

# **The depths of dishonour: Hidden voices and shameful crimes**

An inspection of the police response to  
honour-based violence, forced marriage and  
female genital mutilation

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## Foreword

“Many crimes are unreported, sometimes because victims are vulnerable or otherwise afraid. Examples include so-called honour-based violence, domestic violence, sexual offences, and offences against children. In all these cases, barriers of one kind or another exist, and it is the responsibility of the police proactively to look for these crimes, and to devise and implement measures designed to increase the confidence of victims in reporting crime and giving evidence, and to persuade those who erect and maintain those barriers that they will be pursued and prosecuted. Those who knowingly and deliberately create or tolerate the conditions in which crimes are committed and victims are isolated from protection and justice should be given the most potent grounds to fear the criminal law, operated and applied vigorously by the law enforcement institutions of the state.”<sup>1</sup>

This is the first time that Her Majesty’s Inspectorate of Constabulary (HMIC) has inspected and reported upon the police service’s response to crimes of honour-based violence, forced marriage and female genital mutilation. Further, it is the first time that any inspectorate within England and Wales has examined the service provided to victims<sup>2</sup> of these crimes, actual and potential, supported by the most powerful of insights, from victims themselves. It is one of the most important reports ever produced by HMIC.

Crimes committed in the name of so-called honour are despicable and damaging; they may be life-changing or life-threatening; in some cases, they end in death. Forced marriage is a specific crime that is equally serious, equally damaging. Female genital mutilation is not a requirement for any religion but it is a practice that reaches across numerous cultures to ruin the lives of many women and girls.

This report provides information and analysis for the public about how police forces respond to, investigate, and protect victims of these appalling and damaging crimes. It provides a baseline on which police and other public sector agencies can build to establish effective responses to victims. It should also focus the minds of those organisations to work together to prevent others from becoming victims in future.

The first duty of the state is to protect people, and in civil society this falls primarily to the police. Crime continues to evolve and develop and the police service needs to adapt quickly to meet new and emerging threats. That said, honour-based violence, forced marriage and female genital mutilation are not new; they are part of the

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<sup>1</sup> *State of Policing: The Annual Assessment of Policing in England and Wales 2012/13*, HMIC, London, 2014, para 26.

<sup>2</sup> Reference to victim and victims include actual victims and survivors, and potential victims of honour-based violence (HBV), forced marriage (FM) and female genital mutilation (FGM).

criminal landscape, and have been for many years. It is clear from our report that, whilst there are examples of good practice, the police and other organisations do not yet have a sound and complete understanding of the nature or magnitude of these crimes, nor how best to respond to them.

One of the most significant problems faced by society – and therefore its police – is unreported crime; it is clear that many, many instances of honour-based violence, forced marriage and female genital mutilation go unreported. It is, of course, impossible to measure accurately the size of the problem that this presents. However, vulnerable people who are living with these ‘hidden’ crimes, or who are at risk of becoming a victim, must be better served by their police.

Honour-based violence, forced marriage and female genital mutilation can be particularly complex crimes. Due respect must always be given to lawful cultural traditions and sensitivities, but these should not be barriers behind which desperate people are imprisoned. Barriers which operate in that way are dishonourable and deserve no respect, only destruction.

I wish to place on record my very great appreciation for the many victims and their representatives who have contributed to our work throughout this inspection. This includes our diverse expert reference group and the work undertaken on HMIC’s behalf by the University of Bristol in collaboration with the University of Roehampton. Never before has the voice of the victim been heard so loudly during such an inspection.

This report draws together information and evidence from numerous sources. Our report findings show that honour-based violence, forced marriage and female genital mutilation are not yet being given the priority by the police service that victims deserve. This is something that must improve and in doing so place the victim’s experience at the centre of the service provided. Our findings and recommendations present a real opportunity to set foundations in place that will improve the consistency and quality of the protection and support given to victims of honour-based violence, forced marriage and female genital mutilation.

Given the complex, hidden and highly sensitive nature of these victims’ circumstances, progress will be most effective where service development is informed by the voice of the victim. There are some recommendations that are relevant to other public sector agencies and some that will assist international police and partners in identifying and protecting victims of these terrible crimes. I am committed to helping this happen, and call on others, principally the National Police Chiefs’ Council and the College of Policing, to work together, and act upon this report without delay.

It must always be remembered that we are one society, and everyone is entitled to its protections. Everyone has the right to life, the right not to be mistreated, the right to justice. The police, with the other institutions of the state, can and must ensure that those who are especially vulnerable are especially safeguarded. Their silent cries must resound in all of the agencies of the state, and must never go unheeded.

Sir Thomas P Winsor ws

**Her Majesty's Chief Inspector of Constabulary**

## Summary

### Introduction

Honour-based violence (HBV) is the term used to refer to a collection of practices used predominantly to control the behaviour of women and girls within families or other social groups in order to protect supposed cultural and religious beliefs, values and social norms in the name of 'honour'. HBV incidents and crimes include specific types of offence, such as forced marriage (FM) and female genital mutilation (FGM), and acts which have long been criminalised, such as assault, rape and murder. Throughout this report, we use HBV to refer to the full range of incidents and crimes which perpetrators carry out under the guise of maintaining or protecting perceived 'honour'.

HBV is being suffered on a daily basis by blameless citizens throughout Britain. The cultural context of these practices, and the immense practical as well as emotional difficulty victims have in reporting the incidents and crimes they have suffered, mean that victims are acutely and continually vulnerable. They are assaulted and betrayed by the people closest to them, their family and community, from whom they have the right to expect love and protection.

Together with other public authorities, it is the responsibility of the police service to prevent these abuses where possible and to protect the victims who suffer them. In order to do so, victims and the public must have confidence that their police service has the competence and the ability to understand the unique complexities of HBV and to respond appropriately.

This is the first inspection by HMIC of the police service of England and Wales to focus on HBV. As this is a relatively under-developed area of policing, we anticipated that few forces would have the necessary systems in place to ensure that HBV incidents and crimes were prevented, that victims of HBV were protected effectively, that officers and staff were confident in what to look for and how to handle HBV cases, or that necessary and useful data was being collected by the forces. Our inspection findings found this to be correct.

It is clear to us that the police service has some way to go before the public can be fully confident that HBV is properly understood by the police and that potential and actual victims are adequately and effectively protected.

We emphasise that a small number of forces are well-prepared for the problems that an HBV case can pose, and have well-trained and experienced officers who can intervene early to prevent situations escalating and protect victims. Many other forces are well-prepared in some aspects to protect people from harm caused by HBV, but require improvements to ensure consistency and effectiveness. Some are well below the standards we, and the public, expect from a police force.



However, it was also clear that the majority of forces recognise that HBV is an area which needs improvement in terms of officer awareness, the recording and handling of incident and crime data and the policies and procedures forces have in place for handling HBV cases and liaising with external agencies, both public services and voluntary sector organisations.

We believe that the recommendations we make in this report will place the police service on a surer footing in the prevention and prosecution of HBV, the safeguarding of HBV victims and the management of perpetrators. In particular, we believe that the improvement of data recording will help to understand better the scale of HBV incidents and crimes and identify better the high risk factors. Forces must ensure that they have in place effective joint working with partner agencies in relation to HBV. The creation of up-to-date national materials to help training and procedures and approaches is essential to ensure that forces understand the best ways in which to prevent crime in their area, safeguard victims and bring offenders to justice.

## Approach

The inspection followed the progression of a victim's journey from initial contact with the police to the closure of police involvement. It included awareness and understanding of these types of incidents and crimes; measures and mechanisms to identify and protect victims; investigating offences; identifying and managing offenders; and the leadership being provided by forces. The inspection was designed to answer the following question:

How effective is the police service at protecting people from harm caused by honour-based violence (HBV), forced marriage (FM) and female genital mutilation (FGM), and at supporting victims of these offences?

To answer this question, we:

- reviewed research literature; findings from other relevant HMIC inspections (for instance, those related to the police response to domestic abuse and child protection); relevant legislation and guidance; and statistical information;
- convened an expert reference group (ERG);
- sought opinion from a wider stakeholder group;
- commissioned the University of Bristol in collaboration with the University of Roehampton to conduct a victim engagement project, focusing on HBV victims' experiences and perspectives of the police response;<sup>3</sup>

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<sup>3</sup> *Victim/Survivor Voices – A Participatory Research Project*, University of Bristol, Bristol, 2015. Available from [www.justiceinspectorates.gov.uk/hmic](http://www.justiceinspectorates.gov.uk/hmic)

- commissioned a review of the legal and regulatory framework;<sup>4</sup> and
- considered the data currently collected and held by public agencies and non-governmental organisations in relation to HBV.

This was followed by a two-phase inspection.

- In Phase 1, all 43 police forces in England and Wales completed a self-assessment of their preparedness to protect and support victims of HBV. At the same time, we completed a review of relevant documents and data provided by forces, and an analysis of information available to the public through force and police and crime commissioner websites. This phase of the inspection was designed to provide a point of comparison to inform activity in both police forces and inspection in future years.
- In Phase 2, we conducted fieldwork in eight police forces, during which we interviewed senior and operational lead officers, and held focus groups with frontline officers, staff and partners. We carried out unannounced visits to police stations to test the reality of forces' stated approaches to responding to HBV. Inspection teams included individuals from a number of voluntary sector organisations which support victims of HBV.

## Findings

We do not summarise every finding we have made in this report here. Readers should refer to the text of Chapters 6-10 for our full findings and more extensive examples of good, and poor, practice, along with word for word testimonies from victims who participated in our research project.

### **Phase 1 – police preparedness to protect people from HBV**

It is a real concern to us that, as yet, there is no strong, published evidence base on what works in policing to prevent harm to and protect victims (paragraph 5.9).

This phase of the inspection offered forces an opportunity to identify challenges or inhibitors that they faced in relation to HBV at a local, regional and national level. Overall, the majority of responses to this question identified challenges associated with leadership and awareness or understanding of HBV. Notably fewer issues were identified against the other areas of the inspection, namely protection, enforcement and prevention (paragraph 6.12).

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<sup>4</sup> The review was completed by Ben Emmerson QC, is summarised in Chapter 4 and is available in greater detail in Annex D.

We established that 40 of the 43 police forces in England and Wales were prepared to some extent to protect and support victims of HBV effectively. Three of these were assessed as being prepared overall, that is, prepared in all areas of the inspection's enquiry, based on an analysis of the force's self-assessment, documents, data and websites. Three forces were assessed as not yet prepared in any of the areas. The remainder were prepared across some but not all areas. A clear theme from those self-assessments was that forces were more prepared in relation to the leadership provided by senior and/or specialist officers, and in their responses at the early stages of a victim's case (i.e. around awareness and understanding and protection) than they were in the later stages of enforcement and prevention (such as investigations and identification/management of perpetrators) (paragraph 6.53).

## **Phase 2 – leadership**

Some of the forces we inspected have an identified senior professional lead officer who provides visible leadership on HBV issues, with clear reporting structures. Some police and crime commissioners (PCCs) have included HBV issues in local police and crime plan priorities (paragraph 7.3). Some forces have written specific HBV policies and guidance, although officers and staff were not always aware of their existence (paragraph 7.11). A few forces had a specific 'toolkit' to help officers at all stages which was both easy to access and use (paragraph 7.12).

Overall, we found that HBV was not consistently subject to an enhanced scrutiny or oversight process. Not enough forces have effective mechanisms in place to analyse their own performance (paragraph 7.15).

Forces have generally been better at putting in place effective working relationships with other public services and voluntary sector organisations. However, we found a number of organisations keen to work more closely with the police; there remains knowledge and expertise available which forces are not fully harnessing (paragraphs 7.22-7.23).

## **Phase 2 – awareness and understanding**

Few forces have taken all necessary steps to ensure that they fully understand the nature and scale of HBV in their areas. Inconsistencies in recording and in the sharing of data on HBV between police and partner organisations made this task all the more difficult.

Greater engagement with health, social care and education professionals is required (paragraphs 8.12-8.13). The 'Bristol model' used by Avon and Somerset Constabulary is an excellent example of a collaborative and collective approach to community engagement through multi-agency partnerships (paragraph 8.24).

Linked to this, there was a wide variation between and within forces in understanding HBV and the associated risks and issues. Distinctions between HBV, FM and FGM were not always understood, nor were the differences between HBV and domestic violence cases (paragraphs 8.21-8.22). There were some expert specialist officers and staff, but a clear risk of over-reliance on that small pool (paragraph 8.28).

The variation in understanding is likely to be partly related to the variations in training adopted by forces. Unsurprisingly, officers and staff who have received specific HBV training demonstrated better awareness and understanding of the issues and appropriate responses, but that training is not yet consistent or widespread (paragraphs 8.35-8.38).

The identification, recording and flagging of HBV cases on police computer systems is a particular concern to us. Without accurate data, the scale of the problem and the effectiveness of the police response to it cannot be properly assessed. More importantly, victims may be placed at risk if the context of their records is not clear, and the risk to other vulnerable individuals related to them may not be realised. There were wide variations between forces as to how an HBV aspect of a crime or incident is recorded, or if it was recorded at all (paragraphs 8.44, 8.47-8.48). Case records did not always clearly explain why decisions have been taken, or what assessments had been made (paragraph 8.61).

## **Phase 2 – protection**

Police officers and staff did not always recognise indicators of HBV and take appropriate safeguarding action; there were examples we saw, and heard through our victim engagement project, examples of officers speaking to precisely the wrong type of person (for example, family or community members who may be involved in the abuse) about the reported incident. Where cases were promptly referred to HBV specialists they were handled more effectively (paragraphs 9.4-9.9).

Officers and staff understood the need to take the views of the victim into account when taking decisions, and many understood the difficult position victims find themselves in when accusing family members of criminal offences, as well as the inhibition victims may feel in talking about the abuse that they have suffered (paragraphs 9.12, 9.14). However, where that understanding is missing, victims can feel abandoned.

All forces we inspected had procedures for joint working with other agencies. These are essential. The effectiveness of those procedures is helped by the regularity with which they are used; it was the forces who recorded having very few HBV cases where we are unsure, having spoken to officers, that the multi-agency working is effective and reliable (paragraphs 9.22-9.23). We also found that information sharing practices are not always appropriate or secure, and the risk of information being shared inappropriately in an HBV case is particularly high (paragraphs 9.28-9.31).

We similarly found variations in the extent to which victims felt officers did what they said they would do. Where a dedicated officer was assigned, and a second officer was fully briefed, victims felt reassured and supported (paragraph 9.33). Contact with victims on an ongoing basis is particularly important, and to an agreed timetable. For the most part, we found that this happened, but the ability to do so was undermined where cases are not properly recorded or updated (paragraphs 9.35-9.37, 9.41). A particular challenge is posed by victims who move between force areas, and we found considerable inconsistencies in how forces handled such cases (paragraphs 9.42-9.43).

## **Phase 2 – enforcement and prevention**

We found a difference of approach between FGM cases and other types of HBV when looking at the protocols in place between police forces and the CPS. All inspected forces had an FGM protocol, but not all had an HBV or FM protocol, and where they did it was usually an adapted domestic abuse protocol. Recognising that HBV cases require an appreciation of the aspects that distinguish them from other cases, there are nonetheless various common factors related to the investigation of HBV and other violent offences. We found cases where officers did not identify these similarities and accordingly there is the need for forces to ensure that investigative techniques are mainstreamed (paragraph 11.10).

It was reported to us that the CPS does not have lawyers experienced or specialist in HBV in all areas (although the CPS has confirmed that a specialist HBV prosecutor is allocated to each CPS Area), and we found that the internal legal services departments of some forces had only a limited understanding of the legal measures available, such as Forced Marriage Protection Orders (FMPOs) and Female Genital Mutilation Protection Orders (FGMPOs). We are concerned that some victims were not aware that it was possible for a prosecution to be brought without their co-operation in some cases (paragraphs 10.16-10.18).

In all forces the identification of perpetrators was reliant on victim reports and community intelligence; active information gathering was limited. Neighbourhood policing teams were not seeking HBV intelligence, even though they were best placed to know their local communities (paragraph 10.23). We recognise that in some instances, the police are not helped by organisations or agencies which think it is undesirable to report HBV incidents and crimes to the police, partly because of a lack of confidence in the ability of the police to deal with such a report sensitively and appropriately (paragraph 10.26).

Proactive and early intervention to manage perpetrators was not as regular as it should be. Where civil orders were sought, the records were not always centrally managed and as a result it was not sufficiently clear to officers and staff that they had been made. Orders sought by external agencies were sometimes not passed to the police (paragraph 10.31).

In most cases, a clear rationale was given for the closure of a particular case and there was evidence that appropriate safeguarding had been put in place for the victim throughout the process. However, this was not always the case. Supervisory arrangements varied considerably and did not always account for the particular risks involved (paragraph 10.40). In some cases, the lack of effective supervision had led to crimes and incidents being missed. We cannot have confidence that in all cases safeguarding and support was being provided to victims reliably and systematically (paragraph 10.41).

A number of participants in our victim engagement project said that they had had their cases closed without understanding why, or they had been unaware of the progress (if any) of their case. Others had relied on their caseworker from a voluntary sector specialist organisation to update them (paragraph 10.46). We would also emphasise, however, that there were examples of excellent practice described by victims (paragraph 10.49).

## **Conclusion**

Our findings were essentially consistent across all three areas of HBV (including FM and FGM). Using the framework of the progression of the victim's journey from first report to the closure of police involvement, we found a very mixed picture in terms of police preparedness and effectiveness in responding to HBV. These findings were corroborated by interviews with victims of HBV. Of 34 people who reported their experiences to the police, 20 were happy with the initial police response, but only nine were happy with their experience of contacting the police overall. This level must improve.

Our victim engagement project highlights the critical fact that, while HBV has features in common with domestic abuse and gender-based violence more broadly, it is the aggravating element of perceived 'honour' that shapes the context of the abuse, compounding risks to the victim and potentially involving multiple perpetrators. Some victims expressed concern that the police did not appreciate this aggravating element, and pointed out that speaking to the authorities was itself considered a violation of community norms. This illustrates the difficulties associated with identifying the true levels of HBV. Further, it highlights the risks, for police and other public services, of making the wrong assumptions about the circumstances of reported incidents and crimes and therefore taking the wrong course of action, potentially thereby inadvertently increasing the threat of harm to victims through their interventions.

We found variation in the training of staff in forces across England and Wales. It is possible that any gap in specialist knowledge represents a failure to prepare officers to respond effectively to risks within the local population. It may also reflect a lack of awareness of the levels of those risks.

Notwithstanding the pockets of good practice, our force inspections found inconsistencies in the approach of the police at most stages of the handling of a victim's case. The clearest areas for improvement were in:

- increasing knowledge and awareness of HBV in all its forms, and addressing associated gaps in understanding of what works to protect victims;
- increasing awareness and understanding of officers and staff to ensure more effective first responses;
- ensuring a consistent approach to risk assessment, the protection of victims, and investigation and supervision of HBV crimes;
- improving the collection and handling of data and intelligence on risks to victims within police force areas and nationally;
- engaging more effectively with communities in order to increase the intelligence the police receive, and to promote public confidence that the service is learning from past cases of HBV; and
- ensuring consistent approaches to partnership working (particularly with health, social care and education professionals).

The failure to record and flag incidents and crimes accurately compounds the hidden nature of HBV and has a negative impact on outcomes for victims in a circular way:

- if officers do not understand HBV, it will not be identified and flagged, and victims will lose confidence in the police response, reducing the likelihood of future reporting; while
- if a force's systems do not support consistent recording, relevant intelligence may not be easily accessible when required. If cases cannot easily be identified, victims may not be protected, forces will not be able to audit cases and learn lessons, and officers will not be prompted to learn and respond more appropriately in future, thereby encouraging more victims to report.

These problems also impair a force's ability to understand the levels of HBV incidents and crimes in its area.

Officers or staff may only have one chance to speak to a potential victim and thus may only have one chance to save a life. This means that all professionals working in public services, such as the police service, need to be aware of their responsibilities and obligations when they come across HBV cases. If the victim is allowed to walk out of the door without support being offered, that one chance might be wasted. This is the 'one chance rule'.

It is critical for victims that officers and staff in frontline roles with responsibility for implementing the 'one chance rule' have sufficient knowledge to do so reliably across England and Wales. The findings of this inspection show that this is not currently the case. Raising levels of awareness to equip frontline officers and staff with the skills they need to identify possible cases of HBV and to adapt their handling methods accordingly, need not be costly or extensive. Doing so will improve the response to HBV and the confidence of potential victims to report crimes to the police. That, in turn, will go a significant way towards addressing the unreported nature of these incidents and crimes.



# Recommendations

## To the Home Office

### Recommendation 1

By March 2016, the Home Office should establish a national oversight framework to monitor and report on the progress made in relation to the findings and recommendations in this report.

### Recommendation 2

By June 2016, the Home Office, in conjunction with the National Police Chiefs' Council, should develop an approach to the collection of data recorded by police forces in relation to HBV, FM and FGM. Consideration should be given to this data being recorded as part of the Annual Data Return.

### Recommendation 3

By June 2016, the Home Office should initiate a review of the existing legislative framework for all forms of HBV, and consider whether new legislation should be enacted to cover:

- the definition of HBV;
- the specific criminalisation of all forms of HBV where existing offences do not adequately deal with the particular context of HBV crimes;
- imposition of penalties appropriate to the gravity of such offences, taking account of their inherent aggravating features; and
- provision for appropriate protection orders and a legislative scheme setting out the responsibilities in relation to those orders on relevant public services.

## To the National Police Chiefs' Council

### Recommendation 4

By March 2016, the national policing lead should develop an action plan which addresses the findings and recommendations made within this report through the national oversight framework. The action plan should include reference to the ways in which forces will raise awareness, within local communities, of the role of the police service in preventing HBV, FM and FGM and protecting victims of HBV, FM and FGM.

### **Recommendation 5**

By June 2016, the national policing lead, in conjunction with partner agencies in health, social care and education, should develop a national set of protocols for HBV, FM and FGM to ensure co-ordination and consistency of information sharing at all levels.

### **Recommendation 6**

By June 2016, the national policing lead should, in conjunction with the Crown Prosecution Service, develop an equivalent joint investigation and prosecution protocol for HBV and FM to that which exists for FGM.

### **Recommendation 7**

By June 2016, the national policing lead, in conjunction with the Home Office and the Ministry of Justice, should oversee the development of a national process to co-ordinate the collection and dissemination of all FMPOs and FGMPPOs to police forces, together with other relevant court orders.

### **Recommendation 8**

By December 2016, the national policing lead, in conjunction with the Home Office, should review whether data collected on police activity associated with HBV, FM and FGM is consistent and accurate. Where the national policing lead is not satisfied that the data is consistently and accurately collected, guidance should be issued to forces in order that a sound evidence basis is established to understand the national picture of related demand on the police service and assist forces in effective resource planning.

## **To chief constables**

### **Recommendation 9**

By June 2016, chief constables in consultation with partner agencies should undertake research and analysis using diverse sources to understand better the nature and scale of HBV, FM and FGM in their force areas, and use this information to raise awareness and understanding of HBV, FM and FGM on the parts of their police officers and staff.

### **Recommendation 10**

By June 2016, chief constables should ensure that information management processes are in place to record and flag HBV, FM and FGM information in an efficient, effective and systematic way so that the risk to individual victims is identified at an early stage and properly assessed and managed throughout the progression of victim's case.

### **Recommendation 11**

By June 2016, chief constables together with partner agencies should ensure they have clear policies and joint working structures in place to ensure an integrated approach to HBV, FM and FGM between police forces and other agencies.

## **To the College of Policing**

### **Recommendation 12**

By March 2016, the College of Policing should produce Authorised Professional Practice guidance to provide current and up-to-date standards for the police service in relation to HBV and FM.

### **Recommendation 13**

By June 2016, the College of Policing should review the current approach to risk assessment in relation to cases of HBV, FM and FGM. This should include an assessment of the sufficiency of instruments and methods currently available to assess risk in such cases.

### **Recommendation 14**

By June 2016, the College of Policing should establish a process for the collation and dissemination of good practice ('what works') for the police service in relation to HBV, FM and FGM.

# 1. Introduction

## Background

- 1.1. Banaz Mahmud was in contact with the police five times between September 2005 and January 2006. On the first occasion, she described the physical and sexual abuse (including rape) she had suffered at the hands of her husband. Banaz later reported that her family were threatening to kill her, because they felt she had dishonoured them by leaving her husband and starting a new relationship.
- 1.2. Despite her appeals for help, Banaz was raped and murdered by members of her family in January 2006. Strangled in the family home, her body was then buried in a suitcase in the garden of a disused house. She was 20 years old.
- 1.3. A subsequent investigation by the Independent Police Complaints Commission (IPCC) into the standard of the service provided to Banaz by the two police forces she had spoken to (the Metropolitan Police Service and West Midlands Police) concluded that the police response had been 'at best mixed'. In particular, the final investigation report criticised the fact that officers had taken three months to take a statement from Banaz after she first contacted them, and that the police appeared to have assumed that the information available to them could not lead to a successful prosecution; the criminal investigation was delayed and the opportunity to bring the matter before a court lost.<sup>5</sup>
- 1.4. The IPCC made recommendations for both the Metropolitan Police Service and West Midlands Police, together with one national recommendation for all 43 forces in England and Wales which was:

"The IPCC investigation found a lack of awareness within the two police forces of the trigger factors of domestic violence and the impact that cultural issues can have on the outcome ... [P]olice forces in England and Wales should recognise that so-called "honour-based violence" is more prevalent than previously understood and that this type of crime crosses cultural boundaries. It is therefore important for police forces to raise awareness of these issues by engaging with communities and developing partnerships; review and revise policies and literature in relation to domestic violence and

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<sup>5</sup> *Independent Investigation – Executive Summary. Contact between Banaz Mahmud and the Metropolitan Police Service and West Midlands Police, September 2005 – September 2006.* IPCC, London, 2008. Available from [www.ipcc.gov.uk](http://www.ipcc.gov.uk)

cultural issues; [and] engage with support groups dealing with such issues to develop trust and confidence”.<sup>6</sup>

### **Challenges for the police in responding to HBV**

- 1.5. Lawful cultural traditions and sensitivities deserve to, and should always be, given due respect. But it is our view that “where traditions operate to imprison vulnerable people behind barriers of fear and the threat or reality of violence, and facilitate or intensify crimes committed against those people, such barriers must be broken. They deserve no respect at all”.<sup>7</sup>
- 1.6. There are a number of reasons why cases of honour-based violence (HBV), forced marriage (FM) and female genital mutilation (FGM) are likely to be more prevalent than current data show, making it difficult to measure accurately the scale of such offences. For instance:
  - cases can be simultaneously local and global, crossing force and national borders and jurisdictions, which makes it more difficult to accurately identify the scale of offending;<sup>8</sup>
  - under-reporting, because of the entrenched nature of the practices in families and communities, and the particular vulnerabilities of the victims (who, for example, may not be believed or understood, or may feel loyal to the family and community in which they live, or fear the threat of violence, and/or the possibility of more or worse violence if they try to seek help);<sup>9</sup> and
  - inconsistencies in the way public authorities, including police forces, identify and record these incidents and crimes.<sup>10</sup>

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<sup>6</sup> Independent Investigation – Executive Summary. Contact between Banaz Mahmood and the Metropolitan Police Service and West Midlands Police, September 2005 – September 2006. IPCC, London, 2008, pp.13-14. Available from [www.ipcc.gov.uk](http://www.ipcc.gov.uk)

<sup>7</sup> State of Policing: The Annual Assessment of Policing in England and Wales 2013/14, HMIC, London, 2014, para 1.16.

<sup>8</sup> This means that investigations and evidence have to be obtained from source and transit countries.

<sup>9</sup> Various non-governmental organisations (NGOs) have highlighted these issues. See, for instance, *Honour-based Violence (HBV) and Honour-based Killings in Iraqi Kurdistan and in the Kurdish Diaspora in the UK*, Dr N Begikhani, Dr A Gill, Professor G Hague with Ms K Ibraheem, Roehampton, November 2010, para 8.8 p 124; *Honour Killings in the UK*, Emily Dyer, The Henry Jackson Society, London, January 2015, para 2.2.8; Karma Nirvana Day of Memory 14 July 2015 (see [www.karmanirvana.org.uk](http://www.karmanirvana.org.uk)); *Postcode lottery: police recording of reported 'honour' based violence*, Iranian and Kurdish Women's Rights Organisation (IKWRO), London, January 2014.

<sup>10</sup> Government reply to the sixth report from the Home Affairs Committee Session 2007-08 HC 263 Domestic Violence, Forced Marriage and “Honour”-Based Violence, July 2008; Honour-based

- 1.7. As a result, information is often unreliable and incomplete, victims are hidden, and it is very difficult (if not impossible) to establish the exact number of incidents and crimes involving HBV, FM and FGM within the United Kingdom.

## About this inspection

- 1.8. As shocking as Banaz Mahmood's story is, it is not an isolated case. Shafiea Ahmed, Masha'al Albasman, Surjit Athwal, Arash Ghorbani-Zarin, Tulay Goran, Rukhsana Naz, Samaira Nazir, Laura Wilson and Heshu Yones are among those in the United Kingdom who have also lost their lives to HBV.
- 1.9. The heightened profile of HBV, FM and FGM as a result of these and other cases has increased the focus on how to prevent and tackle such crimes, as evident in (for example) the government's Violence Against Women and Girls (VAWG) Strategy.<sup>11</sup> This strategy emphasises the scope of offences that may be motivated by perceived threats to honour, including forced marriage and female genital mutilation.
- 1.10. To date, in England and Wales there has been no inspection or government review of the police service's response to and work to prevent incidents and crimes of HBV. Recent reports we have published on the police response to domestic abuse<sup>12</sup> and child protection<sup>13</sup> have made reference to HBV. The findings of these reports have relevance for many aspects of policing HBV – in particular the identification of and initial response to the associated vulnerability of victims, and the importance of consistent partnership approaches to the safeguarding of victims.

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Violence (HBV) and Honour-based Killings in Iraqi Kurdistan and in the Kurdish Diaspora in the UK, Dr N Begikhani, Dr A Gill, Professor G Hague with Ms K Ibraheem, Roehampton, November 2010, para 5.4 p 43; Honour Killings in the UK, Emily Dyer, The Henry Jackson Society, London, January 2015, paras 2.1, 3.2.2.2.

<sup>11</sup> *A Call To End Violence Against Women and Girls, Action Plan*, UK Government, 2014. More information on the strategy, together with a summary of relevant legislation and national guidance, is given in Chapter 4.

<sup>12</sup> *Everyone's Business: Improving the Police Response to Domestic Abuse*, HMIC, London, 2014. Available from [www.justiceinspectorates.gov.uk/hmic](http://www.justiceinspectorates.gov.uk/hmic)

<sup>13</sup> *In Harm's Way: The Role of the Police in Keeping Children Safe*, HMIC, London, July 2015. Available from [www.justiceinspectorates.gov.uk/hmic](http://www.justiceinspectorates.gov.uk/hmic)

1.11. HMIC considered HBV to be a priority area for examination and therefore included an inspection of the police response to honour-based violence in its 2014/15 business plan.<sup>14</sup> We used the definition of HBV set out in the government's VAWG Strategy, and used by agencies including the Crown Prosecution Service (CPS) and the police service:<sup>15</sup>

“a crime or incident which has or may have been committed to protect or defend the honour of the family and/or community”.

1.12. At the request of the Home Secretary,<sup>16</sup> the scope of this work was extended to include an assessment of the police response to and work to prevent forced marriage (FM) (i.e. a marriage in which one or both of the parties is married without his or her consent), and female genital mutilation (FGM) (procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons).<sup>17</sup>

### **Inspection purpose and aims**

1.13. This inspection was designed to answer the following question:

How effective is the police service at protecting people from harm caused by honour-based violence (HBV), forced marriage (FM) and female genital mutilation (FGM), and at supporting victims of these offences?

1.14. The aims of the inspection were:

- to report on the effectiveness of the police approach to identifying, responding to and protecting people at risk of harm from HBV, FM and FGM;
- to report on the effectiveness of the police approach to preventing HBV, FM and FGM;
- to highlight and promote effective practice in the police response to and work to prevent HBV, FM and FGM; and

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<sup>14</sup> *Her Majesty's Inspectorate of Constabulary: Business Plan 2014/15*, HMIC, London, 2014. Available from [www.justiceinspectorates.gov.uk/hmic](http://www.justiceinspectorates.gov.uk/hmic)

<sup>15</sup> *Honour-based violence – get the facts*, Metropolitan Police Service website, [http://safe.met.police.uk/crimes\\_of\\_honour/get\\_the\\_facts.html](http://safe.met.police.uk/crimes_of_honour/get_the_facts.html)

<sup>16</sup> In a letter to Her Majesty's Chief Inspector of Constabulary Sir Thomas Winsor dated 15 July 2014, the Home Secretary indicated that she would welcome inclusion of the police handling of investigations of forced marriage (FM) and female genital mutilation (FGM) within the scope of the HBV inspection.

<sup>17</sup> More information on definitions is given in Chapter 2.

- to make recommendations to advance improvements in policing practice in relation to HBV, FM and FGM.

## Inspection approach

- 1.15. The inspection followed the victim's<sup>18</sup> journey from initial contact to closure of police involvement. The detailed methodology is set out in Annex B.
- 1.16. To develop this approach, HMIC established an expert reference group (ERG) of people with an in-depth knowledge of HBV, FM and/or FGM, some of whom have regular contact with victims. The group included academics and interested parties from the criminal justice and voluntary sectors, as well as from the police service. The composition of the ERG is listed in Annex C.
- 1.17. HMIC's inspection team:
- reviewed research literature; findings from other relevant HMIC inspections (for instance, those related to the police response to domestic abuse and child protection); relevant legislation and guidance; and statistical information;
  - convened workshops with the ERG to develop the assessment criteria; sought opinion from a wider group of interested parties;
  - commissioned the University of Bristol, in collaboration with the University of Roehampton, to conduct a victim engagement project, focusing on HBV victims' experiences and perspectives of the police response;<sup>19</sup>
  - commissioned a review of the legal and regulatory framework;<sup>20</sup> and
  - mapped the data currently collected and held by public agencies (set out in Chapter 3) and non-governmental organisations in relation to HBV, FM and FGM.
- 1.18. The preparatory work indicated that there was a significant variation across the police service in terms of awareness and understanding of HBV, FM and FGM. In consultation with the ERG, HMIC therefore settled upon a phased approach:

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<sup>18</sup> Reference to victim and victims include actual victims and survivors, and potential victims of HBV, FM and FGM.

<sup>19</sup> *Victim/Survivor Voices – A Participatory Research Project*. University of Bristol, Bristol, 2015. Available from [www.justiceinspectorates.gov.uk/hmic](http://www.justiceinspectorates.gov.uk/hmic)

<sup>20</sup> This review was undertaken by Ben Emmerson QC and is summarised in chapter 4. The review is available in full at Annex D.



- the first phase considered the preparedness of the police service to identify and respond to HBV, FM and FGM. All 43 forces in England and Wales completed a self-assessment of current practice in this area, with findings complemented by an HMIC review of force websites, documents and data;
- the second phase consisted of fieldwork in eight forces. Conducted between June and August 2015, these in-depth inspections focused on the effectiveness of the police service in responding to and preventing HBV, FM and FGM, through a mix of interviews, focus groups and reality testing. HMIC also examined relevant case files, following the victims' journeys from the point they first made a report to the police, through to the final outcomes of their complaints. The fieldwork was conducted by HMIC inspectors, accompanied by both police service and ERG peers.

1.19. The forces inspected in Phase 2 of the inspection were:

- Avon and Somerset Constabulary;
- Cheshire Constabulary;
- Dyfed-Powys Police;
- Hertfordshire Constabulary;
- Metropolitan Police Service;
- Northumbria Police;
- Thames Valley Police; and
- West Midlands Police.

1.20. These forces were selected because they were identified as outliers<sup>21</sup> in Phase 1 of the inspection, and/or represented a mix of rural and urban policing environments, with different population profiles.

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<sup>21</sup> This means that they were identified as being significantly different to other forces in their levels of preparedness.

## About this report

### Definitions and terminology

- 1.21. 'Honour-based violence' is used in this report as an overarching term for honour-based violence (HBV), forced marriage (FM) and female genital mutilation (FGM), which are dealt with separately as appropriate in the chapters that follow and in our findings.

### Honour-based violence

- 1.22. The definition of HBV set out in the VAWG Strategy (referenced above) includes assault, sexual assault, murder and other general crimes, along with specific honour-based crimes such as forced marriage (FM) and female genital mutilation (FGM).
- 1.23. Following consultation with the ERG (and to reflect the fact that it is in common use in the police service), we have used the term HBV throughout this report. However, we acknowledge that academics and other experts in this field do not consistently agree on the use of the terms 'honour' or (as it is sometimes termed) 'so-called' honour-based violence. In particular:
- some believe that it could perpetuate the idea that such violence is indeed honourable;
  - some hold the view that HBV should be identified and understood as one type of gender-based violence within a range of violence against women and girls;<sup>22</sup> while
  - others believe that the term is useful to highlight and promote understanding of the issue, and should be used as it resonates with the language of those who commit such violence.<sup>23</sup>

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<sup>22</sup> *Honour-based Violence (HBV) and Honour-based Killings in Iraqi Kurdistan and in the Kurdish Diaspora in the UK*, Dr N Begikhani, Dr A Gill, Professor G Hague with Ms K Ibraheem, Roehampton, November 2010, para 2.2.

<sup>23</sup> *The Home Affairs Committee sixth report: Domestic Violence, Forced Marriage & 'Honour'-Based Violence*, House of Commons, Session 2007-08, p3, point 1; *Government reply to the sixth report from the Home Affairs Committee Session 2007-08, HC 263, Domestic Violence, Forced Marriage and "Honour"-Based Violence*, UK Government, July 2008, p3, point 1.

- 1.24. There is, however, clear consensus that there can never be any honour associated with violence and abuse.<sup>24</sup> We agree. Incidents and crimes of this kind are dishonourable in the extreme. None of the terminology used in this report is intended to indicate any acceptance that the practices involved in HBV are honourable.

### **Forced marriage**

- 1.25. A marriage is forced if one or both spouses does or do not consent to it, but is or are coerced into it. Such coercion and duress can include physical, psychological, financial, sexual and emotional pressure. In the cases of some vulnerable adults who lack the capacity to consent, coercion is not required for a marriage to be forced.<sup>25</sup>

### **Female genital mutilation**

- 1.26. Female genital mutilation (FGM) is a practice that intentionally alters or causes injury to the female genital organs for non-medical reasons. It is known by a number of names, including ‘female genital cutting’, being ‘cut’, ‘circumcision’ or ‘initiation’.<sup>26</sup> It is a complex practice, defined by the World Health Organization (WHO), United Kingdom government and other agencies as follows:

“FGM comprises all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reason.”<sup>27</sup>

### **Victims**

- 1.27. We recognise that many potential or actual victims prefer to be referred to as survivors. For brevity, we refer to all those individuals as ‘victims’ throughout the report.

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<sup>24</sup> *‘Honour’ Killing and Violence, Theory, Policy and Practice*, Dr A Gill, Caroline Strange, Karl Roberts, Palgrave MacMillan, Basingstoke, 2014, p2.

<sup>25</sup> *The Right to Choose: Multi-Agency Statutory Guidance for Dealing with Forced Marriage*, UK Government, June 2014, p1.

<sup>26</sup> *Multi-Agency Practice Guidelines, Female Genital Mutilation*, UK Government, 2014, para 2.7.

<sup>27</sup> *Ibid*, para 2.1.

## 2. The nature of honour-based violence (HBV), forced marriage (FM) and female genital mutilation (FGM)

- 2.1. Honour-based violence (HBV), forced marriage (FM) and female genital mutilation (FGM) share some common characteristics, but there are some important distinctions. There are also overlaps with domestic abuse, child abuse and numerous types of crime<sup>28</sup> as well as with human trafficking and modern slavery, which further blur the edges in their definition.
- 2.2. In order to inform the inspection, we consulted our expert reference group (ERG), and reviewed published research findings on HBV, FM and FGM. In this chapter, we summarise the parts of this evidence which helped to shape the design of this inspection. The supporting material is provided in more detail, with references, in Annex E of this report.

### Honour-based violence

#### Meaning of ‘honour’

- 2.3. ‘Honour’ carries different meanings, interpretations or applications in different cultures or groups. As such, it has multiple meanings related to pride, esteem, dignity, reputation and virtue.
- 2.4. In terms of HBV, the notion of ‘honour’ is associated with:
- the behaviour that is expected predominantly of women and girls, in relation to the family or the social value system and norms in a community;
  - the perceived ‘shame’ that results from not complying with those expectations; or
  - seeking to prevent behaviour that would breach those expectations, and so avoiding the perceived ‘shame’ or ‘dishonour’ on the family.
- 2.5. As such, the concepts of honour and shame are fundamentally interconnected with behavioural expectations. Where a family, community or society operates an honour-based value system, HBV refers to the abuse or violence that may be committed in order to obtain, maintain or restore the notion of that honour, if that honour has in some perceived way been lost or threatened.

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<sup>28</sup> For example, there are overlaps with serious and organised crime; sexual and other violence; child abuse and child sexual exploitation (including that which is cyber-enabled); and benefit fraud.

## **Characteristics of HBV**

- 2.6. HBV is a collection of practices used predominantly to control the behaviour of women and girls within families or other social groups to protect perceived cultural and religious beliefs, values or social norms in the name of 'honour'.
- 2.7. HBV is, by its nature, hidden. It is mainly (although not exclusively) perpetrated by the victim's family or community, and may include collusion, acceptance, support, silence or denial. This includes such behaviour on the parts of some community leaders.

## **Characteristics of HBV victims**

- 2.8. HBV is a form of abuse and/or violence that takes place predominantly against women and girls, although HBV and FM can also be committed against men and boys. The family honour and the desire to protect against dishonour and 'shame' is often used, indefensibly, to justify abuse, violence and even murder.
- 2.9. HBV is not linked to any one religion, culture or society. It has been identified as mainly occurring among populations from South Asia. However, it can occur in other cultures and communities, such as African, Middle Eastern, Turkish, Kurdish, Afghan, parts of Europe (including the United Kingdom) American, Australian and Canadian. HBV is not associated with any particular religion or religious practices and has been recorded across a number of faiths, including Christian, Hindu, Jewish, Muslim and Sikh communities.
- 2.10. Victims of HBV and FM are required to live within the honour-based value system and comply with strict unwritten 'honour' codes from birth which effectively place restrictions on their lives and freedom, especially those of women and girls. These codes are often ingrained and are considered as normal, regardless of the abuse or violence a victim may be suffering. Victims are often made to feel personally responsible for the maintenance and protection of that honour. As such, if the victims go against these codes, even by seeking help, they may feel guilty and ashamed and may internalise these feelings, effectively being made to feel like the perpetrators rather than the victims that they are.
- 2.11. If victims successfully escape the abuse, they face significant risks to their lives. They are left vulnerable and isolated. There is loss of family, feelings of guilt and shame, mental anguish, and due to the restrictions imposed victims may often lack independent life skills. In order to restore honour, there have been cases of families reporting the victims missing or falsely accusing them of a crime, or tracing them through medical records or national insurance numbers. Bounty hunters, private investigators, local taxi drivers, members of the community and staff at education centres or workplaces may also be

enlisted in the search. Families may solicit the help of professionals who share similar views or who do not understand the situation and consider mediation an option. If located, the victim may be subjected to further violence, abuse or murder.

### **Characteristics of offenders**

- 2.12. The responsibility to maintain the honour-based value system and codes, including administering punishment for the breach of them, is vested mainly in the male members of the family, although women may also be perpetrators. Female family members can be involved in facilitating violence and abuse through informal conversation, pressurising males of the family to undertake HBV acts or assisting in arranging violence, or actually being involved in the violence or killings. If a perpetrator believes that a relative has shamed the family and/or community by breaking their honour code, they may inflict violence or abuse to restore honour, as well as to deter other family members from committing similar breaches.

### **Similarities with and differences with other forms of abuse**

- 2.13. The rationale for HBV differs from other related crime types such as domestic abuse in that it usually occurs to preserve perceived social, cultural or religious traditions or norms. HBV can involve multiple perpetrators taking drastic action which may be premeditated.
- 2.14. The other difference between HBV and other forms of abuse is that there are potentially significant risks to people associated with the victim, for example the victim's children, siblings and friends as well as members of various authority groups and organisations who seek to assist the victim.

## **Forced marriage**

- 2.15. It is important to distinguish between forced marriage (FM) and arranged marriage. An arranged marriage is a legal practice and has been practised in numerous societies for centuries. Families take a lead role in arranging the marriage, but the final choice as to whether to accept the marriage is a matter for the individuals concerned.
- 2.16. FM is different from an arranged marriage, in that one or both parties does or do not give their full and free valid consent to the marriage. Force, coercion and duress are used (actual or perceived) against the victim and/or someone else, such as a sibling. Alternatively, it may be that a sibling is required to take the victim's place if he or she has refused or disappeared, leaving the marriage promise outstanding. There can be physical, emotional, psychological, financial and sexual pressure exerted on the victim or someone close to them to make them comply.

### **Characteristics of forced marriage victims**

- 2.17. FM can be committed against men, women or children, although the majority of reported cases are committed against girls and women between the ages of 16 and 25. Victims of FM can include people with learning or physical disabilities.
- 2.18. Young people (particularly girls) who are forced to marry are frequently withdrawn from education, restricting their educational and personal development. Victims may feel unable to go against their parents' (or wider family's) wishes, due to fear of violence and/or fear of being disowned by the family. This can often lead them to suffer emotionally, resulting in depression, self-harm or, in extreme cases, suicide.
- 2.19. Victims may be taken abroad to be forced into marriage; they may be blackmailed or deceived by their own family for that purpose and left there for extended periods. They may be subjected to physical and emotional abuse to force them into the marriage in the UK or in other countries. Once forced into marriage, victims may be subjected to repeated serious sexual assaults and ongoing domestic abuse including from extended family members.

### **Female genital mutilation**

- 2.20. Female genital mutilation (FGM) is recognised internationally as a violation of the human rights of girls and women. The procedure is traditionally carried out by women, usually with no medical training. Anaesthetics and antiseptic treatments are not generally used, and the practice is commonly carried out using knives, scissors, scalpels, pieces of glass or razor blades.
- 2.21. There are no health benefits to FGM and it can lead to serious medical conditions that affect the victim throughout her life. The effects are often devastating.
- 2.22. Like HBV and FM, FGM is associated with the concept of family honour and the control of behaviour, especially the sexual behaviour of women and girls. There is no established basis for the practice in any religion, although there are commonly held misconceptions or unfounded beliefs, for example that it is a religious requirement, and that it enhances fertility or makes childbirth safer.

### **Characteristics of FGM victims**

- 2.23. FGM is usually carried out on girls between infancy and 15 years of age, with the majority of cases occurring between the ages of five and eight years. However, it can be carried out on children who are younger or older; for example, when girls reach puberty, as a rite of passage, or when women marry into a community.

### **Characteristics of FGM offenders**

- 2.24. In the cases of women and girls living in Britain, FGM may be carried out in the United Kingdom or abroad. If carried out in the United Kingdom, people known as 'cutters' may be brought into the country for the purpose. 'Cutters' are usually female, although in rare cases can be male. They may carry out the practice on a number of victims at the same time and location. Alternatively, girls can be taken abroad, usually ahead of the six-week or other long school holidays, for the practice to be carried out.



### 3. Published and unpublished data: The extent of HBV offending

- 3.1. In order better to inform our understanding of police practice in this area, we explored the availability of quantitative data on HBV, FM and FGM offences. We consulted with partner organisations, as well as the expert reference group (ERG), to identify relevant sources of data, whether or not previously published.
- 3.2. This chapter sets out our findings.

#### Published data

##### Police-recorded crime statistics

- 3.3. In England and Wales, both FGM and FM are recorded as crimes (under the Female Genital Mutilation Act 2003 and the Anti-social Behaviour, Crime and Policing Act 2014, respectively). However, figures specifically on the numbers of FGM and FM cases are not available; they are instead aggregated into larger crime categories (FGM crimes are counted in the category ‘assault with injury’, for example).
- 3.4. Nor are there national data on the extent of HBV. This is because it is not a recorded crime category in its own right. Where HBV crimes occur and are reported to the police, they are recorded under different categories (homicide or assault with injury, for example) and published under these headings.
- 3.5. In their 2015 report, *Estimating Demand on the Police Service*,<sup>29</sup> the College of Policing explained that there are a number of new and emerging crime types that are generally not captured effectively by the current data returns to the Home Office.
- 3.6. As part of that analysis, 12 forces were asked by the College of Policing to provide data on trends in cases of modern slavery and FGM. Their report found that very few were able to return trend data, partly because they have only recently implemented systems to record such incidents more accurately.

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<sup>29</sup> *Estimating Demand on the Police Service*, College of Policing, London, 2015.

## Crown Prosecution Service (CPS) statistics

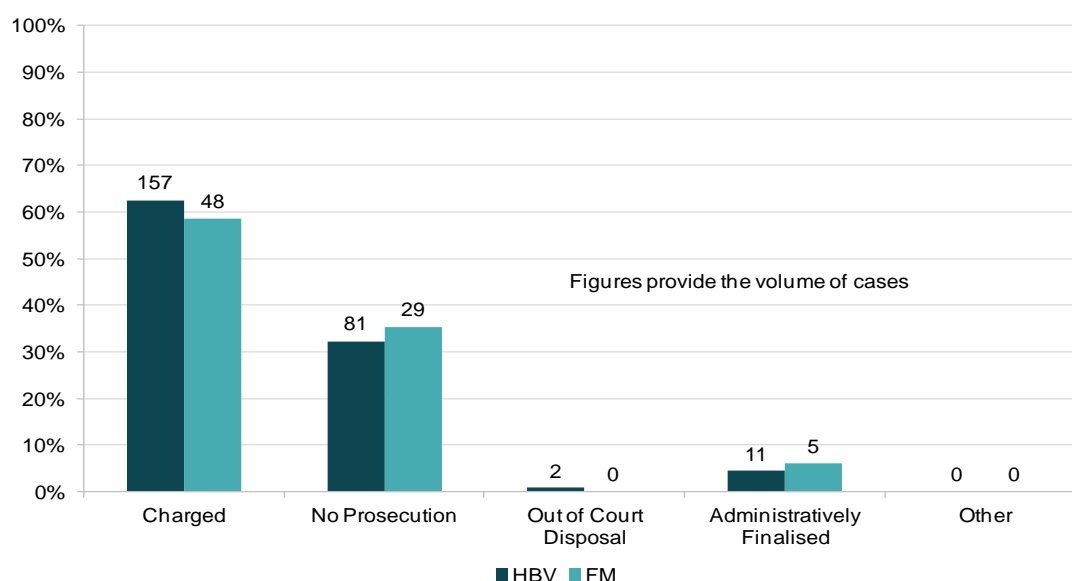
- 3.7. The CPS publishes data on HBV and FM cases<sup>30</sup> each year as part of its annual report (as required by the Violence Against Women and Girls Strategy). Details of FGM cases referred to the CPS by the police for early investigative advice (in accordance with local protocols) are recorded centrally. The accuracy of these records is reliant on manual reporting by the CPS lead prosecutors for FGM.
- 3.8. Since 2012, according to this central record, 15 FGM cases have been referred by the police to the CPS. No further action was taken in respect of 14 of these cases. One case was prosecuted and ended in acquittal. Figures for the number of cases referred to the CPS specifically in 2014/15 are unavailable. Case progress and outcome is also recorded manually.
- 3.9. In 2014/15, the data indicate that there were 251 referrals to the CPS from the police for HBV-related offences.<sup>31</sup> In the same period, there were 82 referrals for FM. Figure 1 below shows the breakdown of action taken as a result of these referrals. For both HBV and FM, the majority resulted in a charge (63 percent and 59 percent respectively). There was no prosecution in around a third of cases for both (see Figure 1 on the next page).
- 3.10. Further, in 2014/15 there were 225 completed prosecutions for HBV, with 129 (57 percent) resulting in a conviction. Over the same period, there were 46 completed prosecutions for FM, with 29 (63 percent) resulting in convictions.
- 3.11. The most common reason for a prosecution not ending in a conviction for HBV-related cases was victim retraction (26 of the 96 times) – that is, where the evidence of the victim supports the prosecution case, but the victim is reluctant to give evidence in court, retracts, or withdraws a complaint. On a further 14 occasions, the victim did not attend court ('victim non-attendance'). In 19 cases, the defendant was found not guilty by the jury after a Crown Court trial. For FM, seven of the 17 cases which did not end in conviction were acquittals after a trial and a further six cases failed because of victim retraction.

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<sup>30</sup> Information on how the CPS identify HBV and FM cases, available from: [www.cps.gov.uk/legal/h\\_to\\_k/forced\\_marriage\\_and\\_honour\\_based\\_violence\\_cases\\_guidance\\_on\\_flagging\\_and\\_identifying\\_cases/index.html](http://www.cps.gov.uk/legal/h_to_k/forced_marriage_and_honour_based_violence_cases_guidance_on_flagging_and_identifying_cases/index.html)

<sup>31</sup> *CPS Violence against Women and Girls Crime Report 2014-2015 data*, Crown Prosecution Service, available from: [www.cps.gov.uk/data/violence\\_against\\_women/vawg\\_2014\\_15\\_report.html](http://www.cps.gov.uk/data/violence_against_women/vawg_2014_15_report.html)

**Figure 1: Breakdown of actions for cases referred to the CPS in England and Wales for HBV and, separately, FM-related offences, 2014/15**



**Source: CPS Violence Against Women and Girls Crime Report**

3.12. The table below shows the full breakdown of prosecution outcomes flagged by the CPS as HBV and FM in 2014/15.

**Figure 2: Breakdown of prosecution outcomes flagged as HBV and FM, 2014/15**

| Outcome                                      | HBV        | FM        |
|--|------------|-----------|
| <b>Prosecutions ending in conviction</b>     | <b>129</b> | <b>29</b> |
| <b>Prosecutions not ending in conviction</b> | <b>96</b>  | <b>17</b> |
| Jury acquittals                              | 19         | 7         |
| Victim retraction <sup>32</sup>              | 26         | 6         |
| Victim evidence does not support the case    | 4          | 1         |
| Victim non-attendance                        | 14         | 1         |
| Conflict of prosecution evidence             | 14         | 1         |
| Essential legal element missing              | 3          | 0         |
| Unreliable witness                           | 1          | 0         |
| Administrative finalisations/Other           | 15         | 1         |

**Source: CPS Violence Against Women and Girls Crime Report**

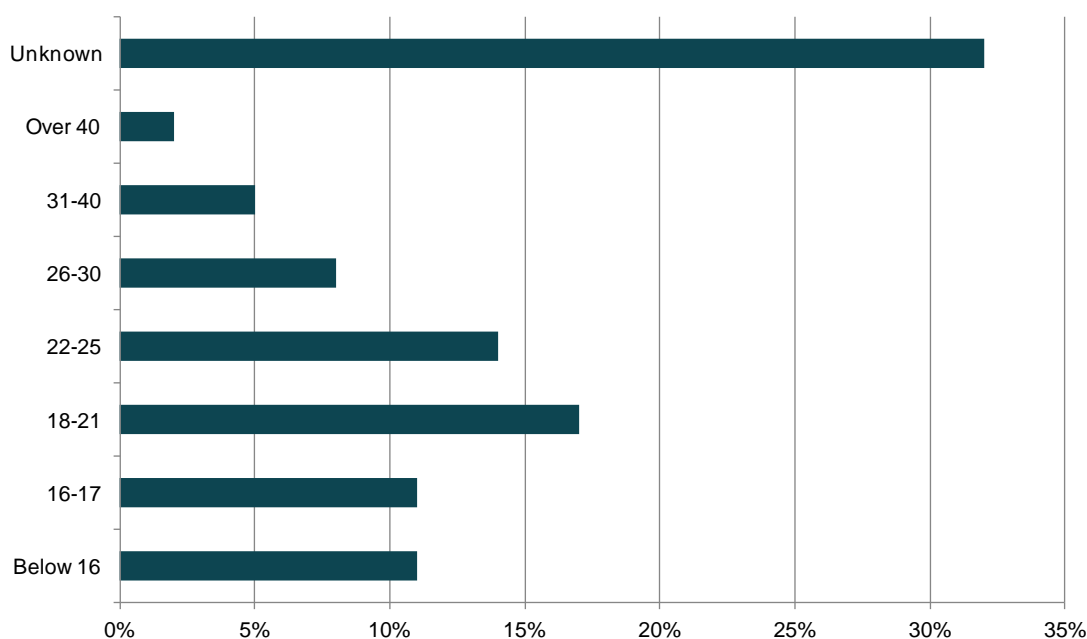
<sup>32</sup> Victim retraction is where the evidence of the victim supports the prosecution case, but the victim is reluctant to give evidence in court, retracts, or withdraws a complaint.

## Forced Marriage Unit (FMU) statistics

3.13. The Forced Marriage Unit (FMU) is a joint Foreign and Commonwealth Office and Home Office unit set up to lead on the government's forced marriage policy, outreach and casework. Each year, the FMU publishes data on the cases of forced marriage where contact has been made with them.

3.14. In 2014, the FMU gave advice or support related to a possible forced marriage in 1,267 cases.<sup>33</sup> The chart below gives details of the victims<sup>34</sup> in these cases.

**Figure 3: Age of victims making contact with the FMU, 2014**



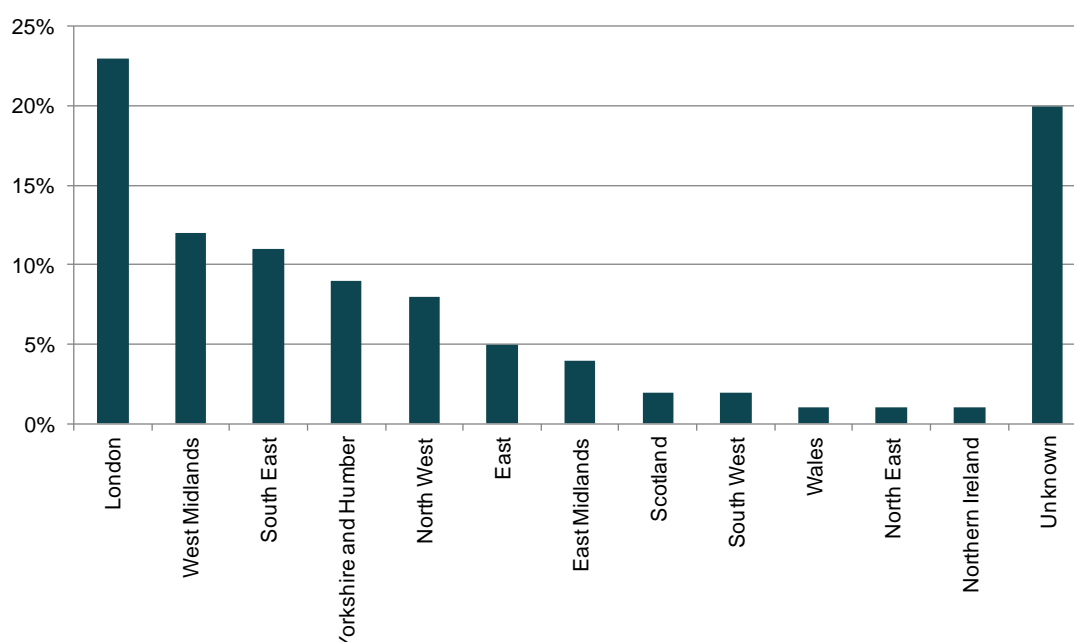
**Source: Forced Marriage Unit statistics**

3.15. Many of those making contact with the FMU have been young adults (nearly a third of contacts were known to be aged between 18 and 25) and around one in every five was known to be under the age of 18. In 32 percent of cases, the age of the victim was unknown.

<sup>33</sup> *Forced Marriage Unit Statistics January to December 2014*, Foreign and Commonwealth Office and Home Office, 2014, available from: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/412667/FMU\\_Stats\\_2014.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/412667/FMU_Stats_2014.pdf)

<sup>34</sup> 'Victim' includes people thought to be at potential risk of future forced marriage, those currently going through a forced marriage and those who have already been forced to marry.

**Figure 4: Location of victims making contact with the FMU, 2014**



**Source: Forced Marriage Unit statistics**

- 3.16. In 20 percent of cases, the location of the victim was not known by the FMU. Where known, however, the location data shows that victims made contact with the FMU from all over the United Kingdom. Nearly one in four was from London.
- 3.17. The gender breakdown of victims is recorded as 79–21 percent female to male. The FMU also collect statistics about the geographical location in which the victim was at risk of forced marriage, or had been taken to so that a forced marriage could take place. Pakistan was the most prevalent destination, at 38 percent.
- 3.18. The most common independent characteristics of the victims supported by the FMU in 2014 were that they were female, young, and at risk of being forced to go to Pakistan.
- 3.19. The data give credence to the assumption that FM is under-reported to the police. Whilst the time periods are different, which limits the comparison, there is evidence of over 1,200 victims of FM seeking support from the FMU in the calendar year 2014, whereas the number of referrals for FM made by the police to the CPS was just over 80 in the financial year 2014/15.

## Forced Marriage Protection Orders (FMPOs)

- 3.20. The Forced Marriage (Civil Protection) Act 2007 came into force on 25 November 2008. The Act amended Part IV of the Family Law Act 1996 to enable 15 designated courts to make Forced Marriage Protection Orders (FMPOs) to prevent forced marriages from occurring and to offer protection to victims who might have already been forced into a marriage. The Anti-social Behaviour, Crime and Policing Act 2014 came into force on 16 June 2014 and made it an offence to force a person to marry against their will, or to breach a FMPO. Further details about the legal protections are set out in Annex D.
- 3.21. The following figure provides the numbers of applications and orders for FMPOs made by family courts:<sup>35</sup>

**Figure 5: The numbers of applications and orders for FMPOs made within the family courts, July 2014 to July 2015**

|                          | Applications | Orders |
|--------------------------|--------------|--------|
| July to September 2014   | 62           | 66     |
| October to December 2014 | 34           | 34     |
| January to March 2015    | 60           | 46     |
| April to June 2015       | 71           | 67     |

Source: Family Court Statistics Quarterly, Ministry of Justice

## The Iranian and Kurdish Women's Rights Organisation (IKWRO)

- 3.22. In 2014, the Iranian and Kurdish Women's Rights Organisation (IKWRO) published its report, Postcode lottery: police recording of reported 'honour' based violence<sup>36</sup> which included responses from police forces to freedom of information requests.

<sup>35</sup> *Family Court Statistics Quarterly*, Ministry of Justice, July 2014 – June 2015. Data provided are a snapshot of court activity within a quarter – there will be a time lag from initial application to an order being made, and not all applications will result in an order. However, the total number of orders made generally exceed the number of applications as FMPOs are sometimes made during the course of applications for other family orders, and there is no differentiation between interim orders and final orders.

<sup>36</sup> *Postcode lottery: police recording of reported 'honour' based violence*, IKWRO, January 2014, <http://ikwro.org.uk/wp-content/uploads/2014/02/HBV-FOI-report-Post-code-lottery-04.02.2014-Final.pdf>

- 3.23. In their report, IKWRO highlighted the gaps in information held by forces, particularly in respect of whether there can be confidence that all HBV incidents and offences are properly recorded (as well as encouraging increased reporting).
- 3.24. The original freedom of information request was made by IKWRO to cover information from 2012; they have subsequently submitted similar requests for 2013 and 2014. This fresh research covered the whole of the United Kingdom (39 of 52 forces<sup>37</sup> gave figures) and showed over 11,000 HBV cases had been recorded over a five-year period (2010 to 2014). Despite these figures, the IKWRO research emphasised that because of the gaps in information held, the scale of the problem remained unknown.

### **Health and Social Care Information Centre (HSCIC) statistics**

- 3.25. The Health and Social Care Information Centre (HSCIC) is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care, and is a non-departmental body sponsored by the Department of Health (DH). It has been collecting data on FGM within England on behalf of the DH and NHS England (NHSE), using the World Health Organization's (WHO) definitions for the four types<sup>38</sup> of FGM. The FGM enhanced dataset began on 1 April 2015, and builds upon the previous FGM prevalence dataset, which ended on 10 April 2015.
- 3.26. The HSCIC published experimental monthly data on FGM from September 2014 to March 2015.<sup>39</sup> The data was gathered from acute hospital providers in England and provided an aggregated return of the incidence of FGM including women who have been previously identified and are being treated (either for

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<sup>37</sup> HMIC's inspection only focused on the 43 Home Office forces of England and Wales.

<sup>38</sup> Female genital mutilation is classified into four major types by The World Health Organization [www.who.int/mediacentre/factsheets/fs241/en/](http://www.who.int/mediacentre/factsheets/fs241/en/)

- 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).
- 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).
- 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.
- Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

<sup>39</sup> *Female genital mutilation experimental statistics*, March 2015, [www.hscic.gov.uk/catalogue/PUB17463/fgm-mar-2015-exp-rep.pdf](http://www.hscic.gov.uk/catalogue/PUB17463/fgm-mar-2015-exp-rep.pdf)

conditions related to FGM, or for other reasons) and newly identified women within the reporting period.

- 3.27. Over the course of this collection, the participating providers reported 3,963 newly identified cases of FGM (almost all in women aged 18 and over). In March 2015, there were 3,164 active cases reported nationally.
- 3.28. In the first enhanced dataset publication, reported on a quarterly basis, there were 1,036 newly recorded cases of FGM reported during April–June 2015,<sup>40</sup> including girls and women identified as having FGM and those having treatment for their FGM. The second publication showed that, between July and September 2015, there were 1,385 new cases.<sup>41</sup> These individuals may have been previously identified by the health provider as having FGM and may have been included in the previous FGM prevalence dataset mentioned above.

### **City University London research**

- 3.29. In July 2015, City University London published a report entitled *The Prevalence of Female Genital Mutilation in England and Wales: National and Local Estimates*.<sup>42</sup>
- 3.30. The report states that the overall number of women aged 15-49 who were permanently resident in England and Wales, but born in FGM-practising countries, increased from 182,000 in 2001 to 283,000 in 2011.
- 3.31. The report estimates that in 2011 there were 137,000 women and girls (across all age ranges) with FGM, born in countries where it is practised, permanently resident in England and Wales. The estimated rates per 1,000 population varied considerably by region (from 21.0 per 1,000 in London to below one per 1,000 in some rural areas).
- 3.32. The report estimates that, in 2011, approximately 60,000 girls aged 0-14 were born in England and Wales to mothers with FGM.

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<sup>40</sup> *Female Genital Mutilation (FGM) Enhanced Dataset*, HSCIC, April to June 2015, [www.hscic.gov.uk/catalogue/PUB18533/fgm-apr-2015-jun-2015-exp-rep.pdf](http://www.hscic.gov.uk/catalogue/PUB18533/fgm-apr-2015-jun-2015-exp-rep.pdf)

<sup>41</sup> *Female Genital Mutilation (FGM) Enhanced Dataset*, HSCIC, July to September 2015, [www.hscic.gov.uk/catalogue/PUB19113/fgm-jul-2015-sep-2015-exp-rep.pdf](http://www.hscic.gov.uk/catalogue/PUB19113/fgm-jul-2015-sep-2015-exp-rep.pdf)

<sup>42</sup> *The Prevalence of Female Genital Mutilation in England and Wales: National and Local Estimates*, City University London, July 2015 [www.city.ac.uk/\\_data/assets/pdf\\_file/0004/282388/FGM-statistics-final-report-21-07-15-released-text.pdf](http://www.city.ac.uk/_data/assets/pdf_file/0004/282388/FGM-statistics-final-report-21-07-15-released-text.pdf)



## Unpublished data

- 3.33. As well as considering the available published statistics, we also contacted several charities to ask what data they collected.
- 3.34. Adult Helpline<sup>43</sup> received a total of 558 contacts (from 24 June 2013 to 31 January 2015) in relation to FGM. These included people making enquiries, people seeking advice and referrals being made to the charity.
- 3.35. In contrast, the total number of counselling sessions which ChildLine (a confidential advice service for children and young adults) carried out in relation to FGM was much lower; they carried out 62 counselling sessions between April 2013 and March 2015.
- 3.36. Karma Nirvana, a specialist voluntary sector organisation supporting victims of honour-based crimes and forced marriages, received over 8,000 calls in 2014. The majority of these were from professionals and individual victims.

## Conclusion

- 3.37. Overall, the published data provide only a limited picture of the levels of HBV, FM and FGM in England and Wales. The more robust data (in the public domain) come from those cases that have progressed the furthest through the criminal justice system. The CPS publishes a dataset dealing with those cases of HBV and FM that make it to court; there are also data on referrals made to the CPS from the police. These necessarily only give a partial indication of the levels of HBV crimes.
- 3.38. While there is more information published on the scale of FGM, data on FM and HBV more widely are limited, and the statistics are reliant on cases reported to different organisations. We recognise, however, that even if more data were to be collected, categorised and published, they would still not provide a complete picture of the scale and nature of HBV in England and Wales, as these crimes are often unreported. All the research we and our ERG have seen indicates that the levels of HBV are significantly higher than the limited published data suggests. This is a common problem with data recording; only reported and recorded incidents and crimes can be collated and published. Ensuring the proper recording of all HBV incidents and crimes which are reported is essential to helping establish the scale of HBV.

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<sup>43</sup> The Adult Helpline is a free NSPCC helpline where people can speak directly to an NSPCC counsellor. The Helpline provides support for adults who are worried about a child, advice for parents and carers, consultations with professionals who come into contact with abused children or children at risk of abuse, and information about child protection and the NSPCC.

## 4. Legal and policy framework for preventing and tackling HBV

- 4.1. Honour-based violence (HBV) refers to all coercive or violent actions committed to protect the social standing of a family unit, normally in accordance with particular religious or cultural beliefs.
- 4.2. Because it is often hidden, occurring within family units or closed social contexts, and because its impact can be devastating, police forces and other agencies need to be highly aware of the risks and indicators associated with HBV to make sure they are responding properly to protect victims and prevent crimes. At all stages, that will require collaboration and close working relationships between different public agencies (particularly between health, social care and education professionals and police forces). The obligations set out in this chapter apply equally throughout England and Wales.

### The law on HBV

- 4.3. Many crimes are capable of amounting to HBV depending on the context in which they occur. For example, any of the following crimes might amount to HBV:
- murder or manslaughter;
  - violent crimes (such as grievous bodily harm, common assault, etc.);
  - false imprisonment; and
  - sex crimes (such as rape or sexual assault).
- 4.4. There are also some specific crimes that normally amount to HBV, for example:
- female genital mutilation (contrary to the Female Genital Mutilation Act 2003, as amended by the Serious Crime Act 2015); and
  - forced marriage (contrary to section 121 of the Anti-social Behaviour, Crime and Policing Act 2014) (although there may be some cases in which a forced marriage does not amount to HBV).<sup>44</sup>

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<sup>44</sup> Cases in which a forced marriage does not amount to HBV is a simple reference to those cases in which marriage is coerced without the use or threat of force or violence; or where marriage is coerced for financial or other reasons that do not involve an honour-based motive.

- 4.5. Police forces are under a continuing general duty to prevent, detect, and investigate all of these crimes when a report is made or there is reason to believe they have been or will be committed. All public authorities also operate under the overarching human rights obligations set out in the next section of this chapter, to protect those rights from violation by criminal actions.
- 4.6. In relation to both FM and FGM, police officers may need to seek a protection order (either a Forced Marriage Protection Order (FMPO); or a Female Genital Mutilation Protection Order (FGMPO)) to protect individuals identified as being at risk of either form of HBV. Police officers can apply to the courts for an order to be made, setting out any terms that the court considers appropriate for ensuring the required protection. For example, the first FGMPO (obtained by Bedfordshire authorities in July 2015) provided for the seizure of the travel documents of two girls whose family were suspected of making arrangements to take them abroad for FGM.
- 4.7. FGM amounts to “significant harm” that meets the threshold required by the Children Act 1989 for intervention in family life in the best interests of children and young people. Where there is reasonable cause to believe that a young person is at risk of significant harm, a police officer may remove the child from the parent and put them in police protection for up to 72 hours (under section 46 of the Children Act 1989). Co-operation with other agencies, in particular children’s social care, will be crucial in such circumstances for the proper protection of a child at risk of FGM.
- 4.8. Police forces should expect to receive increased reports of FGM following section 74 of the Serious Crime Act 2015 coming in to force on 31 October 2015. This provision imposes a legal duty on healthcare professionals,<sup>45</sup> social care<sup>46</sup> workers and teachers<sup>47</sup> to notify police if they discover that an

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<sup>45</sup> Section 5B(11) of the Female Genital Mutilation Act 2003, inserted by section 74, defines a “healthcare professional” as a person registered with any of the regulatory bodies mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002 (bodies within remit of the Professional Standards Authority for Health and Social Care). Read with section 5B(12) of the Female Genital Mutilation Act 2003 (which disapplies certain parts of section 25 of the National Health Service Reform and Health Care Professions Act 2002), this definition has the effect of applying to all regulated medical, pharmaceutical and social care professionals in England and Wales.

<sup>46</sup> Section 5B(11) of the Female Genital Mutilation Act 2003, inserted by section 74, defines a “social care worker” as a person registered in a register maintained by the Care Council for Wales under section 56 of the Care Standards Act 2000. (Social care workers in England are caught by the definition of “healthcare professional”, set out in the preceding footnote.)

<sup>47</sup> Section 5B(11) of the FGM Act 2003, inserted by section 74 of the Serious Crime Act 2015, provides the definition for the term ‘teacher’: “teacher” means – (a) in relation to England, a person within section 141A(1) of the Education Act 2002 (persons employed or engaged to carry out teaching work at schools and other institutions in England); (b) in relation to Wales, a person who falls within a

act of FGM appears to have been carried out on a girl under the age of 18 years. In order to ensure that FGM crimes are properly investigated and prosecuted, it is part of the legal duty on forces to ensure that police officers are trained in how to respond to these reports in a way that is sensitive, effective, and that has child protection as its paramount aim.

## **The obligations of public authorities**

### **Human rights obligations**

- 4.9. Public authorities must take all necessary steps to ensure that the fundamental human rights of everyone with whom they have contact are protected. For police forces, the obligation extends to the human rights of everyone within their area, or about whom they have clear information. HBV can have an impact on the following fundamental rights:
- the right to life;
  - the right not to be tortured, or treated in an inhuman or degrading way;
  - the right not to be enslaved or forced to work;
  - the right to liberty and security of person;
  - the right to a private and family life;
  - the right not to be discriminated against; and
  - the right to marry a person of your choosing.
- 4.10. Public authorities must take appropriate steps to ensure that no-one takes actions that breach those rights, and if they are breached, that there is a proper investigation and prosecution of the perpetrator. For instance, FGM is an act which breaches the right not to be tortured or treated in an inhuman or degrading way. Where a public authority knows that someone is at risk of FGM, it must take all reasonable steps to safeguard that person against FGM, so that their right not to be treated inhumanely is not violated. If a public authority becomes aware that someone has been the victim of FGM, it must take all reasonable steps to investigate who was responsible and bring them to justice.

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category listed in the table in paragraph 1 of Schedule 2 to the Education (Wales) Act 2014 (categories of registration for purposes of Part 2 of that Act) or any other person employed or engaged as a teacher at a school (within the meaning of the Education Act 1996) in Wales”.

- 4.11. It is not only physical harm that can violate fundamental human rights. Serious psychological harm can also amount to torture or inhuman or degrading treatment. Thus, someone being forced to marry against their will, or being prevented from living in a manner of their choosing, can also breach the right not to be subjected to inhuman or degrading treatment if the psychological effect on the victim is sufficiently severe. Of course, in those circumstances other fundamental rights (such as the right to marry freely, and the right to a private and family life) may also be breached.
- 4.12. The principal obligations of the police to protect fundamental human rights are to:
- take all reasonable measures to protect any person who it is known is at risk of serious physical harm;
  - take steps to deter threats, including by properly punishing past acts of violence and taking preventive steps to interrupt future violence;
  - have in place policies and training that ensure, to the greatest extent reasonably practicable, the protection of the life, limb and physical and psychological integrity of persons who are at risk of ill-treatment;
  - investigate fully any breaches of the above obligations, either by the police force itself or by a third party; and
  - allocate adequate resources and appropriate systems of management to ensure the effective protection of rights.
- 4.13. Many of these obligations will also apply to other public authorities who come into contact with people affected by HBV. A collaborative approach between health, social care and education bodies and the police is necessary to ensure that fundamental rights are protected in an effective manner.

### **Other overarching obligations**

- 4.14. Although men and boys are sometimes victims of honour-based violence, it tends to be committed against women and, when it is, it is a category of violence against women and girls. Public authorities must prioritise the prevention of violence against women and girls and domestic violence in line with their obligations to reduce discrimination and promote equality. This reinforces the obligation to allocate sufficient resources to tackling HBV and to be sure that police officers and other public servants are properly trained to identify, prevent and respond to situations of HBV. A multi-agency approach to violence against women and girls (including HBV against women and girls) is likely to be the most effective way of ensuring legal obligations are met and the public is protected.

- 4.15. There is a general obligation on police forces to take all steps that appear to the police to be necessary for keeping the peace and preventing crime. That gives rise to a duty to respond to reports of HBV, or the risk of HBV (as with other crimes), in a timely and appropriate manner. The fact that HBV normally occurs within families or other close social networks makes the obligation to respond in a timely fashion even more important since there may be an ongoing risk to the victim.
- 4.16. Because of that context, people who report HBV may also be at heightened risk. It may therefore be necessary for the police to put in place protective measures to ensure the safety of persons involved in investigations or proceedings. It is the legal duty of police officers to consider carefully whether protection arrangements are warranted any time an allegation of HBV is made, in order to prevent further harm to a victim.
- 4.17. Victims of HBV who are younger than 18 years of age, are owed a specific duty by public authorities to safeguard and promote their welfare. The statutory guidance to the Children Act 2004 states that police are responsible for:
- identifying vulnerable children;
  - taking children into protective custody where necessary;
  - protecting the lives of children; and
  - ensuring the welfare of the child is paramount.
- 4.18. All police officers – not just those working in specialist child-focused units – should be trained in how to identify a young person at risk of HBV. They should also receive training that underlines the importance of prioritising the identification and protection of vulnerable children, and that makes clear the tools at their disposal for doing so (for example, taking children into protective custody or applying for a FGMPO). Every police force should have clear procedures in place for police officers to report concerns about children who might be at risk of HBV or other harm. All of these measures are aspects of the legal duty on the police service to ensure the welfare of the child.

## Statutory guidance and policy on HBV

4.19. The government has published several important pieces of guidance that should inform the way that public authorities prevent and respond to HBV. These include:

- multi-agency statutory guidance on dealing with forced marriage;<sup>48</sup>
- multi-agency practice guidelines on FGM;<sup>49</sup>
- the Department for Health's Female Genital Mutilation Risk and Safeguarding Guidance for Professionals;<sup>50</sup> and
- statutory guidance on working together to safeguard children.<sup>51</sup>

4.20. Those documents provide practical advice and guidance to public bodies on the actions they are required to take in situations of FM, FGM, or where a child is at risk. All public servants – in education, health, social care and the police – are under a legal obligation to have regard to this guidance.

4.21. The guidance emphasises the need for policies and procedures that promote and regulate collaboration between public bodies dealing with FM, FGM, and safeguarding children and vulnerable adults. That should include procedures for appropriate information sharing and referrals to different agencies to ensure the effective handling of cases. Working together across agencies is essential to safeguarding individuals.

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<sup>48</sup> *The Right to Choose: Multi-Agency Statutory Guidance for Dealing with Forced Marriage*, UK Government, June 2014. Available from: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/322310/HMG\\_Statutory\\_Guidance\\_publication\\_180614\\_Final.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322310/HMG_Statutory_Guidance_publication_180614_Final.pdf)

<sup>49</sup> *Multi-Agency Practice Guidelines, Female Genital Mutilation*, UK Government, 2014. [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf)

<sup>50</sup> *Female Genital Mutilation Risk and Safeguarding: Guidance for Professionals*, Department of Health, March 2015. Available from: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/418564/2903800\\_DH\\_FGM\\_Accessible\\_v0.1.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf)

<sup>51</sup> *Working Together to Safeguard Children: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children*, UK Government, March 2015. Available from: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/419595/Working\\_Together\\_to\\_Safeguard\\_Children.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf)

4.22. Some principal obligations set out in the guidance include:

- police officers must investigate HBV robustly and must not let a fear of being branded culturally insensitive affect any decision about the actions to be taken;
- where public bodies become aware of an incident of HBV, all agencies should recognise the risk to other children or family members in that environment. The police and social care agencies must consider whether protection arrangements are required for anyone in that situation (and not just the person identified as the victim of HBV);
- where a child or vulnerable adult presents with signs of FGM, or gives a professional reason to suspect they have been subject to FGM, they must be referred to the appropriate safeguarding board;
- section 74 of the Serious Crime Act 2015 came in to force on 31 October 2015. If a health or education professional becomes aware that a girl under the age of 18 years has undergone FGM, this provision requires that they must report it to the police;
- health professionals must record FGM in a patient's health record if it is established that they have been subject to FGM; and
- public bodies must keep accurate records of risks identified and safeguarding action taken, and must share that information if necessary with other agencies.

4.23. Other significant obligations are contained in the College of Policing's recent Authorised Professional Practice (APP) guidance on FGM.<sup>52</sup>

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<sup>52</sup> *Female genital mutilation Authorised Professional Practice*, College of Policing, 2015. Available from: [www.app.college.police.uk/app-content/major-investigation-and-public-protection/female-genital-mutilation](http://www.app.college.police.uk/app-content/major-investigation-and-public-protection/female-genital-mutilation)



## **5. The police role in preventing and responding to HBV**

### **General obligation to keep the peace and prevent crime**

- 5.1. As set out in Chapter 4, police forces are under a continuing general duty to prevent, detect, and investigate all crimes when a report is made or there is reason to believe a crime has been or will be committed. All public authorities also operate under the overarching human rights obligations set out in Chapter 4, to protect fundamental human rights from violation by criminal actions.
- 5.2. The main roles for the police in responding to HBV are identifying, supporting and protecting those at risk of crime, investigating allegations of criminal offences, managing those who pose a risk to victims and preventing future criminality.
- 5.3. People who report HBV may be at heightened risk because of the aggravating nature of the 'honour' context, such as collusion within extended families/community networks and the possibility of multiple perpetrators. It may therefore be necessary for the police to put in place protective measures to ensure the safety of those involved in investigations or proceedings.

### **Identifying young people at risk of HBV**

- 5.4. As set out in Chapter 4, it is the legal duty of the police service to ensure that all police officers and staff – not just those working for specialist child-focused units – should be trained in how to identify a young person at risk of HBV.<sup>53</sup> They should also receive training that explains the importance of prioritising the identification and protection of vulnerable children, and that makes clear the tools at their disposal for doing so (for example, taking children into protective custody or applying for a FGMPO). Every police force should have clear procedures in place for police officers to report concerns about children who might be at risk of HBV or other harm.

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<sup>53</sup> Set out in the statutory guidance to the Children Act 2004, described in Chapter 4 and in Appendix D.

## **Powers available to the police**

- 5.5. In relation to both FM and FGM, police officers may need to seek a protection order (either an FMPO or an FGMPO), or any other protective measures as appropriate (such as court restraining orders), to protect individuals identified as being at risk of either form of HBV.

## **Challenges for policing this type of offending**

- 5.6. The expectations that victims and the public have of police forces when dealing with HBV are no different to those they have for any other incident or crime. Victims expect to be treated with respect, listened to and protected by police powers when this is necessary.
- 5.7. However, the research and reports on HBV which we have referred to in Chapters 1 and 3 have highlighted the factors that may inhibit victims from approaching the police. A lack of knowledge about United Kingdom laws and criminal justice systems can further heighten such concerns.
- 5.8. The ability to use police powers effectively to protect HBV victims requires recognition of the risk factors applicable to those victims, some of which may be contrary to approaches developed in domestic abuse cases. For example, mediation practices that might be used in domestic abuse cases between the victim and apparent perpetrator could raise the level of risk to victims in HBV cases, not least because there may be perpetrators in the extended family and community who are colluding with the abuse.

## **What works?**

- 5.9. In the context of such complex challenges, it is important to identify the starting point, both for effective policing and for inspection. As yet, there is no strong, published evidence on what works in policing to prevent harm to and protect victims. The current national policing strategy on HBV<sup>54</sup> identifies the use of community engagement and community driven solutions in preventing harmful practices.<sup>55</sup>
- 5.10. The knowledge that these incidents and crimes are recognised to be under-reported should caution forces and other public services against concluding that 'it doesn't happen here'. Published data referred to in Chapter 3 of this report shows that victims of FM have made contact with the Foreign and

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<sup>54</sup> Honour-Based Violence Strategy, ACPO, 2008.

<sup>55</sup> A revised national policing strategy on HBV for 2015–2018 was in draft at the time of writing this report and expected to be published in late 2015.

Commonwealth Office's Forced Marriage Unit (FMU) from every part of the United Kingdom. The distribution is concentrated in, but by no means limited to, the larger urban areas. Notably, in 20 percent of cases, the location of the victim was unknown by FMU. In the context of the information available it is reasonable to assume that every police force in England and Wales has victims of HBV within its population and must be prepared to respond and able to protect the public.

- 5.11. A police force's understanding of the characteristics of the population it serves is critical to its ability to deal effectively with HBV. FGM most frequently occurs between six and eight years of age and FM between 16 and 25 years. Prevention activities undertaken by healthcare or education professionals are most likely to be effective in those age categories. The police can contribute to prevention programmes, including the provision of intelligence about changing patterns of risk, as well as providing information about the police's role in investigation and enforcement.
- 5.12. We expected to find evidence that forces had used a variety of approaches to gathering and using information on the potential nature and scale of HBV, FM and FGM in their areas. These approaches might include working with community groups to raise awareness of the unacceptable and unlawful nature of HBV; providing information on the police role; gathering intelligence through community networks and using local or national population data to estimate the potential scale of the problem in a force area. In this way, forces would be able to develop a 'problem profile' providing an analysis of the level of threat of these incidents and crimes in an area, together with identifying potential and actual victims' needs from the police service.

## 6. Police preparedness to protect people from HBV – Phase 1 – desk-top assessment

- 6.1. In Phase 1 of the HBV<sup>56</sup> inspection, all 43 police forces in England and Wales completed a self-assessment which was designed to answer the question “How prepared is the force for protecting people from harm caused by HBV, and supporting victims?”. In addition, we completed a review of relevant documents and data provided by forces, and an analysis of information available to the public through force and police and crime commissioner websites.
- 6.2. It is important to note that the evidence provided by forces in Phase 1 has not been subject to further validation and has not been crosschecked through interviews, focus groups or reality testing (unannounced visits to police stations) by HMIC. It was a trust-based exercise, asking forces to provide information in response to a series of questions, and adding to that information with a review of documents, data and websites.
- 6.3. This was used to produce a ‘narrative summary’ for each force. These summaries were returned to forces to assist them in developing their approach to identifying and tackling HBV.
- 6.4. A desk-based review based principally on self-assessment is not an approach commonly used in our inspections; it was designed because we recognised, on the advice of our expert reference group, that HBV is an emerging area of activity for many police forces and other public services. It is an area of policing which is still relatively undefined in terms of national guidance on practice, or on approaches to data collection.
- 6.5. In this context we expected that forces would be responding to HBV and collecting related data in different ways. This proved to be the case, and forces’ data was not always comparable or available over the same time periods. For that reason, analysis of the data provided to us was not possible in many instances. We invited forces to provide supplementary information. Our analysts interpreted this additional information using their professional judgment. For this reason, in the findings that follow, specific values have been provided where they are believed to provide a reliable indicator. Where it would be misleading to do so an approximate scale is provided through the use of words broadly indicative of quantity, such as ‘most’, ‘a few’, ‘the majority’.

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<sup>56</sup> As previously detailed in this report, HBV is used as an overarching inspection title. The inspection includes honour-based violence (HBV), forced marriage (FM) and female genital mutilation (FGM) which are dealt with separately where appropriate.

- 6.6. This phase of the inspection was designed to provide a point of comparison, or baseline, to inform activity in both police forces and inspection in future years. Future inspections of police activity in response to the risks associated with HBV will be incorporated into HMIC's all-force inspection programme, PEEL.<sup>57</sup>
- 6.7. This chapter summarises our analysis of the information provided by forces through data, documents and the self-assessment process: Phase 1.

## **Police 'preparedness' for responding to HBV**

- 6.8. The findings from this phase of the inspection are presented under the following headings, reflecting the design of the inspection:
- leadership;
  - awareness and understanding;
  - protection; and
  - enforcement and prevention.<sup>58</sup>
- 6.9. Within this report a force is described as being prepared overall for protecting people from harm caused by HBV if it was assessed by us as prepared in all of the above four areas. In all other instances a force was described as 'not yet prepared'.<sup>59</sup>
- 6.10. We recognise that some forces may be more prepared in their response to one or more of the individual elements of HBV: HBV, FM and FGM. It was not possible to determine how far this was the case from the information requested in Phase 1 of the inspection, but this distinction is explored further in the findings from the Phase 2 fieldwork in forces, set out in Chapters 7 to 10.
- 6.11. Figure 6 summarises our findings on preparedness from Phase 1 of the inspection.

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<sup>57</sup> PEEL stands for Police Effectiveness, Efficiency and Legitimacy. It provides an inspection structure covering every aspect of police force performance.

<sup>58</sup> For more details, see the full methodology in Annex B.

<sup>59</sup> To describe a force as prepared in respect of any of the areas, we looked for positive evidence against 75 percent or more of the questions asked in that area.

**Figure 6: Assessment of forces' preparedness for protecting people from harm from HBV – against each of the inspected areas**

| Force              | Inspection area  |                             |                  |                            |                  |
|--------------------|------------------|-----------------------------|------------------|----------------------------|------------------|
|                    | Leadership       | Awareness and understanding | Protection       | Enforcement and prevention | Overall          |
| Avon and Somerset  | Prepared         | Prepared                    | Not yet prepared | Not yet prepared           | Not yet prepared |
| Bedfordshire       | Not yet prepared | Not yet prepared            | Prepared         | Not yet prepared           | Not yet prepared |
| Cambridgeshire     | Not yet prepared | Prepared                    | Not yet prepared | Not yet prepared           | Not yet prepared |
| Cheshire           | Not yet prepared | Not yet prepared            | Prepared         | Prepared                   | Not yet prepared |
| City of London     | Prepared         | Prepared                    | Not yet prepared | Not yet prepared           | Not yet prepared |
| Cleveland          | Prepared         | Not yet prepared            | Prepared         | Not yet prepared           | Not yet prepared |
| Cumbria            | Not yet prepared | Prepared                    | Not yet prepared | Not yet prepared           | Not yet prepared |
| Derbyshire         | Prepared         | Prepared                    | Prepared         | Prepared                   | Prepared         |
| Devon and Cornwall | Not yet prepared | Not yet prepared            | Prepared         | Not yet prepared           | Not yet prepared |
| Dorset             | Prepared         | Prepared                    | Prepared         | Not yet prepared           | Not yet prepared |
| Durham             | Prepared         | Prepared                    | Prepared         | Not yet prepared           | Not yet prepared |
| Dyfed Powys        | Not yet prepared | Not yet prepared            | Not yet prepared | Not yet prepared           | Not yet prepared |
| Essex              | Not yet prepared | Prepared                    | Prepared         | Not yet prepared           | Not yet prepared |
| Gloucestershire    | Prepared         | Prepared                    | Not yet prepared | Not yet prepared           | Not yet prepared |
| Greater Manchester | Prepared         | Prepared                    | Not yet prepared | Not yet prepared           | Not yet prepared |
| Gwent              | Prepared         | Prepared                    | Not yet prepared | Not yet prepared           | Not yet prepared |
| Hampshire          | Prepared         | Not yet prepared            | Prepared         | Not yet prepared           | Not yet prepared |
| Hertfordshire      | Prepared         | Prepared                    | Not yet prepared | Not yet prepared           | Not yet prepared |
| Humberside         | Not yet prepared | Not yet prepared            | Prepared         | Not yet prepared           | Not yet prepared |
| Kent               | Prepared         | Prepared                    | Not yet prepared | Not yet prepared           | Not yet prepared |
| Lancashire         | Prepared         | Prepared                    | Prepared         | Not yet prepared           | Not yet prepared |
| Leicestershire     | Prepared         | Not yet prepared            | Not yet prepared | Not yet prepared           | Not yet prepared |
| Lincolnshire       | Prepared         | Prepared                    | Not yet prepared | Not yet prepared           | Not yet prepared |
| Merseyside         | Prepared         | Prepared                    | Prepared         | Not yet prepared           | Not yet prepared |
| Metropolitan       | Prepared         | Prepared                    | Prepared         | Not yet prepared           | Not yet prepared |
| Norfolk            | Prepared         | Prepared                    | Prepared         | Not yet prepared           | Not yet prepared |
| North Wales        | Not yet prepared | Prepared                    | Prepared         | Not yet prepared           | Not yet prepared |
| North Yorkshire    | Not yet prepared | Prepared                    | Prepared         | Not yet prepared           | Not yet prepared |
| Northamptonshire   | Not yet prepared | Prepared                    | Prepared         | Not yet prepared           | Not yet prepared |
| Northumbria        | Prepared         | Prepared                    | Prepared         | Prepared                   | Prepared         |
| Nottinghamshire    | Prepared         | Prepared                    | Prepared         | Not yet prepared           | Not yet prepared |
| South Wales        | Not yet prepared | Prepared                    | Prepared         | Not yet prepared           | Not yet prepared |
| South Yorkshire    | Prepared         | Prepared                    | Prepared         | Not yet prepared           | Not yet prepared |
| Staffordshire      | Not yet prepared | Not yet prepared            | Not yet prepared | Not yet prepared           | Not yet prepared |
| Suffolk            | Not yet prepared | Not yet prepared            | Prepared         | Not yet prepared           | Not yet prepared |
| Surrey             | Prepared         | Prepared                    | Prepared         | Not yet prepared           | Not yet prepared |
| Sussex             | Prepared         | Prepared                    | Not yet prepared | Not yet prepared           | Not yet prepared |
| Thames Valley      | Not yet prepared | Not yet prepared            | Not yet prepared | Not yet prepared           | Not yet prepared |
| Warwickshire       | Prepared         | Prepared                    | Not yet prepared | Not yet prepared           | Not yet prepared |
| West Mercia        | Prepared         | Prepared                    | Not yet prepared | Not yet prepared           | Not yet prepared |
| West Midlands      | Prepared         | Prepared                    | Prepared         | Prepared                   | Prepared         |
| West Yorkshire     | Prepared         | Prepared                    | Prepared         | Not yet prepared           | Not yet prepared |
| Wiltshire          | Prepared         | Not yet prepared            | Not yet prepared | Not yet prepared           | Not yet prepared |

**Source: HMIC assessment of forces' own self-assessment**

## Challenges and inhibitors

- 6.12. The final section of the self-assessment offered forces an opportunity to identify challenges or inhibitors that they faced in relation to HBV, FM and FGM at local, regional and national/international levels. A summary of the information collected is provided in each of the sections below. Overall, the majority of force responses were based around challenges with leadership and awareness or understanding of HBV, FM and FGM. Notably fewer issues were raised against the other areas of the inspection, namely protection, enforcement and prevention.
- 6.13. An emerging theme across the 42 forces<sup>60</sup> which responded related to concerns about national leadership, in particular the need for updated national guidance and nationally recognised training on HBV, and a lack of information-sharing or protocols to support working together with other organisations.
- 6.14. Some of the challenges raised related to the complexities associated with the police response to HBV (as set out in Chapter 2). Such observations included, for example, the difficulty experienced by the police in relation to achieving confidence and co-operation from victims when victims are being asked to give evidence against parents or other family members.
- 6.15. Individual points were made by some forces suggesting that a lack of trust in all agencies by victims, combined with a lack of confidence on the part of professionals in raising issues around HBV and FM (for fear that they will be perceived as lacking cultural awareness), leads to under reporting. This, in turn, results in a lack of data, which may mean that HBV is not afforded due priority and that the assessment of specific intelligence about victims and perpetrators is limited. This point was explored further in our Phase 2 force inspections and our victim engagement project.

## Leadership

- 6.16. Twenty-eight out of the 43 forces were assessed as having prepared their leadership and governance structures to support their ability to identify and respond to cases of HBV.

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<sup>60</sup> Forty-two out of 43 police forces provided a response in relation to the challenges or inhibitors that they faced in respect of HBV, FM and FGM.

- 6.17. Forces provided HMIC with their definitions of HBV, FM and FGM. The great majority of forces followed the 2008 ACPO<sup>61</sup> definition for HBV,<sup>62</sup> some with limited small variations or additions. The definitions given for FM differed more than for HBV, with forces variously using their own definition, or variations of that provided by ACPO, or the definition given in the 2014 *Multi-Agency Statutory Guidance for Dealing with Forced Marriage*. For FGM, the majority of forces used the World Health Organization's definition,<sup>63</sup> or an adaptation of it.
- 6.18. Nine of the 43 forces told us they mainly had one or two individuals solely dedicated to HBV, FM or FGM. Others said they had trained staff working within larger teams responsible for broader areas such as domestic abuse or child protection.
- 6.19. Policies and procedural guidance for staff varied considerably across forces in the extent to which they reflected comprehensive coverage of all aspects of HBV, with corresponding clarity of roles and responsibilities. In a few forces, the guidance included a flow diagram and checklists to direct the process for responding to HBV from the first call to police through to attending the incident (where appropriate) and investigation.
- 6.20. All forces provided us with details of other agencies with whom they work, such as charities, non-governmental organisations and academic institutions. Most collaborative relationships were focused on referrals for victims, the provision of training and advice to officers and staff, and supporting the relocation or safeguarding of victims. Other relationships were described as supporting information sharing, the enforcement of FMPOs and community engagement.

## **Challenges and inhibitors**

- 6.21. The challenges or inhibitors most frequently identified by forces, in terms of leadership, were a lack of guidance on information-sharing from and between external partner agencies such as health, social care and education (12 forces); meeting the demands of ongoing training for officers (11 forces); and a requirement for updated national guidance to assist in identifying and responding to cases of HBV, FM and FGM (nine forces).

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<sup>61</sup> The Association of Chief Police Officers (ACPO) was replaced by the National Police Chiefs' Council in April 2015.

<sup>62</sup> The ACPO definition of HBV is "a crime or incident which has or may have been committed to protect or defend the honour of the family and/or community" *Honour-Based Violence Strategy*, ACPO, 2008.

<sup>63</sup> As set out in Chapter 2.



- 6.22. Other reported challenges included: resource constraints (including financial constraints) in the police service and partners, particularly as these affect the size of specialist teams; difficulties in accessing relevant data from their current systems; a need for a common referral mechanism of cases from other agencies to the police; a lack of understanding of multi-agency processes and guidance; and a perception that HBV, FM and FGM are not seen as a priority business area by some forces.

## **Awareness and understanding**

- 6.23. Thirty-one out of the 43 forces were assessed as prepared in respect of their awareness and understanding of HBV, both in terms of ensuring that victims are identified and that officers and staff recognise, understand and identify victims from the first point of contact.

### **Identifying victims, incidents, crimes and outcomes**

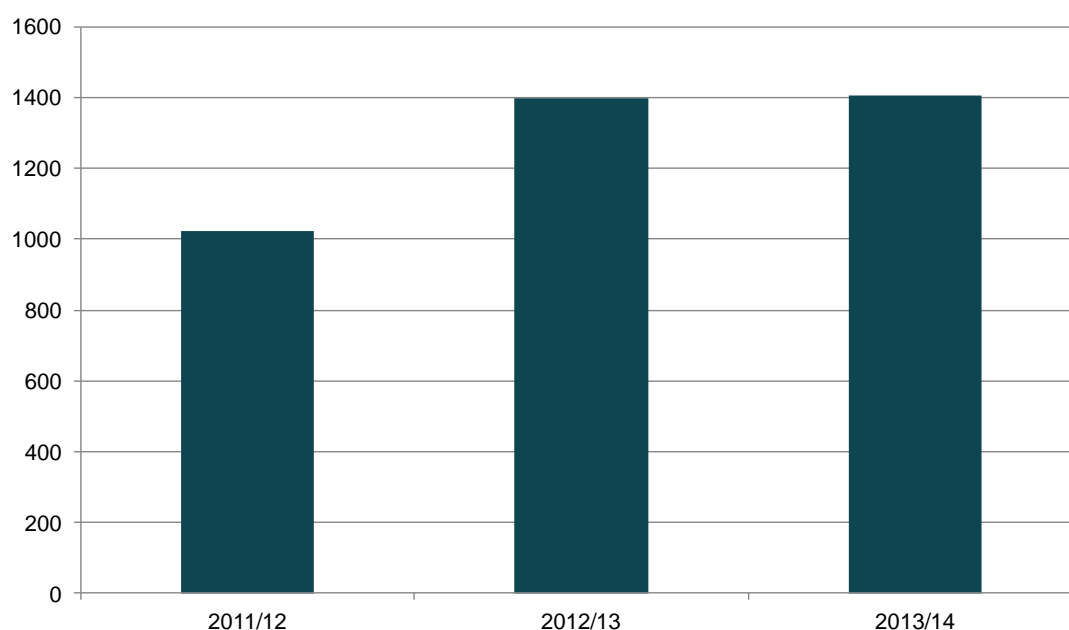
- 6.24. In England and Wales, allegations of FGM and FM are recorded as crimes. HBV offences are not a separately-recorded crime type and therefore are recorded under other offence categories such as homicide or assault with injury. Most forces, however, flag crimes and incidents against all types of HBV. We asked all forces for the number of victims as well as the number of associated incidents and crimes of HBV, FM and FGM.
- 6.25. While the level of data and supplementary detail provided by forces varied considerably, most forces were able to separate this data between the three categories, while some said they were unable to do so due to the flagging system they had in place. Most forces provided data albeit that some only provided estimates for the number of victims. Around half of forces were able to distinguish between crimes and incidents that had been reported directly by the victim and those reported via a third party. Those that did not provide data cited limitations with the IT systems they were using.
- 6.26. The data from 41 forces<sup>64</sup> showed that, in the 10 months to 31 January 2015, there were around 2,600 incidents flagged as HBV, FM or FGM-flagged incidents. Data from 40 forces over the same period reported having approximately 830 associated crimes. Forty-two forces reported the total number of associated victims during the same period as around 2,400, although some forces' submitted figures were based on estimates. One further force provided all of the data but for calendar years only.

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<sup>64</sup> Forty-one out of 43 forces provided data in relation to the number of incidents recorded as involving HBV, FM and FGM flagged incidents.

- 6.27. The difference between numbers of incidents and numbers of crimes may be explained, to some degree, by the fact that some incidents, particularly of FM or FGM, may be reported to police before a crime has been committed; for example, a health service referral of a child identified to be at risk of FGM. In these cases, a successful outcome may be the prevention of the substantive offence (and the need to record the matter as a crime).
- 6.28. Figures 7 to 9 below show the number of HBV, FM and FGM-flagged incidents reported to us by forces between 2011/12 and 2013/14. At the time the data was collected, the full 2014/15 year was not available. We believe the data gives some indication of how the reporting of HBV matters to forces has developed over time.
- 6.29. While the number of reported HBV-flagged incidents recorded by forces remained largely unchanged between 2012/13 and 2013/14, FM-flagged reported incidents declined in each of the three years. FGM-flagged incidents increased substantially between 2012/13 and 2013/14, showing around a three-fold increase.

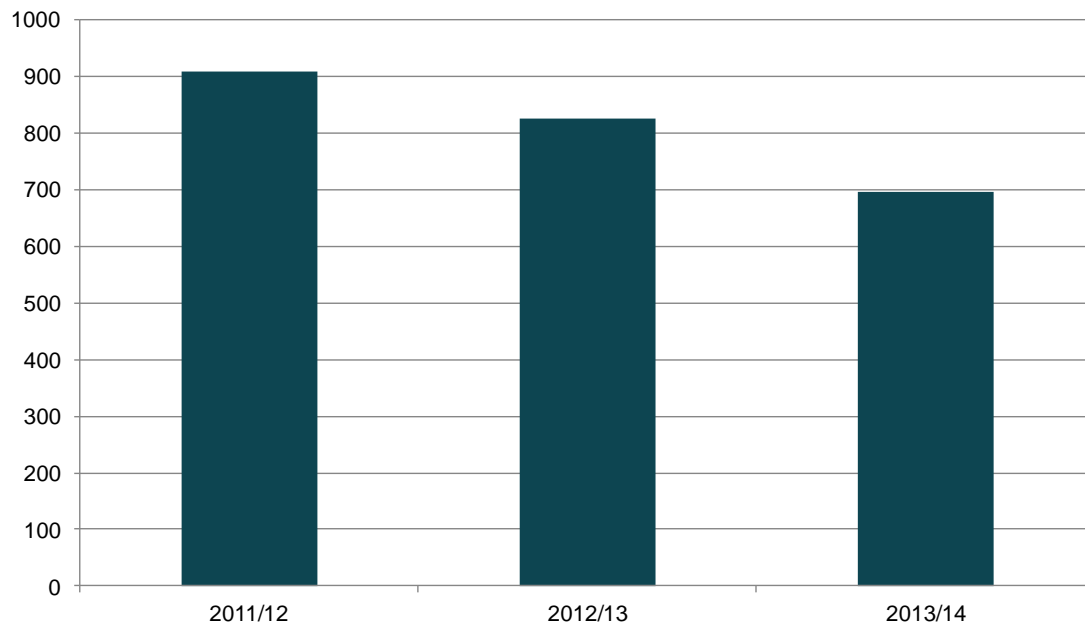
**Figure 7: Number of HBV-flagged incidents 2011/12 to 2013/14** <sup>65</sup>



**Source: HMIC data collection**

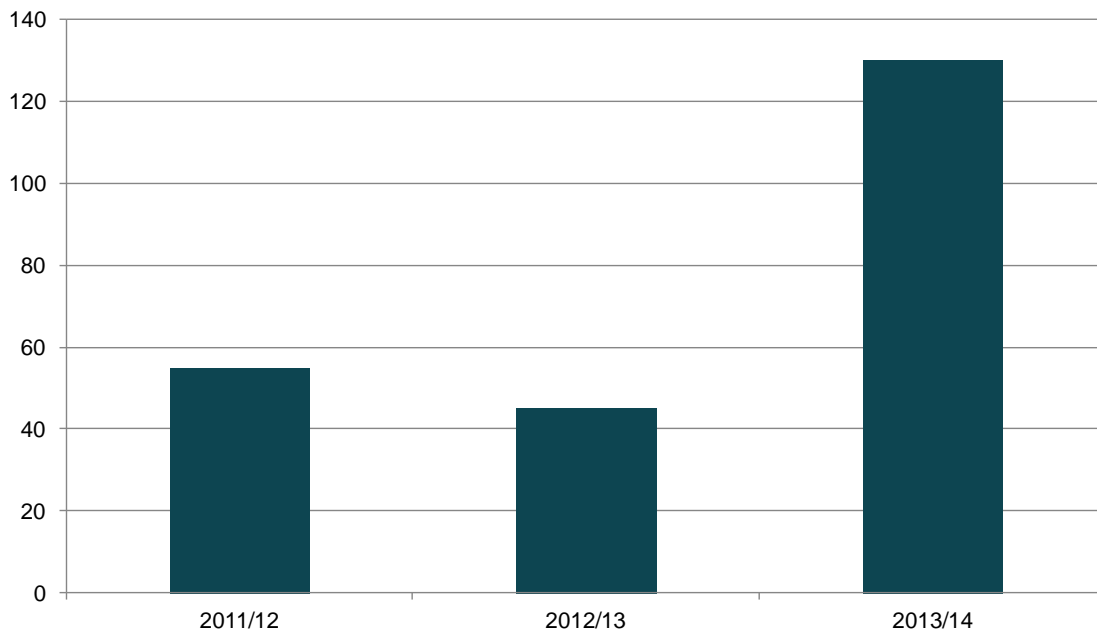
<sup>65</sup> Based on data from 31 forces.

**Figure 8: Number of FM-flagged incidents 2011/12 to 2013/14<sup>66</sup>**



**Source: HMIC data collection**

**Figure 9: Number of FGM-flagged incidents 2011/12 to 2013/14<sup>67</sup>**



**Source: HMIC data collection**

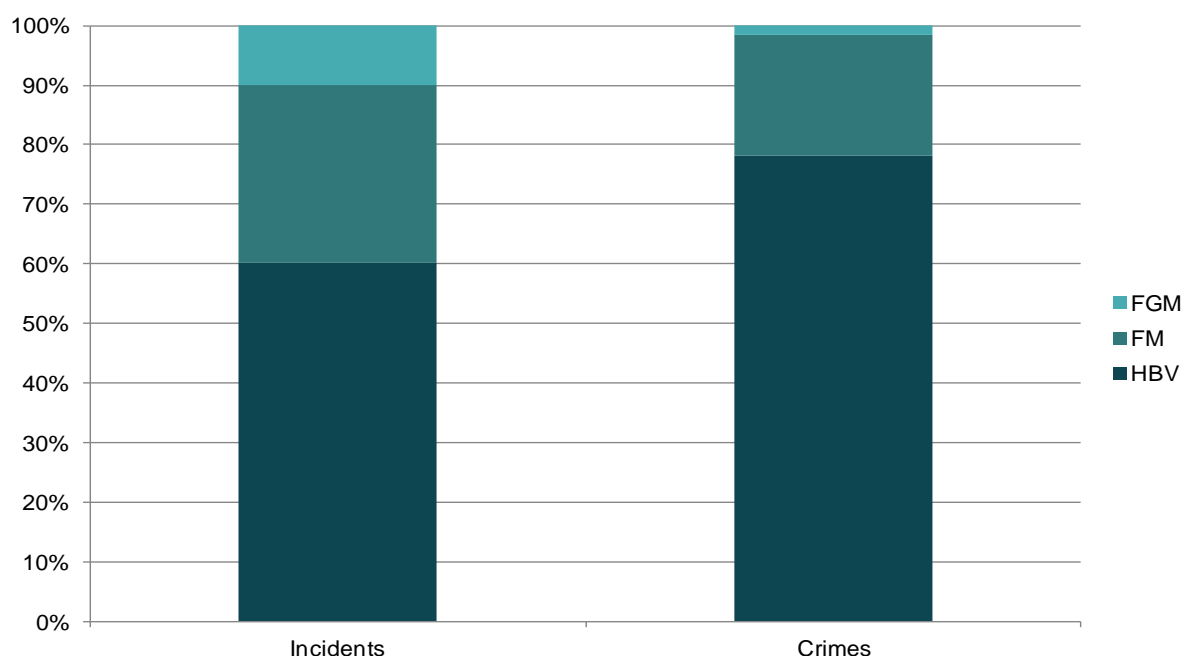
<sup>66</sup> Based on data from 30 forces.

<sup>67</sup> Based on data from 33 forces.

6.30. From the crime and incident data provided to us by 33 forces for the 10 months to 31 January 2015, we looked at the proportion of crimes to incidents. For FGM, the number of flagged crimes reported during the period represented less than five percent of the flagged incidents reported. The same figures for HBV and FM were, however, considerably higher at around 40 percent and 20 percent respectively. Figure 10 below shows the proportion of each for both crimes and incidents reported by forces during the period. The variations could be for a number of reasons including:

- differences in the way these types of incidents are dealt with by forces; and
- varying levels of evidential difficulties for each category of crime.

**Figure 10: Proportion of flagged HBV, FM and FGM incidents and crimes, 10 months to 31 January**



**Source: HMIC data collection**

6.31. In order to compare the rates of HBV, FM and FGM-flagged crimes between forces, we examined the numbers as a proportion of the black, Asian and minority ethnic (BAME) population<sup>68</sup> within each force. While the actual size of the at-risk population within each force area is unknown the crimes are, however, typically associated with specific BAME ethnicities. This is far from an ideal methodology, however, since there are many ethnic groups within the BAME population which are not at risk and, conversely, some ethnicities which are not BAME that are affected. For example, FM affects some eastern European ethnicities. The relative size of a force's BAME population,

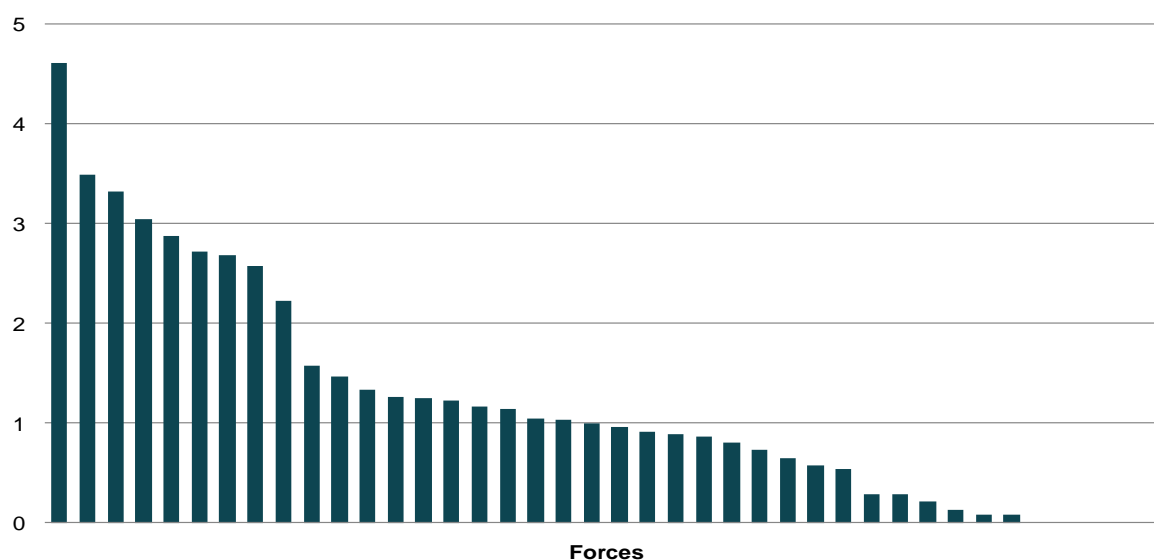
<sup>68</sup> Ethnicity data from the 2011 census.

therefore, provides only an indication of the relative size of the at-risk population within it.

6.32. Figure 11 below shows the rate of HBV, FM and FGM–flagged crimes collectively<sup>69</sup> reported to us by forces, per 10,000 BAME population, for the 10 months to 31 January 2015. Forty forces provided the figures. The chart shows considerable variation between the forces, ranging from 0 to 4.6 flagged crimes per 10,000 BAME population. When considered against broadly comparable crime types, such as violence against the person, the variation is considerably greater. Again, there could be a number of reasons, which could include:

- different criteria to flag these crimes being used within forces;
- forces using different crime-recording practices;
- forces' BAME population size inadequately reflecting the relative size of the at-risk population; and
- large regional variations between the frequency of these crimes within specific ethnic groups.

**Figure 11: HBV, FM and FGM-flagged crimes per 10,000 BAME population in forces, the 10 months to 31 January 2015**

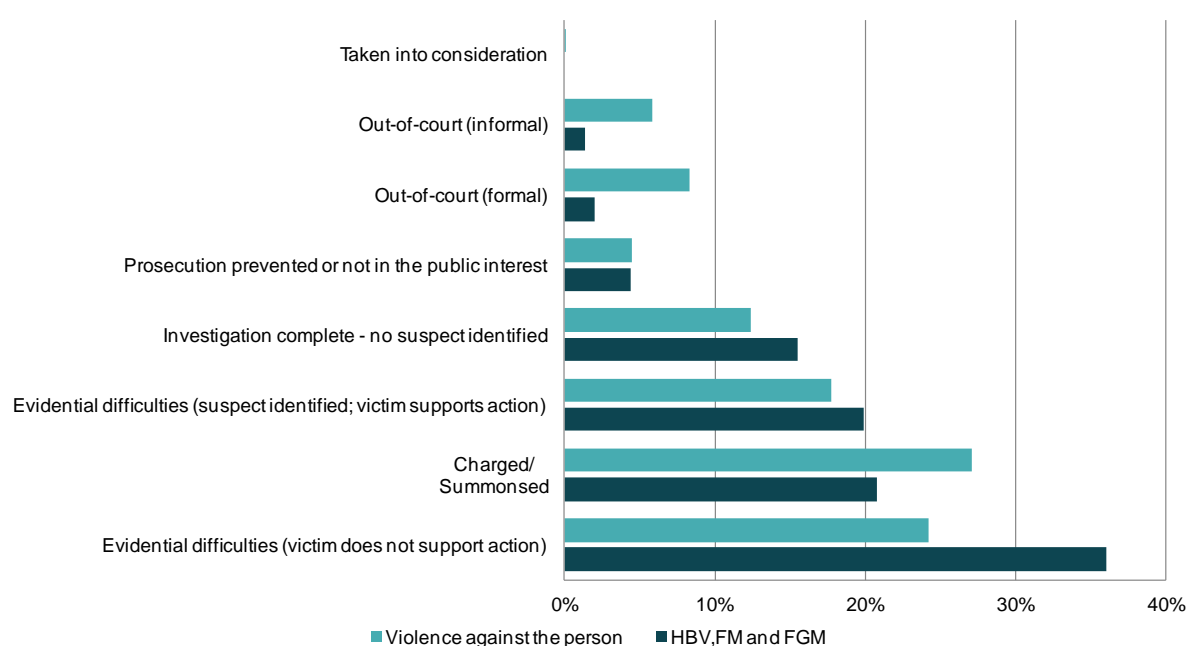


**Sources: HMIC data collection, and Office for National Statistics 2011 Census**

<sup>69</sup> Although data were collected for each category, the numbers for HBV, FM and FGM-flagged crimes were not separated out, as individually they were too small to draw meaningful comparisons.

6.33. We also collected data on the outcomes of HBV, FM and FGM-flagged crimes recorded by the forces, classified according to the Home Office's new recorded crime outcomes framework. The chart below (Figure 12) shows the proportion of the different outcomes used against all three of the categories in the 10 months to 31 January 2015. Thirty-nine of the 43 forces<sup>70</sup> gave us data in relation to the new outcomes framework for 2014/15.

**Figure 12: Proportion of recorded outcomes for HBV, FM and FGM-flagged crimes in the 10 months to 31 January 2015, compared to proportion of recorded outcomes for violence against the person for 2014/15<sup>71</sup>**



**Sources: HMIC data collection, Home Office crime outcomes in England and Wales**

6.34. Of those outcomes recorded for HBV, FM and FGM-related offences, just over 20 percent were a charge/summons. For a substantial proportion (36 percent), there were evidential difficulties where the victim did not support police action. In 20 percent of cases, the victim supported police action but there were other evidential difficulties, although no further detail was provided about what these evidential difficulties were. No suspect was identified in 15 percent of those outcomes recorded.

<sup>70</sup> A further force gave us the data but had not recorded against the new outcomes framework for the entire period and another had the data recorded by calendar year only.

<sup>71</sup> The violence against the person outcome data, as well as outcome groupings is available from: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/445531/hosb0115-tabs.ods](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445531/hosb0115-tabs.ods)

- 6.35. To compare these proportions against another crime category, we examined the figures for the crime of violence against the person. From the outcomes recorded in 2014/15, a larger proportion of these offences resulted in a charge/summons (27 percent) and out-of-court outcomes (14 percent for both formal and informal). The proportion of outcomes where there were evidential difficulties were, however, lower.

## **Training**

- 6.36. We asked forces for data on how many officers and staff, by rank and role, had completed training in relation to HBV, FM and FGM in the two years to 31 January 2015. Most forces provided these data. Of the forces that did not give a breakdown by rank and role, nearly all provided broad details of what training had been held and the numbers attending.
- 6.37. In this phase of the inspection we did not request information on the quality or depth of the training, but supplementary information supplied by forces suggested that this varied widely.

## **Challenges and inhibitors**

- 6.38. The most frequently identified challenges or inhibitors identified by forces in terms of their awareness and understanding of HBV, FM and FGM were the lack of local intelligence and information about the occurrence of HBV in their force areas (12 forces); a need for national training to help build police understanding of HBV, FM and FGM (eight forces); and difficulty in community engagement associated with these crime types, which in turn was perceived to have an impact on victims' confidence in reporting to the police (seven forces). Some forces also identified challenges with engaging with the health service, education bodies and community or faith leaders.

## **Protection**

- 6.39. Twenty-five out of the 43 forces were assessed as prepared in respect of their ability to protect victims and potential victims of HBV. Preparedness in this area means that forces have officers who are equipped to undertake assessments, provide effective help, support and protection to victims, and act as trusted professionals. In short, they have staff doing what they say they will do.
- 6.40. Thirty-eight of the 43 forces in England and Wales provided data on the number of victims with whom the force was actively involved. These 38 forces told us that there were just under 630 victims, or potential victims, of HBV, FM or FGM being actively protected<sup>72</sup> as of 31 January 2015. Forces that did not

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<sup>72</sup> Active protection involves the force committing to protecting individuals on a regular basis.

provide the data said that they did not have an effective way of identifying which of their protected victims were related to HBV, FM or FGM. This gap in intelligence potentially places victims at increased risk if staff are not able quickly to identify and understand the victim's circumstances.

### **Trusted professional**

6.41. We asked forces for the number of individuals at risk of HBV, FGM and FM that had been transferred into and out of their force area. Twenty-two forces provided this information. Seven other forces only provided numbers of individuals who had been transferred into or out of their force but did not provide both. The data showed that 26 forces were managing a total of just over 100 victims who had been transferred in from elsewhere and 25 forces had transferred in total nearly 130 victims out as of 31 January 2015. Those forces that did not provide the data cited different reasons:

- an inability to search for the relevant fields on their systems; or
- to search for the data would have been overly burdensome; or
- they did not record the data at all.

### **Challenges and inhibitors**

6.42. Fewer challenges relating to the protection of people at risk of HBV were identified by forces. This may be reflective of the issues identified in respect of leadership and awareness and understanding, in particular the gaps in national guidance to forces. Two forces reported funding constraints as an inhibitor to their ability to work with others in undertaking assessments to provide effective help, support and protection to victims. Concerns were also raised about funding for the non-government organisations that provide specialist knowledge and assistance to HBV victims. For example, a shortage of available beds in local safe houses or refuges was cited as having a negative impact on the ability of the police and other agencies to keep victims and their dependants safe.

6.43. A lack of clarity about appropriate approaches to information sharing and referrals between the police service and other agencies (such as social care) was seen as unhelpful, creating risks of gaps in the referral processes. An example was provided to us of a recent case where the police were not aware of an FM case with which the Forced Marriage Unit (FMU) had been involved. The victim was under 18 and the FMU contacted the relevant social care authorities, who did not inform police as they thought that the FMU would do so.



## Enforcement and prevention

- 6.44. Only four of the 43 forces were assessed as prepared in respect of their capacity to investigate HBV incidents, work together with others to identify and manage those who pose a risk to victims and to close cases in a victim-centred and timely way.
- 6.45. We asked forces for the number of HBV, FM or FGM-flagged cases they had referred to the CPS. Thirty-six of the 43 forces provided the data which showed that 20 forces had made a total of around 95 referrals in the 10 months to 31 January 2015. Forces that did not provide the data told us that they did not capture, or were unable to retrieve, the information. One of these forces told us they were trialling a process with the courts to capture and monitor this information.
- 6.46. Thirty-seven of the 43 forces provided figures for the number of perpetrators of HBV, FM or FGM in their area. The data from these forces showed considerable variation in the number of perpetrators per 10,000 BAME, ranging from none to 8.2. Eight forces told us they had no recorded perpetrators. Those forces which did not provide the data said either the information was not currently being recorded or that it would have been too burdensome to obtain.
- 6.47. Most forces (36 of the 43) provided us with data on how many FMPOs had been issued in their force area during the 10 month period to 31 January 2015. The data showed that 36 FMPOs had been issued across 14 of these 36 forces. One additional force had issued 41 FMPOs but across the 2014 calendar year. Some forces told us that they were not able to search the data easily on their system and had to approach local authorities, the courts or solicitor firms in order to get this information. Other forces reported being unaware of whether other agencies within their force area had applied for FMPOs.
- 6.48. Domestic Violence Protection Orders (DVPOs) were implemented across England and Wales in March 2014 after a one year pilot. Thirty-three of the 43 forces provided us with data on the numbers issued in relation to HBV, FM or FGM up to 31 January 2015. This showed that a total of four DVPOs had been issued from three forces. The remaining ten forces either did not capture data for DVPOs or were unable to break these data down into those that were related to HBV, FM or FGM.
- 6.49. Finally, four forces reported to us that they had issued a total of four court restraining orders in relation to HBV, FM or FGM in the 10 months to January 2015. Around a half of forces said they had issued none. The 19 forces that did not provide the data reported either not having a system in place to record restraining orders, or no means of identifying those relating to HBV, FM or

FGM. Some forces advised us that a breach of a restraining order would, however, be recorded on their system.

### **Challenges and inhibitors**

- 6.50. As with the protection heading, fewer challenges were identified by forces in relation to enforcement and prevention. Two forces identified a need for mandatory training to assist them in ensuring that their investigations are thorough, timely and meet the needs of victims.
- 6.51. As in the other areas assessed in this inspection, challenges were identified relating to timely and effective liaison with external agencies. For example, one force reported that the police are not always made aware that an FMPO has been obtained. The onus is on the applicant to make the police aware and provide details of the order, but there is no standard method to ensure that this happens, and in the absence of protocols with other agencies and/or a central database, police have no ready means of tracking (and therefore enforcing) FMPOs.
- 6.52. There were many references to the fact that effective identification, safeguarding and protection for victims of HBV requires preparedness in all relevant public services, including health, education and social care, supported by a strong commitment to joint working by all agencies. One force highlighted their positive experience of working together with social care services as a joint investigation team, resulting in improved relationships and information sharing.

### **Summary of police preparedness**

- 6.53. We assessed that 40 of the 43 police forces in England and Wales were prepared to some extent to protect and support victims of HBV effectively. Three of these were assessed as being prepared overall, i.e. they were prepared in all areas of the inspection's enquiry, based on an analysis of the force's self-assessment, documents, data and websites. Three forces were assessed as not yet prepared in any of the areas. The remainder were prepared across some but not all areas. The theme of the data collected in Phase 1 was that forces were more prepared in their leadership and in their responses at the early stages of the victim's journey (awareness and understanding and protection) than they were in the later stages of enforcement and prevention.

## 7. Phase 2 fieldwork – leadership

- 7.1. This chapter reports our findings on the effectiveness of police leadership and governance in addressing HBV.
- 7.2. In the eight force inspections we inspected the leadership and governance structures within the forces for the extent to which they supported the ability of those forces to identify and respond to cases of HBV, FM and FGM.

### **Leadership, governance frameworks and policy in the inspected forces**

- 7.3. Senior leaders in all forces recognised the importance and sensitivities associated with all forms of HBV. In the majority of forces this recognition translated into clear, visible leadership in relation to HBV, FM and FGM. In several instances, we noted that this position was underpinned by local police and crime commissioners' (PCC) police and crime plan priorities, meaning that the force was held to account by the PCC in relation to the progress it was making. For example, in Northumbria the PCC's violence against women and girls strategy has four priorities which relate to HBV, FM and FGM. There is a force lead for the activity focused on developing a better understanding and wider support for victims of HBV, FM and FGM. On a monthly basis the PCC holds the force to account for delivery of the strategy's action plan.

### **Force professional leads**

- 7.4. Five forces had identified senior professional leads for HBV/FM (combined) and FGM. These roles provided the most visible leadership. Although the effectiveness and influence of the work done by these individuals was very apparent, we are concerned that this reliance on key individuals was an indication of potential resilience issues for the forces concerned (i.e. there might not be enough strength in depth on HBV issues). Professional leads focused variously on:
  - developing a better understanding and wider support for victims of all forms of HBV;
  - raising community awareness;
  - providing advice and supervision to staff responding to incidents and crimes;
  - promoting the awareness of HBV in everyday business through the appropriate arrangements through which priorities are set and decisions made; and

- advising national bodies on the development of associated guidance.
- 7.5. In the Metropolitan Police Service, the chief officer lead for HBV and FM is also the National Police Chiefs' Council (NPCC) lead for HBV, FM and FGM.
  - 7.6. A chief officer figurehead demonstrates a force's commitment to tackling HBV and their recognition of the effect it has within the community. In those forces where the leadership on HBV was included only in broader operational responsibilities, it was apparent that staff did not associate any individual being the advocate of HBV issues in the force.
  - 7.7. In some forces there were also clear reporting structures to link HBV senior leads to the force leads for child protection and domestic abuse. In those forces where there were trained specialists in HBV leadership roles, it was evident that these links supported the co-ordination of skills, processes and intelligence as required.
  - 7.8. Conversely, in forces without HBV specialist leaders, a strong or even exclusive reliance on existing domestic and child abuse approaches may raise the risk within the force of inappropriate responses to HBV cases, because of a failure to recognise and act on the critical differences. For example, in cases of FM there are significant risks to involvement of the family and/or the community. In these cases, discussion with the family or any type of family involvement will often place the child or young person at greater risk of harm.<sup>73</sup>

### **Governance and accountability arrangements for managing risk, threat and harm**

- 7.9. All forces had clear governance and accountability arrangements to review and manage threat, risk and harm in relation to HBV, FM and FGM, although in most cases these formed part of wider arrangements for domestic abuse and/or safeguarding of vulnerable people.
- 7.10. Dyfed-Powys Police was in dialogue with other Welsh forces to develop a regional governance structure for HBV, FM and FGM reporting to the national HBV forum, and encompassing existing Welsh government leadership forums for both HBV and FM. It was proposed that this regional Welsh forum would meet quarterly to share learning and good practice. There were examples in other forces of strong partnerships working at a senior level to support co-ordinated responses to HBV across all the relevant agencies.

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<sup>73</sup> *The Right to Choose: Multi-Agency Statutory Guidance for Dealing with Forced Marriage*, UK Government, June 2014.

## **Policies and guidance**

- 7.11. The majority of inspected forces had developed specific policies and guidance for staff on HBV, although they were not always aware of them. A minority of forces relied on their domestic abuse policy documents to support their response to HBV. We found that although such policies made reference to HBV, FM and FGM, they contained very little guidance that could be used to shape the operational response of officers not already familiar with these areas. Some staff will not have experience of HBV incidents and crimes because of the low volume of reporting. It is precisely these staff who would benefit most from specific HBV policies and guidance.
- 7.12. Some forces had developed HBV 'toolkits' to support different stages and levels of police investigations, which were easy to find and use. In other forces, tactical advice was more limited and did not provide a detailed guide or make explicit the steps that should be taken to protect victims.
- 7.13. We found no examples of evaluation by forces to check that available toolkits and guidance had made a positive difference to the response received by HBV victims. Those forces that did not have comprehensive policies in place all recognised the need to refresh and/or strengthen their guidance to staff in relation to all forms of HBV.

## **Understanding outcomes**

- 7.14. We checked that forces had systems in place that would enable them to undertake analysis of their performance, level of service to victims and the outcomes in respect of HBV, FM and FGM. A minority of forces had effective mechanisms in place to analyse their performance in these areas. Recent internal reviews in these forces had highlighted a number of areas of good practice, such as effective specialist risk assessment and management, good immediate safeguarding, comprehensive recording of family members' details and establishing safe contact arrangements with the victim. A number of areas had also been highlighted as requiring improvement. These included: a failure to restrict access to the crime report; failure to flag the crime as involving HBV or FM; cases where there was a lack of documented supervisory scrutiny and direction; and cases where investigation plans and activity had not been documented.
- 7.15. Overall, we found that HBV incidents were not consistently subject to an enhanced scrutiny or oversight process, at either local or force level. The challenges of conducting an analysis of effective police performance were made worse by gaps described elsewhere in this report, for example in accurately flagging HBV cases so that they could be easily identified, or holding relevant case information in a single computer system rather than

across multiple unlinked systems. It was therefore very difficult for forces to be confident about the accuracy of their performance information or to assess whether they were delivering an effective service to victims of HBV, FM and FGM.

## **Partnership working, supporting learning and use of regional or national resources**

- 7.16. As described in the previous chapter, collaborative arrangements with partner organisations and community groups may be used to improve police responses to HBV locally, regionally and nationally.
- 7.17. Given the hidden nature of HBV and the added limitations of the existing approaches to local and national data collection, proactive community engagement will be important if forces are to develop an understanding of the nature and extent of these crimes. That understanding will be an essential requirement if forces are to respond effectively. Forces may also make use of regional, national and international resources (for example, the College of Policing, the government's Forced Marriage Unit (FMU), the National Crime Agency (NCA),<sup>74</sup> Europol and Interpol) where appropriate to support their responses to HBV, FM and FGM.
- 7.18. In all eight forces inspected we found strong examples of engagement with both statutory and non-statutory bodies. Local multi-agency safeguarding arrangements provided the core structures for partnership working on HBV issues. Some forces are operating in very complex environments of with multiple local authorities. It was evident that this complexity presented significant challenges, raising the risks of, for example, duplicating efforts, inconsistency in approach and unreliable intelligence across a force area.
- 7.19. We saw that West Midlands Police has seconded an officer to Public Health England to improve joint working between the two bodies in preventing violence and its associated harms. The outcomes of this work, as described by Public Health England, have been particularly notable in respect of FGM, and are summarised in the box below.

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<sup>74</sup> See Annex F for more information on the related work of these agencies.

### **Public Health England, West Midlands Centre (PHEWM) statement on its alliance with West Midlands Police**

Public Health England is a government department whose purpose is to protect and improve the nation's health and wellbeing, and reduce health inequalities. As a national organisation, it is divided into four regions with 15 centres.

PHEWM and West Midlands Police launched the West Midlands violence prevention alliance (WMVPA) in June 2015. The WMVPA brings together partners to work with a shared understanding that violence and its associated harms are preventable. By adopting a public health approach of identifying and addressing root causal factors, we can reduce violence and improve health, wellbeing and safety across our population. Alliance members do this through implementing evidence based interventions, as well as testing and evaluating new approaches. The WMVPA is a member of the World Health Organization violence prevention alliance international network. Violence against women, and domestic abuse, is a key strand.

#### **FGM**

PHEWM have been working with Coventry City Council and their FGM task force over the last year to develop their FGM strategy, providing public health support and expertise where appropriate. The task force has produced a number of resources including an action plan for Coventry, a literature review, app (the first FGM app, developed by Coventry University and designed to help young girls access help and support – available at: [www.coventry.ac.uk/research/research-directories/spotlight-on/2015/coventry-university-launches-new-app-to-tackle-fgm/](http://www.coventry.ac.uk/research/research-directories/spotlight-on/2015/coventry-university-launches-new-app-to-tackle-fgm/))

PHEWM has recently joined Birmingham's multi-agency FGM group to provide public health expertise. PHEWM has also contributed advice and support to the West Midlands Police and Crime Commissioner's FGM task group.

7.20. In some forces, the PCC was taking a notable lead in promoting collaborative approaches. For example, in Thames Valley, the PCC had written to all doctors' surgeries and secondary schools within the force area to reinforce efforts to continue the collaborative approach regarding all forms of HBV. In Oxfordshire, a local officer with responsibility for protecting vulnerable people had convened an 'FGM strategy group', reporting to the local safeguarding children board (LSCB). The group was attended by experts from the health service and the voluntary sector who met on a quarterly basis and had introduced a number of positive initiatives, including:

- implementation of an example standard operating procedure for medical professionals likely to encounter FGM;
- identification of a single trusted translator available to the police and health service;

- case strategy meetings where the subjects remained anonymous until justification for formal investigation was met; and
- working closely with local students of sixth form age who carry out peer to peer awareness activity and attend the group meetings.

- 7.21. Cheshire Constabulary investigated the murder of 17-year-old Shafilea Ahmed, a high profile HBV crime which attracted both local and national media attention. The parents of Shafilea Ahmed were convicted of her murder. The constabulary has used this tragic and most serious incident to raise awareness of HBV issues. The force has representation at a national level within the HBV, FM and FGM working groups and is integral to the National Day of Memory for victims of HBV.<sup>75</sup> The national representative reports back to the constabulary on issues that are raised nationally, and ensures that those with responsibility for investigating HBV are updated on developments in practice and procedure.
- 7.22. We spoke to partner agencies during the inspection, including representatives from local authority children's and adults' social care, probation, health and mental health services. They reported effective working relationships with forces at a planning level, and that there were subject matter experts and specialist resources dealing with HBV, FM and FGM investigations at an operational level. In those areas with designated subject matter experts, forces recognised a risk that partners, particularly voluntary sector organisations, could become over-reliant on individuals, using them as the single point of contact for all HBV-related issues rather than using established protocols (where these existed) for referral. Where this was a concern, it was being addressed by the force. We also spoke to some police staff who referred to HBV and hate crime interchangeably. Potentially, this confusion could lead to inappropriate steps being taken in the forces' engagement with its local partners and referral for victims.
- 7.23. It was apparent that relationships with partner organisations, particularly specialist voluntary sector agencies, provided forces with an important opportunity to develop expertise and improve their responses to HBV incidents. During the inspection, we spoke to a number of organisations, working in both HBV and domestic abuse areas, who indicated that they were keen to share their expertise with the police service.

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<sup>75</sup> National Day of Memory for victims of HBV, more information available from: [www.cheshire.police.uk/news-and-appeals/news/national-day-of-remembrance-for-victims-of-honor-based-violence/](http://www.cheshire.police.uk/news-and-appeals/news/national-day-of-remembrance-for-victims-of-honor-based-violence/)



- 7.24. In the main, the professional leads in the eight inspected forces were responsible for keeping abreast of developments and emerging threats, supporting learning and improving the responses to HBV, FM and FGM. Only in a minority of forces did we find evidence that this was part of a more structured approach to organisational learning and identification of 'what works' in addressing HBV. Some professional leads had developed informal networking arrangements with their opposite numbers in other forces as a mechanism to share learning and effective ways of working.
- 7.25. One example was 'Operation Limelight' (an initiative at airports designed to increase awareness of and prevent FGM, discussed in the next chapter) which has been replicated across England and Wales. In general we assessed that networking arrangements, both internally and externally, could be improved in order to share effective ways of working and information about what strategies and approaches are successful.

## 8. Phase 2 fieldwork – awareness and understanding

- 8.1. This chapter reports our findings in respect of the level of awareness and understanding of HBV in the eight forces inspected.
- 8.2. In the context of the victim's 'journey' we focused on the initial contact with the police service, checking in each force that the force works to ensure that victims are identified; and from the first point of contact, officers and staff are alert to, and have the knowledge, skills and ability to recognise, understand and identify victims, and protect them.

### Identification

- 8.3. In Phase 1 of the inspection, the lack of local intelligence and information about the occurrence of HBV was one of the most frequently identified challenges or inhibitors to forces effectively preventing and responding to HBV. Evidence from the eight forces inspected in Phase 2 showed that forces are at different stages of development in terms of applying the national intelligence model (NIM)<sup>76</sup> to understand their local communities and the potential scale of HBV in their area.

### Knowledge of local communities

- 8.4. We found that all but one of the eight forces inspected had carried out some research and analysis to understand the characteristics of the populations they serve. The extent of this research ranged from very limited work, drawing only on 2011 census data, to more comprehensive exercises, relying on a variety of sources relevant to HBV risks, including local networks and specialist community organisations.
- 8.5. Four of the forces had used, or were currently using, this intelligence to develop 'problem profiles' or a starting point assessment to help them understand the nature and scale of HBV in the force area, and likely 'hotspots' or high risk areas. In some cases it was apparent that these assessments

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<sup>76</sup> The NIM is a business model used by the police service to ensure that policing is conducted in a targeted manner through the development of information and intelligence. The model supports the decision-making required to prioritise activities and resources effectively and efficiently; for example, when and where to direct patrols, managing priority locations and high risk issues, as well as increasing the understanding of criminality and anti-social behaviour issues. NIM encourages a proactive approach to policing; identifying, understanding and addressing underlying problems and trends rather than responding to crime and non-crime problems in a reactive manner. This is particularly relevant at a time of increasing demand and reducing budgets.

were more developed in respect of specific crimes, such as FGM. In one force we found references to HBV, FM and FGM within a recently developed domestic abuse problem profile, but not in any detail and not in a way which could be used to help address the specific issues that these crimes require.

- 8.6. Two of the eight forces inspected relied on population data about ethnicity for a picture of HBV-related risks in a force area, although some staff in the forces concerned recognised the associated constraints in using this data. These constraints include the fact that: there may have been significant changes in the characteristics of many communities since the 2011 census; HBV is not limited to BAME communities; forces may have large transient communities and there may be victims who have fled, or been transferred for their own safety, from elsewhere.
- 8.7. These staff also recognised that the consequence of this lack of intelligence was likely to be a significant level of under-reporting to the police by victims of HBV in the local population, because the force is less able to communicate effectively with relevant sections of the community in a way that is meaningful for victims.

## **Use of problem profiles**

- 8.8. West Midlands Police produce an annual assessment of priorities that informs their police and crime plan.<sup>77</sup> The most recent assessment identified gaps in knowledge around FGM. Subsequently the force has commissioned a problem profile in respect of HBV, FM and FGM. The profile will be supported by academic research, partnership information and an intelligence collection plan. Local intelligence assessments have already been completed for each of the ten local policing units (LPUs) to help staff understand the potential risk of HBV, FM and FGM in their local communities.

## **Community engagement**

- 8.9. Community engagement can assist police both in the collation of intelligence and in transmitting key messages or advice to targeted communities. The majority of forces we inspected had used their community policing model to develop understanding and raise awareness of HBV, although not always in a way that gave equal consideration and focus to HBV, FM and FGM.

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<sup>77</sup> A police and crime plan sets the police and crime objectives for a force area. It is one of the requirements of the Police Reform and Social Responsibility Act 2011 which introduced police and crime commissioners (PCCs). Police forces are accountable to their PCC for their performance against the objectives of the police and crime plan.

- 8.10. Examples of this in practice included regular and routine partnership working, giving presentations to schools, working with local specialist voluntary sector organisations, speaking with community/faith leaders – all with the aim of improving trust and increasing the confidence of the community in sharing information with the police.
- 8.11. We found no examples of local community policing teams being specifically tasked to gather intelligence on HBV as part of a planned approach to developing problem profiles. In one force we found a strong reliance on key individual networks (KINs)<sup>78</sup> as the source of community intelligence. However, the constituents of these groups, primarily community and faith leaders, meant that this approach was unlikely to be an effective means of gathering intelligence concerning HBV, FM and FGM. It was evident to us that some forces had very limited understanding of trends or the specific communities at risk in their areas and had not yet articulated a clear plan to close these intelligence gaps across all three areas of HBV.
- 8.12. Overall, we found that the need to speak with the right people to build intelligence, and the risk to victims of speaking with the wrong people, was not always well understood by police officers and staff. The right people are not necessarily faith and community leaders, who may sometimes be the very people promoting or supporting harmful practices in the name of honour.
- 8.13. We found limited evidence of direct engagement with women within those communities who may be vulnerable to HBV, FM and FGM. Our victim engagement project showed that sensitive and well-informed communication with victims and community groups representing their interests is essential to increase victims' confidence to report incidents, and provide knowledge of safe reporting methods. It is already part of the government's guidance that this communication be undertaken on a multi-agency basis involving all those public and other services that may be able to assist in providing safe routes to report incidents and crimes (as discussed in Chapter 4). This will include health, education and social services.

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<sup>78</sup> A Key Individual Network is a community engagement mechanism designed to support neighbourhood policing. It is a core group of local people who live, work or regularly pass through a neighbourhood and are particularly in tune with the latest developments. They help local neighbourhood police teams to identify issues and understand the thoughts and feelings of a local community.

## **Victim engagement project findings: Community engagement**

- 8.14. The experiences of some of the participants in our victim engagement project underline the importance of the police establishing strong links and good communication with local community groups representing the interests of victims. In respect of FGM, education for young men and older women was identified as particularly important, as participants felt they were instrumental in the continued practice of FGM. Clarifying the nature and consequences of FGM, the legal position in the United Kingdom, and how to report concerns to police were highlighted as key areas by interviewees. One group of interviewees described how this information was already being delivered effectively through a local specialist voluntary sector organisation.
- 8.15. The findings from the victim engagement project interviews and case studies are included below, and throughout the report, set out coloured boxes.

“That’s why we need the community raising awareness [...] Not just the professional sitting in a big room talking about FGM. We need to take it outside, to the community areas, like parks, we talk about it. Some people don’t know it is illegal in this country. Because they don’t know what is FGM. [We need to explain] it to them the way they are calling it, in their own language, or in their own country. When you educate one woman properly in the community with strong awareness, then that woman will educate ten or fifteen in that same community.” (FGM victim)

## **Victim engagement project findings: Factors affecting decision to contact police**

- 8.16. Participants were asked about the factors that influenced their decisions on whether or not to contact police. It was evident that while the honour-based system was, in many cases, a motivating factor for victims to report their experiences to police, it could also be a constraining factor, as in the following examples:

“I tried to leave before, going to my family, going to the mosque, going to my friends but I was so controlled, he would just bring me back – and I didn’t think I had any option but to stay and be a good Muslim, the dutiful wife and all of that. [...] You know my parents are just saying “You’re mad”. My own brothers are just saying that “You’re mad”. Take him back, drop the charges. And pray for him. You know, get yourself help – like I was the problem.” (HBV victim)

Interviewer: “So during the marriage, you were saying there was no contact to the police during the abuse?”

Participant: “No, I was scared first. Second, he was my cousin. When I was thinking of the things the problems were getting much deeper. Third, I am brought up in a place, and [having been a university lecturer in home country], I have not experienced such a thing before. The problems were new for me and I didn’t know what to do.” (HBV victim)

8.17. Some victims coming from overseas did not know how to contact the police or – and this included United Kingdom-born victims – did not see the police as the appropriate organisation to contact.

8.18. For others, the decision to report was prompted by friends, work colleagues, GPs or voluntary sector specialist organisations. The use of an intermediary was particularly important for those who were effectively being kept under house arrest by their family, and for whom all forms of communication were either monitored or removed by the perpetrator(s) of the abuse. Indeed for these victims, alternative avenues – including online or app-based reporting – were critical.

“My brother sent me a text on WhatsApp to ask the police to come and at that time I wasn’t even aware of the police number in England cos I was so new.” (HBV victim)

8.19. Participants with experience of FGM had not reported to the police that they had been subjected to this practice largely because the incident happened many years ago in childhood and in another country:

Interviewer: “Were the police involved? Did anybody contact the police?”

Participant: “Which police? In Somalia or here in the UK? No, because we already have done it. [...] Everybody knew and was doing it in Somalia. So no contact to the police.” (FGM victims)

8.20. Others feared retribution from the wider community or were concerned that it would represent interference in private family life:

“Yes, but we cannot report to the police because I don’t want to interfere with other people’s lives. If I see someone is doing FGM, I don’t want to interfere with other people. That’s not fair. [...] If someone does FGM and I report to the police that family will come to me and I get into trouble.” (FGM victim)

## **Officer understanding and awareness of HBV, FGM and FM**

- 8.21. We found a wide variation, both between and within the forces, in the understanding of HBV, FM and FGM, and the associated risks and issues. We spoke to frontline police officers and staff, including those working in police call centres speaking to members of the public. In some forces, we found a good level of awareness of the seriousness of HBV, FM and FGM, and its unlawful nature, as well as some of the characteristics to look out for. However there were other forces where many frontline staff had limited awareness and understanding of these areas, even those working in communities where incidents of this nature were most likely, according to information held by the force itself about its local population.
- 8.22. Where staff did have an awareness of HBV, FM and FGM, they did not always understand the complexities and distinctions between HBV, FM, FGM and other related crimes such as domestic abuse. In one force, response officers recognised that domestic abuse incidents are often more complex than they might initially appear, potentially involving HBV or FM, but they told us that they did not always have the time to inquire about, and respond appropriately to, the underlying cause of a domestic incident, because of the volume of incoming calls requiring their attention. They recognised that this could have an impact on how potential HBV or FM incidents are handled, especially in the initial stages of a report being received. The consequences of a mishandled report can be extremely serious.

### **Case study – Ms B age 59**

Ms B arrived in the UK on a spouse visa in 2002. From the outset she was subjected to physical, financial, sexual and emotional abuse by her husband. In 2013, following an argument, her husband left her and their children, but continued to harass and control her. He took to stalking her and to questioning the children about Ms B's movements. He encouraged her brother to 'kill his sister' for 'having a boyfriend' and for 'drinking and smoking' and breaking with their cultural and religious codes of conduct. Ms B's aunt became concerned for her safety when she overheard her brother telling Ms B's husband that if he could find someone to kill her, he would pay the money. Ms B's aunt contacted her and encouraged her to report the matter to the police.

The first contact Ms B had with her local police was in April 2013 after she had been raped and assaulted and had sustained bruising as a result. She attended a local hospital which referred the matter to the police. The police attended her home the next day and she provided a statement. However, she did not agree to a prosecution as she was too frightened of her husband. The police took no further action and gave no further advice.

In February 2015, Ms B's children's school referred her to social services because the children disclosed the fact that there were arguments between their parents; she was referred to a solicitor and a non-molestation order was obtained.

Ms B contacted her local police several times early in 2015 as her ex-husband was harassing her, in breach of the non-molestation order. The police arrived when called and stated that her ex-husband had not done anything wrong as he just wanted to see his children. They took no further action.

In June 2015, Ms B contacted the police again because of threats to kill her made by her ex-husband. The officer replied "He is not killing you, you are still around". She was advised to lock her door and to call them if he entered the house. She did not know whether police carried out a risk assessment or referred her case to other agencies. She was subsequently referred by the local multi-agency risk assessment conference (MARAC). Social services had referred her to a specialist third sector organisation, which assessed her to be at very high risk and immediately referred her to a refuge where she is now being supported and feels safe.



- 8.23. In some areas there had been a focus on awareness raising for frontline staff, particularly those working in the control centre, but this was not always the case for those involved in investigations or working in specialist units dedicated to protecting vulnerable people. Sometimes, the potential links between HBV, FM, FGM and other high priority areas of neighbourhood police officers' work, such as child protection, were not recognised. In at least three forces, it was apparent that there had been a much stronger focus on raising awareness of FGM than on HBV and FM.

## **Partnership working to raise awareness and encourage reporting**

- 8.24. A number of forces have engaged with external organisations, both public and private sector, and/or used social media and other technology to raise awareness of the issues, and to encourage reporting. Avon and Somerset Constabulary works with a range of FGM statutory agencies, voluntary groups, charities and community members through the 'FGM delivery and safeguarding children partnership', which reports to the Bristol Safeguarding Children Board. The collective nature of this work, including the development of multi-agency guidance and training, is recognised nationally as an example of an effective way of working and is known as the 'Bristol model'.<sup>79</sup> The constabulary has also worked with 'Integrate Bristol' – a local voluntary sector organisation – and supported development of a 'use your head' short film, to raise awareness within the community of FGM-related risks.
- 8.25. The Metropolitan Police Service has established 'Project Azure' as their response to FGM. This includes: dedicated specialist officers located in each of the 16 child abuse investigation teams; documented joint working with NHS England; joint deployments on Operation Limelight; and holding an FGM conference.

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<sup>79</sup> *The Bristol Model of FGM work – what we do, 2013*, [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/276232/bristolLSCB\\_FGMwork.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/276232/bristolLSCB_FGMwork.pdf)

## **Operation Limelight**

Operation Limelight is a joint Metropolitan Police Service (MPS) and United Kingdom Visas and Immigration (UKVI) operation which takes place at Heathrow Airport and is aimed at tackling FGM and FM. The operation was originally set up to target flights from countries which have a high prevalence of FGM but has recently been expanded to include FM.

Objectives of the operation include:

- providing a visible law enforcement presence and public reassurance;
- increasing awareness of the illegality of FGM and FM and the health risks of FGM;
- safeguarding children at risk of or who have been victims of FGM;
- safeguarding those at risk of forced marriage; and
- identifying people responsible for FGM and FM and bringing them to justice.

Our inspectors observed one such operation and saw firsthand how officers engaged with passengers. The interactions our inspectors witnessed were all well received. In addition we were advised that passengers had previously commented positively on the visible law enforcement presence and awareness raising concerning FGM.

We recognise the difficulty that police and border force officers face in engaging with passengers on these sensitive topics. Whilst the results to date have not led to crimes or perpetrators being identified, it has resulted in positive feedback. In addition there is anecdotal evidence that law enforcement agencies are more aware of these types of crimes and that passengers from countries with high levels of FGM or FM are likely to be stopped and spoken to when flying from or into Heathrow Airport.

- 8.26. We were told by police officers and staff in one force of some of the difficulties they encounter in engaging with schools in respect of FGM. Overall progress was slow, which was believed to be because FGM is such a sensitive subject. Campaigners working with police officers believe that the affected communities do not discuss these matters at home so do not want their children to discuss them at school, especially when they are young (despite being of the age at which they are most likely to be affected by FGM).
- 8.27. This sensitivity was reflected by participants in our victim engagement project. Participants with experience of FGM had mixed feelings about reporting to the police new cases that they were aware of; some feared retribution from the wider community and some were concerned that it would be an interference in private family life. All, however, agreed that FGM is a cultural practice, not a religious requirement, and claimed they would reject FGM for their own daughters.

- 8.28. As referenced in the last chapter, in some forces it was very apparent that responsibility for awareness raising and developing understanding (and in some cases providing supervision/oversight of risk assessments and/or investigations) was reliant on a small cohort of dedicated individuals. Although the work done by these individuals was effective and influential in terms of making improvements in police practice, we were concerned that this reliance on key individuals was an indication of issues of strength in depth for the forces concerned and presented a wider risk to the police service.
- 8.29. Only in one force (West Midlands Police) did we find that all staff interviewed were confident in their awareness of HBV, FM and FGM. In this force, staff said that their knowledge had come from a variety of sources including briefing days, bespoke training, posters, information shared electronically on force systems and a 'toolkit' of advice for staff who might deal with cases of HBV, FM and FGM.
- 8.30. The West Midlands Police communications team has developed marketing approaches, informed by advice from independent advisory groups (IAGs)<sup>80</sup> within the force, to raise community awareness of vulnerability and hidden crime, including HBV, FM and FGM. This has been achieved through traditional methods, such as poster campaigns, supported by engagement officers at a local level who deliver posters to key locations. Social media has also been used to reach a wider audience, an example being a recent Twitter "Thunderclap" on FGM which was sent to over 500,000 users.

## **Partnership working: Sharing information**

- 8.31. Once a force has received information on HBV, FM and FGM, this should be recorded, risk assessed and shared appropriately with those who need to know (including with those in other agencies). We have made recommendations in relation to this need. Whilst we found little evidence of specific approaches to multi-agency information sharing on HBV cases across the eight forces inspected, all forces had established information sharing mechanisms operating through joint safeguarding arrangements.
- 8.32. We were told of apparent inconsistencies in the referral practices of other agencies within a single force area. For example, in one force police staff expressed concern to us that there was an under-reporting of FGM cases

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<sup>80</sup> Independent advisory groups (IAGs) were first introduced in 1999 following the Stephen Lawrence enquiry and the recommendations of the subsequent report. An IAG is a body of volunteers from various backgrounds that advises a police force as a 'critical friend' in a wide range of policing activities. IAG members are people within the community who have an interest in policing and its effect on the local area. They can advise officers on issues regarding policing that may cause concern in the local community.

from healthcare, and from midwives in particular. In this force area there were a number of local safeguarding children boards (LSCB). One LSCB had introduced mandatory referrals for expectant mothers to multi-agency safeguarding arrangements, whereas another had not. This had resulted in inconsistencies in the sharing of essential information across the force area.

## Initial contact

“But the woman at the desk she was just like, “So are you going to make a complaint?” She was so flippant and just didn’t want to listen to what I was saying. I was standing there, and she was like, “Well what do you want me to do? Do you want to make a statement?” And I said, “Well I just need help. I don’t know where to go, I don’t know what to do”. Because for 13 years I have been controlled by this man (becomes upset) and I know I had to get away. [...] So I said “Yeah, I’ll make a statement”. And then I met another police officer and I have to say he was amazing. He said, “I know this won’t be the first time he has hit you, you don’t have to say anything you don’t want to”. He was really understanding. He said, “I want to know the basics and how I can help you.” And I felt like ‘at last’, you know?” (HBV victim)

- 8.33. All forces inspected had a range of ways for HBV, FM and FGM victims (and those acting on their behalf) to report concerns, incidents and crimes. These included routine methods of direct reporting (calls to the police call centre, or attending in person at a police station front counter), online reporting through force websites, referrals through specialist voluntary sector organisations and referrals through established partnership routes such as multi-agency safeguarding arrangements. During the inspections we spoke to some front office staff at police stations who demonstrated a mixed degree of understanding about HBV and what to do if someone makes a report in person.
- 8.34. The majority of forces had provision for third party reporting although they were not all able to distinguish between direct and third party reporting within the data held on HBV, FM and FGM incidents. In one force, a regional police HBV helpline was answered by the force call handlers, who were able to identify calls from the helpline by a visual display. However, staff answering the helpline were not sufficiently trained to provide specialist advice to the caller.

## Identifying HBV, FM and FGM: training

- 8.35. There was a range of training available in the eight forces, from nothing, to e-learning packages<sup>81</sup> through to more comprehensive and in-depth training provided by specialist organisations and using scenario-based learning opportunities. There was evidence of multi-agency training for some staff involving partner organisations in some forces. A need for national training to help build police understanding of HBV, FM and FGM was one of the challenges/inhibitors most frequently identified by forces in Phase 1 of the inspection.<sup>82</sup>
- 8.36. We did not expect to find that all staff in all forces were trained to understand HBV. However, given the evidence from national data that there are victims of HBV in all areas of England and Wales (see Chapter 3), it is a particular concern to us if those staff in frontline roles with responsibility for implementing the ‘one chance rule’<sup>83</sup> set out in the statutory guidance do not have sufficient training to do so reliably.
- 8.37. In one force inspected, the force had taken positive action by introducing a bespoke approach to assessing risks to victims of HBV, designed by a specialist voluntary sector organisation, but this was undermined in practice because not all frontline officers and staff interviewed were aware of this initiative.
- 8.38. We found clear evidence that police officers and staff who had received enhanced training demonstrated better awareness and understanding of HBV issues and the required responses. Hertfordshire Constabulary has invested in a substantial programme of training as a pilot for the College of Policing domestic abuse training programme. This included enhanced training for supervisors and domestic abuse emergency response officers, which covered

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<sup>81</sup> Some of these are provided through the National Centre for Applied Learning Technologies (NCALT), which is a collaborative arrangement between the College of Policing and the Metropolitan Police Service. NCALT produces and delivers local and national e-learning, and other learning support approaches for the police service.

<sup>82</sup> In an interview to inform the inspection, the College of Policing told us about training materials (which include specific sections on HBV, FM and FGM) produced and disseminated to forces.

<sup>83</sup> *The Right to Choose: Multi-Agency Statutory Guidance for Dealing with Forced Marriage*, UK Government, June 2014, p1: “[Staff] providing services to victims of forced marriage and honour-based violence need to be aware of the “one chance” rule. That is, their staff may only have one chance to speak to a potential victim and thus their staff may only have one chance to save a life. This means that all professionals working within statutory agencies need to be aware of their responsibilities and obligations when they come across forced marriage cases. If the victim is allowed to walk out of the door without support being offered, that one chance might be wasted.”

HBV and FM in more depth. Staff who had attended these training events were positive about their impact.

### **Call-handlers**

- 8.39. In each of the forces we visited, we spoke to call-handlers whose job involved talking and listening to members of the public. They understood, from their training, supervision and force policies that some callers may be vulnerable for a variety of reasons. In some forces they were provided with check lists or questions to help them gather relevant information in specific circumstances, for example, in an incident of domestic abuse which may have an honour-based component. Some forces had provided specialist training on the identification of HBV at the first point of contact, and/or established HBV champions to support colleagues in the control room and in investigations to assist in early identification.
- 8.40. We were told that call-handlers were victim-focused and were trained to gather as much information as possible, to provide immediate safeguarding advice where necessary and to prioritise the call for police response. However, during our reviews of a small number of incidents we found examples where the initial response was not timely, nor were the risks to the victim clearly recorded in the call log, and the call was not promptly brought to the attention of a supervisor.
- 8.41. Call centre staff in all forces were aware of the sensitive nature of HBV-related calls and the need to restrict and control access to information about certain types of incident. In two forces, we were told that it was not possible to restrict access to information on the force computer systems. This meant that, dependent upon the nature of the call, and the required level of confidentiality, paper records were sometimes created which, in turn, would not be readily available to officers needing it for future responses to the victim (potentially putting the victim at increased risk). Nor would the force have an accurate record, within its computer systems, of HBV-related incidents and crimes.
- 8.42. Most call-handlers we spoke to understood the differences between domestic abuse and HBV, for example, that a scheduled response from a member of a specialist team may be preferable to a uniformed officer. This was not always the case amongst frontline officers in all forces. Some officers stated that they would look to take positive action in HBV cases, as they would for domestic abuse, and did not appear to recognise that such action might increase the risk to the victim. We examined one case reported in October 2012 where a Bangladeshi male reported that his 17-year-old daughter was trying to run away as her parents disapproved of her non-Muslim boyfriend. There was no evidence in the incident record that consideration was given to the risk of HBV or FM. The victim was subsequently taken to Bangladesh, forced into

marriage and was the victim of a serious sexual assault, which was reported in March 2014.

## Flagging HBV cases

- 8.43. We assessed the extent to which forces had procedures in place to ensure that HBV, FM and FGM victims, incidents and crimes were recorded on force computer systems, and whether they are identified as such and could easily be retrieved, for example if police received additional intelligence about risks to a victim. Once identified, the incident can be graded according to the level of urgency and a 'flag' can be added to the record so that it can be readily identified by other relevant specialist units such as multi-agency safeguarding hubs (MASH), who can provide the necessary support.
- 8.44. We found a wide variation in procedures for recording HBV, FM and FGM victims, incidents and crimes. Some forces had very limited, or no capability to flag HBV cases. Where such flags do not exist, and/or where the numbers of reported incidents are low in a force area, this makes it more difficult for forces to understand the effectiveness and efficiency of their response to HBV threats in their area. In turn, this compounds the 'hidden' nature of these crimes.
- 8.45. We spoke with one specialist domestic abuse response officer who told us that they had attended around 30 domestic abuse cases in the past ten months where they felt that there was, or could have been, an honour-based element. Without the ability to flag these as such, the officer recorded the honour-based element in a free text field, which is not easily accessible to other users.
- 8.46. This example illustrates the point made by the Iranian and Kurdish Women's Rights Organisation (IKWRO) in their report, *Postcode lottery: police recording of reported 'honour' based violence*<sup>84</sup> and highlighted in Chapter 3 of this report. Police recording of HBV cases may not always accord with the actual number of cases, with the result that some forces may be carrying an unknown level of risk in terms of the safeguarding of victims.
- 8.47. Furthermore, the recording of information across multiple computer systems, and the lack of clear tagging of HBV-related incidents made it very difficult for some forces to identify all such cases.

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<sup>84</sup> *Postcode lottery: police recording of reported 'honour' based violence*, Iranian and Kurdish Women's Rights Organisation (IKWRO), London, January 2014, <http://ikwro.org.uk/wp-content/uploads/2014/02/HBV-FOI-report-Post-code-lottery-04.02.2014-Final.pdf>

- 8.48. A failure to identify or ‘flag’ HBV incidents and crimes either accurately or at all, in police systems – whether due to a lack of understanding or a force’s multiple IT infrastructures - will impair significantly a force’s ability to collect intelligence on the level of risk in the local population, corresponding demand on the police service, and to protect victims. This is not only an issue for understanding the level of the problem within the force area, but also for repeat incidents. These may be in individual cases and within families, for example where there is more than one victim such as a sister or cousin.

## **House calls/victim engagement**

- 8.49. The honour-based element of incidents reported to police may not always be evident when the incident is first reported, for example in incidents of domestic abuse. Findings from our victim engagement project showed how difficult it can be for victims to provide all relevant information when they first contact the police. When making a house call or responding to an emergency request, our interviewees wanted officers to be mindful that victims may be withholding the full picture of abuse, for fear of retribution or of ‘dishonouring’ the family, or they may be struggling to articulate what has happened, given the unfolding trauma.
- 8.50. Interviewers noted that, for some participants, it was the first report (and for a few, the only report to police) after a significant period of abuse which was a critical opportunity for police to intervene and disrupt the violence. Victims wanted responding and investigative officers to be sensitive to the way HBV may operate in families in a variety of ways. These included the way in which coercive control can be exercised by the partner as perpetrator, and also the extended family (and possibly community networks). In the following example, the police seemed preoccupied with whether the victim was physically locked in the house. She illustrates how victims are kept in place by fear:

“Then first I declared that my husband kept me a prisoner, or as his slave and I couldn’t do anything. Then they asked if he locked the door and kept the key and put you in house and I said, “No, but he said that you are not allowed to go out, stay home.” Then I reluctant to go because I know him he gets very aggressive and violent. Yeah. But they only wanted to know if he locked the door and take the key, that’s all. I got the key but I was reluctant to go out and I know what will happen if I go out.” (HBV victim)



- 8.51. A key issue emerging from the victim engagement interviews was the impact that reporting incidents to the police and/or a police visit to the house may have on the victim. This is important in understanding the context, motives and implications of reporting, and the corresponding imperative for police officers and staff to be aware of the complexity of risks to victims. This is the 'one chance rule'.

"So this was the biggest thing that could have happened, so they [the police] didn't understand the dynamics of our culture...how Pakistani family... and if the police shows up that's not normal, and what they would do to me once they leave." (HBV victim)

- 8.52. While the initial police response and presence could be welcome as a brief period of respite, many women in our victim engagement project felt unable to pursue the matter further, for fear of 'dishonouring' the family.

"The police came, I went to the neighbour. I said to the police, arrest him [her husband]. My brother in law came and said, don't arrest him, it is our family matter and we will be dishonoured. I was foolish. I said okay." (HBV victim)

- 8.53. Other victims had made reports to the police in the past but due to a poor experience, decided not to do so again. They were then subjected to escalating violence, as in the example of this participant:

Interviewer: "What happened next?"

Participant: "I went back to live with him."

Interviewer: "Because you were homeless?"

Participant: "Yeah, I went back to him and the same issues started again....the child was growing... and the situation became worse. Yeah, I think it was one year after that in [date] he started hitting me again in front of my child... my child was in my arms... it was 6 in the morning and I was breastfeeding when he hit me. And the child was frightened. I didn't call the police again. He punched me and I had a swollen mouth that's why I decided to leave him. [...] I [was] advised to contact [voluntary sector organisation]. Then I knew there are supporting places." (HBV victim)

- 8.54. The ethnic identity of a responding officer was also a consideration in the context of reporting HBV: ethnic matching could have both positive and negative impacts. For example, in the following case, the victim was made to feel uncomfortable – even at risk – by an officer who made unwarranted assumptions about their supposed common identity and community ties:

“So the [other force] policeman came to [victim’s new address, unaccompanied] and he was Asian as well [...] He did the full risk assessment and then right at the end, what really shocked me is, he was Asian, and he’s from [location], he goes: “Oh, you do understand that in [location]”...he goes, “because one to one I’m just telling you that in [location], all Asian families they know each other, and they know what’s going on... so for you, when you left, you realise that it’s a bit of a... your honour’s basically gone. You do realise that it’s gone because everyone else knows, and ...” he [says], “I know what it’s like because I’m Asian as well, because they’re your family, that’s your mum at the end of the day. So if you feel like...it’s good if you do ever talk to them again [...]” Of course, then I was like, he’s Asian, he from [location], forget it, I’m not going to, I wouldn’t say anything after that so I didn’t tell him anything.” (HBV victim)

- 8.55. However in another case, the similar ethnic background of the police officer and the victim meant that the officer provided additional insight into her situation:

“Yes, it was [force HBV specialist]. So, with her ethnicity that was a big fear, and to be honest I was really scared now to trust anyone who was from a similar ethnicity, because it’s really hard... I know people think, why would you think that way, but I’ve experienced it loads of times and you really cannot trust anyone from a similar ethnicity. So that was a really big fear, I was quite scared to meet her. I met her, and basically that’s how the whole thing started, and she has been a tremendous help in my case.” (HBV and FM victim)

- 8.56. A number of participants in our engagement project expressed their relief at the quick response – in many cases, within ‘minutes’ – of the police and the supportive manner of the responding officers. This response was highly valued by victims. However, a sense of uncertainty from responding officers on what to do next was echoed in a number of experiences, as in the following example where a male police officer responded to a report to the police made by the victim online, apparently unaware of the ‘one chance rule’ and the associated importance of talking to the victim in a safe place on their own:

Participant: “When [the police officer] entered the house, my mother in law was sitting in front of me, and my husband, he was upstairs. I basically said there was no way I could talk with them in the home. [The police officer] was not aware that they were listening to what’s going on...so I said, “I can’t talk to you here – they’re just standing outside”, he [the police officer] was just not aware of what was happening.”

Interviewer: “Was it one police officer or two?”

Participant: “There was only one. [...]...I thought he was very helpful... but once he took me out, he was not sure what to do with me. So he basically contacted someone on the phone, he was in touch with somebody and they told him to bring me to the police station.”  
(HBV victim)

## Initial decision-making and actions

8.57. We checked the effectiveness of decision-making and actions taken during the initial contact with victims of HBV, FM and FGM. We did this by talking to responding police officers and reviewing a sample of case records, with a particular focus on the way in which risks to victims were assessed and acted upon.

### Risk assessments

8.58. All eight forces inspected used an approach to risk assessment primarily designed for identifying and managing risks to victims in domestic abuse cases. This approach, and its accompanying forms, is known as DASH (domestic abuse, stalking and harassment and honour- based violence). Three forces were using a bespoke approach to HBV risk assessment developed by a specialist voluntary sector organisation to supplement the DASH process.

8.59. There is no national template for FGM risk assessment, and we found variations across the forces in the extent to which FGM referrals were responded to similarly to or differently from HBV and FM. We expected that FGM reports would be referred to and assessed by specialist, joint agency child protection teams where the victim was under 18 and in three forces this was the case. In other forces it was not possible to confirm what had happened to these cases, or whether the force had received any FGM referrals, because of the difficulties in identifying HBV-related reports in police computer systems.

- 8.60. There was also variation in the arrangements for ensuring that assessments of risks to victims, and decisions on initial safeguarding arrangements were checked by supervisors. Some forces recognised that their existing approach to risk assessment for HBV cases was unsatisfactory and were in the process of making improvements.

### **Recording decisions**

- 8.61. We examined a number of incidents where the police records did not state who had ownership of, and who was managing, the initial decision making. In some cases examined we found that, even where officers had been trained in the use of a bespoke HBV risk assessment tool, such assessments were not recorded as having been completed. In those cases where assessments had been completed, the information was not always linked to force systems and available to view. This meant that these forces could not ensure that vital information about risks to a victim, and steps taken to safeguard them, would be accessible to officers and staff if the victim made a further call for help.

### **Safeguarding actions**

- 8.62. We found a number of good local examples where appropriate immediate safeguarding action had been taken by initial attending officers, particularly in those forces where these responding officers had received enhanced training on HBV. However it was not always clear who had responsibility for carrying out an enhanced risk assessment to inform the next steps in protecting a victim. In some cases there had been a significant delay in this process after the victim's first contact with police. This delay represents a potential risk to victims. We found one example in the case files we reviewed where there had been a two month delay in completing the full risk assessment because the victim had moved away.

### **Supervision**

- 8.63. The circumstances of many HBV, FM and FGM incidents are often traumatic, and in addition to the impact on the victim and others involved, the officer dealing with the matter can also be affected. Support should be available to officers through traditional supervisory arrangements, though some will require more specialist support. Some of the forces inspected had introduced the trauma, risk management approach.<sup>85</sup> However, such support was not consistently available to officers affected by HBV across all forces. We do not consider this issue to be sufficiently central to our report to make a specific

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<sup>85</sup> This approach equips members of staff with the skills to identify and support colleagues who may be suffering following specific events. These staff could then be referred for counselling or other psychological assistance. This complemented the more formal occupational health support that was also available if required.

recommendation about, but we nonetheless urge police forces to consider the support mechanisms they have in place for staff.

## **The victim's decision to report to police**

- 8.64. Emerging from the interviews in our victim engagement project are two factors that can influence the decision to report to the police: confidence and evidence. If a victim is to have the confidence to stand up to the perpetrator(s), this in turn requires an awareness that what is happening is 'wrong' and not part of a normal relationship(s), an assurance that they will be believed by the police, and that it is possible to stop what is happening. For women who had been controlled for a long period, they reported feeling that no other existence was possible: the perpetrator appeared all-powerful. They described the way that this power was reinforced by beliefs about family honour and shame.
- 8.65. Women also felt that reporting was not possible without 'evidence', and indeed, the issue of evidence was a recurring theme throughout the interviews. Women may have experienced years of physical, emotional and sexual abuse and coercive control: but they said that they were concerned they did not have evidence that would be acceptable to the police, such as 'photos', 'scars' or 'witnesses' who would testify. Having such evidence for the first time, gave them the confidence to report.

Interviewer: "Is that something that you feel you can do now?"

Participant: "Yes. Yes, because at some point [...] we were always going for counselling from the pastor but when we get there, because he's [the husband] somebody that is intelligent, he's more eloquent than me and when we get there I was always the one that can't talk. So when those things were happening, I had to start recording and that's what really helped me. So I had some voice recording of him and he'll be shouting, saying things. So that was what my solicitor was able to extract and when she listened to it and some text messages, she would send me like three pages of text messages insulting me and everything, what he's going to do to me, things like that." (HBV victim)

## 9. Phase 2 fieldwork – protection

9.1. This chapter reports our findings on the effectiveness of the police response in providing protection to victims of HBV. In the context of the victim's 'journey' we focused on assessment and help, and the availability of a trusted professional to support the victim. In each force we checked that:

- the force works together with others, undertaking assessments to provide effective help, support and protection to victims; making a positive difference to their lives; and
- officers and staff do what they say they will do.

### Assessment and help

#### Reporting

9.2. In all the inspected forces, we found that police officers and staff had a good general awareness of initial safeguarding<sup>86</sup> considerations when responding to a call or attending an incident. In our discussions with staff and reviews of case files, we found that they were aware of their responsibility to complete initial safeguarding actions to make sure that the victim is safe and to promote confidence in the police.

9.3. We examined a number of cases, and saw evidence of a range of safeguarding measures. For example, in one FM case the force worked with a wide range of external safeguarding partners to support the victim. Contact with the victim was managed in a way which did not reveal police involvement, avoiding the potential for this to increase the risk to the victim. The force had liaised with both the Forced Marriage Unit (FMU) and the Foreign and Commonwealth Office to block a visa application by the perpetrator who was abroad.

#### Safeguarding

9.4. However, the ability of frontline staff to recognise indicators of HBV and to take appropriate safeguarding measures was more variable. We found inconsistent understanding, for example, in the use of safe means of contact, agreeing code-words, and discussing an emergency plan to leave the family home at short notice if necessary.

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<sup>86</sup> Specifically meaning here to protect, support and reassure victims.

- 9.5. In some cases there was evidence that staff considered all risks and protective factors to put thorough safeguarding plans in place, with actions such as the use of police protection powers, taking possession of passports, setting up airport alerts, and making checks to see if others were potentially at risk. In other cases, we found that officers responded appropriately to the domestic abuse aspects of incidents that were HBV-related, but did not always identify the factors that indicated HBV. This could lead to police inadvertently placing victims at further risk by not ensuring that HBV-appropriate safeguarding or procedures were followed, such as the actions detailed above.
- 9.6. There was some good evidence from our victim engagement interviews of police officers thinking about safeguarding measures, such as the provision of safe accommodation for victims, and providing reassurance. In other cases, victims described how their reluctance to press charges or to move to safe accommodation, often due often to family pressure to safeguard honour, meant that they continued to be at risk.
- 9.7. Some victims called the police in a crisis situation, because they wanted immediate physical protection. Once the police arrived, some withheld information through fear of the perpetrator and/or fear of involving the police further and 'dishonouring' their family. This meant that the risk assessment would not have accurately captured the threats that the victim may have faced.

Participant: "Yeah, they asked me what happened and did he hit me or not. They asked me do I have any friends around to go there. Things like this, yeah. And they asked me to go back and stay there."

Interviewer: "So, did you tell them that you can't go back?"

Participant: "Yeah, I said I don't wanna go back."

Interviewer: "Ok, did you feel that they actually...they understood the risk you were under?"

Participant: "No, no, because I myself did not explain enough for them that he punched me and pushed me down the stairs; I just said we had got some arguments; therefore, they didn't take it so seriously and they said go back upstairs." (HBV victim)

- 9.8. One participant showed interviewers a document suggesting that the views of the family (the perpetrators) were used as a basis for the assessment of risk. Given the way that families often collude in HBV, this approach is highly problematic and again demonstrates the ways that a lack of understanding can result in increased risk to the victim.

Interviewer: “No action was taken against them at all? By the police?”

Participant: “No, no, no [...] Because my in-laws were constantly saying, “We are sending her back to India”. [...] And the police said, “Oh if she’s going back to India there is no risk then” [...] That was in the report I read. That no risk has been assessed, that [name] is here in the country on the basis of spouse visa which was issued to her because of her husband. And so she’s now, if she’s not living with them she has to go back to India and her husband is giving her a paid ticket.” (HBV victim)

### **Referral to HBV specialists**

- 9.9. We found, in general, that cases that came to the attention of HBV specialists in forces were managed well, though in some forces there was an over-reliance on key knowledgeable individuals, which raised the concerns about strength in depth discussed earlier in the report.
- 9.10. The case file reviews we carried out demonstrated that effective steps were taken at the initial stages of investigations and frontline staff gave examples of using statutory and third sector partners to help accommodate victims. There were processes in place for referrals and subsequent assessments of risk at multi-agency safeguarding meetings. However, not all cases were referred to force specialists. Furthermore, and self evidently, such a referral will only be made if the officer or staff member has identified HBV risk factors. As identified in Chapter 8, this does not happen reliably in all forces or in all cases.
- 9.11. In some forces, the good work done in developing thorough safeguarding plans was undermined by the multitude of different systems, some of which were not retrievable, on which those plans were recorded. This could create difficulties in accessing relevant information and providing effective safeguarding plans out of office hours when police were called upon to respond to immediate threats faced by victims.



## **Responding to victims' needs and views**

### **Keeping victims updated**

- 9.12. In all forces, there was a clear focus on meeting victims' needs, although this was subject to the ability of staff to recognise and respond effectively to indicators of HBV, as described above. Officers and staff understood the importance of taking the victim's views into account when making safeguarding decisions, and of keeping them informed. This was apparent in the cases reviewed.
- 9.13. However, officers were not always clear about who was responsible for maintaining contact with the victim. This suggested that the victim would have to initiate contacts with the officer in the case for updates. Some staff stated that other demands meant that victim updates were sometimes missed. In some forces, more effective support for victims was provided by specialist victim and witness care services who worked closely with the multi-agency safeguarding teams.
- 9.14. In many cases it was apparent that officers understood the difficulties faced by victims when reporting crimes perpetrated by members of their family. An example was seen where a FGM victim requested that their parents were educated rather than prosecuted. In another example, the victim was reluctant to proceed with a prosecution and was visited again sometime later to afford them the ability to change their mind.
- 9.15. In some forces it was evident that officers had a well-developed understanding of the factors that may inhibit victims from taking further action following the report of an incident. For example, there may be instances where officers believe the victim is being coerced not to support protective action for themselves, such as seeking an FMPO. In one such case a force had used an expert who was independent of the police and the victim, to advise and assist the court in making the assessment of whether to make an order.
- 9.16. However, there were also examples from our case studies that showed that victims' experiences of police contact are not always positive, as illustrated in the case on the next page:

### **Case study – HBV**

The victim is Maria, age 40. She contacted the police 4 years ago when she first fled from her husband, in laws and family who are all a risk to her and her children. She had been prevented by her family from reporting any crimes before then. She was referred to the police Public Protection Unit. She is also being supported by a voluntary sector organisation. Maria stated to the voluntary sector organisation that since reporting to the police she has felt that they don't know what do with cases of HBV and FM. She has not felt supported by the police, or that her concerns regarding risks been taken seriously. There have been several forces involved as she has had to move a number of times because her family were able to find her location. When interviewed by police she felt that her concerns had not been listened to and the officers did not have any experience or knowledge of HBV.

### **Initial response/action and safeguarding**

Maria stated that the police have always moved her somewhere safe when she has been traced, but no support was provided afterwards even though it was always promised. Initially after reporting she said that they had made her National Insurance number case sensitive. She later found out that this needs to be renewed every 6 months. She informed the police about this but the police told her that this wasn't true and she has also been told that they can't keep renewing it. Maria has informed the voluntary sector organisation a number of times that the police have misinformed her about safety measures and have made empty promises which then has led to her not trusting or having any faith in the police.

Recently a professionals' meeting took place regarding Maria. The police did not attend this meeting but safeguarding was discussed at length between other professionals, including measures that should be in place, for example, CCTV, protection orders, and FMPOs for her children as they are at risk of FM.

Maria was eventually referred to the independent domestic violence advocacy service within the police. She is also being supported by the voluntary sector organisation, a welfare and support worker, GP and a social worker. The identified police officer in charge of the case has been on sick leave for a while and Maria has not been assigned another officer. She was told that she didn't need one by the officer's superior. Maria stated that the communication and updates from the police have been very poor and disappointing. She said that she wouldn't hear from them for weeks at a time and if she left messages for anyone to call her back they wouldn't contact her for weeks. She said that they would tell her they would call her on certain days/times but the majority of the time she wouldn't hear back from them at the date/time agreed.

- 9.17. Our interviews with victims of HBV suggested that of 34 people who reported their experiences to the police, 20 were happy with the initial police response but only nine were happy with their experience of contacting the police overall.
- 9.18. Victims' views of their experience of the police were strongly influenced by what happened in the following days and weeks, rather than by the initial response alone. While victims appreciated the immediate securing of physical safety that police offered, they felt that their ongoing and longer term safety was taken less seriously. There was a sense among some participants that the role of the police was to move women to safe accommodation and then withdraw. Some victims reported positive and co-operative experiences where the police tried to find suitable accommodation and provided interim security measures, but others had much less positive experiences:

Participant: "So after three days the police took me away."

Interviewer: "Where did they take you? [...] Did they take you to a refuge?"

Participant: "No. Some woman took me to a hotel. There was a pub below and my room above."

Interviewer: "How did you feel there?"

Participant: "Very bad. I was scared. I didn't go out for two days. They told me there is breakfast at 9 am but I couldn't go. I didn't eat for two days. Then [name of worker] from [voluntary sector organisation] came, she came to help me. She took me from the pub and roamed about with me for so many days to help me." (HBV victim)

- 9.19. There were some very concerning accounts, including a woman and her two small children who were left by police outside a hotel without food or money and without contact for three days. Another woman, who was pregnant, was taken by police to a hotel but she could only afford to stay for one night. The following morning she travelled on a 24 hour bus for safety and was later taken in by strangers. The failure of the police to follow up contact with this victim as a matter of urgency meant she was at considerable risk both from other potential abusers and from returning home to the perpetrator, which in desperation, she ultimately did.

- 9.20. Where victims experienced proactive contact by police during their stay in temporary accommodation and beyond, their wellbeing and confidence were significantly enhanced. This victim, for example, outlined a history of repeated calls to the police and, in her view, a slow and unsatisfactory response. She then found a sudden change in their approach:

Participant: “Yeah they just turned up! And just looking at me and, saying are you okay?”

Interviewer: “Just to make sure you were okay?”

Participant: “Yeah just to make sure I am fine. And at this time I’m very happy [laughs] – yeah, it’s very good. They say, if something happen, you call the police again, and I say Okay”. (HBV victim)

## Multi-agency responses

- 9.21. Safeguarding plans and associated action to protect victims often require the involvement of other agencies such as social services, refuges or other voluntary sector organisations, as the following two case examples illustrate:

### **Case study (forced marriage) – Ms X**

A school reported to social services that Ms X had been taken out of her GCSEs by her parents. Ms X’s secret boyfriend told the school that she was being forced into marriage, having received messages from her. Social services told the school welfare officer that there was nothing they could do as Ms X was out of the country. The welfare officer contacted the police who immediately obtained an FMPO. Within four days of the FMPO being served Ms X returned to the UK.

### **Case example (FGM) – three-year-old child born in the UK**

A voluntary sector organisation received a call from an outreach worker raising concerns for a toddler child at risk from FGM. The outreach worker had become aware, through a conversation with the mother, that she was planning to fly to Nigeria with the child the next day. The mother had originally told government officials that she would never go back to Nigeria because her daughter would be at risk of FGM.

As the family location was unknown the voluntary sector organisation contacted the local police who then liaised with British Transport Police to intercept flights to Nigeria over the next 24 hours. The FMU was also contacted to request support in locating the child and mother. This was successful as the flight was confirmed through checks and police were subsequently able to seize the child's passport and put a trace marker on the mother to stop her from leaving the country.

- 9.22. All eight forces had systems in place for joint working with other agencies. These systems were used for those cases where officers identified a need for safeguarding plans that involved services additional to the police. The systems operated in different ways across the forces, with some forces having well established multi-agency safeguarding hubs (MASH) and others working towards this, and/or using multi-agency risk assessment conferences (MARAC) to co-ordinate joint responses to the safeguarding of victims. Forces also engaged with partner agencies on a regular and less formal basis whilst managing the safeguarding of victims, although some specialist staff stated that they were not always aware of safeguarding plans which have been agreed by victims with other partner organisations such as refuges.
- 9.23. There was a wide variation in the volume of HBV cases managed through these processes. In some forces we were confident from talking to staff and reviewing case files that multi-agency safeguarding arrangements were effective. In those forces with a low volume of HBV cases, however, evidence of assessment and allocation of safeguarding responsibilities was less reliable. Some forces were working closely with partners in the health service to develop appropriate responses to reports of FGM. In general, forces' joint working in respect of FGM followed existing child protection arrangements.
- 9.24. The investigations reviewed during the inspection did not routinely summarise how either the police or other agencies were going to manage ongoing safeguarding when these cases were closed. (We say more about closure of cases in the next chapter.) There was no common approach across the forces to the recording or review of ongoing safeguarding arrangements when cases were closed by police.

### **Case study – FM/HBV – good practice example**

The victim was a young woman in her twenties. Her family were pressuring her to marry and she was experiencing sexual abuse from a relative. She reported to police and presented at a police station for help as she did not wish to return home. Police worked with a specialist third sector organisation to reassure the victim and identify safe areas for refuge. A refuge place was secured in another county, and police provided a travel warrant.

The options for protecting the victim were discussed with her, including an FMPO, a non molestation order and injunctions. She did not wish to proceed with any of these because she feared her family's response and wanted to maintain a relationship with them in future. A witness statement was recorded. Police made contact with the family on the victim's behalf and obtained a warrant to collect her belongings. The police officer in the case was extremely supportive and reassuring towards the victim and worked alongside the third sector organisation to provide ongoing support.

There were younger nieces and nephews in the family who potentially could be at risk of the same abuse.

- 9.25. The police officer maintained contact with the victim throughout and always respected her wishes in relation to family. Risks were perceived and dealt with. She was eventually referred to a different refuge in another area when she became vulnerable again through a family connection. Police communicated with other relevant forces and with the third sector organisation, and made referrals to ensure the victim was safeguarded and had relevant points of contact.
- 9.26. The victim now lives away from her family but has contact with them. Police are still involved and monitor contact at the victim's request to ensure she is safeguarded as far as possible. Support from the third sector organisation also continues for the victim.

## Information sharing and confidentiality

- 9.27. The risks to victims of inappropriate information sharing, however inadvertent, are illustrated by this example from our victim interviews:

Participant: “Then what happened was that [...] I went to the police station to deposit the house keys of my old house. They asked for my address, and name. The police gave the keys to [the husband] and with that they gave him the address of my new house where I had shifted.”

Interviewer: “They gave him your address?”

Participant: “Yes, by mistake. I think if they had taken this matter seriously, they wouldn’t have given him the address. [...] They came to me, to my new house and said, “You are not safe here, we will move you again”. I said to them, “I am not moving again. You have created this mess, how many times can I keep running away from him? He is sitting there happily, I am running here and there with my children.” (HBV victim)

- 9.28. All forces had established protocols or agreements in place to support the sharing of sensitive information relating to victims’ circumstances and safeguarding plans. Officers involved in processes such as the MARAC were aware of the need to share information in HBV and FM cases with only those who need to know. Some forces only deal with such matters in closed sessions, restricting the circulation of the meeting minutes. Appropriate information-sharing with partners was evident from the case files we reviewed, with dissemination as necessary to the policing leads within community areas.
- 9.29. There was evidence that these approaches were not always comprehensive or reliable from the perspective of how the victim’s case progressed through the criminal justice system and safeguarding procedures. For example, in one force we found that there were no specific procedures in relation to how sensitive material in such cases should be stored and retained on force systems. In some forces, information held on HBV cases was not readily available to others in the organisation, for example where was kept on paper records.
- 9.30. In one instance, whilst all HBV cases were referred through to a MARAC, we found that the force was not restricting the accessibility of information to those that needed to know. We were told that the meeting minutes from all MARAC cases were circulated to all MARAC members, irrespective of whether they had attended a closed meeting.

- 9.31. Where information was disseminated to policing leads within community areas, it was not always evident that this had been followed up to check what action had been taken. We found one case where briefing material containing information relating to HBV perpetrators had not been reviewed or updated for six months.
- 9.32. The most effective arrangements for multi-agency working overall appeared to exist in those places where police and partner agency staff were co-located, sharing office space and operating joint procedures on a daily basis.

## **Trusted professional**

- 9.33. We checked for evidence in each force that officers and staff do what they tell victims they will do. From the perspective of our victim interviews, good experiences were characterised by timely, personal updates on the progress of the case in the days and weeks following a report and, where appropriate, additional security measures. Victims appreciated a dedicated officer who knew the case, avoiding the victim repeating their story, and a second officer who was similarly well-briefed. Those participants who had been contacted by a force HBV specialist were particularly happy with the support they received.
- 9.34. Victims described poor experiences as characterised by no contact either at all or for long periods, by being directed simply to call 999 if needed, or by contact only being maintained through the perseverance of the victim. We heard that the impact of no contact meant that some victims were vulnerable to pressure to return to the family, putting them (and their children) at significant risk of harm. We noted too that victims may be prevented from making contact, underlining the need for proactive police follow-up.
- 9.35. We found that officers and staff were aware of their responsibility to keep victims safe and informed, and understood their obligations with regard to the Code of Practice for Victims of Crime (or Victim's Code).<sup>87</sup> Although, they were not always confident of the detail, nor of any specific needs that may exist in respect of victims of HBV, FM and FGM. However, as identified earlier in this chapter, some officers and staff do not always fulfil these the obligations.

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<sup>87</sup> The Code of Practice for Victims of Crime is a legal code which sets out the minimum level of service that victims of crime should get from criminal justice agencies. It applies to all criminal justice agencies, including the police, Crown Prosecution Service, Courts Service, and the Probation Service.



- 9.36. Forces supported officers and staff with a range of policies and guidance to highlight everyone's personal responsibility to victims of crime. During the inspection, staff demonstrated a personal pride in their job and a clear commitment to safeguarding and supporting vulnerable victims, working with specialist units and others where necessary. There were a number of processes across the eight forces to ensure that contact with victims was maintained. These included the use of victim contracts<sup>88</sup> and referrals to specialist victim and witness support services.
- 9.37. From the files we reviewed, it was clear that in most cases the frequency and means of contact was discussed and agreed with victims, and that victims were regularly updated in line with their wishes. In most cases, forces ensured that victims received their entitlements under the Victim's Code.<sup>89</sup> However, we found some evidence of child victims' entitlements (such as a video-recorded witness interview) not being identified in cases which were not investigated by specialist child protection teams.

### **Partnership working**

- 9.38. We examined a number of cases of HBV and FM where another agency was involved in safeguarding and supporting the victim. In one force it was noted that the role of independent domestic violence advocates was particularly important, for example in maintaining contact with the victim in a way which did not increase the risk. Where partner agencies are involved, it is important for forces to handle this in a way that protects, supports and reassures the victim. In our case reviews we found evidence of constructive challenges made by police to other agencies, for example to children's social care staff on a perceived lack of appreciation of the risk relating to a 16-year-old and FM. We also found evidence from case files indicating appropriate signposting of victims to non-government organisations and other help groups.
- 9.39. Generally the involvement of other agencies in supporting and safeguarding victims was co-ordinated through the multi-agency arrangements that were in place to protect, support and reassure vulnerable people and/or victims. However examples were seen where, in addition, local teams were working informally to raise awareness of HBV. In the Metropolitan Police Service, one borough had produced a one page leaflet with advice on how victims can stay safe, and a theatre company had produced a DVD which was used during training in another borough.

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<sup>88</sup> A 'victim contract' is agreed with every victim when a police officer attends either a crime or an incident. The contract ensures that victim contact is determined by the victim in terms of how often and by what means they are kept informed regarding progress of the investigation.

<sup>89</sup> *Code of Practice for Victims of Crime*, Ministry of Justice, October 2013, available from: [www.cps.gov.uk/publications/docs/victims\\_code\\_2013.pdf](http://www.cps.gov.uk/publications/docs/victims_code_2013.pdf)

## **Communicating with victims**

- 9.40. The responsibility for communicating with victims varied depending on the circumstances of the case and the progress of the case. In some instances we found that cases were not identified or flagged as HBV cases prior to allocation for investigation and staff involved in those cases had not received any specific training on HBV. This affected staff's ability to identify and recognise HBV cases, make referrals to victim support services and/or to communicate with victims appropriately.
- 9.41. In some cases it was apparent that several staff, each with different roles, could be responsible for communicating with the victim. In FGM cases, for example, up to four officers or staff could be responsible for communication: the officer in charge; the sexual offences investigation team officer; the family liaison officer; and the witness care clerk. In some instances communication responsibilities were not documented but were based on long established protocols. The lack of documentation represented a risk to the consistent good management of communication with victims.

## **Force transfers**

- 9.42. Where HBV, FM or FGM cases or victims pass to or from another force, it is essential that the transition is handled in a way which protects, supports and reassures the victim. The understanding amongst officers and staff of safe approaches to the management of force transfers in high risk cases was mixed. We identified a number of risks relating to the management of cases transferred between force areas. We spoke to senior officers who were not certain whether they would be specifically briefed about cases in their area, or whether there would be any reference made during daily management meetings.
- 9.43. Despite the fact that there is national guidance to the police service on relocation of HBV victims between force areas,<sup>90</sup> we found considerable inconsistencies in forces' approach to and management of this in practice, with associated risks to victims. In one such force which had developed its own guidance and protocols to support the transfer of HBV victims, we examined two records of transfers. In neither case had there been a formal transfer process, nor was there a record of any formal agreement between the forces to ensure continuity in protecting the victim.

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<sup>90</sup> *Guidance on the Relocation of Victims of Forced Marriage and Honour Based Violence Between Force Areas*, ACPO, June 2008.

- 9.44. We also found cases which had been transferred to other forces at constable level, with no evidence of senior oversight, where problems had arisen. One force also informed us that it may not always be made aware in cases where the relocation is arranged by a third party, citing an example of when this had occurred.
- 9.45. In our victim engagement project interviews, a small number of cases had involved force transfer. Each had different and complex features. Broadly, the transfer from one force to another occurred because the abuse happened in one location, but the woman reported from the location where she had since moved. In all cases, victims said that force transfer made reporting, seeking updates and understanding police decision making extremely difficult. There were also issues of service provision across local authority boundaries.

“They just gave me a crime reference number and referred me to [police force where victim lived before, over 250 miles away]. How can I do a report there?”  
(HBV victim)

- 9.46. In the Metropolitan Police Service (MPS) the force transfers HBV and FM cases or victims to another force by completing an inter-force transfer form. This form was developed based on the approach used by Police Scotland when transferring HBV cases, and using the learning from the force’s previous experience of transferring cases or victims to other forces. The form is comprehensive and requires information relating to all elements of the case. In addition, the detective sergeant from the transferring community safety unit makes contact with a named individual in the receiving force to confirm the transfer. The crime management unit reviews all transferred cases to check that the process has been correctly followed.

## 10. Phase 2 fieldwork – enforcement and prevention

- 10.1. This chapter reports our findings on the effectiveness of police investigations, identification and management of perpetrators and case closure in HBV incidents and crimes.
- 10.2. In each force we assessed the extent to which:
- HBV, FM and FGM investigations (crime and non-crime) are thorough, timely and the needs of the victim are central;
  - the force works together with others, to identify and manage those who pose a risk to victims; and
  - officers and staff close cases in a victim-centred and timely way.

### Investigation and specialist support

#### Who investigates?

- 10.3. We found that investigations of HBV incidents and crimes were undertaken by a range of specialist units across the eight forces, mostly within public protection or protecting vulnerable people teams. In some places we were told that the capacity of these teams was at full stretch, with the consequence that there were backlogs in assessments and investigations in all but the highest risk cases. This was concerning, not least because evidence from domestic homicide reviews<sup>91</sup> shows that low and medium risk cases can sometimes escalate quickly to high risk, which might be missed if they are part of a backlog.
- 10.4. When we spoke to investigators within those teams, they described a gap in their professional skills and knowledge to deal with all categories of HBV, but mostly they had access to specialist advice to support their assessment and decision-making.

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<sup>91</sup> In April 2011, the government implemented section 9 of the Domestic Violence, Crime and Victims Act 2004. This means that local areas are obliged to undertake a multi-agency review, following a domestic homicide, to assist all those involved in the review process, in identifying the lessons that can be learned with a view to preventing future homicides and violence.

## **Training**

- 10.5. There was wide variation in the extent to which officers and staff working in specialist investigation units had received training on HBV. In one force there had been no training for these staff. Some forces had provided guidance in relation to the investigation of HBV, FM and FGM cases to ensure the right information was collected for evidential and intelligence purposes. There was very little evidence of a systematic approach to continuing professional development for specialist staff in this area.

## **Case review findings**

- 10.6. We reviewed a number of cases in each force. In some forces there were a very limited number of investigations recorded, reflecting the low numbers of HBV, FM or FGM reports received or identified by police as relating to those areas. Overall we considered the investigations to be effective, and they appeared to be timely, with the needs of the victim central to the investigation. Joint safeguarding with partners was evident, including joint visits in cases of FGM. However, we found an inconsistent approach, between and within forces, to the identification and follow-up of lines of enquiry. There is no national guidance to the police service on the format or structure of HBV investigations, which contrasts with other types of investigation.

## **Supervision**

- 10.7. All forces had established supervisory arrangements to provide oversight and direction and ensure that investigations were effective. However, supervision was not clearly recorded in all cases. Regular reviews by supervisors for certain crime types were mandatory in some forces; in others review arrangements were made according to the assessed risk. In some instances we found inconsistent levels of understanding amongst staff about which crimes or incidents were subject to such reviews. There was very little evidence that reviews and monitoring processes were clearly linked to organisational learning.

## **Access to specialists**

- 10.8. The majority of forces had access to specialist support to assist HBV investigations where required. In the case of FGM reports, some forces had established links with local hospitals or other health professionals to examine victims where necessary. All forces had access to interpretation services, although there was considerable variation in the extent to which officers and staff were aware of the potential risks associated with the use of third parties in HBV, FM and FGM cases.

- 10.9. Third parties could include interpreters, but also members of the victim's community who might act as intermediaries (possibly in an attempt to conduct mediation). In some HBV cases, especially where the victim does not wish for anyone else to know they have been in contact with the police, an approach to anyone in the community to assist with the enquiry could pose a risk to the victim. Careful consideration should always be given as to why there may be a need for someone in the community to be informed, along with a clear recognition of the potential risks that such action may bring.

### **Findings from the victim engagement project**

- 10.10. Participants in our victim engagement project felt that the police could be more proactive in investigating their cases. Otherwise, victims said, perpetrators of HBV continue to act with impunity:

"It really isn't as bad [in victim's home country] as it is here [in the UK] with what happens to girls. At least there [in the victim's home country], people are afraid that these girls might speak and ruin their reputation so it's a question of honour. Here no one is scared because they know they can send the girls back home, and some of the girls do just that, because like me they probably don't know any better. They don't know they can get help, and I only found out after I tried to commit suicide." (HBV and FM victim)

- 10.11. Many of the women that we spoke to called the police in a moment of crisis, to provide immediate safety. After being asked by the police if they wanted the perpetrator(s) arrested or charges brought, some felt reluctant to pursue the case further for a number of reasons, including fear and protecting the family honour. A number of victims who were keen for the perpetrators to be prosecuted were later told (or in some cases, discovered second-hand which underlines failures in communication on the part of police) that their cases were dropped due to lack of evidence.
- 10.12. This issue of evidence was often compounded by the enforced isolation of HBV victims so that, for example, the testimony of friends or work colleagues was not available to provide corroboration. Family members who were implicated in the abuse were unwilling to testify, or would actively provide false statements or alibis. Some interviews revealed contact with other professionals (health workers, social workers and teachers) and potential witnesses, which victims felt might have supported their accounts if they had been pursued:

“I reported to the police every time [ongoing honour-based abuse perpetrated towards her by members of her community]. A different officer would turn up every time: there was no linking of the incidents. [...] I would name members of the community but they are networked through marriage, they would cover for each other. If 20 people give an alibi, the police are not going to believe the person reporting. I looked like a liar, like a complete fantasist, like I was wasting police time.” (HBV victim)

“But that made me really upset. I’m suffering too much, even my colleagues know it, sometimes I’m crying, I’m depressed, I’m not good situation in my work. And [...] everybody’s seen my face sometimes I got bruises and I got problems when I’m walking cos my husband always hit me in my private part so [nobody can see], you know, so I got a problem when I’m walking and sit down because my work is heavy and I’m lifting the people because I’m so...everybody knows I’m suffering problems but I don’t know why my case is closed down.” (HBV victim)

“It was nursery, the teachers, cos this time I wasn’t the one to call the police, I would just say all these little bits of things but it was the nursery, the teacher they say you need to call police.” (HBV victim)

10.13. Victims identified the importance of the police acting promptly to take photos of bruising and records of injuries. One participant expressed frustration that her historic medical records, documenting the effects of her abuse, were not used by the police as evidence to support an investigation. Some victims discovered too that their decision not to contact the police previously meant that they did not have a ‘reporting history’, which could have strengthened their case.

Interviewer: “Did they contact you after that? After they came [...], they took photographs of the bruises and everything that you had?”

Participant: “They did not take photo.” (HBV victim)

10.14. More than one participant wryly observed that it appeared only murder or kidnap would suffice as ‘evidence’:

“So if so many girls come and tell you this stuff, can’t you think for yourselves or listen that something is happening here in this country? When the girl been murdered, then you open a case – how does that help? You can’t bring the girl back at that point can you? So you need to support them, but they don’t support them.” (HBV and FM victim)

“But they [her husband and in-laws] beat me and they are asking that [same] family for information – if I beat someone like my mother in law, my husband and father in law would they tell on each other? No. I said that there aren’t any cameras in the house that there is a recording of what they did with me for you to see. [...] When they saw me [at the first police response], they saw what I looked like, it wasn’t good what happened. They stopped me from dying. If I died they would not have proof: they would have declared suicide.” (HBV victim)

## Working with the CPS

- 10.15. We checked to see how effectively forces worked with the CPS to ensure that HBV investigations and prosecutions were clearly flagged and vigorously pursued where appropriate.
- 10.16. We found that all eight forces inspected had joint protocols in place with the CPS to support the investigation and prosecution of FGM; some of these were on a regional basis with other forces in the locality. A few forces had protocols in place in relation to the investigation and prosecution of HBV/FM although in the main this was included as part of a protocol for domestic abuse. Most forces had an agreement in place with the CPS to provide access to specialist lawyers. In those forces without a protocol to support the investigation and prosecution of HBV and FM, there was a reliance on protocols used to prosecute domestic abuse cases. Most were aware that these were not necessarily appropriate for HBV and were taking steps to address the gap.
- 10.17. Even where HBV protocols were in place, staff reported that it was not always possible to secure timely advice from a lawyer with a specialism in HBV. In some areas, forces told us that they were not aware of any specialist prosecutors within the CPS for HBV, FM, or FGM (although the CPS has confirmed that there are specialist prosecutors in each of the 13 CPS areas). Officers did not always consider involving internal police legal services<sup>92</sup> in a timely way as part of their approach to safeguarding a victim. In several forces we found that these legal services teams were not aware of agreed protocols and that they had a limited understanding of preventative legislation such as FMPOs.
- 10.18. The reliance on the victim to take the lead and to provide evidence was a recurrent theme in our victim engagement interviews. None of our interviewees were aware that it was possible for the police and the CPS to

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<sup>92</sup> A force’s legal services department provides a comprehensive legal service to the chief constable, officers and staff on all matters of law and legal representation. The department does not undertake criminal proceedings for a force as this is the remit of the CPS but can advise on civil remedies and the legal position more generally.



bring the perpetrator to justice, without the victim's cooperation, subject to documented decisions that there was sufficient evidence to justify such a course and that this approach was the best option to mitigate the risk to the victim.

## Outcomes

- 10.19. While participants indicated that there were arrests in almost half of those cases which were reported to the police (34 people in our sample had reported to the police), we recorded only three cases which had resulted in a criminal prosecution and two successful criminal convictions.
- 10.20. One victim told us that she had been to court but the perpetrator was found 'not guilty' which she said left her feeling more vulnerable. She did not appear to have been given any advice on other legal measures that could be applied to assure her and her children's safety.
- 10.21. This woman, who had the most positive police experience overall within our sample, related the excellent support that she had received from the police in navigating the court process:

"First of all I was scared to go to court cos I was like, you know, 'What's going to happen in court?' and she [the dedicated officer] was like, 'Don't be scared, I'm going to be with you'. So when she said she's going to be with me, I felt really more confident [...] And she said, 'I'm going to sit next to you. If there is anything, you can just talk to me or give me like, you know, sign language or anything like, you know. You need to stop then obviously. I'm next to you.' And I was like okay. She [even takes me] to the court and picks me up and drops me." (HBV victim)

## Identification and management of those who pose a risk to victims

- 10.22. In each force inspected, we looked at the way that police officers and staff worked with others to identify perpetrators of HBV and to put measures in place to manage the risk they pose to victims. Forces used a variety of arrangements for monitoring known offenders and/or perpetrators of domestic abuse and to highlight those who present the greatest risk. These arrangements operate in partnership with other relevant agencies. They include, for example, integrated offender management schemes and multi-agency public protection arrangements, which are commonly used across other crimes where offenders are likely to pose an ongoing risk.

10.23. In all forces, we found that, in respect of HBV incidents and crimes, the identification of perpetrators and potential perpetrators was primarily reliant on victim disclosure and limited community intelligence. Few forces had used local policing resources actively to seek information and intelligence in respect of HBV, FM and FGM and potential perpetrators of these offences. As set out in Chapter 7, neighbourhood policing teams were not tasked with collecting HBV-related intelligence (which could assist in identifying potential perpetrators) even though they are the people most likely to know their local communities.

10.24. Information sharing with other forces in relation to known and potential perpetrators was not always carried out in a systematic way when a victim was transferred to another area, but was reliant upon individuals within a force. This meant that there were acknowledged intelligence gaps on police systems in relation to HBV perpetrators in each area.

### **Partnership working**

10.25. The range of factors contributing to intelligence gaps in police knowledge of risks to HBV victims have already been identified earlier in this report. Three examples are: the reluctance of some victims to report HBV incidents and crimes; a lack of awareness on the part of responding officers; and the failure systematically to flag HBV-related incidents on police computer systems. An important potential source of intelligence about perpetrators is partner agencies. As set out in Chapter 4 of this report, anyone who works in a regulated profession (that is: healthcare professionals, teachers and social care workers) and believes that a girl under the age of 18 years has undergone or shows signs of FGM is now legally required to report this to police. However, a legal requirement to report information is only one source; it does not mean that the police service cannot obtain a much wider range of information from partner agencies by developing closer working relationships.

10.26. That said, we spoke to voluntary sector organisations in one area who gave the opinion, specifically about FGM, that sharing information with the police was not always considered desirable, by either the victim or the specialist organisation. They said that the vulnerability of victims was a significant factor and that at present there was a lack of confidence in the ability of the police to deal sensitively with a victim's circumstances.

## Community engagement

10.27. One way to increase trust and encourage the flow of intelligence about potential perpetrators is through police engagement with local communities and those directly affected. An example was Avon and Somerset Constabulary's involvement with Integrate Bristol (discussed in Chapter 8), where officers and staff have been involved in a young persons' advocacy project to empower and educate young people regarding FGM and their rights. As a result, Integrate Bristol told us that there had been an increased level of trust in reporting concerns about matters such as FGM to the police.

## Awareness/use of tools to manage risk

### Case example: HBV

The victim is a woman in her forties. She describes her experiences which started in 2012 and are ongoing: "My daughter, late teens, insisted we contact the police and she called them. She had not been at the incident, which happened at about 9 or 10 in the morning, but she saw me afterwards and seeing the state that I was in, she questioned me and I had to tell her what had happened. This was the second violent incident perpetrated against me by my ex-husband. I had not told my daughter about the first incident and I had not called the police the first time because I was terrified. My ex-husband had warned and threatened me not to go to the police. I also didn't trust that anyone, including the police, could protect me from my ex-husband because his motivation to control me and save his "honour" was so strong.

"Immediately after the incident, my children and I stayed away from the house. We were still out of the house when we called the police at about 5 or 6pm. We asked them to be with us when we re-entered house, in case my ex-husband was there. But they just told me to take a friend with us, as if a friend could protect us from my ex-husband. About an hour after we called them, the police came to the house and took some details. They seemed really cold and not at all bothered when I told them what had happened and that I had been tortured for an hour. The police said that because I didn't call them immediately in the morning, when the incident happened, they could not take it further, even though it was the same day. I expected an injunction but they offered me nothing. They just told me to lock the doors and keep a log of anything that happened. Then they left me to get on with my life. I felt terrible; I felt unprotected, I felt really unsupported. There was no follow up from the police. Over a week later I received a letter from a DV organisation. That was it.

“I changed the locks but my ex-husband got copies (of keys). I called the police several times; to tell them he was harassing me including over the telephone and through my children. I kept on calling them and I got so frustrated that they were not doing anything. One time I called the police, they told me they were too busy to come and see me. They made me feel like I was being unreasonable. I was crying on the phone. I insisted they look at the case to see that I wasn’t being unreasonable. It should not have been for me to have to argue with them to convince them I was in danger. Every time I called the police they had to search my files, when I was on the phone and highly distressed and he was knocking on the door. Then they’d send someone hours later, when it was too late. I don’t think they understood my case as “honour”-based violence. A few times the police did come, but they always just gave me same advice; keep the doors locked, change your phone number.

“I told the police about his threats to attack me with acid. But they didn’t take it seriously. They underestimated the level of his motivation to control and hurt me because of his motivation of “honour”. They looked at the case like he was a Western man who would have been worried about getting in trouble with the police. But when it comes to “honour” saving face is more important than anything else. My ex-husband didn’t care if he went to prison because he thought his friends and family would think he was man for what he did. I tried to get an injunction for two years but the police would not support me. I was emotionally exhausted. The police never referred me to solicitors. The only referral to professionals was to social services because of my young son. Social services called me and spoke to me over the telephone. They said I was doing everything that I could do to protect my children. They didn’t see that I needed them to help me.

“When I moved from [area A] to [area B] I approached the council for housing and I gave them all the crime report numbers and I don’t know if they followed up. Since then further incidents have made me seek an injunction and I am in legal proceedings about that. I was shocked – my solicitor requested the police records from before I moved and they still haven’t sent them and it’s been over two months.”

- 10.28. We found that levels of awareness and the use of specific measures to manage the risks posed to victims by perpetrators was variable within, as well as between, forces. Only in one force (West Midlands Police) were we confident that there was a broad understanding amongst police officers and staff of the need for early intervention and proactive measures to prevent criminal acts by perpetrators.

- 10.29. There was a more mixed picture in the other forces, in part because the volume of relevant cases managed by a force was sometimes very low. It was particularly notable that legal services within forces were not always well engaged with the efforts of HBV specialists to promote measures such as protection orders or non-molestation orders as a means of controlling the activity of perpetrators.
- 10.30. Some forces had experience of using Domestic Violence Protection Orders and Notices (DVPOs/DVPNs) to manage perpetrators in HBV cases. Some had considered and/or taken out FMPOs in appropriate cases, in consultation with social care and other agencies. Our case examinations during the inspection showed that, in forces that had not yet applied for such orders, there had been cases where an FMPO could have been an effective tool. It was unclear from the records of these cases why the order was not sought. The first FGMPO in England and Wales was obtained by Bedfordshire authorities in July 2015.<sup>93</sup>

#### **Case study – Bedfordshire authorities' application for a FGM protection order**

Bedfordshire Police was alerted to a case involving two young female children. The two children, whose parents are Somalian asylum seekers, were both coming to the high risk age of FGM.

The police were alerted by school staff as the father had arrived taken the two girls stating that he was removing them for six weeks to break their bond with their mother. Police investigations revealed that in 2013 the father had been previously investigated by another police force regarding an elder stepsister (now 16 years of age) for FGM offences. The stepsister had already been cut but it was not possible to prove whether the offence had been committed in the UK or abroad.

The family were known to social services and so when they then moved into the Bedfordshire area, Bedfordshire social services were alerted about the family.

Following the contact from the school, the police found the family home and visited with social services. The mother admitted she was cut and subjected to FGM but she does not want her girls cut. The father had taken the girls and she stated he was out. Bedfordshire police intercepted a telephone call to the house and spoke to the father who admitted he was going to the airport. The police informed him they wanted to see and speak to the girls immediately. The father agreed that the girls would be left at the grandparents' home in London.

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<sup>93</sup> 'Police obtain first FGM protection order', *The Guardian*, 17 July 2015, [www.theguardian.com/society/2015/jul/17/police-obtain-first-fgm-protection-order](http://www.theguardian.com/society/2015/jul/17/police-obtain-first-fgm-protection-order)

The police were then alerted that the father was at Gatwick airport. Special Branch officers investigated and found he was already on a flight travelling towards Somalia. Police officers found that the two girls were not on this flight and traced them to an address in the Metropolitan area.

The police at the family home in Bedfordshire spoke to the remaining children a male child spoke to the police officers and said the girls were also going. The eldest son then stopped him speaking. Police believed that the girls were in imminent high risk of being taken out of the country for FGM purposes or, if this could not be achieved, then at risk in this country. The two girls were found in London and seen by police with a lady who is called their aunty. They were assessed as safe and well.

The police started an application for an emergency FGMPO. Statements were obtained from the attending officers regarding all incidents. Evidence was obtained of the previous police investigation into FGM offences with the father from 2013.

Working together with the local authority the case was presented to the court. The police evidence on the risk to the children was presented, with the attending police officer giving evidence to the court. An FGMPO was granted for both female children. The order also had a power of arrest and the power to seize passports and an all ports alert. The FGMPO was served by the police on the mother, father, grandmother and aunty.

10.31. We also found that the coordination of restraining and other civil orders was not always centrally managed within forces. Orders could be recorded in a number of different places and in those cases where the order had not been initiated by the police, we were told that the force was often not made aware of the existence of the order at all. This lack of central co-ordination limits the ability of the police and partner agencies to take effective action in respect of monitoring, oversight and information sharing relating to perpetrators.

10.32. In a few instances, forces were working actively with the Probation Service to identify and manage HBV offenders, jointly reviewing safeguarding plans in response to release dates and bail conditions.

### **Victim engagement project findings**

10.33. Seven participants in our victim engagement project described civil measures including 'injunctions', 'bans' or 'protection orders' being imposed against their partner. In at least two of these cases, these orders were secured through victims seeking their own legal representation. Other protection orders relating to FM or FGM were not mentioned or obtained by interviewees.

- 10.34. As regards criminal cases, two victims acknowledged that their cases were currently with the CPS and they were trying to find the strength to pursue the charges in court; others had given up pursuing criminal charges because of the multiple practical and emotional demands they were facing.
- 10.35. Finally, it is worth noting that cases brought in the family courts for ‘no contact between children and father’ appeared to be particularly important especially when, for most victims, attempts to seek justice through the criminal system had been unsuccessful. Victims described a ‘no contact’ judgement as a way of removing the perpetrator from their lives and helping to keep them safe.

Participant: “When the divorce was going through he [the husband] went to the school once and picked the children up. I went to a solicitor, and he told me to go to the court. The judge asked the children, CAFCASS [Children and Family Court Advisory and Support Service] was very good at the time, they spent a lot of time with the children, were convinced that the children really don’t want to see the father. So the court order was that he can’t see the children.”

Interviewer: “How was his relationship with the children?”

Participant: “When we were together, he used to abuse the children, he used to beat them, threaten them. They used to see what was happening to me. They told the judge, we are happy now with our mother.”

Interviewer: “Did the police help with the custody case?”

Participant: “No, they weren’t asked to come”. (HBV victim)

## Closure

- 10.36. We examined the extent to which officers and staff close cases in a victim-centred and timely way. In the majority of forces, staff demonstrated an awareness of their responsibility to ensure that victims are kept updated in relation to any investigation and are informed of the outcome when a case is concluded. Officers were aware of their obligations with regard to the Victims’ Code. In some of our case reviews, there was evidence that the views of the victim were considered when police involvement in cases of HBV, FM and FGM ends.

10.37. West Midlands Police had produced guidance for staff in relation to victim contact, including closure of cases. Staff across the force stated that they used this guidance to ensure cases were closed in a way that took account of the victim's needs and views.

### **Recording decisions to finalise**

10.38. We expected that decisions taken on the finalisation of HBV, FM and FGM cases would be properly recorded, and that where a decision was made to take no further action, not to charge or to record a 'no-crime', this would be appropriately reviewed by senior officers and/or managers. Where necessary, forces should develop long term strategies (with other agencies where appropriate, as described in Chapter 7) to ensure continued safeguarding of victims, including those who move out of or into a force area.

### **Supervision**

10.39. Supervisory arrangements for the closure of HBV, FM and FGM cases varied considerably. Where investigations of HBV were not subject to a bespoke investigation or scrutiny process, we found that there was a generalist approach to supervision, which was not necessarily targeted to the specific risks involved. When cases were brought to a conclusion, they were closed with the consent of a first line supervisor, generally a sergeant who had not necessarily received any training in relation to HBV, FM or FGM. In other areas, the finalisation of all types of HBV where no further action was to be taken by the force was the responsibility of senior staff in the public protection or specialist safeguarding teams.

10.40. Amongst the cases that we reviewed, the rationale for the decision to end an investigation were variable in that they did not always explain fully the reason for closing the case or show how the victim would continue to be safeguarded. The explanation for cases that had been considered for charge, but dropped by the police, was not always clear. The quality of long-term safeguarding plans was also variable, and the plans were not always recorded in a way that would be readily accessible. This represents a risk to the victim if they contact the police for further support at a future date and the full context of their case is not readily apparent to the responding officer.

10.41. In a few instances, we noted that the absence of specific scrutiny or subject matter expertise on HBV-related cases had led to incidents and crimes being missed until the reports reached the final closing administrative checking stage. Furthermore, we identified a number of case files that had been closed as "no further action" without evidence of a final supervisory review or authorisation. None of this provided confidence that ongoing safeguarding or specialist support for victims of HBV were being addressed systematically or reliably.



10.42. Of course, we accept that the question of when it is right to end police involvement in an HBV-related case may be a very difficult judgment, depending on the circumstances of the case and the assessment of continuing risks to the victim. But this difficulty only emphasises the need for clear recording of decisions and the reasons for them.

### **Victim satisfaction**

10.43. Forces were at different stages in the development of approaches to assess 'victim satisfaction' and the effectiveness of victim protection. Only one of those inspected had any specific process in place to explore victim satisfaction in relation to HBV, FM and FGM.

10.44. Avon and Somerset Constabulary had established a victim reference group. We were told that this group included survivors of HBV, and provided an opportunity for staff to listen to, and understand the victims' perspective, in a way that is expected to shape future operational responses. Other forces that had recently begun to seek the views of domestic abuse victims expressed the view that these initiatives could be developed in the future to include HBV victims. There was no information available to us that has enabled us to take a view about the effectiveness or otherwise of these initiatives in engaging with victims of HBV.

10.45. The Metropolitan Police Service is developing a 'my voice' survey which will be offered to all victims of sexual offences and domestic abuse, including HBV. The primary aim of the survey is to drive improvement in police effectiveness.

10.46. In our interviews with HBV victims, it was hard to identify the nature of 'closure' within our participants' accounts. Despite general satisfaction with the initial police response, the majority of reporters were unhappy with their experience of the police overall. A number of participants said that their cases had been closed without understanding why, or they were unaware of the stage (if any) at which their case was. Others relied on their caseworker from a voluntary sector specialist organisation to update them.

10.47. One victim had a particularly poor experience, where a case outcome was communicated by text message:

Interviewer: “How did that make you feel?”

Participant: “I don’t know. The statement said he [the police officer] tried to contact me but couldn’t and then he sent a text. That’s maybe because I tried to call several charity places and my phone line was engaged? Anyway he only sent a text [...] So I feel that now that I am the one who faced this problem and I am the victim, it’s very unfair and unjust if you do this like this.” (HBV victim)

10.48. An important consideration was the handling of media coverage. One victim, who had an excellent experience of reporting to the police, was worried by coverage in local and national media following her court case, which included details that she felt compromised her anonymity. Her understanding from the police was that her identity would be protected: her dedicated officers acknowledged that they were not necessarily able to influence what was published following a court case and this was an area for future learning.

10.49. One victim, who described her experience of the police as ‘fantastic’, described being called to meet the commander and the team at the station after her successful court case. She told interviewers that she had received exceptional aftercare, maintaining occasional contact with her dedicated officers.

### **Case example – HBV victim Rafeeqa**

Rafeeqa is of Pakistani origin and is married to a man who is physically and sexually abusive. She tries to leave the marriage and her partner waits for her after work and is harassing her, being physically abusive, asking for money and making threats to kidnap and kill her. Her colleague encourages her to call the police, which she does. In the meantime, her husband is calling her family telling them that their daughter is betraying him to the police. Her family had recently warned her that if she contacts the police, she will not be welcome back in the family home.

Two male officers arrive quickly, one is White British, the other tells her that he is of Pakistani origin. Rafeeqa is happy with their response and she feels that they understand her situation. She is contacted in the coming days by a female officer who becomes her dedicated officer and with whom she develops a strong relationship. She feels able to trust this officer with her story, despite the voices within her family who are warning her not to pursue the matter further. Rafeeqa is also given a second dedicated female officer who is up-to-date with the case: she is happy about this because she expressed a preference for female officers.

These officers refer her to Victim Support, to dedicated services for sexual and domestic violence, and to a specialist NGO for honour-based violence, even giving her a lift to sessions on occasion. She is also given a one-touch phone which links her automatically to the police and identifies her location, which makes her feel very secure.

A dedicated officer sits next to Rafeeqa throughout the court process and tells her to signal if she is uncomfortable or there is anything that she does not understand. This significantly improves her confidence in going through with the court case, which she is very apprehensive about. They prepare Rafeeqa for the possibility of an unsuccessful outcome.

The case is successful and her husband receives a significant prison tariff. After the verdict, Rafeeqa goes for coffee with her dedicated officers and they discuss aftercare and continuing contact details. In addition, the commanding officer invites her to the station to meet the team and solicit views of her experience of the service she received from the force.

Her only negative feedback is that she finds media coverage of the verdict potentially compromises her anonymity: the police acknowledge there is work to be done, in terms of their relationship with the media in both satisfying public interest and continuing to safeguard particularly vulnerable victims.

Overall, Rafeeqa describes her experience of the police as "fantastic".

## 11. Conclusion

- 11.1. Honour-based violence (HBV), by its very nature, is often hidden, occurring within extended family units or closed social contexts and aimed predominantly at women and girls. It is a set of abusive practices which are manifested in multiple ways. One of those ways is physical violence. It is only within the last 10 to 15 years, prompted by high profile media coverage of victim deaths, that HBV has come to public attention in England and Wales. Central government has been instrumental in tackling these issues. The Prime Minister and the United Nations International Children's Emergency Fund (UNICEF) hosted the first Girl Summit in July 2014, aimed at mobilising domestic and international efforts to end FGM and child and forced marriage (FM) within a generation.<sup>94</sup> The focus on FGM is particularly strong, as evidenced by the launch of a specialist FGM unit for England and Wales and the introduction, through the Serious Crime Act 2015, of FGMPOs.
- 11.2. National attention has correspondingly focused, with increasing momentum, on the associated requirements on the police and other public services to protect victims and potential victims of HBV in all forms. We found that a number of police and crime plans include HBV-related priorities and, in keeping with the national focus, are weighted towards FGM. In this context, we recognise that HBV is an emerging area of activity for many police forces. A historic parallel can be drawn with the police response to domestic abuse, which is now more widely recognised as having particular problems and risks.
- 11.3. The legal framework does not yet fully cover the range of risks faced by victims. FM and FGM have been criminalised, and associated protection orders have been established. However, in the case of HBV that does not include FM and FGM there is currently no bespoke provision in law for the protection of victims and or specific sentencing penalties for HBV perpetrators. Instead, the criminal justice system must use the general criminal law, such as violence against the person, rape or sexual assault in order to protect victims and prosecute perpetrators of HBV. In addition, there are no specific sentencing guidelines from the Sentencing Council of England and Wales dealing with HBV crimes to provide a clear structure and indication of how such crimes will be dealt with by the courts.<sup>95</sup>

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<sup>94</sup> *Declaration on UK government progress since Girl Summit 2014*, Home Office, 22 July 2015, available from: [www.gov.uk/government/publications/declaration-on-uk-government-progress-since-girl-summit-2014](http://www.gov.uk/government/publications/declaration-on-uk-government-progress-since-girl-summit-2014)

<sup>95</sup> *Sentencing Guidance Note – 'Honour-based' Crime*, Lord Chief Justice's Sentencing Group, [www.jsbni.com/Publications/sentencing-guidelines/Documents/Sentencing%20Guidance%20Note%20Honour-based%20crime.pdf](http://www.jsbni.com/Publications/sentencing-guidelines/Documents/Sentencing%20Guidance%20Note%20Honour-based%20crime.pdf). However,

- 11.4. The findings from this inspection – and in particular the findings from our victim engagement project – lead us to conclude that this gap in the current framework places a damaging constraint on the ability of the police service to protect victims of HBV.
- 11.5. We anticipated significant variations in the degree to which police forces across England and Wales were prepared for protecting people from HBV. This hypothesis has been proved correct. It is also clear, from analysis of the national data contained in this report, and the evidence from our victim engagement project, that no force in England and Wales can afford to say: ‘It doesn’t happen here’.
- 11.6. The impact of HBV can be devastating (and potentially fatal) if services fail to recognise indicators of risks and respond properly to protect victims. The investigation conducted by the IPCC into the death of Banaz Mahmood in 2006 (which we highlighted at the beginning of this report) included a recommendation that “police forces in England and Wales should recognise that honour-based violence is more prevalent than previously understood, and that this type of crime crosses cultural boundaries”. The IPCC’s report went on to set out the importance of engaging with communities; developing partnerships; reviewing and revising policies in relation to domestic violence; and raising awareness of cultural issues, in order to develop communities’ trust and confidence.
- 11.7. Nearly ten years later, our inspection found pockets of good practice, but overall, our conclusions for the most part echo the IPCC’s observations. Our findings were essentially consistent across all three areas of HBV (including FM and FGM). Using the framework of a victim’s ‘journey’, from first concern to closure of police involvement, we found a very mixed picture in terms of police preparedness and effectiveness in responding to HBV. These findings were corroborated by interviews with victims of HBV. Of 34 people who reported their experiences to the police, 20 were happy with the initial police response, but only nine were happy with their experience of contacting the police overall.
- 11.8. Victims’ views of their experience of the police were strongly influenced by what happened in the following days and weeks, rather than by the initial response alone. These interviews also illustrated the factors that may inhibit victims from reporting to the police, thereby compounding the hidden nature of HBV and underscoring the importance of victim-centred engagement between the police and relevant communities to build trust, confidence and informed responses.

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as the Sentencing Guidance records, the Court of Appeal has previously endorsed the need for severe deterrent sentences in crimes of HBV: *R v Ibrahim and Iqbal* [2011] EWCA Crim 3244.

“The police are educated by people who have not been through what I have been through. They are educated by books. That’s great but it’s not good enough. Speak to people like me: you’ll get a better understanding. You’ll start to understand how they [the perpetrators of honour based violence] work. Each culture, Indian, Pakistani or Arabic, has different rules and regulations. I can see it from the police point of view: it’s a lot to get their head around. But they get mixed up, they are too scared of coming across as racist. They need a dedicated team, who really understand the different cultures. And they need to talk to victims and survivors.” (HBV victim)

- 11.9. As this quoted HBV victim makes clear, it will not be sufficient for police forces to simply read this report to understand the nature of the very serious HBV risks in their communities. There is no substitute for genuine and long-term engagement with community groups representing the interests of victims.
- 11.10. Our victim engagement project highlights the critical fact that, while HBV has features in common with domestic abuse and gender-based violence more broadly, it is the aggravating element of perceived ‘honour’ that shapes the context of the abuse, compounding risks to the victim and potentially involving multiple perpetrators. Some victims expressed concern that the police did not appreciate this aggravating element, and pointed out that speaking to the authorities was itself considered a violation of community norms. This illustrates the difficulties associated with identifying the true levels of HBV. Further, it highlights the risks, for police and other public services, of making the wrong assumptions about the circumstances of reported incidents and therefore taking the wrong course of action, potentially thereby inadvertently increasing the threat of harm to victims through their interventions. That said, whilst the distinctions of HBV are appreciated, and acted upon, by forces, there are similarities in dealing with mainstream offending, for instance in relation to the investigation of offences of violence, which can result in successful outcomes being achieved in these cases.
- 11.11. The cross-cultural nature of HBV exacerbates these risks. Our interviews with victims illustrated the way in which expectations about police assumptions or attitudes related to ethnicity can deter victims from placing trust and confidence in the police service. Our evidence on inhibitors and challenges to the police service successfully tackling HBV (gathered during Phase 1 of this inspection) showed that some officers are concerned about being perceived as culturally insensitive when dealing with or making enquiries regarding HBV.
- 11.12. We found variation in the training of specialist staff in forces across England and Wales. It is possible that any gap in specialist knowledge represents a failure to prepare officers to respond effectively to risks within the local population. It may also reflect a lack of awareness of the levels of those risks.

- 11.13. Officers and staff may only have one chance to speak to a potential victim and thus may only have one chance to save a life. This means that all professionals working in public services, such as the police service, need to be aware of their responsibilities and obligations when they come across HBV cases. If the victim is allowed to walk out of the door without support being offered, that one chance might be wasted. This is the 'one chance rule'.
- 11.14. It is critical for victims that staff in frontline roles with responsibility for implementing the 'one chance rule'<sup>96</sup> have sufficient knowledge to do so reliably across England and Wales. The findings of this inspection show that this is not currently the case. Raising levels of awareness to equip frontline staff with the skills they need to identify possible cases of HBV, and to adapt their handling methods accordingly, need not be costly or extensive. Doing so will improve the response to HBV and the confidence of potential victims to report incidents and crimes to the police. That, in turn, will go a significant way towards addressing the unreported nature of these offences.
- 11.15. Comparison between the outcomes of forces' self-assessment in Phase 1 of this inspection, and those from our detailed fieldwork of eight forces, shows that many forces are aware of limitations in the police service's current level of response to HBV. The chief inhibitors or challenges identified by forces were the lack of local intelligence and information about the occurrence of HBV; a need for updated national guidance and training to help build police understanding of HBV, FM and FGM; and difficulty in community engagement associated with these incidents and crimes, which in turn was perceived to have an impact on victims' confidence in reporting to the police.
- 11.16. Notwithstanding the pockets of good practice, our force inspections found inconsistencies in the approach of the police at every stage of the victim's 'journey'. The clearest areas for improvement were in:
- increasing knowledge and awareness of HBV in all its forms, and addressing associated gaps in understanding of what works to protect victims;
  - increasing awareness and understanding of officers and staff to ensure more perceptive first responses;

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<sup>96</sup> *The Right to Choose: Multi-agency Statutory Guidance for Dealing with Forced Marriage*, HM Government, London, 2014, p.1: '[Staff] providing services to victims of forced marriage and honour-based violence need to be aware of the "one chance" rule. That is, their staff may only have one chance to speak to a potential victim and thus their staff may only have one chance to save a life. This means that all professionals working within statutory agencies need to be aware of their responsibilities and obligations when they come across forced marriage cases. If the victim is allowed to walk out of the door without support being offered, that one chance might be wasted'.

- ensuring a consistent approach to risk assessment, the protection of victims, and investigation and supervision of HBV incidents and crimes;
- improving the collection and handling of data and intelligence on risks to victims within police force areas and nationally;
- engaging more effectively with communities in order to increase the intelligence the police receive, and to promote public confidence that the service is learning from past cases of HBV; and
- ensuring consistent approaches to partnership working (particularly with health, social care and education professionals).

11.17. In our analysis of information and data from Phase 1 of the inspection, forces' preparedness to respond to HBV diminished across the stages of the victim's journey. Associated with this assessment is the very strong theme running through our findings from the force inspections of gaps in the police's knowledge of risks to HBV victims.

11.18. We found a wide range of factors contributing to intelligence gaps in police knowledge of risks to HBV victims. These included the reluctance of some victims to report; lack of awareness on the part of responding officers; and the failure to systematically flag HBV-related incidents and crimes on police computer systems. It was apparent that police recording of HBV cases may not always accord with the actual number of cases, with the result that some forces will be carrying an unknown level of risk in terms of the safeguarding of victims. This is borne out by a recent analysis of demands on the police service conducted by the College of Policing, which makes reference to current inadequacies in police data on FGM.<sup>97</sup>

11.19. The failure to flag incidents accurately compounds the hidden nature of HBV and has a negative impact on outcomes for victims in a circular way:

- if staff do not understand HBV, it will not be identified and flagged, and victims will lose confidence in the police response, reducing the likelihood of future reporting; while
- if a force's systems do not support consistent flagging, relevant intelligence may not be easily accessible when required. If cases cannot easily be identified, victims may not be protected, forces will not be able to audit cases and learn lessons, and staff will not be prompted to learn and respond more appropriately in future, thereby encouraging more victims to report.

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<sup>97</sup> *Estimating Demand on the Police Service*, College of Policing, London, 2015.



- 11.20. These problems also impair a force's ability to understand the levels of HBV incidents and crimes in its area. This is a very serious failing given the highly vulnerable nature of victims of HBV.
- 11.21. Our data show a low translation of reported HBV incidents to crimes, and a high proportion (36 percent) of victims choosing not to support further police action following the initial report. It is not possible to tell from existing data on police activity how far this reflects how appropriate the outcomes are from the victims' perspective. Preventive measures taken by the police are not reflected in such data; the time spent responding to a victim at risk, liaising with partner agencies, taking out a protection order and putting other safeguarding measures in place will not be picked up in current approaches to measuring police activity.
- 11.22. Sound safeguarding practices (i.e. responding to threat, risk and harm, and ensuring that vulnerable people are adequately protected from the risk of serious harm at the hands of others) are central to effective police responses to HBV victims. In this sense, the findings of this report have many echoes of other recent HMIC inspections that have focused on vulnerability. For example, our child protection report, published earlier this year, found that:
- good police practice in crisis situations or in those cases where the nature of a specific vulnerability is clearly understood from the outset;
  - weaknesses in investigations, assessments and plans and communicating with victims;
  - specialist teams perform better than generalists; and
  - good practice is too dependent on highly skilled, well-motivated and committed police officers.<sup>98</sup>
- 11.23. Our domestic abuse report findings, published in 2014, included:
- the victim's first contact with the police is the most positive part of their experience and that most call handlers understand domestic abuse, can identify it, and send an officer to the scene;
  - victims' experiences of attending officers are mixed. Nearly four out of five victims we surveyed were satisfied with the initial police response, but a third said they felt no safer. Victims told us that they did not always feel they were being taken seriously, or believed; and

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<sup>98</sup> *In Harm's Way: The Role of the Police in Keeping People Safe*, HMIC, London, 2015. Available from: [www.justiceinspectorates.gov.uk/hmic/publications/in-harms-way-the-role-of-the-police-in-keeping-children-safe/](http://www.justiceinspectorates.gov.uk/hmic/publications/in-harms-way-the-role-of-the-police-in-keeping-children-safe/)

- the issue of risk assessment requires urgent attention. We found inconsistent approaches to this.<sup>99</sup>

11.24. All of these findings have also been themes in this inspection. This similarity echoes the existing practices of many forces in treating HBV cases as particular forms of domestic abuse or child protection. However, whilst this approach may go some way to improving outcomes that are related to the investigation of HBV cases, and potentially improve outcomes overall, it would not, of itself, be sufficient to remedy the particular range of problems in handling HBV cases. The context of HBV cases is usually more complicated and importantly different to domestic abuse and child protection cases and that context requires specific and bespoke police approaches.

11.25. Safeguarding requires a very different response to tackling volume crime. In particular, it emphasises the need for partnership working. It was evident from this inspection that the cultural shift that a focus on safeguarding requires is not necessarily well understood at all levels of the police service. Further, the police service is reliant on the availability of other public and specialist voluntary sector services to discharge its safeguarding responsibilities. Working together, agencies need to develop services such as safe houses, refugee provision, health care and additional support. These services are essential so that, when action is taken either to enforce the law or to remove a child or vulnerable person from risk, the continued safety and wellbeing of the person is not compromised and they can, where necessary, start a new life in a safe environment. In this regard, police forces have considerable experience of working with other agencies to develop services to meet need (for example, through specialist child protection services); but are also reliant on those other agencies in providing effective protection to victims.

11.26. As highlighted earlier in this report, this is the first inspection or government review in England and Wales of the police service's response to crimes and incidents of HBV, FM and FGM. Just as the police response to HBV requires a collective approach, we recognise the benefits that a future joint agency inspection may help to further understand and develop a true partnership and victim-centred approach to HBV.

11.27. HBV raises difficult questions about the nature and scope of the police role, alongside the responsibilities of other public services, in safeguarding and protecting victims, particularly once any investigation has concluded. These questions require active leadership and determination at both national and local levels if victims are not to fall through the gaps between services. Our

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<sup>99</sup> *Everybody's Business: Improving the Police Response to Domestic Abuse*, HMIC, London, 2014. Available from: [www.justiceinspectorates.gov.uk/hmic/publications/improving-the-police-response-to-domestic-abuse/](http://www.justiceinspectorates.gov.uk/hmic/publications/improving-the-police-response-to-domestic-abuse/)

findings from this inspection show that many forces feel constrained in their response to HBV by deficits in national leadership, guidance and policy. We note that the national policing strategy on HBV has not been updated in published form since 2008, regardless of the increased national awareness of the need to eradicate HBV. We consider that the lack of an updated strategy is significantly inhibiting forces' operational activity in this area.

- 11.28. Our work has found very limited evidence of what works in policing HBV. We encourage academic institutions to explore this area for potential research that will enhance national and international efforts to prevent HBV. Our victim engagement project, together with advice from our expert reference group, has immeasurably enhanced our understanding of this complex, hidden and poorly understood area. The most powerful messages and insights have come from the victims themselves. It is our strong view that more effective policing of HBV will be most effective where it is informed by the voice of the victim.

# Recommendations

## To the Home Office

### Recommendation 1

By March 2016, the Home Office should establish a national oversight framework to monitor and report on the progress made in relation to the findings and recommendations in this report.

### Recommendation 2

By June 2016, the Home Office, in conjunction with the National Police Chiefs' Council, should develop an approach to the collection of data recorded by police forces in relation to HBV, FM and FGM. Consideration should be given to this data being recorded as part of the Annual Data Return.

### Recommendation 3

By June 2016, the Home Office should initiate a review of the existing legislative framework for all forms of HBV, and consider whether new legislation should be enacted to cover:

- the definition of HBV;
- the specific criminalisation of all forms of HBV where existing offences do not adequately deal with the particular context of HBV crimes;
- imposition of penalties appropriate to the gravity of such offences, taking account of their inherent aggravating features; and
- provision for appropriate protection orders and a legislative scheme setting out the responsibilities in relation to those orders on relevant public services.

## To the National Police Chiefs' Council

### Recommendation 4

By March 2016, the national policing lead should develop an action plan which addresses the findings and recommendations made within this report through the national oversight framework. The action plan should include reference to the ways in which forces will raise awareness, within local communities, of the role of the police service in preventing HBV, FM and FGM and protecting victims of HBV, FM and FGM.

### **Recommendation 5**

By June 2016, the national policing lead, in conjunction with partner agencies in health, social care and education, should develop a national set of protocols for HBV, FM and FGM to ensure co-ordination and consistency of information sharing at all levels.

### **Recommendation 6**

By June 2016, the national policing lead should, in conjunction with the Crown Prosecution Service, develop an equivalent joint investigation and prosecution protocol for HBV and FM to that which exists for FGM.

### **Recommendation 7**

By June 2016, the national policing lead, in conjunction with the Home Office and the Ministry of Justice, should oversee the development of a national process to co-ordinate the collection and dissemination of all FMPOs and FGMPOs to police forces, together with other relevant court orders.

### **Recommendation 8**

By December 2016, the national policing lead, in conjunction with the Home Office, should review whether data collected on police activity associated with HBV, FM and FGM is consistent and accurate. Where the national policing lead is not satisfied that the data is consistently and accurately collected, guidance should be issued to forces in order that a sound evidence basis is established to understand the national picture of related demand on the police service and assist forces in effective resource planning.

## **To chief constables**

### **Recommendation 9**

By June 2016, chief constables in consultation with partner agencies should undertake research and analysis using diverse sources to understand better the nature and scale of HBV, FM and FGM in their force areas, and use this information to raise awareness and understanding of HBV, FM and FGM on the parts of their police officers and staff.

### **Recommendation 10**

By June 2016, chief constables should ensure that information management processes are in place to record and flag HBV, FM and FGM information in an efficient, effective and systematic way so that the risk to individual victims is identified at an early stage and properly assessed and managed throughout the progression of victim's case.

### **Recommendation 11**

By June 2016, chief constables together with partner agencies should ensure they have clear policies and joint working structures in place to ensure an integrated approach to HBV, FM and FGM between police forces and other agencies.

## **To the College of Policing**

### **Recommendation 12**

By March 2016, the College of Policing should produce Authorised Professional Practice guidance to provide current and up-to-date standards for the police service in relation to HBV and FM.

### **Recommendation 13**

By June 2016, the College of Policing should review the current approach to risk assessment in relation to cases of HBV, FM and FGM. This should include an assessment of the sufficiency of instruments and methods currently available to assess risk in such cases.

### **Recommendation 14**

By June 2016, the College of Policing should establish a process for the collation and dissemination of good practice ('what works') for the police service in relation to HBV, FM and FGM.

## Annex A – Glossary

|   |   |
|---|---|
| <i>A Call to End Violence against Women and Girls</i> | UK government's strategy to end violence against women and girls  |
| ACC   | assistant chief constable   |
| ACPO  | Association of Chief Police Officers  |
| APP   | authorised professional practice  |
| arranged marriage                                     | union in which both parties fully and freely consent to the marriage, although their families take a leading role in the choice of partner  |
| Association of Chief Police Officers                  | professional association of police officers of assistant chief constable rank and above, and their police staff equivalents, in England, Wales and Northern Ireland; led and co-ordinated operational policing nationally; a company limited by guarantee and a statutory consultee; its president was a full-time post under the Police Reform Act 2002; replaced by the National Police Chiefs' Council on 1 April 2015   |
| audit   | a means of checking upon and monitoring the accuracy of recorded data in order to oversee the effectiveness and efficiency of the recording system, and the accuracy of the records it contains   |
| Authorised Professional Practice                      | official source of professional practice on policing, developed and approved by the College of Policing, to which police officers and staff are expected to have regard in the discharge of their duties  |
| bail conditions                                       | conditions imposed to ensure that a defendant attends the next court hearing, commits no new offences in the meantime, and does not interfere with any witnesses or obstruct the course of justice; a court can remand a defendant in custody or grant bail, with or without conditions attached; before the first court hearing, the police can also retain a defendant in custody or grant bail with or without conditions attached, but their powers to do so are more limited than those of the court |
| BAME  | black, Asian and minority ethnic  |

|                                       |   |
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| baseline assessment                   | the minimum or starting point used for comparisons  |
| child abuse                           | categorised in the government guidance Working Together to Safeguard Children (2006) as physical, emotional and sexual abuse, neglect and bullying  |
| Code of Practice for Victims of Crime | code of practice that sets out the statutory obligation on criminal justice agencies to provide a standard of service to victims of crime or, where the victim died as a result of the criminal conduct, their relatives  |
| coercive control                      | a term and concept developed by Evan Stark which seeks to explain the range of tactics used by perpetrators and the impact of those on victims; highlights the ongoing nature of the behaviour and the extent to which the actions of the perpetrator control the victim through isolation, intimidation, degradation and micro-regulation of everyday life; crucially, it sets out that such abuse can be psychological as well as physical; is explicitly covered by the definition of domestic abuse |
| College of Policing                   | the professional body for policing; established to set standards in professional development, including codes of practice and regulations, to ensure consistency across the 43 forces in England and Wales; also has a remit to set standards for the police service on training, development, skills and qualifications  |
| controlling behaviour                 | a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour   |
| control room                          | police control and communications room which manages emergency (999) and non-emergency (101) calls, and sending police officers to these calls  |



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| counter-allegation         | where someone initially identified as the perpetrator makes an allegation against the victim; if counter-allegations are not identified and resolved agencies may be providing services to the perpetrator and inadvertently helping them isolate and control the victim, and the victim may not get access to the services they need because they are labelled 'the perpetrator' |
| crime                      | an unlawful act punishable by the state   |
| CPS                        | Crown Prosecution Service   |
| Crown Prosecution Service  | the principal prosecuting authority for England and Wales, acting independently in criminal cases investigated by the police and others – for further information see the CPS website: <a href="http://www.cps.gov.uk/about/facts.html">www.cps.gov.uk/about/facts.html</a>   |
| domestic abuse             | an incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners, or family members regardless of gender or sexuality; the abuse can encompass, but is not limited to, psychological, physical, sexual, financial and emotional means                                |
| DASH (DASH 2009)           | domestic abuse, stalking and harassment and honour-based violence (DASH 2009) assessment; a risk identification, assessment and management model adopted by United Kingdom police forces and partner agencies in 2009   |
| domestic homicide review   | multi-agency review completed by local agencies following a domestic homicide; aims to assist all those involved to identify the lessons that can be learned from homicides where a person is killed as a result of domestic violence, with a view to preventing future homicides and violence  |
| Emergency Protection Order | protective order under section 44 of the Children Act 1989, where the applicant can apply to the court to remove the child or to keep the child in a safe place for a specified duration.   |
| EPO                        | Emergency Protection Order  |
| Europol                    | European Union's law enforcement agency; main goal is to help achieve a safer Europe for the benefit of all EU citizens, by assisting the European Union's Member States in their fight against serious international crime and terrorism   |

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| female genital mutilation                  | sometimes referred to as female circumcision, refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons; the practice is illegal in the United Kingdom |
| Female Genital Mutilation Protection Order | protective civil order to protect girls and women from being subjected to FGM under section 5A of the Female Genital Mutilation Act 2003  |
| Female Genital Mutilation Unit             | government department unit set up to provide workshops to safeguarding boards, road shows to raise awareness and peer support to combat FGM   |
| FGM  | female genital mutilation   |
| FGMPO                                      | Female Genital Mutilation Protection Order  |
| FM   | forced marriage   |
| FMPO                                       | Forced Marriage Protection Order  |
| FMU  | Forced Marriage Unit  |
| forced marriage                            | a marriage conducted without the valid consent of one or both parties   |
| Forced Marriage Protection Order           | civil protection order to protect people at risk from being forced into a marriage made under the Forced Marriage (Civil Protection) Act 2007   |
| Forced Marriage Unit                       | unit established by the Home Office and the Foreign and Commonwealth Office to give advice and support to victims and agencies in relation to a possible forced marriage  |
| gender-based violence                      | harm that is perpetrated resulting from power inequalities that are based on gender roles   |
| general practitioner                       | doctor who works in the NHS   |
| governance                                 | method by which the efficiency and effectiveness of a service, including the outcomes of a service, are overseen  |
| GP   | general practitioner  |
| harassment                                 | offences under sections 2 and 4 of the Protection from Harassment Act 1997 criminalising conduct which causes alarm or distress or puts people in fear of violence  |
| HBV  | honour-based violence   |

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| high risk                             | term used when, following a risk assessment, there are identifiable indicators of risk of serious harm; the potential event could happen at any time and the impact would be serious   |
| honour-based value system             | where a family, society, tribe or community feels obliged to comply with social, cultural and traditional norms within that community which emphasise the importance of honourable conduct   |
| honour-based violence                 | crime or incident which has or may have been committed to protect or defend the honour of the family and/or community; a collection of practices which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour; such violence can occur when perpetrators perceive that a relative has shamed the family and/or community by breaking their honour code |
| IAG                                   | independent advisory group   |
| independent advisory group            | group of people or organisations brought together to provide senior police officers with the opportunity to discuss issues of concern about policing in local communities where trust in the police can be problematic; the need for such independent advice was identified in the Stephen Lawrence Inquiry Report published in 1999, which concluded more should be done to engender trust and confidence in such communities         |
| independent domestic violence adviser | trained specialist who provides a service to victims at high risk of harm from intimate partners, ex-partners or family members, with the aim of securing their safety and the safety of their children; serve as a victim's primary point of contact; normally works with a victim from the point of crisis, to assess the level of risk, discuss the range of suitable options and develop safety plans                              |
| IDVA                                  | independent domestic violence adviser  |
| incident                              | a record created by the police when a member of the public calls for police assistance, or a police officer observes or discovers a crime, prior to a decision whether a crime has been committed  |

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| Integrated Offender Management           | management of the most persistent and problematic offenders by police and partner agencies   |
| IOM                                      | integrated offender management   |
| intelligence                             | information that is evaluated and risk-assessed to assist the police in their decision-making  |
| Interpol                                 | the world's largest international police organisation, with 190 member countries   |
| Independent Police Complaints Commission | organisation established under the Police Reform Act 2002, responsible for overseeing the police complaints system in England and Wales, including monitoring the way complaints are handled by local police forces; it investigates the most serious complaints, incidents and allegations of misconduct; can call in the most serious cases from forces; can manage or supervise a police investigation into a complaint; and can deal with appeals from people who are not satisfied with the way their complaint has been dealt with by the police |
| IPCC                                     | Independent Police Complaints Commission   |
| key individual network                   | community engagement, consisting of a core group of local people who live, work or regularly pass through a neighbourhood  |
| KIN                                      | key individual network   |
| local safeguarding children's board      | way that local organisations come together to agree on how they will cooperate with one another to safeguard and promote the welfare of children in their areas; established by the Children Act 2004  |
| local policing units                     | small units comprising police officers and community police support officers with specific responsibility for that local area  |
| LPU                                      | local policing unit  |
| LSCB                                     | local safeguarding children's board  |
| MAPPA                                    | multi-agency public protection arrangements  |
| MARAC                                    | multi-agency risk assessment conference  |
| MASH                                     | multi-agency safeguarding hub  |

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| multi-agency public protection arrangements | arrangements put in place to ensure the successful management of violent and sexual offenders  |
| multi-agency risk assessment conference     | locally-held meeting where statutory and voluntary agency representatives come together and share information about high-risk victims of domestic abuse; any agency can refer an adult or child whom they believe to be at high risk of harm; the aim of the meeting is to produce a co-ordinated action plan to increase an adult or child's safety, health and well-being; agencies that attend vary, but are likely to include the police, probation, children's, health and housing services; over 250 currently in operation across England and Wales |
| multi-agency safeguarding hub               | entity in which public sector organisations with common or aligned responsibilities in relation to the safety of vulnerable people work; comprise staff from organisations such as the police and local authority social services, who work alongside one another, sharing information and co-ordinating activities to help protect the most vulnerable children and adults from harm, neglect and abuse   |
| National Crime Agency                       | non-ministerial department established under the Crime and Courts Act 2013 as an operational crime-fighting agency to work at a national level to tackle organised crime, strengthen national borders, fight fraud and cyber crime, and protect children and young people from sexual abuse and exploitation; provides leadership in these areas through its organised crime, border policing, economic crime and Child Exploitation and Online Protection Centre commands, the National Cyber Crime Unit and specialist capability teams                  |
| National Police Chiefs' Council             | organisation which brings together 43 operationally independent and locally accountable chief constables and their chief officer teams to co-ordinate national operational policing; works closely with the College of Policing, which is responsible for developing professional standards, to develop national approaches on issues such as finance, technology and human resources; replaced the Association of Chief Police Officers on 1 April 2015   |
| national policing lead                      | senior police officer with responsibility in England and Wales for maintaining and developing standards and guidance for all police forces in respect of a particular area of policing   |

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| NGO                           | non-governmental organisation  |
| 'no crime'                    | incident initially recorded as a crime and subsequently established not to have been a crime on the basis of additional verifiable information   |
| non-governmental organisation | inclusive term for both charities and charitable organisations (not registered as charities) which undertake work of benefit to society  |
| NPCC                          | National Police Chiefs' Council  |
| one chance rule               | concept denoting the fact that there may be only one chance to speak to and save the life of a potential victim  |
| PCC                           | police and crime commissioner  |
| perpetrator                   | someone who has committed a crime  |
| police and crime commissioner | elected entity for a police area, established under section 1 of the Police Reform and Social Responsibility Act 2011, who is responsible for: securing the maintenance of the police force for that area and ensuring that the police force is efficient and effective; holding the relevant chief constable to account for the policing of the area; establishing the budget and police and crime plan for the police force; and appointing and, after due process, remove the chief constable from office |
| police and crime plan         | strategic plan issued by the police and crime commissioner under section 5 of the Police Reform and Social Responsibility Act 2011 which sets out the matters listed in section 7 of that Act  |
| police officer                | individual with warranted powers of arrest, search and detention who, under the direction of his chief constable, is deployed to uphold the law, protect life and property, maintain and restore the Queen's peace, and pursue and bring offenders to justice  |
| police protection powers      | powers exercisable by a police officer under section 46 of the Children Act 1989 to remove a child to a place of safety if the child is considered to be at risk of significant harm   |

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| positive action              | steps and action taken at all stages of the police response to ensure effective protection of victims and children, while allowing the criminal justice system to hold the offender to account; often used in the context of arrest policy |
| pro-activity                 | activity to understand a potential crime problem, for example, through gathering and analysis of information and intelligence to help devise and implement a strategy for preventing or tackling a problem                                 |
| problem profile              | strategic review based on information gathered as to the potential scale of a problem in the relevant area   |
| professional lead            | nominated senior organisational lead for a particular discipline   |
| protected persons            | those considered to be at risk of serious harm and/or persons identified within a civil protective order   |
| refuge                       | safe house where women and children who are experiencing domestic violence can stay free from abuse  |
| risk assessment              | assessment intended to assist officers in deciding appropriate levels of intervention for victims  |
| SAB                          | safeguarding adult board   |
| safeguarding                 | the process of protecting vulnerable people from abuse or neglect  |
| safeguarding adult board     | an entity comprising specified bodies, including the police, to make inquiries into situations of safeguarding risk and make recommendations for future action; established under the Care Act 2014  |
| sexual violence              | any act, attempt, or threat of a sexual nature that result, or is likely to result in, physical, psychological and emotional harm; a form of gender-based violence   |
| survivors                    | person who has suffered HBV, FM or FGM   |
| UK Protected Persons Service | department with the National Crime Agency which provides authorised protection to members of the public judged to be at risk of serious harm   |

|                                       |  |
|---------------------------------------|--|
| VAWG                                  | Violence Against Women and Girls Strategy of the United Kingdom Government   |
| violence against women                | any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life; a form of gender-based violence and includes sexual violence        |
| vulnerable                            | a person who is in need of special care, support, or protection because of age, disability, or risk of abuse or neglect  |
| ward of court                         | child or young person for whom a guardian has been appointed by the court or who has become directly subject to the authority of that court  |
| What Works Centre for Crime Reduction | hosted by the College of Policing to review research on practices and interventions to reduce crime; label the evidence base in terms of quality; cost and impact; and provide police and crime commissioners and other crime reduction partners with the knowledge, tools and guidance to help them target their resources more effectively |



## Annex B – Methodology

### HBV inspection methodology

To initiate work on the HBV inspection a comprehensive review was undertaken of current legislation, policy and literature. Two stakeholder workshops were convened to develop the scope, methodology and aims of the inspection. An expert reference group (ERG) was established to inform the scoping and progress of the inspection, acting as critical advisors.

#### Inspection purpose and aims

This inspection was designed to answer the following question:

“How effective is the police service at protecting people from harm caused by honour-based violence (HBV), forced marriage (FM) and female genital mutilation (FGM), and at supporting victims of these offences?”

The aims of the inspection were to:

- to report on the effectiveness of the police approach to identifying, responding to and protecting people at risk of harm from HBV, FM and FGM;
- to report on the effectiveness of the police approach to preventing HBV, FM and FGM;
- to highlight and promote effective practice in the police response to and work to prevent HBV, FM and FGM; and
- to make recommendations to advance improvements in policing practice in relation to HBV, FM and FGM.

The preparatory work suggested significant variation in capability across the police service to respond to HBV, FM and FGM. A phased approach was considered to be the most appropriate means of exploring this variation.

Phase 1 considered the preparedness of the police service to identify and respond to HBV by means of a self-assessment process. The purposes of the self-assessment were to:

- raise awareness within each force about the strengths and weaknesses of current practice;
- serve as a catalyst and benchmark for future service improvements; and
- provide us with information on the level of preparedness of all forces in England and Wales.

Phase 2 made a more in-depth examination of the ability of forces to effectively prevent and respond to HBV.

The forces inspected in Phase 2 of the inspection were:

- Avon and Somerset Constabulary;
- Cheshire Constabulary;
- Dyfed-Powys Police;
- Hertfordshire Constabulary;
- Metropolitan Police Service;
- Northumbria Police;
- Thames Valley Police; and
- West Midlands Police.

The forces were selected to form the inspection sample because they provide a cross-section of the service. Our sampling decisions were informed by data and assessment in Phase 1<sup>100</sup> and the relative policing environment<sup>101</sup> of each force. We wanted to inspect a mix of rural and urban areas with differing population profiles.

### **Inspection approach**

The approach focused on the experience of the victim<sup>102</sup> from initial contact with the police, through any criminal investigation processes and prosecutions, to closure of police involvement. The inspection also considered how the leadership and management of the police service contributed to and supported effective practice on the ground.

A set of inspection criteria was developed (see table below) based on known risks identified through the initial literature review and consultation with our ERG. The criteria were structured as follows:

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<sup>100</sup> Approximately 40 percent of all HBV, FM and FGM incidents recorded by police in the ten months to 31 January 2015 were recorded in the eight forces selected.

<sup>101</sup> Approximately 60 percent of the BAME population of England and Wales live in the eight forces selected.

<sup>102</sup> Reference to victim and victims include actual and potential victims of HBV, FM and FGM.

- The stages of the victim's journey were grouped into four sections: leadership; awareness and understanding; protection; and enforcement and prevention.
- Each section comprised a number of distinct stages with a corresponding descriptor.
- Each stage included a number of positive indicators of what the descriptor might mean in practice.

| Section                                     | Stage  | Descriptor  |
|---|--|---|
| <b>One:<br/>Leadership</b>                  | 1. Leadership and governance   | The leadership and governance structure within the force supports its ability to identify and respond to cases of HBV, FM and FGM.  |
| <b>Two:<br/>Awareness and understanding</b> | 2. Identification  | The force works to ensure that victims are identified.  |
|   | 3. Initial contact   | From the first point of contact, officers and staff are alert to, and have the knowledge, skills and ability to recognise, understand and identify victims, and protect them. |
| <b>Three:<br/>Protection</b>                | 4. Assessment and help   | The force works together with others, undertaking assessments to provide effective help, support and protection to victims; making a positive difference to their lives.      |
|   | 5. Trusted professional  | Officers and staff do what they say they will do.   |
| <b>Four:<br/>Enforcement and prevention</b> | 6. Investigation and specialist support                              | Investigations (crime and non-crime) are thorough, timely and the needs of victims are central.   |
|   | 7. Identification and management of those who pose a risk to victims | The force works together with others, to identify and manage those who pose a risk to victims.  |
|   | 8. Closure   | Officers and staff close cases in a victim-centred and timely way.  |

## **Summary of Methods**

### **1. Preparation**

- A review of current research and academic literature.
- A review of the legal and regulatory framework by specialist counsel with expertise in human rights.

### **2. Phase 1 – all forces in England and Wales**

- Force self-assessments.
- Data and document collection and analysis.

### **3. Phase 2 inspections**

- Examination of police case files.
- Discussions with officers and staff from within the police service and staff from external organisations.
- Examination of service statistics, reports, policies and other relevant written materials.
- Examination of force websites.
- Thematic analysis of all findings.

### **4. Examination of the current data collected and held by public agencies in relation to HBV.**

### **5. Commissioning the University of Bristol in collaboration with the University of Roehampton to conduct a victim engagement project, focusing on HBV victims' experiences and perspectives of the police response.**

## **Annex C – Expert reference group terms of reference and membership**

### **The expert reference group (ERG)**

To initiate work on the HBV inspection two stakeholder workshops were convened to develop the scope, methodology and aims of the inspection.

The ERG was then established to inform the remit and progress of the inspection, acting as our critical advisors. The membership of the ERG included a range of individuals and agencies who had relevant knowledge and expertise and were able both to challenge and support our work. The ERG was consulted throughout the inspection, and was able to advise on issues such as the inspection aims.

#### **Terms of reference**

1. To provide HMIC with specialist advice and constructive challenge from a range of perspectives in relation to honour-based violence, forced marriage and female genital mutilation.
2. To identify and advise on areas within the scope of the inspection that group members consider are either not being examined, or not being examined in sufficient depth.
3. To ensure the inspection approach is appropriately balanced so as to reflect the views of, and impact upon, those affected by police forces' management of honour-based violence, forced marriage and female genital mutilation.
4. To provide support in accessing other experts to enhance the quality of the inspection.
5. To provide feedback on the quality and content of inspection methodology and products.

#### **Membership of the ERG**

The ERG consisted of members drawn from the following organisations:

- the Association of Police and Crime Commissioners (APCC);
- the College of Policing;
- the Crown Prosecution Service (CPS);
- Dahlia Project;

- Freedom Charity;
- the Foundation for Women's Health, Research & Development (FORWARD);
- the Home Office (FGM, forced marriage and hate crime policy lead);
- Iranian and Kurdish Women's Rights Organisation (IKWRO);
- a Visiting Professor, Criminal Justice Studies, Portsmouth University;
- Karma Nirvana;
- the National Police Chiefs' Council (NPCC);
- National Society for the Prevention of Cruelty to Children (NSPCC);
- the Office of the Children's Commissioner;
- Sikh Police Association;
- Southall Black Sisters;
- University of Roehampton;
- University of Sussex;
- University of Cardiff;
- University of Greenwich;
- Welsh government; and
- 28 Too Many.

## **Annex D – Honour-based violence, forced marriage and female genital mutilation: the obligations on public authorities**

### **Introduction<sup>103</sup>**

Honour-based violence (HBV) refers to the collection of coercive practices used predominantly to control the behaviour of women and girls within families and other social groups with the purpose of protecting perceived cultural and religious beliefs, and maintaining or restoring the family's perceived social standing or "honour". A wide variety of acts fall under that umbrella definition. Violence which is inflicted as a punishment following a transgression of the perceived cultural code, psychological abuse and physical confinement, forced marriage (FM) and female genital mutilation (FGM) are all examples of HBV.

HBV is characteristically committed in a familial or similar social context. That means that organisations need to be particularly alive to indications of HBV and risks of HBV to respond effectively. The way in which the police and other public authorities respond should take into account the extraordinary damage that HBV can do and the different obligations on local and national organisations in such circumstances.

Primary among these obligations is that all public authorities are legally required to conduct themselves in a way that complies with the protection of fundamental human rights. An interlocking series of duties arise under the Human Rights Act 1998, international treaties, and the common law. Many of those obligations will inform the way in which public authorities are required to respond to HBV in general and to FM and FGM in particular.

The established framework of domestic criminal legislation also applies in the context of HBV, FM and FGM. The ordinary obligations on the police to investigate and, as far as possible, prevent criminal activity will mount up in relation to breaches of these provisions. Police forces should be aware of the criminal offences that may amount to HBV and officers should be properly trained to identify and respond to HBV incidents.

Public authorities should at all times be aware that discharging their various duties will require working together with other agencies. In particular, police forces should collaborate closely with health, social care, and education services to ensure a consistent and effective response to HBV.

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<sup>103</sup> This Annex summarises legal advice received from Ben Emmerson QC. It does not set out the full text of that advice but summarises the content which is of most direct relevance to this report. Legal advice should always be sought on the application of the law to specific circumstances.

The obligations discussed below apply across England and Wales, and should be adhered to by public authorities and police forces throughout those regions.

## **The criminal law on HBV**

A plethora of crimes are capable of amounting to HBV depending on the motive for, and context of, their commission. These include (non-exhaustively) murder, manslaughter, crimes contrary to the Offences Against the Person Act 1861 (for example, grievous bodily harm, common assault, etc.), false imprisonment, and of course the specific offences of FM (section 121 of the Anti-social Behaviour, Crime and Policing Act 2014) and FGM (the Female Genital Mutilation Act 2003, as amended by the Serious Crime Act 2015). The overarching obligations on the police that arise under statute and the common law (as addressed above) apply in relation to the prevention, detection and investigation of each of these.

## **Crimes associated with forced marriage**

The Marriage Act 1949 and the Matrimonial Causes Act 1973 govern the civil law on marriage, and are relevant to the issue of FM as follows:

- The minimum age at which a person is able to consent to a marriage is 16 years old; a person under the age of 18 may not marry without parental consent (Matrimonial Causes Act 1973, section 11(a) (ii)).
- A marriage can be annulled where either party did not validly consent to it, whether in consequence of duress, mistake, unsoundness of mind or otherwise (Matrimonial Causes Act 1973, section 12(c)).
- A petition for a decree of nullity based on lack of consent must be brought within three years of the date of the marriage. Provided the necessary formalities are complied with, a forced marriage is valid until it is voided in nullity proceedings (Matrimonial Causes Act 1973, section 13(c)).

For someone to have lawfully consented to a marriage, they must (1) have freely chosen to enter the marriage, and (2) they must have the capacity to have made that decision. That means that they must be able to understand information relevant to deciding whether to marry; must be able to retain and weigh up that information as part of the decision-making process; and they must be able to communicate their decision. They must not suffer from any impairment of the mind or brain that prevents them from making decisions for themselves. Then, in exercising their capacity to consent, they must not be subject to duress or threats that undermine their freedom of choice. The crucial question for deciding whether a marriage is the result of duress is whether threats or pressure are applied such as to overbear the will of the individual and destroy the reality of consent: *Hirani v Hirani* (1983) 4 FLR 232.



Section 121 of the Anti-social Behaviour, Crime and Policing Act 2014 explicitly criminalises FM. By that section, a person commits an offence under the law of England and Wales if he or she:

- a) uses violence, threats or any other form of coercion for the purpose of causing another person to enter into a marriage; and
- b) believes, or ought reasonably to believe, that the conduct may cause the other person to enter into the marriage without free and full consent.

The crime requires that the purpose of the violence, threats or coercion is to cause a person to enter a marriage, which will include any occasion on which violence, threats or coercion are used for that purpose even if the person does not in fact enter a marriage. Thus an FM crime under section 121 of the Anti-social Behaviour, Crime and Policing Act 2014 can be committed even if no marriage actually takes place.

Further, in relation to a victim who lacks capacity to consent to marriage, it is an offence to carry out any conduct for the purpose of causing the victim to enter into a marriage (whether or not the conduct amounts to violence, threats or any other form coercion). Thus, where a party to a marriage lacks capacity (for the purposes of the Mental Capacity Act 2005), anyone responsible for causing them to get married will have committed a criminal offence whether or not they believed the marriage to be in the person's best interests.

It is also an offence (under the same section) to practise any form of deception with the intention of causing someone to leave the United Kingdom in order to bring about (by violence, threats or coercion, unless the person lacks capacity) a marriage which is entered without free and full consent. That reflects the fact that FM often has an international element, with victims taken abroad on purported holidays during which they are married against their will.

The criminal prohibition on FM applies where the victim or the perpetrator are in England or Wales (whether or not they are UK nationals), or where either of them are habitually resident in England or Wales (whether or not they are UK nationals), or where they are both outside the UK but at least one of them is a UK national.

In some countries, child marriage is not prohibited. If an underage girl has married a man in accordance with the law of the country in which the marriage took place, British legislation does not criminalise that marriage unless it can be established that violence, threats or coercion were used to bring it about. If that can be established, and either the victim or the perpetrator comes to the UK, then the perpetrator could be prosecuted under section 121 of the Anti-social Behaviour, Crime and Policing Act 2014.

A person convicted of FM is liable to imprisonment of up to seven years (if tried on indictment) or 12 months (if tried summarily). The first conviction for FM was secured in June 2015, with the perpetrator (a 32-year-old man who had coerced a 25-year-old woman into marrying him by threatening to kill her father and release videos he had covertly made of her in the shower) sentenced to four years' imprisonment.

Occasionally, FM will have an immigration offence element, in that it will be used in an attempt to acquire immigration status in the UK. In these circumstances, an FM will also amount to a sham marriage (i.e. a marriage entered into with no intention from the outset of living together as a man and wife in a settled and genuine relationship).<sup>104</sup> When investigating sham marriages, the police should be alive to the possibility that the UK or EEA national involved may be a victim of FM.

The Forced Marriage (Civil Protection) Act 2007, amending provisions of the Family Law Act 1996, and as amended by the Anti-Social Behaviour, Crime and Policing Act 2014, provides a protective tool for people who are at risk of forced marriage, or who have entered an FM. A Forced Marriage Protection Order (FMPO) may be imposed by a court (on an application by a person at risk of or in a forced marriage, or by a third party, or where the court of its own motion considers it to be necessary). An FMPO will be directed at a respondent (who need not have been given notice of the proceedings) and will contain a clear prohibition, restriction, or requirement along with such other terms as the court considers are appropriate for the purposes of the order.

Breach of an FMPO is a criminal offence in its own right, punishable by up to five years' imprisonment. The police should refer any instances of breach to the CPS for prosecution.

Where FM amounts to slavery/forced labour, or human trafficking contrary to the Palermo Protocol, additional criminal offences will be committed. Those may include offences contrary to section 1 of the Modern Slavery Act 2015, which establishes that a person commits an offence if they:

- a) hold another person in slavery or servitude and the circumstances are such that the person knows or ought to know that the other person is held in slavery or servitude; or
- b) require another person to perform forced or compulsory labour and the circumstances are such that the person knows or ought to know that the other person is being required to perform forced or compulsory labour.

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<sup>104</sup> *R v Ali* [2015] EWCA Crim 43.

The Act adopts definitions whereby slavery or servitude encompasses any case where a right of ownership over another is exercised. That will include cases of control of a person's movement or physical environment, psychological control, measures taken to prevent or deter escape, and the control of a person's sexuality as well as forced labour as colloquially understood.

In determining whether the crime is committed, the court will have regard to all the circumstances including whether the victim is a child, their mental and physical state and their relationship to the offender. Importantly, the consent of a person to any of the acts that breach the prohibition does not preclude a determination that the person is being held in unlawful conditions. A perpetrator can be imprisoned for life.

The Modern Slavery Act 2015 also prohibits human trafficking, a category into which FM might fall. It is an offence to arrange or facilitate the travel of another person with a view to their exploitation (which would include their entry into a marriage to which they do not freely and fully consent). The circumstances in which that offence can be committed are expansive: a UK national may be guilty regardless of where the action takes place; and a non-UK national can be prosecuted if any part of the arranging, facilitating or travelling takes place in the UK. Persons convicted of slavery or human trafficking either in the UK or equivalent offences elsewhere, or found not guilty by reason of insanity, may have a slavery and trafficking prevention order made against them, which prohibits them from doing any action described in the order. Breach of an order is a criminal offence in its own right.

The police also have a power to apply for a slavery and trafficking risk order if it is necessary for the purposes of protecting persons at risk of trafficking from the physical or psychological harm which would be likely to occur if an offence was committed.

There are thus a number of ways in which the police can take proactive steps to protect against the risk of FM and its associated crimes.

The primary duty on public authorities when dealing with a victim of FM is to ensure their safety. Involving the family or community may increase the risk of harm to the person. Proper risk assessments should be done and information should be shared with other relevant safeguarding agencies. If a police officer suspects a situation involves FM, he or she should discuss the case with the Forced Marriage Unit – a central government body with specific expertise and responsibilities relating to FM.

## **The crimes relating to female genital mutilation**

The Female Genital Mutilation Act 2003 makes it an offence to excise, infibulate, or otherwise mutilate the whole or any part of a girl or woman's labia majora, labia minora, or clitoris, except for necessary operations performed by a registered medical practitioner on physical or mental health grounds; or an operation performed during labour or just after giving birth for purposes connected with the labour or birth.

For the purpose of determining whether an operation is necessary for a person's mental health, it is immaterial whether the girl or any other person believes that the operation is required as a matter of custom or ritual.

It is an offence for any person (regardless of their nationality or residence status) to:

- a) perform FGM in England, Wales or Northern Ireland (section 1 of the Act);
- b) assist a girl to carry out FGM on herself in England, Wales or Northern Ireland (section 2 of the Act); and
- c) assist (from England, Wales or Northern Ireland) a non-UK person to carry out FGM outside the UK on a UK national or permanent UK resident (section 3 of the Act).

It is also an offence for a UK national or a habitual UK resident to:

- a) perform FGM abroad (sections 4 and 1 of the Act);
- b) assist a girl to perform FGM on herself outside the UK (sections 4 and 2 of the Act); and
- c) assist (from outside the UK) a non-UK person to carry out FGM outside the UK on a UK national or permanent UK resident (sections 4 and 3 of the Act).

Furthermore, it is an offence for an adult who is responsible for a girl under the age of 16 to fail to protect her from FGM. An adult is responsible if they have parental responsibility for the child and have frequent contact with her; or if they are aged 18 or over and have assumed responsibility for the child in the manner of a parent. It is a defence for the defendant to show that at the relevant time, the defendant did not think that there was a significant risk of a genital mutilation offence being committed against the girl, and could not reasonably have been expected to be aware that there was any such risk, or the defendant took such steps as he or she could reasonably have been expected to take to protect the girl from being the victim of a genital mutilation offence.

Police forces should expect to receive increased reports of FGM following section 74 of the Serious Crime Act 2015 coming in to force on 31 October 2015. This provision imposes a legal duty on healthcare workers, social care workers and teachers,<sup>105</sup> to notify police if they discover that an act of FGM appears to have been carried out on a girl under the age of 18 years. Police officers should be trained in how to respond to these reports in line with the above duties and in a way that is sensitive, effective, and that has child protection as its paramount aim.

FGM amounts to “significant harm” that meets the threshold introduced by the Children Act 1989 for intervention in family life in the best interests of children and young people. Where there is reasonable cause to believe that a young person is at risk of significant harm, a police officer may remove the child from the parent and put them in police protection for up to 72 hours (under section 46 of the Children Act 1989). Co-operation with other agencies, in particular children’s social care, will be crucial in such circumstances to the proper protection of a child at risk of FGM.

There is a risk that the fear of prosecution will prevent those concerned from seeking help, resulting in possible health complications for the girl; thus police action will need to be in partnership with other agencies, affected communities and specialist non-governmental organisations.

Criminal investigations should follow national and local police guidance on safeguarding and child abuse investigations. Investigating officers must consult at an early stage with the CPS in all FGM cases so the most effective investigation and prosecution opportunities are identified.<sup>106</sup>

As with all criminal investigations, children and young people should be interviewed under the relevant procedure/guidelines (e.g. Achieving Best Evidence) to obtain the best possible evidence for use in any prosecution. Consent should be obtained to record the interview and for allowing the use of the interview in family and/or criminal courts. In addition, information gained from the interview process will enable a risk assessment to be conducted as to the risk to any other children or siblings. Police officers should refer to the Crown Prosecution Service’s guidance document entitled *Provision of Therapy for Child Witnesses Prior to a Criminal Trial*.

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<sup>105</sup> The definitions of these terms in section 5B(11) of the Female Genital Mutilation Act 2003 (as inserted by section 74 of the Serious Crime Act 2015) are set out in Chapter 4.

<sup>106</sup> Further reference may be made to a number of Association of Chief Police Officer and College of Policing guidance documents on investigating child abuse and safeguarding children. *Guidance on Investigating Domestic Abuse*, ACPO, 2008; *Risk Identification and Assessment Model for Police Staff – Domestic Abuse, Stalking and Harassment and Honour-Based Violence (DASH)*, 2009. Available from [www.app.college.police.uk](http://www.app.college.police.uk)

Corroborative evidence should be sought through a medical examination conducted by a qualified medical professional trained in identifying the different types of FGM. Consideration should be given to the effective use of a specialist FGM nurse. In all cases involving children, an experienced paediatrician should be involved in setting up the medical examination. This is to ensure that an holistic assessment that explores any other medical, support and safeguarding needs of the girl or young woman is offered and that appropriate referrals are made as necessary. Where a child refuses to be interviewed or undergo medical examination, assistance should be sought from an intermediary or community organisation.

If it is suspected that FGM has or will occur, as well as launching a criminal investigation public authorities may need to apply for an FGMPO. An FGMPO may be made to protect a girl against the commission of FGM, or to protect a girl against whom such an offence has already been committed (Female Genital Mutilation Act 2003, section 5A). In deciding whether to make such an order, 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.

An FGMPO may contain any prohibitions that the court considers appropriate for the purposes of the order, and may be directed at individuals who are aiding, abetting, counselling, procuring, encouraging or assisting another person to commit an FGM crime. For example, the first FGMPO (obtained by Bedfordshire Police in July 2015) seized the travel documents of two girls whose family were suspected of making arrangements to take them abroad for FGM. Breach of an order is a criminal offence in its own right.

## **The overarching obligations on public authorities**

### **The European Convention on Human Rights (ECHR)**

The core enforceable obligations that govern public authorities' response to HBV arise under the ECHR (incorporated into domestic law by the Human Rights Act 1998). Of particular relevance in the context of HBV are:

- Article 2: the right to life;
- Article 3: the prohibition of torture and inhuman or degrading treatment;
- Article 4: the prohibition of slavery and forced labour;
- Article 5: the right to liberty and security of person;
- Article 8: the right to respect for private and family life;
- Article 12: the right to freely marry; and
- Article 14: the prohibition of discrimination.

The most publicised and shocking cases of HBV are those where a person is murdered with the motive of restoring the family's perceived honour. Article 2 of the ECHR instructs the State not only to refrain from the intentional and unlawful taking of life itself, but also to take appropriate steps to safeguard the lives of those within its jurisdiction from the actions of third parties.<sup>107</sup> Thus the police and other state agencies may be liable for breach of a victim's Article 2 right to life where the victim has been killed by a third party and the police have failed to take the steps required of them under the ECHR. Those steps are explained in more detail below.

HBV generally, and FM and FGM specifically, are all capable of amounting to treatment that breaches the Article 3 ECHR prohibition on torture and inhuman and degrading treatment. While FGM, in inflicting extraordinary physical harm and pain, is perhaps the most obvious to fall within this category,<sup>108</sup> psychological harm reaching a threshold severity also amounts to torture or inhuman and degrading treatment.<sup>109</sup> Thus the mental suffering occasioned by FM and other forms of HBV (which may of course also be associated with physical suffering) will also often amount to a violation of the prohibition of torture.

The prohibition of slavery and forced labour may also be violated by HBV since any exercise of powers attached to the right of ownership over another will breach this right.<sup>110</sup> For instance, control of a person's movement or physical environment, psychological control, measures taken to prevent or deter escape, and the control of a person's sexuality are all possible features of HBV that breach Article 4. There is also a clear interaction in such circumstances with the Article 5 right to liberty.

HBV has an enormously detrimental effect on a person's private life, which is protected by Article 8 of the ECHR. A person's private life extends to their personal identity, their physical and moral integrity, the development of their personality and their relations with other human beings.<sup>111</sup>

There are thus many ways in which HBV in all its forms is capable of violating fundamental human rights. Police and state agencies need to be conscious of the various rights abuses that might result from HBV, in order to ensure that they are taking appropriate steps to comply with their obligations under the ECHR.

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<sup>107</sup> For example, see *LCB v United Kingdom* (1998) 27 EHRR 212, paragraph 36.

<sup>108</sup> This has been recognised as such by our highest court: *Secretary of State v K and Fornah* [2006] UKHL 46 at paragraphs 70 and 94.

<sup>109</sup> *Opuz v Turkey* (2010) 50 EHRR 28; *Niemietz v Germany* (1992) 16 EHRR 97.

<sup>110</sup> *Rantsev v Cyprus & Russia* (2010) 51 EHRR 1.

<sup>111</sup> *Von Hannover v Germany* (No. 2) (2012) 55 EHRR 15.

The duties that arise under the ECHR are not discharged simply by public authorities themselves refraining from action that would breach those rights. Rather, there are substantive positive duties under the ECHR that require state action to protect individuals from acts by third parties. The State also has a procedural, investigative duty in cases of breach (either by third parties or by the State itself). The content of those duties is as follows:

- There are operational duties to act to prevent immediate risk that is known, or should have been known to the authorities.<sup>112</sup> When state agencies have been made or become aware that life or physical integrity are under threat, they are obliged to take all reasonable measures to protect the threatened individuals. They must also seek out ways of effectively deterring threats, which requires the proper punishment of past acts of violence and any steps necessary to interrupt future violence.<sup>113</sup>
- There is a general or systemic duty to adopt appropriate measures to ensure, to the greatest extent reasonably practicable, the protection of the life, limb and physical and psychological integrity of categories of persons who are at risk of ill-treatment by third parties.<sup>114</sup> While national legislation goes some way to meet this obligation, police forces should also have appropriate policies and training in place to ensure a consistent and effective response to HBV. They should also work closely with other public bodies to ensure a safe and effective system for responding to HBV is established and maintained.
- There is an investigatory obligation to establish whether there is compliance with the operational and systemic duties.<sup>115</sup> This means that incidents of HBV must be investigated properly, and failures on the part of the police or other state agencies in detecting and preventing HBV must also be investigated.

HBV is (mainly, although not exclusively) a form of violence against women and girls. That means that failure to discharge the duties detailed above might also amount to a breach of Article 14, the prohibition of discrimination.

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<sup>112</sup> *Osman v United Kingdom* (2000) 29 EHRR 245, paragraph 115.

<sup>113</sup> *Opuz v Turkey* (2010) 50 EHRR 28; *Eremia v Moldova* (2014) 58 EHRR 2.

<sup>114</sup> For example (in relation to killings) *Oneryildiz v Turkey* (2005) 41 EHRR 20, paragraph 89; *Savage v Essex Partnership NHS Foundation Trust* [2009] 1 AC 681, paragraph 19; *Van Colle v Chief Constable of Hertfordshire* [2009] 1 AC 225, paragraph 31, and (in relation to violence, in particular sexual violence) *DSD and NBV v Commissioner of Police for the Metropolis* [2014] EWHC 436 (QB).

<sup>115</sup> *McCann v United Kingdom* (1995) 21 EHRR 97, paragraph 161.



Further, the courts have identified those at risk of gender-based violence as a vulnerable category of persons requiring special protection from the State,<sup>116</sup> and so it is crucial that public authorities fulfil their substantive obligations to protect potential victims of HBV.

In general, and as set out by the High Court in *DSD and NBV v Commissioner of Police of the Metropolis* [2014] EWHC 436 (QB) at paragraph 245 (a case concerning police failure to properly investigate sexual assault allegations and to protect women from a serial rapist), the obligations arising under the ECHR require the police at least to have in place proper training, supervision and management; to make proper use of available intelligence sources; to have in place proper systems that ensure victim confidence; and to allocate adequate resources to a matter.

### **Other international fundamental rights treaties**

The other key fundamental rights treaties that relate to HBV are:

- the International Covenant on Civil and Political Rights (ICCPR);
- the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); and
- the UN Convention on the Rights of the Child (UNCRC).

In many respects, these treaties repeat the rights and obligations that arise under the ECHR. However, they do give rise to a number of supplementary obligations that should inform public authorities' response to HBV.

The first relevant obligation is the due diligence obligation arising under CEDAW and the ICCPR.<sup>117</sup> This duty requires State parties not only to have a comprehensive state infrastructure to address gender-based violence, but also to ensure that that infrastructure is properly supported by state officers who act with due diligence to prevent violations of rights and investigate and punish them when they occur. On a practical level, this requires the police to take steps to respond to and investigate HBV, to document the steps that are taken and allocate trained officers with adequate resources to conduct the investigation, and to take steps (including the arrest of a perpetrator or protection of a victim) that are necessary to prevent HBV from occurring. It will also require close collaboration and, where appropriate, information sharing between different state agencies to provide a coherent response to HBV.

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<sup>116</sup> *Bevacqua and S v Bulgaria*, App. 71127/01, 12 June 2008; *Opuz v Turkey* (2010) 50 EHRR 28 para 132.

<sup>117</sup> ICCPR General Comment 28; CEDAW Committee Communications No5/2005 and No6/2007.

CEDAW also requires the state to take all appropriate measures to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women (Article 5 CEDAW).

The interpretation of the supplementary obligations arising under CEDAW is assisted by the recommendations of the Committee on the Elimination of Discrimination Against Women. Its General Recommendation No 19 (11th session, 1992) states that gender-based violence (which includes HBV and “private act”/“family violence”) is a form of discrimination that seriously inhibits women’s ability to enjoy rights and freedoms on a basis of equality with men. It recommends, among other things, that State parties should ensure that laws against family violence and abuse give adequate protection to all women; that there are in place effective complaints procedures and remedies, including compensation; and that civil and criminal measures to overcome family violence are introduced and enforced. Public information campaigns, education, the provision of counselling and refuges are all actions that can assist the State in discharging its anti-discrimination obligations under CEDAW. The role of the police in providing effective implementation and enforcement of laws that protect women is crucial.<sup>118</sup>

Many victims of HBV are under 18 years of age and therefore protected by obligations enshrined in the UNCRC. Those include requirements that the government takes all appropriate measures to:

- protect the child from all forms of physical or mental violence, injury, abuse, maltreatment, and exploitation; and
- abolish traditional practices prejudicial to the health of children; and
- more generally, act with the best interests of the child as a primary consideration and ensure such protection and care as is necessary for the child’s wellbeing.

HBV generally, and FM and FGM specifically, are indisputably contrary to the provisions of UNCRC where the victim is a child. The special protection of children that is required under UNCRC mirrors and augments the obligation arising under the ECHR to protect the physical integrity of children and to act in their best interests.<sup>119</sup> That duty should be at the forefront of public authorities’ response to HBV, and effectively safeguarding children in line with that duty will require a particular focus on collaboration between different state agencies.

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<sup>118</sup> *Fatma Yildirim v Austria* decision (Communication No. 6/2005), United Nations Committee on the Elimination of Discrimination against Women, 6 August 2007.

<sup>119</sup> For example as discussed in *A v United Kingdom* (1999) 27 EHRR 611, paragraph 22.

## **Further human rights obligations in respect of FM**

The obligations set out above apply generally to HBV, but there are some specific supplementary obligations that relate to the issue of FM.

Article 12 of the ECHR protects the right to marry. Inseparable from that is the right not to marry, and the right to choose freely who and when to marry. Article 16 of CEDAW sets these components out explicitly, requiring States to take all appropriate measures to ensure (among others):

- a) the same right between men and women to enter into marriage;
- b) the same right freely to choose a spouse and to enter into marriage only with their free and full consent;
- c) the same rights and responsibilities during marriage and at its dissolution.

Further, Article 16 sets out that the betrothal and the marriage of a child shall have no legal effect.

The obligations on public authorities in relation to these rights arise from their transfer into UK legislation. Those are discussed in further detail below.

Public authorities should be aware that FM might engage Article 4 ECHR (prohibition of forced labour, as discussed above) and human trafficking provisions (for instance the Palermo Protocol to Prevent, Suppress and Punish Trafficking in Persons). Again, domestic legislation transposes those obligations fairly comprehensively into our criminal law, which will direct the action that should be taken.

## **Further human rights obligations in respect of FGM**

The Committee on the Elimination of Discrimination against Women has commented specifically and repeatedly on the violation of CEDAW occasioned by FGM.<sup>120</sup> Those comments have noted the severe health consequences – both long and short term, mental and physical – for women and girls subjected to FGM, and its role in perpetuating the discriminatory belief in the subordinate role of women and girls. The obligation on the police and other state agencies to prevent, and support prosecution of, FGM is profound.

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<sup>120</sup> CEDAW Committee's General Recommendation No. 14 (1990); CEDAW Committee's General Recommendation No. 21 (1992); CEDAW Committee's General Recommendation No. 24 (1999).

## Other overarching obligations

There are additional general obligations that pertain to public authorities' response to HBV as a whole.

### The police response to HBV

Every police constable attests (under section 29 of the Police Act 2006, as amended by section 83 of the Police Reform Act 2002) to “well and truly serve the Queen in the office of constable, with fairness, integrity, diligence and impartiality, upholding fundamental human rights and according equal respect to all people...” That is a shortened description of the police's common law obligation to take all steps that appear to them to be necessary for keeping the peace and preventing crime.<sup>121</sup> The duty is one that any member of the public affected by a threat of breach of the peace (including by violence to the person) is entitled to call on the police to perform.<sup>122</sup>

There is thus a duty on the police to respond to criminal actions that amount to HBV. Breach of the duty does not give rise to liability in private law; but where the police have assumed a specific duty of care by representing to a victim that they will protect them, and the victim has relied on police protection, then liability in negligence for breach of the duty could arise.

In cases of HBV, it may be necessary for the police to put in place protective measures under section 82 of the Serious Organised Crime and Police Act 2005, to ensure the safety of persons involved in investigations or proceedings. Since HBV tends to occur within families or other close social networks, the risk to a victim who has reported HBV to the police might be higher than in many other contexts. That should be borne in mind when determining whether to instigate section 82 protection arrangements.

The Welsh Assembly has recently passed the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015. The overarching purpose of that Act is to improve the public sector response in Wales to gender-based violence, domestic abuse and sexual violence. Although it does not impose explicit obligations on the police, the Act is intended to provide a strategic focus on gender-based violence and ensure consistent consideration of preventative, protective and support mechanisms in the delivery of services. It is therefore relevant to Welsh police forces as a multi-agency partner to other public bodies (such as local authorities and health boards) which deliver services to tackle domestic abuse and sexual violence.

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<sup>121</sup> *Rice v Connolly* [1996] 2 QB 414, p 419.

<sup>122</sup> *Michaels v Chief Constable of South Wales Police* [2015] UKSC 2, paragraph 33.

## **Safeguarding obligations under the Children Act 2004, the Care Act 2014 and Social Services and Well-being (Wales) Act 2014**

In relation to child victims of HBV, section 11 of the Children Act 2004 imposes a duty on all agencies to safeguard and promote the welfare of children. The statutory guidance on that duty specifies that the police are responsible for identifying vulnerable children, taking children into protective custody where necessary, protecting the lives of children and ensuring that the welfare of the child is paramount. The police should disseminate and communicate policies and establish good practice and training that recognises the welfare of children as the prime consideration. This should underline the responsibility of every police officer (not just those working for specialist units with a child-related focus) to prioritise the protection and identification of vulnerable children. Every public body should have regard to the specific obligations set out in the statutory guidance on section 11.

The Care Act 2014 imposes a safeguarding obligation in relation to vulnerable adults similar to the pre-existing obligation towards children. Adults who are already vulnerable (for example, because they lack capacity) may be at particular risk from coercive conduct such as FM. In upholding the safeguarding obligation, public authorities should be particularly sensitive to this risk, and should work in partnership with each other to protect against it.

When the relevant provisions of the Social Services and Well-being (Wales) Act 2014 are in force, they will provide for the establishment of Safeguarding Children Boards and Safeguarding Adult Boards which will include representatives of the police. The objectives of those Boards will be to:

- (a) protect children within its area who are experiencing, or are at risk of, abuse, neglect or other kinds of harm, and to prevent children within its area from becoming at risk of abuse, neglect or other kinds of harm; and
- (b) protect adults within its area who have needs for care and support (whether or not a local authority is meeting any of those needs), and are experiencing, or are at risk of, abuse or neglect, and to prevent those adults within its area from becoming at risk of abuse or neglect.

The Act will also introduce a power for a local authority authorised officer to apply to the courts for an Adult Protection and Support Order. An order will enable an authorised officer to secure entry to premises in order to speak in private with the adult suspected of being at risk to determine whether they are making decisions freely; whether they are at risk and what care and support needs they may have. Before making an order, the courts must be satisfied that there is reasonable cause to suspect that the adult is at risk; that it is necessary to gain access to assess the risks; and that exercising the power of entry will not result in the adult being at greater risk of abuse or neglect.

An Adult Protection and Support Order must provide that the authorised officer may be accompanied by a constable. These provisions will apply, of course, only in Wales.

### **The public sector equality duty**

Under section 149 of the Equality Act 2010 (which sets out the public sector equality duty) a public authority must, in the exercise of its functions, have due regard to the need to (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act; (b) advance equality of opportunity between persons who share a relevant protected characteristic (which includes gender and race) and persons who do not share it; and (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Police forces are bound by that obligation in the exercise of their functions and so must have regard to whether their response to HBV satisfies the statutory aims of the public sector equality duty.

## **Statutory guidance on HBV**

The government has issued statutory guidance on forced marriage: *The Right to Choose: Multi-Agency Statutory Guidance for Dealing with Forced Marriage*.<sup>123</sup> Public authorities must have regard to this guidance in the exercise of their functions.

The government has also issued multi-agency practice guidelines on FGM.<sup>124</sup> They detail how professionals should intervene to safeguard women and girls who are at risk of, or affected by, FGM. The guidelines underline the fact that FGM is a clear and severe form of child abuse and violence against women and girls, and that the relevant professionals have to intervene to safeguard the welfare of children and women and act in a child's best interest. The guidelines provide that police are to pay special attention to the vulnerability of the victims of FGM. This should affect the approach of police forces in relation to any investigation, medical examinations, interviewing and subsequent prosecution.

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<sup>123</sup> *The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage*, UK Government, June 2014, available from: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/322310/HMG\\_Statutory\\_Guidance\\_publication\\_180614\\_Final.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322310/HMG_Statutory_Guidance_publication_180614_Final.pdf)

<sup>124</sup> *Multi-Agency Practice Guidelines: Female Genital Mutilation*, UK Government, 2014, available from: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf)

The Statutory Guidance on Working Together to Safeguard Children<sup>125</sup> (which provides practical assistance on complying with the safeguarding duty that arises under the Children Act 2004) is also important in guiding state agencies' approach to HBV.

Some principal obligations set out in the guidance include:

- Police officers must investigate HBV robustly and must not let a fear of being branded culturally insensitive affect any decision about the actions to be taken.
- Where public bodies become aware of an incident of HBV, all agencies should recognise the risk to other children or family members in that environment. The police and social care agencies must consider whether protection arrangements are required for anyone in that situation (and not just the person identified to be the victim of HBV).
- Where a child or vulnerable adult presents with signs of FGM, or gives a professional reason to suspect they have been subject to FGM, they must be referred to the appropriate safeguarding board.
- Section 74 of the Serious Crime Act 2015 came into force on 31 October 2015. This section introduced a mandatory reporting duty in relation to 'known' cases of FGM. As such regulated health and social care or education professionals (as defined by section 5B(11) of the Female Genital Mutilation Act 2003) who become aware that a girl under the age of 18 years has undergone FGM must report it to the police.
- Health professionals must record FGM in a patient's health record if it is identified that they have been subject to FGM.
- Public bodies must keep accurate records of risks identified and safeguarding action taken, and must share that information if necessary with other agencies.

As a matter of public law, public authorities should be familiar with this guidance and should use it to inform the way in which they respond to and work in partnership on tackling HBV.

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<sup>125</sup> *Working Together to Safeguard Children: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children*, UK Government, March 2015, available from: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/419595/Working\\_Together\\_to\\_Safeguard\\_Children.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf)

There are also specific policy documents that relate to the police response to HBV. In particular, the College of Policing has recently published Authorised Professional Practice (APP) guidance on FGM.<sup>126</sup> The APP provides useful background information on FGM to assist police officers in understanding FGM and the ways in which they should be responding to it.

Many of the obligations set out in the government's policy documents are repeated in the APP, but it also provides more specific guidance of which police officers should be aware. It highlights the need for a three-fold approach to tackling FGM, with officers pursuing (1) prevention, (2) protection and (3) prosecution of individuals involved in FGM-related offences. Police forces should therefore engage with communities to provide education about the harm and criminal implications of FGM. Police officers who become aware that a woman or girl is at risk of FGM must:

- take immediate steps to make that person safe;
- take immediate steps to secure evidence of an offence (including a preparatory offence);
- consider arresting suspects; and
- seek the advice of a supervisor.

An older Association of Chief Police Officers (ACPO) strategy document<sup>127</sup> provides similar practical advice for police forces responding to HBV. It was published before many of the specific criminal offences relating to HBV were introduced but it nevertheless contains extensive general guidance that police officers will find useful on the overarching approaches that should be employed by police forces to tackle HBV.

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<sup>126</sup> *Female genital mutilation*, Authorised Professional Practice, College of Policing, 2015, [www.app.college.police.uk/app-content/major-investigation-and-public-protection/female-genital-mutilation/](http://www.app.college.police.uk/app-content/major-investigation-and-public-protection/female-genital-mutilation/)

<sup>127</sup> *Honour Based Violence Strategy*, Association of Chief Police Officers, 2008.



## Annex E – The nature of HBV: Findings from the literature review

HBV, FM and FGM share some common characteristics; however there are also important distinctions. There are also overlaps with domestic abuse, child abuse and numerous crime types<sup>128</sup> as well as with human trafficking and modern slavery, which further blurs the edges in their definition.

Our preparatory work for this inspection indicated that there was a significant variation across the police service in terms of awareness and understanding of HBV, FM and FGM. In order to inform the inspection, we consulted our expert reference group, and reviewed published research findings on HBV, FM and FGM. In this Annex, we describe in some detail the current literature on the nature of this kind of offending, elements of which helped to shape the design of our inspection.

### Honour-based violence (HBV)

#### Meaning of ‘honour’

‘Honour’ has generally been interpreted as a beneficial concept for a society or community. It relates to how an individual may conduct him or herself (in relation to integrity and morals for example), and therefore to his or her self-worth/respect. It can also relate to how an individual is perceived publicly (in society or as part of a community), and to an individual’s recognition of his or her right to respect.<sup>129</sup>

‘Honour’ carries different meanings, interpretations or applications in different cultures or groups.<sup>130</sup> As such, it has multiple meanings related to pride, esteem, dignity, reputation and virtue.<sup>131</sup>

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<sup>128</sup> For example, there are overlaps with serious and organised crime; sexual and other violence; child abuse and child sexual exploitation (including that which is cyber enabled); and benefit fraud.

<sup>129</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, p3; *‘Honour’ Killing and Violence, Theory, Policy and Practice*, Dr A Gill, Caroline Strange, Karl Roberts, Palgrave Macmillan, Basingstoke, 2014, p2.

<sup>130</sup> *‘Honour’ Killing and Violence, Theory, Policy and Practice*, Dr A Gill, Caroline Strange, Karl Roberts, Palgrave Macmillan, Basingstoke, 2014, p2

<sup>131</sup> *Ibid*, p 2.

In terms of HBV, the notion of 'honour' is associated with:

- the behaviour that is expected in relation to the family or the social value system and norms in a community;
- the perceived 'shame' that results from not complying with those expectations; or
- seeking to prevent the behaviour that would breach those expectations, and so avoiding the perceived 'shame' or 'dishonour' on the family.

As such, the concepts of honour and shame are fundamentally interconnected with behavioural expectations.<sup>132</sup> Where a family, community or society operates an honour-based value system, HBV refers to the abuse or violence that may be committed in order to obtain, maintain or restore the notion of that honour,<sup>133</sup> if that honour has in some perceived way been lost or threatened.<sup>134</sup>

### **Characteristics of HBV**

HBV is a collection of practices used predominantly to control the behaviour of women and girls within families or other social groups to protect perceived cultural and religious beliefs, values or social norms in the name of 'honour'.

HBV is rooted in a patriarchal social system,<sup>135</sup> in which power is vested in the males of a family group, society, community or tribe, and where the extended family or social group is the primary means of social organisation and economic well-being.<sup>136</sup>

A family's honour is determined by that of the patriarch (who is usually the male head of a family), with his "claim to pride" deriving from his ancestry, wealth and

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<sup>132</sup> *The Home Affairs Committee sixth report: Domestic Violence, Forced Marriage & 'Honour'- Based Violence*, House of Commons, Session 2007-08, p 12, point 7.

<sup>133</sup> *The Home Affairs Committee sixth report: Domestic Violence, Forced Marriage & 'Honour'- Based Violence*, House of Commons, Session 2007-08, p 12, point 7.

<sup>134</sup> *Honour-based Violence (HBV) and Honour-based Killings in Iraqi Kurdistan and in the Kurdish Diaspora in the UK*, Dr N Begikhani, Dr A Gill, Professor G Hague with Ms K Ibraheem, Roehampton, November 2010, para 2.2.

<sup>135</sup> *Ibid.*, para 2.1 & 2.2; 'Bargaining with Patriarchy', *Gender and Society*, Vol 2, No 3, Special Issue to Honour Jessie Bernard, Deniz Kandiyoti, 1988, pp 278-281.

<sup>136</sup> *Neopatriarchy: A Theory of Distorted Change in Arab Society*, H Sharabi, Oxford University Press, Oxford, 1988; *Beyond Honour: A Historical Materialist Explanation of Honour Related Violence*, T Khan, Oxford University Press, Oxford, 2006.

generosity, but also – and most significantly - from the conduct of the female members of his family.<sup>137</sup>

HBV is, by its nature, hidden, as the violence or abuse is mainly (although not exclusively) perpetrated by the victim's family or community, and may include collusion, acceptance, support, silence or denial. This includes such behaviour on the parts of some community and/or faith leaders.<sup>138</sup>

### Characteristics of HBV victims

HBV is a form of abuse and/or violence that takes place predominately against women and girls, although HBV and FM can also be committed against men and boys.<sup>139</sup> The family honour and the desire to protect against dishonour and 'shame' is often used to justify abuse, violence and even murder.<sup>140</sup>

HBV is not linked to any one religion, culture or society. It has been identified<sup>141</sup> as mainly occurring among populations from South Asia. However it can occur in other cultures and communities, such as African, Middle Eastern, Turkish, Kurdish, Afghan, parts of Europe (including the United Kingdom) American, Australian and Canadian.<sup>142</sup>

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<sup>137</sup> *Crimes of Honour and Shame: Violence against Women in non-Western and Western Societies*, Feather Journal of Postmodern Criminology, Sharon K Araji, 2000; *Honour Killings in the UK*, Emily Dyer, The Henry Jackson Society, January 2015, para 1.1.

<sup>138</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, pp 89-91; *Honour Killings in the UK*, Emily Dyer, The Henry Jackson Society, January 2015, para 3.2.1.

<sup>139</sup> *The Home Affairs Committee sixth report: Domestic Violence, Forced Marriage & 'Honour'-Based Violence*, House of Commons, Session 2007-08, p13, point 9; *Britain's Forgotten Women: Speaking to Survivors of 'Honour'-Based Abuse*, Emily Dyer, The Henry Jackson Society, July 2015, para 3.1.

<sup>140</sup> *Honour-based Violence (HBV) and Honour-based Killings in Iraqi Kurdistan and in the Kurdish Diaspora in the UK*, Dr N Begikhani, Dr A Gill, Professor G Hague with Ms K Ibraheem, Roehampton, November 2010, paras 2.1 & 2.2; *Honour Killings in the UK*, Emily Dyer, The Henry Jackson Society, January 2015, para 1.1; *Britain's Forgotten Women: Speaking to Survivors of 'Honour'-Based Abuse*, Emily Dyer, The Henry Jackson Society, July 2015, para 3.1; *The Home Affairs Committee sixth report: Domestic Violence, Forced Marriage & 'Honour'-Based Violence*, House of Commons, Session 2007-08, p 12, point 7; *'Honour' Killing and Violence, Theory, Policy and Practice*, Dr A Gill, Caroline Strange, Karl Roberts, Palgrave Macmillan, Basingstoke, 2014, p3.

<sup>141</sup> *The Right to Choose: Multi-Agency Statutory Guidance for Dealing with Forced Marriage*, UK Government, June 2014, pp1, 2.

<sup>142</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, pp 4-5; *The Missing Link: A Joined Up Approach to Addressing Harmful Practices in London*, Sumanta Roy, Dr Patricia Ng, Ikamara Larasi (Imkaan), Greater London Authority, 2011, p 62; *Honour Killings in the UK*, Emily Dyer, The Henry Jackson Society, January 2015, para 2.2.6; *Honour-based Violence (HBV) and Honour-based Killings in Iraqi Kurdistan and in the Kurdish Diaspora in the UK*, Dr N Begikhani, Dr A Gill, Professor G Hague with

HBV is not associated with any particular religion or religious practices and has been recorded across a number of faiths, including Christian, Hindu, Jewish, Muslim and Sikh communities.<sup>143</sup>

For victims of HBV and FM, the honour-based value system and unwritten codes place restrictions on their lives and freedoms. These are often ingrained and are considered as normal, regardless of the abuse or violence they may be suffering. Victims are often made to feel personally responsible for the maintenance and protection of that honour. As such if the victims go against these codes, even by seeking help, then they may feel guilty and ashamed and may internalise these feelings, effectively being made to feel like the perpetrators instead of the victims that they are.<sup>144</sup>

If victims successfully escape the abuse, they face real and significant risks to their lives.<sup>145</sup> They are left vulnerable and isolated. There may be a loss of family, feelings of guilt and shame, mental anguish, and due to the restrictions imposed they may often lack independent life skills. In order to restore honour there are cited cases of families reporting the victims missing or falsely accusing them of a crime, or tracing them through medical records or national insurance numbers. Bounty hunters, private investigators, local taxi drivers, members of the community and staff at education centres or workplaces may also be enlisted in the search.

Families may solicit the help of professionals<sup>146</sup> who share similar views or who do not understand the situation and consider mediation an option.<sup>147</sup> If located, the victim may be subjected to further violence, abuse or murder.<sup>148</sup>

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Ms K Ibraheem, Roehampton, November 2010, para 2.1; *The Home Affairs Committee sixth report: Domestic Violence, Forced Marriage & 'Honour'-Based Violence*, House of Commons, Session 2007-08, pp 13-14, point 12.

<sup>143</sup> *The Home Affairs Committee sixth report: Domestic Violence, Forced Marriage & 'Honour'-Based Violence*, House of Commons, Session 2007-08, p13, point 9; *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, p 29; *Forced Marriage: The Risk Factors and the Effect of Raising the Minimum Age for a Sponsor, and of Leave to Enter the UK as a Spouse or Fiancé(e)*, Professor Marianne Hester, Dr Khatidja Chantler, Dr Geetanjali Gangoli, Jasvinder Devgon, Sandhya Sharma and Ann Singleton, Bristol, August 2007, p2.

<sup>144</sup> *Britain's Forgotten Women: Speaking to Survivors of 'Honour'-Based Abuse*, Emily Dyer, The Henry Jackson Society, July 2015, paras 3.2-3.3.

<sup>145</sup> *The Home Affairs Committee sixth report: Domestic Violence, Forced Marriage & 'Honour'-Based Violence*, House of Commons, Session 2007-08, pp 69-70, points 204-205.

<sup>146</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, pp 94-96.

<sup>147</sup> *Honour Killings in the UK*, Emily Dyer, The Henry Jackson Society, January 2015, para 2.2.8.

## Characteristics of offenders

While honour codes apply to both men and women, the demands are different.<sup>149</sup> Women are required from birth to follow a set of strict unwritten rules, or honour codes, which impose limits on their lives and activities, to prevent perceived dishonourable behaviour and shame being brought on their families.<sup>150</sup> While these codes can vary from family to family, they are based upon and employed to justify the control of a woman's independence and freedom of movement.<sup>151</sup>

The responsibility to maintain these codes, including administering punishment for the breach of them, is vested mainly in the male members of the family, although females may also be perpetrators.<sup>152</sup> While HBV is rooted in a patriarchal system, females, usually senior members of a family (for example mothers or mothers in law), have a vested interest in obtaining or securing social status and honour through monitoring normally younger relatives. They can be involved in facilitating violence and abuse through informal conversation, pressurising males of the family to undertake HBV acts or assisting in arranging violence, or actually being involved in the violence or killings.<sup>153</sup> If a perpetrator believes that a relative has shamed the family and/or community by breaking their honour code, then they may inflict such

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<sup>148</sup> *The Home Affairs Committee sixth report: Domestic Violence, Forced Marriage & 'Honour'-Based Violence*, House of Commons, Session 2007-08, pp 69-70, point 204-205; *Honour Killings in the UK*, Emily Dyer, The Henry Jackson Society, January 2015, p 2; *Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage*, UK Government, June 2014, pp 12-13; *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, pp 94-96.

<sup>149</sup> *'Honour' Killing and Violence, Theory, Policy and Practice*, Dr A Gill, Caroline Strange, Karl Roberts, Palgrave Macmillan, Basingstoke, 2014, p5.

<sup>150</sup> *Honour-based Violence (HBV) and Honour-based Killings in Iraqi Kurdistan and in the Kurdish Diaspora in the UK*, Dr N Begikhani, Dr A Gill, Professor G Hague with Ms K Ibraheem, Roehampton, November 2010, para 2.1; *Honour Killings in the UK*, Emily Dyer, The Henry Jackson Society, January 2015, para 1.1.

<sup>151</sup> *Honour Killings in the UK*, Emily Dyer, The Henry Jackson Society, January 2015, p 11; *Honour-based Violence (HBV) and Honour-based Killings in Iraqi Kurdistan and in the Kurdish Diaspora in the UK*, Dr N Begikhani, Dr A Gill, Professor G Hague with Ms K Ibraheem, Roehampton, November 2010, para 2.1; *'Honour' Killing and Violence, Theory, Policy and Practice*, Dr A Gill, Caroline Strange, Karl Roberts, Palgrave Macmillan, Basingstoke, 2014, p2.

<sup>152</sup> *Honour-based Violence (HBV) and Honour-based Killings in Iraqi Kurdistan and in the Kurdish Diaspora in the UK*, Dr N Begikhani, Dr A Gill, Professor G Hague with Ms K Ibraheem, Roehampton, November 2010; *'Honour' Killing and Violence, Theory, Policy and Practice*, Dr A Gill, Caroline Strange, Karl Roberts, Palgrave Macmillan, Basingstoke, 2014, p79 discussing the cases of Shafilea Ahmed and Surjit Athwal.

<sup>153</sup> *'Honour' Killing and Violence, Theory, Policy and Practice*, Dr A Gill, Caroline Strange, Karl Roberts, Palgrave Macmillan, Basingstoke, 2014, pp 6-7, p79 discussing the cases of Shafilea Ahmed, Surjit Athwal and Rukhsana Naz.

violence or abuse to restore honour, as well as to deter other family members from committing similar breaches.<sup>154</sup>

## Motivations

The motives for HBV are linked to the desire to control a victim's unwanted behaviour, including their sexuality. This perceived behaviour might include, for example, defying parental authority, using alcohol or drugs, or engaging in relationships considered inappropriate (such as becoming involved with someone from a different caste, religion or ethnicity). In these cases the other party may also be killed.<sup>155</sup>

Other behaviour could include having pre-marital or extra-marital sex, or being lesbian, gay or transgender, seeking or refusing a divorce,<sup>156</sup> becoming pregnant outside of marriage or being unable to conceive.<sup>157</sup> Or it may merely be that in the family's view, the victim is becoming too 'westernised' (as indicated by their dress, behaviour etc). Associations with men or mere gossip can also lead to perceived dishonour.<sup>158</sup> In addition, male victims can be subjected to violence for refusing to commit an act of HBV.<sup>159</sup>

Alternatively HBV could effectively constrain a victim in a situation due to the perceived dishonour they may face by leaving it, which could include the necessity to seek a divorce. These victims can be kept effectively in servitude in many ways as the social pressure to remain and accept the abuse is strong, or they may lack the economic means to leave.<sup>160</sup>

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<sup>154</sup> *Britain's Forgotten Women: Speaking to Survivors of 'Honour'-Based Abuse*, Emily Dyer, The Henry Jackson Society, July 2015, p19.

<sup>155</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, pp 6, 45 & 61 discussing the cases of Arash Ghorbani-Zarin and Shafilea Ahmed.

<sup>156</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, pp 6, 46 & 61 discussing the case studies of Arash Ghorbani-Zarin and Surjit Athwal.

<sup>157</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, p42.

<sup>158</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, pp 6 & 8.

<sup>159</sup> *'Honour' Killing and Violence, Theory, Policy and Practice*, Dr A Gill, Caroline Strange, Karl Roberts, Palgrave Macmillan, Basingstoke, 2014, p79.

<sup>160</sup> *'Honour' Killing and Violence, Theory, Policy and Practice*, Dr A Gill, Caroline Strange, Karl Roberts, Palgrave Macmillan, Basingstoke, 2014, p 79, discussing the cases of Surjit Athwal and Kiranjit Ahluwalia.

In order to preserve or maintain the family's honour, individuals, families and communities may take extreme measures. This can include substantial human rights abuses and a range of crimes, for example blackmail, surveillance, harassment, rape, forced suicide, abduction, forced marriage and murder.<sup>161</sup>

### **Similarities with and differences with other forms of abuse**

There is no specific crime of HBV, although it has clear links with domestic abuse, child abuse, abuse of vulnerable adults and numerous other crime types. However, the rationale differs in that HBV usually occurs within the family or community context, to preserve perceived social, cultural, religious traditions or norms.<sup>162</sup> The family's honour, social status and reputation and desire to avoid shame are considered more important than the welfare of the victim<sup>163</sup> or their basic human rights. As such, HBV can involve multiple perpetrators taking drastic action which may be premeditated. This can involve members of the victims immediate and or extended family (husbands, parents, siblings, sons, in-laws etc), and sometimes community collusion.<sup>164</sup>

In some cases of honour killings the perpetrators' actions have been considered as heroic and the victims are actually condemned for betraying the family.<sup>165</sup> The acts may vary from community to community, depending on each group's cultural, social and religious traditions or beliefs.<sup>166</sup>

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<sup>161</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, p 42 ; *'Honour' Killing and Violence, Theory, Policy and Practice*, Dr A Gill, Caroline Strange, Karl Roberts, Palgrave Macmillan, Basingstoke, 2014, p5.

<sup>162</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, p8; *'Honour' Killing and Violence, Theory, Policy and Practice*, Dr A Gill, Caroline Strange, Karl Roberts, Palgrave Macmillan, Basingstoke, 2014, pp 29-30.

<sup>163</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, p27 discussing the case of Shafiea Ahmed.

<sup>164</sup> *Honour Killings in the UK*, Emily Dyer, The Henry Jackson Society, January 2015, paras 1.1, 2.2.28, 3.2.1, pp 12 ,24, 29. *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, pp 2 & 8.

<sup>165</sup> *Honour Killings in the UK*, Emily Dyer, The Henry Jackson Society, January 2015, para 3.2.1; *'Honour' Killing and Violence, Theory, Policy and Practice*, Dr A Gill, Caroline Strange, Karl Roberts, Palgrave Macmillan, Basingstoke, 2014, p5.

<sup>166</sup> *'Honour' Killing and Violence, Theory, Policy and Practice*, Dr A Gill, Caroline Strange, Karl Roberts, Palgrave Macmillan, Basingstoke, 2014, pp 2-3.

The other difference between HBV and other forms of abuse is that there are potentially significant risks to people associated with the victim, for example the victim's children, siblings and friends as well as members of various organisations who seek to assist the victim.<sup>167</sup>

## **Forced marriage**

It is important to distinguish between forced marriage (FM) and arranged marriage. An arranged marriage is a legal practice and has been practised in numerous societies for centuries. Families take a lead role in arranging the marriage, but the final choice as to whether to accept the marriage is a matter for the individuals concerned.

FM is different from an arranged marriage, in that one or both parties do not give their full and free valid consent to the marriage. Force, coercion and duress are used (actual or perceived), against the victim and/or someone else, such as a sibling. Alternatively it may be that a sibling is required to take the victim's place if the victim has refused or disappeared, leaving the marriage promise outstanding.<sup>168</sup> There can be physical, emotional, psychological, financial and sexual pressure exerted on the victim or someone close to them to make them comply. By law, in cases involving vulnerable adults who lack the capacity to consent to marriage, coercion is not required for a marriage to be defined as forced.<sup>169</sup>

### **Characteristics of victims**

FM is a specific crime under the Anti-Social Behaviour, Crime and Policing Act 2014. It can be committed against men, women or children, although the large majority of reported cases are committed against girls and women between the ages of 16 and 25.<sup>170</sup> The exact scale of the problem is unclear given the hidden nature of the crime.

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<sup>167</sup> *Honour Killings in the UK*, Emily Dyer, The Henry Jackson Society, January 2015, para 3.2.1.

<sup>168</sup> *Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage*, UK Government, June 2014, p11, para 3.10.

<sup>169</sup> *Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage*, UK Government, June 2014, p3.

<sup>170</sup> *Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage*, UK Government, June 2014, p 10.



The Forced Marriage Unit (FMU)<sup>171</sup> operates a public helpline to provide advice and support to victims of FM as well as to professionals dealing with these cases. Over the last three years an average of 79–82 percent of calls received by the FMU have been from or about female victims and 18–21 percent have been in relation to male victims. The FMU has recorded cases of female victims who are older and younger than 16 to 25; in 2012 the FMU reported calls involving people aged as young as two and as old as 71 years-old.

Victims of FM can include people with learning or physical disabilities. In the same period (2012 to 2014), the FMU received between 97 and 135 calls per year from victims who were identified as having a disability.<sup>172</sup>

Young people (particularly girls) who are forced to marry are frequently withdrawn from education, restricting their educational and personal development. Victims may feel unable to go against their parents' (or wider family's) wishes, due to fear of violence and/or fear of being disowned by the family. This can often lead them to suffer emotionally, resulting in depression, self-harm or, in extreme cases, suicide.<sup>173</sup> It can also lead to impaired social development, limited career and educational opportunities, financial dependence and lifestyle restrictions, all of which in turn render victims even more vulnerable to continued abuse.<sup>174</sup>

Victims may be taken abroad to be forced into marriage; they may be blackmailed or deceived by their own family for that purpose and left there for extended periods. They may be subjected to physical and emotional abuse to force them into the marriage in the UK or in other countries.<sup>175</sup> Once forced into marriage, victims may be subjected to repeated serious sexual assaults and ongoing domestic abuse including from extended family members.<sup>176</sup>

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<sup>171</sup> The Forced Marriage Unit (FMU) is a joint Foreign and Commonwealth Office and Home Office unit which leads on the government's forced marriage policy, outreach and casework. It operates both inside the UK, where support is provided to any individual, and overseas, where consular assistance is provided to British nationals, including dual nationals, see: [www.gov.uk/forced-marriage](http://www.gov.uk/forced-marriage)

<sup>174</sup> Statistics on Forced Marriage for 2012, 2013 and 2014, [www.gov.uk/forced-marriage](http://www.gov.uk/forced-marriage)

<sup>173</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, pp 15-16.

<sup>174</sup> *Forced Marriage, Family Cohesion and Community Engagement: National Learning through a Case Study of Luton*, Dr Nazia Khanum OBE, Bartham Press, Watford, March 2008, p50, paras 118 & 119; *Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage*, UK Government, June 2014, p12.

<sup>175</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, pp 15-26.

<sup>176</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, pp 21-26.

These victims may be particularly vulnerable. They may have feelings of isolation, guilt and shame as they consider that they are breaching the honour codes by wishing to escape from the FM. They are likely to have minimal experience of life outside the family environment and some may speak little or no English.<sup>177</sup> They may be fearful of leaving behind their family, children and friends.<sup>178</sup> In the case of victims without permanent leave to remain, they may also face spousal abandonment<sup>179</sup> and consequent immigration status difficulties. Victims with disabilities may also be abandoned by their spouses, causing further harm, stigmatisation and possibly the loss of a carer.<sup>180</sup> It can also be argued that victims with disabilities are at greater risk because of the increased likelihood of social isolation, dependency on their parents or family for care, impaired capacity to resist or understand, increased communication needs or their lack of access to a trusted person.<sup>181</sup>

If a victim feels they have no alternative but to leave their home to prevent the FM taking place, or leaves after it has taken place, the risk for that victim and any associated persons (for example partners, friends, siblings) increases.

The victim may be isolated, with no financial or emotional support and may be homeless.<sup>182</sup> Due to the perceived dishonour they may be ostracised and harassed by their family and community. After leaving, victims often live in fear of their own family, as families will go to considerable lengths to locate them in order to restore the honour, as outlined previously regarding HBV.<sup>183</sup>

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<sup>177</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, pp 22-26 & 62; *Britain's Forgotten Women: Speaking to Survivors of 'Honour'-Based Abuse*, Emily Dyer, The Henry Jackson Society, July 2015, para 3.2; *The Right to Choose: Multi-Agency Statutory Guidance for Dealing with Forced Marriage*, UK Government, June 2014, p 9.

<sup>178</sup> *Britain's Forgotten Women: Speaking to Survivors of 'Honour'-Based Abuse*, Emily Dyer, The Henry Jackson Society, July 2015, paras 3.2-3.5.

<sup>179</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, pp 22-23.

<sup>180</sup> *Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage*, UK Government, June 2014, pp 12-13.

<sup>181</sup> *Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage*, UK Government, June 2014, pp 6-7.

<sup>182</sup> *Britain's Forgotten Women: Speaking to Survivors of 'Honour'-Based Abuse*, Emily Dyer, The Henry Jackson Society, July 2015, para 2.

<sup>183</sup> *The Home Affairs Committee sixth report : Domestic Violence, Forced Marriage & 'Honour'-Based Violence*, House of Commons, Session 2007-08, pp 69-70, points 204-205; *Honour Killings in the UK*, Emily Dyer, The Henry Jackson Society, January 2015, p 2; *Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage*, UK Government, June 2014, pp 12-13. *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008.

## Motivations

The motivations for FM include the same as those identified for HBV: the practice is associated with maintaining the family honour and avoiding shame. In addition, FM can be a means for controlling the sexuality of people who are lesbian, gay, bisexual or transgender, as the wider family may believe that by forcing the victim to marry, their sexuality or gender identity will not be questioned, or that it will 'cure' them of what they believe to be abnormal sexual practices.<sup>184</sup>

It can also be used as a means of complying with long-standing family commitments, securing family assets, strengthening family links, improving status, or for financial gain or for immigration purposes.<sup>185</sup> In the case of victims with learning or physical disabilities, FM could be a means of ensuring care for a child or adult with additional needs when the existing carers are unable to do so.<sup>186</sup> FM can also affect a bereaved widow or the children of the family, as a marriage may be seen by the wider family as a way to secure their future, maintain honour and/or prevent the possibility of dishonour.<sup>187</sup>

## Female genital mutilation (FGM)

FGM is recognised internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women.<sup>188</sup> The procedure is traditionally carried out by women with no medical training. Anaesthetics and antiseptic treatments are not generally used, and the practice is usually carried out using knives, scissors, scalpels, pieces of glass or razor blades.<sup>189</sup>

FGM is a crime under the Female Genital Mutilation Act 2003.

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<sup>184</sup> *Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage*, UK Government, June 2014, p11.

<sup>185</sup> *Exposure: The sham marriage racket – how to buy your way into Britain*, ITV Report, 2 July 2015, [www.itv.com/news/2015-07-02/exposure-the-sham-marriage-racket-how-to-buy-your-way-into-britain/](http://www.itv.com/news/2015-07-02/exposure-the-sham-marriage-racket-how-to-buy-your-way-into-britain/)

<sup>186</sup> *Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage*, UK Government, June 2014, pp 11-12; *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, p 47 discussing the case of Rasheedah.

<sup>187</sup> *Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage*, UK Government, June 2014, p11.

<sup>188</sup> *Female genital mutilation*, World Health Organization, February 2014, [www.who.int/mediacentre/factsheets/fs241/en/](http://www.who.int/mediacentre/factsheets/fs241/en/)

<sup>189</sup> *Female genital mutilation overview*, NHS, [www.nhs.uk/Conditions/female-genital-mutilation/Pages/Introduction.aspx](http://www.nhs.uk/Conditions/female-genital-mutilation/Pages/Introduction.aspx)

There are no health benefits to FGM and it can lead to medical conditions that affect the victim throughout her life and are often devastating. The short-term implications of FGM can include severe pain, shock, bleeding, wound and/or blood infections, an inability to urinate and physical injury to the tissues and organs nearby, for example the urethra and bowel. Sometimes the immediate impact can be the death of the victim from uncontrolled bleeding.<sup>190</sup> The long-term complications can also be significant: wounds that will not heal; infection; pain during intercourse; issues with menstruation; difficulty passing urine and/or persistent urinary infections; kidney impairment; complications in pregnancy and childbirth; including newborn and maternal deaths; The psychological impacts can include depression and post-traumatic stress, having a life-long and potentially debilitating impact on victims.<sup>191</sup>

### **Characteristics of victims**

FGM is usually carried out on girls between infancy and 15 years of age, with the majority of cases occurring between the ages of five and eight.<sup>192</sup> However, it can be, and is, carried out on younger or older girls and women, for example, when girls reach puberty, as a rite of passage, or when women marry into a community. A trend has also been noted to 'cut' girls at a younger age (sometimes before their first birthday), potentially as a response to legislation and efforts to eradicate the practice.<sup>193</sup> It can also be undertaken on adult women who have, through expectation or coercion, the procedure restored after childbirth – known as reinfibulation – or cases in which a woman is forced into the procedure by her husband after marriage.<sup>194</sup>

The hidden nature of the crime makes it difficult to estimate the levels of FGM in the UK. A recent study estimated that 60,000 girls aged 0-14 born in England and Wales were born to mothers who had undergone FGM and that approximately 103,000 women aged 15 to 49 and 24,000 women aged 50 and over who have migrated to

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<sup>190</sup> *Multi-Agency Practice Guidelines, Female Genital Mutilation*, UK Government, 2014, p13, paras 2.10.1 & 2.10.2; *Home Affairs Committee, Female Genital Mutilation: the Case for a National Action Plan*, House of Commons, Second Report of Session 2014-2015, 25 June 2014, points 2 & 3.

<sup>191</sup> *Multi-Agency Practice Guidelines, Female Genital Mutilation*, UK Government, 2014, pp 12-13, paras 2.10-2.11; *Home Affairs Committee, Female Genital Mutilation: the Case for a National Action Plan*, House of Commons, Second Report of Session 2014-2015, 25 June 2014, points 2 & 3.

<sup>192</sup> *Home Affairs Committee, Female Genital Mutilation: the Case for a National Action Plan*, House of Commons, Second Report of Session 2014-2015, 25 June 2014, p5; *Multi-Agency Practice Guidelines, Female Genital Mutilation*, UK Government, 2014, p16, para 3.2.

<sup>193</sup> *Country profile: FGM in Tanzania*, December 2013, p14, [www.28toomany.org/media/uploads/tanzania\\_final\\_final\\_final.pdf](http://www.28toomany.org/media/uploads/tanzania_final_final_final.pdf)

<sup>194</sup> *Home Affairs Committee, Female Genital Mutilation: the Case for a National Action Plan*, House of Commons, Second Report of Session 2014-2015, 25 June 2014, p2.

England or Wales, are living with the consequences of FGM.<sup>195</sup> It is estimated that approximately 10,000 girls aged 15 years or under who have migrated to England and Wales are likely to have undergone FGM.<sup>196</sup>

The United Nations Children's Fund (UNICEF) estimates that 125 million women and girls worldwide have undergone FGM, the majority in a belt of 28 African countries that stretches from the Atlantic to the Horn of Africa, throughout the Middle East and some Asian communities. FGM has been seen in the west as an African issue, but it can be found in other countries too.<sup>197</sup> In Somalia, Guinea, Djibouti and Egypt, for example, more than 90 percent of the female population aged between 15 and 49 have been subjected to FGM, whereas in Niger, Cameroon and Uganda it is less than two percent. Levels of FGM also vary greatly within countries and can be more closely associated with particular ethnic groups.<sup>198</sup> Overall, it is believed that up to three million girls worldwide are subjected to FGM every year.<sup>199</sup>

In the case of women and girls living in Britain, FGM may be carried out in the UK or abroad. If carried out in the UK, people known as 'cutters' may be brought into the country for the purpose of carrying out FGM. 'Cutters' are usually female, although in rare cases can be male.

They may carry out the practice on a number of victims at the same time and location. Alternatively, girls can be taken abroad, usually ahead of the six-week or other long school holidays, for the practice to be carried out.<sup>200</sup>

There have also been reports of victims feeling betrayed by parents, feeling incomplete, regret and anger at what they have been subjected to. This could result in mental health problems and/or dependency issues.<sup>201</sup>

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<sup>195</sup> *Multi-Agency Practice Guidelines, Female Genital Mutilation*, UK Government, 2014, p11, para 2.6.

<sup>196</sup> *Multi-Agency Practice Guidelines, Female Genital Mutilation*, UK Government, 2014, p11, para 2.6.

<sup>197</sup> *Multi-Agency Practice Guidelines, Female Genital Mutilation*, UK Government, 2014, pp 9-10, para 2.5.

<sup>198</sup> *Home Affairs Committee, Female Genital Mutilation: the Case for a National Action Plan*, House of Commons, Second Report of Session 2014-2015, 25 June 2014, p6, point 4.

<sup>199</sup> *Home Affairs Committee, Female Genital Mutilation: the Case for a National Action Plan*, House of Commons, Second Report of Session 2014-2015, 25 June 2014, p6, point 4.

<sup>200</sup> *Multi-Agency Practice Guidelines, Female Genital Mutilation*, UK Government, 2014, p12, para 2.9.

<sup>201</sup> *Multi-Agency Practice Guidelines, Female Genital Mutilation*, UK Government, 2014, p14, para 2.11.

## Characteristics of offenders

In the countries where this practice originates, FGM is often performed by a village elder who oversees maternity issues and will not usually have any medical qualifications.<sup>202</sup> According to the World Health Organization, there are indications of a developing trend towards FGM being carried out by healthcare practitioners, with a view towards medicalisation by those who support the practice, to make it more acceptable, and to eliminate infection.<sup>203</sup>

## Motivations

FGM is based on the control and subordination of women and their sexuality,<sup>204</sup> and can in some cases be linked to economic security and social status. Like HBV and FM, FGM is associated with the concept of family honour and the control of behaviour, especially the sexual behaviour of women and girls.<sup>205</sup> It is rooted in a patriarchal system, although the practice can be promoted and performed by females as part of the culture or tradition. It is increasingly being recognised on an international level as a severe form of gender-based violence. Where this is carried out on a child it is an extreme form of child abuse.<sup>206</sup> Those that adhere to the practice may have a strong sense of obligation to conform, as they fear social exclusion, ridicule and potentially not being able to make their daughters marriageable.<sup>207</sup>

The motivation behind FGM includes:

- to bring status and respect to the girl;
- to preserve a girl's virginity/chastity before marriage;
- to preserve chastity in marriage;

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<sup>202</sup> *Multi-Agency Practice Guidelines, Female Genital Mutilation*, UK Government, 2014, p13, para 2.9; *Home Affairs Committee, Female Genital Mutilation: the Case for a National Action Plan*, House of Commons, Second Report of Session 2014-2015, 25 June 2014, p5, point 2.

<sup>203</sup> *Multi-Agency Practice Guidelines, Female Genital Mutilation*, UK Government, 2014, p13, para 2.9; *Home Affairs Committee, Female Genital Mutilation: the Case for a National Action Plan*, House of Commons, Second Report of Session 2014-2015, 25 June 2014.

<sup>204</sup> *Home Affairs Committee, Female Genital Mutilation: the Case for a National Action Plan*, House of Commons, Second Report of Session 2014-2015, 25 June 2014, p7, point 6.

<sup>205</sup> *Crimes of the Community: Honour Based Violence in the UK*, J Brandon and S. Hafez, second edition, Centre for Social Cohesion, London, 2008, p66.

<sup>206</sup> *Home Affairs Committee, Female Genital Mutilation: the Case for a National Action Plan*, House of Commons, Second Report of Session 2014-2015, 25 June 2014, p7, point 8.

<sup>207</sup> *Home Affairs Committee, Female Genital Mutilation: the Case for a National Action Plan*, House of Commons, Second Report of Session 2014-2015, 25 June 2014, p6, point 6.

- a rite of passage to adulthood;
- social acceptance, especially for marriage; and
- to 'purify' the girl.<sup>208</sup>

There are various beliefs associated with FGM. These include:

- that it gives the girl and her family a sense of belonging to a community, continuing a custom or tradition;
- that it helps with women and girls to be hygienic; and
- that it is aesthetically desirable.

There is no established basis for the practice in any religion, although there are commonly held misconceptions that it is a religious requirement, and that it enhances fertility or makes childbirth safer. Following marriage, the assumption is that it will ensure fidelity of the woman to her husband and increases sexual pleasure for the man.<sup>209</sup>

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<sup>208</sup> *Multi-Agency Practice Guidelines, Female Genital Mutilation*, UK Government, 2014, p11, para 2.8.

<sup>209</sup> *Home Affairs Committee, Female Genital Mutilation: the Case for a National Action Plan*, House of Commons, Second Report of Session 2014-2015, 25 June 2014, p6, point 6.

## Annex F – National agencies involved in preventing and tackling honour-based violence

HMIC offered the main national agencies that work with the police to respond to HBV the opportunity to provide information on the work they are doing in response to the risks presented by HBV. This section sets out the statements received from:

- the Home Office;
- the Welsh government;
- the College of Policing;
- the National Police Chiefs' Council lead for HBV;
- the National Crime Agency; and
- the Crown Prosecution Service.

### Home Office

For the police service in England, the government department with responsibility for leading and overseeing policy development is the Home Office.

The Home Office is the government department responsible for immigration, counter-terrorism, police, drugs policy, and related science and research. This includes lead responsibility for domestic policy on honour-based violence (HBV), including female genital mutilation (FGM) and forced marriage (FM).

Tackling so-called 'honour-based' violence (HBV) in all its forms is a key priority for this government. In developing policies and process in relation to HBV, the Home Office works closely with a range of stakeholders, this includes the police and the national policing lead for HBV.

### Female genital mutilation (FGM)

All of the commitments made at the first Girl Summit [in 2014] have now been delivered, including the following commitments led by the Home Office:

- a new mandatory reporting duty, as described in chapter three;
- the launch of the Home Office's FGM Unit (see chapter eight); and
- providing resources for frontline professionals, including: a resource pack, e-learning, and distributing over 440,000 communication materials.



The government has recently consulted on updated draft multi-agency guidance on FGM ([www.gov.uk/government/consultations/consultation-on-the-draft-statutory-multi-agency-practice-guidance-on-female-genital-mutilation-fgm](http://www.gov.uk/government/consultations/consultation-on-the-draft-statutory-multi-agency-practice-guidance-on-female-genital-mutilation-fgm)) for frontline professionals which is being put on a statutory footing.

### **Forced marriage**

Forcing someone to marry was made a criminal offence in England and Wales as part of the Anti-social Behaviour, Crime and Policing Act 2014, as described in Chapter 3. The government has published statutory multi-agency guidance and practice guidelines ([www.gov.uk/guidance/forced-marriage#guidance-for-professionals](http://www.gov.uk/guidance/forced-marriage#guidance-for-professionals)) on forced marriage for frontline professionals

### **Female Genital Mutilation (FGM) Unit**

The Home Office's FGM Unit coordinates efforts across government to prevent FGM, provides outreach support to local areas and works with the police, voluntary and community sector, survivors and professionals to develop policies and practices to end FGM. The Unit also works with the police, Crown Prosecution Service, Border Force, and the College of Policing to improve the identification and prosecution of offenders.

### **Forced Marriage Unit (FMU)**

The FMU was established in 2005 to lead on the government's forced marriage policy, outreach and casework. The FMU operates both inside the UK, where support is provided to any individual, and overseas, where consular assistance is provided to British nationals, including dual nationals.

The FMU operates a public helpline to provide advice and support to victims of forced marriage as well as to professionals dealing with cases. The assistance provided ranges from simple safety advice, through to aiding a victim to prevent their unwanted spouse moving to the UK ('reluctant sponsor' cases), and, in extreme circumstances, to rescues of victims held against their will overseas.

### **Border Force**

Border Force is a law enforcement command within the Home Office, securing the UK border by carrying out immigration and customs controls for people and goods entering the UK.

Border Force continues to work with the police in protecting girls and young women at risk of FGM. This includes carrying out joint operations during risk periods such as Operation Limelight (see Chapter 7 of this report).

Border Force has developed an FGM e-learning package aimed at professionals including Border Force. The training alerts staff about what to look out for (such as all female groups, dates of travel - e.g. extended trips or girls taken out of school), and advises the staff member of what to do if they suspect someone is at risk of FGM.

## **UK Visas and Immigration**

UK Visas and Immigration (UKVI), is an operational directorate of the Home Office and responsibilities include considering applications for visitors, students, workers, asylum claims, applications for British citizenship, and handles case queries through customer contact centres and MPs correspondence. UKVI delivers the government's immigration objectives in partnership with the other services that make up the Border, Immigration and Citizenship system (Border Force, Immigration Enforcement and HM Passport Office), and the Immigration and Border Policy Directorate within Home Office.

In regards to applications which may involve FGM or honour-based violence, it is normally established as part of the decision making process. There are protocols in place where an allegation of forced marriage is made UKVI works with the FM Unit or FGM Unit. As set out in section 55 of the Borders, Citizenship and Immigration Act 2009 UKVI has a particular duty to protect and safeguard the wellbeing of children and checks are made on the accompanying or sponsor adults to ensure that they are related as claimed. The (UKVI) Safeguarding Children Strategy was launched to staff in 2015 to reinforce the safeguarding children duty commitment, and includes current training provision and processes in place for safeguarding and contacts for local safeguarding business leads. Staff are also encouraged to refer to the Office of the Children's Champion (OCC). The OCC provides specialist safeguarding and welfare advice to borders and immigration staff who have questions or concerns about cases involving children.

## **Welsh government**

Whilst HBV, FM and FGM policy is non devolved, the Welsh government is committed to end these practices by working collaboratively to promote awareness and prevention of FGM, HBV and FM in Wales. Our approach involves community engagement, training, and developing strong multi-agency governance arrangements to drive this work forward.

The Wales Strategic FGM Leadership group was established in 2014, membership includes key decision-makers from organisations including the voluntary sector, health, education and police with the aim to provide plans for tackling FGM in Wales. Objectives of the leadership group focus on eradication, education and prevention of FGM.

The Welsh government has recently begun to strategically review how HBV and FM is tackled in Wales through their HBV and FM leadership group. This group is made up of key decision-makers from organisations involved in this area of work.

The Welsh government's national training framework on violence against women, domestic violence and sexual abuse will introduce a standard of training for these issues, related to job role, across the Welsh public service. The national training framework will include both basic, fundamental levels of training and a specialist subject syllabus, each of which include FGM, HBV and FM. This will ensure a consistent approach to training and drive a collaborative approach to tackling these practices in Wales.

As a result of the Intercollegiate report on tackling FGM in the UK (Tackling FGM in the UK: Intercollegiate recommendations for identifying, recording and reporting 2013), Welsh government and National Health Service (NHS) Wales have developed a health workstream which has so far: established a FGM safeguarding lead in each of the local health boards in Wales; ensured FGM training is included in mandatory safeguarding training; and developed a FGM care pathway to ensure consistency of physical and psychological care for those that have undergone FGM.

The Welsh government recognises the need to work towards sustainable longer term cultural change to tackle such issues. To mark International 'zero tolerance day' of FGM in February 2015, the Welsh government organised a community-based conference – Making our voices heard. The aim was to build trust with communities and encourage them to work together with government and public services to change perceptions of this cultural practice. The conference was attended by 150 community members, including men, from practicing communities in Wales.

The Welsh government will be building on this during 2015-16, working with the National Society for the Prevention of Cruelty to Children (NSPCC) and voluntary sector organisations in Wales with a particular focus on youth participation, culminating in a national youth conference to mark international zero tolerance day in February 2016.

Welsh government guidance 'Keeping Learners' Safe' also provides specific advice on HBV and FM to those working within education.

## College of Policing

The College of Policing sets standards of professional practice for the police service in England and Wales, identifying and promoting good practice and learning. In support of this it produces authorised professional practice (APP) guidance, together with a range of briefing and information sources and access to evidence about what works in policing and crime reduction through the 'What Works' centre.<sup>210</sup>

APP is designed to provide up-to-date standards and guidance for the police service. It also acts as the standard against which forces are measured by bodies such as HMIC and the Independent Police Complaints Commission (IPCC). Once APP is published it effectively supersedes any previous guidance produced by the police service. There is currently no APP for HBV or FM. The APP for child abuse does contain specific advice on complex investigations including HBV, FM and FGM. The College of Policing has produced APP for FGM. The College's website describes the FGM APP as follows:

"This APP reference document is designed to raise awareness of and demystify the practice of female genital mutilation (FGM) for officers and those they work with so that it can be more proactively prevented and prosecuted. Effective ways of policing FGM are still being established. This content draws on material from international organisations, voluntary sector and statutory partners and police practitioners to support officers and forces in developing their response to FGM."

The College of Policing has designed and promoted a public protection training programme, which includes specific sections on HBV, FM and FGM. The programme currently delivers learning standards through the national curriculum and supporting resources, licensed to forces for delivery to staff and is embedded within national courses for new recruits (Initial Police Learning Development Programme) and detectives (Initial Crime Investigation Development Programme). Each level of the programme is a pre-requisite to the next level. Resources include:

- Level 1 – a suite of eLearning based around case studies, student notes, immersive learning exercises,<sup>211</sup> trainer guide and handbook;
- Level 2 – trainer guide, PowerPoint presentation training (PPT), videos, immersive learning exercise and course handbook; and
- Specialist level – pre-reads, PPT, DVD, trainer guide and course handbook.

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<sup>210</sup> *What works crime reduction*, College of Policing, available from: <http://whatworks.college.police.uk/Pages/default.aspx>

<sup>211</sup> Immersive learning is a delivery technique designed to simulate the reality of critical incident management. Immersed in a realistic environment, where students can experience the decision-making process and understand the complex issues involved.

## **National Police Chiefs' Council**

A new HBV strategy is in development under the leadership of the National Police Chiefs' Council lead for HBV.<sup>212</sup>

The role of the NPCC lead is to develop the strategy for the police service in respect of HBV. The original HBV strategy (ACPO) published in 2008 has since been updated and the revised version is expected to be published in late 2015. The strategy outlines high level aims for the police service and will support authorised professional practice (APP) on HBV when this is published by the College of Policing. The revised strategy places an emphasis on a victim led approach and calls for all agencies to acknowledge their roles amongst a coalition of partners.

The NPCC lead for HBV must also be able to influence the activity required to meet the strategy, both within the police service and more widely. For example the NPCC lead is in regular dialogue with chief officers across the country, and has represented the police service at ministerial round table groups on HBV, including the Home Office, Ministry of Justice, Foreign and Commonwealth Office and Ministry of Health. The NPCC lead also maintains dialogue with key individuals in a number of voluntary sector organisations.

There are nine regional HBV policing leads corresponding to the NPCC areas in England and Wales, who are each given areas of responsibility to support the HBV strategy. The NPCC lead maintains a regular dialogue with each of these leads (approximately on a quarterly basis) and they in turn are expected to ensure regular dialogue with the forces in their region (each force has an identified HBV point of contact). The lines of communication should provide for the flow of information in both directions, including emerging threats and lessons learned. This does not require formal meetings. The NPCC lead seeks to bring the regional leads together for a formal meeting on an annual basis.

The NPCC lead is developing a data request for all forces that would be managed through the national structure to collate information that will assist with providing a more accurate picture of the nature and scale of HBV across England and Wales

## **National Crime Agency**

The National Crime Agency (NCA) works with the police service and other law enforcement organisations in the UK and internationally to identify and disrupt serious and organised crime. The NCA has five priority areas of work: organised crime; cyber-crime; economic crime; child sexual exploitation and serious and organised crime within and crossing UK borders.

Although HBV, FM and FGM are not planned priorities for the NCA, their work on child sexual exploitation links to these types of offences.

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<sup>212</sup> Revised in 2015 but not published at the time of writing.

The NCA has a number of specialist teams with international connections. The UK International Crime Bureau (UK ICB) is the specialist team that assists UK police forces with international enquiries in relation to HBV, FM and FGM. For example, if a UK police force makes enquiries in relation to a female who has been taken abroad for the purpose of FGM or FM, the UK ICB will liaise with their international colleagues to try and locate the victim and assist her safe return to the UK.

### **UK protected persons service (PPS)**

The PPS is a UK-wide service which provides protected person status to witnesses and other vulnerable people where there is a real and immediate risk to their lives. The NCA is responsible for the national coordination of this service, with police forces responsible for operational delivery on a regional basis via the regional organised crime units (ROCUs). As of September 1 2015 there were 14 cases involving 36 individuals related to HBV, FM and FGM in the PPS scheme.

### **The Crown Prosecution Service**

The Crown Prosecution Service (CPS) is the principal prosecuting authority for England and Wales, acting independently in criminal cases investigated primarily by the police. The CPS decides which cases should be prosecuted – keeping them all under continuous review; determines the appropriate charges in more serious or complex cases – advising the police during the early stages of investigations; prepares cases and presents them at court - using a range of in-house advocates, self-employed advocates or agents in court; and provides information, assistance and support to victims and prosecution witnesses.

Legal Guidance on FM and HBV was updated in 2014, in line with the new legislation relating to forced marriage. Specialist prosecutors have been trained and during 2014 the CPS and the police jointly delivered a number of workshops on HBV, FM, and FGM to the police and prosecutors, including raising awareness of the FM offence. Following the joint training, an e-learning training programme for prosecutors was developed and launched.

During 2014/15 the CPS continued to deliver on the CPS FGM action plans, published in 2012 and 2013. The CPS has been working closely with the police, other government departments and third sector organisations to identify how effective action can be taken to increase awareness of FGM; improve reporting and strengthen investigation to lead to prosecutions.

All CPS areas have agreed protocols with their local police forces setting out the arrangements for investigation and prosecution of FGM; these also outline how both agencies will raise awareness through community events. Progress is reported on this and on cases referred to the CPS for early investigative advice through on-going monthly telecom meetings with lead CPS prosecutors, which are reported to the Director of Public Prosecutions (DPP).

Through close work between the CPS and police examining cases which had been reported but where a prosecution could not be brought, proposals were developed to strengthen the legislation. All proposals were accepted and have been implemented through the Serious Crime Act 2015, which came into force on 3 May 2015.

This included extending the scope of extra-territorial offences so that those with temporary residency status in the United Kingdom are covered; granting victims of FGM lifelong anonymity; placing a positive duty on medical/health care professionals to report cases of FGM or risk of FGM; and a new offence of placing a positive duty on parents or carers to prevent their child from being mutilated by another.

A civil FGM Protection Order was also introduced in July 2015, just before the school holidays, to protect girls at risk and prevent them from being taken out of the United Kingdom; a number of which have been successfully obtained.