This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court

This Transcript is Crown Copyright. It may not be reproduced in whole or in part other than in accordance with relevant licence or with the express consent of the Authority. All rights are reserved

IN THE HIGH COURT OF JUSTICE

FAMILY DIVISION

[2019] EWHC 527 (Fam)

Royal Courts of Justice
London, WC2A 2LL

Monday, 18 February 2019

Before:

THE HONOURABLE MRS JUSTICE GWYNNETH KNOWLES

(**In Private**)

Re M (Female Genital Mutilation Protection Order: No Order on Application)

MS S. GEORGE appeared on behalf of the Applicant.

MR M. BAILEY appeared on behalf of the First Respondent.

MS N. SULTAN appeared on behalf of the Second Respondent.

MR J. CREGAN appeared on behalf of the Children's Guardian.

J U D G M E N T

MRS JUSTICE KNOWLES:

1 I am concerned with M, a little girl who was born on 7 February 2011 and who is now 8 years old. The issue before me is whether a female genital mutilation protection order made without notice to the parents in respect of M on 30 July 2018 and continued thereafter should, in fact, continue until M is 18 or older.

2 The applicant for the female genital mutilation protection order is the local authority in whose area M and her family live. The respondents to the proceedings are M's mother, her father, and M through her children's guardian. I should say that M has an older brother, O, who was born on 1 November 2008 and is thus 10 years old, and a younger brother, I, who was born on 30 September 2002 and is thus 4 years old. M and her family are of Somalian origin.

3 The representatives in the proceedings today are as follows: Ms George represents the local authority; Mr Bailey represents the mother; Ms Sultan represents the father; and Mr Cregan represents M through her children's guardian Dionne Roberts.

4 I have read the voluminous bundle provided to me which includes the statements from both parents and the guardian's final case analysis. I have also read a position and skeleton argument by the local authority and position statements prepared on behalf of the parents and the children's guardian. All the parties are as one today in inviting me to discharge the female genital mutilation protection order and the associated orders which prevent M from travelling outside this jurisdiction and all invite me to conclude the proceedings on the basis of no order being made on the local authority's application.

5 I summarise the background to the proceedings as follows. M and her brother O became known to the local authority following a child protection referral from the school that both attended in mid-June 2018. On 14 June 2018, O attended school with a bruised eye and marks on his nose. He was crying and distressed and was holding his eye. He refused to say what had happened. M was spoken to by school staff and told them that her father had beaten O that morning, punching and kicking him after discovering that O had taken money from the father's coat pocket. M said that she, her mother, and her younger brother had been present when this incident took place and that her father had warned both her and O not to tell anyone at school what had happened.

6 A child protection medical of O took place the following day on 15 June 2018 and that medical concluded that O's injuries were in-keeping with forceful impacts to his face and that an accidental explanation of him being accidentally injured due to a toy being thrown was unlikely to cause such significant injuries to him. That report confirmed, essentially, that O's injuries were consistent with what M had said. I should record that on 14 June, when the local authority began its child protection investigation, the parents signed a written agreement that all three children should live with the paternal grandparents. Despite that agreement, however, shortly thereafter the parents moved into the paternal grandparents' home without informing the social worker.

7 On 21 June 2018, the social worker spoke to O at the school. Both children had changed their account about what had happened to O and had said that their father told them to tell professionals that O was injured as a result of I throwing a toy car to his face.

8 An initial child protection case conference took place on 5 July 2018. During the course of that meeting, the local authority became aware for the first time that the mother was a victim

of type 1 female genital mutilation (clitoridectomy) namely removal of part or all of the clitoris. The mother said this this had been done when she was 4 years old and that three generations of her family had also been victims of female genital mutilation. The local authority was aware at that stage that the paternal aunts had not been subject to female genital mutilation even though they were part of this large family group where marriages between family members were commonplace.

9 Though the parents said they would not permit M to be subject to female genital mutilation, the local authority had real concerns about the parents' undertaking in this regard. Those concerns arose from the experience of working with the parents and their unwillingness to accept the father's responsibility for causing O's injury as well as the threats made to the children about the consequences of telling anyone at school about what had happened in the family home.

10 On 6 July 2018, the parents entered into a written agreement with the local authority. This recorded the concerns about female genital mutilation and that the family were seeking to travel to Kenya on 23 July 2018 to 20 August in order to visit relatives. It was noted that the local authority was concerned that M might be the subject of female genital mutilation during that holiday. Amongst other matters, the parents were to inform the local authority where they intended to stay in Kenya and of any changes to their travel plans.

11 Regrettably, the parents did not provide details of where they would be staying in Kenya and had initially not told the local authority that they would be travelling via Egypt. The local authority was aware from information provided by the World Health Organisation that female genital mutilation in Egypt is strikingly prevalent at a rate of 91 percent, that it is prevalent in Kenya at a rate of 27 percent, and in Somalia and within the Somalian community at the rate of 98 percent.

12 All of those factors played their part in the local authority's decision to apply on 20 July for a female genital mutilation protection order in respect of M. That application was made out of hours to Theis J because there were concerns that the parents would leave the jurisdiction with M if they were given notice of the hearing. Theis J's order also prohibited M's removal from the United Kingdom and required the surrender of her passport to the local authority.

13 The out of hours order made by Theis J was continued by Hayden J on 23 July 2018 and the matter was listed before me on 12 October 2018. On that date, I continued the order and listed the matter for a five-day hearing commencing on 18 February 2019. I gave case management directions which included a requirement for a paediatric assessment of M and the instruction of an independent social worker to assess the family. At the pre-hearing review on 6 February 2019, the local authority indicated that it was satisfied that M could be adequately safeguarded whilst in the care of her parents and that it would not be seeking a continuation of the female genital mutilation protection order.

14 I note that the paediatric report by Dr Hodes of the University College Hospital dated 9 November 2018 confirmed that M had not been the subject of any form of female genital mutilation. The parenting assessment carried out by the independent social worker, Ms Huda, dated 16 December 2018, was also positive. She concluded that the strength of the parents' relationship, the paternal family's strong opposition to female genital mutilation, and the positive parenting of the children all pointed to M being safe from such a procedure in the care of her parents.

15 I turn now to the law. As far as I am aware, there is no reported case law which addresses the circumstances in which a local authority seeks no order on an application for a female genital mutilation protection order. I begin my analysis by considering Article 3 of the European Convention on Human Rights which was incorporated into UK law by way of the Human Rights Act 1998. Article 3 states, in terms:

> "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

16 I respectfully adopt the analysis carried out by Hayden J in *A Local Authority v M & N* [2018] EWHC 870 (Fam) a case which concerned female genital mutilation and paragraphs [26] to [44] of his judgment set out his analysis of Article 3 within the context of applications for female genital mutilation protection orders pursuant to Schedule 2 of the Female Genital Mutilation Act 2003 which came into force on 17 July 2015. I adopt his analysis of the European and domestic case law which I summarise as follows.

17 First of all, the obligations pursuant to Article 3 require that the State must not, either on its own or through its agents, subject its citizens and other persons within its territory to torture or to inhuman or degrading treatment. It must also pass criminal laws outlawing and punishing ill-treatment amounting to torture or inhuman or degrading treatment. It has an obligation to investigate arguable breaches of Article 3 and an obligation to take reasonable steps to prevent real and immediate risks of torture or inhuman or degrading treatment at the hands of non-State agents.

18 Those obligations impose upon the State a positive obligation to take steps to prevent a person from suffering treatment which violates Article 3 when they are also outside the jurisdiction. The counter point is the negative obligation on the State to provide mechanisms to criminalise the treatment which would violate Article 3 and to ensure that there are lawful investigatory processes in place.

19 Thus wherever substantive grounds are shown for believing that an individual would face a real risk of being subjected to such treatment contrary to Article 3 if removed to another country, the State becomes responsible for safeguarding against such treatment.

20 The State is obliged to take preventative measures to provide the necessary protection to a child who is at risk from another individual. The State's positive obligation to protect an individual's Article 3 rights is analysed as extending only to that which can be achieved by reasonable and effective measures.

21 The distinction between positive and negative obligations on the State arising from Article 3 is generally unhelpful as Baroness Hale records in *E v Chief Constable of the Royal Ulster Constabulary* [2008] UKHL 66. Baroness Hale said the following:

> "Nevertheless, there must be some distinction between the scope of the state's duty not to take life or ill-treat people in a way which falls foul of article 3 and its duty to protect people from the harm which others may do to them. In the one case, there is an absolute duty not to do it. In the other, there is a duty to do what is reasonable in all the circumstances to protect people from a real and immediate risk of harm. Both duties may be described as absolute but their content is different. So once again it may be a false dichotomy between the absolute negative duty and a qualified positive one."

22 Thus, where the State has a duty to protect children from harm which others might cause them, the duty remains absolute but the obligations under it require the State to do that which is reasonable in all the circumstances to protect children from real and immediate risk of harm.

23 Hayden J's judgment concluded in [44] as follows:

> "All this makes it very clear that the State is required to take active measures, designed to ensure the protection of the individual's Article 3 rights. Such protection has to provide adequate protection from the identified risk. The failure to provide protection which can objectively be assessed as adequate will itself constitute a violation of Article 3. What is adequate however, will require to be assessed on a case by case basis, in line with the approach of the Strasbourg court."

24 As Hayden J observed in paragraph [24] of his decision, the provisions of the Female Genital Mutilation Act 2003 require to be evaluated through the prism of Article 3. Like Hayden J, I regard female genital mutilation as an abomination. It is inhuman, degrading, and torturous to its victims. Its consequences, both short and long-term, were highlighted in paragraph [18] of Hayden J's judgment which drew on **HM Government: Multi-Agency Statutory Guidance on Female Genital Mutilation**:

> "The Guidance highlights the immediate/short-term consequences of FGM as including: severe pain; shock; haemorrhage; wound infection; urinary retention; injury to adjacent tissue; and genital swelling. It is also emphasised that the practice can sometimes cause the death of the victim. The longer term consequences are equally alarming: genital scarring; genital cysts and keloid scar formation; recurrent urinary tract infections and difficulties in passing urine; possible increased risk of blood infections such as Hepatitis B and HIV; pain during sexual intercourse, lack of pleasurable sensation and impaired sexual function; psychological impact such as anxiety, flashbacks and post traumatic stress disorder; difficulties with menstruation; complications in pregnancy or childbirth (including prolonged labour, bleeding or tears during childbirth, increased risk of caesarean section); and increased risk of stillbirth and death of child during or just after birth."

25 On the basis of the above, when practiced on those under the age of 18, female genital mutilation is, in my view, child abuse pure and simple and if attributable to parental behaviour would, in my view, comfortably fall within s.31(2) of the Children Act 1989 as being significant physical harm which would justify the making of a public law order.

26 Schedule 2 of the 2003 Act gives the court power to make a female genital mutilation protection order as follows. At paragraph 1:

> "(1) The court in England and Wales may make an order (an "FGM protection order") for the purposes of—
>
> (a) protecting a girl against the commission of a genital mutilation offence, or...
>
> (2) In deciding whether to exercise its powers under this paragraph and, if so, in what manner, the court must have regard to all the

circumstances, including the need to secure the health, safety and well-being of the girl to be protected.

(3) An FGM protection order may contain—

(a) such prohibitions, restrictions or requirements, and

(b) such other terms,

as the court considers appropriate for the purposes of the order.

(4) The terms of an FGM protection order may, in particular, relate to—

(a) conduct outside England and Wales as well as (or instead of) conduct within England and Wales..."

27 The court must therefore have regard to all the circumstances including the need to secure the health, safety, and wellbeing of the girl to be protected. When viewed through the prism of Article 3, it is my view that the health, safety, and wellbeing of the girl to be protected is the court's first and paramount consideration.

DISCUSSION

28 These are serious proceedings which were properly brought by the local authority in July 2018. The starting point in evaluating the risk to M is to consider the practice of FGM within Somalia and the Somalian community. The Home Office publishes country and information guidance in relation to Somalia which is of particular application in immigration and asylum claims. Nevertheless, it also has value in an application of this sort. That guidance is informed by judgments given by judges of the Upper Tribunal in the Immigration and Asylum Chamber. The relevant country guidance dated April 2018 is entitled **"Country Policy and Information Note - Somalia: Women fearing gender-based violence"** and provides in relation to female genital mutilation at paragraphs 2.3.13 and 2.3.14 as follows:

"2.3.13 Female Genital Mutilation (FGM) is almost universally practiced throughout Somalia and a very strong cultural belief persists in its practice.

2.3.14 In the country guidance case of AMM and others, which was heard in 2011, the Upper Tribunal held that the incidence of FGM in Somalia was universally agreed to be over 90% (paragraph 241 and country guidance headnote (16)). In South and Central Somalia, no significant changes in FGM prevalence have been observed since the 1990s (paragraph 547) and that 'the societal requirement for any girl or woman to undergo FGM is strong. In general, an uncircumcised, unmarried Somali woman, up to the age of 39, will be at real risk of suffering FGM. The risk will be greatest in cases where both parents are in favour of FGM.' (paragraphs 609 & 610 and country guidance headnote (16)).

2.3.15 AMM and others also held that should both parents oppose FGM, 'the question of whether the risk will reach the requisite level will need to be determined by reference to the extent to which the parents are likely to be able to withstand the strong societal

> pressures. Unless the parents are from a socio-economic background that is likely to distance them from mainstream social attitudes, or there is some other particular feature of their case, the fact of parental opposition may well as a general matter be incapable of eliminating the real risk to the daughter that others (particularly relatives will at some point inflict FGM on her' (para 610) and country guidance headnote (17))."

29 The guidance identifies the general risk to which M was potentially exposed. The strong societal pressures within Somalia and within the Somalian community in this jurisdiction are matters to which I must have regard when looking at all the circumstances in this case.

30 The risks, in my judgment, have altered somewhat since the commencement of these proceedings. Firstly, M herself has not been subjected to female genital mutilation as the paediatric assessment by Dr Hodes from University College Hospital makes plain. Secondly, the parents have cooperated with the court and the local authority since the issue of proceedings. Third, the assessment by the ISW, Ms Huda, is positive. She is an experienced social worker with 30 years' experience and a particular expertise in working with Muslim families. Her report is enormously insightful about the impact of female genital mutilation upon the mother who was cut at the age of 4. Her feelings of shame, terror, and humiliation remain ever present when talking about what happened to her as a child and she is determined that M will never be subjected to FGM. The father too told Ms Huda that he was opposed to FGM. His mother and his sisters have not been cut and the entire paternal family is opposed to the practice. Tellingly, the father told Ms Huda that if FGM was a good thing, people would celebrate it and have parties of the sort held when children were born. Instead, people do it in secret as they know how wrong it is.

31 Ms Huda interviewed members of the father's family, including his mother and three younger sisters. All three sisters were clear that the practice of FGM was abhorrent and all had been to see their GP for the purpose of a medical examination in order to prove that they had not been subjected to this practice. The paternal family have also travelled to areas where the father's younger sisters might have been at risk of FGM, but they have not been victims.

32 Ms Huda concluded on page 28 of her report:

> "I am of the opinion that neither parent has any intention of forcing their daughter to endure such procedure. The mother's experience of FGM and the trauma that she still suffers is a strong factor in her determination to protect her daughter from it. It is not a practice in the father's family. There is now evidence that his sisters did not have FGM and his mother states that she also did not experience it. The mother and father have consistently said they do not believe in FGM. There is no one in the wider family that I have come across who believes that a young child should undergo this procedure. The father's parents are still powerful and influential figures in his life and his mother has said that FGM will never be practiced on M. There does not appear to be anyone in the family's wider network that could influence them to enforce this procedure. There is evidence to suggest that the father is able to resist pressure to follow paths that do not fit into his personal value base and FGM does not. The father has also said that the mother's father in Kenya has not allowed his five daughters to have the procedure. So it is unlikely that should the mother ever go to Kenya that she would be placed under any pressure to have this procedure performed on M."

33 I accept Ms Huda's conclusions. The pressures within families to submit girls to FGM do not appear to be present in this family. The strong opposition of both parents and the paternal family make it unlikely that even on travel to areas where the practice is commonplace, M would be at risk. I also note that the parents are content for M to have keep safe work with the local authority social worker. I am told this work will commence in the summer for five sessions and that this will hopefully equip M to speak out if she felt unsafe or experienced anything which made her feel uncomfortable or unsafe.

34 M is otherwise a quiet yet confident little girl who is doing well in school. She has a wide circle of friends and the school is pleased with her presentation and attitude towards learning. She is a credit to her parents. Ms Huda spoke of the warm, caring, and supportive relationship between the parents and between the parents and their children. Though the parents continue to deny that the father assaulted O, both are adamant that O will not be at risk in their care. Ms Huda concluded that the risks of a repetition of this incident had been lowered by the parents' involvement in the child protection process. None of the children are presently the subject of child protection plans and I note that both parents are to undertake some parenting classes aimed at helping them meet the challenges presented by the children as they move into their teenage years.

35 The local authority submits that the known risks set out in the country guidance have to be balanced against the specific facts of this case. Undertaking that balancing exercise leads to the conclusion that M can be protected from female genital mutilation whilst in the care of her parents.

36 M's welfare is at the forefront of my mind when I consider if there is some solid advantage to her in making a female genital mutilation protection order. On the basis of the evidence before me, I have concluded that such an order is neither necessary nor proportionate. M's Article 3 rights are unlikely to be breached in the specific circumstances of this case. Had the evidence been otherwise, however, I would have had no hesitation whatsoever in making such an order until M reached the age of 18.

37 It follows that the supplemental orders, including the holding of M's passport and for the restriction on her travel outside the jurisdiction, are also discharged as I make no order on the local authority's application pursuant to the 2003 Act.

38 That is my decision.

CERTIFICATE

Opus 2 International Limited hereby certifies that the above is an accurate and complete record of the Judgment or part thereof.

Transcribed by ***Opus 2 International Limited***

Official Court Reporters and Audio Transcribers

5 New Street Square, London, EC4A 3BF

Tel: 020 7831 5627 Fax: 020 7831 7737

civil@opus2.digital

This transcript has been approved by the Judge