Neutral Citation Number: [2020] EWHC 323 (Fam)

Case No: NR18F05001

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 18/02/2020

Before:

MR JUSTICE NEWTON

- -

Between:

SUFFOLK COUNTY COUNCIL	**Applicant**
- and -	
R D	**First Respondent**
- and –	
A A	**Second Respondent**
-and-	
M A (through her Guardian)	**Third Respondent**

- -
- -

James Holmes (instructed by **Suffolk County Council**) for the **Applicant**
Dr Charlotte Proudman (instructed by **Duncan Lewis**) for the **First Respondent**
Kathryn Cronin and **Artis Kakonge** (instructed by **Miles and Partners**) for the **Third Respondent**

Hearing dates: 9-11 December 2019

- -

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

....

MR JUSTICE NEWTON

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.

Mr Justice Newton:

1. This is an application brought under section 5A of, and Schedule 2 to, the Female Genital Mutilation Act 2003 for a Female Genital Mutilation Protection Order (FGMPO) in relation to a girl, A, who is 10 years old. The application by the local authority was made on 27 September 2018. The father was not, and has not been, served with the application. The father is believed to be held in a military prison in Bahrain. Extensive enquiries have been made of the UK Embassy in Bahrain, the Bahrain Embassy in the UK, and the Foreign and Commonwealth Office, but these have been unable to elicit any information about the father.

2. The matter came before HHJ Richards on 1 October 2018. The mother attended court in person and was assisted by an interpreter. The judge transferred the matter to the Family Division of the High Court and invited the Secretary of State for the Home Department to be joined as an intervener and to attend the next hearing. The following orders were also made pursuant to Paragraph 4, Part 1 of Schedule 2 to the Female Genital Mutilation Act 2003:

   > "1. The First Respondent is prohibited from leaving the jurisdiction of England and Wales with or in the company of [A].
   >
   > 2. The Secretary of State for the Home Department or anyone acting on his behalf are prohibited from removing, instructing or encouraging any other person to remove [A] from the jurisdiction of England and Wales.
   >
   > 3. The Secretary of State for the Home Department or the First Respondent are prohibited from obtaining a Passport or any other Travel Document for [A], if one has not already been obtained."

   The order of HHJ Richards also includes the following recitals:

   > "UPON the Court being satisfied that on the following information having been provided to the court, there is a risk of Female Genital Mutilation to [A]:
   >
   > a. An assessment has been undertaken by Barnardo's which has concluded that if [A] was to remain in the United Kingdom there is low risk of FGM but that this would need to be reassessed if [A] was to be removed from the United Kingdom;
   >
   > b. That it is likely if the Mother is removed to Bahrain that she would be then removed to Sudan, where there is a high prevalence of Female Genital Mutilation;
   >
   > c. The Mother has undergone a medical examination which has established that she has been subjected to FGM and that her two sisters have died from such a procedure; and

> d. The Father is currently in military prison in Bahrain and is therefore unable to protect [A] from any risk of Female Genital Mutilation.
>
> …
>
> C) AND UPON the Court being of the view that this application is not a device to circumvent any immigration orders, as such application has been brought by the Local Authority on the advice of Barnardo's who are respected and recognised, for their expertise in relation to Female Genital Mutilation.
>
> …
>
> E) AND UPON the Court accepting the below order does restrict the Secretary of State for the Home Department's discretion, but the Family Courts primary consideration is the welfare of [A] and that further evidence is required, namely the extent to which the issue of FGM was considered by the Secretary of State for the Home Department when dealing with this family's asylum application so the court maybe properly informed before exercising its discretion under this Act."

3. A further hearing took place on 31 October 2018 before me. The Secretary of State submitted that he was not bound by the FGMPO and that the order should be discharged as having been made in excess of the court's jurisdiction, however he agreed not to set removal directions for a period of 6 weeks. The matter was transferred to the President of the Family Division for hearing on 30 and 31 January.

4. On 25 September 2019 the President of the Family Division handed down Judgment on the three questions formulated by me on 31 October 2018. Re A (A child) Female Genital Mutilation: Asylum [2019] EWHC 2475 (Fam).

5. In relation to the first question (the Family Court's power to injunct the Secretary of State), the President, in line with clearly established authority, ruled that there is no power for a family court to make an injunction pursuant to an FGMPO against the Secretary of State for the Home Department to control the exercise of jurisdiction with respect to matters of immigration and asylum. The extent of the family court's jurisdiction extends only to respectfully invite the Secretary of State to take the order into account, and for relevant tribunals to consider any determinations made by the Court in FGMA proceedings.

6. The second question concerned the relevance of the previous FTT evaluation in the Family Court risk assessment. The President specifically rejected the Secretary of State's submission that an FTT assessment must be the starting point, or the default position for the Court, and should only deviate from the FTT assessment if there is good reason to do so, relying on Re H (A Child) [2016] EWCA Civ 988 which made it very clear that the whole basis for each consideration is entirely different.

> "25. In approaching an asylum/humanitarian protection claim, the Home Office looks to see whether the person concerned has

> a well- founded fear of persecution or is at real risk of serious harm for a non-Convention reason. The approach to risk is not the same as that taken in a family case. In a family case, establishing risk is a two-stage process. First, the court considers what facts are established on the balance of probabilities; then it proceeds to consider whether those facts give rise to a risk of harm, see *Re J (Children)* [2013] UKSC 9. In contrast, in an asylum/humanitarian protection claim, the material presented by the claimant is looked at as a whole with a view to determining whether there is a well- founded fear of persecution or substantial grounds for believing that a person would face a real risk of serious harm, a reasonable degree of likelihood of serious harm being what is required. There is no comparable process of searching for facts which are established on the balance of probabilities."

7. So, the approach to risk assessment in a family case is a different exercise from that undertaken in the context of immigration and asylum. The family court has a duty by FGMA 2003, Schedule 2, paragraph 1(2) to 'have regard to all the circumstances' and, to discharge that duty, the court must consider all the relevant available evidence before deciding any facts on the balance of probability and then moving on to assess the risk and the need for an FGMPO. Although the Family Court will necessarily take note of any FTT risk assessment, the exercise undertaken by the FTT is not a compatible process with that required in the family court. It is not therefore possible for a FTT assessment to be taken as the starting point or default position in the family court. The Family Court has a duty to form its own assessment, unencumbered by having to afford priority or precedence to the outcome of a similarly labelled, but materially different, process in the immigration jurisdiction. On that issue permission to appeal has just been granted by King LJ.

8. The decision of the President in this case is further highlighted by *Mohan v Home Secretary* [2013] 1 WLR 922. Even if that approach is wrong, my assessment is the same, relying both on *AA (Somalia v Secretary of State for the Homes Department* [2007] EWCA Civ 1040 – so here I am focussing on A, better than the mother who is only one element, A not being a party to the earlier immigration and asylum litigation in any event.

9. The third question - the duty of the local authority to investigate, was clear. The authority have a duty to safeguard and promote the welfare of children in its area under ss.17 and 47 of the Children Act 1989. If it determines that a FGMPO is necessary it will issue an application as here. This local authority has done everything that it should have done, not just within this application, but generally, so far fulfilling its statutory responsibilities to the fullest extent.

The Law – Female Genital Mutilation Protection Orders

10. Female Genital Mutilation Act 2003, s 5A (as inserted by the Serious Crime Act 2015) makes provision through Schedule 2 Part 1 of that Act for a court in England and Wales to make female genital mutilation protection orders ['FGM protection orders'].

11. Schedule 2, paragraph 1 provides as follows:

> (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
>
> (b) protecting a girl against whom any such offence has been committed.
>
> (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;
>
> (b) respondents who are, or may become, involved in other respects as well as (or instead of) respondents who commit or attempt to commit, or may commit or attempt to commit, a genital mutilation offence against a girl;
>
> (c) other persons who are, or may become, involved in other respects as well as respondents of any kind.
>
> (5) For the purposes of sub-paragraph (4) examples of involvement in other respects are—
>
> (a) aiding, abetting, counselling, procuring, encouraging or assisting another person to commit, or attempt to commit, a genital mutilation offence against a girl;
>
> (b) conspiring to commit, or to attempt to commit, such an offence.
>
> (6) An FGM protection order may be made for a specified period or until varied or discharged (see paragraph 6).

12. In Schedule 2, 'the court' in England and Wales means the High Court or the family court [Schedule 2, paragraph 17].

13. So, this Court forms its own risk assessment and makes its own findings. Risk assessment in this context, as in other contexts in family law, should be an ongoing process. Risk is dynamic, not static; the barometer of risk is often relatively sensitive. Courts should be alert to the possibility that as or when new evidence emerges, and/or the contextual or individual characteristics of a given situation shift, the index of risk may well shift.

Female Genital Mutilation

14. The practice of Female Genital Mutilation ("FGM") is "an abuse of human rights" (see *Re B and G (Children)(No 2)* [2015] 1FLR 905 at [55]); it is well-recognised that FGM violates *Article 3* of the *ECHR*, which serves to protect persons from "torture or … inhuman or degrading treatment or punishment". As Baroness Hale observed in *Fornah v Secretary of State for the Home Department* [2006] UKHL 46; [2007] 1 AC 412, at [94]:

> "… the procedure will almost inevitably amount either to torture or to other cruel, inhuman or degrading treatment within the meaning, not only of article 3 of the European Convention on Human Rights, but also of article 1 or 16 of the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, article 7 of the International Covenant on Civil and Political Rights, and article 37(a) of the Convention on the Rights of the Child".

And Lord Bingham in the same case said this at [8]:

> "FGM has been condemned as cruel, discriminatory and degrading by a long series of international instruments, declarations, resolutions, pronouncements and recommendations. … Therefore, those cultural practices that involve "severe pain and suffering" for the woman or the girl child, those that do not respect the physical integrity of the female body, must receive maximum international scrutiny and agitation. It is imperative that practices such as female genital mutilation, honour killings, Sati or any other form of cultural practice that brutalizes the female body receive international attention, and international leverage should be used to ensure that these practices are curtailed and eliminated as quickly as possible".

15. When confronted with a case of suspected or threatened FGM, the court has an *obligation* "to take measures within the scope of [the court's] powers which, judged reasonably, might have been expected to avoid the risk" of FGM where that risk is "real and immediate" (see by analogy *Osman v United Kingdom* (1998) 29 EHRR 245, and *E v Chief Constable of the Royal Ulster Constabulary and another* [2009] 1 AC 536). In *E v United Kingdom* (2003) 36 EHRR 31 it was said that:

> "A failure to take reasonably available measures which could have had a real prospect of altering the outcome or mitigating the harm is sufficient to engage the responsibility of the state" (para.99).

16. In this case, as in many like it, *Article 8 ECHR* is actively engaged as X and her parents have a right (albeit qualified) to respect for their family life. In balancing the *Article 3* and *Article 8* rights of X, I must be careful to ensure that "the interference with [X's] *Article 8* rights, and those of her … family… [are]… limited to that which is necessary to protect her *Article 3* rights" per Hayden J in *A Local Authority v M & N* [2018] EWHC 870 (Fam) [2018] 4 WLR 98. endorsed by Moylan LJ in his judgment in this case at [30].

17. In *Re X (A Child) (FGMPO*) [2018] EWCA Civ 1825 Moylan LJ made the following observations at [31-32]:

> "[31] The court will have to consider the degree of the risk of FGM (which, I would suggest, needs to be at least a real risk); the quality of available protective factors (which could include a broad range of matters including the court's assessment of the parents); and the nature and extent of the interference with family life which any proposed order would cause.
>
> [32] The need for specific analysis balancing these and other relevant factors extends to any additional prohibitions or other terms the judge may be considering including in the FGMPO. This is because each term included within the FGMPO must be separately justified. In this exercise, although the nature of the harm would, self-evidently, be a breach of Article 3, it is the court's assessment of the degree or level of the risk which is central to the issue of proportionality and to the question of whether a less intrusive measure, which nevertheless does not unacceptably compromise the objective of protecting the child, might be the proportionate answer".

18. FGM is a practice widely carried out mainly among specific ethnic populations in Africa and parts of the Middle East and Asia. FGM is a generic term for a range of procedures which involve the partial or total removal of the external female genitalia for non-medical reasons; it serves as a complex form of social control of women's sexual and reproductive rights. In 1997, the World Health Organisation ('WHO') together with the United Nations Children's Fund and the United Nations Population Fund jointly classified FGM into four types; see the identification and discussion of these types in domestic caselaw (see Sir James Munby P in *Re B & G (No.2)* [2015] EWFC 3 at [7]).

19. The Government's Multi-Agency Statutory Guidance on Female Genital Mutilation issued in April 2016 (updated October 2018) which cites the WHO's most recent categorisation identifies the categories:

> Type 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); this type is subdivided into type 1a: removal of the clitoral hood or prepuce only, and type 1b, removal of the clitoris with the prepuce;
>
> Type 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); when it is important to distinguish between the major variations that have been documented, the WHO propose three subdivisions: type 2a, removal of the labia minora only, type 2b partial or total removal of the clitoris and the labia minora, and type 2c, partial or total removal of the clitoris, the labia minora and the labia majora;
>
> Type 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; type 3a describes the removal and apposition of the labia minora, and type 3b describes the removal and apposition of the labia majora; and
>
> Type 4 – Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

20. Professor Bradley, a specialist in FGM practice, instructed as an expert witness, warned that a serious danger of classification is that one type of FGM may be seen as 'less bad' than another; in many respects labelling the mutilation" is not helpful. It might appear that some cutting is not as harmful as others. That understanding needs to be dispelled. All of what is described above is abusive, harmful and serious ill-treatment. … Type 1 is not 'lighter' than the others".

21. While the practice of FGM is heinous and abhorrent, and its practice impossible to justify, it is important to understand how and why its practice is supported in Sudan as in other parts of the world. The justifications and motivations are generally based on a belief that FGM brings status and respect to the girl, it preserves a girl's virginity/chastity, it is said to be part of being a woman, it is a rite of passage, it gives a girl social acceptance, especially for marriage, it upholds the family "honour", it cleanses and purifies the girl. Some who support the practice have sought to eliminate risks of infection (by, for example, carrying out the procedure in a medical environment), this gives the appearance of legitimising FGM. But FGM signifies a woman's subservience and obedience to men.

22. FGM is a crime and its practice is repugnant and objectionable. There are multiple serious harmful consequences of FGM for any young girl or woman, which, short term, can include severe pain, shock, haemorrhage, wound infections, urinary retention, injury to adjacent tissues, genital swelling, and/or death. Among the longer-term consequences are 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 sex, lack of

pleasurable sensation and impaired sexual function, psychological concerns such as anxiety, flashbacks and post-traumatic stress disorder, difficulties with menstruation, complications in pregnancy or childbirth, and/or increased risk of stillbirth and death of child during or just after birth. It is obvious and evident from the mother that devastating and long-term psychological and physical effects of the procedure endure.

23. In assessing the evidence, I bear in mind that much of the evidence is now several years old and it is not always easy to recall events, let alone conversations, accurately. I bear in mind too that the mother is not only suffering from PTSD, as well as anxiety and depression, but very obviously required the assistance of an intermediary, something which has not been available to her before and which she obviously needed. I bear in mind too that other factors, such as immigration status, also bear on the lay witnesses and their perspectives. It is entirely possible, indeed rather more than possible, that the Court has not heard the truth, either from the mother, or in respect of the father, in order to hide her true feelings, motives or intentions. But just because she may have told lies earlier or not, or is untrustworthy or unreliable in respect of some aspects, does not mean it applies to everything (*R v Lucas* 1987 QB720), and may be a very long way from being determinative having regard to the overall canvass, and other (expert opinion) which is available to the Court.

24. There is too the issue of language. It is entirely possible (indeed I witnessed at first-hand how easy it is) for miscommunications, misunderstandings, and misrepresentations to occur simply through errors of translation misunderstanding. Further, I am also acutely aware of the sensitivity of this case, in common with others like it, those sensitivities cross culture, gender and generations. I have been guided by the expert evidence in respect of that, anxious not to impose my own perspectives, even inadvertently.

The Evidence

25. I heard oral evidence from Professor Bradley, the social worker, and the mother (who had clearly, as I have recorded, needed the assistance of a most helpful intermediary, and of an interpreter) and the Guardian, Lynn Magson. In addition, I have had available to me the evidence of a Bahrain legal expert, Dr Ratnam (Forensic Psychiatrist) and Shamiso Mahachi (a social worker from the National FGM Centre).

26. Professor Bradley. Professor Bradley's evidence was balanced, very well researched and informed. She has particular knowledge of Sudan.

   i) It is noted that FGM is highly prevalent in Sudan [86.6-97.7% prevalence rates].

   ii) Whilst FGM is not prevalent in Bahrain, "it is likely that the practice is still observed by this community [Sudanese] either in Bahrain or by travelling back to Sudan".

   iii) The father's ethnicity is a risk factor and he and his extended family have the authority to decide whether the child is cut.

   iv) Anti-FGM criminal laws in Sudan are rarely enforced and FGM is still widely performed. There have been no convictions in Sudan or Bahrain for FGM.

v) "Given the inconsistency of the legal provision against FGM the realities of reduced funding and the ongoing political turbulence it is unlikely that the mother in this case would be able to draw on much support from civil and/or national support groups even though the end FGM campaigning has been ongoing for some time in Sudan."

vi) In Bahrain, "No NGOs actively campaign against FGM. The mother and her daughter in this case would not have an enabling environment to protect her. The mother would not be able to draw on support from civil society or national organisations. This is particularly the case given the lack of legal provision."

vii) "As detailed in this report a number of factors make the likelihood of the girl in this case being subjected to FGM/C extremely high… It is combined view of the experts behind this report that the girl is at extreme risk of being cut should she be deported to either Bahrain or Sudan."

27. If A is not cut it will make her different, and she will be harassed (physically and verbally), and stigmatised.

28. In order to be confident that no FGM will occur, it needs to have ceased over 2 clear generations.

29. The wider family will decide whether A will be subjected to FGM, the decision does not rest with one person. The occurrence within the family and their expressed views are the relevant factors. The parents' ability to protect A has to be seen in that context. Language is a further difficulty, A speaks no Arabic. The older a girl gets, the greater the risk including into and through adulthood, particularly, for example, marriage, and it never goes away.

30. The evidence of the social worker from the National FGM Centre confirms

i) the mother's family put pressure on the mother and she is not able to sustain that pressure.

ii) A would be at risk of FGM in Sudan or Bahrain due to extended family pressures leaving mother / siblings as A's only protection.

iii) Mother would struggle to manage family pressures and FGM is entrenched in her family.

iv) A is at risk of significant harm if returned to Sudan/Bahrain.

31. <u>D</u>, a Bahrain legal expert, confirmed:

i) There is evidence indicating that the Bahraini authorities actively seek the return and prosecution of individual asylum seekers of Bahrani origin and a list of cases where this has occurred. This would accord with the evidence given by the mother (that her husband and eldest son are in prison in Bahrain). The expert notes that "this is legally possible". It is noted that, "it could still happen" (i.e. what the mother contends could well be correct).

ii) Furthermore, it is possible that they would be "deported" and deprived of their citizenship especially if there is a "political problem". If the husband has been stripped of his citizenship, the mother and her family would be stripped of their citizenship.

iii) Given the mother and the family have been absent from Bahrain for over five years, they would be liable for "removal of their citizenship and subsequent deportation".

iv) There is no central system that can identify prisoners in Bahrain.

v) It is unlikely that a FGMPO could be enforceable in Bahrain.

vi) Furthermore, the expert states that the mother and the children could be stripped of their Bahrain citizenship, "it is legally possible".

vii) The expert makes sweeping assertions that FGM is not performed in the Gulf states but no evidence is provided to reinforce this.

32. Dr Ratnam, consultant psychiatrist, advises:

i) The mother suffers from a diagnosis of recurrent depression, anxiety and PTSD.

ii) The report provides helpful background information on the impact of the mother having suffered (Type three) FGM, forced marriage, coercive control during the marriage and sexual abuse as a child.

iii) The mother continues to suffer "adverse physical consequences of FGM and is fearful of her daughter having the same procedure".

iv) In the light of the mother's mental health and patriarchal hierarchal structures, the mother may struggle to "effectively protect A from FGM".

v) The mother requires consistent medication and therapy. However, the mother was reticent to engage with therapy in the past due to cultural and language barriers. The report notes that the mother will find it difficult to engage with therapy whilst proceedings are on-going.

vi) Importantly, Dr Ratnam notes that "depression can impact on concentration and recall of information, particularly as the mother is also anxious. It is important that questioning does not re-traumatise her after". The report recommends that the mother needed the benefit of an intermediary in court. Questioning of the mother will have to be considered and careful in light of the mother's status as a vulnerable witness.

vii) Dr Ratnam gave a bleak prognosis if the mother is returned to Bahrain/ Sudan. The mother would become a suicide risk.

33. The social worker has built up an extremely good relationship with the mother, A and the other children. Having heard her, it would be of considerable assistance to this vulnerable family if she could remain the allocated social worker. The plans have

been fluid but in her statement, she confirmed that once proceedings have concluded A will no longer be subject to a CIN Plan and will therefore not have the benefit of a social worker, which this family clearly needs given the mother's ongoing mental health difficulties and their precarious immigration status. This is a family with high levels of vulnerability that require ongoing assistance and support to ensure A's needs are being fully met.

34. In oral evidence she discussed the mother's deteriorating condition, confirming Dr Ratnam's opinion. The plan is to move the case to a different team which may have some advantages. But A needs someone to take responsibility for her case. Specialist Immigration advice needs pursuing, a firm has already been identified; life story work is required; financial assistance is also required to enable A to learn Arabic, as well as quite delicate education on topic of FGM, about which A currently knows nothing. I was very impressed with the social worker who seemed to me to be both naturally intuitive and supportive, as well as proactive, even where topics might be outside her usual experience.

35. The mother found giving evidence difficult even with the help of a sympathetic intermediary and interpreter. I was struck how her presentation mirrored the professional evidence precisely.

36. A has had the benefit of a most experienced Guardian, in her report she concludes:

> "In seeking an FGMPO for A, the social worker has assessed A to be at risk of FGM if returned to Bahrain or Sudan; this position is supported by the assessments of Professor Bradley and colleague and the National FGM Centre. I support and share their view. Whilst the risk to A in Bahrain is deemed less than in Sudan, it is assessed a level of risk remains and it is not possible to be assured that the mother, A and her brothers would not be further deported from Bahrain to Sudan.
>
> The mother has expressed her commitment to protecting A from being subject to FGM and has been able to ensure A has been protected whilst in the UK. The negative impact on the mother's mental health if the family were to be removed to either Bahrain or Sudan would render her less able to provide protection for A, particularly in the context of the family and cultural expectations and the patriarchal hierarchy in Bahrain and Sudan. This is supported by the assessment of Dr Ratnam, who assessed the mother to be suffering from depression, anxiety and PTSD, which will not be amenable to treatment until the mother is in a stable situation. The mother reports also suffering poor physical health, which will be further impacted by the stress and anxiety she is currently experiencing. From my own observations of the mother at the early stage of these proceedings and interviewing her recently, I observed her emotional presentation to have deteriorated. Dr Ratnam concluded there would be a further negative impact upon the

mother if deported, which in turn would impact on the care and protection she could provide to A and her other children,

The mother's expressed her concerns the paternal family will attempt to "take the children off her" and believes they will be successful in doing so, A then being at a high risk of being subject to FGM. As The mother may have no recourse to funds if returned and considering her emotional fragility, she would be unlikely to be able to seek work and may have no alternative but to turn to family for support.

There has been no concern raised by the local authority as to the mother's ability to provide basic care to the children, which must be challenging as the mother is in receipt of limited funds. All the children have presented as polite, well-behaved young people when I have visited and from my last visit it was evident Mohammed and his partner are a support to the family and a protective factor. Discussions have taken place with Mohammed as to the risks to A of FGM and he has expressed he would protect his sister. Should The mother and the children be returned to Bahrain, this protection would not be available, and it cannot be expected A's younger brothers could provide the same level of support and would be experiencing their own distress and anxieties as to their futures. As noted, A is a quiet young girl, who presents as compliant and non-challenging, such characteristics heightening the risks for her.

A has no recollection of living in Bahrain. She has very limited knowledge of her African heritage and has been raised within British culture and norms. A does not speak or understand Arabic. The lack of ability to communicate in Arabic exposes A to a heightened risk if removed from the UK as she would not readily be able to seek help. Had A been raised in a community and culture where FGM is the norm and celebrated, she would have been raised with the expectation she would be subjected to being cut. Whilst such expectation and knowledge does not eradicate the psychological and physical distress and pain associated with FGM, A has been positively supported by her social workers and Barnardo's workers to have an expectation "her body is her own" and the assault of FGM could be additionally traumatic for her.

Considering whether the father would be a protective factor should the family return to Bahrain or Sudan, as his whereabouts are unknown it is difficult to fully assess his impact on the risks posed. Whilst The mother has not been able to produce evidence to corroborate the father was imprisoned and remains in prison, from speaking to A and the other children, they all confirmed there has been no recent contact with their father and A has spoken at school about missing him. If the father remains in custody, he cannot be a protective factor for A against

> the risks of being subject to FGM. If no longer in custody, but has not sought contact with his family, it would not indicate he is prioritising the needs of his children or be a protective factor. The mother stated the paternal family blame her for the father's imprisonment, and she does not feel supported by any of the maternal or paternal family and as noted, the mother would not have the emotional strength to challenge or oppose family members if returned to Bahrain or Sudan".

37. She expanded her conclusions in evidence, concluding that only an indefinite order would protect A. She had of course read all the papers, including the judgment of 25 July 2017, to which she gave full weight, but her professional perspective was from a different stand point and through a different prism. She found the mother credible, she had regard to the mother's physical and mental health.

38. As is clear elsewhere, one of the major hurdles in such cases is that all the families are related and interconnected. Language too is a barrier. The mother speaks little or no English, and A no Arabic. Notwithstanding that, or perhaps because of it, A and her mother clearly have a particularly close bond and connection.

Risk

39. I have been greatly assisted by the helpful list of possible relevant factors set out by Cobb J in *Re X (FGMPO No 2) [2019] EWHC 1990 Fam*, both 'contextual' factors relevant to the case (sometimes called the 'macro-factors') from the 'individual', and specific features (or 'micro-factors') applicable to this case alone. Both are highly relevant to the determination of risk. I record below a set of questions which I consider it helpful to ask, to tease out the risk factors:

Contextual considerations / 'Macro' factors

i) What is the prevalence of FGM in the country to which it is proposed that the child will be taken?

ii) What are the societal expectations of FGM in the country?

iii) If known, what is the prevalence of FGM in the specific region of the country to which it is proposed that the child will be taken?

iv) Is FGM illegal in the country to which it is proposed that the child will be taken?

v) If illegal, how effective are the authorities in the country in question in enforcing the prohibition on FGM?

vi) Given the extra-territorial reach of the *2003 Act*, and the fact that the act of carrying out FGM (and aiding and abetting, counselling or procuring the act) is a crime punishable on indictment to imprisonment not exceeding 14 years, is there an extradition treaty between the UK and the country to which the child will be taken (Bahrain or Sudan in the instant case) in the event that there is evidence of a breach of the order?

vii) What formal safeguards are available in the country to which it is proposed to take the child to mitigate the risks (access to local tourist police, FCO representatives / consular assistance, NGO workers)?

viii) At what age are girls commonly cut in the country to which it is proposed that the child will be taken? (how does this compare with the age of the subject child?).

Individual considerations / 'Micro' factors

ix) ix) Is there a history of FGM in the child's wider family or in the family to which the child will be exposed abroad?

x) x) If so, on which generation or generations of women has this been perpetrated? Specifically, what is the position in relation to the younger generation(s)?

xi) xi) What are the attitudes of the mother and/or father to FGM generally, and/or in relation to their daughter?

xii) xii) Is FGM / circumcision regarded as a woman's issue or a man's issue within the family? Where is the power-balance in the family?

xiii) What are the attitudes of the wider family to female circumcision generally, and/or in relation to the subject child?

xiv) What safeguards can the family themselves devise and impose to mitigate the risk?

xv) How well have the family co-operated with the authorities?

xvi) What is the professional assessment of family relationships and of the capabilities of the parents?

xvii) Are there any other specific features of the case which make FGM more or less likely?

40. Selecting the main questions applicable to A.

i) What is the prevalence of FGM in the country to which it is proposed that the child will be taken?

In Bahrain the practice of FGM appears uncommon; Bahrain does not appear on any global risk list. However, the significant Sudanese minority there is likely, probably highly likely, to observe the practice ether in Bahrain or by travelling back to Sudan.

In Sudan the prevalence of FGM in the North Kordofan State (the home areas of both families) is 97.7%. In Khaston State (where the parents lived and their extended families continue to live) is 87%.

(iii), (iv) and (v)

41. ii) What are the societal expectations of FGM in those countries or communities and the regional prevalence, what is the effectiveness of enforcement?

    Whilst FGM is illegal in Bahrain, there are no NGO's actively campaigning against FGM, and the mother would be unable to draw on any practical support. Within the diaspora Sudanese community different social forces in any event apply. In Sudan there is no law banning FGM, in Khartoum State, and no legal protection. In Kordofan State (where FGM is almost universal) there are banning laws, but as the figures underline, only one (pending) prosecution where a child died, she bled to death consequent upon the FGM.

42. (vi) Any order made here will be of no effect either in Bahrain or Sudan.

43. (vii) and (viii) There are no formal safeguards.

44. (ix) There is a history of FGM in A's family. The mother was subjected to Type 3 mutilation, the most serious form, from which she has suffered lifelong serious consequences. Both her mother and grandmother were cut. Within the current family, two of the mother's sisters died directly from being cut. Another sister and all 3 of her daughters have been cut, another sister has had her son and daughter cut, the youngest is planned to be cut next March, her remaining sister has had her children cut. Prevalence in the father's family is similar.

45. (xi) The mother has consistently been opposed to FGM. It is clear that her actions in coming to the UK in 2012 were motivated by her overwhelming desire to protect A from FGM. The father's position is unknown, he has expressed differing views.

46. (xii) The current activities of the wider family exert significance influence. Both the mother's and father's families have actively endeavoured to place pressure on both parents to carry out FGM, and that is continuing.

47. (xiv) Safeguards. It is highly unlikely that the mother would be able to withstand the family pressures. Notwithstanding her evidenced sustained determination to protect A, on the evidence she would a) not be able to withstand familial pressure and b) be unable to access any assistance in Bahrain. In Sudan the position would be hopeless. The decision would be taken out of her hands. The father (as evidenced by his ambivalence) would not be a protective factor.

48. (xvii) There is the additional risk factor of repatriation. Whilst I have looked at Bahrain and the Sudan, Dr D advises that it is possible that the mother's nationality could be revoked, if she has not obtained permission to remain abroad for more than 5 years (she has been here and did not obtain permission). There is no clarity about the father's position. It is not known why he is imprisoned. It may be politically motivated. The family status in Bahrain is in any event dependant on the father. It is likely that he and consequently the family will be required to leave Bahrain. Thus, I conclude that it is more likely than not that A is unlikely to remain in Bahrain, and would ultimately finish up in Sudan.

49. Thus I conclude that on the "macro risks", the evidence is powerful, indeed overwhelming. Cutting in the areas of Sudan with which I am concerned is almost universal. It has so far been unaffected by international condemnation, nor from being illegal in some of the federal states. The practice is deeply embedded in both sides of A's family, and shows no sign of abating, indeed quite the reverse. All the children of the current generation have been mutilated.

50. So far as the micro risks are concerned the mother is in no position to defend A from the sustained efforts of the whole family. (The mother temporarily lost custody of a child in Sudan in order to ensure familial compliance). Zero assistance would be available in Sudan, and in Bahrain it is conspicuous by its absence, since the practice remains in the diaspora, there would be no practical defence available to her.

51. The father's position is unknown. He however has expressed contrary views (influenced by the strongly expressed views of his family) and in any event, is currently incarcerated, his whereabouts unknown. He could not be of any assistance to A.

52. Whilst a very long way from being determinative, within the prism of my enquiry, I do not find the mother inconsistent or unreliable. Circumstances and the clarity of the evidence have significantly changed since 2017. The mother came to this country having made elaborate plans to do so. Her express motivation was the protection of A. In the context of a different marital relationship, and a family who were (and are) united in their zealous support for FGM, the mother took a courageous stand. Since then the evidence today is much clearer, putting her journey for protection in a clear perspective.

53. For the avoidance of doubt, I find as follows.

54. On 31 August 2012 the mother applied for asylum citing her risk of harm due to her conversion to Shia Islam practice and A's risk of being subjected to FGM. Her claim was rejected and the Secretary of State's refusal was upheld on appeal by the First Tier and Upper Tribunals. A was a dependant - not a claimant or an appellant in the asylum process.

55. The prevalence of FGM in the North Kordofan – the home area of the maternal and paternal families is 97.7%, and the prevalence in Omdurman, the extended family's place of residence is at 87 %. Campaigning efforts by UN and NGO agencies are assessed to have brought 'very little change or impact in terms of reducing the prevalence rates of FGM in Sudan.'

56. The father has played no role in the family for some 7 years. He is stated to support the practice of FGM and has shown deference to his family on this issue. The mother reported that it was the father's intention to take A to The Sudan to undergo the procedure and that he had last mentioned this to her in 2015. The father cannot be considered a protective factor against the risk of FGM.

57. The mother suffers from disabling PTSD, is very fearful of returning to Bahrain or The Sudan and does not have the resolve or standing to protect A from family pressure regarding FGM.

58. A has lived in the UK from the age of 3. If she is removed to Bahrain or the Sudan, she will be isolated and unsupported. She is unable to speak Arabic fluently, limiting her ability to communicate freely with her Mother and seek help independently.

59. A is unaware of the practice of FGM or that she is at risk of this procedure. Informing A that she could be cut will cause her significant emotional harm.

60. It is difficult to think of a clearer or more serious case where the risk to A of FGM is so high. I find without hesitation overwhelmingly that there is a high risk of FGM to A, and I accordingly make the order sought.

61. Importantly in relation to the order (relating to conduct outside the jurisdiction) the mother is most unlikely to be in a position to ensure that the order is adhered to because of her own vulnerabilities and the wider sustained family pressure. Secondly, the order will have no real effect either in Bahrain or Sudan.