Home Affairs Committee
Roundtable Discussion on Female Genital Mutilation
Wednesday 6 July 2016

Members present: Keith Vaz (Chair); Victoria Atkins; James Berry; Mr David Burrowes.

Questions 1-42

Participants

I: Gerry Campbell, Detective Chief Superintendent, National Police Chiefs’ Council; Dr Mwenya Chimba, Violence Against Women Director, Bawso; Alimatu Dimonekene, Founder of ProjectACEi; Janet Fyle, Professional policy advisor, Royal College of Midwives and Intercollegiate Group on FGM; Naimah Hassan, Co-ordinator, Guardian Media Campaign to End FGM; Joe Hayman, Chief Executive, PSHE Association; Celia Jeffreys, Head of National FGM Centre; Vanessa Lodge, Director of Nursing North Central and East London; Sarah McCulloch, Director, ACCM UK; Neil Moore, Principal Legal Advisor to the Director of Public Prosecutions, Crown Prosecution Service; Sue Mountstevens, Avon and Somerset Police and Crime Commissioner; Dr Emmanuelle Piet, French gynaecologist and County Medical Officer, Seine Saint-Denis; Dr Judy Shakespeare, Clinical lead for FGM, Royal College of GPs; Hibo Wardere, Author of “Cut: One Woman’s Fight Against FGM”; Linda Weil-Curiel, Attorney at the Paris Bar; and Dr Ann-Marie Wilson, Executive Director, 28 Too Many.
Chair: Good afternoon everybody and thank you so much for coming. We welcome you most warmly to this event and thank you for making the effort to come to the House of Commons to look at this very important subject. We have people who have travelled from all over the United Kingdom, but also visitors from France. In the spirit of co-operation with our French partners, we wish them luck in their match against Germany—unless, of course, there are Germans here—[Interruption.] There is one German. In which case, we wish you luck, too, Sir, and we hope Germany does well.

All of you bring to this event the widest range of expertise, knowledge and experience of FGM. You represent policing, health, the law, education and, most important, the organisations that work constantly to support the young people—especially young women—directly affected by this. We need to draw together today on the rich resources that you have to offer us to ensure that we make progress in tackling the important issue of FGM.

As I said, we have visitors from France. I particularly welcome Linda Weil-Cureil, a French attorney, and Dr Emmanuelle Piet, a county medical officer in the Seine-Saint-Denis district, who have travelled from France to join us here. I first met them when we launched our inquiry into FGM. I was told that the French did it better than we did, so I went over to talk to them. It was a fascinating visit, and we invited them to give evidence to the Committee. Much of what they do in France is reflected in the conclusions that we put forward.

Our theme today is the progress that has been made since our predecessor Committee reported on FGM. One of the features of the work we do in Home Affairs is not just to publish a report—we had never looked at FGM before that report—but to see what progress has been made in respect to the recommendations that we made. There is no point in Parliament conducting an inquiry and making recommendations, but then not seeing whether those recommendations have been met or achieved. I think what we will find as we hear from our speakers—we already discovered this when we looked at our conclusions and recommendations—is that there has been a gross lack of progress in respect of dealing with this subject.

Let’s just look at the facts. It is estimated that 170,000 women and girls are living with FGM in the United Kingdom today, and that 65,000 girls aged 13 and under are at risk of FGM. A case of FGM is reported in England every 109 minutes, on average, so by the time we finish this seminar, another young girl will have been affected by FGM. FGM protection orders were introduced in July 2015 and 32 were issued by the end of that year. Between January and March 2016, there were 1,242 newly recorded cases of FGM across the NHS in England, 11 of which were on girls born in the United Kingdom.

As I have said, the Home Affairs Committee published a report in July...
2014—it doesn’t actually feel like two years ago, but it is two years since we published that report. We followed this up with a progress report just before the last general election, in keeping with our promise that we would look every year at subjects that we had recommended progress on. We looked at it again in March 2015. In 2014, we called for urgent action to be taken. In 2015, we welcomed the work done by the media, politicians and, most important, survivors and campaigners to raise the profile of FGM so that many more people are aware of this horrendous form of child abuse. However, we also regretted the lack of progress in other areas, particularly in formal legal proceedings. Unfortunately, this remains the case over a year on.

There are events that occur in your life—they used to say that a lot of people who were of that age remembered the date and the day and the time when John F. Kennedy was assassinated. I can actually remember the precise moment and where I was when I heard from the DPP that the first person was going to be prosecuted for FGM. I was in a supermarket with Jane Ellison, who had campaigned so hard on FGM. She was the Minister for Diabetes and I was with her in her local supermarket testing people for diabetes. Strangely enough, the call came through from the DPP to tell us that the first prosecution had in fact been agreed. I can remember that very well.

The record on prosecutions and referrals to the police since then has been lamentable. There has still not been a successful prosecution, 20 years on from the offence being created. This is despite a single hospital in Birmingham alone recording 1,500 cases of FGM over the previous five years, with doctors seeing six patients each week who have undergone the procedure. We described the chasm that exists between the number of reported cases and the lack of prosecutions, and concluded, “Someone, somewhere is not doing their job effectively.” This failure to take legal action can only have negative consequences for those who are brave enough to come forward to highlight this crime, and in the meantime, FGM remains an ongoing national scandal that is continuing to result in the preventable mutilation of thousands of girls.

Last year, in our follow-up report, the Committee accused key agencies involved in bringing FGM offences to justice—the Crown Prosecution Service, the police and the health service—of playing pass the parcel with responsibility for dealing with this very important issue. We called this approach “deplorable”. We reiterated our belief that FGM is a barbaric crime committed on a daily basis and on a huge scale across the United Kingdom, and we urged that it should not continue to go unpunished.

In our earlier report, we had called on the Government to follow the example set in France and remove any barriers to referral of suspected cases of FGM. Last year, we welcomed the provisions in the Serious Crime Act introduced by the Government, which introduced mandatory reporting of FGM by healthcare professionals, teachers and social care workers. However, we noted that it remained unclear what the sanctions were if a professional failed to make a report. This followed our earlier
recommendation that if reporting did not increase, failure to report suspected FGM should itself be made a criminal offence.

We highlighted that doctors are on the front line in dealing with this potential crime and that the professional organisations needed to take a much more active role. We particularly called on the Royal Colleges to do more to ensure that doctors are properly informed about FGM and to encourage them to report cases that they encounter. Without doctors actively reporting these cases, the full extent of FGM will continue to remain hidden.

Central parts of the NHS, particularly those dealing with reproductive health services, clearly have a particular role to play. The Committee called for the inclusion of mandatory questioning on FGM for antenatal booking interviews and at GP registration and for changes to the personal child health record red book to specifically refer to FGM.

Education is also a crucial area. We called for all schools to be required to provide training on FGM and for headteachers to pay heed to the guidance or face funding penalties. So it was quite a tough report from the Committee, because we were extremely worried about the lack of progress that had been made in this area.

Let me say this in conclusion. We look forward to hearing from you today whether you feel that sufficient progress has been made on these fronts of education and health. What you say will be taken down and used not in evidence against you but in evidence for the Committee in respect of our follow-up report and in particular when we see the Minister, Karen Bradley, in about a week’s time—next Tuesday, in fact, and you are welcome to attend the session—and hear about the Government’s current thinking on this issue.

We recognised in our 2014 and 2015 reports, and we reiterate this message today, that we owe survivors of FGM the chance to save others from this horrific abuse. Part of this contribution will come from allowing them to give their evidence anonymously. We also recognise that providing victims with a safe place to live, including in refuge shelters if necessary, is essential in helping to eradicate this practice.

Last year, we recommended the establishment of an advisory panel of FGM campaigners, which we said should be consulted before any major decisions are taken and that it should also act as a sounding board to ensure that sufficient action is taken. It does not seem that there has been enough progress in setting up this panel. We must use every opportunity to give victims a voice, and I hope that this roundtable discussion will contribute to that process.

We now need to get down to business, so I will close, but I want to welcome two members of the Committee who are here. Others will come during the session—they will drop in and drop out. There is actually a very important debate going on in the Chamber on EU nationals in the UK, which I have briefly taken part in and which I need to take part in again.
later on before it finishes, but I want to thank you for coming and for allowing us to hear what you have to say, in advance of what you do say.

Allow me to introduce David Burrowes, a long-standing member of our Committee—a very senior member of our Committee—who was around when we produced our last report, and Victoria Atkins, who has served on the Committee since her election, who plays a very important part in our deliberations. Others will come—I know Stuart McDonald has said that he will attend. I am very pleased to see Alun Michael, a former member of our Committee who played a part in our previous inquiries and who is now the Police and Crime Commissioner for South Wales. Thank you very much for coming. I hope that together we will be able to move this whole issue forward.

Let us go to specific questions to speakers. I want to frame this discussion with a group of questions—not Select Committee style, because we will not be coming back and asking you lots of additional questions. This is a much more informal and relaxed atmosphere than what you may have seen on television. Of course I am a pussycat compared with Mr Burrowes and Victoria Atkins when she really gets going.

I will start with a question to all our panellists around the table, who were specifically invited. There have been more than 1,200 newly recorded cases in the first quarter of this year—a huge number. Why do we not seem to be making headway in preventing this from happening? Who would like to start? If we could have incisive contributions, that would be great. Please introduce yourself and then let us have your views.

**Alimatu Dimonekene:** My name is Alimatu Dimonekene. I am an FGM survivor and the founder of ProjectACE, which is a survivor-led organisation based in Enfield. I think a lot of the work in trying to galvanise communities and get women, and sometimes young girls, to seek or access services is done by survivors like ourselves going into our communities and encouraging women, because we know what it feels like to get the best support. But there is still a stumbling block in terms of understanding the needs of women, how we support communities and how we talk to women about FGM. It is often looked down on, demeaning, and we lose track of the importance.

We play a crucial role, but our communities question us because our work tends to be done on our own time, our own effort and our own money. We do not get support. When things go wrong, they come back to us. We are trying to put things right. The work does not go into your books in terms of data, accounts or what you would equate to being best work, because it is done within the community. A lot of work is being done, but you are not going to see that because it is not done along a formal route; it is done informally.

**Chair:** That is very helpful. We are on prevention at the moment, before we go on to other aspects.
Sarah McCulloch: I am Sarah McCulloch, the director-founder of ACCM UK. I have been campaigning since 1997. I got involved in the FGM review in 2003. When I look at FGM now, I tend to think it is very disappointing, because we do not seem to have moved away from where we started—or where we were when I started in 1997. The campaign in the last two or three years has been London-based and London-funded. All the resources are in London. Go outside Watford and there is nothing. I work across Birmingham, Milton Keynes, Wolverhampton and Sheffield, and there are no services. Without funding, we cannot achieve anything.

As the previous speaker said, we are using our own resources and our own manpower and we are not achieving anything. Victims come with issues and we have to refer them to London, but they do not have transport, they have language issues, or if they are a single parent they do not have childcare. There are no local services. To reach out to communities, you have to engage, and that needs resources. Professionals are looking at protocols—for example, FGM is child abuse and it is barbaric. That drives away the communities they want to engage with.

Chair: That is very helpful. We are still on prevention as a theme for this section.

Hibo Wardere: I am Hibo Wardere. I am an FGM survivor, campaigner and trustee of ProjectACE. On the new numbers that have just come out, we want to see the difference between the new cases and the historical ones—the women who have already undergone FGM before they arrived are part of those numbers, I think. We do a lot of work—especially survivors. For the last five years survivors have been at the forefront of all of the changes you have seen because we are liaising with the professionals. They are unsung heroes who do a lot of work with us.

The way the Government fund things and do things is unjust because, as I said earlier, we do a lot of work but we are not recognised for that. Nobody takes an interest in that. They are just interested in established organisations that are already big and have a name. We don't have that but we work as hard as them and sometimes even harder. As we said earlier, we should clarify which of these numbers are historical cases and which are new ones.

In terms of prevention, we are doing a lot of work, whether that is education of adults or children. We are doing our best. We can do even more if we get the necessary help that we desperately need.

Chair: That is helpful. We now go to Vanessa Lodge. Vanessa, could you also address the next point I want to put to you all, which is the issue of mandatory reporting? You are the Director of Nursing for North Central and East London.

Vanessa Lodge: I am the FGM lead for NHS England.

Chair: Yes, so if you address both points. First, prevention seems to be a problem because no one is funded to do that within the communities. Secondly, has the mandatory reporting aspect made any difference?
Vanessa Lodge: Okay. I think there is definitely a gap in terms of community engagement and who takes responsibility for that and who funds it. I absolutely recognise that. From a health perspective I think the issue we have around prevention is that we are beginning to get better and better at risk assessing which children are at risk of FGM and referring that to social care. What I think we need to strengthen is how social care and health work together in terms of coming up with ways of protecting girls because we both have different resources at our disposal and different health professionals that we could use to do that. I don’t think we do that as well as we possibly could.

Chair: We go on to Celia Jeffreys, who is the head of the National FGM Centre. What has happened, Celia? We have a national centre but there are no prosecutions and community groups are saying they are not funded so they cannot do their prevention work. Why?

Celia Jeffreys: The National FGM Centre is funded by the Department for Education. We have social workers who sit in local authority areas and work specifically on cases of children at risk of FGM, so if there have been cases that have been highlighted by health. I think risk assessment is something that we need to address. I think the risk assessment that is done early on by the Department of Health risk assessment tool has been good; there has been definite movement in that. It is more the further risk assessment when cases come into social care and recognition around what work needs to be done. For example, some of the cases that we work on in local authority areas would fall below the threshold in those local authorities for social workers to work those cases, but we take those cases on and work on a long-term basis with those families. That is where prevention work has to be. When you get to a point at which children are at a high enough risk for them to reach the thresholds of social care they are almost about to have it done. The work needs to be done at an earlier point to be able to do that real risk assessment.

Chair: Since we have got a national centre, what are the kind of figures you have of referrals to you daily?

Celia Jeffreys: Probably one or two cases a week. They are in six local authority areas in the south-east of England. We have worked with 71 cases.

Chair: That is not a huge number, is it?

Celia Jeffreys: We work particularly in low-prevalence areas. We don’t work within London. I suspect if we worked within London we would have a lot more cases.

Chair: And who covers London?

Celia Jeffreys: As far as social care is concerned, just the local authority social workers, not any specialist services. However, they will work around cases of social care. We have specialist social workers who understand the dynamic of all the areas that are involved in a child at risk of FGM and the embedded practices. We have worked with 123 girls in the south-east of England since the FGM centre has been around.
Q7 **Chair:** And how long has it been around?

*Celia Jeffreys:* Since March 2015, but it really started working operationally in October. That is just under a year with that many children that we have worked with.

Q8 **Chair:** So we are now dealing with prevention and mandatory reporting as well as the issue of co-ordination. Let’s bring in Dr Ann-Marie Wilson, who is the executive director of 28 Too Many.

**Dr Wilson:** Covering one of the prevention issues, many of us think that there are pockets of activity and pockets of improvement. Many of us have worked in this sector for decades. We acknowledge that, and we are grateful for it, but we feel that there is often not sufficient joined-upness around the sector, which of course means there are gaps between schools and education work, health, policing professionals, policy committees, communities and the media. There are gaps between them, whether in terms of policy or implementation. Of course, funding is done on a departmental level. Even in the sector, although we know each other and we meet on many occasions, the danger is that things slip through the cracks. I think that is something that really needs addressing, and the resources could be used in a much more effective way.

**Chair:** Yes. Commissioner Mountstevens?

*Sue Mountstevens:* You need to give the police the information. We have had 22 referrals, five of which have come from mandatory reporting in the last three months, but why can’t we get to the point where we have information about women who have already been cut and give birth to female babies? Why can we not have that information? Then, at least under safeguarding, we would be able to do something. I know there are some broad reasons why we can’t, but sometimes we’ve just got to be a little bolder. We have not achieved much at the moment, so let’s be bolder and take risks.

Q9 **Chair:** But if you had that information, you are saying it should go to the commissioners locally, rather than—

*Sue Mountstevens:* No, to the police.

Q10 **Chair:** What would the police be expected to do with that information?

*Sue Mountstevens:* They would have the opportunity to work with other agencies, and to be able to talk and work with those families. We are not getting that information. It seems to be being blocked by social care because of the thresholds.

Q11 **Chair:** But are the police the best agency to go into the community and speak to women about this issue? They would need the necessary training to do so, wouldn’t they?

*Sue Mountstevens:* We work very closely with our communities in Bristol. We work very closely with Integrate Bristol, which is a fantastic charity that we have been able to support. It has been particularly prevalent on working with the new videos, and it has trained over 1,000
people—teachers and young people—across the country. We have a really good relationship with the communities in Bristol.

Q12 **Chair:** Janet, you had your hand up. One of our criticisms was not so much of the Royal College of Nursing, but we were quite critical of the doctors for not reporting. Why has mandatory reporting not worked?

**Janet Fyle:** I think mandatory reporting has not worked because sections of health and medical professionals believe that they don’t have to do it and have franchised it out to some community groups, from what we are hearing.

I want to go back to talk about the 29 cases that were recorded in the last quarter of the HSCIC statistics, and about prosecutions. We have 29 cases of girls under the age of 18, and 11 of them were born in the UK. We have asked midwives, doctors and others to report to the police, but there is no feedback from the police about what happened to those 29 to ensure that people continue to report. My view is that there should be a summary—“In the last quarter we had x number. This is where we are with it, and this is what we have done”—but we have got no such feedback. It is as though these statistics and the mandatory reporting are going into a black hole, and there is no feedback to the professionals to know what the police are doing.

Secondly, on what my colleague said about joined-up work, I think that we need to have a national action plan. I am very pleased by what the current Government has done over the last few years. It has taken a leap forward, but if we don’t have a national action plan with a clear strategy for implementing the various aspects of Government policy so we can monitor how it is working and evaluate and adjust it, there is a risk that we will go back to the bad old days when all this stuff was left to the community.

I come back to the community. When we are dealing with women who have been traumatised through violence of this sort, we have to be careful that we do not cause further harm. In the last few years, I have noticed that everyone has become an expert in FGM, so we need to have certain standards by which people who work in the community must abide. I know that, last week, when we were at the Home Office, they were trying to do this. We really need to have a renewed focus on ending FGM. It is unacceptable that we have failed 29 women under the age of 18 in our country, and that we have not done anything about the people who perpetrated the violence against them.

**Dr Shakespeare:** I am Judy Shakespeare from the RCGP. I wanted to say that we don’t really have the figures for mandatory reporting. There was a letter in the *Archives of Disease of Children* published on 8 June. There were freedom of information requests sent to the Home Office, NHS England—I have got them all here—the Department of Health and all the police forces in the UK. It appeared that the Home Office was not...
collecting those figures, the Department of Health was not, the Office for National Statistics was not, and most police forces did not actually give information, so we do not have that data.

Q13 Chair: Okay. Can you tell us? We were not very happy with the evidence given by the Royal College of GPs to the original inquiry. Are you a GP?

Dr Shakespeare: I am a GP but now retired. I have been the lead for three years for FGM.

Chair: This is not personal; this is business.

Dr Shakespeare: I am not taking it personally.

Q14 Chair: Give us some figures for last year of how you know from local GPs where they have encountered examples of FGM.

Dr Shakespeare: Of the people I know, nobody who has encountered FGM in a child has not done their duty.

Q15 Chair: It’s not that. I need to know from you who is collecting the figures—this is what the Committee said last time—where a GP has found that there they are concerned about FGM. They have not gone to the police but they have told their professional body. Who do they tell? This is the problem.

Dr Shakespeare: That is not the role of the RCGP. We do not collect figures.

Q16 Chair: No, I know you don’t. But you are the only GP sitting round this table at the moment, I think, and you said you practised for a number of years. When a GP finds this out, who do they talk to and tell?

Dr Shakespeare: In a child? They talk to their safeguarding lead, who may be in the practice or outside, and then they follow their obligation under mandatory reporting, which is to report to the police, as of 31 October 2015.

Q17 Chair: Do we have any figures as to how many have been reported?

Dr Shakespeare: We have absolutely none. Nobody is collecting those figures, as far as I know. Maybe Mr Campbell is able to comment.

Q18 Chair: We will come on to the police later. I am just asking you because you put your hand up.

Dr Shakespeare: There is no process by which GPs could collect. As far as we know, nobody is collecting those figures, which would seem to be important.

Q19 Chair: Right. If people who have not spoken before, unless it is a point of information to clarify what has just been said—

Vanessa Lodge: The process is that any registered professional will directly call the police if they encounter an affected child under the age of 18. That came in on 31 October, so it is relatively young. I do collect the
numbers from London because that is my region. I have problems with other parts of the region but I think we need to get that sorted out. For London, I know that since the end of October, we have had 31 reports of which 26 came from health and eight of those came from GPs.

Q20 **Chair:** And what do you do with those figures?

**Vanessa Lodge:** They go straight through to the police and the police then investigate whether they are cases that they want to take forward. There is also a safeguarding duty placed on the professional to ensure that they follow their safeguarding responsibilities along that line, too.

Q21 **Chair:** I will come back to the others. Let us go to the police now.

**Gerry Campbell:** I am Gerry Campbell, detective chief superintendent with the Metropolitan Police Service, and I support the national policing lead. By way of starting, I will say that I support the comments that Vanessa just made on the London-based figures around referrals by regulated professionals. They do accord with Metropolitan Police statistics.

Regarding statistics from elsewhere in the country, the following figures are not finite because I don’t have returns for the whole of the country, and I am not aware of the FOI area request previously alluded to. Since 31 October 2015, there has been in excess of 152 referrals that I am aware of from regulated professionals, notably from health, education—different tiers of education, including nursery, primary and secondary schools—and from children’s social care. But I would say that we treat some of those figures with caution at the moment, because not all of the forces have reported back.

What I can say is that one of the forces in the country has reported quite a large number of referrals from regulated professionals, and that requires some work by the national policing leads to get a better understanding of the learning and what really works within that particular force so that that can be promulgated throughout the country as best practice.

Q22 **Chair:** Would anyone else like to contribute or to come back on anything that has been said?

**Sarah McCulloch:** I have serious reservations with regard to the mandatory recording and reporting. I have said that we do need to record so that we can have data on how many victims of FGM there are. However, when it comes to reporting, if you have a victim giving birth to a baby girl and she gets reported to the police, where is the crime? We are victimising victims and making them feel that they are criminals. It is an assumption to think that because she is a victim of FGM she is going to do it on her daughter. This is making victims really angry and stopping them using services.

Q23 **Chair:** Do you want to come back on that?

**Gerry Campbell:** I acknowledge the point that you have just made. It accords with some of the comments that have been made by the lead from the National FGM Centre. In those circumstances, that information is
recorded for risk assessment purposes only, so that we can make informed choices and decisions with regard to the future of the newborn baby and any other children born into a family that might practise harmful cultural practices. The other point to the reporting through the risk assessment processes is absolutely not to criminalise the victim and survivor of FGM. When we are dealing with prospective victims and survivors, as well as working with the regulated professionals, we give them absolute reassurance around the confidentiality of how their information will be handled and a description of what we will do and, occasionally, a description of what we will not do.

Q24 Chair: But there have been no prosecutions. This is what really worries Parliament and our Committee. We have massive numbers, lots of referrals and community groups saying this is prevalent, but you are not arresting or charging anybody, except the two doctors who were arrested, charged and prosecuted, and many people felt that that was just because of the climate. I am not saying it was, but that is what the perception was. Everyone was putting pressure on the police, so they arrested somebody, and of course they then were able to be acquitted. What is going wrong here? Why are the police not arresting and charging all these cutters who we know exist and are running round the country cutting up little girls?

Gerry Campbell: That in itself is a matter of concern and regret for the police service. However, let me be absolutely clear to everyone sitting around this table and in the room. We recognise the devastating lifelong impact that FGM has on women and girls. We are absolutely committed to taking proactive action to identify victims, prospective victims and those who are involved in cutting.

Arrests have been made. For example, I draw attention to Operation Limelight, conducted at a London base but also at other regional airports. There are well laid plans afoot to industrialise what we are doing there. In London alone, at Heathrow, 10,000 people have been engaged with, five people have been arrested and four young girls have been taken into police protection to protect and safeguard them. There have been other arrests and other referrals made for the Crown Prosecution Service to consider the evidence.

Chair: We will come on to the CPS in a second, and I will come on to you, Dr Chimba, in a second. Can I bring in David Burrowes? I also welcome James Berry, another member of the Select Committee, representing Kingston and Surbiton. Thank you for coming, Mr Berry.

Q25 Mr Burrowes: On those that have been arrested, do you have information on the particular offence for which they have been arrested and whether that has involved the offence of failing to protect a girl from FGM? It would be useful to know where the particular focus of attention of the police has been, where the arrests are, the evidence of criminality, and perhaps where you see the gaps.
**Gerry Campbell:** Yes, of course. Five arrests have been made. Those arrests, to my recollection and knowledge, were made prior to the amendment to the FGM Act in the Serious Crime Act 2015; but we see each arrest as a criminal intelligence opportunity. What we have discussed and given evidence about previously in Committee was the fact that we are prepared to take and use covert intelligence and surveillance methods where we have got intelligence around people performing FGM—communicating intelligence, talking about cutters. We have taken covert surveillance activity to gather information around individuals; but the wider intelligence picture, I have to say, is bereft of detail.

Q26 **Chair:** Is not the reason that you are not working sufficiently with community groups? This is an issue that is primarily—what the Committee said is that it should be community-led. You are never going to get into the DNA of the community unless you engage with community groups.

**Dr Chimba:** I was going to talk about that as well. I am Dr Chimba and I work for Bawso in the community in Wales. The first comment I would make is that even listening to the discussion it is so England-centred, so London-centric, it makes you wonder what is happening outside England in the nation states. I come from Wales, and in Wales—here you are getting figures and you are talking about figures—we are just getting to grips with getting those figures. It is a concern that we are one nation, however, there is a very big disconnect.

Secondly, it is the issue of leaving behind the communities. We have a serious issue around that, where professionals are making headway. Last year the review, the Serious Crime Act, made things happen for professionals—a lot of professionals have come together and they are working out pathways and all sorts of things. Meanwhile, the communities who are affected, who are very key in changing all of that—that is where attitudinal change has to happen. They are the people who should play a significant role in defining the direction we are heading. That isn’t happening.

The other thing I wanted to comment on was the issue of calling 101—you know, mandatory reporting. We had a case last week where it was reported that this mother was having a baby, and 101 was called because she had undergone FGM. The response was “Give us the address, and we are going out there now.” What that highlighted was that unless we get to a point where people are adequately trained, we are at risk of causing more harm than helping the situation. So 101—are people all adequately trained? How far are we with training professionals so that they don’t cause more harm than good?

Q27 **Chair:** Can I bring in the CPS? A heavy responsibility falls on your shoulders, which does not seem to be being discharged at the moment. Where are the prosecutions?

**Neil Moore:** I am Neil Moore, the legal adviser to the Director of Public Prosecutions. Of course the Crown Prosecution Service can only bring a
case if it is referred to us, and it can only be referred to us if there is sufficient evidence—that is, if the police believe there is sufficient evidence. We can only bring a prosecution if the evidential stage of our code test is met, which means there has to be sufficient evidence to provide a realistic prospect of conviction. My experience is that, unfortunately, these cases are notoriously difficult to prove. One way of proving—perhaps the most usual way—would be to have a victim you called who could testify—

Q28 Chair: There is no problem with finding victims.

Neil Moore: Victims are, if I may say so, perhaps for entirely understandable reasons, extremely unwilling to report these matters. Normally the people who are cutting them are their parents or their carers. You could imagine it would take enormous courage for a young child—as often they are—to report that their parents or carers have been responsible for this serious act. Even if they did, they then have to continue to support a prosecution.

We of course put in place as many measures as we can under the victims code and using special measures to try to provide support to victims in any case, but very often if they are willing to support a prosecution that position can often change. So it is very difficult to prosecute a case with a victim—in fact, I have worked for the Crown Prosecution Service for nearly two years and I have not come across a case where there is in fact a victim.

We have come across cases where you can prove there has been FGM—not any at the moment, I should say, that I am aware of through mandatory reporting, but obviously from reporting before mandatory reporting came into place. There have been such cases, but the difficulty then is proving when it happened and who did it. It may not have happened in this jurisdiction. It may not be possible to say when it happened?

That is why I really welcome the amendment to introduce the new offence contrary to section 3A of the 2003 Act—what I call the parental responsibility provision. I welcome that because of course once you can prove that FGM has taken place, if you can prove in a timespan when that took place, effectively you then shift the evidential burden on to those responsible and you can show who was responsible at the material time to satisfy what is effectively a statutory defence. There have been no such referrals at the moment, but I have certainly come across one case where had that law been in force at the time, I would have advised that that was an offence that could be prosecuted, but unfortunately it took place before the amendment came into force last year.

Q29 Chair: Are you just not getting the referrals? Is this the problem? We referred to pass the parcel. What we are hearing from the statutory sector is they are not getting the information. What we are hearing from the GPs is the information is not being collected and therefore passed on and shared. What we are hearing from the police is that they do not have
enough cases to send to you. The sausage machine did not produce the sausage.

**Neil Moore:** I made a note of that comment when you made it because I wanted to try to address it.

**Chair:** But it is in our report. It has not changed in a year. We are very frustrated.

**Neil Moore:** Yes.

**Chair:** Short of the Committee going out undercover and finding out who these cutters are—they are coming into the country and going out of the country; some of them are living in the community. The statutory sector—the police and the head of the unit—does not seem to understand that it is community that holds all of the secrets.

**Neil Moore:** Yes.

**Chair:** They need to be at the forefront of this and that does not seem to be happening. We have got a lot of professionals in suits, if I may say so, but not the community, and they are in the lead, are they not?

**Neil Moore:** Well, on the pass the parcel point, we are of course at the end of the process, so it is perhaps a fair comment for us to say that as we are at the end of the process, we rely on what precedes it in order to bring a prosecution. It is not our job to go out into the community and encourage people to report. That said, we do whatever we can to liaise with the community in order to promote understanding and better practice among our prosecutors. We are at the end of the chain, so in that sense—“pass the parcel” is the phrase that has been used, but by definition, we are at the very end of the troubles.

**Chair:** I understand that. I will have to vacate the Chair shortly, but Mr Berry will take over. I have to go to a debate and will then come back. I want to hear from Naimah Hassan, since she had her hand up and has not spoken.

**Naimah Hassan** I am Naimah Hassan, and I am working for the Guardian Global Media Campaign to End FGM. In terms of being community-led, the language and the narrative that are used around FGM are key. Not enough is being said about communities being at the forefront, about how the community should be supported to come forward and be protected and about understanding some of the reasons why FGM continues. At The Guardian, we have tried to raise the profile of FGM, to change some of the narrative around FGM and to increase the positive stories about FGM. We need to work more collectively, as a unit, with national planning, to be encouraging. We are open to working with everyone to find a collective, responsible solution to the problem. It is quite frustrating. I come from a community that practises FGM. Nobody is ever really open to talking about it, because everyone goes into defence mode and nobody encourages them—there are not the structures in place to encourage them to openly speak about it. We need to find a solution to that.
Chair: Can we have Janet again?

Janet Fyle: I just want to make two points. The first is a point of clarification. Sarah McCulloch talked about a woman giving birth and being reported to the police. I want to make it clear that we do not report to the police. Mandatory reporting is not for women over the age of 18, unless the person you are referring to has given birth under the age of 18.

There is a point on community working. I have worked with communities for many years. The messages that go out to the community, whether we like it or not, have to be consistent with those that have been agreed with Government and other bodies. We may not like it, but that is the message that should go out.

In terms of the law, my colleague Neil said that it is difficult to prosecute. I am not a legal person, but my understanding is that the law has been changed to facilitate prosecution. We should think about this very carefully and feed back to the professionals who have to work with the law makers and those who implement the law or would bring challenges, so that the issue of FGM is carefully considered. I urge folks to think about what they mean when they say “working with the communities”, because sometimes—this is not popular—it is the community themselves who undermine the work we are doing.

(James Berry took the Chair.)

Hibo Wardere: I want to come back to a point Naimah made about communities not being engaged. I do not know where you are, but in the area I am in, I make sure my community is engaged, that the women talk about FGM and that they are involved from the beginning. Their views on how this has to happen and how they want to be helped are very important. Someone said that if a lady gives birth and has undergone FGM, we need to be notified. You actually do not need to be notified. She has not committed any crime. I am a survivor. If I give birth tomorrow, does that mean the police have to knock on my door and come in and talk about it? No, because we are survivors. They are victims as well; they just do not understand it yet. It is for us and other professionals to make them understand that and to make them aware of the law.

It is all about educating them. Most of them lack an understanding of UK law. They lack the language. They have not integrated. A lot of things are going on besides FGM that need to be talked about. Professionals themselves need to be open to community workers and to grassroots workers. Some of them are amazing professionals who seek our advice and work with us, but the majority of them do not do that. We are the ones who are going inside the communities. Sometimes we are not even trusted by our own community, but we still go in there. We are not giving up on working with them, because we know what is happening outside.

Nowadays, everybody has become professional in FGM. People who are wearing suits—people who are different—come in and tell the community, “We are going to talk about FGM.” That is not going to help the
community. It is not. The professionals and the Government need to go inside the community and talk to the community. Don’t talk at them. Don’t bring professionals who are from God knows where. Talk to them, because they can understand what you say. They will feel valued. They will feel that they can actually open up and talk—rather than you sending someone who does not understand at all.

Chair: Thank you. Alimatu.

Alimatu Dimonekene: I am an FGM campaigner and survivor, and founder of ProjectACEi. I and other survivors were involved in the initial part of the End FGM campaign. A lot of the professionals actually had no idea how you go about working on FGM—how you go about dealing with or even investigating FGM. We were instrumental in training the police in Project Limelight and Project Azure, because people often do not understand the complexity when it comes to FGM.

What bothers me is all these people who are now coming and saying they are professionals and experts on FGM—from the media and other organisations—and are losing the essence of why End FGM is so important. It needs to end. We had a case not so long ago. There are cases coming forward to the police, but survivors, or victims, need to be supported. They do not get that support, because the people who are dealing with these issues do not understand the deepness of FGM. We do not just look at the physical cut of FGM; there are other issues. When women or young girls in my community come to me and say, “Alima, we need you to help us,” they don’t come because they want help with their FGM; they first of all come and say, “I need help with my housing. I need help with education.” You need to look at FGM holistically.

These issues have gone on for centuries. Given the sort of control and power that this has, you could talk to those women from now until forever and it would not change. A media house told me recently, “Oh, you do not bring money into the campaign, so I’m going to find a survivor who can bring me money so we can talk FGM.” I look at that as demeaning. You are not ready to end FGM if you are looking to make it about money and raise funds for yourself and your organisation. You are not going to end FGM. Every day, women are coming to us and saying, “I have to speak to my husband. I’ve got to speak to my father and my brothers. They want FGM.” These folks do not understand. They come with their razzmatazz and their trumpets, and they blow their horn so loud, but they do not look at it holistically and psychologically. They do not look at the trauma that these women have to go through to just say, “No.” It is like with rape. It is like with any other traumatic experience. We have to solve the wound and stop putting plasters over it and glossing it like that, because it just doesn't work.

We’re going to go round this table every single time—bless, Efua is not here, but these are the things that Efua said. You sometimes have to give the communities that practise this the lead. They have to look the evilness of FGM in the face for them to say, “This is not right.” If we start being PC about the situation—I’m sorry, I’m going to be real with you: I have
trained over 1,000 GPs; I have trained over 500 police officers; I have trained over 5,000 teachers; I have done that in Enfield; and I have gone overseas to train people. It is the same point each time: you have to look at it from the point of view of the survivors and the victims. What the victims want will get us the answers that we are looking for. Otherwise, we will just be going round again.

**Dr Wilson:** Following up our sector colleagues’ comments earlier, this national action plan is something that we need to look at again. We had one, and we need this again. Without this, we will continue this lack of joined-up-ness.

Following up Alima’s point, if we are going to identify people who have been involved in this—survivors—they need psychological support. There is an absolute paucity in the UK. I have worked in Africa for nearly two decades now. It is no good interfering and opening up and exposing an area and leaving people without the psychological support to sort out their trauma. Otherwise, we are actually creating more harm, not less, which is completely immoral and unethical.

Another thing is that we need to build confidence. We have some training for professionals now but there is a nervousness, almost universally, among professionals in terms of what they do in scenarios and how to deal with that. We need to build their confidence and bring in survivors to talk to them and we need to bring up scenario planning so that they really know what to do. It is as quickly assimilated as with some medical procedure or technicality. We have also got to clean up our language. Some of our professionals, dare I even say in the houses, talk about cultural practice that needs eliminating. This is not a cultural practice; it is child abuse. We need to clean up our language. We have progressed to calling it FGM almost universally but that still needs to be addressed and I think the Committee should look at that as well.

We also have pockets where we have some flagship schools but that is not universal across the UK from literally cradle to age 18. We need people such as school counsellors, who are probably the most likely people to actually be addressed by survivors in schools or people at risk, and we need to train them as well.

Finally, on pockets of excellence like the training the Department of Health has rolled out, we, as sector-specialists and technical experts, are not even allowed to see that, which I always think is ridiculous. If we can’t see what is actually available we can’t plug gaps and add to resources. I am a great believer, in our organisation, in research and filling in gaps of what is not available so we don’t waste money and duplicate. We can’t plug gaps unless we can share what we already have. I don’t know why we still align on our professional lines, even around this table. The FGM Unit seems to me the obvious place to have everything where everything could be shared. In our charity we give everything away; we put it on our website so it can be universally accessed. Unless all of us around this table and in the audience have the same philosophy we will never actually be
able to add to that body and make a final impact on FGM, which is what we are really all here for.

**Chair:** Thank you. Gerry Campbell.

**Gerry Campbell:** I would like to make a couple of points, if I may. It is the NPCC’s view that to prevent, end and eradicate FGM requires a whole partnership approach, which has got to come from the coalition of partners—in its widest sense—of statutory, non-statutory, NGOs and the wider community in communities that may practice FGM to come together for that common aim and objective. It is our view that the solution to eradicating FGM rests within communities. We talk about community-driven solutions. Given perhaps the deeply ingrained nature of the decision-making and the offending, real, true and longer lasting solutions have got to come from within communities.

One of the previous speakers talked about risk and women who have historically undergone FGM giving birth. I still think there is a really important point about managing the issues around risk here and now and for the future. For example, I took part in a Somalian community talk show based out of north-west London that has a massive reach in the UK and beyond. There was one caller to that station who talked about her concerns. She had undergone FGM and there was community pressure on her for her daughters to undergo FGM. She felt defenceless and she was asking us what the solution was. Community-driven solutions are absolutely integral to that.

One of our concerns is around training. There can absolutely not be enough training but that that has to be delivered by police professionals alongside the College of Policing and working with NGOs that have been working in the sector for what we recognise as a substantial period of time.

One of our other concerns is the medium to longer term support for victims and survivors. That is a matter of substantial concern to us because, to be absolutely frank, the Police Service does not have the resources. We deal with very short-term investigations and work with our partners around support needs, but those investigators cannot keep—at what point in the process do those investigators stop working with victims and the other people in that wider partnership take responsibility for those victims?

**Chair:** I just want to bring in Sue Mountstevens.

**Sue Mountstevens:** Working with communities is key and it is absolutely key that we invest in that, especially working with our young people. They are our future. If we can work with them—as we certainly are in Bristol—that will make a really big difference. We also need to challenge the myths. So many of our communities feel that when the police and social care come in they are going to take their children away from them, so it is not really a surprise that they don’t want to engage. We really need to challenge those myths and explain that we are there for prevention.
The psychological support is just woeful. We mustn’t get too wrapped up in just dealing with the physical problems. It is the psychological element that will live with the victims forever unless we actually give them a considerable amount of support. There really needs to be a much more holistic way of doing that, working together with all of our institutions and with the voluntary sector, but we need to be careful that we don’t silo this into being different from child abuse. We need to make sure that this is under child abuse, because we have safeguarding and everything else. It is not difficult. When working with the GPs and midwives if we just call it child abuse I think people will be more comfortable in coming forward. If we just make it so difficult because it is FGM—“Woah, this is a bit difficult”—I think we will have a real problem.

Q32 Chair: Thank you. We have heard the successes and difficulties of the situation in the UK but I want to turn to the situation in France. Thank you for waiting patiently. It seems that you have a very strong record on securing prosecutions for FGM. What lessons can we learn, despite our new position in the EU, from France?

Linda Weil-Curiel: Banish the channel. Come back to us and to Europe. I feel foreign—because I am French and because of what I hear. As you rightly say this is purely child abuse. If you have a child beaten black and blue you wouldn’t bother asking your community or saying we must understand or that we have to train the community leaders and so on. Maybe. I don’t say no to that, but I say there is a child that has been cut; that has been mutilated. If it were a white child you would not hesitate to prosecute. I understand that in your system you need the victim to be the accuser. That is a very difficult point that you have to overcome. In our system, the police investigate as soon as mutilation is reported. At the beginning of the investigation the parents are called to the police station because they are the guardians and we all know that they have asked for the mutilation and have paid for it. At the least they are abettors.

Q33 Chair: And are most of the reports made by doctors?

Linda Weil-Curiel: Yes, because they have opened the legs and have seen that the child has been cut. The evidence is simple to see—just open the legs and you have the evidence. The parents will never tell you who did it—hardly ever. We have only had two that were identified, but they have been behind bars for quite a while, thanks to—maybe not thanks to me, because they may not think that way. The parents will not say who did it. They will lie; you must know that they will lie. But they are the guardians. They are responsible for that child. The cutter did not come to the house, open the door, grab the kid and cut the kid. Of course not. They have been requested to do that and paid for that.

Q34 Chair: So you are saying you have had a successful rate of prosecutions, but they are by and large of parents rather than of the actual perpetrator.

Linda Weil-Curiel: Yes, more parents. Over 100 parents have been prosecuted, tried and punished.
Q35 **Chair:** Over what period have you prosecuted that many parents?

**Linda Weil-Curiel:** The beginning was in 1982. That was when it began, when a baby died.

Q36 **Chair:** Is that when your law was last changed?

**Linda Weil-Curiel:** We never changed the law. I opposed it—but that does not mean my word was important. I said we don’t need a special law because mutilation is a crime. To mutilate a child is a crime. I said that if we wrote a special law, it would be terrible because it would be like pointing an accusing finger at foreigners in our country. We don’t need that; we did not need to change the law.

Q37 **Chair:** What about the wider point that has been made by some of the speakers about psychological services, support and work with communities? How do you do that in France?

**Dr Piet:** I apologise for my English. We have an obligatory medical certificate for babies at 8 days, 9 months and 24 months. You have to look at all of the baby and the sexual organs. It is obligatory for all doctors to look at the baby. If something is not normal, you have to say it. It is in our law to report. We have to report. That is the law. We report to the procureur—the persecutor.

**Linda Weil-Curiel:** The prosecutor is not always a persecutor.

**Dr Piet:** To the prosecutor.

Q38 **Chair:** So the manner of detection is through regular checks at certain stages in the child’s upbringing. It might be said that the law is quite harsh, in the sense that some of the parents may have had varying levels of culpability but are prosecuted in any event. Do you know if that law has resulted in a reduction in the incidence of FGM in France?

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

**Linda Weil-Curiel:** Forced marriage.

**Dr Piet:** Merci. And then they come back before 16, pregnant. So, we change our prevention tactics and then we work with maternity services to look at the women who—

**Chair:** During childbirth and maternity, yes.

**Dr Piet:** And then we do training for midwives and doctors—everyone—in looking and reporting.
Chair: So who gets prosecuted if the girl is 16? Is it still the parents?

Dr Piet: If they are 16 and they were born in France, and they are cut, you can prosecute, but it is very difficult for the maternity services to do that now. That is where we are.

Chair: What would you say is the biggest challenge you have at the moment in France?

Dr Piet: Our difficulty is doing the maternity reports for pregnant women. That is very difficult, but we are going to do it, because we have a lot of reconstructive surgery near maternity, so they can see it now, and they are starting to speak about it in maternity. I have a student who did a paper last month and asked a lot of women who have been cut what they want to do for their child, and there was no one who wanted to do something for their girl.

Chair: Can I bring in Neil Moore? Neil, the law in France seems much more straightforward. I understand there is a sort of declaratory purpose to us having a specific law with respect to FGM here, and it has certainly raised the profile of this whole area. Why would the more straightforward approach that has been taken in France not work in the UK? Maybe it would.

Neil Moore: Well, of course our systems are completely different. In order to try to answer that, may I just take up a couple of points? You mentioned, Madame, that the parents lie but you just prosecute both of them, even though you cannot work out who is actually responsible. Under our law, it is completely the opposite. We have a rule of law, started in a case called Abbott in the ‘60s or ‘70s, that says that if a child has been injured in any way in the presence of two parents and there is no evidence pointing to one or the other and there is no evidence of them acting together, each is entitled to be acquitted. There was another case, subsequent to that, called Strudwick and Merry, in which it was said that even if the parents—or one of them—lie repeatedly about why the child has been injured, you cannot mount a case on lies alone. That perhaps contrasts the differing approaches. Our law means that you have to prove who is responsible—either directly responsible or by joint enterprise, in which case there would have to be some evidence of the parents acting together. Of course, in a situation where they each point the finger at each other, it is impossible to do anything about that.

The other point that I want to take up is that you draw an analogy: “Why is this different to any other abuse? If a child was black and blue, that would be prosecuted as a physical assault.” The difference is that if a child was physically beaten in the home, somebody—a friend, a neighbour, a teacher—would notice that pretty quickly and they would report it. The difficulty with FGM is that it can take place and nobody is aware of it for a very long time indeed, at which point it becomes impossible to say who was actually there or responsible for the child at the time.

You have the advantage, Madame, that in your country you have much more mandatory examination. In fact, I think children have to be
subjected to yearly examinations in order to receive social benefits. [Interruption.] That’s what I’m saying. If you could pinpoint when the FGM happened, it would be much easier to prosecute, certainly for the offence in respect of parental responsibility—the amendment. If you can prove who was responsible for doing it at the time a child was cut and they are people who are deemed under the law to be responsible, they have to prove these criteria under the statute—that they did not appreciate there was a risk and they did all they could to prevent it.

Those are the two differences that I draw from what our French friends have just said.

**Chair:** Okay. Thank you.

**Hibo Wardere:** I have two questions for the ladies from France. First, I want to know whether their law applies to the white French kids—whether everyone has to be examined. The other question is this. Does their law say that only the people who come from these countries specifically have to be checked? Even if the child is a teenager who already has issues with their body, do they have to be subjected to being examined whether they like it or not? Is that something that we really want to adopt in the UK? Is it your law that people who come from these countries have to be checked? That seems like a discriminatory law. Is your law targeted; does it target these coloured children?

**Dr Piet:** It is every child—not the children from these countries, but every child.

**Hibo Wardere:** Even the French ones?

**Dr Piet:** Even the French ones. It is every child—girls and boys. You have to see—

**Hibo Wardere:** So what happens to the kids whose mothers and fathers you have jailed? Are you providing psychological support? Are you there? How are they feeling? You have to understand that the parents who are committing these crimes—FGM is a crime; I agree with that. But you have to understand that in the communities we come from, we do not see this as child abuse. These parents are loving parents. They think that what they did—[Interruption.] Let me explain. They think that what they did is a loving thing because that is what was done to them and that is the mentality they have. Do you consider that perhaps you should open up a different approach from your approach of being aggressive—the way you go for it?

**Dr Piet:** Well, I am not aggressive. When I look at a baby, it is every baby. You have to see all the babies each time, so it is normal when you go to the doctor that—

**Hibo Wardere:** What happens when they are a teenager and don’t want to be checked?

**Chair:** Order. Can we have one person speaking at a time, please? Have
you finished answering? Yes. Okay, let’s hear from Sue Mountstevens.

**Sue Mountstevens:** Can I just say that if we had 65,000 little white girls involved in this, we would not be having this discussion about mandatory examination? That is the first thing I would like to say. I would also like to say that in Bristol, we have 2,000 who are at risk of FGM this summer. Again, if we had 2,000 little white girls who might have their right leg cut off, we would not be having this conversation, so I think we just need to move on.

**Janet Fyle:** I just want to say a couple of things around being clear. First, the message should go out absolutely that FGM is child abuse. We cannot compromise on that. Secondly, of course there needs to be awareness raising within the communities that practise this, but trust me, I come from one of those communities and, as my friend Efua always says, we know the communities are always one step ahead of us, in terms of how the practice is adjusted and the way they try to hide this.

Going back to Neil explaining to our French colleagues why we cannot prosecute, we have been sitting here hearing all the time why we cannot prosecute. I don’t believe in the examination of the girls. We have to look at SRE and PSHE—personal, social and health education in schools. You have one arm of Government that is not really keen on it and another arm of Government that is, so we need to go definitely and advise teachers on this area and actually make it mandatory in schools. But I’m going to come back to the issue of prosecution. We have to be very clear. I don’t understand the law as such—I said this earlier. I thought that last year the law was adjusted around parental liability, so I am not seeing the point you are making, Neil.

**Neil Moore:** I agree with you. It is a change in the law, which I think is going to make things better. Unfortunately there have been no cases referred to us under the new law, but, as I think I said before, I consider it a really positive move. You are quite right: it is going to be easier to bring these cases. It is more adopting part of the French scheme in the sense that once you have identified that a parent or two parents are responsible for the child when the cutting happened, then effectively the burden shifts on to them to prove they are not responsible. You are right, it is going to make things easier, but I am afraid at the moment no cases under that provision have been referred to us.

**Joe Hayman:** I am Joe Hayman from the PSHE Association. PSHE is personal, social, health and economic education: the school subjects in which children learn about personal safety, bodily autonomy and healthy relationships. The 2014 report on FGM from the Home Affairs Committee recommended that this should be a statutory subject and that all children and young people should learn how to keep themselves and others safe.

We have spoken a lot about criminal justice today and I think that is a really important element, but coming back to prevention, this subject, which has been shown at the very least to increase the number of disclosures in children and young people seeking help, is still a non-
statutory subject, still taught by untrained teachers and still left off the curriculum altogether in many schools across the country. There is evidence that provision of the subject is decreasing.

Many of the partners around the table have done really good things in terms of education. We ourselves have rewritten our national curriculum for PSHE to have an explicit reference to FGM at key stage 2—children of primary age. We have worked with the charities Freedom and FORWARD on teaching resources. We have worked with the Science Association on a briefing about teaching about the human body at primary age—proper names for genitalia and so on—and we produced guidance on linked issues like consent.

That is just during the last two years. During that period membership of the PSHE Association has doubled, but the amount of time given to PSHE in schools has gone down by more than 20%. I would say this is all about school accountability: what is measured and what is not, and what is statutory and what is not. We really appreciate the leadership from the Committee on this issue, but we need leadership from Government as well, because we cannot play our part in prevention if we are delivering these lessons by untrained teachers or if we do not have these lessons at all.

(Keith Vaz took the Chair.)

Chair: Thank you.

Sarah McCulloch: I have two issues—one is a question. I have cases where a parent is completely against FGM and wants to protect their daughters. However, she is under enormous pressure from extended family—her husband’s family and her own family. In such occasions they will take the child away and do it anyway. Is that parent going to be sent to court? She doesn’t want it done, but the child has been abused because of the extended family pressure.

The second one is the issue about FGM protection orders. If a mother has had FGM and she is travelling to her country of origin with her daughter, protection orders are put in place, but I have at least four mothers who have daughters they are trying to protect but they have been refused leave to remain in the UK.

Q42 Chair: That is very important. Could I have final comments? Then we will summarise and wrap up.

Dr Wilson: Commenting on the French and English issues, I find it strange that there is this piece of law now that allows for parental negligence—effectively responsibility—yet we have still got children being taken overseas; we have got children who will be cut this summer; we have got children being cut in Britain as we speak. I wonder what it will take in terms of the CPS, the police and other agencies to ensure that either we move to having prosecutions, or indeed—what we would all prefer—we do not need prosecutions because there is no FGM. But I find it
frustrating that we have moved towards the law being improved to cover for this and there has still been no progress.

Chair: Thank you.

Alimatu Dimonekene: I support what Joe said. We know for a fact, based on some of the evidence that a lot of the survivors have given and from our training, from going into communities and from working with professionals, that most people, and women in general, cannot even identify what the labia or the clitoris are. For women to even begin to explain what has happened to them—in some communities FGM happens to women when they are very little and they are not aware until they present in maternity.

What has been very successful in areas where it has been tested and tried is when sexual health education has been taught to very little children. We gave a recommendation of the Norbury School in Harrow, which has one of the best practices. Children as little as seven or eight are taught the NSPCC model, “PANTS”. They can identify their private parts, and can tell when abuse has happened and what abuse looks like.

I am sorry that we do not have any young people or children represented here because they can make a case for us to understand the impact, not just of FGM. We have to stop looking at FGM in isolation, because we already know from the Girl Summit, which the Government hosted in July 2014, that wherever FGM is prevalent, domestic and sexual abuse, and forced marriage and other honour-based things such as breast ironing and self-harm are happening. We are putting too much focus on FGM, so everybody is so scared about FGM.

Chair: Thank you. Gerry, you can have the final point, and then I am going to sum up because I am afraid there is going to be a vote very shortly, which will curtail out proceedings.

Gerry Campbell: I want to make it absolutely clear that the police service is not trying to pass the parcel on to any other agencies. The police service is absolutely committed and determined in its work around carrying out quality investigations with a view to refer cases to the Crown Prosecution Service and secure prosecutions where it is appropriate to do so.

In the past 12 months alone—yet again, I would sound a note of caution to some of the figures—584 FGM crime and incidents have been investigated. In the last submission to the Home Affairs Committee, over a six-year period from the financial year 2008-09 there were 386 cases only. A number of changes have taken place nationally around the National Police Chiefs Council policing strategy for England, Wales and Northern Ireland, with four key points and strands of work around prevention, protection—take that to mean safeguarding as well—partnerships and prosecutions.
There has been a wealth of training, led—although not exclusively—by the College of Policing, around the tiers and the accreditation of training for investigators at different levels, most notably investigators who have responsibility for conducting investigations into child abuse, including FGM and child sexual exploitation. We will refer cases to the CPS where it is appropriate to do so. A number of cases rest with the CPS for decision making.

In closing, to parallel some of this to our work and other referrals to the Crown Prosecution Service around honour-based abuse, violence and forced marriage—

**Chair:** I think the best thing is for you to do on honour-based violence is to drop us a note. That would be very helpful.

**Gerry Campbell:** In parallel, our referrals from the Police Service around those two subject areas have totalled 334 different referrals. I see the same happening in our work on FGM.

**Chair:** I think the main concern is that you are not getting the arrests and prosecutions. At the end of the day, the only prosecution we have had has been unsuccessful. You can’t have laws that have been in existence for 20 years with no one prosecuted. There is no point in having the law. As the French have shown us—I know you have heard from our French colleagues—it is possible for this to happen, but it is not happening in the United Kingdom. That is why we are so anxious.

I can’t think of another subject to which the Home Affairs Committee has gone back year after year after year. We didn’t want to do what Parliament normally does: pick up a subject, make a series of recommendations, and nothing happens. For as long as I remain Chair of this Committee, we will revisit this every single year until we get it stopped. At the moment, that is not happening.

Let me pick up the key themes that I think you were telling us about. Please be aware that we have the Minister for FGM—if we can call her that, although she has got other things in her portfolio—next Tuesday in a formal Home Affairs session, which you can see on the BBC Parliament channel and on the internet. You don’t all have to turn up; you can watch it there. We will be putting all your points to her, and what you have said today will form part of our report. The note of today’s proceedings will be circulated to all other members of the Committee. As I said earlier to others, this is not to be taken personally. It is a worry. I am sure it’s a worry to you; it is a worry to us. No prosecutions and no arrests that lead to prosecutions: this is a problem, and it can’t go on like this.

To summarise, these are the things that I think we can draw from today. First, any successful prevention programme must be community led. It is still not community led. The communities are still not in the driving seat as far as eradicating FGM is concerned.

Secondly, there are genuine concerns that professionals tasked with
engaging with communities do not have the skills or the confidence to earn the trust of communities. The people we are putting into the front line just do not have the capacity to do what we want them to do.

Thirdly, individuals within communities are already fearful that they are being criminalised, perhaps through mandatory reporting. We support mandatory reporting because we think it is a step forward, but there is this fear, and we should acknowledge it and try to make sure it is marginalised.

We heard that there might be real problems with the language that is used with regard to FGM. We also heard that treating FGM with the same seriousness as horrific child abuse, which undoubtedly FGM is, might be the way forward. We have got a major inquiry headed by Lord Justice Goddard into this area, but we have really only had Select Committee inquiries into FGM. Maybe it is a much, much bigger subject for even Parliament to tackle.

More should be done to assess the psychological traumas associated with FGM, and not just the physical consequences.

As I have said, we also remain concerned about the lack of prosecutions in the United Kingdom. We heard that France has a more robust examination and reporting system than we do in Britain. There are clear differences between the legal systems of our two countries, but lessons can be learned. We say, “Vive la France”, in respect of what the French are doing.

Schools have an obvious role in raising awareness. Excellent work is being done in the PHSE field, but the Government must lead if results are to be maximised.

We will keep doing this every year. The Committee will keep coming back, and we will keep calling you all together. We will keep doing this until something changes and something is done. Please do watch the proceedings next Tuesday. If you have any specific questions to the Minister that you would like the Committee to ask, email us. Go to our website tonight—after the football match, of course—and you will be able to find our email address. Adrian and Kunal have been involved in this conference, but Adrian is the lead on this. I’m sorry we didn’t find a woman to do this, but it’s got to be Adrian because he was available to do it. Of course, Carol is the chief Clerk of the Committee. We want to refine our report and make it even stronger. We want Ministers to sit up, and we want the statutory organisations to sit up as well.

Thank you very much for coming. We are so grateful, especially to our colleagues from France. We are most grateful to you for coming all the way over here. Perhaps the Committee will make a journey to France as part of our next inquiry. Rather than just taking parliamentarians with us, it would be good to take community organisations and groups with us so we can see what they are doing there. If you are interested in doing that, keep in touch with the Committee, keep in touch with Adrian, and you can come with us on our visit to France so we can see why they do better than
we do. A big thank you to everyone—all our speakers, the audience, the commissioners who have come here and others—for participating in this seminar. This is not the end. We have only just begun. Thank you very much.