14 January 2015

**Home Office consultation on Introducing mandatory reporting for female genital mutilation**

1. The RCGP welcomes the opportunity to respond to the Home Office consultation on ‘Introducing mandatory reporting for female genital mutilation’.

2. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 49,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with expertise in patient-centred generalist clinical care.

**Summary**

3. The RCGP welcomes the proposal to only apply mandatory reporting in cases of ‘confirmed’ FGM, and that confirmation should be either visual or a disclosure made on the part of the victim. We would view the requirement to mandatory report cases of suspected or ‘at risk’ FGM as tantamount to stigmatizing individuals and communities on the basis of categories such as religion and county of origin. In this context we also welcome the assertion within the document that there would be no routine examinations of young girls, and would view this as a gross invasion of privacy.

4. However, the concept of mandatory reporting for FGM presents unique problems for GPs, many of whom will not be in the position to visually confirm cases of FGM as part of routine contacts with patients. As such GPs may find themselves commonly in the position of encountering a suspected case of FGM without the means to formally identify it. The RCGP therefore believes that the more appropriate course of action for many GPs would be for them to refer suspected cases onto other parts of the health and social care system, which may be able to make a confirmation. However, well understood mechanisms for this do not currently...
exist, and specialist support services for victims of FGM currently only exist in small pockets within some large cities.

5. We welcome the fact that mandatory reporting will only apply for those under 18. Mandatory reporting for FGM in adults would in our view represent an unethical breach of patient confidentiality, without the safeguarding justification that is associated with child abuse. Indeed we have concerns that the mandatory reporting for FGM for adults would in many cases act as a deterrent for patients accessing the health service. If an adult patient is aware that they may be reported to either the police or social services as a result of a GP appointment, they may choose not to attend unless they have a severe health condition.

6. The RCGP is strongly apposed to the proposal that mandatory reporting of cases of FGM should be made to the police rather than social services. FGM is form of child abuse, and as such we see no reason why it should be addressed in a different fashion from other forms of child abuse, where the child will be referred to social services, with the police becoming involved at a later date or at the discretion of the clinician who has identified the abuse. Indeed, it is our view that awareness of mandatory reporting to the police amongst affected communities would act as a major deterrent for many members from said communities to interact with the health service, even in relatively severe circumstances. Indeed, it is difficult to see what purpose it would in fact serve, given that child abuse is not generally dealt with by the police, in the initial stages of an investigation.

7. Moreover, we have severe concerns around the suggestions within the consultation that clinicians would be reported to the Disclosure and Barring Service. It is our view that GPs who fail to report cases of FGM should be dealt with by existing mechanisms, such as those applied by the GMC, and that the most severe punishment that can be applied would be removal from the medical register, which would ensure the clinician was never in a position to prevent a referral again. However we would expect the majority of cases of a failure to report FGM to be as a result of a lack of understanding on the part of the clinician as to the epidemiology of FGM, and as such applying minor sanctions such as medical retraining would be the most appropriate action to take.

8. Indeed, we have significant concerns that little information has been given as to what the threshold for sanctions to be applied would be. As GPs would not be in a position to routinely identify patients with confirmed cases of FGM it is very likely that a patient will be seen many times by a GP without the opportunity to formally confirm their condition. As such we would expect the threshold for when sanctions would be applied to GPs to be relatively high and to take into account the inability of many GPs to formally identify FGM.

9. The RCGP also has concerns about the lack of focus on prevention within the consultation document. While mandatory reporting for confirmed cases has a place in helping to combat the image of FGM as an acceptable practice within communities, it does not stop the crime from being committed. We would like to see more guidance produced on how GPs and other professionals will be enabled to record and report suspected cases of ‘at risk’ FGM, and to refer these on to other parts of the health service, or specialist FGM victim services.

Question one: Do you agree with the government’s proposal that the mandatory reporting duty of FGM should apply to cases of ‘known’ abuse?

10. The RCGP strongly agrees with this proposal. The RCGP would view the mandatory reporting of ‘suspected’ or ‘at risk’ cases to be overly cautious and risk stigmatizing individuals and communities on the basis of categories such as religion and county of origin. This is especially true given that the proposals specify a referral to the police rather than social services. Medical professionals should be free to use their judgment with regards to ‘suspected or ‘at risk’ cases, and many GPs may feel the need to refer a patient whose FGM is not ‘known’ to social services based on the associated risks of a case.

Question two: Do you agree with the government’s definition of ‘known’ abuse, as something which is visually confirmed and/or disclosed by the victim?
11. The RCGP supports this definition. However, the need to confirm a case as ‘known’ in this way as part of the mandatory reporting duty presents unique problems for health professionals such as GPs, many of whom will not be in the position to visually confirm cases of FGM as part of routine contacts with patients, or indeed in a position that a patient might make a voluntary disclosure. As such GPs may find themselves commonly in the position of encountering a suspected case of FGM without the means to formally identify it.

12. Although many GPs may choose to report ‘suspected’ or ‘at risk’ cases to social services based on the associated risks or severity of each case, there may be cases where a GP feels uncertain about the diagnosis and would seek a confirmation before any action was taken. Therefore the RCGP would like to see proposals regarding allowing health professionals such as GPs to report a suspected case of FGM to other agencies within the health and social care system who may be able to confirm a case more easily, without the need to inform either the police or social care.

Question three: Do you agree with the government’s proposal that the duty be limited to FGM in under 18s?

13. The RCGP strongly agrees with the proposal to limit the mandatory reporting duty to those under 18. With patients under 18 there is a clear safeguarding duty to be performed in line with that which is currently expected of GPs for other forms of child abuse. However, with adult patients mandatory reporting risks breaching patient confidentiality, by disclosing patient information without the consent of the patient, without the justification that it is for the purposes of child safeguarding or harm prevention.

14. Moreover it is difficult to see what the positive outcome would be of referring an adult patient of FGM to social services or the police without their consent. In most cases the crime would have been committed significantly in the past in a foreign country, as such there would be little to be gained from reporting the crime to the UK police. In addition, although a victim of FGM is undoubtedly vulnerable, it is difficult to see how a forced referral to social services would provide them with the help they need and it could indeed be detrimental to their general mental health.

15. Indeed the RCGP has concerns that the mandatory reporting for FGM would in many cases act as a deterrent for patients accessing the health service. If an adult patient is aware that they may be reported to either the police or social services as a result of a GP appointment, they may choose not to attend unless they have a severe health condition. For example, take up of cervical screening programmes is already lower among women from affected communities. The RCGP would expect to see a drop in uptake of vital programmes such as this, in mandatory reporting were introduced for adults.

16. However, the RCGP would see the value in the routine recording of adult victims of FGM on a discretionary basis. In this way we could get some understanding about the scale of FGM in this country, while also flagging up potential victims (most victims of FGM will be the daughter of an affected woman), without alienating women from affected communities. The RCGP has promoted a specific code for use by GPs in recording cases of FGM in our position statement on FGM published in July 2014.

Question four: Do you agree with the government’s proposal that the duty should be placed on health care professionals, teachers and social care professionals?

17. The RCGP agrees that the proposals should apply to all those who come into contact with children and have an existing safeguarding duty.

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

18. The RCGP has concerns that little consideration has been made within the consultation document for the ability of the different professions to visually identify victims of FGM or to experience a disclosure. While we would expect midwives or gynaecologist to have a great number of opportunities to experience both, a teacher or a GP might struggle to visually confirm
FGM or indeed to be in a position where a patient might willingly disclose they are a victim of FGM, especially if that patient is a child.

19. Moreover little information has been given as to the expectations that will be placed on different health professionals to report. For example, midwives who might have many opportunities to identify victims and potential victims may be expected to frequently refer, however there is no standard referral rate we would expect from general practice, due to the diverse nature of the work of GPs. No provision has been made for this fact within the consultation document.

Question seven: Do you agree with the government’s proposal that all reports should be made to the police?

20. The RCGP strongly disagrees with this proposal. Under the current system if a child is a suspected or confirmed victim of child abuse a GP would refer the child to child protection services, under Local Safeguarding Children Board (LSCB) procedures. Given that FGM is a form of child abuse we see no reason for a different approach.

21. Indeed, we have concerns that singling out FGM in this way would have a negative effect on recording and combatting FGM, as the threat of referral to the police rather than social services would act as a serious deterrent for many women to access the health care system, even in extreme circumstances.

22. In addition, we have concerns that referral to the police would be an ineffective method of referral, as child abuse is not commonly dealt with by the police in the early stages of the investigation, where the role of social services in paramount.

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

23. The RCGP disagrees that all reports should be made at the point of initial disclosure or identification. Each case of FGM will differ in its urgency and the position of the victim/potential victim. As such there should be room for a clinician to apply their judgment to this situation.

24. In cases such as this, we would expect that clinicians should be able to record adult FGM/suspected FGM cases without the need to report it to the police/social services, in order that a proper referral may be acted upon at a more appropriate time by perhaps a more appropriate agency.

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

25. Ideally an individual would only be reported once from within the entire healthcare system, as to report repeatedly would risk stigmatizing the patient and duplicating vital services. However, there are long standing issues around data sharing between different parts of the NHS and between the NHS and outside bodies. For example if a patient appears at A&E and an identification is made of FGM, the attending doctor may not be aware if they had been identified previously within another part of the health care system. If FGM reporting is to be truly effective a system must be put in place to share information between different parts of the health service relating specifically to child or maternal health.

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

26. The RCGP would expect that any GP who fails to report a ‘known’ case of FGM in under 18s to be dealt with by the GMC, the professional regulatory body for GPs, in line with all current cases of medical malpractice. The GMC has the means and methods in place to adequately address failures in medical practice and ethics. The creation of a new body, or new powers given to an existing body, would only serve to create a double layer of administration, and confuse the regulation of health care.
Question eleven: What level of sanction do you think should be placed upon individuals who fail to report FGM upon the new duty?

27. The sanction should depend on the severity of each case, and should be in line with current GMC guidance on similar issues. Removal from the medical practitioner's list would be the sanction that we would expect to be applied in the most extreme cases, where a doctor can be proved to have deliberately not reported a case of FGM with full awareness of the consequences of that act. With lesser offences where a GP could conceivably have acted in good faith, but their actions have resulted in FGM not being reported, we would expect retraining on this particular issue to be the sanction that was applied.

28. However we have concerns that under the current proposals to only refer cases of known or confirmed FGM GPs would not in most cases be able to easily identify a case through the normal interaction between GPs and patients. As such a situation might arise where a patient presents at secondary care with an obvious case of FGM which a GP had missed through no fault of their own. In order to stop GPs from being punished for a situation which is outside of their control, we would suggest that the threshold for punishment should be relatively high.

29. In addition, we strongly oppose the idea of reporting GPs to the Disclosure and Barring Service as suggested in the consultation document, and view this as a gross over reaction. Failure to report is a medical error, not evidence of child abuse. Removal from the medical register will be enough to ensure that a GP never contributes to the harming of a child in this fashion again, if they have been found guilty of doing so.

Question twelve: 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?

30. We would agree in principle, however many GPs work in rural areas with very few or no members from affected communities on their patient list. As such they are very unlikely to come into contact with victims of FGM and their relative understanding of the issue should be seen within this light.

What evidence or information do you have on the expected increase in reports to the police or social services from introducing mandatory reporting of FGM and how do you think they will vary with the different proposals?

31. The RCGP has concerns that an increase in reports which would accompany mandatory reporting would put more pressure on an already overstretched system, especially if those reports were to be made to the police. Unless there is an equivalent increase in budget we are concerned that an increase in reports would lead to either an overly cautious approach to prosecuting, as a way to manage an unsustainable workload.