within practising countries would help the police and Border Force officers to better target and engage with individuals and families who are seen to be at risk of travelling overseas to commit an FGM offence. It would also prevent an overly narrow targeting of flights between the UK and high-prevalence countries which serves to mask the full extent of locations where FGM is practised.

We recommend that the FGM Unit immediately form operational links with police and Border Force airside operations, to provide intelligence and guidance on high-risk countries. This intelligence should be informed by the work carried out over the last 25 years by the United Nations, the World Health Organization and NGOs, and information provided by the Department for International Development and Foreign and Commonwealth Office overseas posts. (Paragraph 35)

9. Personal, Social, Health and Economic (PSHE) education has a key role to play in helping pupils to keep themselves and others safe but successive Governments have failed to provide sufficient leadership on this. We recommend that PSHE education be made compulsory and that it include tackling violence against women and girls, and teaching children about FGM in particularly high-prevalence areas. Such discussions between teachers and pupils would be likely to contribute to increasing the level of reporting and to safeguarding at-risk girls. (Paragraph 38)
10. FGM is a hidden crime, practised in some communities within the UK on a daily basis. There is no doubt about the Government's willingness to confront this abuse but unless sufficient resources are provided to those groups who work and campaign within the communities where FGM is practised, efforts to prevent it will be in vain. (Paragraph 41)

### Prosecuting FGM offences

11. The police rely on professionals in the education, health and social care sectors to identify signs that FGM has taken place. Prosecutions will not be possible if we wait for daughters to report their parents to the police, which is unlikely to happen. On that basis, we believe the Government was right to introduce mandatory reporting. If a health professional, social worker or teacher saw someone who had been the victim of another crime, they would be expected to report it. In the same way, they must report FGM, which is equally a crime. (Paragraph 44)
12. Existing disciplinary procedures for professionals who ignore the duty on mandatory reporting are insufficient and ineffective and it is unacceptable that some clinicians appear to refuse to accept it as their responsibility. The duty to report must not be seen as optional. A decision not to report puts children's lives at risk and is complicit in a crime being committed. We repeat our predecessor Committee's recommendation that the Government introduce stronger sanctions for failure to meet the mandatory reporting responsibility, beyond the relevant professions' own general disciplinary procedures. (Paragraph 45)
13. We were surprised and disappointed that there still appears to be no central Government office collating data on the mandatory reporting of FGM. One way to encourage reporting would be to publish readily available statistics so that those reporting can see the results of their diligence as well as that of their colleagues across the health, social care and education sectors. A centralised system for pooling reports of FGM would also be a positive step and would aid data analysis from which examples of best practice could be drawn. We recommend that the FGM Unit publish quarterly reports showing high-level results, progress in police investigations and examples of best practice that should then be disseminated to all

professionals with a mandatory duty to report FGM. Ideally those reports should incorporate the data collated by the Health and Social Care Information Centre to encourage the standard of that data also to be improved. (Paragraph 49)

14. France has an excellent record on securing prosecutions for FGM offences but the UK's distinct legal tradition makes the adoption of similar practices unlikely and possibly unworkable. We welcome the introduction under the Serious Crime Act 2015 of the new offence of failing to protect a girl from FGM, which is similar to provisions in French law for prosecuting parents as abettors of the crime. The UK could learn a great deal from identifying the methods used in other countries, particularly France, to support girls who are prepared to give evidence against perpetrators. The Home Office should take steps to investigate additional legislative measures which might be successful in securing more prosecutions and in supporting victims who wish to contribute to legal proceedings, despite the obvious difficulties and conflicts this presents for young women. (Paragraph 55)
15. It is beyond belief that there still has not been a successful prosecution for an FGM offence since it was made illegal over 30 years ago. That is a lamentable record and the failure to identify cases, to prosecute and to achieve convictions can only have negative consequences for those who are brave enough to come forward to highlight this crime. In the absence of successful prosecutions, FGM remains a national scandal that is continuing to result in the preventable mutilation of thousands of girls. We welcome the measures that the Government has introduced in recent years to deter parents and others from attempting to inflict FGM on girls and to bring those to justice who succeed in this. When we next review FGM the new laws will have had longer to 'bed in' and we will expect to see a number of successful and ongoing prosecutions, in line with other countries in Europe. (Paragraph 56)
16. We recommend that the Government reconvenes its FGM Summit of June 2014 within the next year, to bring together the leaders of other European countries dealing with this problem and those from 'home' countries where girls living in the UK are taken in order for FGM to be carried out. The current Prime Minister took action to tackle FGM when she was the Home Secretary and she should take the opportunity to provide global leadership in tackling this form of child abuse. (Paragraph 57)
17. When our predecessors published their report on FGM last year, they were so appalled by the lack of progress that they announced their intention to revisit this matter again. We will continue to draw attention to this horrific crime until prosecutions and convictions are achieved and we are able to turn the tide of violence against girls and women. (Paragraph 58)

# Appendix 1: Recommendations from 2015 Home Affairs Committee Report on FGM

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## Raising the profile of FGM

1) The work that has been done by the media, politicians and most importantly by survivors and campaigners has raised the profile of FGM, so that many more people are aware of this horrendous form of child abuse. However, it is still the case that there have been no successful prosecutions for FGM in the UK in the last 20 years. This record is lamentable. The message must be repeated clearly: the practice of FGM is abominable and it must be challenged wherever it is found. A sustained campaign will increase awareness among professionals of the training that is available to them, and direct victims of FGM to the support services that are provided.

## Prosecuting FGM

2) The Committee welcomed the first prosecution under the Female Genital Mutilation Act 2003 brought by the DPP a few days before she was to appear before the Committee as part of our first report into FGM. The first prosecution under the Act was a problematic case: it was not a “classic” example of primary FGM involving a child, and the defence argued successfully that the defendant’s actions were clinically indicated and were in the best interests of the patient.

3) In Heartlands Hospital in Birmingham alone, 1,500 cases of FGM were recorded over the last five years, with doctors seeing six patients who have undergone the procedure each week. There seems to be a chasm between the amount of reported cases and the lack of prosecutions. Someone, somewhere is not doing their job effectively. The DPP informed the Committee that she could only prosecute on the basis of evidence, the police said that they could only investigate on the basis of referral, and the health professionals told us that they could not refer cases because their members were not fully trained and aware of the procedure. While agencies play pass the parcel of responsibility, young girls are being mutilated every hour of every day. This is deplorable. We wish to see more prosecutions brought and convictions secured. This barbaric crime which is committed daily on such a huge scale across the UK cannot continue to go unpunished.

## Female genital cosmetic surgery

4) Despite the Government’s assurances that there is no ambiguity in the law relating to female genital cosmetic surgery, our evidence demonstrates that the police, midwives and campaigners would all like to see greater clarity on this point. We cannot tell communities in Sierra Leone and Somalia to stop a practice which is freely permitted in Harley Street. We recommend that the Government amend the Female Genital Mutilation Act 2003 in order to make it very clear that female genital cosmetic surgery would be a criminal offence.

## Safeguarding at-risk girls

5) Doctors and health workers are in the front line in the fight against FGM. We do not believe that enough is being done by the Royal Colleges to encourage their members to report cases of FGM. Given the recent prosecution there may be an even greater reluctance to do so, however, we consider that it is imperative that the Royal College of GPs inform every single doctor about this practice and give them an indication of where adequate training can be provided.

## Government action since June 2014

6) We welcome the steps that the Government have taken to strengthen the law related to FGM. In particular, we welcome the provision in the Serious Crime Act to introduce mandatory reporting of FGM, by healthcare professionals, teachers and social care workers, to the police. This should help to bring about further prosecutions, sending a strong message both in the UK and overseas. However, it remains unclear what would happen in the event that a professional should fail to make a report. We recommend that the Government set out the sanctions that may apply when a professional has failed to meet their duty, which should range from compulsory training to a criminal offence for intentional or repeated failures.

7) We commend the work done by Jane Ellison MP in the Department of Health to spearhead their work against FGM. This has produced results and significant funding for a programme aimed at health professionals. We urge the Home Office to follow this example, and step up to the mark by providing funds for the tireless campaigners such as Leyla Hussein and Alimatu Dimonekene. These are the people who can reach out to communities and bring back information and intelligence to the police, so that investigations can take place and prosecutions be initiated.

8) The Government needs to be aware of the impact that its decisions have on FGM campaigners within practicing communities. We recommend the establishment of an advisory panel of FGM campaigners, which should be consulted before any major policy decisions are taken and also act as a sounding board to ensure that sufficient action is taken. The panel should advise on both the substance of policy decisions and on the way in which policies are to be communicated to the target communities, recognising that the final decision on these matters will rest with ministers.

## Formal Minutes

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**Tuesday 6 September 2016**

Members present:

|                   |                   |
|-------------------|-------------------|
| James Berry       | Stuart C McDonald |
| Mr David Burrowes | Chuka Umunna      |
| Nusrat Ghani      | Mr David Winnick  |
| Tim Loughton      |                   |

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In the absence of the Chair, Tim Loughton was called to the chair.

Draft Report (*Female genital mutilation: abuse unchecked*), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 58 read and agreed to.

A Paper was appended to the Report as Appendix 1.

*Resolved*, That the Report be the Ninth Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

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[Adjourned till tomorrow at 2.30 pm.]

## Witness

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The following witness gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

**Tuesday 12 July 2016**

*Question number*

**Karen Bradley MP, Minister for Preventing Abuse, Exploitation and Crime**

[Q1–34](#)

## Published written evidence

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The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

FGM numbers are generated by the evidence processing system and so may not be complete.

- 1 Sarah Newton MP, Minister for Vulnerability, Safeguarding and Countering Extremism ([FGM0001](#))



## List of Reports from the Committee during the current Parliament

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All publications from the Committee are available on the [publications page](#) of the Committee's website.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

### Session 2015–16

|                       |   |                    |
|-----------------------|---|--------------------|
| First Report          | Psychoactive substances   | HC 361<br>(HC 755) |
| Second Report         | The work of the Immigration Directorates (Q2 2015)  | HC 512<br>(HC 693) |
| Third Report          | Police investigations and the role of the Crown Prosecution Service   | HC 534             |
| Fourth Report         | Reform of the Police Funding Formula  | HC 476             |
| Fifth Report          | Immigration: skill shortages  | HC 429<br>(HC 857) |
| Sixth Report          | The work of the Immigration Directorates (Q3 2015)  | HC 772<br>(HC 213) |
| Seventh Report        | Police and Crime Commissioners: here to stay  | HC 844             |
| First Special Report  | The work of the Immigration Directorates: Calais: Government Response to the Committee's Eighteenth Report of Session 2014–15 | HC 380             |
| Second Special Report | Out-of-court Disposals: Government Response to the Committee's Fourteenth Report of Session 2014–15                           | HC 379             |
| Third Special Report  | The work of the Immigration Directorates (Q2 2015): Government Response to the Committee's Second Report of Session 2015–16   | HC 693             |
| Fourth Special Report | Psychoactive substances: Government Response to the Committee's First Report of Session 2015–16                               | HC 755             |
| Fifth Special Report  | Immigration: skill shortages: Government Response to the Committee's Fifth Report of Session 2015–16                          | HC 857             |

### Session 2016–17

|               |  |                   |
|---------------|--|-------------------|
| First Report  | Police diversity                                   | HC 27<br>(HC 612) |
| Second Report | The work of the Immigration Directorates (Q4 2015) | HC 22             |
| Third Report  | Prostitution                                       | HC 26             |
| Fourth Report | College of Policing: three years on                | HC 23             |
| Fifth Report  | Proceeds of crime                                  | HC 25             |
| Sixth Report  | The work of the Immigration Directorates (Q1 2016) | HC 151            |

|                       |  |        |
|-----------------------|--|--------|
| Seventh Report        | Migration Crisis   | HC 24  |
| Eighth Report         | Radicalisation: the counter-narrative and identifying the tipping point  | HC 135 |
| First Special Report  | The work of the Immigration Directorates (Q3 2015): Government Response to the Committee's Sixth Report of Session 2015–16 | HC 213 |
| Second Special Report | Police diversity: Government Response to the Committee's First Report of Session 2016–17                                   | HC 612 |