



Home Affairs Committee

Oral evidence: [Female genital mutilation](#) , HC 1091

Tuesday 6 May 2014

Ordered by the House of Commons to be published on 6 May 2014

Written evidence from witnesses:

- [The Intercollegiate Group on FGM](#)
- [The Royal College of General Practitioners](#)
- [Dr Comfort Momoh MBE](#)
- [Dr Deborah T Hodes \(For Kerry Robinson\)](#)

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Members present: Keith Vaz (Chair), Mr James Clappison, Michael Ellis, Paul Flynn, Mark Reckless, Mr David Winnick.

Questions 296 – 453

Witnesses: **Professor Nigel Mathers**, Royal College of General Practitioners, **Janet Fyle**, Royal College of Midwives, and **Professor Janice Rymer**, Royal College of Obstetricians and Gynaecologists, gave evidence.

Q296 Chair: This is the final session of the Committee's inquiry into female genital mutilation, and we are very pleased to have before us today Professor Nigel Mathers, Professor Janice Rymer and Janet Fyle. Thank you very much for coming.

Perhaps I could start with you, Professor Mathers. Having taken a great deal of evidence from the various individuals and agencies involved in FGM, it is very clear that we have in FGM what I regard as being a chain of despair. There are victims who have suffered horrendous mutilation, but the agencies that were there to try to protect them have failed to do so, and last week's evidence from the Metropolitan Police was very clear. They felt that the professionals—that is the doctors and the social workers and other health officials—had not done their job sufficiently well. If they had done their job well then we would have had more prosecutions. Do you agree with that, Professor Mathers?

Professor Mathers: I think it is a very difficult area for health professionals, I must say, and I think blaming health professionals for a failure to prosecute is not putting the blame in the right place. I think it is difficult to raise the issue. As we say in our evidence, it is difficult as a GP to raise the issue for a number of reasons, which include things like consent to the examination and desire to maintain confidentiality. There are some health professionals who feel that once it has happened it is too late, so there is not a lot that can

be done, and there is also a lack of knowledge as well on behalf of the health professionals about what services are available and what appropriate action—

Q297 Chair: Yes. You represent the Royal College.

Professor Mathers: That is right.

Chair: Why have you not brought in guidelines in the last 20 years, or made your members more aware of what is happening? We know it is a difficult issue, that is why Parliament is looking at it, but merely to say you have confidentiality issues on issues where people may well have committed a crime—crimes have been committed. Do you accept that?

Professor Mathers: Absolutely, and we have—

Chair: Professionals have examined victims of crime and they have failed to report them. What the police have said to us last week is—and this is Mr Rowley—“If I look at 2010 to 2013, one of the things that strikes me is the Metropolitan Police has uncovered more potential cases than have been referred by the health service”. Basically your members are observing but not reporting and, as a result of that, crimes have gone unpunished. It is pretty straightforward, isn’t it?

Professor Mathers: I don’t think so. It is much more a question of identifying those who are at risk and those who have been subjected to this crime. We absolutely agree with that.

Q298 Chair: So let’s deal with those who have been subjected to the crime. A GP examines a young girl who has been the subject of FGM. What does the GP do then? What should the GP do?

Professor Mathers: As this is clearly child abuse, the GP has a statutory responsibility to refer the child and the case to the social services.

Chair: That has clearly not been happening.

Professor Mathers: I think when the case has been identified that has been happening. The difficulty is identifying. In terms of—

Q299 Chair: What numbers do you have for this Committee on referrals? How many? We have numbers from the police and other agencies. Do you have any numbers of referrals from GPs to the prosecuting authorities or the police of cases involving FGM?

Professor Mathers: We do not have those numbers, so we do not know how prevalent the referral is to the police. But I would challenge your point around the College has done very little in terms of FGM. We have contributed to not only the Department of Health guidelines but the intercollegiate guidelines. We are members of the Primary Care Society, which is called the Safeguarding Forum. We have contributed to the publication “Tackling FGM in the UK”. We have our own toolkit, which we have prepared with the NSPCC, which deals with child abuse in general.

Q300 Chair: Yes, that is very helpful and you have written to us about this. We have noted all that but, Professor Mathers, the point is this: you may have been involved in many drafting of documents and drafting of guidelines but I find it astonishing that you cannot give this Committee any indication of how many cases have been referred by your members to the authorities, and that you have not even sought that information.

Professor Mathers: We have supported our members in identifying cases.

Q301 Chair: Is that right, have you not even sought this information?

Professor Mathers: We have not sought this information from our members.

Q302 Chair: Thank you. Professor Rymer, what about from your point of view and your Royal College, have you sought this information? Have you asked how prevalent it is, bearing in mind the huge concern by everybody that we have had no prosecutions?

Professor Rymer: I think there are two types of women that we come across, the women who have had FGM and the majority of people that we see in our practice are women who have had FGM somewhere between the ages of four and 10 and we are seeing them in their early 20s. To actually then report those cases to the police is quite challenging.

Q303 Chair: Why?

Professor Rymer: Those women then—and it is a great network of these women—may go underground and say, “Do not go and get your FGM reversed because they are going to report you to the police”, so that is a difficult one and also the confidentiality. On the shop floor, because I do the reversals of FGM, I do have difficulty with that.

Q304 Chair: Yes, let us explore those difficulties. Have you in your work—obviously as a very senior member, you have studied all over the world and you are a professor and a very distinguished authority on these subjects—come across cases of FGM?

Professor Rymer: Yes, I see—

Q305 Chair: You have examined patients?

Professor Rymer: Yes, I have been—

Q306 Chair: Have you referred any of them to the authorities?

Professor Rymer: No—

Chair: None?

Professor Rymer: —because they are mainly women who have had it done, let's say, 16 years ago and I am now seeing them because they are coming into our culture here. They want to be sexually active. They want to be like their chums. So they are coming almost under cover because a lot of them do not want to let their associates know; they come in to have their FGM reversed.

Q307 Chair: But do you ask them? Do you say to them, “I am thinking of referring this to the police in respect of what has happened to you because I fear it is going to happen to others. Do you mind if I refer this?”? Have you asked them?

Professor Rymer: No, I haven't asked them if they would be happy for me to refer them to the police. We have a very good conversation about their attitudes towards the FGM and if, in the event that they got pregnant, what they would do about their own children. The women who I think are much more at risk are the antenatal patients from the 28 identified countries, when they have female children. Those are the ones who we should be reporting to the police. I do not do obstetrics anymore but that is what I think we should do. Those to me are the ones that are most at risk: pregnant women from identified countries or who have partners from identified countries are the ones that we should be reporting to the police.

Chair: Very helpful.

Professor Rymer: I think we are going to stop the 20-year-olds who had it done 16 years ago coming forward.

Q308 Chair: Do you not feel that if that information was referred on at least we would have a better picture of where it was happening and how it was happening in order to prevent it happening in the future? The attitude that you have displayed—I understand the reasons and please do not take this as a criticism—some may feel is rather complacent, “It has happened a few years ago, we're not going to do anything about it”. Do you not feel that that information in the right hands could be extremely helpful in stopping it happening in the future?

Professor Rymer: I do accept that but, as a clinician operating and doing reversal on a woman who has come to me, there is that issue of confidentiality and, as a doctor, I find that very challenging.

Q309 Chair: Thank you. Please tell us, Janet Fyle, that your organisation has information about this and is much more active than the two Royal Colleges that we have just heard from.

Janet Fyle: I do not think I am going to say that. What I will say, though, is that in 2012 the Royal College of Midwives carried out a survey of its members to find out a whole host of issues around their knowledge, their awareness of FGM, whether they have referral pathways, how they identify women and if they want further training or have further training, and the results of that.

Q310 Chair: What was the response? How many came forward and said, yes, they knew?

Janet Fyle: It was about a third of them. A third of midwives said their trusts—

Chair: A third of midwives?

Janet Fyle: Yes. A third of the 2,000-odd midwives who responded said their trust collected data or that they know of women who have come forward with FGM, but only at the booking interview that they are able to identify these women.

Q311 Chair: Were you all able to identify how many of those women actually had referred the cases on to the relevant authorities? As you know, until now there have been no prosecutions even though in other countries, like France, there have been.

Janet Fyle: What I know and what we know is the fact that midwives tell us that they refer to social workers and social services, because they have social workers within antenatal and obstetrics. They refer to them and the social workers will tell them that these women do not meet the threshold, that they are busy and that is not something they want to give priority to.

Q312 Chair: Let me ask you each one of you very quickly: do you think there should be a statutory requirement of a referral being made to the police where your members feel, and they assess, that there has been FGM? Ms Fyle?

Janet Fyle: Would you mind if I just say this before I answer the question? I want to pay tribute to the survivors who told us their stories for the Royal College of Midwives to work with their partners to produce the intercollegiate guidelines. That has provoked such a widespread reaction in the UK. Most of these young women are taken out of the country. They are British citizens so they are resident here. They are taken to Africa, for example, where they think they are going to be running free, climbing trees, and somebody kidnaps them.

Chair: Yes, we know all that. We have heard all this evidence.

Janet Fyle: Yes, but what I want to say about that is that their stories should make us treat FGM as a matter of urgency, that we have to provide leadership to ensure that we end FGM in this country and that no one is—

Q313 Chair: Indeed. In trying to provide that leadership, would it help you if Parliament was to make it a requirement, a statutory referral when your members find that there are cases of FGM, so you are not hiding behind any issues? You would have to refer it. Would that be helpful to ending FGM in this country? At the moment, of course, it is not reported.

Janet Fyle: I think there are statutory requirements on health professionals to refer where they know that a child is at risk of harm, and I would not see it any different from another form of child abuse.

Q314 Chair: So, you support that? You think that and your colleague does?

Janet Fyle: I support that because FGM is child abuse so we should refer the same as we would for that.

Q315 Chair: Professor Rymer, what about a statutory requirement that when you find this crime has been committed you should refer?

Professor Rymer: I do support that in principle, but you also acknowledge my problem of someone having it done 16 years ago and me—treating them as a doctor—reporting them to the police. I have no problem, having found that a child has had FGM done, absolutely a statutory requirement, but I do have that difficulty when it was done a long time ago, forced upon a woman and then you are reporting her to the police because she has come to see me because she wants something done about it. I have a problem with that.

Q316 Chair: I have to say I do not have sympathy with you, simply because—and though I understand and respect confidentiality because we have things told to us as Members of Parliament that are confidential—where we are trying to find out why people have not been prosecuted, the life stories of the individuals that you could have referred, even though it was 16 years ago, would have been extremely helpful in putting together a jigsaw of what has happened in the past. Otherwise, all we would ever do is say, “Crimes have been committed. There is a time limit. We will never go back” and you never prosecute people for historical crimes. After all, you are not the DPP, you are there to try to stop this practice, so I am afraid I do not have sympathy with you on this.

Professor Mathers, do you think there should be a statutory requirement?

Professor Mathers: I think that the existing legislation is probably sufficient. That if we, as a health professional, feel that a child has experienced abuse such as FGM then there is a mandatory responsibility to refer to social services.

Q317 Chair: That is it. You do not want to take it further?

Professor Mathers: I think that we can deal with this issue under the existing legislation, yes.

Q318 Mr Winnick: Of course one understands all the sensitivity, which we also appreciate as lay people. The Chair has spoken about where crimes have been committed. If we take, for example, those children who might be in danger, and the feeling that if this crime is not committed in the UK the child will be taken abroad, what I really want to dwell on for a moment or two is does a GP have a responsibility if he or she feels that that child is in danger of having FGM inflicted if not in the UK?

Professor Mathers: Absolutely. I agree with that 100%. If, as a clinician, one suspects that a child is at risk of harm in that way then it is mandatory to refer to social services.

Q319 Mr Winnick: As far as I understand these matters, a Catholic priest would always argue that according to his religion he cannot disclose what was in a confessional. This does not apply?

Professor Mathers: Absolutely not. As Mr Vaz has said, if a crime has been committed or is about to be committed then our responsibility is to put the child at the centre of everything that we do, and that means referral to social services.

Q320 Mr Winnick: Yes. Of course, if a crime has been committed that is pretty clear to a professional doctor or otherwise, but for a feeling that a doctor may have he or she can have no hard evidence that a child is in danger. If there is an instinct, looking at the family history and the rest of the background, you would accept that a doctor should not hesitate and should tell the authorities?

Professor Mathers: Absolutely. A wise professional would always discuss that feeling of the child who is at risk with colleagues and with social services, yes.

Q321 Mr Winnick: You would both agree I take it. Would you take the view that some doctors would feel a sensitivity that they are intruding—without in any way condoning FGM; far from it—but nevertheless feel that they are treating a certain type of patient, who may be Muslim? FGM is not exclusive to some—the vast majority do not—who believe in the Islamic religion. There are some who by probing, which they would not do otherwise, certainly to white patients or the rest, feel some sensitivity. That is a possibility, presumably?

Professor Mathers: It may be a possibility but the guidance from our college is absolutely clear that we should not have misplaced concerns around cultural sensitivity or anti-racism if we suspect that FGM has either taken place or will be taking place, and that our duty to that child or that young woman overrides any other politically correct concerns that a doctor may have.

Q322 Mr Winnick: You think that doctors accept that the overriding concern—as you rightly put it—is for the child; nothing else matters except to protect the child from such a crime?

Professor Mathers: Absolutely, and that is the firm view of our college.

Q323 Mr Winnick: That is your view yourself, presumably?

Janet Fyle: Yes. I want to add that we should not see this as some exotic rite of passage that happens to young girls in our country or be culturally correct, but we need to report any girl, any parent to the appropriate individual professional that we suspect to be at risk of FGM, and the mother having had FGM is such a risk.

Q324 Mr Winnick: The last question I put to you, the Chair—and I would not dream of criticising the Chair for one moment—seemed to feel that the professionals have been rather slow on the uptake. Do you think politicians have been somewhat slow? After all, I cannot

remember evidence being taken on this subject until now. You can be frank in your answers. The Chair was frank.

Professor Mathers: I would say that we haven't been slow. We have been talking about this for at least the past five years with college guidelines.

Q325 Mr Winnick: With respect, Professor, do you think politicians have been slow?

Professor Mathers: Frankly, yes, sir.

Professor Rymer: Yes, I do and I have been delighted over the last 12 to 24 months how the media and Parliament are now getting on board with this. I think the key to succeeding here is for joined-up responses, so we need education both in schools and in all the health professions. It has to be in our undergraduate curricula and it is not at the moment. We need to get the schools and schoolchildren to know all about it. We need all the health professionals. We need to get social workers and the police all working together, and I think that is the only way we are going to succeed and that is really important. We need your help.

Q326 Mr Winnick: Yes. Politicians slow?

Janet Fyle: I think there has been a general malaise among politicians, health professionals and others with this attitude of not offending cultural sensitivities. We need to focus on what the issue is, and it is about the health and wellbeing of young girls.

Q327 Michael Ellis: Pursuing this point a little bit, is the crux of the issue here whether it ought to be mandatory in law for doctors to report what they see in an FGM case, or mandatory by way of your professional bodies' ethics or code of conduct? There is a difference, isn't there? At the moment it is a requirement of your professional bodies, is it not? Please correct me if I am wrong. If you don't know also please say so but I think I am right, am I? Professor Mathers?

Professor Mathers: Yes.

Q328 Michael Ellis: I personally do not feel in the circumstances that it would necessarily be appropriate to create a new law about it but I am open to suggestions. Do you think that a new law should be put on the statute books to compel doctors, over and above their professional bodies, to report it, or do you think that they will do anyway, as in duty bound?

Professor Mathers: I think they will do it anyway, and I think that existing legislation is sufficient under child abuse regulations.

Q329 Michael Ellis: Professor Rymer, do you agree with that?

Professor Rymer: Probably. It sounds a bit weak but it—

Q330 Michael Ellis: Professor Fyle?

Janet Fyle: I am not Professor—

Michael Ellis: Sorry.

Janet Fyle: —but I do think that the existing imperatives upon professionals to report has been around for a long while, but professionals have failed to do so. We need to think what we do to move this issue along.

Q331 Michael Ellis: So you are interested in that. Do you know if it is right that there are other forms of injury that also there is a mandatory requirement to report to the police? For example, if someone comes in with a gunshot wound—I am not sure whether this is an urban myth but I think I have read it somewhere—that there is an absolute requirement on a doctor. They cannot just treat that gunshot wound. They have to report it to the police. Am I right about that, do you know?

Professor Mathers: One should certainly discuss it with the patient and I think if push comes to shove then the public interest outweighs the personal confidentiality.

Michael Ellis: So it is left to the discretion and judgment of the doctor?

Professor Mathers: Yes.

Michael Ellis: I mention it because it would be an example that has been in use for quite some time that we could marry up with this particular case. Do you agree with that? I want to say finally, briefly, that Mr Winnick has talked about how this has not been on the radar very long—and you have mentioned the last year or two—and that the media, I think the *London Evening Standard*, has done an awful lot of good work on this and have helped push the agenda forward. Thank you very much.

Q332 Mr Clappison: Can I ask one or two questions that arise in my mind out of what has been said already? First of all, Professor Mathers, so I can understand the whole picture on this, can you tell me in what circumstances that might arise in a relationship between a patient and a GP the GP might think that the patient had either been the victim of FGM or was likely to become a victim of it?

Professor Mathers: In that situation it is mandatory—

Mr Clappison: Yes, but how would it arise?

Professor Mathers: How would it arise?

Mr Clappison: Yes.

Professor Mathers: It may arise because a woman, for example, has recurrent urinary tract infections or particular menstrual problems. It may occur at the registration for pregnancy at the start of her pregnancy. It may occur with new registration when a patient registers with a practice, and one of the recommendations from the intercollegiate guidelines is that

when a new patient joins a practice a question about FGM is included in the registration data.

Q333 Mr Clappison: That is very helpful. Thank you for that. Professor Rymer and Janet Fyle, you have been talking to us on the basis that most FGM is carried out abroad; girls are taken to another country and it is carried out there. Do you believe that FGM takes place in this country as well or not?

Professor Rymer: Yes, I do.

Q334 Mr Clappison: How prevalent would you say it was?

Professor Rymer: We have no idea, no data, but I am quite sure it is happening in this country.

Q335 Mr Clappison: So there are people who are carrying out FGM? Girls are being taken to them for them to carry it out?

Professor Rymer: Yes.

Q336 Mr Clappison: Do you have anything to add to that, Janet Fyle?

Janet Fyle: Yes, I think FGM takes place in this country. What is interesting is the fact that the police have been chasing the cutters, because if you bring in a 60-year-old woman from a practising country and you get a dozen girls together, by the time those girls are cut the woman is on the flight back to where she came from. So we need to tackle it both here and when girls are taken out of the country. But we need to look at what teachers do because those girls who have FGM carried out here go back to school a different type of girl, and it is about how teachers identify and talk to young girls about a whole range of issues, which we do not currently do.

Q337 Mr Clappison: These are people—cutters I think is the term—who are brought in from another country to carry out the operation on a number of girls here, if you can call it an operation.

Janet Fyle: At FGM parties.

Mr Clappison: Yes. Is there anything you think that can be done to stop that?

Janet Fyle: I think that, because we cannot go after the cutter—we do not know who she or he is—the parents have to be held responsible for any harm that comes to the child.

Q338 Mr Clappison: Do you think there are cutters who are resident in this country who carry this out?

Janet Fyle: I don't know.

Professor Mathers: Can I just answer that?

Mr Clappison: Yes, please.

Professor Mathers: Relatively recently two doctors and one dentist have been struck off for being engaged in FGM, which you may or may not be aware of. None were prosecuted.

Q339 Mr Clappison: No, I understand. Could I ask you, Professor Mathers, how effective you think the multiagency guidelines are on FGM?

Professor Mathers: I think they are excellent guidelines. They provide health professionals with just about everything that they need to know in order to tackle the problem. However, I think the issue as far as education is concerned is that most health professionals will be aware of the guidelines but not everyone is aware of the content of the guidelines. To a certain extent that depends on the prevalence of FGM within the practice population, so I am talking GPs here. In some areas there will be health professionals who are absolutely red hot about the guidelines applying and using them, but in other areas practitioners may only be aware of the guidelines and not the content because the prevalence is so much lower. As far as the guidelines, I think they are most definitely fit for purpose and they need to be used locally according to the need.

Q340 Mr Clappison: Do you think they should be made statutory or not? Is there any need for that?

Professor Mathers: Again, as I have said earlier, I think that existing legislation is sufficient to ensure that this problem is addressed.

Q341 Mr Clappison: Thank you. Professor Rymer, do you have anything to add to that on the guidelines?

Professor Rymer: I think Professor Mathers' point about the guidelines are relevant but they need to be read, and I think they need to be implemented with the intercollegiate group document that we did.

Q342 Mr Clappison: Janet Fyle?

Janet Fyle: I am assuming you are speaking about the Home Office multiagency guidelines?

Mr Clappison: Yes.

Janet Fyle: There are about 59 pages of that and if you are a busy health professional I don't know that you could get through 59 pages. I see it as being made statutory and mandatory, but operated from the local Safeguarding Children's Board, a multiagency hub. You will have the doctor, the midwife, the nurse, the social worker, or whoever it is, teachers, health visitors, come around that hub, each knowing what we need to do. But

whoever the professional is, they cannot read through 59 pages. They are good, but good to stay on the shelf.

Q343 Paul Flynn: I understand the Government has invested a large sum of money—£700,000—through the Victoria Climbié Foundation in order to reduce the effects of FGM. In practical terms, how do you see it working? We understand that there are a relatively small number of schools in which children would be at risk, but if the teachers in that school know that the young girls of a certain age are about to return on holiday to Horn of Africa countries, what can they do to stop it happening?

Professor Rymer: Refer to social services I assume. I am not working at the school age, clearly. I am a gynaecologist. Refer to social services, “This girl is at risk of child abuse”.

Q344 Paul Flynn: Does this in fact happen? Is it working that way? Are schools aware of what is going on? They have recommendations—

Professor Rymer: This is one of the problems I was trying to say before. It is the joining up of the social services, the schools, the health professionals, and the police. It is the joining up of all these people working together that I think has been the problem and we can do better.

Professor Mathers: I understand that the Department for Education’s statutory guidance only mentions FGM in appendix rather than as part of the core document.

Q345 Paul Flynn: We have all been alerted by the recent campaign by Fahma Mohamed. Do you think the Department for Education has responded adequately to her campaign?

Professor Mathers: That is outside my competency. I do not wish to comment on that.

Professor Rymer: I think we need more data on the department’s plans to protect these girls, and I do not think we have that data now. We need action points and plans from the Department for Education.

Q346 Paul Flynn: When the child has returned from one of the countries and the schools suspects that FGM has taken place, what should they do then? Do they have an obligation or are they empowered to examine the child and to report it?

Professor Rymer: Yes.

Professor Mathers: Yes, I think a teacher should be under the same professional obligation as a clinician. If he or she suspects that some harm has been done to that child then the child should be referred to social services, if not the local health professional who should do the referral. Again, I would support Professor Rymer’s point about this all needs to be joined up and we all need to be working from the same set of rules.

Q347 Paul Flynn: A final question. Do you think that the publicity that has occurred—and I believe, as my colleague, David Winnick has said, that we are probably all responsible for not

paying this matter the attention it deserved—means that things will improve in future and that there will be more recognition of the dangers to the children in some way?

Professor Rymer: I think the awareness of FGM has come up enormously over the last two years, and I think that is great. We are all much more aware of it now and hopefully now we will get the joined-up management of these girls and the girls at risk.

Janet Fyle: I want to come back to your previous question about teachers. The NSPCC carried out a survey—I believe it was in 2012—and 83% of those teachers said they don't know anything about FGM, so we need to be careful what rules we are assigning to teachers before they are adequately changed. Secondly, the *Working together to safeguard children*, those professionals who work with children could work within the context of those documents, the ones in 2010 and 2011. It does not have to explicitly say that the child is at risk of FGM but that the child is at risk of harm.

Then finally, I want to say that we need to be careful here that we don't say, "Because we have raised the issue of FGM it is going to get sorted out and all will be well". There are many young women in this country that need access to psychological therapies. We need to make it easier for those young women to access such therapies. We need to make it easier for those who have not disclosed yet to us to disclose because sometimes at the antenatal clinic it will be the first time that a woman has talked about FGM, so we need to make it easier to refer them for psychological therapy as well.

Paul Flynn: I am grateful to you. Thank you.

Q348 Michael Ellis: I noticed in the submission of the Royal College of General Practitioners that it highlights that GP systems have a specific code for recording FGM. To what extent, Professor, do you think that GPs are aware of this code within their systems and are actually making use of it?

Professor Mathers: I think that is a very good question. Very often there are a lot of services within our computer systems that we are not necessarily aware of. One of our roles as the RCGP is to make sure that people know that there is a code for FGM. Indeed, with the new set of codes that we are going to publish in June, read codes, it does have the statutory recognition of FGM as one of the codes. So we do have new guidelines that will appear in June, which give six codes for FGM that are to be incorporated within the systems. That is really useful because it enables audit around the prevalence as well. Perhaps that will answer Mr Vaz's question, because then we will know how many have been referred and how much activity there is.

Q349 Michael Ellis: Just so people understand, is there a code for every type of injury, ailment and condition, and GPs basically have to put this code within the computer systems?

Professor Mathers: Yes, that is right and then that code can be shared with other health professionals, so you get a quick list of diagnoses.

Michael Ellis: Thank you very much.

Q350 Chair: Professor Rymer, you talked about historical cases and I accept that at the moment you may not be practising because of your role as a member of the Royal College, but are you seriously telling this Committee that there are no current examples? You talk about people coming to you who have had their FGM done to them 16 years ago. Are you telling this Committee that there are no recent examples that you have come across or your members have come across?

Professor Rymer: I need to clarify that I am still a practising gynaecologist.

Chair: You are?

Professor Rymer: Yes, very much so. I just don't do obstetrics. I still have an FGM clinic every few weeks and I am seeing mainly young women who have had FGM done some time ago as a child. Some were aged between four and 10 years old.

Q351 Chair: Yes, but there are others where it is happening now.

Professor Rymer: I am not seeing those in my clinic.

Q352 Chair: And nobody in your Royal College. How many members are there in your Royal College? Thousands?

Professor Rymer: Many thousands, yes.

Q353 Chair: Are you telling this Committee that among the many thousands of members of the Royal College none have come to the Royal College and said, "Look, this is ongoing at the moment. We need to do something about it"?

Professor Rymer: I am not aware of anyone doing that recently, no.

Q354 Chair: Professor Mathers, on a daily basis, on an hourly basis, GPs are seeing young girls who have suffered the mutilation of FGM. Are you also telling this Committee that there are no current cases that you are aware of, or are you saying to this Committee that there are such cases?

Professor Mathers: Our members report that there are such cases. The difficulty is having the data. With the new FGM codes we will be able to find out the extent of the problem, but members do tell us and, as I said earlier, we have been working on this for the last five years in terms of trying to produce appropriate, effective guidelines that enable timely referral of young girls and women who are at risk of FGM, or have had FGM, to the appropriate social services.

Q355 Chair: I wanted to become a doctor but I did not get the grades, so I became a politician. But these are supposed to be clever people and you must be writing to them very regularly. Would they not realise that if they saw a case of FGM they should report this case? Are they really waiting for you to finish your five-year guidelines?

Professor Mathers: No, as I say we have done a series of reports over the last five years.

Q356 Chair: Yes. Are they waiting for these reports and these guidelines?

Professor Mathers: They are not waiting for these reports, no, sir.

Q357 Chair: Are there not intelligent enough members of your profession to understand that it is happening now in their thousands and they need to report it now?

Professor Mathers: I think that all GPs, if they suspect a case of FGM or abuse, will refer them to social services. Where they go from social services is perhaps another issue.

Q358 Chair: But the Royal College has no information for this Committee as to how many have been referred, for example, in the last year?

Professor Mathers: No.

Q359 Chair: Are you now going to get that information?

Professor Mathers: We will be able to get that information with the new read codes.

Q360 Chair: Which come into effect—

Professor Mathers: We hope that they will come into effect in June this year.

Q361 Chair: By then some more young girls will have been subjected to FGM. Do we have to wait until June?

Professor Mathers: It takes time to implement change.

Q362 Chair: Even though as we speak we are told there are victims. They just have to wait for the codes to take effect?

Professor Mathers: Not at all, no. The codes are to help us to find the extent of the issue and to help us audit and make sure that appropriate action has been taken. The actual referrals are going on all the time by all our members. Any child who is suspected of experiencing FGM or about to experience FGM will be referred under the current child protection guidelines, because GPs, health professionals all have a statutory responsibility to do that and that is going on all the time.

Q363 Chair: Yes, and one of the reasons we are having this report is because it has all been such a failure, hasn't it? Nobody has been prosecuted until now after 20 years. As Mr Winnick says, even the politicians have woken up to this and everyone is saying there have been no prosecutions. Did the Royal College sign up to the intercollegiate report?

Professor Mathers: Yes, we certainly supported the intercollegiate guidelines.

Chair: So you have signed up to it?

Professor Mathers: We are signed up to it, most definitely.

Chair: And you support its recommendations?

Professor Mathers: We support its recommendations as well. But the question of prosecutions must surely be as much to do with the Crown Prosecution Service as it does with referrals.

Q364 Chair: I can assure you that we have had the DPP in here. What we found as a feature of our evidence sessions is that each set of agencies say it is up to somebody else, and quite a lot of the agencies have said it is up to you because, of course, at the end of the day people around this table do not examine people on a regular basis but GPs do. Therefore, you are the best people in those circumstances to be able to be on the front line on these issues.

Professor Mathers: Absolutely, and I would say that the referrals going on—

Q365 Chair: But you are quite happy. You think that things should carry on as they are?

Professor Mathers: Absolutely not.

Chair: You do not want a change in the law?

Professor Mathers: I don't think the law needs to be changed. I think that we need to implement the guidelines more effectively.

Q366 Chair: We are going to hear evidence a little bit later on from colleagues from France. You will know that there have been quite extensive prosecutions in France. Has the Royal College had any dialogue with your colleagues in France to see what they are doing in order to get these prosecutions?

Professor Mathers: Not to my knowledge, Mr Vaz.

Chair: None?

Professor Mathers: Not to my knowledge, no.

Q367 Chair: Not to your knowledge. Professor Rymer?

Professor Rymer: No, I don't know of any.

Chair: No, you haven't?

Professor Rymer: No.

Q368 Chair: Ms Fyle?

Janet Fyle: We know what is going on in France and also in Spain, hence my earlier comments about making parents responsible for the harm that comes to their girls. We have been urging the Director for Public Prosecutions to change the way that evidence is given at the moment, so that girls under five can tell you who carried out the FGM. Babies two weeks old cannot tell you but the state can do it for them. This is what we are urging the DPP to do, as a Royal College and as a joint body that produced the intercollegiate report.

Q369 Chair: As you have said, this is not just about the UK, this is happening in other countries.

Janet Fyle: Yes.

Chair: Do you think good practice should therefore be shared between these countries and there may be a need for your organisations to find out what is happening there?

Janet Fyle: Sometimes good practice can be shared but perhaps there is a certain aspect of the way the French go about particularly examining little girls that I would not approve of, but I will approve of the way Spain makes the parents responsible.

Chair: Indeed. Perhaps you can hang on and hear the evidence we are going to hear. Mr Winnick has a final question.

Q370 Mr Winnick: Public health advertisements are taken from time to time, which obviously you are very familiar with. Would it help if there were such advertisements on FGM on television screens and the rest, warning of the consequences if this crime was committed, and reporting it?

Professor Mathers: I think that anything that raises the publicity and the issue itself is good, but I think that any posters or advertisements that threaten punishment would be unhelpful because it would dissuade people from going to the access points, to the health service to see their health professional. They should be, I suppose, like sexually transmitted disease posters, which is “If you need help come and talk to us in confidence about it”.

Q371 Mr Winnick: Presumably you both agree, without the question of punishment?

Janet Fyle: I disagree because I remember when people said we should not talk about domestic abuse and domestic violence, but the minute we put up a poster by the tube station—I remember seeing that poster, “This morning he gave her flowers and in the evening he gave her a black eye”—people woke up to domestic violence and I think we should do the same for FGM.

Mr Winnick: Professor Rymer, do you agree?

Professor Rymer: Yes.

Mr Winnick: Thank you.

Q372 Chair: Just one point. Leyla Hussein in her evidence to us on 11 March said this, “The moment a girl child is born it should be alerted on her red book”. This is the possibility of FGM. “The red book will go to the health visitor. The health visitor should pass that on to the nursery. The nursery should pass that on to the primary school teacher. Without even physically examining them, the parent knows that these children are being monitored. The school nurse will have that information and it will carry on until high school”. Do you agree with that practical approach that has been suggested by Leyla Hussein to this Committee? Professor Mathers?

Professor Mathers: I think that the use of the paediatric red book has been very useful to identify conditions that individuals are prey to or susceptible to. I think the only danger is labelling; that because a child is born to a particular ethnic group the labelling would perhaps be problematic. But I think as risk identification within the health records it is extremely useful.

Q373 Chair: Professor Rymer?

Professor Rymer: I think it is really important and particularly now that the red book is going electronic that is going to make it more powerful. But I think it is really important.

Q374 Chair: Janet Fyle?

Janet Fyle: Yes, I think so and excuse my impatience for not subscribing to this idea of labelling, because we are health professionals and there is something about the health and wellbeing of a child here. So whatever it takes to protect that girl we must do. I am pleased that the red book will be used in this manner, and if the parents say they have lost the red book there is an electronic backup to say a health professional or social worker has had the discussion with the parents about FGM and they have talked about the law and they have talked about the consequences. It will be recorded.

Chair: Thank you very much. Professor Mathers, Professor Rymer, Ms Fyle, thank you very much for giving evidence today. We are most grateful for your time. Thank you.

Examination of Witnesses

Witnesses: **Obi Amadi**, Community Practitioners and Health Visitors Association, **Dr Kerry Robinson**, Consultant Paediatrician, Whittington Health, and **Dr Comfort Momoh MBE**, African Well Women’s Clinic, Guys’ and St Thomas’ Hospitals, gave evidence.

Q375 Chair: Thank you very much for coming here to give evidence. Some of our questions will be a repetition obviously, because the subject matter is of interest to this Committee and some of the questions need to be put to all witnesses, but we are most grateful. If I could come to you, Obi Amadi. We have come to the end of our inquiry, although we will be

making some field visits. One I hope will be to St Thomas' to have a look at your clinic, Dr Momoh. We are very keen to go out rather than just sit in Westminster. Because it is only across the river, of course, it has taken months to arrange this, but we will do this.

What struck me, as someone who knows very little about this subject and knew very little until we began our inquiry, is this seems to be a complete car crash. Here you have a very firm law. You have well meaning professionals, all wanting to do something, but at the end of the day it is continuing day after day after day. Are you satisfied, as far as members of your organisation are concerned, that they have the tools and the ability to report this horrendous crime and to get something done about those responsible? Ms Amadi?

Obi Amadi: In my response to you I would say that there are some health professional concerns in terms of being able to fully address this issue. We would not be at the stage that we are now without the help, the stories from the people who have been subjected to FGM, and for that I would like to thank them because otherwise we would not be having this discussion today, right now.

In terms of health professionals, there are a range of things that I think have created the car crash that you describe. I think there is an ignorance in terms of the real repercussions of FGM in terms of health professionals. There are problems around the reporting and recording systems that we have that makes it sometimes something that health professionals do not always see as a priority and address in the way that they should. They—

Q376 Chair: But as far as your members are concerned—because we have heard from the other professionals over the last three months—are you satisfied that they know enough about this and are reporting it? We took evidence from the police last week and they were very clear that there were not the kind of referrals that they would have expected. They need the referrals to do the prosecutions, not the other way around. Are you satisfied that this is happening among your—

Obi Amadi: It is not happening enough. It is not happening the way that it should.

Q377 Chair: Tell me what your members should be doing.

Obi Amadi: In terms of when they meet and they are giving care and services to women who may be at risk, or the women who have children who may be at risk, there needs to be more diligence applied in terms of the questioning, the flagging up and the referring on of these women who are at risk. One of the problems in terms of health visitors—because if I speak from the health visitor and the school nursing perspective—it is not always reported by the midwife, so the health visitor is not always aware. In terms of the prevalent countries where FGM is practised, for some health visitors they are not aware of what those countries are. So the level of information—

Q378 Chair: You are saying there is a huge awareness problem before we get on to anything like referral?

Obi Amadi: Yes, there is.

Q379 Chair: Dr Momoh, you have obviously done a huge amount of work. You are widely respected in this field and we have seen all the statements that you have made and all the positive work you are doing at your clinics. Do you accept what the Royal College has told us, which was basically, “If it is 16 years old we cannot do anything about it now and, therefore, we will not really refer” or do you think every single case needs to be looked at very, very carefully no matter how long ago it was that it happened?

Dr Momoh: I guess we need to review all cases. I think the problem we have had is we are not having a joined-up approach, which has been the case. We need to work together and have a multiagency approach if we need to do anything around FGM. I would urge that we review all cases. Obviously we need to raise more awareness because from my own experience in working within health, I would say perhaps 50% to 60% of health professionals are unfortunately still unaware of how to refer cases to health visitors or to social services. Also, we all need to know what our roles and responsibilities are. We need clarity on that. I have been trying to work very closely with social services within Lambeth and Lewisham where I work, but it hasn’t been very successful because they are not aware of what their roles and responsibilities are. Each time they say, “Even if you refer cases to us what are we going to do? We don’t have the capacity and we don’t know what to do. We need a clear—”

Chair: Direction.

Dr Momoh: Yes, pathway if you like.

Q380 Chair: Therefore, do you feel that there ought to be statutory referral and that people who see this happening need to refer it on as a matter of law; it needs to be mandatory?

Dr Momoh: I guess there needs to be mandatory reporting. That is why we have been working with the Department of Health so that we can have robust data; so that we can have a clear pathway. At the same time, we need to know who we are referring. Are we referring all cases to the social services or to the police? That needs clear direction because from my own experience and also from working with other colleagues, what we have come up with or what the consensus is that it is mandatory to report all pregnant women obviously rather than gynae or women coming with gynae cases or to the clinic or family planning.

Q381 Chair: Indeed. To give the Committee an idea of your average month at St Thomas’ or Guys at your clinic, how many cases would you see of FGM now in a typical month? I know there is no such thing, but give us some figures on this.

Dr Momoh: Yes. It varies. Typical months on an average perhaps about 38 to 40 cases every month, and we see pregnant and non-pregnant women obviously. The non-pregnant women come for various reasons.

Q382 Chair: You endorse the view that this is going on as we speak; somewhere in London FGM is being committed against a young girl?

Dr Momoh: I believe so.

Q383 Chair: Dr Robinson, did it come as a shock to you and your colleagues when one of your colleagues—we are not going to talk about the case but whatever is in the public domain—was prosecuted at the Whittington Hospital for FGM?

Dr Robinson: So the question is was it a shock? Yes, that was a shock but the specifics of the case are yet to come into the public domain.

Q384 Chair: Yes, we know, we are not trying the case here. This is therefore happening, as Dr Momoh has said, in every hospital in London. You are getting cases of this kind coming before doctors and to casualty on some occasions. Yet they do not seem to be being referred on, so we have the police telling us, “We could do much more if only we had more referrals”. What stops people referring on these cases?

Dr Robinson: From a paediatric perspective, I think there is a lack of awareness. There is a lack of awareness about FGM. There is a difficulty having the conversation. There is a time issue in the way that we practice. You cannot always have that sensitive conversation, and certainly, if you are not used to using that language in a quick 10 minute consultation, to suddenly ask about cutting when you might be seeing them for a respiratory tract infection is tricky. So there is something about education. There is something about the setting. But I think the infrastructure with a referral to social care is there. Female genital mutilation, or cutting, is child abuse and we have good infrastructure for child protection within the world of paediatrics. If it is seen within that context, then the pathways of referral and information sharing are there.

So, if I talk about the cohort of patients of children that we have collected at University College Hospital—

Chair: Over what period?

Dr Robinson: Collected data from 2006, so up to date that is eight years. We have had 34 children that have been referred. 10 of those had had no FGM and 24 had had FGM. So this is just children under 16. Of those that could have been referred, i.e. it was within the law post-2003, then seven were referred to the police but none of them have gone forward from there. We don’t always get the feedback but the thinking is that the police do not have the evidence to prosecute because it is incredibly difficult to get a child to speak out against their family because FGM is done within the context of a loving setting.

Q385 Chair: We understand all that and that is very helpful to remind us of that. But what is interesting about what you have said is three points: first of all that the number is so low. It is only 34 in a hospital like the University College Hospitals. Secondly, that the police have not come back and told you why and you would like to see more feedback. You say it is working, but is it really working? Until you got to the prosecutions at your hospital 20 years have gone by and absolutely nothing has happened by way of a prosecution. How can it be working when we have been given figures of thousands and thousands of girls and women in the UK having been subjected to this?

Dr Robinson: Sure. So it is not working. What we don't know is what we have prevented. Prosecution is only one top-down infrastructure. There should be a bottom-up approach as well that has been talked about in these settings: education across the board, engagement of community workers, engagement of appropriate people to talk to both men and women within practising cultures, across the board education in schools, both in primary and secondary tiers. People who come to hospital are only a minority of the population, so there are—

Chair: Sure. It is the GPs who would probably see many more of these cases.

Dr Robinson: But the point I was thinking about when the GP was talking was that to identify female genital mutilation in a child is incredibly difficult, even for a paediatrician who looks at children's genitalia on a regular basis. Often there is nothing to see, so type 4 you do not even see it. You do not see that and in several of the cases that we have seen there is nothing to see even when examined by a specialist. Also the changes over the course of puberty are difficult to identify. So I think it is not right to expect a GP to be able to identify those changes.

Q386 Chair: That is very interesting. Finally, from me, in terms of statutory changes, Obi Amadi, should there be a change? You think this should be done on a statutory basis, do you?

Obi Amadi: I think there needs to be some strengthening of this. The level of awareness that would go with that would I think be most helpful in terms of increasing the number of cases that are reported.

Q387 Chair: Dr Robinson?

Dr Robinson: I think that the infrastructure that we have in place is enough. I think that education is more important, raising awareness, a poster in every healthcare setting telling people who to go to, who to contact if they are worried, a campaign across the board.

Q388 Chair: Thank you. Dr Momoh?

Dr Momoh: We need to raise more awareness and also we need to work directly with the community. It is very, very important.

Q389 Chair: Which is perhaps not happening at the moment. We have had Leyla Hussein and others obviously coming in and there is a lot of work to be done.

Dr Momoh: We need to improve in that. Yes, definitely.

Chair: Thank you.

Q390 Mr Winnick: The multiagency guidelines obviously are meant first and foremost for health professionals, as one would expect. But the point is made that they should also apply to teachers, social workers and so on. There was a survey carried out by the National Society for Prevention of Cruelty to Children, which said that many professionals lacked

understanding and knowledge. But when it came to a YouGov poll last year about teachers and FGM, it found that seven out of 10 teachers—so this is a poll, which may not be accurate—said they were not aware there was Government guidance on how they should be dealing with FGM at their school. One in six teachers said they did not know that FGM was illegal in the UK and that there was a legal duty on them to take action to safeguard children at risk. Does any of that come as a surprise to you; that there remain so many teachers who are not aware of the problem?

Dr Momoh: Not at all to me, but it clearly demonstrates that there is a lack of awareness and it is similar to health as well because although we have the multiagency guidelines, we have the professional body guidelines, but professionals are not aware of these guidelines. I think we need to do more to point them to these guidelines. The guidelines are there. They are there to support us as professionals, as frontline providers, but half of us are not aware of these guidelines. I know that from some of the research or scoping that I have done recently.

Q391 Mr Winnick: Is that your view?

Dr Robinson: I would echo the same. The guidelines are in place. It is about using them. It is about education for professionals, consultants down to juniors within the world of health.

Q392 Mr Winnick: How far do the three of you feel that there still remains a—how can I describe this—cultural reluctance, not necessarily accusations of racism as such, but a feeling that one has to be ultra-sensitive and therefore hesitate to take the sort of action that obviously needs to be taken? Do you think any of that remains among doctors and other professionals in the health field?

Obi Amadi: I would say it does, unfortunately. I think that again with more education and more clarity about the issue, health professionals will feel much more confident about addressing it and not think, “If I raise this with a woman, people will think that I am being racist”. Once you are very clear about what the issue is and the fact that this is about protecting children, the voice of the child that we don’t hear when they are so young, the health professionals should not have any problem. There should not be a conflict. It should be a straightforward thing to do.

Q393 Mr Winnick: Dr Robinson, to be blunt about it, does this sort of ultra-sensitivity exist among some white professionals, wrongly as we all know and you are the first to say this?

Dr Robinson: I think less so with increasing teaching around child protection and teaching professionals how to have that conversation in simple, straightforward language. Before there was the campaign around domestic violence, people found that a difficult conversation to have. If you put it as part of your history taking when you take a family history as a standard question to ask, “Are you related to your partner?” which if you ask a white Caucasian they think you are mad but it is a routine question that you ask or, “Is

there any domestic violence?” “Does your community practise cutting?” then the sensitivity is taken away. So, yes, to a degree, but getting better.

Dr Momoh: I think we need to move away from the sensitivity issue. If we see FGM as child abuse, we all need to work together and safeguard girls and young women who are at risk, so we need to take that sensitivity barrier away.

Mr Winnick: Child abuse?

Dr Momoh: It is child abuse and that is what it is.

Q394 Mr Winnick: My last question is one I put to the previous witnesses, namely do you think it would be useful to have advertisements on television and elsewhere, making this even more of a prominent issue?

Dr Robinson: Yes, definitely. Raising awareness of practising communities, that it is illegal and it is child abuse would be great.

Dr Momoh: Could I add to that? I think so as well. I just came back from Nigeria. I was doing a scoping visit or scoping exercise and one of the advertisements that was around is “Clitoris is a gift. Don’t mess about with it” or something, so we need something like that out there. We need to have a global and exciting advertisement out there so that it will raise people’s awareness. People will be aware of FGM and know the consequences and ill effects of it, so to me we need to flag it out there.

Mr Winnick: I think a good amount of that could be done in Nigeria at the moment.

Obi Amadi: I agree completely. The information in the advertising also needs to very clearly say where you can go, how you go and the fact that there is somewhere safe that you can go to speak and have your issue dealt with.

Q395 Chair: Dr Momoh, was that a Nigerian Government advertisement or was it by one of the—

Dr Momoh: I think it is a local advertisement and they are out there trying to raise more awareness and work with the local communities.

Q396 Chair: The figures from some of the west African countries are horrendous in terms of FGM and even higher than Nigeria, are they not?

Dr Momoh: In Nigeria, although it says 30% to 40% prevalence, because of the population size it is the largest in the whole world apparently. Nigeria has a population of about 160 million to 166 million, so it is very high.

Chair: It is a very large figure.

Q397 Mr Clappison: As a matter of pure curiosity on the Nigerian point—and I haven’t visited Nigeria—Nigeria’s population is divided roughly between the Christian south and the

Muslim north. Am I right in imagining that it is not prevalent so much among the Christians in the south and it is more of an issue for the north?

Dr Momoh: Not really. It is both.

Mr Clappison: It is both, is it?

Dr Momoh: Yes. From the scoping exercise, it happens in the south, south-west.

Mr Clappison: So it is a widespread cultural thing.

Dr Momoh: It is, definitely.

Q398 Mr Clappison: Could I ask each of you in turn if you think the standard of services for women who have undergone FGM is good enough and is there anything else you think the Government should do to improve them? Perhaps we will start with Obi.

Obi Amadi: There are sometimes issues with access to specialist services available to women because maybe there are not enough specialist services set up. Also, apart from dealing with the physical, there needs to be a good, strong psychological service so that women have somewhere that they can go to and be treated without a time limit, “And then we can’t see you anymore”. It has to be something that is substantial and meaningful.

Dr Robinson: I would echo that. I am a paediatrician, so obviously I come from services for children of which there are very few. The service at UCH works with the well women’s service. So it is limited and I also echo what was said that it is the long-term psychological, mental health consequences that are not catered for. So it is much more commissioning of services and also for the commissioners to understand the problem, which is why data collection is so important. We need services and we need commissioners to understand the problem so that the appropriate services are commissioned.

Dr Momoh: I guess we need more clinics. I run one of the few clinics that we have here in the UK—I think we have about 15—and we have women having to travel from Manchester and Bristol to my clinic. It would be very good to have clinics in different cities and areas. I echo that psychological wellbeing is very crucial and very important. Coming to seek help, from my experience of working with women, brings flashbacks. It brings memories, so these need to be addressed and supported. I think I will slip this in: I am off to Ireland tomorrow to launch the first FGM clinic in Dublin, which is good.

Q399 Mr Clappison: In your clinic’s evidence you said you were seeing 38 to 40 cases a month. Are those new cases?

Dr Momoh: Some are new cases but mostly follow-up, like pregnant women who are coming to have their second babies or subsequent pregnancy. Again, we need to see them to give them necessary information, address issues and readdress legal issues as well.

Q400 Paul Flynn: I think your evidence has been very helpful. What I would like to ask—and I know this is possibly outside your expertise—is do you have any ideas of how we break

down the cultural loyalty in these communities to this practice? It is very difficult to get across that what has been happening to them for generations is very undesirable. Have you any ideas of how this might be done?

Dr Robinson: There are pockets of good practice and there are community workers who have gone into local communities and held focus groups, with both men and women. We know from the UNICEF report that it is beneficial for men and women to talk to each other. Often each sex does not know about their partner's attitudes towards FGM, so it is to get people talking about it within their own community and for them to meet people who have not been cut, because often they think that is not a good thing, from my understanding. It is to meet people who have not been cut and to say that it is all right not to be cut, for people to have role models in other ways rather than the generational expectation that you will be cut.

But it is also education. Everybody in this country goes to school and compulsory sexual education in both primary and secondary school would be a way forward, not just to teach the children but to invite their parents in before you teach a child. You could say, "We are going to have this workshop on FGM" but invite the parents the week before so that they know what the authorities are going to teach their children and then that conversation is had at home, to break it down into an education thing.

Q401 Paul Flynn: It is very difficult to persuade adult Somali women and men to mix together on social occasions when they are strictly segregated. To get them together to discuss this I would imagine would take a great deal of persuasion.

Dr Robinson: It does but it has happened. There are pockets of good practice where it has happened that probably Comfort knows better than me.

Q402 Paul Flynn: Where are the good practices, apart from in France, which we are going to hear about later?

Dr Momoh: They are doing fantastic work in Bristol.

Q403 Paul Flynn: Could you let us know what is happening in Bristol, from your perspective? We have heard from Bristol, but what is your view of it and is it something that we can emulate elsewhere?

Dr Momoh: I guess so in terms of multiagency work and the multiagency approach, the schools, the health, and also they have the national action plan. For good practice I must not forget my area, Lambeth, where we are doing fantastic work, not because I am from Lambeth or because I work in Lambeth. We have the national action plan and we meet regularly and we not only look at FGM but we look at violence against women as a whole.

To answer your first question, in terms of what to do I think we need to mobilise everybody. We need to work together with young people. We need to empower the young people. We need to work with the older generation. As you have rightly said, it is very difficult to change their mind-set and their attitude, but we need to work with everybody. The young people are going to be the future generation. We need to be able to empower

them and to feel comfortable in addressing FGM as well. We need to work with the religious leaders. If some believe it is a religious obligation, we need to demystify that issue. Also we need to work with the community leaders as well.

Q404 Michael Ellis: Do you think that with respect to monitoring of the FGM risk there is a case for separately identifying the risk of FGM in personal child health records, the red book that is given to parents? Do you think there is a case to separately identify it in that way? Should there be a statutory duty on health visitors to ensure that this information is included in the GP's computerised notes for mother and child? I would be interested in your views on that.

Obi Amadi: I think entry into the personal child health record is perfectly appropriate. As we have heard earlier, people initially feel uncomfortable about asking particular questions. With the training and awareness raising, professionals will be much more confident in being able to raise that. In particular, the relationship the health visitor has with a woman is something that is built on, so they could have the subsequent conversations. In terms of mobile families, once it is there in that record it remains in that record. I know that there are people who say that the record will just disappear and get lost. They don't go missing in other high risk notifications in personal child health records. From that point of view, I say yes.

In terms of the GP and it being statutory, health visitors in their practice don't necessarily have access to or work in GP environments to be able to do that. We are awash with different information data systems, so health visitors will have their child information system where they work and that usually does not speak to the GP system. It is one of those where we are caught up.

Q405 Michael Ellis: So you feel in your case that it is a yes to the red book but that it would be asking too much as far as health visitors are concerned to make sure that is placed on a GP's records?

Obi Amadi: I think that would happen more easily if the responsibility was for the employer to have it happen, but it is less practical for the health visitor to have to physically drive to a centre, unless there is another way of getting that.

Dr Momoh: My own experience starts with the midwife because the midwife is the one who is going to give out the red book. It is very important that all midwives identify the risk and then notify it in the red book so that, once it is passed to the health visitor, the health visitor can in turn liaise with the GPs as well as social services. I think the midwives needs to know what their roles and responsibilities are for making sure.

Q406 Michael Ellis: Would you be confident that the red book would be sufficient?

Dr Momoh: Definitely.

Michael Ellis: It is respected in other areas sufficiently that if it was in the red book it would get followed through the chain?

Dr Momoh: We hope so, but it needs to be backed up electronically as well because the red book can easily be misplaced or get lost, which happens from my experience.

Q407 Michael Ellis: No system is foolproof of course. Dr Robinson, did you want to say anything?

Dr Robinson: I think there is a space in the red book within the family history bit where you can write that this mother has had FGM, but you have to think about the reason that you are writing it in red book. You are writing it to highlight that this child is at risk of the procedure. Documentation is obviously important, but the important thing is to have that conversation and ask the mother what her intentions are for that female child. It has to be really clear who is going to have that conversation. Whose responsibility is it? Is it the paediatrician when they do the health check, is it the midwife, is it the health visitor, and has that conversation been had? So, documentation is important but the most important thing is having that conversation and safeguarding the child.

Q408 Michael Ellis: It is very difficult, isn't it, because none of these people are police detectives? They are having to ask questions that they may not feel comfortable asking and certainly the person being questioned may not feel comfortable in answering. It is quite an ask, isn't it?

Dr Robinson: It is but, as we said previously, once you get used to having those conversations, if it becomes a standard setting, if you ask it to everybody, then it destigmatises it. If you ask it to your white Caucasian who you think is not going to have it happen then they might laugh at you but it raises awareness, so there is a role for that. But also you are having those conversations, so you are meeting a woman who has just had a baby. If you are the midwife you have been asking all sorts of questions around that, to then say, "You have been cut. Will you do that to your own daughter?"

Michael Ellis: It is more fitting.

Dr Robinson: It is.

Obi Amadi: Going on from that and just thinking about the example of it being asked across the board and people feeling uncomfortable about it, we had that problem in the past over sickle-cell until we had more and more cases of white people with sickle-cell disease. In terms of the child health record, we need to remember it is the child's record so the mother's status and the mother's health should not be recorded in it. It is just about the child at risk not whether the mum has had FGM or not.

Q409 Chair: We will be hearing very shortly about the experience in France and, of course, Dr Momoh has been to Nigeria to look over there and see what is happening. From your point of view, Dr Robinson, do you think there is a sufficient exchange of information in London itself between the Whittington Hospital and St Thomas' and Guy's? This is obviously happening all over London as we speak, as we know. Doctors are very busy professionals. Where is the mechanism for you all to be able to sit down, other than at the Home Affairs

Select Committee giving evidence, to actually talk about pushing the barriers forward on this issue? Is there such a mechanism at the moment?

Dr Robinson: Not specifically for female genital mutilation, cutting, but if it is seen within the child protection infrastructure then health professionals do liaise. There is supervision for child protection, certainly for paediatricians, that is not necessarily pan-London but sector-wide and so difficult cases are discussed. If a case is seen within the infrastructure of a child protection situation then there is a forum to discuss it, but I don't think there is enough sharing of practice specific to FGM.

Q410 Chair: Ms Amadi, as far as your organisation is concerned—you have been invited to give evidence here—are you called upon by the Royal Colleges to be part of a dialogue on this issue? Have you ever been asked, as an organisation, your views as to how you would fit into the jigsaw that is the prosecution system?

Obi Amadi: Our organisation is part of the intercollegiate group that put together the recommendations and we have had those discussions in the past leading up to the production of the report, so we have had some of that discussion and debate.

Q411 Chair: But that is discussion and debate. We are talking about practical cases. Is there a proper exchange of information on practical cases on a regular basis?

Obi Amadi: I would have to say that it is lacking. It could be better.

Q412 Chair: Dr Momoh, if you were looking at one way in which perhaps the doctors could improve reporting what is happening, what would that be?

Dr Momoh: I think, as you have rightly identified, everybody speaking together, which is really lacking. Exchanging expertise, information and knowledge is lacking, although I get involved with raising awareness in conferences. That is not enough. Maybe we need to set up a pan-London or national forum where we come together maybe once a month or bimonthly to discuss issues and real cases and how we can move things forward. That is lacking at the moment.

Q413 Chair: I understand that your clinic does a lot of reversals of FGM. Is that right?

Dr Momoh: We do.

Chair: I think the figure was given of 350 women have had reverse procedures.

Dr Momoh: Is that per year?

Chair: Is it more than that?

Dr Momoh: It is about 75 to 80 reversals or deinfibulation per year.

Q414 Chair: Do you ever come across a case where you have performed a reversal where the woman comes back, having had another procedure for FGM?

Dr Momoh: If I can remember, we had one case when the clinic first started. The clinic started in 1997 and I think we had one in 1998 and she denied that she had had reinfibulation. We have had one case.

Chair: Dr Momoh, Dr Robinson and Ms Amadi, thank you so much for coming in to see us. It has been extremely helpful evidence and we are very grateful indeed.

Dr Momoh: Thank you for inviting us.

Chair: We will be visiting your clinic, Dr Momoh, in the near future.

Dr Momoh: That is fine. You are welcome.

Examination of Witnesses

Witnesses: **Linda Weil-Curiel**, Lawyer at the Paris Bar, **Dr Emmanuelle Piet**, French gynaecologist and County Medical Officer of Seine Saint-Denis, and **Agnes Bangoura**, Interpreter, gave evidence.

Q415 Chair: Let us go to our final witnesses on our FGM inquiry, Linda Weil-Curiel and Dr Emmanuelle Piet. Bonjour. Merci beaucoup. Thank you very much for coming here. They are probably the only French words spoken at the Home Affairs Select Committee. We are most grateful to you for coming here to give evidence to us. We have heard a lot of witnesses over the last eight weeks and I have been over to Paris where I have met both of you to talk about what is happening in France. This is a unique opportunity for this Committee to hear about what you are doing in France from your point of view, Linda Weil-Curiel, about the prosecutions that you have undertaken, which we are very interested in compared to our prosecutions, and from your standpoint, Dr Piet, how as a gynaecologist you are able to refer cases to the appropriate authorities.

If I could start with you, Linda Weil-Curiel. I am not suggesting you are an expert on our methods of prosecution—and I know you are not—but why have you been so successful in being able to prosecute so many people responsible for FGM? I think it is over 100 separate prosecutions of cutters.

Linda Weil-Curiel: It is a bit difficult to explain because our systems are so different, but it all began because babies died after the procedure and of course you can't turn a blind eye to the death of a baby. When the first case was reported, nobody knew about the practice itself in France. It was in 1978. The Senegalese woman who was responsible for the death of the baby was tried for causing death to a baby but it was not considered like a volunteered act, an act that was wanted. Nobody heard about it because it was not a case that was reported, but in 1982 another baby died, little Bobo Traore aged three months. She was cut at her parents' home and the baby continued bleeding. The parents did not

want to go to hospital or seek medical help and the baby died three days later. When the baby had died, the father did not know what to do with the corpse so he called an ambulance and went to the hospital and then the cause of the death was found out. The parents were prosecuted for not giving assistance to someone who needed it.

Q416 Chair: It was a particular offence that was used, which was not FGM but a particular offence.

Linda Weil-Curiel: No. This is when I stepped in and I said, “Excuse me but before not giving assistance to this child, there was the voluntary act of cutting and this is mutilation”. This is among the highest crimes in our penal code.

Chair: The mutilation of an individual?

Linda Weil-Curiel: Yes, mutilation. I said, “You should prosecute under this qualification”, and this has been my personal battle, I am sorry to say. I did not want to come forward but I had to fight the prosecuting team because they said, “No, come on, you are not going to take a big hammer to squash a fly. Prosecuting is enough for these people”.

Q417 Chair: Yes but you found what you regarded as the right way to prosecute. How easy is it to convince? You have told us about your battle with the prosecutors. How many cases of successful prosecution for FGM have there been in France?

Linda Weil-Curiel: For my part—because we know of only two prosecutions and trials that I was not in; it was in Provence, outside Paris—I counted them before coming and I believe it is 43 and over 100 parents.

Chair: Over 100 parents have been prosecuted?

Linda Weil-Curiel: Yes, and punished.

Q418 Chair: Do you think these prosecutions, now that they have occurred, actually help to raise awareness to stop other parents doing this?

Linda Weil-Curiel: Yes. This was one of my aims, not only that the prosecution should be aimed at the right criminal qualification but I thought this is a way to lift the taboo. A trial in the highest criminal court, the assizes court, always gets a lot of publicity and there was something new about these trials and that sent a message because they all listened to the news and they knew, “Oh my god, if we do it and we are pinched then this is where we will end up”.

Q419 Chair: It started with the death of a baby and it ended up with this massive awareness about what was happening.

Dr Piet, you said something very interesting recently. You said, “People talk of culture and tradition, but children have a fundamental human right not to be mutilated. It is racist to think otherwise. Can you imagine the outcry if this was happening to white, blonde girls?” Why did you say that? What was so important about making that statement?

Dr Piet (Translation): Just because when we started taking care of female FGM we said it is sexual because it does not prevent anything on the genital but it prevents any pleasure for the women.

Q420 Chair: I think you will have to say your sentence and then the interpreter will speak, not simultaneously, because it is easier for us.

Dr Piet (Translation): In French we have chosen to call it sexual mutilation because it prevents mainly the pleasure not the sex itself. I work in a borough of Seine Saint-Denis. There are 1.5 million inhabitants and 42 nationalities, and 16% of the women from these nationalities were mutilated. All the ladies that gave birth in the hospital in that borough were mutilated.

Q421 Chair: All the women?

Dr Piet (Translation): 16%. We have worked for the prevention of FGM for 40 years now. At the beginning, the GPs had a lot of problems knowing what FGM was, because they were saying, “It is their customs. We should leave them alone to do this”. That is when I entered into action. We started working with them, but when the immigrants came to France they started mutilating children between zero and six years old. They were saying these children are not going to talk and they knew that it was a crime to do it. From that point, we talked to all our health professionals, telling them to be aware of all the different mutilations and check the children between the age of zero and six.

Q422 Chair: What Dr Piet is telling us is that the lack of awareness among the professionals themselves allowed this to continue in the way in which it has.

Dr Piet (Translation): We trained the professionals, telling them that it harms children, it is risky, it just hurts them and it is forbidden.

Linda Weil-Curiel: Excuse me, but there was something else that was added. Dr Piet called me in 1984 and she said, “Come and talk to my doctors because some of them are reluctant”. I said, “But it is against the law and if you do not do that and if you do not inform the prosecutor if you spot a child that has been mutilated, then the law will come on you because you have to inform them”.

Q423 Chair: So you basically said to the doctors that this was a crime that was being committed. If they just let it pass then the state would come after them, in effect.

Linda Weil-Curiel: Yes, because if you turn a blind eye then it is a very bad message that you are sending because you are contradicting what the doctors tell the mothers, “Don’t do it otherwise you will be prosecuted”. If you don’t inform the authorities when you spot that the child has been cut, then you allow the next little girl in this family to be cut, and

not only in this family but in all the vicinity because people talk, “The doctor says don’t do it but he saw that my daughter was cut. He didn’t say anything so I am going to do it”.

Q424 Chair: Let me ask you about the examination of young girls in France, because it is very important. We have been told that this is not compulsory but it is by invitation. How important is it that there is this examination of young girls in France? There is a view in this country that we are concerned if the state was to force young girls to be examined. We understand that is not the position in France, but that they are invited to come and be examined by their doctors. Is that right?

Dr Piet (Translation): We have in France free compulsory examinations. There are different stages where the children are examined: zero, nine months, 12 months and 24 months. All these examinations will then be sent to the GP.

Q425 Chair: Are those compulsory? Does every French child have to have this?

Dr Piet: Every French child, boy, girl, black, white.

Chair: They have to do it. What happens after two years?

Dr Piet (Translation): After two years, it is not compulsory but it is required that all paediatricians look at the children and examine them just in case there is any FGM.

Q426 Chair: You wanted to come in, Linda Weil-Curiel. How important is this?

Linda Weil-Curiel: It gives the evidence of the mutilation. If a doctor spots a child that has been mutilated, the doctor will report to their own administration, but I say no because it will go down in the sense of administration. You report immediately to the prosecutor and then the prosecutor opens a case because it has a medical certificate saying this little child has been mutilated, but it is not sufficient for the case to come. Then the parents are called to the police station for interrogation and all the girls in the family are also brought to the police station and the police take them to hospital for gynaecological examination. That is how a case is opened.

Q427 Chair: That is very helpful. Other colleagues are going to ask you questions and they will be very slow when asking questions.

Linda Weil-Curiel: Yes, because it is not my mother tongue and I need to understand.

Chair: We are very grateful. You are doing very well so far. Merci beaucoup. I don’t think we could manage this before the French National Assembly, but Mr Winnick is a noted linguist and he will—

Q428 Mr Winnick: If only I could speak your language like you speak English so perfectly. As I understand it, you said over 100 parents have been prosecuted.

Linda Weil-Curiel: And tried.

Mr Winnick: What was the outcome when found guilty?

Linda Weil-Curiel: They always are found guilty, except one or two fathers who could argue and prove they were not there at the time of the mutilation. They were in Africa or elsewhere so they had no influence.

Q429 Mr Winnick: What was the court's sentence in those cases?

Linda Weil-Curiel: It all depends, because our system is that the jury at that time was nine citizens plus three magistrates, professional judges. Together they all compose the court and they all decide guilty or not guilty and, if found guilty, the penalty. In the beginning, against my own will and wish, the penalties were suspended prison sentences but in my opinion it was not a good sentence because it sent a bad message. I know because of the African people I met afterwards and worked with. They said, "Everybody knew about this trial so we were all watching TV and when we saw the family walk out of court free then we understood that the French understood us". So it was not a good penalty.

Q430 Mr Winnick: Have there been no prison sentences?

Linda Weil-Curiel: Prison but suspended.

Mr Winnick: But no one has actually gone to prison, because the sentences have been suspended.

Linda Weil-Curiel: Yes, prison but suspended.

Q431 Mr Winnick: If I could get the position right: not a single person has been put in prison so far?

Linda Weil-Curiel: Yes, they have been afterwards but at the first trial it was suspended. The magistrates, the judges, the juries did not know anything about FGM, so they had to come to—

Q432 Mr Winnick: Yes, I understand. How many people have been put in prison where there has been no suspension of a sentence?

Linda Weil-Curiel: I didn't count but at least a dozen.

Chair: Maybe you can write to us. If you could let us have an email with that, that would be helpful.

Linda Weil-Curiel: Yes, sure.

Q433 Mr Winnick: Probably about a dozen?

Linda Weil-Curiel: Yes, but because our prisons are so crowded—I shouldn't say this because it is public—

Chair: And it is England.

Linda Weil-Curiel: Yes, the channel between. Under a certain penalty, we know that they will not go to prison. It can be changed by electronic tagging.

Q434 Mr Winnick: I would like to turn to another aspect. In Britain the extreme nature of some of the political organisations in France is known. Is there a political aspect where, to put it bluntly, parties on the extreme right campaign on this?

Linda Weil-Curiel: No, it is not a political concern. It is not.

Q435 Mr Winnick: I note that you belong to a non-political organisation that is renowned for human rights, the International Women's Rights League, and that has taken—

Linda Weil-Curiel: But it is not a political party.

Mr Winnick: No, I said it is a non-political organisation. Has this organisation taken a lead on this particular issue?

Linda Weil-Curiel: It was founded by and with Simone de Beauvoir in 1983 because these cases starting arising. The idea behind this is that men fight for their universal rights to be recognised but they neglect the fact that women are also entitled to the recognition of their rights.

Q436 Chair: Dr Piet, would you like to add anything in response to Mr Winnick's questions? Do you want to add anything to what has been said by Linda Weil-Curiel?

Dr Piet (Translation): In the last 10 years we have improved a lot in the surgery so this has encouraged the doctors and health professionals to talk to the ladies about FGM and also to help the women who went through FGM, especially on the traumatic side and psychological side of the effects. This has enabled us to have deep discussions with these women who went through FGM.

Linda Weil-Curiel: Can I add something?

Chair: Very quickly.

Linda Weil-Curiel: I wanted to add that two perpetrators have been sent to prison, one for five stiff years and the other one for eight. There is hope, because the one that was sent behind bars for eight years knew that I was responsible for that too and when they saw me on the TV the husband would say, "That is the one who we have to go against. That is the naughty one, the bad one". After she had served her term in prison, then she started calling me and we started dialoguing. In the end, we wrote a book together and I am her lawyer against her husband who would not give her any alimony. She speaks out now against FGM.

Chair: That is very helpful.

Q437 Mr Winnick: You said the prisons are very crowded in France, and the Chair said it is somewhat like in Britain, but at the end of the day it is better, surely, that there should be prison sentences in some of these cases, that it would give the right message. Do you agree?

Linda Weil-Curiel: Yes. Stiff prison sentences. When parents are sent behind bars very many people say, “We are not going to try to cut our girls because we don’t want to end up there”.

Q438 Mr Clappison: Do you think the prosecutions that there have been in France have had the effect of reducing the numbers of FGM cases?

Linda Weil-Curiel: Sure, yes.

Q439 Mr Clappison: Can I ask one other thing that arises out of your evidence? You have told us about very young children, babies, having this procedure performed on them. The evidence we have heard is that in many cases in Britain it is older girls. Do you have any views as to how that could be tackled as well?

Linda Weil-Curiel: In the beginning we only found out about very small children but, of course, the older ones were not spared. It may be more difficult for the doctors here in England to examine children that are older. I understand that, but we have to find a way.

Dr Piet (Translation): At the beginning in the early 1980s children between zero and six were mutilated. Then in the 1990s they were mutilated from two years upwards, and now the older ones, the 12 year-olds, are sent back to their home country to be cut and then come back.

Q440 Michael Ellis: First of all, can I congratulate you, Madame, on your leadership in this area? You can be very proud of what you have done over many years and you, Doctor, as well on the medical front. Can I ask you, as a lawyer, what is the average sentence that is being passed? I appreciate that it differs because of your system, but are you finding now that there is inevitably a sentence of imprisonment and do you have guidelines? In this country we have sentencing guidelines and usually judges will tend to sentence people within a certain range. Do you have that in France and are people being sentenced to a particular range of sentences?

Linda Weil-Curiel: It is difficult for me to answer this. We don’t have guidelines. I am a lawyer, I am a avocat civil. It is a system that you don’t have here. I am not a prosecutor but I team with a prosecution. I would say that maybe judges are sometimes embarrassed when they are not familiar with that type of case and naturally they would ring colleagues and ask what they think. I cannot say anything further.

Q441 Michael Ellis: In the cases that you have been involved with, what is the lowest sentence that you have seen passed and what is the highest sentence?

Linda Weil-Curiel: One year suspended, but the baby did not die. The stiffest is eight years, and for the mother two years stiff.

Q442 Michael Ellis: Was the eight-year sentence for the person who performed the mutilating act?

Linda Weil-Curiel: Yes.

Q443 Michael Ellis: Do the lower sentences tend to be for the parents of the children who have allowed the act to take place?

Linda Weil-Curiel: Yes, but I believe it is not fair because, as I say, the cutters come into the families and snatch away the children. It is the parents who are the worst culprits because it is their will. They pay for that. They hand over the child so it is their responsibility.

Q444 Michael Ellis: Do you think the sentences should be just as tough for the parents as it is for the people who the parents engage?

Linda Weil-Curiel: Equal.

Q445 Michael Ellis: Despite your long work over many years in this area and despite the practices of the French courts and system, is this still going on in France and, if so, how much is still going on? Do you think it is rare now or still quite common?

Linda Weil-Curiel: I believe it is rare now, but now the practice has shifted. Very many parents have abandoned the practice but those who really want it done will send the child abroad and it is very sad because they wait until the child is maybe 12, 13, 14. The kids are sent to the village. Of course they are very happy to meet their families, their cousins and so on. They do not know what they are going to go through. They are cut and sometimes married—I say this like that—which amounts to rape. I have had two cases like that. When they come back to France either they come back to give birth or, with the help of the French consulate, they can come back to France and then of course they are very angry so they go straight to the police and complain. But afterwards, as they stay within their family, it is very sad for them because then they realise that their family will be prosecuted. So there is this conflict and many girls will not talk now.

Q446 Michael Ellis: This is a point that I wanted to ask you about, because it is clearly easier for the authorities to prosecute cases where either a doctor has seen a baby who has been mutilated or where a young person makes a complaint. It is much more difficult where there is this conflict with the young person who does not want to complain against her parents. How do you resolve that and what recommendations would you have for us here as to how we deal with those problems?

Linda Weil-Curiel: One part is for Dr Piet to answer, but I know the answer she says. We are only dealing with minors under 18 and she asks all hospitals and clinics to be aware of girls under 18 giving birth and being cut. As they are minors, they should be reported to the police.

Q447 Michael Ellis: I know that Dr Piet wants to say something but before I call her in, are you saying that if somebody is over the age of 18 you don't prosecute those anymore?

Linda Weil-Curiel: It could be done, yes, but we are dealing with minors.

Michael Ellis: You deal with minors?

Linda Weil-Curiel: It is very seldom that grown-up women go through the procedure. They know better.

Q448 Michael Ellis: Does it happen that it happened to them as children but it is only coming to the attention of the authorities when they are over the age of 18?

Linda Weil-Curiel: Yes.

Dr Piet (Translation): Ladies under the age of 18 will be examined and a doctor will report that. After the age of 18, even though they have been mutilated at the age of two, they can still prosecute up to 20 years after the majority of 18.

Linda Weil-Curiel: The statute of limitation.

Michael Ellis: We don't have that in this country, but they have 20 years after 18. Thank you very much.

Q449 Paul Flynn: Thank you very much for this presentation. I have one question finally, briefly. There is a great gulf between the young women who were born in this country, or born in France and educated in France, and the generation that immigrated here. That great tension is there between the two. Is it possible to get over the conflict in the families towards exposing what is going on? Do you think that the prosecutions have done this and frightened the parents to a state where FGM will become a thing of the past?

Linda Weil-Curiel: I am not sure I completely understood the question.

Chair: Do you want Mr Flynn to repeat it? He will do so.

Linda Weil-Curiel: Yes. It is a question of generations.

Paul Flynn: A generation of people who were born here or in France and those immigrants who came across as adults and their culture is part of Djibouti or Somalia.

Linda Weil-Curiel: Yes, and the girls claim, "I am French. It can't be done to me. My parents did not know", but the girls want to ignore that their parents have been informed. They would rather think, "My parents, of course, were not aware of what they were doing to me" but, excuse me, the parents know exactly what is being done to the child and the harm that is being done to the child and they want it to be done. They don't want to harm necessarily but they want the act, the cutting to be done. It is more comfortable for a child to believe that the parents did not know.

Q450 Paul Flynn: Dr Piet, do you have any suggestions based on the French practice of compulsory examinations that we could copy here? Do you think we should adopt the French system of ensuring that every child has the examination?

Dr Piet (Translation): Outside FGM I also work on the sexual abuse of women and children. The examination of children, white or black, should be compulsory. Whatever happens, they need to go through this examination. For the wellbeing of the children, the examination of all their genitals and sexual parts is important and compulsory, so we advise everybody to do it. It tells the parents that if they are looking at something that is missing they will be aware of it because they have had the training and they will be able to report it.

Q451 Chair: Dr Piet, how do we stop this practice once and for all? Here we are, the United Kingdom and France; we have heard this is also happening in Spain and other countries of the EU. What is the plan to stop this happening? Why are our professionals, our doctors, in some cases not reporting this? Why did Linda Weil-Curiel spend so long battling with prosecutors? Why did you spend so long trying to make people aware of what is going on? This is heavy weather of something that really is quite simple. What can we do? What is your three-point plan to stop this?

Dr Piet (Translation): It is very difficult in France to see the children having rights to integration and parents do not have all rights over their children. These are very recent notions. The cultural alibi has been something that has been used by all the communities and this has to be broken by training and laws.

Q452 Chair: Dr Piet, Linda Weil-Curiel, thank you so much on behalf of the Committee and those of us who follow these matters internationally. Can I commend you for the incredibly important work that you have done that has inspired this Committee to wish to take matters forward in respect of our inquiry? Do you want to say something?

Linda Weil-Curiel: Men are our allies and we should make sure that they are part of the whole educational thing. I have noticed in speaking with men that they will not go public. That is a problem with men. They are shy, let's say.

Chair: Not on this Committee.

Linda Weil-Curiel: No, but they are shy. Very often they will say, "No, I wouldn't have that done to my daughter because I know how my wife suffers from the procedure", but they will not speak before other men.

Chair: Yes, we understand the point and we are very grateful.

Linda Weil-Curiel: We must have them with us.

Q453 Chair: Of course. Presumably, if the British ambassador in Paris, Sir Peter Ricketts, was to put organisations in touch with yourselves you would be very happy to meet with them and share this important experience.

Linda Weil-Curiel: Of course.

Chair: It is a very good example of UK-French co-operation.

Linda Weil-Curiel: I must say that the UK has taught me and us in France one thing that we have included in our law because I learned that the British had done it. It is the possibility to prosecute when it has been done abroad, not on a French or British national but somebody residing in England. We adapted it. I stole the idea and we have it in our law now, so thanks to England and the fighting spirit of England.

Chair: Thank you. To you, our interpreter Agnes Bangoura, merci beaucoup, thank you very much. Merci. Thank you for coming all the way from Paris. We are very grateful.