Dear Sir/Madam

Consultation: mandatory reporting for female genital mutilation

The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 153,000 which continues to grow every year.

The BMA recognises that doctors have a vital role in breaking the generational cycle of the illegal and harmful practice of Female Genital Mutilation (FGM). FGM is a serious crime and form of abuse that no child should have to suffer.

The BMA will continue its work to help eradicate FGM by raising awareness of the issue, and supporting doctors to protect girls and women who are at risk of or who have undergone FGM.

At the BMA’s annual representatives meeting in July 2014, doctors passed new policy calling on the Government to protect girls and young women through the promotion of joint training and strategy on FGM for health, education, social work, police and prosecution services; and through the appropriate prosecution of perpetrators of the crime.

The BMA welcomes the government’s work to tackle FGM. The Association has serious concerns about this consultation, however.

Consultation questions

The BMA does not support the basic premise on which the consultation is based: that mandatory reporting is the best way to protect women and girls from this abuse. In our view, the government should have first consulted, or as a minimum asked the question in this consultation, whether mandatory reporting should be introduced, instead of focusing solely on how it should be introduced. This is of particular importance given the collective unease towards mandatory reporting amongst many medical bodies. The consultation document
(paragraph 2.9) recognises that healthcare professionals will be the key group that will routinely identify FGM, and will, therefore, be most affected by any introduction of mandatory reporting. It is therefore critical that the Home Office consults with the health sector in a meaningful way. The BMA’s responses to the questions in the Home Office’s consultation document can be found at Annex A.

**Mandatory reporting – the evidence**

In May 2014, the Secretary of State for the Home Department, Theresa May, noted in parliamentary debate, that when considering mandatory reporting it is “important in doing so that we properly look at the evidence of whether it is effective in protecting children.”

The government will be aware of the recent review by the Royal College of Paediatrics and Child Health (RCPCH) of the current international academic literature in relation to mandatory reporting of child maltreatment concerns in general, which notes that “Ultimately there is no credible or conclusive evidence that it [mandatory reporting] better protects children at risk of harm, and its introduction would undermine the cultural approach of risk and responsibility sharing that has been developed in the current system. Mandatory reporting still raises more questions than it provides answers. It is, unfortunately, a blunt instrument which is a simplistic and ineffective answer to a far more complex set of problems.”

The BMA strongly believes that, as with medicine, a rigorous evidence-based approach is important to ensure that the outcomes intended are delivered. In this case, the outcome must be that the best interests of girls and women are effectively protected.

**Putting girls and women first**

In the launch of the consultation, Crime Prevention Minister Lynne Featherstone noted that “FGM is a highly complex and sensitive issue and we must tread carefully to ensure that all our actions put survivors and potential victims first”. The BMA believes that in most cases FGM should be reported to the appropriate authorities, but there are some exceptions. The BMA does not believe mandatory reporting always puts survivors and potential victims first. For example, in those instances where immediate disclosure may expose the victim to a greater risk of harm, professionals should be able to exercise discretion and delay disclosure, or exceptionally, not disclose, if it would be against the overall interests of the girl or young woman.

---

The BMA believes that blanket mandatory reporting may also result in vulnerable people not seeking access to health services. Vital opportunities to offer help and support may therefore be lost. The BMA is, therefore, opposed to a blanket mandatory obligation to report that does not take into account the individual circumstances of the survivor or potential victim.

The consultation document itself recognises these risks (paragraph 1.15) but makes the assumption that these risks can be mitigated or outweighed by the benefits. The consultation fails to acknowledge that these risks may, for an individual patient, outweigh the benefit of automatically reporting to social services and the police, or, as emphasised frequently throughout the consultation document, the police alone.

**Professional duty to report**

Although opposed to mandatory reporting, it is important to stress that the BMA believes that in many cases there will already be a professional obligation to report and that any decision not to report must not mean inaction. Any decision not to report must be based on good reasons linked to the wellbeing of the patient concerned. Advice must be sought from experienced colleagues, and the decision and its justification should be carefully recorded. Where managed disclosure at an appropriate time and place may be in the interests of the patient, health professionals should work supportively with patients, where possible, to encourage voluntary disclosure.

**Consultation process**

Finally, given the importance of ensuring that FGM is tackled as effectively as possible, it is regrettable that the government has given just five weeks, over the Christmas period, to seek views on how this might best be achieved.

In addition, it would have been helpful to allow sufficient time to establish and evaluate the impact of the government’s FGM Prevention Programme, launched in the summer, on the prevention and identification of FGM; before proposing the introduction of mandatory reporting.

Yours sincerely

Hilary Lloyd
Policy Director
Part A: What should be in scope of the mandatory reporting duty?

1. Do you agree with the government’s proposal that the mandatory reporting duty should apply to cases of ‘known’ abuse? Please use the text box below to provide any additional comments you have on this question.

No. As noted at the outset, the BMA is opposed to mandatory reporting. The exploration in the consultation document of the distinctions between “known”, “suspected” and “at risk” at paragraphs 2.1-2.6 highlight the need for professional discretion based on the individual circumstances of each case, not blanket policies based on whether a girl is “known” to have undergone or is “at risk” of FGM. From a medical perspective, the distinctions and concomitant duties on doctors between “known”, “suspected” and “at risk” cases are not homogenous but case specific based on the individual interests of the girl or young woman.

For example, a competent 17 year old accessing medical services for corrective surgery for FGM will be “known” to have FGM. If the FGM was carried out on her when she was five, in another country, by her grandmother who is long dead, against her parents’ wishes, there are no known risks to other girls or women, and it is clear from the way the 17 year old presents that she will never let a child of her own undergo FGM; should there be a statutory duty to report to social services and/or the police, particularly if she explicitly states that she does not want anyone outside the health sector to know that she has undergone FGM? In this situation there will be no prospect of a prosecution. It is difficult to identify any benefit in reporting. The 17 year old may have been reticent to access health services and talk about her FGM. The priority for health care professionals will be to establish a relationship of trust with the young woman and ensure that she is supported and her physical and mental health needs are met. In these circumstances, the BMA does not believe there should be a statutory duty on doctors to report the case to social services and/or the police.

On the other hand, if an eight year old girl is brought into a GP practice for a Yellow Fever vaccination as she is travelling to Sudan to spend the whole of the summer holidays there, and she mentions that she is excited about going as she will be “made a woman” during her holiday, there are a number of risk factors that should trigger the GP to consider that the girl is at risk of FGM. Although this would not classify as a “known” case, the duty on a doctor to report will be far greater than in the first scenario. Doctors are already bound by the General Medical Council’s (GMC) guidance in these circumstances, which states:
“32. You must tell an appropriate agency, such as your local authority children’s services, the NSPCC or the police, promptly if you are concerned that a child or young person is at risk of, or is suffering, abuse or neglect unless it is not in their best interests to do so (see paragraphs 39 and 40). You do not need to be certain that the child or young person is at risk of significant harm to take this step. If a child or young person is at risk of, or is suffering, abuse or neglect, the possible consequences of not sharing relevant information will, in the overwhelming majority of cases, outweigh any harm that sharing your concerns with an appropriate agency might cause.”

What is critical is that doctors are aware and have the ability to identify the risk factors for FGM; and if they are planning to report the case to social services and/or the police, they are confident that there are appropriate care and safeguarding pathways in place to manage the situation sensitively and supportively for the girl or young woman.

2. Do you agree with the government’s definition of ‘known’ abuse, as something which is visually confirmed and/or disclosed by the victim? Please use the text box below to provide any additional comments you have on this question.

As noted in the consultation document (paragraph 2.6), it can be very difficult for even expert clinicians to confirm FGM following physical examination, particularly, for example, type 4 FGM on a girl whose genitals have changed over the years and whose genitals may appear normal or near normal on examination. If “known” is also based on disclosure by the girl, in young girls it may be unclear what is being disclosed. For example, a young girl may be embarrassed to talk in detail about the FGM she has undergone, she may present to a doctor for an unrelated medical issue and may try and broach the issue by making a comment in passing that she has undergone “Sunna”, “Kadin Sunneti”, or “Xatna” (or one of the other different terms used for FGM). A doctor may be unfamiliar with all of the terms used for FGM.

Further consideration of what it means for doctors in different specialties to “know” needs to be discussed and agreed between key stakeholders, particularly if new sanctions are placed upon doctors who fail to report FGM.

---

5 D Hodes, A Armitage, A Dykes. Symposium — Child Protection Special Interest Group. G165 Female genital mutilation in London and the UNICEF report; a local perspective on worldwide statistics. Arch Dis Child 2014;99:57. Available at http://adc.bmj.com/content/99/Suppl_1/A73.1
Doctors should be supported through education and training to consider FGM and refer through existing safeguard mechanisms, not just for “known” cases but also for girls who are at risk or suspected as having undergone FGM.

3. Do you agree with the government’s proposal that the duty be limited to FGM in under-18s? Please use the text box below to provide any additional comments you have on this question.

As noted at the outset, the BMA is opposed to all mandatory reporting. Doctors owe a duty of confidentiality to under-18s and adults. Confidentiality can already be breached in both instances with consent or on public interest grounds depending on the individual circumstances of the case – for example, the risk of serious harm, the competence or capacity of the girl or woman, and if they lack this, whether a disclosure is in the girls or woman’s best interests.

4. Do you agree with the government’s proposal that the duty should be placed on health care professionals, teachers and social care professionals? Please use the text box below to provide any additional comments you have on this question.

No. The BMA does not believe a mandatory duty to report should be placed on health care professionals for the reasons noted above. Health care professionals already have appropriate professional duties placed on them, which are sensitive to the individual interests of a girl or young woman, through current legislation and professional standards. More work is needed to raise awareness of the issue amongst health professionals, including how to identify girls and young women who are at risk, and what action to take. Introducing mandatory reporting is not, in our view, the best way to achieve this.

5. How do you think mandatory reporting should apply in the early years sector? Please use the text box below to provide your answer.

No comment.
6. Do you agree with the government’s proposal that all reports should be made to the police? Please use the text box below to provide any additional comments you have on this question.

No. The BMA is opposed to mandatory reporting but in the circumstances in which a doctor already has a legal and/or professional obligation to report, there needs to be discretion to ensure that it is reported to the most appropriate authority, as established by current safeguarding pathways. In some cases this will be to social services, in others, where there is an immediate serious risk to the child, this will be to the police.

All authorities who are tasked to respond to reports of FGM need to be equipped with the resources and training to effectively manage these reports and to support the girls and young women affected.

The BMA would have very serious concerns if the impression was given that girls and young women who have been subjected to FGM could not access vital medical help without their confidential medical information automatically being disclosed to the police.

Great sensitivity is required in handling these cases, particularly as a girl develops the competence to make decisions for herself.

The BMA has serious concerns that automatic reporting to the police will move focus away from the young woman as a victim of a crime to making her feel stigmatised, and in some cases, criminalised. We are also concerned that doctors will cease to be seen as independent providers of medical care and will be viewed, by victims of FGM - who are in need of care and support - as part of the criminal justice system.

7. Do you agree that reports should be made at the point of initial disclosure/identification? Please use the text box below to provide any additional comments you have on this question.

No. In some circumstances further information may be required to verify the information, for example, from another health professional within another organisation if there is uncertainty about what has been seen on examination, or if it is unclear what has been disclosed by a young child. There is a risk if sanctions are introduced for non-reporting, that in these circumstances, doctors will believe they are obliged to report directly to social services and/or the police anything they are uncertain of before seeking expert advice,
resulting in inappropriate over reporting of cases where FGM has not occurred or there is no risk of FGM.

It is also critical that appropriate ongoing support is in place for the girl or young woman. This may require the disclosure to be made by the service the girl or young woman was referred to and will be responsible for her ongoing care, rather than the initial identification point. It is critical that health professionals are trained to manage disclosures sensitively so girls and young women do not feel stigmatised.

For example, a 17 year old who attends an emergency department for an unrelated medical issue that requires examination, which results in a doctor finding out that she has had FGM in the past. In these circumstances, the doctor may be better placed to refer the young woman to a specialist service, or to her own GP, for follow up care, and support before, during and after any potential disclosure to the authorities.

8. If an individual is in contact with multiple organisations, should they be reported once, once from within a sector, or repeatedly throughout life? Please use the text box below to provide your answer.

In the BMA’s view incidents should be reported as and when a healthcare professional makes a professional judgment that a disclosure is necessary and appropriate. If reported this should be documented, along with any outcomes, in individual and shared documentation that is already established within safeguarding structures. Appropriate documentation is essential to ensure that where a case has already been investigated, the girl or young woman is not repeatedly reported to social services and/or the police.

It is possible that there will be cases where a young woman has two noted reports of FGM incidents. For example, a 17 year old woman who seeks re-infibulation after childbirth who had FGM as an eight year old.

Part B: Sanctions for failure to report

9. By what mechanism do you think sanctions should be placed upon individuals who fail to report FGM under the new duty? Please use the text box below to provide your answer.
In cases where there are already professional obligations on doctors to report, there are already professional sanctions that apply. The BMA believes there should be no sanctions additional to those already established.

The consultation document notes that the GMC does not have specific professional regulation to the reporting of FGM (paragraph 3.7). The consultation fails to recognise, however, that as FGM falls within the context of child abuse, doctors are obliged to follow the GMC’s guidance on protecting children and young people – available at http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp

Any “serious or persistent failure” to follow GMC guidance puts doctors’ registration at risk.

10. What level of sanction do you think should be placed upon individuals who fail to report FGM upon the new duty? Please use the text box below to provide your answer.

See response above.

Part C: Statutory Guidelines.

11. Do you agree that all persons exercising public functions in relation to tackling FGM should be under a duty to have regard to the statutory guidance? Please use the text box below to provide your answer.

Healthcare professionals already have statutory guidance on child protection – Working Together to Safeguard Children - and this is where FGM should be positioned.

The FGM guidelines are not currently statutory. The BMA would have serious concerns about placing the current Multi-Agency FGM guidance on a statutory footing. The Multi-Agency guidelines have not been widely consulted on.

12. Are there substantive amendments which could be made to the guidelines, which would help to prevent FGM and protect and support victims? Please use the text box below to provide your answer.
A comprehensive review of the guidelines is needed with time to allow for a full and proper consultation. This has not happened with the current version.

**Additional questions.**

13. What evidence or information do you have on the expected increase in reports to the police or social services from introducing mandatory reporting and how do you think they will vary with the different proposals? Please use the text box below to provide your answer.

See comments at the outset of this consultation response referring to the RCPCH’s comprehensive review.

14. What evidence or information do you have on the cost of referring FGM to the police or social services? For example, information on the length of time it takes to file a report or the length of time the police spend investigating a case will enable us to better establish the cost of the policy. Please use the text box below to provide your answer.

No comment.

15. What do you think the expected impact of mandatory reporting would be on the prevalence of FGM and would this change with the different proposals?

No comment.