MINUTES OF A MEETING OF THE CHILDREN & LEARNING OVERVIEW & SCRUTINY SUB-COMMITTEE (JOINT MEETING WITH HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE)
Town Hall
20 April 2016 (7.00 - 8.05 pm)

Present: Councillors Gillian Ford (Chairman), Carol Smith (Vice-Chair), Nic Dodin, John Glanville, Joshua Chapman and Ray Best (In place of Philippa Crowder)

Co-opted Members: Lynda Rice and Lynne Bennett

Non-voting Member: Ian Rusha

Caolin Maclaverty, Consultant Obstetrician, Barking, Havering and Redbridge University Hospitals' NHS Trust

Tim Aldridge, Assistant Director, Children's Services was present as were three other staff members from children's services.

One member of the press was also present.

47 CHAIRMAN'S ANNOUNCEMENTS

The Chairman gave details of arrangements in case of fire or other event that may require the evacuation of the meeting room.

48 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

Apologies were received from Councillor Jason Frost.

49 DISCLOSURE OF INTERESTS

There were no disclosures of pencuniary interests.

50 FEMALE GENITAL MUTILATION (FGM)

A consultant obstetrician from Barking Havering and Redbridge University Hospitals' NHS Trust (BHRUT) explained that female genital mutilation (FGM) was most common in the Horn of Africa countries where there was in excess of 90% prevalence. It was emphasised that FGM was not endorsed by any faith and was considered as more of a cultural practice.

The consultant added that most cases were relatively minimal, involving the removal of the clitoris but other forms were more invasive. The most extreme cases of FGM often led to problems such as urine infections, menstrual difficulties, problems in childbirth and psychiatric problems. Most

FGM cases the consultant had seen were less severe but still caused a lot of physical and psychological distress.

The practice had been illegal in the UK since 2003 and it was also illegal for e.g. family members to take a child abroad for FGM. FGM usually took place between the ages of 5 and 10 and the consultant was not aware of any cases being performed in Havering although she did some cases that had been performed abroad. Around three deinfibulation procedures to partially reverse FGM were performed at BHRUT each year. This was a much lower figure than in hospitals in central London.

All pregnant women were asked, on their first visit to BHRUT about whether had ever had genital surgery and were asked this again, even if they had answered no, at a later stage of their pregnancy. If signs of female genital mutilation were identified, patients would be referred by community midwives to the consultant's team for specialist treatment. FGM had only been seen in Havering in first generation immigrants with the consultant never having seen any cases in second generation immigrants.

Community midwives were also able to advise women that taking a child abroad for FGM was illegal in the UK. With effect from October 2015, any child born to a woman had had undergone FGM also received a safeguarding alert.

Any cases of girls under 18 seen at the hospital with FGM had to be reported to the Police. In addition, a referral would be made to the multi-agency safeguarding hub (MASH) and the safeguarding midwife would be informed. BHRUT had also introduced a 'time to talk' programme where a midwife spoke individually with a pregnant woman about any confidential concerns or issues.

Most cases of FGM were identified in maternity units but only 10% of these required surgical intervention. Referrals could also come from areas such as paediatrics and sexual health services. It would be the responsibility of social care staff rather than the hospital to contact a young person's school if FGM was suspected.

The Assistant Director, Children's Services explained that Kensington & Chelsea had received funding to work with Horn of Africa communities on this issue. This had led to the establishment of a specific clinic and support to encourage women in the community to take ownership of the issue. A helpline for cases of FGM had also been established at Homerton Hospital. The FGM issue was normally led by women although it was agreed that there would be benefits if men in the community could also be brought on side over the issue.

The consultant felt that the main reason FGM was carried out was to improve a young person's prospects of marriage within the community by preserving their virginity.

Steps could be taken to prevent a person of in danger of FGM leaving the country but this would require a far higher level of evidence than a MASH referral. Teachers were also trained to spot cases of FGM as part of school safeguarding responsibilities. FGM referrals could also be made by schools to the MASH and schools had been proactive in doing this. It was also confirmed that the FGM was illegal in countries such as Egypt and Nigeria but still took place in these areas.

Community midwives received training annually on FGM and the consultant agreed that the most severe forms of the practice were quite shocking. It was also felt that it was unlikely that mothers who had undergone FGM would wish to pass this on to their children.

There had not been any convictions for FGM to date in the UK. There had however been convictions in France where there was a higher prevalence of FGM. It was not currently the practice to check whether children presenting at hospital had mothers who had undergone FGM. The consultant felt this was a complex issue as parents often did not feel they were being cruel to their child. It was also important to make sure the victim did not feel like a criminal.

It was confirmed that the Council's Children's Services would carry out a child protection investigation if they felt a child was at risk of undergoing FGM. The police would warn parents that they were liable to prosecution and a medical examination of a child could be ordered if it was felt that FGM may have taken place. A FGM order could be quickly obtained through the courts if needed although strong evidence was required. The police could also use their powers of protection if it was felt there was a risk of imminent harm.

Severe cases of FGM could be reversed during labour if found and it was also confirmed that it was illegal to close back up a case of FGM. Safeguarding guidance was sent to schools on a regular basis and this would cover FGM issues. FGM was also discussed at the Local Safeguarding Children's Board. Full data was kept by the MASH on where FGM referrals originated from.

The Sub-Committee **NOTED** the position and thanked the consultant obstetrician for her attendance and input to the meeting.

Chairman