**FEMALE GENITAL MUTILATION: THE LAW AS IT RELATES TO CHILDREN**

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*“FGM is an evil practice internationally condemned and in clear violation of Article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950. It is a repulsive practice…deleterious to women’s health.” [[1]](#footnote-1)*

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What is Female Genital Mutilation (FGM)?

1. Some potential for confusion might arise with regard to a definition of FGM as there are differences between the World Health Organisation (WHO) definition and that provided by UNICEF.
2. The WHO definition is to be found in “Eliminating Female Genital Mutilation” which was published by the WHO in 2008. Annex 2 defines FGM as:
3. **Type I**: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

When it is important to distinguish between the major variations of Type 1 mutilation, the following subdivisions are proposed:

* + 1. **Type Ia**, removal of the clitoral hood or prepuce only;
		2. **Type Ib**, removal of the clitoris with the prepuce.
1. **Type II**: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

When it is important to distinguish between the major variations that have been documented, the following subdivisions are proposed:

* + 1. **Type IIa**, removal of the labia minora only;
		2. **Type IIb**, partial or total removal of the clitoris and the labia minora;
		3. **Type IIc**, partial or total removal of the clitoris, the labia minora and the labia majora.
1. **Type III**: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

When it is important to distinguish between the variations in infibulations, the following subdivisions are proposed;

* + 1. **Type IIIa**: removal and apposition of the labia minora;
		2. **Type IIIb**: removal and apposition of the labia majora.
1. **Type IV**: Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterisation.
2. Reference to the WHO Fact sheet N241 as to Female Genital Mutilation (updated in February 2016) reflects similar classification to that which was previously identified by the WHO in that FGM remains classified into 4 major types:
	* 1. **Type 1**: Clitoridectomy, this is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals), and in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
		2. **Type 2**: Excision, this is the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva).
		3. **Type 3**: Infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy).
		4. **Type 4**: This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.
3. For reasons that are not altogether clear, Unicef uses a different classification to the WHO classifications set out above. The Unicef classification[[2]](#footnote-2) encompasses four main categories:
4. Cut, no flesh removed;
5. Cut, some flesh removed;
6. Sewn closed; and
7. Type not determined/not sure/doesn’t know.
8. These categories do not fully match the WHO typology. Cut, no flesh removed describes a practice known as nicking or pricking, which is currently categorised as Type IV. Cut, some flesh removed corresponds to Type I (clitoridectomy) and Type II (excision) combined. And sewn closed corresponds to Type III, infibulation.
9. The issue of the use of different classifications of FGM has recently been considered in the family court by the President of the Family Division (Munby P) when he indicated:

“Knowledge and understanding of the classification and categorisation of the various types of FGM is vital. The WHO classification is the one widely used. For forensic purposes, the WHO classification, as recommended by Professor Creighton, is the one that should be used[[3]](#footnote-3).”

1. Therefore, it would seem sensible for all professionals to utilise the WHO classifications as opposed to the less widely used classifications provided by Unicef. The need for a uniform approach as to nomenclature and classification is essential, both in a clinical and forensic setting, if safeguarding duties are to be properly and efficiently implemented.

**The Law on FGM**

1. The undertaking of FGM is a clear violation of the absolute right pursuant to Article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950[[4]](#footnote-4) that states that no one will be “subjected to torture or to inhuman or degrading treatment or punishment”. It is a human rights violation, a form of child abuse and breaches the United Nations Convention on the Rights of the Child.
2. Female Genital Mutilation was first criminalised in the United Kingdom under the **Prohibition of Female Circumcision Act in 1985**. This was replaced by the **Female Genital Mutilation Act 2003** which updated the offence of carrying out FGM, or assisting a girl to carry out FGM on herself. Section 1 of The Female Genital Mutilation Act 2003 states:

 **Offence of Female Genital Mutilation**

* 1. A person is guilty of an offence if he excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris.
	2. But no offence is committed by an approved person who performs;
		1. A surgical operation on a girl which is necessary for her physical or mental health, or
		2. A surgical operation on a girl who is in any stage of labour, or has just given birth, for purposes connected with the labour or birth.
	3. The following are approved persons –
	4. In relation to an operation falling within subsection (2)(a), a registered medical practitioner,
	5. In relation to an operation falling within subsection (2)(b), a registered medical practitioner, a registered midwife or a person undergoing a course of training with a view to becoming such a practitioner or midwife.
	6. There is also no offence committed by a person who –
	7. performs a surgical operation falling within subsection (2)(a) or (b) outside the United Kingdom, and
	8. in relation to such an operation exercises functions corresponding to those of an approved person.
	9. For the purpose of determining whether an operation is necessary for the mental health of a girl it is immaterial whether she or any other person believes that the operation is required as a matter of custom or ritual.
1. Therefore, sections 1 and 2 of the 2003 Act make it an offence for any person within England and Wales to carry out FGM, or to assist a girl to carry out FGM on herself.
2. Section 3 of the 2003 Act makes it an offence for someone from within the UK to assist a non-UK national to carry out FGM outside the UK on a UK national or permanent UK resident. Section 4 of the 2003 Act makes it an offence for a UK national or permanent resident to perform FGM abroad, assist a girl to perform FGM on herself abroad or to assist a non UK national to perform FGM on a UK national or permanent UK resident abroad.
3. To reflect the serious harm caused by FGM, the 2003 Act increased the maximum penalty for any of the FGM offences from five to fourteen years imprisonment.
4. Following the introduction of the 2003 Act problems began to arise in a small number of cases whereby the CPS were unable to prosecute as the victims did not meet the criteria of permanent UK residence as required by the legislation. In order to address this issue, further reform was introduced in the form of the **Serious Crime Act 2015.**
5. Section 70(1) of the Serious Crime Act 2015 (“the 2015 Act)” amends sections 3 and 4 of the 2003 Act to cover prohibited acts done outside of the UK *by* a UK national or person resident in the UK and acts of FGM done *to* a UK national or person resident in the UK. Essentially these changes permit the 2003 Act to capture offences of FGM committed abroad by or against those who are at the time habitually resident in the UK irrespective of whether they are subject to immigration restrictions. The question of habitual residence is a question of fact for the Court in each case.

**Failing to Protect**

1. Section 72 of the 2015 Act inserts a new section 3A into the 2003 Act. This creates a new offence of failing to protect a girl from FGM. In effect, if an offence of FGM is committed against a girl of 16 or under, the person or persons with responsibility for her at the time of the offence will be guilty of the offence of failure to protect. The maximum penalty is seven years imprisonment, or a fine or both.

**FGM Protection Orders**

1. Section 73 of the 2015 Act provides for the making of Female Genital Mutilation Protection Orders (FGMPO’s). These orders can be made to protect a girl against the commission of a genital mutilation offence, or to protect a girl or woman against whom an offence has been committed. The terms of such an order can be broad and flexible and enable the court to include whatever terms it considers necessary and appropriate to protect the girl. They can be made on the application of the girl concerned, or by a third party. Local Authorities and the Police are likely to be such third party applicants. The Court may also make such orders of its own motion, both in family and criminal proceedings. The case of ***Re E (Children) (Female Genital Mutilation Protection Orders) [2015] EW*HC 2275 (Fam)** is an interesting recent example. This case concerned applications for Female Genital Mutilation Protection Orders in respect of three girls aged 12, 9 and 6. The parents and children originated from Nigeria (where the father remained living) but the mother and children lived in London. The mother had been the subject of FGM herself and claimed that the father had always viewed the female genital mutilation of the girls as inevitable and necessary. The mother alleged that the father had requested that the two older girls be sent to Nigeria during the school holidays for this to take place. The mother sought and obtained without notice FGMPO’s. At the on notice hearing (held only 2 days later), the court continued the FGMPO and, pursuant to paragraph 1(3) of Schedule 2 of the 2003 Act, restricted the father from coming within 100 metres of the home and children’s school. The evidence at that point was properly described as “one sided” as the court only had a statement from the mother. The father had yet to file any evidence and was unable to attend the hearing, nor was he represented.
2. At the substantive hearing of the mother’s application for FGMPO’s the father was represented and had filed evidence. This part of the case is reported as ***Re E (Female Genital Mutilation and Permission to Remove) [2016] EWHC 1052 (Fam)****.* Having heard full evidence, the court concluded that it was satisfied that there was no appreciable risk of the children being subjected to female genital mutilation and that the application for continuation of the FGMPO’s should be dismissed. This demonstrates the inevitable issues faced by the court at a without notice hearing. At such a hearing there is likely to be a paucity of evidence and the real risk is that such evidence that is available is likely to be “one sided”. The court will often have a very limited evidential picture upon which to decide whether an FGMPO is required.
3. The Court is required to consider all the circumstances of the case, including the need to protect the health, safety and wellbeing of the girl concerned. The first FGMPO was obtained by Bedfordshire Police on the 17th July 2015. Subsequently, further FGMPO’s have been obtained by other Police forces.

**Duty to Notify**

1. Section 74 of the 2015 Act inserts a new section 5B into the 2003 Act which creates a new mandatory reporting duty requiring specified regulated professionals in England and Wales to report ‘known’ cases of FGM in under 18’s which they identify in the course of their professional work, to the police. This duty applies from 31 October 2015 onwards. Section 5B of the 2003 Act states:

**Duty to notify police of female genital mutilation**

* + - 1. A person who works in a regulated profession in England and Wales must make a notification under this section (an ‘FGM notification') if, in the course of his or her work in the profession, the person discovers that an act of female genital mutilation appears to have been carried out on a girl who is aged under 18.
			2. For the purposes of this section –
				1. A person works in a ‘regulated profession' if the person is –

A healthcare professional,

A teacher, or

A social care worker in Wales;

* + - * 1. A person ‘discovers' that an act of female genital mutilation appears to have been carried out on a girl in either of the following two cases.

 The first case is where the girl informs the person that an act of female genital mutilation (however described) has been carried out on her.

 The second case is where –

* + - * 1. The person observes physical signs on the girl appearing to show that an act of female genital mutilation has been carried out on her, and
				2. The person has no reason to believe that the act was, or was part of, a surgical operation within section 1(2)(a) or (b).
			1. An FGM notification –
				1. Is to be made to the chief officer of police for the area in which the girl resides;
				2. Must identify the girl and explain why the notification is made;
				3. Must be made before the end of one month from the time when the person making the notification first discovers that an act of female genital mutilation appears to have been carried out on the girl;
				4. May be made orally or in writing.
			2. The duty of a person working in a particular regulated profession to make an FGM notification does not apply if the person has reason to believe that another person working in that profession has previously made an FGM notification in connection with the same act of female genital mutilation. For this purpose, all persons falling within subsection (2)(a)(i) are to be treated as working in the same regulated profession.
			3. A disclosure made in an FGM notification does not breach –
				1. Any obligation of confidence owed by the person making the disclosure, or
				2. Any other restriction on the disclosure of information.
1. This duty does not apply in relation to at risk or suspected cases or cases where the woman is over 18. In these cases the local safeguarding procedures should be followed.
2. Useful Guidance has been issued by the Home Office regarding mandatory reporting and this is likely to be a good point of reference for professionals requiring clarification of their duties under section 5B[[5]](#footnote-5).Of particular note is the helpful inclusion of a process map at Annex A of that guidance. This will aid the busy frontline professional as to whether the mandatory reporting duty applies.

**The Future**

1. Plainly, all frontline professionals coming into contact with children and young people have a duty to safeguard them from abuse. FGM is properly described as child abuse but is an immensely complex topic that is often seen by those who practise it as a non-abusive `cultural practice’. It is an embedded and deep rooted practice which, research suggests, is widely practiced in specific ethnic populations in Africa, parts of the Middle East and Asia. The WHO estimates that between 100 and 140 million girls and women worldwide have experienced FGM and around 3 million girls undergo some form of the procedure each year in Africa alone. Figures published by the leading UK female health charity FORWARD have identified that as many as 23,000 girls under 15 in the UK could be at risk of FGM in England and Wales and nearly 60,000 women could be living with the consequences of FGM. Many commentators consider that these figures represent only the “tip of the iceberg.” The collection of reliable data is inherently difficult.
2. Frontline professionals will include, but should not be limited to NHS professionals, police officers, social care workers and educational professionals. It is essential that those professionals are aware of the issue of FGM and what steps to take if they become aware that this has been undertaken on a child or there is a risk that this will occur.
3. Essential reading for NHS professionals would include:
4. Multi-Agency Practice Guidelines: Female Genital Mutilation[[6]](#footnote-6)
5. Female Genital Mutilation Risk and Safeguarding; Guidance for professionals[[7]](#footnote-7)
6. Female Genital Mutilation and its Management[[8]](#footnote-8)
7. Female Genital Mutilation: Report of a survey on midwives views and knowledge[[9]](#footnote-9)
8. Female Genital Mutilation: Caring for patients and safeguarding children: Guidance from the British Medical Association[[10]](#footnote-10)
9. As was identified by Munby P[[11]](#footnote-11) there is a dearth of expert witnesses in the area of FGM (particularly in relation to young children) and specific training and education is “highly desirable”. Munby P also took the opportunity in that family case to provide specific guidance on the manner in which examinations in the context of FGM ought to take place;
10. *“Careful planning of the process of examination is required to ensure that an expert with the appropriate level of relevant expertise is instructed at the earliest opportunity. Wherever feasible, referrals should be made as early as possible to one of the specialist FGM clinics referred to by Professor Creighton. If that is not possible, consideration should be given to arranging for a suitably qualified safeguarding consultant paediatrician to carry out an examination recorded with the use of a colposcope so that the images can be reviewed subsequently by an appropriate expert.”*
11. *“Whoever is conducting the examination, the colposcope should be used wherever possible.”*
12. *“Whoever is conducting the examination, it is vital that clear and detailed notes are made, recording (with the use of appropriate drawings or diagrams) exactly what is observed. If an opinion is expressed in relation to FGM, it is vital that (a) the opinion is expressed by reference to the precise type of FGM that has been diagnosed, which must be identified clearly and precisely and (b) that the diagnosis is explained, clearly and precisely, by reference to what is recorded as having been observed."*
13. In the case of Re B and G[[12]](#footnote-12) the President held that ‘any form of FGM constitutes “significant harm” within the meaning of sections 31 and 100 of the Children Act 1989. In doing so, he cited Re B (Care Proceedings: Appeal) [2013] UKSC 33, [2013] 2 FLR 1075, at para 185 from the judgment of Baroness Hale of Richmond, "that any form of FGM, including FGM WHO Type IV, amounts to “significant harm”.

**References**

**Cases:**

Fornah v Secretary of State for the Home Department [2005] EWCA Civ 680, [2005] 2 FLR 1085

In the Matter of B and G (Children) (No.2) [2015] EWFC 3 at paragraph 79 (ii)

Re E (Children) (Female Genital Mutilation Protection Orders) [2015] EWHC 2275 (Fam)

Re E (Female Genital Mutilation and Permission to Remove) [2016] EWHC 1052 (Fam)

**Guidance:**

“Female Genital Mutilation/Cutting”: ‘A statistical overview and exploration of the dynamics of change’ [2013] (page 48)

Mandatory Reporting of Female Genital Mutilation- procedural information

Multi Agency Practice Guidelines : Female Genital Mutilation

Female Genital Mutilation Risk and Safeguarding: Guidance for professionals - Department of Health (March 2015)

Female Genital Mutilation and its Management – Royal College of Obstetricians & Gynecologists. Green top Guideline 53 (July 2015)

Female Genital Mutilation: Report of a survey on midwives views and knowledge – The Royal College of Midwives

Female Genital Mutilation: Caring for patients and safeguarding children: Guidance from the British Medical Association.

1. Per Arden LJ in Fornah v Secretary of State for the Home Department [2005] EWCA Civ 680, [2005] 2 FLR 1085 [↑](#footnote-ref-1)
2. “Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change “[2013] (page 48) [↑](#footnote-ref-2)
3. In the Matter of B and G (Children) (No 2) [2015] EWFC 3 at paragraph 79 (ii) [↑](#footnote-ref-3)
4. Fornah v Secretary of State for the Home Department [2005] EWCA Civ 680, [2005] 2 FLR 1085 [↑](#footnote-ref-4)
5. Mandatory Reporting of Female Genital Mutilation-procedural information [↑](#footnote-ref-5)
6. HM Government [↑](#footnote-ref-6)
7. Department of Health (March 2015) [↑](#footnote-ref-7)
8. Royal College of Obstetricians & Gynaecologists. Green-top Guideline 53 (July 2015) [↑](#footnote-ref-8)
9. The Royal College of Midwives [↑](#footnote-ref-9)
10. BMA (2011). **Please note that this Guidance is currently under review by the BMA to take account of the recent legislative changes.**  [↑](#footnote-ref-10)
11. In The Matter of B and G (Children) (No 2) [2015] EWFC 3 at paragraph 79 (i) [↑](#footnote-ref-11)
12. Re B and G (Children) (No 2) [2015] EWFC 3 at paragraphs 66-68 [↑](#footnote-ref-12)