



Home Affairs Committee

Oral evidence: [Female genital mutilation: follow-up](#), HC 961

Tuesday 27 January 2015

Ordered by the House of Commons to be published on 27 January 2015

[Watch the meeting](#)

Members present: Keith Vaz (Chair); Nicola Blackwood, Michael Ellis, Paul Flynn, Dr Julian Huppert, Tim Loughton, Mr David Winnick.

Questions 1 – 115

Witness: **Leyla Hussein**, Daughters of Eve, gave evidence.

Q1 Chair: I welcome Leyla Hussein back before the Select Committee. When the Committee produced its report into female genital mutilation, on 25 June 2014, we said we would revisit this subject before the general election, so that is why we are having this session. It is a brief session with Leyla Hussein and a number of other stakeholders. We do not want to go back to the beginning, Leyla Hussein, and thank you for coming to be with us today. We want to talk about things post June of last year, because we all know the seriousness of female genital mutilation. I want to yet again commend you for all the work you have done, but since June and since the Girl Summit that was organised by the Government, have you seen a change in awareness by professionals and the public about FGM?

Leyla Hussein: From my experience as a campaigner and as a psychotherapist, one of the changes I have seen, because of the recent profile, is that we have had many women who have called in asking for our service but also we have been approached by many professionals who are seeking training for their staff. In those terms, it has been quite positive. That is a big change I have noticed and that has a lot to do with the recent profiling and I think the Girl Summit helped push that to the level it is at today.

Q2 Chair: One of the issues we addressed was the fact that there were not sufficient people like you and not sufficient organisations in the country, not just in London but in other major cities, that dealt with this issue. Is the increased demand, as a result of the awareness, the Girl Summit, the report, your campaigns and other issues, being met at the moment or are there still problems with meeting that need?

Leyla Hussein: Last summer when I was here I think one of the things I mentioned was that there is a great need in training professionals and one of the things I was hoping to come out after the Girl Summit was to see whether FGM will be mandated training for all professionals who are working with women and children. That would make my role much easier. There are not 10 million of me out there and we cannot cover the whole of the country.

However, if we had this as part of mandatory training for anyone who is working with women and children, it could easily be part of their child protection training. That would meet that particular need, because I think a lot of professionals are seeking help in terms of what they should do and what signs to look out for. Even now on my phone I have 400 e-mails. I can't respond to 400 e-mails by myself, but if we had a system where all those needs could be covered it would make it much easier and I think that awareness would spread more around the country.

Q3 Chair: Do you receive any grant aid from the Government for the work you are doing?

Leyla Hussein: No, I don't receive any Government funding. The only funding we get for the counselling service that I run is from Comic Relief.

Q4 Chair: Some have said that the problems of FGM would not be eradicated from this country unless they were also eradicated abroad. Those who seek to say, "We will get rid of FGM in the UK", need to understand, do they not, that the practice is not just a UK-based practice? This comes from other countries and it needs a global approach rather than just an approach from one particular country.

Leyla Hussein: Absolutely. For example, the Girl Generation programme recognises the need to work at both ends. There is a big connection between the diaspora community and the grassroots communities back in Africa, for example, and there has to be cohesive work where, if we don't end FGM in the countries it originates from, it is very difficult to end it here. I know specifically, being a member of a diaspora myself, holding on to your culture, especially living in the western world, is absolutely vital and very important. From my experience when I went to Kenya, I met with grassroots campaigners who said one of the risks the diaspora community presented in Africa was it had more money. For example, some of the campaigners in Kenya have closed down homes where girls have been cut, but the community from the diaspora will come, pay double money and reopen those houses; so one cannot be without the other.

Q5 Nicola Blackwood: Thank you for coming in to give evidence. We are now in the process of at last having our first prosecution. Do you think the publicity and the awareness associated with that has in any way improved the situation that young women and girls are facing in the UK?

Leyla Hussein: Personally, I do welcome such headlines because it sends out a very strong message to the practising community, me being from the community myself. We do not know what the outcome of the case will be, but the fact that it has ended up in a trial just shows that now in this country we are taking it very seriously. As a campaigner, that has been important for me. So far I think that is the only positive outcome in terms of having it so publicly out there, but we need to see what the outcome will be and the lessons we need to learn from that particular case.

Q6 Nicola Blackwood: The case is ongoing, so obviously we can't talk about the case, but for you as a campaigner it has given you confidence. Do you think it has given victims and potential victims confidence to come forward if they fear they will become victims?

Leyla Hussein: Again, I think it will depend on the outcome. If this case is dismissed or no one gets prosecuted for it, my fear is no one will come out and speak up just in case they might have the same outcome. I think it depends on the outcome of this case. The outcome will set the

foundation on what is going to happen in the future, but my other fear also is that we still don't have safe spaces for survivors who are at risk, women who could be at risk. Unfortunately, if a young girl called me today and said she is at risk and I report it to the police, she might be isolated on her own in a hostel. There are no refuges for these women to go to.

If I use the example I have seen in Kenya where there is an organisation called Tasaru, which is a safe house for girls who are escaping FGM, and this is in a small village of Narok outside of Nairobi. I could not believe that girls in this particular house took their parents to court and I was quite surprised that it did not happen here in the UK. It all went back to being in a safe space where they are supported, from the house mother to the security to the person who runs the house. Until we put those safety measures in place, I don't think more women will come out and say that they have undergone FGM or they are at risk of FGM, because they need to feel safe before they can do anything.

Q7 Nicola Blackwood: Do you find you are getting much contact from professionals seeking advice about how to handle cases?

Leyla Hussein: Absolutely, yes.

Q8 Nicola Blackwood: Do you think that has increased over the last few months when there has been so much more focus on the issue in the media?

Leyla Hussein: Absolutely. Over the last 14 months I would say there has been a great increase.

Q9 Nicola Blackwood: Could you put an estimate figure on that, a 10% or 20% increase?

Leyla Hussein: I don't keep particular records. I just go by people contacting me via e-mail, but from campaigning for the past 12 years now, where before I would do FGM training maybe six times a year, in 2014 I have done 24 to 30, I guess. Even just now as I was sitting outside I booked a couple more to do in the next couple of months for the Department of Health who have asked me to join the training they are doing across the country at the moment. Until that builds on, I think the need will be greater as more of this subject will be out there.

Q10 Nicola Blackwood: You have found a more than quadrupling of the interest from professionals?

Leyla Hussein: Absolutely, yes, and I am sure most organisations are getting similar phone calls from professionals.

Q11 Michael Ellis: As you were saying, you have seen a significant increase, a quadrupling in interest from other sources in your specialist field. Do you recognise, therefore, that there has been a marked effort by this Government to focus attention on this issue that you have been working on for 12 years, and you have noticed a marked improvement in that?

Leyla Hussein: Absolutely. In this country we have one of the best multiagency guidelines, which I think was published in 2010. I feel last year was the first time that was put to practice. We were working at Government level, grassroots level and voluntary level, working with different

departments. I think for the first time we were all at the same table, speaking the same language and taking the same approach. The media played a big part in this and having survivors at the forefront helped. I feel there is a political will but at the same time, like I said before, my worry is the media interest will die out unless we have some sustained action plans in place. For me personally it is making sure that FGM is part of the child protection training. I feel that would solve a lot of problems.

Q12 Michael Ellis: You have seen an enormous increase in media attention that has helped the cause you have fought for so many years so nobly in and you have seen the political will there. Your concern is keeping up with the e-mails and keeping up with all of the attention and also that the media attention keeps up?

Leyla Hussein: The other aspect that is constantly missed is the risk that is put on survivors like myself, campaigners, who are speaking out. Sometimes what will happen is those who are decision-makers will make an announcement, for example, without consulting either with myself or other campaigners and we at grassroots level are the ones who get blamed for it. Sometimes I will get tweets and Facebook messages and e-mails from people saying, "Oh, Leyla, how could you make these decisions? You must have said this", and I am sitting there thinking, "This had nothing to do with me". The decisions the Government make have an impact on me and my other colleagues.

Michael Ellis: Yes, of course. The political will is there.

Leyla Hussein: Absolutely, yes.

Q13 Michael Ellis: On that subject, the Government are introducing new offences and legislation in the Serious Crime Bill. Do you think the offences that are envisaged in that Bill, new offences known to the criminal law in England and Wales, are adequate? Would you want any further legislation?

Leyla Hussein: My stance on this has always been obviously we need to tweak the previous legislation we already have in place. However, I personally do not think we need to add anything else to it because we already have legislation that protects children. Going back to this, this is children—

Q14 Michael Ellis: It is just applying the law?

Leyla Hussein: Yes. For me, it is using existing laws that are already there.

Michael Ellis: That is often said on different subjects as well. It is not so much that a new law is needed; it is applying the law that already exists.

Leyla Hussein: Absolutely, yes.

Michael Ellis: That is how you feel?

Leyla Hussein: That is how I feel, yes.

Q15 Michael Ellis: Just finally from me, have you personally had any direct negative attention? Have you had any threats put on you from anyone or from any source or have you heard of anybody who has from anyone who disapproves of the work you do?

Leyla Hussein: That just comes with the role and I have to carry a personal alarm, let us just say.

Michael Ellis: You do?

Leyla Hussein: Yes, and a panic alarm at one point.

Q16 Michael Ellis: You have had threats?

Leyla Hussein: I have had threats many times and moved home a couple of times. My address is protected, and the effect just doesn't stay with me. I have a 12 year-old daughter who this also affects. It affects her in school and other children's approach to her.

Q17 Michael Ellis: We don't want to upset you about it.

Leyla Hussein: It is not that. I just want the panel to understand. Those of us who speak do not just put ourselves at risk; we put all our families at risk.

Michael Ellis: Yes.

Chair: We do understand that.

Leyla Hussein: Yes. My mother, bless her, she supports me all the time but she has to deal with the backlash that I get and it is not fun for a parent to read negative stuff about her own child.

Q18 Michael Ellis: No. If you wish to give us any more detail about that then perhaps you can write to the Committee as opposed to doing it now if it is going to be distressing.

Leyla Hussein: Yes.

Q19 Chair: It must be distressing for you, but do you know where these are coming from? Are they community based or are they from people—

Leyla Hussein: Community based, mainly social media or via my work phone. I get horrible messages. The police have been great at supporting me and making sure I am safe and they support me. I have two local police officers in my area who constantly check on me to make sure I am okay. That has been good, but psychologically it leaves you in a place where you are constantly paranoid but at the same time—

Q20 Chair: Is there more that could be done? You are providing a great service to the country by indulging in these campaigns and leading these campaigns. Is there more that could be done to protect you, to enable you to be able to speak out?

Leyla Hussein: For me, it is making sure that women like myself, those in my position, should be consulted at all times whenever any changes or any consultations are taking place. Like I said before, the impact comes back to me. Whenever there is a headline about community, it always

comes back to those of us who are speaking out and there is only so much backlash you can deal with. You try to be strong. Don't get me wrong—

Q21 Chair: But you have never thought of giving up the campaign?

Leyla Hussein: Oh god, so many times. I have written many resignation letters, but my mother always said to me, "Leyla, sleep on it", because she knew deep down this is exactly what I want to do. The reason I stayed on until now is I go back to what happened to me as a child and I do not want any child ever going through that. I tell myself verbal abuse from other people—and do you know what, if someone kills me because of this I am going to die for something I believe in. Really, that is how I feel about it. I hope it won't happen.

Chair: That is a terrible thing to say, but if—

Leyla Hussein: But that is how strongly I feel about it. Obviously it is making sure that those of us speaking are also safeguarded, and by safeguarding, that means we also need to be part of those conversations.

Chair: Of course, but also we need to be able to protect you. We will certainly put these points to the police when they come in.

Q22 Mr Winnick: Everyone has the greatest admiration for what you have done and sympathy for what you have suffered yourself and what you have written about in your article. As far as your daughter is concerned, am I not right that you took every step to ensure she did not have to go through the suffering that you had to go through as a result of FGM?

Leyla Hussein: I am sitting here today because of her. I wanted to protect her when she was born but I realised there were so many gaps. I call myself the accidental campaigner. It really came from a very personal place for me. This year it is going to be 13 years and it is just making sure that every child has the same safeguarding that my daughter had. For me to even be in this position, it took a health professional—I am going to name her, Jennifer Bourne—who asked me the question that no other health professional had asked me before. When I told her exactly what happened to me she spoke to me as if that was going to be the last time she was going to see me. She said to me, "It is illegal in this country. If you are at any risk, this is the number you would call". Having that piece of information helped me to be sitting here today and it saved my daughter from this, but what scared me was not many people have that kind of information. Not many people are as passionate as Jennifer Bourne was to make sure I was safeguarded from it.

Q23 Mr Winnick: Your article referred to the fact that your brother was criticised by those who are in favour of this infamous business along the lines of, "Your niece is not cut". Is that the situation?

Leyla Hussein: Absolutely, yes. The fact that my daughter is not cut also brings a stigma to her as well to a point where there have been situations in school where some girls from the practising community were told by their parents not to play with her. I openly talked about my daughter not being cut because I do not want to put that shame on her. I want to celebrate her the way she is, because I had met women who have not gone through FGM but it was hidden. It was a big family secret. I did not want that for my daughter. It affects her and it will affect her for the rest of her life because there is that stigma. It affects my brother, my sister and my mother, who is her grandmother. We are talking about a whole group of people.

Q24 Mr Winnick: Your brother is clearly a person of principle who has stood with you.

Leyla Hussein: My brother, absolutely. Oh god, yes. My brother and my sister have absolutely stood by me the whole time, yes.

Q25 Mr Winnick: Could I ask you one or two questions briefly on the more general issue? The Prohibition of Female Circumcision Act was passed in 1985 and there was a further Act, the Female Genital Mutilation Act of 2003. So it goes back to a time in 1985 and more recently in this century, as I have mentioned. It was defined, as you know yourself, as a crime in French law in 1983 with a threat of 10 years in prison. I have asked the clerks to look into what has happened and it seems the first conviction in France, certainly not in this country, was in 1988 against a father and his two wives who were given three-year suspended sentences. Then in 1999 a cutter was gaoled, in France again, for five years and then a mother was given a three-year sentence, two of which were suspended. All in all, there have been about 40 cases, so the position is quite unlike this country where one case is pending. How do you explain why there seems to be more effective action in France?

Leyla Hussein: I can't believe I am going to say this about France, but I think there is no tolerance for political correctness. That is my opinion. I think in this country we have tiptoed around this subject because we were fearful of offending communities and we forgot that this is a child we were supposed to protect. That is where we got it wrong. The reason my family moved to this country is because we do respect other people's cultures, and that is one thing I love about Britain, but somehow the lines were crossed where children were lost in that situation. Those children were not identified as being at risk.

Until we change our attitudes towards FGM and also using the right language—only a couple of years ago we started calling FGM child abuse. For years we kept saying, “It is a cultural practice; it is a religious practice”. In theory, that is what perpetrators will use, “Oh, the communities are practising”, but in reality that is not the case. This is a form of Hannibal, if you think about. A body part is taken away and what over 140 million women have been guilty of is we were born as females. So the reason we were cut was just because we were women. Decision-makers need to change their attitude towards how they challenge FGM and it is very simple. It is child abuse and it is one of the worst forms of violence a woman or a girl will ever experience.

Q26 Mr Winnick: The 2003 Act closed the loophole whereby those who were subject to FGM abroad and were settled in Britain with their parents then under British law it became a crime, which was not the situation before. It is very good and the fact that it is a problem needs to be more publicised.

Leyla Hussein: I think that is what it comes down to.

Mr Winnick: It is a criminal activity.

Leyla Hussein: That came just after I started campaigning, but I did not even know until that health professional said to me it has been against the law in this country since 1985. My fear is the community who practise it do not know this Act even exists; professionals do not know this Act even exists. So until that is well publicised—and I think among professionals we will only do that through training.

Q27 Tim Loughton: Ms Hussein, you do not need me to say how incredibly brave you have been and there is no doubt it is because of you and a small number of others and your persistence and courage that we are making the progress on this that we now are, which is great. On the mechanics of making sure the perpetrators are dealt with and the consultation on mandatory reporting that the Home Secretary announced before Christmas, are you in favour of mandatory reporting as a principle and what penalties do you think there should be against those people who are then caught up because it?

Leyla Hussein: Like any other form of child abuse, there should be mandatory reporting but what it means has to be clarified. We are going to be on very dangerous grounds if we start sending out messages to professionals who have never heard of FGM and are all of a sudden being told to report it. We have to be careful how we send that message out. However, I am definitely in favour of mandatory reporting because what that will do is safeguard those who are at risk. From my experience when I worked in Waltham Forest, I remember at the time at Whipps Cross Hospital there was a policy where, although they do not do it anymore, there was mandatory reporting. What made it successful was how it was approached. For example, the moment the mother was identified as an FGM survivor and she had a baby girl, it was reported to social services. I think the moment you say the words “social services” people freak out. So what would end up happening was the social worker would phone the mother and explain why they have to come over, just to give information or advice, but at the same time it is to keep an eye on them and it is another way of telling the practising community, “We are keeping an eye on you”. That was quite controversial for a lot of people, but for me it is the only way—

Q28 Tim Loughton: I have concerns about mandatory reporting for child abuse generally because I think it could lead to a bit of a tick-box mentality and pile an awful lot of work on professionals.

Leyla Hussein: But that is what I meant. It would depend on how that—

Tim Loughton: Sure, but the difference between mandatory reporting for FGM is either it has happened or it has not, where child abuse is more subjective as to whether it is happening or there may be a vexatious complaint and things like that. The case you just cited was clearly somebody who presented to a professional and so it became clear what had happened to her, but is there not a greater concern for girls who have been victims of FGM that, if it became mandatory reporting and they had to disclose to somebody, they would not come forward for fear that they could implicate a relation or whatever? Therefore, they may have physical and mental problems they need support and help with and they are going to be reluctant to come forward because they would know that somebody, maybe a family member, could now be prosecuted as a result.

Leyla Hussein: I absolutely take on board your concern. However, this comes back to FGM is child abuse and if someone has done it they should be prosecuted. I am quite clear on that, but again, like I said, we need to be very clear on what that means because the reason it needs to be reported is first to protect that child. If the child is identified as undergoing FGM then we need to support that particular child, because by the time the women come to the FGM survivors clinic they are adult women. A lot of them say to me, “No one has ever approached me. No one has ever offered me any support. If I could go back and something was in my school or maybe my GP or somebody would have picked up on it I might have had a different outcome in life”.

What you also have to understand is FGM is the beginning of many forms of violence that could take place. What I have found with FGM survivors is that the moment FGM

happens it is usually followed by child marriage, forced marriage, domestic violence. I have had women who came to my clinic and I said, "Why didn't you report domestic violence?" who would say to me, "Well, if someone cuts off your flesh, a punch and a kick is not a big deal". So something has happened where this child received a message that they are not worthy of being protected.

Exactly what mandatory reporting means has to be clarified, but it will only work if we train professionals in knowing how to deal with it. For example, for me and my daughter it was that health professional who gave me that piece of information. If a social worker came in and said, "This is very serious. You could go to prison if you end up cutting your own child", for me, unless I know I am not going to do anything wrong, it shouldn't affect me, but I do also understand the stigma it might bring to a particular community. You might be seen as lynching a community, but it comes back to protecting children.

Q29 Tim Loughton: It is complicated and I entirely take your point. The last point is the mechanics of how you would make it a legal requirement for a doctor, a social worker and other professionals to report it. Would you go as far as that if a girl presented to a doctor for some physical problem, that she was clearly from a Muslim community where it was known that FGM takes place, that it should be incumbent on that professional to ascertain whether or not she has been the victim of FGM, even though physically he/she would not necessarily be examining her to ascertain that? Should she have to even if she has only come to talk about something minor?

Leyla Hussein: For me it goes back to: if that doctor realised she had cuts and bruises would he have reported? It is the same thing. As a professional you are in a position where if you notice or see any symptoms of abuse you have to report it. As a campaigner, all I ask is to treat this as any form of child protection issue.

Q30 Chair: Indeed that is what we said in our report very clearly, based on your last evidence. I will bring Dr Huppert in on a quick point because we have other witnesses. But you did not answer Mr Loughton's question about penalties. If a doctor sees that a child has been the subject of FGM and does not report it what should be the penalty?

Leyla Hussein: I do not work in that field so I wouldn't know, but there should be a consequence and I think that will be with any other professional. It will be treated like any other professional who has—

Chair: We are talking about a criminal offence here, so obviously there will be criminal sanctions.

Leyla Hussein: If they do not report it?

Chair: Yes.

Leyla Hussein: I could not answer that question, to be honest, because I do not think—

Q31 Chair: Should it be a fine, should it be imprisonment, or what?

Leyla Hussein: There should be a consequence.

Chair: Yes, a criminal sanction, a fine or—

Leyla Hussein: A fine or—and again it depends. Each case will be different.

Chair: Of course, yes. There are degrees, aren't there?

Leyla Hussein: Now we are talking about doctors but that could also fall into teachers as far as I am concerned, because teachers can really pick up these children.

Q32 Chair: Indeed. On the issue that is currently in the public domain about designer vaginas, those who specifically go and have cosmetic surgery to their vaginas, do you think that that should also be the subject of criminal sanction?

Leyla Hussein: Absolutely, I—

Chair: Even though the women go and ask for it and they are of the right age and they can consent?

Leyla Hussein: You could say that about FGM, couldn't you? There is a very big danger when we say one particular group are barbaric and abusive towards their children. From my own experience I did a training session with schoolchildren, where a 16 year-old white girl said to me, "I'm saving money to trim my labia because my boyfriend said they were too big", and another girl said, "The men in my community won't accept me unless I have—" So the idea behind it, the patriarchy behind it is the same thing, but there is a danger in saying one group is barbaric and the other one—

Chair: Yes, of course, I understand. That is very clear.

Leyla Hussein: Yes, I do not think it should be legal.

Q33 Dr Huppert: Just very quickly, you spoke quite a bit about the responsibility for the medical professionals but you spoke less until just now about education. What do you think is the role of education at school to try to get some of these messages across to people?

Leyla Hussein: I think I have said on many occasions that school teachers are really vital in terms of prevention because eight hours a day our children are in schools, and schools play a key role because they can easily pick up the behaviours of the child. It goes back to compulsory checks. A lot of the professionals I have been working with recently are school teachers, because after the recent profiling they are suspecting, they are not sure, so for me training school teachers is absolutely key. They also play, like I said, a key role in preventing it from happening but also supporting those who have undergone FGM. For example, they can refer them to the right agencies. Obviously they have to report it so that child can get justice, I would think, but schools play an absolutely big role.

Chair: Leyla Hussein, thank you very much, as usual, for coming in to give evidence to us. We will be preparing a report. If there is anything that you wish to write to us about further on this issue, please do so. The timetable is probably the end of February. We kept our promise to revisit before the election, so this was not a report that was just published and left on the shelf. Thank you for coming in.

Examination of Witness

Witness: Alimatu Dimonekene, FGM Campaigner and Survivor, gave evidence.

Q34 Chair: Ms Dimonekene, thank you very much for coming in today. The reason we have you on separate panels is because of the professional relationship you have with Leyla Hussein. We have about 20 minutes on this. We have other witnesses from the police and the Royal College, but maybe I could start by asking you: have you seen much of a change between your campaigns over a number of years and last year when we had the Girl Summit, we had the Select Committee report and we had the first two prosecutions?

Alimatu Dimonekene: I have seen a massive change, I think for the last two years, seeing the overall involvement from the political side, from the statutory agencies and communities coming together. As a survivor, I made it a personal challenge that unless I put myself in the position where I am able to make a change, change will not come because it took that long. Having huge campaigners like Efua Dorkenoo on the front instigating and insisting that FGM should be at the fore, and FGM had to have a place where we are talking about FGM—because in the past no one was talking about FGM. That has now changed. We are seeing it beginning to change with professionals who had concerns initially about what their role was in interviewing and dealing with women who have undergone the practice, or how they even had a conversation with us.

Q35 Chair: We will be talking to those professionals. Let me ask you a specific question about mandatory reporting and penalties. As you know, the Government is consulting on this. What is your view on the penalties that should be imposed on doctors who fail to report?

Alimatu Dimonekene: I think it is unfair to pinpoint one group of professionals because I want it to be blanket mandatory reporting. It doesn't follow just the role of the doctors. Yes, they are the ones who may have direct contact with women who present in their hospitals or in their surgeries, but it could also be for social workers and health visitors.

Chair: So anyone involved should be—

Alimatu Dimonekene: Anyone involved has a—

Q36 Chair: What should the penalties be?

Alimatu Dimonekene: It depends on what the disciplinary rules are for those individuals. I think it starts off with training, because we cannot start penalising until we know for sure that we have given the right information and the right tools to those professionals.

Chair: But you think there should be a penalty?

Alimatu Dimonekene: I think there should be a penalty because there are now enough tools. The multiagency guidelines spell it out and the intercollegiate report for medical professionals makes it very clear.

Q37 Chair: You say that doctors need more training in this, but I would imagine a doctor would know if it has happened. I take your point about teachers and social workers, but certainly a doctor would know if a procedure has occurred.

Alimatu Dimonekene: That is right.

Chair: They would be the most trained of those three groups, wouldn't they?

Alimatu Dimonekene: I think there is not so much a myth, but you would be surprised how many doctors don't know the anatomy of a person because they don't spend much time now in their training rooms learning about anatomy. Some do general practice, and that is all it is. They give you advice. You come into their surgery, you are sitting down, and within two minutes a prescription is written, and so not much discussion. But I know the clinical approach that was sent out in October has helped because we have found a lot of GPs are now not so overawed. There is still a battle for GPs to come on board but there are certain GPs who have now taken it on, and a lot of the CCGs now are asking for GPs to have at least some form of training. But again you still find a lot more who know nothing about FGM.

Q38 Chair: How has the general community taken this laser-like interest in the practice of FGM? This is a community practice and not initiated by the state. It is mums and aunts who know about it and fathers and uncles and brothers. It is a family thing; people know. How have they taken this new light that has been shone upon community practices?

Alimatu Dimonekene: In some aspects some communities welcome what is happening now. I come from Sierra Leone and for far too long Sierra Leone has been one of those countries that has refused to accept anything when it comes to FGM. You are ostracised. I get more threats from my community from Sierra Leone, not that they don't—

Chair: For opposing FGM?

Alimatu Dimonekene: For opposing FGM, because they see themselves as having a higher backing if anyone was to speak against FGM. But fortunately for us as campaigners, what we have seen in Sierra Leone is that because of the Ebola, FGM was halted temporarily. But we are still finding there are areas where you cannot even go and talk about—

Chair: Is that right, in Sierra Leone because of Ebola this was—

Alimatu Dimonekene: FGM was halted because of Ebola. There were certain parts of Sierra Leone where the practice still carried on even when the virus was rife, because they thought by cutting girls that would cure the girls of Ebola, but it just made it worse. So the Government had to take the step, knowing that if they didn't the virus would rapidly spread. So certain practices have now become a discussion. I find myself going on to the BBC and saying to them, "In order for you to understand why Ebola is spreading in Sierra Leone at this rapid rate, you have to look at harmful practices and obviously FGM is one of those practices".

Q39 Chair: What puzzles me, and what puzzled me about the last report, is that there seems to be no funding going to organisations that are community-based and, therefore, are best placed to reach parts that Government leaflets cannot reach.

Alimatu Dimonekene: That is right.

Chair: Those involved in the community will know; not everyone watches the 10 o'clock news. Do you feel that more should be done to empower local community groups to take this message forward in a much clearer way, because that has not happened, has it? The Girl Summit was a great event.

Alimatu Dimonekene: I know.

Chair: We had so many prime ministers and presidents there, and you and Leyla and others were there, but at the end of the day this was not an inner city activity somewhere. This was all behind a great security fence. Do you think there needs to be more empowerment?

Alimatu Dimonekene: Absolutely. I was the first person to speak on stage in the Girl Summit. I went back home and months after members would come up to me and say, "What are you doing about this? You had this opportunity" and I go, "Well, I don't know". I did literally, in May of last year, having been working in local authorities for many years, because I felt I had to do something; no one else was doing it. Everyone was saying they were doing something, helping survivors, but the only place I could go to get help was to the Dahlia Project and it was because it was another survivor who has set up something. There was nothing and there is no funding there. I recently had to set up something in Enfield where I live because again I am finding, day in and day out, just doing my normal shopping women will come up to me and say, "We saw you in the paper. We saw you in the news. Is there anywhere we could go?" Literally I say to them, "You can call me at any time" and I give them my personal telephone number because I don't get any funding. Sometimes I am on Twitter giving out messages and information to my community so they know. I am on Facebook. Our personal pages on Facebook have become more or less a campaign page. So we use that because we think that is the only way and in doing that communities are constantly—

Chair: Sure, but not every member of the community would know to go to Facebook. It is a huge resource but there are still areas you cannot reach.

Alimatu Dimonekene: Yes. In my case what I have done, I literally was knocking on every door I could knock on, from councillors to community groups to faith groups in my borough. In March of this year I partnered with the Enfield Safeguarding Children Board because, as Leyla was saying, for me FGM is child abuse and we have to respect the rights of our children. What messages are we sending to young girls, in particular? In my borough we have a high rate of teenage pregnancy, a high rate of gang involvement, and a lot of these are from girls themselves.

Chair: This is Enfield?

Alimatu Dimonekene: This is Enfield, and so if we are not helping and supporting them—

Chair: Thank you, very helpful.

Q40 Dr Huppert: Could I ask again the question I was asking about the role of teachers and how far do you think we can go in giving teachers a strong role?

Alimatu Dimonekene: We can go as far as we can go and I think, with having teachers on board, I can honestly say we can eradicate FGM in the UK because teachers spend a lot of time—and for me I loved school and it was where I felt the most safe in terms of space. I felt I could be myself even though I underwent FGM at the age of 16. But if you do not have a strong lead in schools, teaching children, especially young boys and girls, about their rights and their bodies, you find a

lot of girls who leave school—even boys—not having had sex education. In fact, the discussion around sex education is so blurred these days you have to draw the line in how you protect our children by reinforcing education.

Q41 Dr Huppert: Let us be clear, should it be compulsory for all pupils to have sex relationships education, FGM education where appropriate and so forth?

Alimatu Dimonekene: In my personal opinion, yes, because they would learn more from knowing themselves as people.

Q42 Chair: I raised with Leyla Hussein the issue of designer vaginas, and the desire for young girls and young women to alter their genital areas. Do you think that should also be the subject of a penalty?

Alimatu Dimonekene: Definitely. In my community in fact we have an FGM campaigner campaigning strongly for FGM, and what she has done is challenge the UK Government, the UK people, by using images of women who are going to Harley Street to have designer vaginas and saying to the communities in Sierra Leone, “If they are having that in London, who are they to tell us in Sierra Leone to stop having FGM?” I take it as a personal vendetta to have this stopped. We have to, otherwise we cannot have the conversation with the countries where we are from, where the practice is still ongoing, if we are going to eradicate it in the UK.

Chair: Thank you very much for coming to share your experience with us. If you have any information that you wish to give us before we compile our revisit report, please write to us as soon as possible. Thank you very much.

Examination of Witness

Witness: **Detective Chief Superintendent Keith Niven**, Metropolitan Police, gave evidence.

Q43 Chair: Chief Superintendent Niven, thank you very much for coming here today. When we published our report last year we were pretty critical of the police service, in particular ACPO, for failing to take the initiative as far as prosecutions were concerned. We now have two prosecutions, which of course we cannot talk about because they are currently ongoing. Do you have any news for this Committee as to any more prosecutions, because at the moment we have only had two in the last decade and a half?

Detective Chief Superintendent Niven: Yes, that is very true. At the moment there are a number of investigations still ongoing, and I have the figures that might help the panel on this. We have had 17 cases that have been submitted to the CPS over a number of years; 12 of those were no further action. As you know, we have a trial and we have four cases ongoing at the moment in liaison with the CPS.

Q44 Chair: I think they may be the figures you had before. Have you started any new investigations since June of last year?

Detective Chief Superintendent Niven: Yes, we have 22 live investigations at the moment; eight are under review at this stage, which equates to 20 in total. I think one of the most important things as well is in relation to the intelligence that we have started to receive.

Q45 Chair: Just on those figures, before we go on to that, obviously those are very small numbers.

Detective Chief Superintendent Niven: Yes.

Chair: We are talking about thousands and thousands of young girls in the UK who are being subjected to FGM. The Prime Minister has hosted this massive international conference; we have published a report; there have been prosecutions; the DPP has told us that she is doing her best. That sounds like a very small number.

Detective Chief Superintendent Niven: It is a very small number that I am concerned about and when I was last here I spoke of the number of referrals that we had received over a number of years.

Q46 Chair: Does that remain the problem? The problem for you is that you cannot obviously start an investigation unless somebody comes to you with the information for you to begin that work. Are people still not giving you the information?

Detective Chief Superintendent Niven: Certainly not in the volumes. If we look at Efua's most recent figures, tens of thousands of women have been subjected to FGM. I think our figures last year were somewhere in the region of 81 referrals. We are at about 83 referrals this year. We are not at the end of the financial year yet, so there is an increase. There has been an increase year on year, but these are still small numbers. Of those referrals, not all are FGM. A very low number turn out to be FGM. I would reiterate that we need those referrals to come in to us. We need a starting point for an investigation and, once we have that then we will—

Q47 Chair: But you see the problem for us, Chief Superintendent—and we know you are doing your best and you have this very important remit—the problem for Parliament and this Committee is everyone is talking about FGM, we have great campaigners out there, we have people writing in and saying, “My daughter has been subject to FGM, please we need help”, but at the end of the day, if the criminal justice system does not respond we are left with this very big gap, aren't we?

Detective Chief Superintendent Niven: We are, and the Government pledged that in 10 years we would eradicate FGM. We are certainly not prosecuting our way to eradicating in 10 years, and—

Chair: No. That is an impossible target to meet at the rate of 22 live investigations a year.

Detective Chief Superintendent Niven: Absolutely, and I—

Chair: So the Government is not going to meet its target, is it?

Detective Chief Superintendent Niven: I think the situation is that if we suggest that prosecutions are the only solution, then somebody has to go through a tortuous process of FGM to do so. So we have to break the cycle.

Q48 Chair: No, go back to what I am saying. The target that was set is not going to be met at the rate of two prosecutions a year and 22 live investigations.

Detective Chief Superintendent Niven: If prosecution is the only measurement.

Chair: What other measurement is there?

Detective Chief Superintendent Niven: The other measurement is if the numbers of individuals who have been subjected to FGM continue to appear before medical settings or if they reduce. I think that would be a more accurate way of assessing whether or not—

Q49 Chair: But you are not going to eradicate it at that rate, are you? How many have appeared in the last year since you sat before this Committee? How many cases have come to the attention of the medical profession that have not ended up in an investigation?

Detective Chief Superintendent Niven: I do not know.

Chair: Is that not the problem?

Detective Chief Superintendent Niven: The problem is the reporting to police. We had this discussion last time.

Chair: We did.

Detective Chief Superintendent Niven: I was very clear that it is those referrals; it is the referrals to the NHS and the referrals from education. Once we get those lines of enquiry we robustly investigate.

Q50 Chair: But it is not even a referral, is it? What you are talking about is you, in the position that you hold, are not being given basic information of how many cases have come before doctors, teachers, social workers.

Detective Chief Superintendent Niven: Absolutely.

Chair: You do not even have that information.

Detective Chief Superintendent Niven: No, I don't.

Q51 Chair: Have you asked for it?

Detective Chief Superintendent Niven: Yes, we have asked for it.

Q52 Chair: Who do you ask?

Detective Chief Superintendent Niven: We have a very close relationship with the NHS and my understanding is that now data is being recorded in relation to the number of individuals. That is a good starting point.

Q53 Chair: Yes, but who do you ask? You may have a close relationship with the NHS but to whom do you say, “I am going to go before the Home Affairs Select Committee. I would like to know on a monthly basis how many cases have come before the NHS”? Who do you ask for that information?

Detective Chief Superintendent Niven: We have a strategic group that one of my superintendents holds. The NHS are on that. I also go to the London Safeguarding Board, which is chaired by Cheryl Coppel, and the NHS are represented there as well, and we talk about referrals. There has just been a consultation regarding mandatory referrals. We have—

Q54 Chair: Do you support that?

Detective Chief Superintendent Niven: Yes, I do.

Chair: Do you support mandatory referrals?

Detective Chief Superintendent Niven: Yes, I support mandatory referrals and one of the—

Q55 Chair: Do you feel that if you have just one case of one doctor who fails to report, who is then the subject of criminal proceedings, that will send out a very powerful message to everyone else that they had better look carefully and report their information?

Detective Chief Superintendent Niven: I am sure that would send out a very strong message.

Q56 Chair: What do you think the penalty should be for a doctor who fails to report?

Detective Chief Superintendent Niven: I think—and this was the response that I gave when the consultation came—that these agencies and bodies have their own disciplinary proceedings because—

Chair: But that is professional.

Detective Chief Superintendent Niven: Yes, that is professional.

Q57 Chair: I am talking about the criminal law here. We know that the doctors have the BMA and the Royal College. They are coming in to see us, but what is the criminal sanction here?

Detective Chief Superintendent Niven: That would have to be assessed by others rather than—

Chair: What do you think it should be, bearing in mind you sit before us frustrated, telling us about 22 cases and saying to us nobody is telling you information? What should the penalty be? If I was the Home Secretary and I asked you what that penalty should be before I brought my legislation through, what do you think it should be? A personal opinion based on your experience.

Detective Chief Superintendent Niven: At the moment I think every case would be based upon its merits and I do not know what that penalty or what the appropriate penalty would be. I would want to seek legal advice about that and speak to people who are experts in the field, with the

judiciary. I am not in a position to say what a penalty should be. The only thing I am saying is that I want to see the referrals coming in to the police so that we can investigate them.

Q58 Chair: Yes, but that is what you said last time, you see, and there has been no change. You came here and you lamented that and we lamented with you.

Detective Chief Superintendent Niven: Absolutely.

Chair: But I have not seen a mandatory answer.

Detective Chief Superintendent Niven: At that point in time though, when we last spoke, there was not mandatory recording of the information and up until this point there still is not mandatory reporting. It is at consultation stage.

Chair: No, indeed.

Detective Chief Superintendent Niven: But I do look to the future with optimism. I think we will receive more referrals. One example that I can give you—

Chair: That is based on just your normal optimistic demeanour or—

Detective Chief Superintendent Niven: Well, no, based on the fact that, following the consultation and if mandatory reporting is brought in, then I will be the recipient of some of those reports.

Q59 Chair: Right, so you cannot wait?

Detective Chief Superintendent Niven: Soon enough is—

Chair: Soon enough is better. Thank you.

Q60 Nicola Blackwood: Obviously we have heard a little bit from Leyla, the witness before, who I think you were sitting in listening to, were you?

Detective Chief Superintendent Niven: Yes.

Nicola Blackwood: She had a lot of good things to say about the multiagency guidance, saying that we have one of the best, but last year is probably the first time it has been put into practice. It is not statutory and obviously it is used by but not limited to the NHS staff, health professionals, yourselves, social workers, teachers, other educational professionals and so on. At the same time there is also a College of Policing consultation, the mandatory reporting consultation, the NHS England prevention of FGM package, which are trying to drive through change. You have just spoken to me about a roundtable of professionals getting together. I am wondering if there is a bit of FGM slipping through the gaps of who actually has responsibility for taking hold and driving through the change: which agency takes the lead on FGM and makes sure? A multiagency approach can be very strong unless nobody is taking responsibility and nobody is making sure that there are prosecutions, deterrents, preventions and so on. Do you think that there is a lot of activity but no actual outcome yet?

Detective Chief Superintendent Niven: I think there is a lot of activity. The heads of those agencies and organisations have responsibility and they should be held accountable by Parliament, and there are Ministers who have responsibility for those particular areas. In relation to those policies, the Chair mentioned ACPO and that is a national approach with the College of Policing. That will be advice and guidance to all police forces. I head that locally so it would be my responsibility, but subsequently that responsibility would be held by the Commissioner and we are accountable to MOPAC and Parliament. In relation to policies and procedures, I think you mentioned that there is nothing mandatory in relation to FGM, but FGM is child abuse, so it is mandated that people—

Q61 Nicola Blackwood: Yes. This is an exercise in accountability and so what I am asking you is: how can we approve the outcomes where we have a lot of agencies with a lot of consultations and still reporting and referrals do not seem to be going up particularly? We have had pleas for more training and more awareness; there has been a lot in the media; we have the first prosecution. There has been a lot that should be improving the situation but it does not quite seem to work. Do you think, for example, the multiagency guidelines should be statutory? You said that you think mandatory reporting should. I am just trying to understand what you think would improve the situation, because it doesn't seem to have improved much since last—

Detective Chief Superintendent Niven: I think the guidelines should be statutory. If mandatory reporting is brought in, then it will be statutory and people will be held accountable for not reporting or referring particular cases. I think we will get the strength behind that. I am sure we will achieve that in the future. That is what this process is about at the moment; the consultation is out. For me, personally, investigating crimes and sending out a very serious and robust message, yes, mandatory reporting should come in. Those organisations that do not or fail to do so will be held accountable accordingly.

Q62 Nicola Blackwood: Once mandatory reporting comes in, are you confident that you would be able to come back to the Committee and there would be a significantly different story to tell?

Detective Chief Superintendent Niven: If the data is correct regarding the prevalence of FGM in the UK, over the next five to 10 years girls presenting at maternity clinics will be UK citizens who potentially have had FGM while living in this country, either here or being taken abroad, and to not report those individuals when they present at maternity settings is an absolute offence. I do hold optimism around that because if there is mandatory reporting and those situations arise, I will get that information and I will investigate those offences.

Q63 Dr Huppert: How many police officers in the country do you think are working on FGM at the moment?

Detective Chief Superintendent Niven: I am sorry, I don't know. I can tell you how many are working on it in the Metropolitan Police.

Dr Huppert: Okay, how many are working on it in the Metropolitan Police?

Detective Chief Superintendent Niven: I have a unit of five individuals who are Project Azure. You may have heard of Project Azure. They are my strategic group. Then I have 16 child abuse teams who investigate all cases of FGM.

Q64 Dr Huppert: They also have to investigate all other child abuse cases?

Detective Chief Superintendent Niven: Yes, they do. They are trained in all aspects of child abuse investigation.

Q65 Dr Huppert: We can presumably assume that the Met Police would have the vast majority of people working on this in the country. Would that be fair?

Detective Chief Superintendent Niven: Yes, I think we take 20% of most of the crime in the UK. I would suggest that is correct.

Q66 Dr Huppert: This is a major Government priority to try to sort out and you are saying you have five people plus a share of 16 teams.

Detective Chief Superintendent Niven: Yes.

Dr Huppert: Does that sound proportionate to what is needed?

Detective Chief Superintendent Niven: My project team, as they are, are my partnership team. Should demand increase, then I would put other resources into that. That does not include if there are proactive operations. I have other resources that I can draw on for those operations and, of course, the 16 teams across London that deal with the investigations. Project Azure really is about partnership, awareness, training and liaising with other agencies, and that is what they have been doing and will continue to do.

Q67 Dr Huppert: If you do start to get more reports as you are hoping, are you 100% confident that you will be able to deal with all of that information appropriately?

Detective Chief Superintendent Niven: I will resource that. If I cannot resource it from within my current complement, then I will seek other resources from above me to counter that demand.

Q68 Dr Huppert: Have you had assurances that you will be able to get those?

Detective Chief Superintendent Niven: Well, they will be assessed accordingly, but we have a responsibility to investigate crimes of FGM and that is what the Metropolitan Police will do.

Chair: Mr Loughton has to go to Westminster Hall. Would you ask your question now?

Q69 Tim Loughton: My apologies, I have to lead a debate at 4.00 pm. We have talked a lot about mandatory reporting and the very small incidences of prosecutions and so on. Do you think—and it is difficult to explain a negative—the prevalence of FGM has decreased with all the publicity there has been? Do people think, “Gosh, we had better not do it now because we may get hauled up”, or

do you think the prevalence has remained the same but more of it has migrated overseas rather than happening in the UK? It is a difficult question but just your judgment.

Detective Chief Superintendent Niven: I can answer it but in a very narrow way insomuch as we have had intelligence following our Operation Limelight project that we have engaged with at the airports prior and since the last Committee. Some of the information we have had is people have been deterred from taking their children abroad to have the process because they may get caught coming back into the country. That only amounts to a very small number of individuals, so it is difficult to tell. At the moment, we are very reliant upon our partners and charity workers such as Leyla to assess the temperature and give us that information. We have had community events where we have asked for that information. Unfortunately it is not an accurate picture, but again I go back to if there are women presenting at maternity clinics who have had FGM that has to be our best starting point because that will give us a gauge of what the prevalence looks like. I think conversations with those individuals will show whether or not it has happened in the UK or abroad and whether it is recent or historic.

Q70 Tim Loughton: That is a very interesting point. The logic of what you said is to suggest that if prevalence remains the same, more of it is happening in the UK rather than happening outside of the country. It is happening more on our own doorstep than it is out of sight where the children—

Detective Chief Superintendent Niven: That could be the case. Unfortunately, I do not have the data to corroborate that.

Q71 Mr Winnick: Arising from some of the questions Dr Huppert asked you, can I clarify that you said you have five altogether in the unit you lead?

Detective Chief Superintendent Niven: Yes, there are five who are dedicated to my partnership side of this work. I have 16 child abuse investigation teams to deal with the criminal investigations and I have other proactive assets that I can draw upon if they are required for proactive work. The Metropolitan Police is not just working in silos. I can draw on specialist resources but my permanent resources are 16 child abuse teams.

Mr Winnick: Within the Met?

Detective Chief Superintendent Niven: Within the Met, yes.

Q72 Mr Winnick: As regards the other police forces—mine is the West Midlands, of course; I say “of course” bearing in mind my constituency—is there co-ordination between the various police forces, including the Met?

Detective Chief Superintendent Niven: Yes, there is co-ordination. Mr Chishty, who appeared before this Committee back in April, is the ACPO lead and he co-ordinates that activity across the country.

Q73 Mr Winnick: Is there some senior police officer, more senior than yourself, who has overall responsibility at national level? That is what I am getting at.

Detective Chief Superintendent Niven: He is the ACPO lead, but each chief constable has responsibility for the activity of his or her own forces; he co-ordinates. For example, the College of Policing at the moment has just recently closed a consultation regarding guidelines to all police forces in England and Wales. That will lead the guidance for the future. Mr Chishty is involved in that because he is an ACPO lead, but ACPO officers have leads for a variety of different types of criminal activity or procedures. It just happens that he is the ACPO lead for FGM.

Q74 Chair: Do you think that mandatory reporting should be extended to those women who of their own volition go to places like Harley Street and have operations in order to create these so-called designer vaginas? Do you think that it should be extended to that?

Detective Chief Superintendent Niven: In fact, I think we raised the issue of the confusion that there is in relation to the law about this or the practice of the law. The law is very clear that that activity is FGM. I think there is a debate to be had on whether or not the designer vagina and the cosmetic surgery falls within that part of the legislation. If it does, it will then be a decision for the Crown Prosecution Service whether or not it is in the public interest to prosecute those cases if the evidence is sufficient to do so.

Q75 Chair: You think there may well be a case, but would you investigate such cases?

Detective Chief Superintendent Niven: I think there is definitely room for a debate about this because I think it needs some clarity.

Q76 Chair: Have you thought about using any of the funds that you have at the moment in order to fund projects such as those we have heard of today? They seem to be able to reach parts of the community that the Metropolitan Police may be unable to reach. Do you not think that would help you in your desire to get more information and more intelligence and more stakeholders involved?

Detective Chief Superintendent Niven: I absolutely think that outreach workers are the way forward. If we look at history, we do not get that much information being brought to our attention. Since the last Committee, our previous year was about 33 pieces of information; we have had about 130 pieces of information since. There is some progress there, which I am encouraged by. However, conversations with police officers around this are not regular and they are not consistent.

Chair: The question was: would you fund those organisations?

Detective Chief Superintendent Niven: I think there should be funding available.

Q77 Chair: Can you provide it out of your budget?

Detective Chief Superintendent Niven: That is not a matter for me because our budget is held by MOPAC. That would be a question to MOPAC.

Q78 Chair: Would you support such a move?

Detective Chief Superintendent Niven: I would definitely support that an outreach worker who is an expert in FGM should be available for each of the boroughs to talk to people. I think we would gain more intelligence and information. I have noted here that since the Girl Summit the Government has committed £270,000 for community projects to prevent female genital mutilation and £100,000 from the Home Office to run a female genital mutilation community engagement initiative. There is money there and I think that money should be spent on people who can work with communities, who are outreach workers, and that will provide opportunities for people to talk about it and provide a comfortable environment to do so. From that I think more information would flow, because the answer here is within the community, certainly from a policing point of view.

Chair: Very helpful.

Q79 Nicola Blackwood: There was a comment made in earlier evidence implying that FGM is sometimes linked to later abuse and some survivors of FGM then go on to experience child marriage, forced marriage, domestic abuse with a higher incidence. In your experience, have you found this to be true?

Detective Chief Superintendent Niven: I have not investigated cases that relate to that. Sometimes we investigate child abuse cases and then we discover that FGM has happened as well. I have one case in mind where we got to a position where we could provide the CPS with evidence of FGM because there was child abuse prior to that and historic FGM that had taken place. I did attend the Girl Summit in the summer and those correlations and links were definitely being made by people from across the world, experts in their field. I think potentially there is a link to that and again—and I apologise for repeating this—when we get those referrals in I will be in the position to absolutely say whether or not those links are true. At the moment, the suggestion is that there are links to other offences and FGM is one of those offences.

Q80 Nicola Blackwood: I wonder if the reverse process might also be possible where you have a victim or a survivor who comes in as a victim of child abuse or of domestic abuse and perhaps they fit the profile of being possibly at risk of FGM. That might be a line of investigation and a way in which to also proceed rather than having direct referrals. Have you ever considered that line of enquiry?

Detective Chief Superintendent Niven: Absolutely, and I think one of the things that we have said previously is that FGM is a unique offence, or our data suggests that it is. I accept that that might not be the case, but why it has been difficult to detect is that in a lot of cases there are no precursors to the FGM. In some families this is an honestly held belief; wrongly, but it is held by families. It is the only abuse that takes place in that child's life, so there is nothing before and nothing afterwards. That is why I think historically it has been difficult because people do not understand the signs of FGM. It is about training and I think that is now coming more to the fore with the public.

Normally child abuse indicators mainly are from schools where child abuse issues are identified—it might be bruising to a child or the behaviour of a child—and then referrals take place. This is secret. Children are taken away, as we understand, to countries. They are kept for long periods of time in those countries so the effects are not obvious when they come back to school. That is why it has been hidden, I think, or one of the reasons it has been hidden in the past. As professionals find out much more about this and there are signs that can trigger concerns in

teachers and other professionals, as they learn what they are they will make those referrals to social services and risk assessments will be made.

Q81 Nicola Blackwood: I understand that. It is just I had always understood it as a single event. This is the idea that FGM could then have later links to other forms of abuse. I wonder if this is perhaps leading us to a different understanding and perhaps possibly may be of use in terms of your work.

Detective Chief Superintendent Niven: We are very open-minded in relation to this. Historically, as it has been explained to us—and we only have a basic amount of information—in a lot of cases it is a one-off event, but I certainly would not be closed to the fact that it is part of other abuse. In fact, we have one case that proves that it was part of other abuse. That report led us to discover FGM, so certainly it is a strong possibility.

Chair: Chief Superintendent, thank you very much for coming here to give evidence to us. We hope to have our report ready by the end of February.

Detective Chief Superintendent Niven: Chair, thank you very much.

Examination of Witnesses

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

Q82 Chair: Professor Mathers, Janet Fyle, thank you very much for coming in. I am not going to start with a long introduction of why we are here; you know that. Of course, both of your organisations are critical to our understanding of FGM but also how to deal with this issue. Just to refresh our memories, Professor Mathers, is it a breach of professional guidance for a member of your organisation not to report FGM at the moment? I know you were preparing fresh guidance.

Professor Mathers: Yes. The short answer is yes. Under the clinical guidelines and under the statutory responsibilities around child abuse, it is.

Q83 Chair: How many cases of disciplinary action were taken against doctors who failed to report it last year?

Professor Mathers: To my knowledge, none.

Q84 Chair: Janet Fyle, is it in your code of ethical practice and your guidance to your members that they should report this in the same way as for GPs?

Janet Fyle: Yes, it is in the Nursing and Midwifery Council code. Midwives have a duty of care to report anything that would have an impact on the health and wellbeing of a child or a woman or anyone in their care.

Q85 Chair: How many were disciplined last year for failing to report?

Janet Fyle: I do not think anyone was disciplined but I do not know exactly.

Q86 Chair: You see, this is the problem for the Committee almost a year after we produced our report, after the Girl Summit. The medical profession in particular does not seem to have gripped the importance of what Parliament is saying and what community groups are saying. What has changed since last June when we published our report?

Professor Mathers: I think there has been a huge upsurge in interest and knowledge about FGM. The Girl Summit launched a process that has been followed through. It has been followed through by our college with the production of e-modules. E-modules are what doctors need to do as part of their continuing professional development. An e-module on FGM is being produced. There are other systems being put in place around collecting data, about its prevalence, and various other initiatives that I can list for you if that helps.

Q87 Chair: The initiatives are there but the numbers are zero still. It is still going on. The Government says it is going on; the police say it is going on. You heard the lament of Chief Superintendent Niven that he is not getting the information and he is not getting the referrals. You are not disciplining anybody for not reporting this and, Ms Fyle, your organisation is not either. Do you see the frustration of all of us?

Professor Mathers: I absolutely understand that, but we are not a disciplinary organisation. We are a membership organisation. The regulatory authority is the GMC, the General Medical Council.

Q88 Chair: How many cases have gone to the GMC?

Professor Mathers: I am sorry, I do not know that. You would have to ask them that.

Q89 Chair: All right. It just seems a little like buck passing between all these various organisations. There is clearly a desire to get something done, but there seems to be no finality to it all. Everyone is against FGM. Your members are, presumably. They regard it as being child abuse, but no one seems to be prosecuted, apart from the two individuals who are currently in court. Is that a worry to you?

Professor Mathers: Yes, I think we need to do more to address the problem of FGM. The difficulty is what you do and how you can practically apply some of the interagency guidance that exists. For a start, on the prevention side there needs to be some community initiative such as the Chief Superintendent spoke about, the outreach workers. On the education side, I think that training about FGM should be included in the statutory training for child abuse. On the raising awareness side, then there is all the material that we are producing that our members will have access to to learn about FGM.

Q90 Chair: Do you think that there should be criminal sanctions for those who fail to report FGM? A doctor arrives at the surgery in the morning; child is brought in; the doctor finds FGM has been perpetrated against this child and fails to report. Do you think that there should be a criminal sanction?

Professor Mathers: We believe that there should be mandatory reporting of those particular cases. These are cases of FGM that have been either seen or disclosed. The difficulty comes with reporting cases who are at risk or suspected because you are asking a health professional to make a decision on incomplete information. The referral or reporting should then go to the local safeguarding board where there is expertise and knowledge in order to either confirm or not confirm the diagnosis.

Q91 Chair: Let us stick to the diagnosis of the doctor seen or disclosed. Do you think that there should be a penalty if a doctor, having seen or received information of disclosure of FGM, does not report?

Professor Mathers: Yes, we do agree with that.

Q92 Chair: What do you think the sanction should be?

Professor Mathers: I think the sanction would depend on the merits of the case, as has already been stated. We think the threshold should be very high for referral to the disbarring board and that the GMC should be closely involved in the process of deciding what the appropriate punishment for deliberate non-referral of FGM is.

Q93 Chair: It does not sound very harsh. If I was a doctor and I heard that Professor Mathers told the Select Committee that the threshold should be very high and it depended on the offence and all these other caveats you put in, I would not be that keen to do it.

Professor Mathers: The threat of a criminal prosecution is a considerable one for doctors and I think a non-referral may well be down to the fact that the doctor does not know sufficient about FGM or the grades of FGM and requires more training. It may be an inadvertent failure to refer.

Q94 Chair: Indeed. That would go to mitigation, of course. Tell me something: what should you do in your royal college in order to get better training for doctors? We heard some evidence today from one of our witnesses—you were here when she said it—that doctors these days will see people for a few minutes and will not necessarily examine. Their training does not require this to happen. What are you going to do as far as training is concerned?

Professor Mathers: The training that we offer is around the e-module, which I have already mentioned. We have produced clinical guidelines that explain FGM for our members to refer to as well. We also have the recording of FGM now on the computer systems, which did not exist a year ago. The advice and encouragement from the college is to use the educational materials that are available, be aware of the law and take appropriate action when you see a proven case, either visually or disclosed, of FGM.

Q95 Chair: Janet Fyle, tell me that the Royal College of Midwives is doing more than the Royal College of General Practitioners on this.

Janet Fyle: I do not think it is about doing more or less. The Royal College of Midwives has done more than most to bring FGM to the spotlight. In 2013, we got together a group of all the medical

royal colleges and wrote the nine recommendations. If we look at those, we are slightly happier that the Government is going in the right direction by trying to implement them.

The issue is when you have inconsistencies in how we report FGM. For example, midwives might want to report FGM and there are others who might not want to report FGM. We had a discussion this morning about perhaps mandatory reporting, but you need to make reporting of FGM statutory because that way people will do it. We have had a very long period in this country where people have decided, "Perhaps we will report, perhaps we will not; perhaps we will take action, perhaps we will not".

Another issue for me is the fact that we are just focusing on under-18s. FGM is something that when you open this can of worms you will find that we have our own British-born children, European children, who might marry into that community and at 18-plus they might be pressured into having FGM. There are lots and lots of issues around it and I think personally we should report all cases of FGM.

Q96 Chair: Should there be a criminal sanction if that is not done?

Janet Fyle: It depends on whether the person refuses to report or deliberately does not report.

Chair: If they deliberately do not report?

Janet Fyle: I would not know what sanction to give to those people, but I think there should be sanctions if they deliberately do not.

Q97 Nicola Blackwood: I am struck by the points that you made, Professor Mathers, about professionals perhaps being uncertain in cases that are borderline, where they are not certain. We have been here before with child sexual exploitation where there was lack of knowledge, uncertainty, medical professionals, social workers and so on not sure what to do with cases because they did not know what they were identifying. We have moved a long way on that in the last few years. One of the things that I think really tipped the balance is multiagency hubs where the professionals are together. It almost acts as a referral mechanism. Those in the field can refer their worries in without being concerned that there is going to be an adverse reaction. That referral can then be assessed for whether it needs to go to the police to be investigated or early intervention or, in fact, that there is no problem at all and it does not need to be referred and no action needs to be taken. Do you think that that is the sort of model that needs to happen with FGM and perhaps would act as a reassurance to professionals in all different backgrounds, whether it is teaching or other areas, who are not going to be specialists in FGM but we are going to need to play their role in reporting in order to make sure that we make the progress on eradicating FGM that we need to do in this country?

Professor Mathers: We would strongly support such a model. We think that is exactly the right way to go. It can be difficult with the different grades of FGM, even if you are an expert paediatrician in this area, to make the diagnosis. We do need a referral agency to whom we can send women or children who we feel are at risk or suspected FGM for a definitive statement on that. It would be the local safeguarding board, because the police are represented on the local safeguarding board and so are the social services. It would be a good system if we were to refer suspected or at risk cases of children with FGM to a local safeguarding board.

Q98 Nicola Blackwood: You are comfortable with the LSB being the right body for that? You do not think that there needs to be a specialist body like the MASHs? In my area, we have the Kingfisher unit, which is set up for CSE. This is a very similar model.

Professor Mathers: In an ideal world there would be a specialist unit, but in practicality it is a question of resource, having the availability of such a resource to all the 10,000 practices in the UK.

Nicola Blackwood: Most areas in the country now have these MASHs. It is just whether they expand to include FGM or not and that is what I am wondering.

Professor Mathers: Yes.

Q99 Nicola Blackwood: What do you think?

Janet Fyle: For suspected or at risk cases where the professional is uncertain what is going on, from my perspective they need to get a doctor who is an expert to tell them what exactly they are looking at and then take it from there. The multiagency safeguarding hubs can be another place where people discuss those issues so that we can normalise it and it does not become a taboo, for health professionals not to intervene or do not want to talk about. I think we need to separate the suspected or at risk from those that we actually know about so that we know where we are going with reporting FGM.

Q100 Mr Winnick: There is no comparison, is there, Professor, between the confidences of a priest who, according to the Roman Catholic Church rules—at least as I understand it—does not disclose and a medical professional? There are no similarities, are there?

Professor Mathers: There are some similarities, not very many similarities but there are some similarities with patient confidentiality. When it comes to the law of the country and as a citizen of the country, we have to ensure that the law is followed.

Q101 Mr Winnick: As far as FGM, the position in law is quite clear. It is the duty and responsibility of a doctor to report where incidents have occurred where he believes a child has been subject or could be subject to FGM. Am I right?

Professor Mathers: You are correct, yes.

Q102 Mr Winnick: Professor, I know that you represent the Royal College of General Practitioners, but in practice it is more likely to be doctors in hospitals, isn't it, rather than GPs? Without getting into all these details, in the main examination of a body, male or female, tends to be in a hospital. Am I not right?

Professor Mathers: No, we do plenty of examinations in practice, but it will be the midwives who will be the first to observe FGM in an adult woman. It would not be in a routine consultation.

Q103 Mr Winnick: Do you feel there is some reluctance on the part of doctors, be they, to use the term, white or of Muslim or Jewish origin or what have you, who feel there is some sensitivity? Although they do not in any way, heaven forbid, condone FGM, they do not want to feel that they

are taking what could be considered to be—it would be wrong to come to that conclusion—a racist position? Therefore, they have an obligation to those who come to them to serve them in such a way that they do not betray confidences?

Professor Mathers: One has to be sensitive to the individual. You have to have some professional judgment, but I do think when it comes to obeying the law, then the law is pretty clear that if we, as professionals, suspect a case of child abuse—and FGM is the most terrible abuse—then it is incumbent on us to refer it. We need to do that with the agreement of the patient or the person in front of us.

Q104 Mr Winnick: As far as the medical profession is concerned, it is quite clear you are urging doctors, and obviously others in the medical profession, to report such incidents according to the law of the land?

Professor Mathers: Absolutely, along with child sex abuse and other forms of child abuse.

Q105 Mr Winnick: That is the position with midwives, presumably, to report all such incidents?

Janet Fyle: That is our position.

Mr Winnick: In all circumstances?

Janet Fyle: In all circumstances regardless. If we go back, we have had 30 years in this country where we have a law on the statute books that does not achieve anything for the victims of FGM. Consistently, every year, we come to this matter and talk about it. I think it is about time that we, as a society, say that FGM is against the law and we have to mean what we say.

Q106 Nicola Blackwood: I wanted to clarify a point that you made just now, Professor Mathers, where you said, rightly, that FGM is a terrible form of child abuse and that where you suspect any form of child abuse you are required to refer it to the responsible authorities. Then you said “with the consent of the patient”. That sounds a little strange to me. I am not aware that you seek the consent of a child to refer them to protective services. I have not heard of that before and I was a bit confused.

Professor Mathers: Sorry, the guidance is that one needs to engage the family and they need to know what is going on, but they do not have a veto on your referral decision. For the future, because you will be looking after that family for the next X number of years, it is very important to maintain the relationship, to be very clear about what is going on here and to explain that this referral is taking place.

Q107 Nicola Blackwood: But your primary responsibility is the protection of the child, is it not?

Professor Mathers: Yes.

Nicola Blackwood: If you have suspicions that that child is at risk, your primary responsibility is to ensure that protective services, whether it is social services or police, are notified, not to be considering your long-term relationship with other members of the family.

Professor Mathers: They are not mutually exclusive. I think you need to do both.

Nicola Blackwood: You mean try to do both?

Professor Mathers: Trying to do both, yes.

Q108 Nicola Blackwood: Try to do both, perhaps, but I think that is a mixed message that is possibly quite dangerous. I would be quite worried about the message that that would send out if it was not clarified. I think there is one that does need to be.

My second question is: there must have been a time when referring for child abuse, bruises on a child or something like that, was just such a difficult decision but it has now become a much more standard procedure. I think most GPs would be well trained and well practised in that and have the training. Why is it different for FGM?

Professor Mathers: In a sense, the profile of FGM has only started to rise among the profession in the last few years. Reporting of FGM is where the reporting of child abuse a few years ago was at. I can see a future whereby FGM becomes part of the normal repertoire of care for children who are abused. I think that things are changing and have changed since the Girl Summit and the big political push that there has been to eradicate FGM from our society as far as we possibly can.

Q109 Dr Huppert: Another thing you said that took me by surprise is I think both of you talked about the difficulties in diagnosis. Are you saying that GPs and midwives cannot tell when somebody has been subjected to FGM? I can see it may be hard to predict who is at risk, but is it hard for people who have actually been subjected to FGM, Ms Fyle?

Janet Fyle: It is not that difficult to diagnose FGM, to look at it and say from my perspective as a midwife or other midwives, but sometimes the communities vary the practice. Sometimes it is just a little prick and people cannot see it. As we get more vigilant, the communities who practise FGM vary how and what they do and when. That is why I talked about the difficulties. There are standard definitions for the different types of FGM that we know, but recently somebody has come across something that we have never seen before. They do it in a different way, so that is why I said difficult. Sometimes it is just a pinprick.

Q110 Dr Huppert: The standard types look like they would be very easy to tell.

Janet Fyle: The standard types, yes. There are standard types, but the communities vary what they do. They are always one step ahead of those who are trying to stop them.

Q111 Dr Huppert: You would be able to diagnose the standard types but it is harder if it is done with an intention to conceal?

Janet Fyle: That is the issue.

Dr Huppert: Okay, that is helpful. Professor Mathers?

Professor Mathers: I would say that some of grade 1 FGM, unless you have seen a lot of FGM, is quite difficult to diagnose. This is why we need the expertise in the community for a definitive diagnosis to be made.

Q112 Chair: Are you confident that you are doing enough to inform your members of the seriousness of the situation, bearing in mind they have not been able to have a huge increase in training since the publication of this report and the Girl Summit? You talked about a number of initiatives, but at the end of the day this is happening in a surgery somewhere in Britain where somebody may not be able to go to the Girl Summit or any of these other conferences or events. It is happening at the frontline, isn't it?

Professor Mathers: We are always open to new initiatives. We are doing everything we can think of to raise the profile and to raise the awareness and training of our members.

Q113 Chair: Did I put the issue of the private clinics to you before?

Professor Mathers: No.

Chair: I have put it to all the other witnesses so I should put it to you. Do you think those who are operating private clinics in places like Harley Street and elsewhere and are performing these designer vagina operations should also be covered by this law?

Professor Mathers: Yes.

Janet Fyle: I think so. I will expand a little bit on that. We could be accused of double standards if we are saying to the communities, "You cannot do that" but we are saying to doctors and surgeons, "Yes, of course, you can do that if you give anaesthetic and have a very nice room where you can put the girl". Sometimes girls of 16 and 17 are at greater risk of being taken to one of these places to have it done, so I think we should look at that because there is not much difference.

Q114 Chair: Ms Fyle and Professor Mathers, thank you very much for coming in today. If you have any statistics for us, especially from the GMC—obviously we will write to the GMC about this but if you know of any statistics—please would you write and tell us about them?

Professor Mathers: We will. Last time you asked us to look at best practice overseas and we have looked at that and have some interesting data that the Committee might be interested in.

Chair: Have you? Tell us about that before you go. Which countries?

Professor Mathers: Well, particularly the Netherlands. We looked at the situation in the Netherlands, Australia and France, following your recommendation. In the Netherlands a report has just been produced that of 70,000 women living in the communities that are likely to be affected by FGM, the estimate is about 40%. But from that community they estimate that there are about 40 to 50 girls out of the 70,000 community who are at risk of FGM. That is a surprisingly small number but they have a very robust methodology. I will obviously forward that report to you.

Q115 Chair: Thank you for taking our recommendation. Janet Fyle?

Janet Fyle: I was just going to say about the statistics that you probably are aware that there is another part of the prevalence study about to be reported on 6 February that would give us a rough estimate or prediction of how many girls are at risk. It is going to be quite surprising.

Chair: Thank you very much for coming in. We are most grateful. That concludes the session today.