Neutral Citation Number: [2015] EWFC 3

Case No: LJ13C00295

IN THE FAMILY COURT
Sitting at LEEDS

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14 January 2015

Before :

SIR JAMES MUNBY PRESIDENT OF THE FAMILY DIVISION

- -

In the matter of B and G (Children) (No 2)

Between :

LEEDS CITY COUNCIL	**Applicant**
- and -	
(1) M	
(2) F	
(3) B	
(4) G	
(B and G by their children's guardian Victoria Wilson)	**Respondents**

- -
- -

Mr John Hayes QC and Ms Joanne Astbury (instructed by the local authority) for the Applicant (local authority)
Mr John Myers and Ms Lucy Sowden (instructed by Lester Morrill) for the First Respondent (mother)
Mr Nkumbe Ekaney QC and Ms Pamela Warner (instructed by Crocketts) for the Second Respondent (father)
Ms Clare Garnham (instructed by Ramsdens) **and Miss Vikki Horspool** (of Ramsdens) for the children' guardian

Hearing dates: 20-23, 27-30 October, 3-5, 7 November 2014

- -

Judgment

This judgment was delivered in open court

Sir James Munby, President of the Family Division :

1. These are care proceedings in relation to two children, B, a boy, born in July 2010 and G, a girl, born in July 2011 (these are not their real initials). In terms of their ethnic origin, both the father, F, and the mother, M, come from an African country which I shall refer to as country A, though the mother was born and brought up in a Scandinavian country which I shall refer to as country S (again, these are not the real initials). The family are Muslims. The proceedings were commenced in November 2013, triggered by M's seeming abandonment of G in the street. B and G were placed

in foster care the same month and have remained with the same foster carer throughout.

2. I heard the case over twelve days at Leeds in October and November 2014. The local authority, Leeds City Council, was represented by Mr John Hayes QC and Ms Joanne Astbury, M by Mr John Myers and Ms Lucy Sowden, F by Mr Nkumbe Ekaney QC and Ms Pamela Warner, and B and G, through their children's guardian, by Ms Clare Garnham and Miss Vikki Horspool. I am very grateful to all of them for the enormous assistance they provided me in an unusual and complex case.

3. At the end of the hearing on 7 November 2014 I reserved judgment. On 11 November 2014 I handed down a very short judgment announcing my decision and my conclusions on various issues: *Re B and G (Children)* [2014] EWFC 43. I said that I would give detailed reasons in due course.

The issue

4. The most important issue in the proceedings is whether G has been subjected to female genital mutilation (FGM) and, if she has, what the implications of that are in relation to planning for her and her brother's future.

5. As I announced in my previous judgment (*Re B and G*, para 2(i)), I have concluded that the local authority is unable on the evidence to establish that G either has been or is at risk of being subjected to any form of FGM.

6. This is, I believe, the first time such an issue has been canvassed in the context of care proceedings. Because of the importance of the point, this judgment is confined to the issue in relation to FGM. A separate judgment will deal with all the other issues in the case.

Female genital mutilation (FGM)

7. Before proceeding further, however, it is necessary to be clear as to what is meant by FGM. I start with *Eliminating Female genital mutilation*, an interagency statement published by the World Health Organization (WHO) and others in 2008. Annex 2 sets out the following typology, dating from 2007:

> "**Type I**: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
>
> When it is important to distinguish between the major variations of **Type I** mutilation, the following subdivisions are proposed: **Type Ia**, removal of the clitoral hood or prepuce only; **Type Ib**, removal of the clitoris with the prepuce.
>
> **Type II**: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
>
> When it is important to distinguish between the major variations that have been documented, the following subdivisions are proposed: **Type IIa**, removal of the labia

> minora only; **Type IIb**, partial or total removal of the clitoris and the labia minora; **Type IIc**, partial or total removal of the clitoris, the labia minora and the labia majora.
>
> **Type III**: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
>
> When it is important to distinguish between variations in infibulations, the following subdivisions are proposed: **Type IIIa**: removal and apposition of the labia minora; **Type IIIb**: removal and apposition of the labia majora.
>
> **Type IV**: Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization."

8. The same classification is reflected in the WHO's Fact Sheet N241, *Female genital mutilation*, published in February 2014:

> "Female genital mutilation is classified into four major types.
>
> 1 Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
>
> 2 Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
>
> 3 Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
>
> 4 Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area."

9. For some purposes unicef uses a different classification. *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, published by unicef in 2013, sets out the following typology (page 48):

> "types of FGM/C are classified into four main categories: 1) *cut, no flesh removed*, 2) *cut, some flesh removed*, 3) *sewn closed*, and 4) *type not determined/not sure/doesn't know*. These categories do not fully match the WHO typology. *Cut, no flesh removed* describes a practice known as nicking or pricking, which currently is categorized as Type IV. *Cut, some*

> *flesh removed* corresponds to Type I (clitoridectomy) and Type II (excision) combined. And *sewn closed* corresponds to Type III, infibulation."

10. Next, it is necessary to consider the Female Genital Mutilation Act 2003. It suffices for present purposes to refer to section 1, which is in the following terms:

> "(1) A person is guilty of an offence if he excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris.
>
> (2) But no offence is committed by an approved person who performs –
>
> (a) a surgical operation on a girl which is necessary for her physical or mental health, or
>
> (b) a surgical operation on a girl who is in any stage of labour, or has just given birth, for purposes connected with the labour or birth.
>
> (3) The following are approved persons –
>
> (a) in relation to an operation falling within subsection (2)(a), a registered medical practitioner,
>
> (b) in relation to an operation falling within subsection (2)(b), a registered medical practitioner, a registered midwife or a person undergoing a course of training with a view to becoming such a practitioner or midwife.
>
> (4) There is also no offence committed by a person who –
>
> (a) performs a surgical operation falling within subsection (2)(a) or (b) outside the United Kingdom, and
>
> (b) in relation to such an operation exercises functions corresponding to those of an approved person.
>
> (5) For the purpose of determining whether an operation is necessary for the mental health of a girl it is immaterial whether she or any other person believes that the operation is required as a matter of custom or ritual."

Section 6(1) provides that "Girl includes woman."

11. It will be seen that for the purposes of the criminal law what is prohibited is to "excise, infibulate or otherwise mutilate" the "whole or any part" of the "labia majora, labia minora or clitoris." This brings within the ambit of the criminal law all forms of FGM of WHO Types I, II and III (including, it may be noted Type Ia). But WHO Type IV comes within the ambit of the criminal law only if it involves "mutilation".

12. The word "mutilation" is not further elaborated or defined in the statute, so I turn to the dictionary. The Oxford English Dictionary defines "mutilation" as meaning "the action of mutilating a person or animal; the severing or maiming of a limb or bodily organ", "mutilate" being defined as meaning "To deprive (a person or animal) of the use of a limb or bodily organ, by dismemberment or otherwise; to cut off or destroy (a limb or organ); to wound severely, inflict violent or disfiguring injury on."

The expert evidence

13. The suspicion that G had been subjected to FGM first arose in November 2012 in country S after blood had been found in her nappy when she was at nursery. She was examined by two doctors who found (I quote the translation) "no sign [she] had any damage to female organs." A further medical report states "outer and inner labia normal and the clitoris is normal. No sign of any circumcision."

14. The question was raised again in November 2013 when the foster carer reported G's "irregular genitalia." This led to the expert investigations to which I must now turn.

15. I have had the benefit of reports from three experts: Dr Alison Share, a Consultant Community Paediatrician at St James's University Hospital in Leeds; Dr Comfort Momoh MBE, a Registered Midwife employed by Guy's and St Thomas Hospital NHS Foundation Trust in London (she is not a medical doctor; her doctorate is an honorary doctorate from Middlesex University); and Professor Sarah Creighton, a Consultant Obstetrician and Gynaecologist at University College Hospital in London and Consultant Adolescent Gynaecologist at Great Ormond Street Hospital.

16. The three experts differ in their expertise and experience.

17. Dr Share has undoubted expertise in child sexual abuse but does not claim to be an expert on FGM though professing expertise in the assessment of female genitalia. She had examined approximately five girls with FGM over the past three years, though only one was a baby. Her previous forensic experience was as an expert in child abuse cases, not in cases involving FGM.

18. Dr Momah describes herself as a midwife and FGM, reproductive and public health specialist. There is no doubt about her knowledge of and expertise in many aspects of FGM and its medical and other consequences, topics on which she has published and spoken extensively both in this country and abroad. She received her MBE in 2008 in recognition of her services to women's healthcare. As a midwife, her primary expertise – and it is very extensive indeed – is in relation to pregnant women who have been subjected to FGM. But it was, to speak plainly, very difficult when she was giving oral evidence to pin her down as to the extent of her experience in relation to very young girls (I return to this topic below). It turned out that it was extremely limited.

19. Professor Creighton describes her experience with regard to female genital mutilation as follows:

> "I am a consultant gynaecologist with a major interest in paediatric and adolescent gynaecology, reconstructive genital surgery and Female Genital Mutilation (FGM). In 1999 I

> established the African Women's Clinic at University College London Hospital for women with health consequences of FGM. I am a founder member and past Chair of the FGM National Clinical Group. I have advised on FGM at a strategic level to the Department of Health, Home Office, Director of Public Prosecutions and NHS London and NHS England. I am currently involved in revising the Royal College of Obstetricians and Gynaecologists (RCOG) Greentop Guidelines on the management of FGM. I lecture and teach on FGM widely. I have published on FGM in the medical literature. I am a member of the newly formed RCOG FGM task force. I am a member of the RCOG Ethics Committee. I am a founder member and past Chair of the British Society for Paediatric and Adolescent Gynaecology."

As she explained in her oral evidence, her clinic at University College Hospital is the only specialist *paediatric* FGM clinic in the country.

20. It is necessary for me to go through the various reports of these experts in some detail. At the outset, however, it is important to appreciate that, by the end of a meeting between them on 25 September 2014, all three experts were agreed that *if* G had been subjected to FGM (and on this there was a division of opinion), it took the form of a scar adjacent to the left clitoral hood and was therefore WHO Type IV.

21. The first expert to be instructed was Dr Share, who examined G on 13 February 2014. The examination was recorded on DVD using a video-colposcope. Dr Share wrote her report the same day. The key passage reads as follows:

> "On genital examination, [G] had evidence of a scar extending adjacent to her clitoral hood on the left side. There was also some distortion and adhesions around her clitoral hood, but underneath this there was evidence of a clitoral body. The labium minus on the left side appeared to be adhering to the inner aspect of her left labium majus. The labium minus on the right side appeared small but no there was no obvious scar tissue or adhesions. There were no disruptions to her urethra. Her hymen was visualised using separation and traction. I feel there was a bump on the hymen at the 5 o'clock position. This is a normal variant. Her hymen was otherwise smooth and there were no obvious disruptions. Her anus was not examined.
>
> In summary, I feel that there is evidence to support that there has been removal of part of the clitoris and clitoral hood with scarring present to her clitoral area. I am unclear as to the cause of her labial adhesion on the left side, this may be due to chronic vulvovaginitis, but it may also be due to removal of part of the labium and healing has allowed this labium to adhere to the labium majus. I think it is appropriate that a second opinion is sought so the findings can be confirmed, but

> in my opinion [G] has been a victim of female genital mutilation type 1 and possibly type 2."

22. After some initial confusion, Dr Share confirmed in her oral evidence (Transcript, 22 October 2014, page 32) that she had adopted the WHO typology. Earlier, at the experts meeting on 25 September 2014 she said she had used the unicef classification. She added, as recorded in the minute, that "it was always her view that if FGM has occurred it is through a nicking cut as detailed by the WHO as level 4" – a comment which, if accurately recorded, is at variance with what she was saying in this report and which, as Mr Myers put it, does not bear close scrutiny. The fact is that, assuming she was using the WHO classification, Dr Share was not considering FGM Type IV at this stage.

23. Also on 13 February 2014, Dr Share completed an adoption medical report on G, on Form IHA-C. So far as relevant for present purposes, this document is in two parts. Part B (which is retained within the child's health record) was completed in manuscript and contains these words on page 8:

> "Evidence of scarring around the left side of her clitoral hood. This is indicative of female genital mutilation type I."

Part C (which is returned to the social worker) was completed in typescript and contains on page 10:

> "She has had a medical examination for female genital mutilation and it appears that she has type 1 and possibly type 2."

In her oral evidence (Transcript page 41) Dr Share explained that she had written Part B "as she went along" with her examination and before G left. She explained the discrepancy between the reference in Part B to "type 1" and the reference in Part C to "type 1 and possibly type 2" on the basis (Transcript page 42) that Part C was prepared a little later, after "going back to my office, looking at the DVD and reviewing what I am seeing."

24. Starting at 2.15pm on 7 April 2014 G was examined by Dr Share and Dr Momoh. Again, the examination was recorded on DVD using a video-colposcope. In her oral evidence (Transcript, 27 October 2014, page 38) Dr Momoh confirmed that, prior to the examination, she had read Dr Share's report of 13 February 2014 and discussed with Dr Share the latter's finding of scarring. The notes of the examination (with a detailed drawing of G's genitalia) were prepared by Dr Momoh and, as she agreed, are in her handwriting. In her oral evidence (Transcript pages 20-21) she said that she had written them up within about 10 or 15 minutes after the examination, when the detail would have been fresh in her mind.

25. The various parts shown in the drawing are labelled as follows: "Hood of clitoris (clitoris not visible)"; "Right labia minora (appears missing)"; "Left labia minora (partly stuck to the left side of labia majora)"; "Urethra"; "Labia majora present (Both)"; "Introitus appears normal". The notes underneath the drawing, again in Dr Momoh's handwriting, are as follows:

> "From assessment and state of [G]'s vulva → it appears that [G] has been subjected to some form of FGM. (Vulva does not appear normal)"

Beneath, written by Dr Share "in retrospect" at 5pm, the notes record "description as above – appears to be a victim of FGM." When I put it to her that her concern had always been the *left* labia, whereas Dr Momoh's notes referred to the *right*, Dr Share had to concede (Transcript page 43) that she had missed the fact that Dr Momoh had referred to the right one.

26. Dr Share's report of the examination is in the form of a letter dated 9 April 2014:

> "The hood of [G]'s clitoris appeared to be deficient with the possibility of scarring on the left side. Her right labia minora was very small and her left labia minora was partly stuck to the inside of her labia majora. The hymen was smooth and non-disruptive. Both Dr Momah and I felt that [G] had been the victim of female genital mutilation."

27. Dr Momoh's report is dated 23 April 2014. In terms of what had been observed at examination on 7 April 2014, all the report said was this:

> "Hood of clitoris present, clitoris not visible, left labia minora adhered to the left side of labia majora. Both labia majora present. It appears that [G] has been subjected to some form of FGM as her vulva does not appear normal … In conclusion and in my opinion, it appears that [G] has been subjected to some form of FGM as her vulva does not appear normal as mentioned above."

In her oral evidence Dr Momoh explained (Transcript page 3) that she did not categorise the type of FGM "because I wasn't sure what type of FGM initially."

28. Professor Creighton's report was dated 1 September 2014. She did not herself examine G but had access to Dr Share's and Dr Momoh's reports and to the DVD of G's examination on 7 April 2014. Her opinion, based on the DVD, was as follows:

> "• Labia Majora
>
> Both labia majora are present, symmetrical and of a normal size.
>
> • Labia Minora
>
> Both labia minora are present. The left labia minora is slightly larger than the right. Slight asymmetry is a common finding and is part of normal variation.
>
> The left labia minora is adherent to the left labia majora. This can occur with chronic inflammation such as vulvovaginitis.

> The contour of the left labia minora is smooth and the line of pigmentation uninterrupted. This means the left labia is intact and has not been partially removed.
>
> • Clitoris
>
> The clitoris is present and the clitoral hood is visible. The clitoral hood looks slightly irregular and is less prominent on the right hand side of the clitoris but this can occur as part of normal variation.
>
> • Scarring
>
> Dr Share refers to a scar lateral to the left side of the clitoris. The DVD does show a faint paler area on some views which may be the scar described by Dr Share. However there is physiological white discharge on both sides of the clitoris obscuring the area. The discharge extends into the skin creases on either side of the clitoris making it impossible to distinguish between a skin crease and a scar. It may have been possible to wipe the discharge away with a cotton tipped swab to expose the scar but this was not done. No measurements are given for the length of the scar. The light reflection by the camera also interferes with the image in some of the views. It is not possible from the DVD images to confirm the present of the scar.
>
> • Other features
>
> [G]'s genitalia were clean and healthy. There was a small amount of white physiological discharge. There were no features suggestive vulvovaginitis at this time.
>
> Conclusion
>
> [G]'s clitoris, labia minora, labia majora and vagina are within normal limits.
>
> There is no evidence of removal of any genital tissue.
>
> There is no evidence of WHO FGM Types 1, 2 or 3.
>
> However I am unable from the DVD to confirm the scar to the left lateral aspect [G]'s clitoris described by Dr Share.
>
> A small scar of this nature if present could be consistent with Type 4 FGM."

29. Professor Creighton had been asked various specific questions. In answer to the question *Is there any evidence of excision of G's prepuce with or without excision of any part of the clitoris?* she said: There is no evidence of excision of any part of G's clitoris. In answer to the question *Is there any evidence of partial or total excision of*

the labia minora or majora? she said: There is no evidence of partial or total excision of the labia minora or majora.

30. The three experts met on 25 September 2014, Dr Momoh attending by Skype from the United States of America. I have the list of questions formulated for consideration by the experts, a detailed (but not verbatim) minute of the meeting and a schedule of agreement and disagreement. For present purposes the key conclusions of the experts can be summarised as follows:

i) There was no evidence of the removal of all or part of the clitoris or clitoral hood.

ii) No-one suggested that any part of the right labia had been removed. Professor Creighton was clear that the left labia had not been removed. No-one suggested that it had been.

iii) All the experts agreed the presence of adhesions at the site of the left labia. Dr Share and Professor Creighton thought that on the balance of probabilities the most likely cause of the adhesions was chronic vulvovaginitis (ie, not FGM). Dr Momoh identified the most likely cause as "possible chronic vulvovaginitis and/or FGM."

iv) All the experts agreed that *if* G had been subjected to FGM (and on this there was a division of opinion), it took the form of a scar adjacent to the left clitoral hood. Asked to elaborate the statement in her report dated 23 April 2014 that "[G] has been subjected to some form of FGM as her vulva does not appear normal", Dr Momoh is recorded as saying that this "was due to the scarring and adhesions observed during her examination."

v) All the experts agreed that *if* G had been subjected to FGM, it was therefore WHO Type IV.

vi) In relation to the crucial question of whether or not a scar was present there was a difference of opinion. Dr Share and Dr Momoh confirmed its presence. Dr Share said:

> "I believe to the best of ability … that [G] has been a victim of type 4 FGM. I recognise that there is a history of previous episodes of vulvovaginitis that may have led to the appearance of adhesions of her left labium minus. I have done child protection assessments for almost 11 years and have not seen this presentation before and this would increase the concern that the scarring around the clitoral hood is due to FGM."

Professor Creighton said:

> "I cannot confirm the presence of a scar. I have viewed both DVDs but have not examined [G] myself. There is a small pale area lateral to the skin crease. On the

> DVD it appears as an ill defined patch rather than a line. I cannot be confident that it is a scar from the DVD appearance." She also said "If it is a scar it is very small."

31. All three experts gave oral evidence, Dr Share on 22 October 2014, Professor Creighton on 23 October 2014 and Dr Momoh on 27 October 2014.

32. Dr Share said (Transcript page 7) that the scar was not the result of an abrasive injury but of a cut. She said (Transcript page 43) it was about five millimetres long and "quite arched", "quite curved". She described the scar (Transcript page 36) as "raised" but had to concede that this was the first time she had mentioned the point. (Professor Creighton confirmed (Transcript page 11) that it had not been mentioned at the experts' meeting.) Dr Share conceded quite frankly (Transcript pages 17, 31, that her first report was simply wrong and (Transcript pages 19, 37) that her opinion had changed since the second examination with Dr Momoh on 7 April 2014. There is a very revealing comment by Dr Share when, answering questions about the discussion at the experts' meeting about whether G had been subjected to FGM, she said (Transcript page 20) "I was going to say I don't know but I didn't want that to be minuted." She readily acknowledged that the entire process had been a learning curve for her.

33. Professor Creighton said (Transcript page 11 that the scar did not look raised on the DVD at all.

34. Dr Momoh's oral evidence was exceedingly unsatisfactory. She had difficulty in providing answers to even the simplest factual question. Her cross-examination by Mr Myers directed to obtaining answers to the two questions *How many children under five have you examined with suspected FGM in the last twelve months?* and *How many children have you diagnosed with FGM in the last twelve months?* extends over many pages of single-spaced transcript (Transcript pages 11-18) before Mr Myers was able to extract the answers, respectively five (two of whom were babies) and "about two or three". This part of the cross-examination finished with this illuminating exchange (Transcript pages 18-19):

> "Q … two or three children within the last twelve months, examined by you, have been diagnosed by you with FGM?
>
> A That's correct.
>
> Q What category of FGM did you diagnose these children with?
>
> A As far as I can remember, I guess it was type 2 and 1.
>
> Q Have you ever had a case where you have examined a child who you have believed to have type 4 FGM?
>
> A No.

> Q So your diagnosis of [G] in this case is the first time in your career that you will have diagnosed type 4, is that correct?
>
> A I can … Yes, that's correct."

35. Asked to explain why there was no reference to scarring either in her notes of the examination on 7 April 2014 or in her report dated 23 April 2014 (Transcript pages 3, 22-24, 28, 38-39), she was quite unable, despite repeated probing, to come up with any coherent, let alone any satisfactory, explanation. At the very end of her evidence I offered her (Transcript page 37) "a final opportunity" to give me an answer. I quote the exchange (Transcript pages 38-39):

> "Q … scarring was something that you and Dr Share discussed before the examination started –
>
> A Yes.
>
> Q And you were aware that scarring was something which Dr Share had in mind as being present.
>
> A Correct.
>
> Q And you are telling us that on your examination in April, you saw scarring.
>
> A I did.
>
> Q The very thing that Dr Share and you had discussed.
>
> A That's correct.
>
> Q Yes. Now, the question is a very simple one: why do we have no reference at all to scarring, either in the notes you wrote out in your own handwriting ten or 15 minutes after the examination, nor later in your written report? What is the explanation?
>
> A Like I said earlier, I don't have an explanation for that, unfortunately, because I must have missed that, but as far as I can remember, that was discussed.
>
> Q How could you have missed it? It was the point you had discussed with Dr Share –
>
> A Yes.
>
> Q – it was the basis of Dr Share's diagnosis, how could you have missed it? That is what I do not understand.
>
> A I know. I don't have an answer for that, unfortunately."

Mr Ekaney in his closing submissions characterised the position as being "extraordinary". I can only agree.

36. Likewise Dr Momoh was unable to come up with any adequate explanation when pressed (Transcript pages 21-24) to explain the statement in her notes (but not referred to in her report) that the right labia minora "appears missing". She had difficulty (Transcript pages 6, 28-29) even in describing the scar except when prompted– "I guess a scar is a scar" – but was clear (Transcript pages 30-31) that the scar was "not a lumpy scar", was linear, not curved, and that it was not raised. Asked by me how long the scar was (Transcript page 32) she said "maybe about a centimetre, if I can remember … About a centimetre, or half a centimetre. I can't remember on top of my head now". Asked by Mr Ekaney to explain why she had not identified, either in her notes or her report, what type of FGM she said G had suffered, she said "I can't give you answer to that. I don't know".

The issues

37. The local authority's case is that G has been subjected to FGM, WHO Type IV, in the form of the scar adjacent to her left clitoral hood identified by Dr Share and Dr Momoh. The local authority's case, both when it was first opened to me and in final submissions, is that this constitutes "significant harm" within the meaning of section 31 of the Children Act 1989. The local authority's case in opening was that this alone, assuming the parents were implicated in what had been done to G, was sufficient, even in the absence of any findings against the parents in relation to the other 'threshold' matters relied on, to justify a care plan for the adoption of both children. After I had queried this on the first day of the hearing (20 October 2014), the local authority reconsidered the matter. Having reflected, it filed a position statement dated 29 October 2014 indicating that it had modified its position and that it would not seek to persuade the court that such a finding *without anything more* would make adoption proportionate. That remains its position.

38. There are therefore three issues which potentially require determination: (1) Was G subjected to FGM as alleged? (2) If so, did this amount to significant harm? (3) If so, what are the implications? I shall deal with these in turn.

Issue (1): Was G subjected to FGM as alleged?

39. Both parents deny that G has ever been subjected to FGM but first and foremost the question turns on the evidence of the three experts.

40. Mr Hayes, on behalf of the local authority, was realistic and measured in his closing submissions. He accepted that I would need to examine critically the manner in which Dr Share's evidence had changed since her initial report but suggested, and I entirely agree, that she had been refreshingly frank in acknowledging the errors in her initial report. He accepted that I would likely treat Dr Momoh's evidence with considerable caution. He accepted Professor Creighton as a clear and measured witness who spoke with authority, an assessment shared by both Mr Myers and Mr Ekaney.

41. His key point, understandably, was that both Dr Share and Dr Momoh had actually examined G with the naked eye, Dr Share twice, but Professor Creighton had not. Despite the various deficiencies in the evidence of Dr Share and Dr Momoh, he

submitted that I could nonetheless conclude, on the balance of probabilities, that there was a scar. He asked rhetorically, if the abnormality identified is not a scar, what is it? Less controversially, he submitted that if there was indeed a scar the likely cause was trauma, namely cutting either with a sharp instrument or a finger nail. As to the circumstances in which such cutting occurred (if it did) and which of the parents was implicated, he submitted that the truth was being concealed by the parents, neither of whom, he said, could claim to be an honest historian.

42. Mr Myers and Mr Ekaney invited me to accept Professor Creighton's evidence. Mr Myers suggested that Dr Share's evidence demonstrated the lack of awareness and training within the medical profession on the issue of FGM. Despite being a respected and experienced consultant community paediatrician with expertise and extensive experience in conducting child protection investigations, she openly and honestly admitted to having made significant errors in her reports. Mr Ekaney made similar points, questioning her expertise, whether clinical or forensic, in FGM cases. In relation to Dr Momoh neither pulled their punches. Mr Myers submitted that both her report and her oral evidence were "well below the standard required of an expert witness". He described her evidence as "confused, contradictory and wholly unreliable" and submitted that I should attach no weight at all to her evidence on scarring. Mr Ekaney characterised her oral evidence as "unclear, dogmatic and unreliable".

43. It is unavoidable that I make findings about the expertise and reliability of the three experts.

44. Dr Share is an experienced and highly regarded consultant community paediatrician but did not put herself forward as having particular expertise in FGM. She very candidly admitted that her initial findings were wrong and that she had changed her mind even after the second examination. In giving oral evidence she was an entirely honest, open and frank witness. The critical question is how reliable a witness she was in terms of what she thought she had seen when examining G.

45. I regret to have to say that Dr Momoh merited all the harsh criticism expressed by Mr Myers and Mr Ekaney. Whatever her expertise in relation to FGM in pregnant women, in relation to young children it was extremely limited. Her inability in the witness box to provide explanations for matters that cried out for explanation was striking. Her report dated 23 April 2014 was a remarkably shoddy piece of work. A report that says, without further explanation or elaboration, and this is *all* it said, "It appears that [G] has been subjected to some form of FGM as her vulva does not appear normal", is worse than useless. In my judgment her report and her oral evidence were well below the standard required of an expert witness. She was not a reliable witness. Her oral evidence was exceedingly unsatisfactory.

46. In contrast, Professor Creighton merited all the encomiums she received from Mr Hayes, Mr Myers and Mr Ekaney. She was the only one of the three with real experience of FGM in a paediatric context. Her evidence, both written and oral, was clear and measured; it did not change; it was delivered with authority; it carried conviction.

47. I make every allowance for the fact that Dr Share and Dr Momoh examined G with the naked eye, Dr Share twice, whilst Professor Creighton did not, but I nonetheless find it quite impossible to rely upon their evidence as reliably establishing, even on a balance of probabilities, that G had been subjected to FGM.

48. The fundamental problem is that, on their own evidence, neither Dr Share nor Dr Momoh has been able to give a clear, accurate or *consistent* account of what it is they thought they were seeing when examining G:

    i) Dr Share began off thinking that what she had seen was the *removal of tissue*, that is, FGM WHO Type I and possibly Type II; she ended up thinking that what she had seen was a scar, FGM WHO Type IV.

    ii) Dr Momoh recorded *missing* tissue; she also ended up thinking that what she had seen was a scar.

49. An equally significant problem is presented by the fact that Dr Share and Dr Momoh disagree about the features of the scar they both say they saw. Dr Share described it as "curved" and "raised", Dr Momoh as "straight" and not raised. As Mr Ekaney observed, they cannot both be right.

50. Another significant problem is presented by the difficulties both Dr Share and, in much greater measure, Dr Momoh had in explaining the content of Dr Momoh's notes of their joint examination.

51. For all these reasons, and having regard also to all the other troubling aspects of their evidence to which I have drawn attention, I find it quite impossible to rely upon Dr Share's and Dr Momoh's evidence as establishing the local authority's case. I am not persuaded of the presence of the scar which is now the only feature relied upon by the local authority in support of its allegation of FGM.

52. I should add that there is no evidential basis for any finding that G is at risk of being subjected to FGM in future. The suggestion that having been subjected to FGM Type IV led to a risk of being subjected in future to further, more serious, FGM, was discounted as a matter of principle by Professor Creighton and in any event falls away given my finding. And at no point did the local authority seek to make good a case that, even if she had not already been subjected to FGM, there was a risk that she might be in future.

53. Accordingly I have concluded that the local authority is unable on the evidence to establish that G either has been or is at risk of being subjected to any form of FGM.

Issue (2): If G was subjected to FGM as alleged, did this amount to significant harm?

54. In the light of finding on issue (1), this point falls away, but given its obvious importance and the fact that I have heard argument on it, it is appropriate that I deal with it.

55. I do not want there to be any doubt. FGM is a criminal offence under the Female Genital Mutilation Act 2003. It is an abuse of human rights. It has no basis in any religion. I repeat what I first said as long ago as 2004 in *Singh v Entry Clearance*

Officer, New Delhi [2004] EWCA Civ 1075, [2005] 1 FLR 308, para 68: it is a "barbarous" practice which is "beyond the pale."

56. In *Fornah v Secretary of State for the Home Department* [2005] EWCA Civ 680, [2005] 2 FLR 1085, Auld LJ (para 1) described it as "an evil practice internationally condemned and in clear violation of Art 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950." In the same case, Arden LJ (para 58) described it as "a repulsive practice ... deleterious to women's health." I entirely agree.

57. In *NS v MI* [2006] EWHC 1646 (Fam), [2007] 1 FLR 444. a forced marriage case, I said this (paras 3-4):

> "[3] Forced marriages ... are utterly unacceptable. I repeat what I said in *Re K, A Local Authority v N* [2005] EWHC 2956, (Fam) [20071 1 FLR 399, at para [85]:
>
> > 'Forced marriage is a gross abuse of human rights. It is a form of domestic violence that dehumanises people by denying them their right to choose how to live their lives. It is an appalling practice. [I then quoted what I had said in *Singh* before continuing] No social or cultural imperative can extenuate and no pretended recourse to religious belief can possibly justify forced marriage.'
>
> [4] Forced marriage is intolerable. It is an abomination. And, as I also said in *Re K*, at paras [87]-[88], the court must bend all its powers to preventing it happening. The court must not hesitate to use every weapon in its protective arsenal if faced with what is, or appears to be, a case of forced marriage."

In my judgment, every word that I there used in relation to forced marriage applies with equal force to FGM.

58. Without wishing in any way to qualify what I have just said in relation to FGM in general, there is a particular issue in relation to FGM WHO Type IV which cannot be shirked. And that brings me to the topic of male circumcision.

59. Circumcision of the male (from the Latin *circumcidere* to cut round) is the removal of some, or all, of the prepuce (foreskin), the retractable fold of skin that surrounds and covers the glans of the penis, so as to expose the glans. Circumcision involves the removal of a significant amount of tissue, creates an obvious alteration to the appearance of the genitals and leaves a more or less prominent scar around the circumference of the penis. Apart from the removal of the foreskin, and sometimes of the frenulum, the ligament that connects the foreskin to the glans, the genitals are left intact.

60. It can readily be seen that although FGM of WHO Types I, II and III are all very much more invasive than male circumcision,[1] at least some forms of Type IV, for example, pricking, piercing and incising, are on any view much less invasive than male circumcision.

61. It is also important to recognise that comparatively few male circumcisions are performed for therapeutic reasons. Many are performed for religious reasons (as in Judaism and Islam). However, large numbers of circumcisions are performed for reasons which, as the particular prevalence of the practice in, for example, the English-speaking world and non-Muslim Africa suggests, are as much to do with social, societal, cultural, customary or conventional reasons as with anything else, and this notwithstanding the justifications sometimes put forward, that circumcision of the male is hygienic or has prophylactic benefits, for example, the belief that it reduces the incidence of penile cancer in the male, the incidence of cervical cancer in female partners and the incidence of HIV transmission.

62. Now there is a very simple but important point to all this. There is nothing in the case-law to suggest that male circumcision is, of itself, such as to justify care proceedings: see *Re J (Specific Issue Orders: Muslim Upbringing and Circumcision)* [1999] 2 FLR 678, on appeal *Re J (Specific Issue Orders: Child's Religious Upbringing and Circumcision)* [2000] 1 FLR 571, and *Re S (Specific Issue Order: Religion: Circumcision)* [2004] EWHC 1282 (Fam), [2005] 1 FLR 236. On the contrary, judges in the Family Division have on occasions made orders providing for non-therapeutic circumcision: see, for example, *Re S (Change of Names: Cultural Factors)* [2001] 2 FLR 1005, 1015-1016 (*T v S (Wardship)* [2011] EWHC 1608 (Fam), [2012] 1 FLR 230, was a case of a medically indicated circumcision). As against that, and as Mr Hayes helpfully points out, there are voices in the Academy who take a different view: see, for example, Christopher Price, *Male Circumcision: An ethical and legal affront*, Bulletin of Medical Ethics (May) 1997; 128, 13-19, and Brian D Earp, *Female genital mutilation (FGM) and male circumcision: Should there be a separate ethical discourse*, Practical Ethics (2014).

63. In the present case the point arises in striking form. The family, as I have said are Muslims. I assume, therefore, that B either has been or will in due course be circumcised. Yet, entirely understandably, and, if I may say so, entirely appropriately, this is not a matter that has been raised before me. There is no suggestion, nor could there be, that B's circumcision can or should give rise to care proceedings. So, given the nature of the local authority's case on this point, we are in this curious situation. G's FGM Type IV (had it been proved) would have been relied upon by the local authority, prior to its change of stance referred to above, as justifying the adoption of *both* children, even though on any objective view it might be thought that G would have subjected to a process much less invasive, no more traumatic (if, indeed, as traumatic) and with no greater long-term consequences, whether physical, emotional or psychological, than the process to which B has been or will be subjected.

64. I appreciate that, in Holmes J's famous observation (Holmes, The Common Law, 1881, page 1):

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[1] There is a possible qualification in relation to FGM Type Ia, which, although apparently very rare, is physiologically somewhat analogous to male circumcision.

> "The life of the law has not been logic; it has been experience. The felt necessities of the time, the prevalent moral and political theories, intuitions of public policy, avowed or unconscious, even the prejudices which judges share with their fellow-men, have had a good deal more to do than the syllogism in determining the rules by which men should be governed."

Yet the curiosity remains. The explanation, it must be, is simply that in 2015 the law generally, and family law in particular, is still prepared to tolerate non-therapeutic male circumcision performed for religious or even for purely cultural or conventional reasons, while no longer being willing to tolerate FGM in any of its forms: cf the analysis in *Re G (Education: Religious Upbringing)* [2012] EWCA Civ 1233, [2013] 1 FLR 677, paras 39-41. Certainly current judicial thinking seems to be that there is no equivalence between the two: see *K v Secretary of State for the Home Department, Fornah v Secretary of State for the Home Department* [2006] UKHL 46, [2007] 1 AC 412, paras 31, 93, and *SS (Malaysia) v Secretary of State for the Home Department* [2013] EWCA Civ 888, [2014] Imm AR 170, paras 13-15.

65. These are deep waters which I hesitate to enter. I am concerned with a narrower question, namely how one accommodates the law's seemingly very different approaches to FGM and male circumcision within the provisions of section 31 of the Children Act 1989.

66. Mr Hayes helpfully reminded me that the statutory test of 'threshold' in section 31 has two components, and this, as it seems to me, provides the key to what might otherwise be thought rather puzzling. Section 31(2) provides as follows:

> "A court may only make a care order or supervision order if it is satisfied –
>
> (a) that the child concerned is suffering, or is likely to suffer, significant harm; and
>
> (b) that the harm, or likelihood of harm, is attributable to –
>
> (i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or
>
> (ii) the child's being beyond parental control."

I can ignore section 31(2)(b)(ii). So before the State can intervene, the local authority has to prove two things: "significant harm" attributable to parental care which is not what it would be "reasonable to expect" of a parent.

67. Mr Hayes submits, by reference in particular to what Baroness Hale of Richmond said in *Re B (Care Proceedings: Appeal)* [2013] UKSC 33, [2013] 2 FLR 1075, para 185, that any form of FGM, including FGM WHO Type IV, amounts to "significant harm". To use Lady Hale's language, no form of FGM can, he says, be characterised as trivial or unimportant, having regard not merely to its purely physical

characteristics but also to its associated trauma and potential emotional or psychological consequences. Mr Hayes also makes an exceedingly important practical point. Unless FGM in all its forms is treated as constituting significant harm, local authorities and other agencies, and indeed family courts, may be very significantly hampered in their ability to protect vulnerable children, given that "significant harm" is the jurisdictional hurdle that has to be overcome not merely under section 31(2) but also under section 100(4)(b) of the Children Act 1989.

68. I agree with Mr Hayes. In my judgment, any form of FGM constitutes "significant harm" within the meaning of sections 31 and 100. What then of male circumcision?

69. Mr Hayes points to the recognition, both by Wall J, as he then was, and by the Court of Appeal in *Re J (Specific Issue Orders: Muslim Upbringing and Circumcision)* [1999] 2 FLR 678, 693, on appeal *Re J (Specific Issue Orders: Child's Religious Upbringing and Circumcision)* [2000] 1 FLR 571, 573, 576, that male circumcision does involve harm, or the risk of harm. Given the comparison between what is involved in male circumcision and FGM WHO Type IV, to dispute that the more invasive procedure involves the significant harm involved in the less invasive procedure would seem almost irrational. In my judgment, if FGM Type IV amounts to significant harm, as in my judgment it does, then the same must be so of male circumcision.

70. I should add that my conclusions in relation to whether FGM, including FGM Type IV, constitutes "significant harm" for the purposes of family law, is quite separate from the question of whether particular examples of FGM Type IV involve the commission of criminal offences under the Female Genital Mutilation Act 2003. As I have already pointed out, FGM Type IV comes within the ambit of the criminal law only if it involves "mutilation". The question of whether a particular case of FGM Type IV – for example, the case as presented here by the local authority in relation to G – involves mutilation is, in my judgment, not a matter for determination by the family court, and certainly not a matter I need to determine in the present case. It is a matter properly for determination by a criminal court as and when the point arises for decision in a particular case.

71. Moving on to the second limb of the statutory test, Mr Hayes submits that in assessing whether the infliction of any form of FGM can ever be an aspect of "reasonable" parenting, it is vital to bear in mind that FGM involves physical harm which, it is common ground, has (except in the very narrow circumstances defined in section 1(2)(a) of the Female Genital Mutilation Act 2003, not relevant in a case such as this) *no* medical justification and confers *no* health benefits. The fact that it may be a "cultural" practice does not make FGM reasonable; indeed, the proposition is specifically negatived by section 1(5) of the 2003 Act. And, as I have already pointed out, FGM has no religious justification. So, he submits, it can never be reasonable parenting to inflict *any* form of FGM on a child. I agree.

72. It is at this point in the analysis, as it seems to me, that the clear distinction between FGM and male circumcision appears. Whereas it can never be reasonable parenting to inflict *any* form of FGM on a child, the position is quite different with male circumcision. Society and the law, including family law, are prepared to tolerate non-therapeutic male circumcision performed for religious or even for purely cultural or

conventional reasons, while no longer being willing to tolerate FGM in any of its forms. There are, after all, at least two important distinctions between the two.[2] FGM has no basis in any religion; male circumcision is often performed for religious reasons. FGM has no medical justification and confers no health benefits; male circumcision is seen by some (although opinions are divided) as providing hygienic or prophylactic benefits. Be that as it may, "reasonable" parenting is treated as permitting male circumcision.

73. I conclude therefore that although both involve significant harm, there is a very clear distinction in family law between FGM and male circumcision. FGM in any form will suffice to establish 'threshold' in accordance with section 31 of the Children Act 1989; male circumcision without more will not.

Issue (3): Implications

74. The issue of what the outcome should be had I found that G had indeed been subjected to FGM largely fell away once the local authority modified its position. Given my finding, it has fallen away entirely.

75. Since in the circumstances the point was only briefly explored in submissions, I propose to say very little about it. No generalisations are possible. Much will obviously depend upon the particular type of FGM in question, upon the nature and significance of any other 'threshold' findings, and, more generally, upon a very wide range of welfare issues as they arise in the particular circumstances of the specific case. Arriving at an overall welfare evaluation and identifying the appropriately proportionate outcome is likely to be especially difficult in many FGM cases.

76. There are two particular problems. The first is that once a girl has been subjected to FGM, the damage has been done but, on the evidence I have heard, she is unlikely to be subjected to further FGM (though of course female siblings who have not yet been subjected to it are likely to be at risk of FGM). How does that reality feed through into an overall welfare evaluation? The other problem is that, by definition, FGM is practised only on girls and not on boys. In a case where FGM is the only 'threshold' factor in play, there will be no statutory basis for care proceedings in relation to any male sibling(s). Suppose, for example, that the FGM is so severe and the circumstances so far as concerns the girl are such that, were she an only child, adoption would be the appropriate outcome: what is the appropriate outcome if she has a brother who cannot be made the subject of proceedings? Is her welfare best served by separating her permanently from her parents at the price of severing the sibling bond? Or is it best served by preserving the family unit? I do not hazard an answer. I merely identify the very real difficulties than can arise in such a case. In cases where there are other threshold factors in play, balancing the welfare arguments as between the girl(s) and the boy(s) may be more than usually complex, particularly if FGM is a factor of magnetic importance.

77. The only further comment I would hazard is that local authorities and judges are probably well advised not to jump too readily to the conclusion that proven FGM should lead to adoption.

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[2] In saying this I do not overlook the other important distinctions identified in the authorities I referred to in paragraph 64 above.

78. I add a final observation. Plainly, given the nature of the evil, prevention is infinitely better than 'cure'. Local authorities need to be pro-active and vigilant in taking appropriate protective measures to prevent girls being subjected to FGM. And, as I have already said, the court must not hesitate to use every weapon in its protective arsenal if faced with a case of actual or anticipated FGM. An important tool which lies readily to hand for use by local authorities is that provided by section 100 of the 1989 Act. The inherent jurisdiction, as well as all the other jurisdictions of the High Court and the Family Court, must be as vigorously mobilised in the prevention of FGM as they have hitherto been in relation to forced marriage. Given what we now know is the distressingly great prevalence of FGM in this country even today, some thirty years after FGM was first criminalised, it is sobering to reflect that this is not merely the first care case where FGM has featured but also, I suspect, if not the first one of only a handful of FGM cases that have yet found their way to the family courts. The courts alone, whether the family courts or the criminal courts, cannot eradicate this great evil but they have an important role to play and a very much greater role than they have hitherto been able to play.

For the future

79. There are important lessons to be learnt from this case. What follows significantly reflects various helpful comments and suggestions made by Professor Creighton, largely at my invitation, in the course of her oral evidence.

i) There is a dearth of medical experts in this area, particularly in relation to FGM in young children. Specific training and education is highly desirable. As Professor Creighton explained (Transcript pages 23, 27-28), there is an awareness problem and a need for more education and training of medical professionals, including paediatricians. In answer to my question, "presumably we need more paediatric expertise than we have at present?" (Transcript page 29), she said "Yes, definitely". She told me (Transcript pages 28-29) that there are at present only 12 specialist FGM clinics throughout the country, of which six are in London, and that her clinic at University College Hospital is the only specialist paediatric FGM clinic in the country.

ii) Knowledge and understanding of the classification and categorisation of the various types of FGM is vital. The WHO classification is the one widely used. For forensic purposes, the WHO classification, as recommended by Professor Creighton (Transcript page 2), is the one that should be used.

iii) Careful planning of the process of examination is required to ensure that an expert with the appropriate level of relevant expertise is instructed at the earliest opportunity. Wherever feasible, referrals should be made as early as possible to one of the specialist FGM clinics referred to by Professor Creighton. If that is not possible, consideration should be given to arranging for a suitably qualified safeguarding consultant paediatrician to carry out an examination recorded with the use of a colposcope so that the images can be reviewed subsequently by an appropriate expert.

iv) Whoever is conducting the examination, the colposcope should be used wherever possible.

v) Whoever is conducting the examination, it is vital that clear and detailed notes are made, recording (with the use of appropriate drawings or diagrams) exactly what is observed. If an opinion is expressed in relation to FGM, it is vital that (a) the opinion is expressed by reference to the precise type of FGM that has been diagnosed, which must be identified clearly and precisely and (b) that the diagnosis is explained, clearly and precisely, by reference to what is recorded as having been observed.