

January 2015

## **MPS's response to: Introducing mandatory reporting for female genital mutilation; a consultation**

### **Overview**

MPS recognises that the policy decision has been made to introduce mandatory reporting for female genital mutilation (FGM). For this reason we will not comment on the policy decision itself. Having said that, MPS is of the view that the current General Medical Council (GMC) guidelines for reporting FGM are, in general, clear and appropriate.

Doctors are already under a professional obligation to report cases of FGM as it is a form of child abuse. Under the current GMC guidance 'Protecting Children and Young People 2012' (paragraph 32), doctors must refer cases of FGM as one form of child abuse to the local authority children's services, if it is in the best interests of the child. It requires that the practitioner does so 'promptly'.

Furthermore, as recognised in the consultation, practitioners have a further duty to make a referral to children's social care any cases where they suspect a child has suffered abuse or is at risk of abuse under existing statutory guidance 'Working Together to Safeguard Children'.

When introducing a mandatory reporting system as is proposed, the Government should recognise that a doctor must maintain the trust of their patient. A balance has to be achieved between any duty to report and ensuring patients are not deterred from seeking medical advice or withdrawing from it. There is a risk that mandatory reporting may mean that some girls/women choose not to seek advice for medical concerns, and particularly for pregnancy and other gynaecological problems. Thorough consideration must be given as to how to mitigate this risk.

Additionally, legislation must be flexible enough to ensure that individual, and sometimes quite complex, circumstances of a case are taken into account. As we explore later, depending on the experience of the doctor and the Type of the FGM, identification can be harder in some cases.

We would advocate a sunset clause being included in this legislation. This will ensure that a post-implementation review will take place. It is important that legislation is reviewed against its objectives after an initial five year period. This will allow for any necessary changes to be made based on the experience of its implementation. Added to this, due to the sensitive nature of the legislation, we would also advocate an initial one year review.

MPS is disappointed with the way in which this consultation has been undertaken. Considering the complex nature of the proposals a five week consultation period, taking place over the Christmas and New Year break, does not seem appropriate. Nor do we feel has it been done within the true spirit of the Cabinet Office's 'statement on consultation principles'. This statement includes the recommendation that:

*'For a new and contentious policy, 12 weeks or more may still be appropriate. When deciding on the timescale for a given consultation the capacity of the groups being consulted to respond should be taken into consideration.'*

*'Timeframes for consultation should be proportionate and realistic to allow stakeholders sufficient time to provide a considered response and where the consultation spans all or part of a holiday period policy makers should consider what if any impact there may be and take appropriate mitigating action'<sup>1</sup>*

Indeed when announcing the Government's intention to consult on this proposal, Lord Bates committed to the consultation running for the full 12 weeks "given the significance of the issue"<sup>2</sup>.

Bearing in mind the short time period given for consultation, MPS recommends that a one year post implementation review will be of particular importance.

## Questions

1. Do you agree with the government's proposal that the mandatory reporting duty of FGM should apply to cases of 'known' abuse?

MPS agrees with the Government's approach in this regard. If mandatory reporting is to be introduced, it is only appropriate for the remit to extend to 'known' cases of abuse.

We agree that there are too many risks involved in widening the remit to cover 'suspected' or 'at risk' cases of FGM. It is difficult to describe definitively the factors which a practitioner should be looking for to indicate a 'suspected' or 'at risk' case of FGM. The decision would largely depend on individual circumstances, and some factors would matter more in one case than another. If you combine these complex, case-by-case decisions with the fear of potential sanction for non-reporting, there is a strong likelihood of over-reporting which would have a number of negative consequences.

However, we agree that current guidance which requires practitioners to refer cases, where appropriate and using their discretion, of children where they suspect abuse or believe that they are at risk of abuse, should remain as is.

2. Do you agree with the government's definition of 'known' abuse, as something which is visually confirmed and/ or disclosed by the victim?

MPS agrees with the principle behind the notion that 'known' abuse can be defined as something that is visually confirmed or disclosed by the victim. However, in practice a case of FGM cannot always be easily identified and in some circumstances an expert opinion will be required to confirm that FGM has occurred.

Some doctors will be less experienced at identifying a case of FGM. There will be cases that a gynaecologist may be able to identify relatively easily but a GP may not because of the difference in experience of cases of this kind.

<sup>1</sup> Cabinet Office 'Statement of consultation principles' October 2013

<sup>2</sup> <http://www.publications.parliament.uk/pa/ld201415/ldhansrd/text/141028-0001.htm> - Hansard 28th Oct column 1084

Depending on whether it is Type I, II, III or IV greater levels of expertise may be needed to confidently identify it as a case of FGM. Factors such as childbirth can also complicate a case. There is also a growing trend for more 'limited' procedures symbolic of FGM such as a small 'nick' to the clitoris. This may be hard for some doctors to definitively identify as a case of FGM.

It is important to retain a degree of flexibility in any proposals. Any new legislation should allow for complex cases to be considered on a case-by-case basis. The Type of the FGM and the experience of the practitioner must be considered before a sanction is applied.

3. Do you agree with the government's proposal that the duty be limited to FGM in under 18s?

Government is right to limit any mandatory reporting of FGM to 'known' cases of under 18s only. It would often be inappropriate to report a case of FGM in an adult if the adult concerned had no worries about the FGM. This may particularly be the case if the adult is elderly. MPS argues that it would be inappropriate for doctors to even discuss FGM with all potential patients, again in particular the very elderly. It is suggested on the consultation document that doctors should exercise discretion as to 'when' to discuss the patient's FGM; this would be better phrased 'if' to discuss at all.

However, when considering under 18s, it should be recognised that there is a fine line between safeguarding children and potentially putting adolescents in an extremely difficult position. The older victims may be wary of accessing medical help for fear of getting their parents into trouble, whereas the younger age group will not necessarily see this as a threat. The repercussions of such a fear in an adolescent have the potential to be severe, such as if a pregnant teenager were reluctant to seek medical help and as a result were unsupported throughout pregnancy and birth.

Legislation needs to take into account difficult circumstances such as those described above, and sanctions applied only after such factors have been taken into account.

4. Do you agree with the government's proposal that the duty should be placed on health care professionals, teachers and social care professionals?

Not applicable

5. Do you have views on any necessary differentiation between different professional groups on whether the duty should cover disclosure and/or visual identification?

Not applicable

6. How do you think mandatory reporting of FGM should apply in the early years sector?

Not applicable

7. Do you agree with the government's proposal that all reports should be made to the police?

MPS disagrees with the proposals that all reports of FGM by practitioners must be made to the police specifically. However, it does view these changes as a welcome opportunity to clarify and

rationalise the current arrangements. Currently doctors are required to report cases of FGM as a form of child abuse – when in the best interests of the child – to the local authority children’s services, NSPCC or the police.

To minimise confusion, avoid creating an overlapping system and to ensure efficiency, the system for reporting FGM should require practitioners to make all reports of FGM as child abuse to the local authority children’s services. It will then rest with the Safeguarding Officer and children’s services to report cases to the police.

We disagree with the proposal in the consultation that a practitioner would need to both report a case to the police and, outside of this new reporting requirement, also refer the case to children’s social care. We believe that this risks creating confusion and would be burdensome for practitioners.

8. Do you agree that reports should be made at the point of initial disclosure/ identification?

Under the current GMC guidance there is no specific time frame within which a report of FGM must be made. MPS would prefer this to remain the case. However, if it is decided to proceed with a statutory timeframe, it is necessary to include a defined ‘assessment period’. This could be a month or two which would allow the practitioner, depending on the individual circumstances, to meet with the patient and possibly the patient’s family, explain why reporting is mandatory and ensure they are aware of help available to them. It would also allow the practitioner, in some cases, to mitigate harmful consequences.

9. If an individual is in contact with multiple organisations, should they be reported once, once from within a sector, or repeatedly throughout life?

It would be disproportionate and potentially damaging to the patient if they become the subject of continued reporting of FGM throughout their childhood.

MPS agrees with Government that the links between the multiple organisations involved need to be robust to ensure that one report is enough, but it is necessary that Government ensures that this is the case.

10. By what mechanism do you think sanctions should be placed upon individuals who fail to report FGM under the new duty?

MPS is pleased that Government is not proposing to introduce a criminal offence for non-reporting. When choosing between option 1 (report to the Disclosure and Barring Service) and option 2 (Disciplinary sanctions) we would prefer option 2.

The GMC already has a hearings and sanctions mechanism in place and it is one which doctors are familiar with. The GMC has within its power a range of sanctions which would avoid the ‘one size fits all’ approach which option 1 offers. This would allow for an element of proportionality.

Option 1 provides for a seemingly rigid sanctions system which would not necessarily allow for individual circumstances and mitigating factors (as explored in answer to question 2) to be taken into account. Furthermore, option 1 could effectively end a career. By placing a GP on the DBS list

they would no longer be able to treat children which would effectively make them unemployable in general practice. It would also mean that the health service loses a potentially otherwise good doctor. This is a disproportionate sanction for failure to adequately comply with this requirement.

11. What level of sanction do you think should be placed upon individuals who fail to report FGM upon the new duty?

The appropriate level of a sanction depends on several factors which should be taken into account.

These include:

- Experience of the practitioner
- The Type I, II, III or IV
- Any remediation that had taken by the practitioner before their hearing comes to the GMC.

MPS believes that it is important that a practitioner is able to demonstrate to the GMC that they have reflected on what went wrong and have remediated. For example, as a result of what went wrong the doctor has attended educational courses or has visited and FGM clinic to expand their expertise. It is important that practitioners are able to use an adverse incident as an opportunity to learn from mistakes.

12. 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?’

MPS agrees that practitioners should have knowledge of the guidance but is not convinced that it is necessary to place it on a statutory footing.

13. Are there substantive amendments which could be made to the guidelines, which would help to prevent FGM and protect and support victims?

Some GPs might benefit from a ‘desk friendly’ flow-chart style guide to remind them of the steps they should take when dealing with and reporting a case of FGM.

## Concluding remarks

In recognition of the stage of this consultation – implementation and not policy – we have decided not to comment on the policy decision. However, MPS is clear that any new legislation must achieve the right balance between the need to report cases of FGM for safeguarding purposes and maintaining good doctor-patient relationships. This is particularly the case when considering adolescents. All actions must be taken in the interests of the patient.

The legislation should have a sunset clause built into it as well as an initial one year review to ensure that any unintended consequences are dealt with early.

## About MPS

MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 290,000 members around the world. Our benefits include access to indemnity, expert advice and peace of mind. Highly qualified advisers are on hand to talk through a question or concern at any time.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This includes clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.

## CONTACT

Should you require further information about any aspects of our response to this consultation, please do not hesitate to contact me.

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