A discussion of the legal aspects of female genital mutilation

Susan Hopkins RGN MMedSci RNT DipSocStudies ONC CertEd CHSM
Nursing Lecturer, Central Sheffield University Hospitals and the University of Sheffield, Sheffield, UK

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The purpose of this paper is to examine the position of the nurse/midwife in the United Kingdom when involved with the care of a woman or female child who has suffered genital mutilation, which is an illegal practice in this country and most other areas of the world. The types of circumcision commonly practised are introduced, the prevalent reasons for the continuation of the practice among certain ethnic groups are presented, and the range of issues to be considered by the nurse is examined. These include international and national legal aspects which do not exist in isolation and are considered in context with cultural, medical, human rights and gender issues. Nursing legal issues include child protection, consent, advocacy and confidentiality, which invoke the Code Of Professional Conduct of the United Kingdom Central Council for Nursing Midwifery & Health Visiting. Midwives and nurses working in the field of gynaecology have raised questions regarding possible courses of action to take when presented with this issue. Increased knowledge can help to inform those decisions. Therefore, implications for future practice are addressed, together with recommendations to assist nurses with decision making when faced with this scenario in the future.

Keywords: cultural issues, female circumcision, female genital mutilation, legal issues, nursing/midwifery, women’s issues

INTRODUCTION

What is female genital mutilation?
Female circumcision should be considered a violation of the right to life from the perspective of reproduction. When the very organs that allow human beings to reproduce and to give life to future generations are mutilated, there has been a violation of one of the fundamental human rights (Wilson 1993).

Female genital mutilation takes place in over 30 countries in Africa, the Middle East and south-east Asia (Jordan 1994). The practice and its consequences affects an estimated 80 million women in the world today. As populations disperse due to war and poverty, this practice is becoming an issue wherever practising groups have settled, including Europe, America and Australia (Armstrong 1991).

There is current evidence of genital mutilation of young girls in certain communities in the United Kingdom (UK), especially refugees from Eritrea, Somalia and the Yemen, although it is unlawful (Black & Debelle 1995).

Grandmothers often take young girls on ‘holiday’ for the operation to be performed in their native land, although a recent Channel 4 television programme Cutting the Rose (Channel 4 Productions 1997) discovered two men (one medically unqualified) who were performing the operation on girls in Sheffield and Manchester. School teachers in Sheffield had suspected that three girls were at risk, but
had not reported their concerns. They were reported to be ‘unwilling to interfere in others’ culture’.

The commonly used term ‘female circumcision’ is misleading, for it implies a minor operation similar to male circumcision, which is simple removal of skin without damage to organs, although the practice of male circumcision is now being questioned (Harbinson 1997). The female operation almost always involves the removal of healthy and very sensitive organs. The first UK national conference on this subject held in 1991 called for the practice to be known as ‘female genital mutilation’ as a term which reflects the radical nature of the operation.

Different cultures perform different operations. The Muslim ‘Sunna’, involves the removal of the prepuce of the clitoris, which is analogous to male circumcision — this is the rarest form and is medically referred to as clitoridectomy. Excision involves the removal of the clitoris and labia minora, while infibulation, also known as ‘pharaonic circumcision’, involves the removal of all the external organs and the stitching up of the sides of the vulva, leaving a tiny opening for micturition and menstruation (Downie 1988).

The operation is extremely bloody and painful, and performed without anaesthesia. The extent and age at which the operation is performed varies. In some groups it is performed on babies, in others it is part of pubescent rites of passage, or a premarital ritual (Myers et al. 1985).

In Western Nigeria a limited excision of the labia majora and the tip of the clitoris is undertaken in infancy. In other countries, wider excision is performed with resultant extensive scarring and may be carried out at any age up until marriage. The operation is performed by older village women with a razor, traditional knife or pieces of glass, usually in extremely unsanitary conditions.

An infibulated woman is ‘reopened’ for her wedding night, sometimes by her husband with his knife or repeatedly attempting intercourse (Ussher 1991). More graphic detail is described in Alice Walker’s (1992) novel Possessing the Secret of Joy and the documentary video Another Form of Abuse (FORWARD 1992).

Medical issues

Belsey (1976) described the procedure as:

A radical procedure with a very high immediate risk of haemorrhage and infection which may frequently result in severe scarring and nearly complete obliteration of the vaginal entrance.

The immediate and long-term risks to health are considerable: death due to haemorrhage, postoperative shock, sepsicaemia, tetanus, human immunodeficiency virus infection; uterine and urinary infection; and infertility caused by endometriosis, when the menstrual flow cannot escape.

Childbirth may be difficult, requiring incision or caesarean section, and reinfibulation after each birth, and may result in intrauterine foetal death (Dorkenoo & Elworthy 1992).

In addition are the psychological effects and sexual difficulties (Koso-Thomas 1987), discussed also in Toni Morrison’s novel The Bluest Eye (Morrison 1970). The sharing or speaking out about these difficulties is discouraged as a sign of weakness.

Cultural issues: origins and justification

Maintenance of tradition, the enhancement of fertility, fulfilment of religious requirements, promotion of social and political cohesion, prevention of promiscuity, promotion of female hygiene and the preservation of virginity, are the main reasons given by the proponents of the practice as justification (Hosken 1982).

Tradition

Female circumcision has taken place since ancient Egypt, ancient Rome, Arabia and Tsarist Russia. It was used in Victorian England to treat psychological disorders and to prevent masturbation (Jeffreys 1987). It was once an initiation into adulthood, but is now increasingly performed at a younger age and has little to do with initiation rites.

Gender issues

The role and status of women is the issue at the heart of the practice. Genital mutilation was used as a physiological chastity belt by the Ancient Romans, rooted in the low social status of women. In the present day it is an essential social passport for those women who undergo genital mutilation. Their only support is from their own community.

Female genital mutilation confers full social acceptability upon the females and integration into the community. It is a prerequisite to being accepted as a member of their ethnic group.

Wilson (1993) argues that this leaves the girls:

... in an unjust position of having to jeopardise either their right to health and bodily integrity or the esteemed privilege of social acceptance.

The operation ensures virginity before marriage and fidelity by suppressing the women’s sexuality; a non-excised girl has no chance of marriage and may be seen as promiscuous. Other beliefs are that female genitalia are unclean, and that the clitoris is a ‘male’ organ and must be excised to make the child wholly female. Although these reasons may be easily argued against, the custom continues to be perpetuated, explained by Dorkenoo & Hedley (1992) to be due to the following:

Male dominance, financial gain for the practitioners, female spite, poor health education and suspicion of Western influences.
Black & Debelle (1995 p. 1590) contend that the operation is: ‘an exercise in male supremacy and the oppression of women’. Western women describe these practices as mutilation, whereas African feminists take a different stance. Boulware-Miller (1985 p. 170) remonstrates that these Western views ‘...offend all Africans’.

This perspective is reinforced by Awa Thiam (1986) who also feels that African women have suffered from colonial attitudes.

Teare (1998) argues that girls are ‘...circumcised because their parents love them and want them to be happy in their adult lives’. The strongest proponents of the practice are its victims, including the older women who continue to perpetrate the practice. These women have been labelled the ‘token torturers’ who assist in maintaining the patriarchal culture (Daly 1991).

Men remove themselves from the issue by not taking part in the operation, but it is the attitude of men that serves to maintain the practice, necessitating circumcision for social acceptance.

Religion
Female circumcision is not required by any formal religious doctrine, therefore religious texts such as the bible cannot be cited in verification of this claim. The Koran is often given as justification, although Islamic theology has no evidence that the practice is based on religious doctrine and the practice predates Islam (Brooks 1995).

It may be concluded that female genital mutilation is therefore a form of social control of girls and women (El Saadawi 1980).

THE LEGAL BACKGROUND

The law is only one of the factors that can influence changes in this practice. To be effective, laws must be aligned with education, counselling, socio-economic and attitudinal change. There is also concern that law enforcement actually reinforces the practice, as discussed below.

International conventions
It is widely considered that in the context of international human rights, female genital mutilation is a physical and moral assault on the female child (Dorkenoo 1994).

There are many international conventions that apparently offer women and children protection from genital mutilation, including the Universal Declaration of Human Rights (1948). Article 5 states that ‘no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment’. In addition, Article 24 (3) of the United Nations Convention on Children’s Rights, asserts that:

States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

The United Nations Declaration of the Rights of the Child (1959) is contravened by this practice. The United Nations Convention on the Elimination of All Forms of Discrimination against Women (United Nations 1992), calls for an end both to gender discrimination in general and to social and cultural customs based on the idea of the inferiority or superiority of either of the sexes.

Other conventions under which female genital mutilation is considered include the World Health Organization (WHO 1986), against traditional practices affecting the health of women and children, and the United Nations Commission on Human Rights (United Nations 1988).

Female genital mutilation was also condemned by the World Medical Association in 1993 (Richards 1993).


The European Parliament’s report on Women and Health Care (cited in Dorkenoo & Elworthy 1992) refers to female genital mutilation and directs member countries to take specific action to prevent clitoridectomy within the European Community. Sweden, Norway, Belgium and the United States of America all have specific legislation prohibiting female excision, with or without consent (Dorkenoo & Elworthy 1992).

In reality, however, international human rights laws are difficult to enforce due to arguments based on cultural relativism, which claims that violation of rights in one culture can be perceived to be as morally just in another (Engle 1992).

The legal framework in the United Kingdom

British law has always offered protection against such a practice, under section 18 of the Offences against the Person Act 1861:

... whosoever shall unlawfully and maliciously by any means whatever wound or cause any grievous bodily harm to any person with intent to do some grievous bodily harm shall be liable to imprisonment for life.

In addition, under section 20 of the Act:

... whosoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any other person shall be liable to imprisonment for five years.

In 1983, Lord Hailsham, speaking in his capacity as Lord Chancellor, stated that female genital mutilation was covered by this existing law in addition to the fact that a child under the age of 16 could not consent to an act consisting of grievous bodily harm (Hansard 1983). The Children &
Young Persons Act of 1933 would also have added to criminal law at the time, allowing the prosecution of:

... any person over 16 having custody, charge or care of them and wilfully exposing them in a manner likely to cause unnecessary suffering or injury to health.

After much debate in 1985 specific legislation was passed in the form of the Prohibition of Female Circumcision Act. The main parts of the Act are as follows:

1 (1) Subject to section 2 below, it shall be an offence for any person —
   (a) To excise, inßbulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person; or
   (b) To aid, abet, counsel or procure the performance by another person of any of those acts on that other person’s own body.

2 (1) Subsection 1(a) of section 1 shall not render unlawful the performance of a surgical operation if that operation —
   (a) Is necessary for the physical or mental health of the person on whom it is performed and is performed by a registered medical practitioner; or
   (b) Is performed on a person who is in any stage of labour or has just given birth and is so performed for purposes connected with that labour or birth by —
      (i) a registered medical practitioner or a registered midwife; or
      (ii) a person undergoing a course of training with a view to becoming a registered medical practitioner or midwife.

3 In determining for the purposes of this section whether an operation is necessary for the mental health of a person, no account shall be taken of the effect on that person of any belief on the part of that or any other person that the operation is required as a matter of custom or ritual.

The Act is backed by the British Medical Association, the Royal College of Obstetricians and Gynaecologists and numerous other medical and pressure groups (WHO/International Federation of Gynaecology and Obstetrics (FIGO) Task Force 1992).

The General Medical Council ruled in 1983 that:

The performance of such an operation in the United Kingdom on other than medical grounds is unethical.

This means that doctors conducting this procedure can be struck-off the medical register for gross misconduct (Mackay 1983).

**FEMALE GENITAL MUTILATION IN BRITAIN**

**Child protection**

There is a moral dilemma when examining the role of agencies involved in child protection in Britain. There is always the worry of being accused of racism and of imposing Western values upon other cultures. Health professionals are required to observe the existing law at all times. However, if the subject is approached with sensitivity and shown to be based upon humanitarian rather than cultural grounds, then eradication is an issue of concern for child protection. In the UK the issue affects minority black females, many of whom are refugees from war and poverty.

It is estimated that up to 10 000 children are at risk within the immigrant communities in the UK, who feel that keeping their cultural identity in a foreign land is essential (Dorkenoo & Hedley 1992).

The children are either returned to their country of origin for the operation, or traditional operators have been brought over to practise, their identities closely protected. Psychological effects may be more severe for a girl living in Britain as they come to realize their difference from their peers.

The 1985 Prohibition of Female Circumcision Act does not make provisions to prohibit children being taken out of the country, but under Section 47 (1) of the Children Act 1989, local authorities have a duty to investigate and protect children who are at risk of female genital mutilation. The Children Act: Section 8, can be used to prevent girls from being removed from the country, by obtaining a Prohibited Steps Order. Care proceedings may be taken under Section 31, if needed, to prevent ‘significant harm’ to the child and therefore as a last resort.

The parents have a legal duty to provide care for their dependent children under Section 1 (1) of the Children’s & Young Persons Act 1933.

In 1991, in line with the Children Act 1989 and the guidance of Working Together (1991), a female Asian social worker in Ealing worked on a case where two girls under the age of 10 were believed to be at risk of genital mutilation and were placed on the child protection register. The social worker used persuasion and education to dissuade the family from undertaking the practice, although the family were new refugees, and after 6 months, the girls were removed from the register. There are obvious lessons to be learned from the strategies employed in that case (Sone 1992).

There have been no prosecutions in Britain under the 1985 Prohibition of Female Circumcision Act. However, in France a mother who had paid a traditional exciser to operate on her 1-week-old daughter was convicted in 1989 and given a 3-year suspended jail sentence, and an exciser was jailed for 5 years in 1991, under Article 312–3 of the French Penal Code.

Two other women in France have been imprisoned for performing this procedure (Jordan 1994). Both were immigrant traditional excisers, one jailed for the death of three babies, the other for mutilating the genitals of her baby daughters.
Akers (1994) discusses a case which she investigated as a police officer in 1983 in London with evidence that female genital mutilation had taken place in a private clinic, which in 1983, would have been brought under the 1861 Offences against the Person Act. The case failed due to lack of evidence from both victim and doctor.

In 1993, Dr F.H. Siddique was struck-off the medical register by the General Medical Council for agreeing to perform an illegal female circumcision on a Sunday Times journalist posing as a Nigerian, engaged to be married. Siddique was arrested and a file sent to the Crown Prosecution Service, but the case did not proceed due to insufficient evidence (Dyer 1993).

Consent
The two main positions taken regarding this issue are the advocates for the right to ‘cultural self-determination’, which states that genital mutilation is not harmful or abusive, and which would appear to be corroborated by the moral view that everyone has the right of self-determination with regard to his/her body (Mason & McCall Smith 1998).

The opposing view argues for the eradication of the practice, as it constitutes abuse (Ogiamien 1988). It may be argued that a woman decides of her own free will, after being informed of the consequences, to undergo the operation. In Britain adults are, as a general rule, allowed to treat their own body as they wish, as discussed in the recent case of Rex v Brown & Others (1993) 2 All ER 75 (HL), cited in Giles (1994).

The issue differs when harmful practices are performed on children, because of the child’s diminished capacity to consent. It is for this reason that children below the age of legal competence are not allowed to consent to medical treatment for themselves. If the parents consent to the procedure, they are as liable to prosecution as the operator.

Female genital mutilation is a special case in that, whether with or without consent, it is illegal and is therefore no defence even in an adult woman, as consent does not legitimize a serious injury, as in the case of Rex v Donovan (1934). The rationale is that there is no good medical or other reason for the procedure, unlike other forms of surgical operation, and that the consequences are to the disadvantage of the woman or child.

The offence of maim or mayhem is considered by Mackay (1983), in relevance to consent, as although maiming is no longer indicted at common law, it falls within section 18 of the 1861 Offences against the Person Act. The case of Adesanya is cited as relevant, where a Nigerian woman scarred her two young sons’ cheeks with a razor blade as part of a tribal custom and was convicted under section 47 of the Offences against the Person Act 1861, which strengthens the opposition to the justification of injury on cultural grounds.

Implications of legal enforcement
In Mali, a hospital employed a person to perform female circumcision under anaesthesia and in sterile conditions as it was requested frequently by parents of new-born girls. This has been discontinued because of growing opposition, especially by the World Health Organization (Armstrong 1991, McConville 1998).

In Kenya and Sudan, where missionaries and colonialists have campaigned against the practice (Lightfoot-Klein & Shaw 1991), it became a sign of resistance against foreign interference. This has affected all attempts to impose decrees against female genital mutilation, which highlights the possibility of being accused of racism and cultural imperialism. In less developed countries the introduction of legislation has pushed the practice underground, therefore it is performed illegally, deaths are not reported and subsequent morbidity not treated by hospitals (Traore 1999).

The danger of legislation in the UK is that skilled practitioners will be unable to assist. People will fear seeking medical help and the operation will be performed either in the country of origin, or in unsterile environments. It is often the case that legal intervention is unnecessary and inappropriate in the resolution of social and medical problems, although the law in this case may be used in a child protection case, or to prosecute a doctor performing circumcision. In respect of the 1985 Prohibition of Female Circumcision Act, the families involved surely benefit from being counselled regarding legal prohibition and the possible implications of infringement.

The implications of this difficult situation are that clear policies for health, social care and teaching staff are required to be developed concerning appropriate intervention, and the support and guidance of specialist workers who should, ideally, be people with similar background to the groups who practise the operation. Many groups are working at both national and local level, often with limited influence due to a lack of publicity and multi-agency collaboration (Walder 1995).

The role of the nurse/midwife
The International Council of Nurses (ICN) adopted a statement in 1983 concerning human rights which declared:

The need for nursing actions to safeguard human rights where abuse of patients is suspected.

Female genital mutilation clearly cannot be seen as an issue to be dealt with by any one professional body in isolation and must be addressed as a multiprofessional concern, working in collaboration.

The nurse’s/midwife’s role incorporates that of advocate, cultural liaison, educator and skilled knowledgeable
practitioner; skills that can be utilized as part of the multiprofessional team. Women in African societies highly respect nurses and midwives, who are believed to hold the power of life and death (Lightfoot-Klein & Shaw 1991). Female western nurses and midwives can serve as authoritative educators, to inform parents of the harmful effects of the operation to allow them to make an informed decision regarding their daughters. Nurses and midwives must, however, be aware of the cultural implications of this role.

Nurses in touch with families practising genital mutilation should use their skills in health promotion to counsel parents about the inevitable health problems. The nursing professions are strongly directed by the Royal College of Nursing to increase their knowledge of the subject, raise the awareness of others and develop networks with local authority and local statutory and voluntary organizations (RCN 1994). It is important that we develop clear policies and procedures and report suspected cases to nursing management, the patient’s general practitioner and social services, to be able to work in partnership to give appropriate sensitive help and support. Again, it is stressed that cultural sensitivity and liaison with specialist workers is vital in order that the problem is not hidden.

A number of nursing roles are likely to encounter this concern within different care arenas. These include 4midwifery, paediatrics, family planning, gynaecology, school nursing and health visiting. For midwives it is important to inform and counsel both the woman and her partner. If deinfibulation is required for delivery, the couple must be made aware that suturing will only be repaired as necessary, and the woman will not be reinfibulated, as this would contravene the Act, nevertheless emphasizing the health benefits for the woman. Family planning nurses may find it difficult to deliver a service to infibulated women due to the inability to perform vaginal examination. The opportunity must be grasped for advice and counselling for deinfibulation if this would assist the woman in the relief of the problem she is presenting at the clinic. Again, the partner must be involved and a rapport gained, as he may be the sole decision maker.

In the hospital setting, the paediatric nurse must be alert to the possibility of children at risk and must follow the hospital procedure for dealing with suspected or potential abuse. Gynaecology nurses may encounter women with a variety of problems related to the operation. School nurses need to be aware of possible removal of girls abroad for the operation and also work in conjunction with teaching staff, regarding sex education and to raise awareness amongst her colleagues. Health visitors have a duty under the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (1992) Code of Professional Conduct to participate in child protection issues in close association with other professionals with this remit.

**Confidentiality**

The nurse has a duty of confidentiality, implicitly arising within the duty of care owed to the patient, from the implied duties under the contract of employment, and from the duty to keep information which has been passed on in confidence, based on equity (discussed in the case of W. v Edgell 1989).

The UKCC (1992) Code of Professional Conduct for nurses also clearly sets out the duty of the nurse with regard to confidentiality in Clause 10:

The nurse must protect all confidential information concerning patients and clients obtained in the course of practice and make disclosures only with consent, where required by the order of a court or where you can justify disclosure in the wider public interest.

Disclosure between professionals caring, or potentially caring, for the patient, is justified on the basis that the patient may suffer if this is not undertaken. The case of a nurse working in a children’s ward, who discovers that a young girl upon admission has undergone recent genital mutilation, has the duty to inform only the necessary professionals, who should decide, in a multidisciplinary forum, what action to take. The extent to which this occurs obviously depends upon the individual case and family circumstances. Lord Walton in his capacity as proposer of the Disclosure & Use of Personal Health Information Bill (1996) framed this legislation to clarify the exceptional cases where health professionals can breach patient confidentiality (Woodward 1996). Disclosure of personal health information is allowed to prevent serious injury or damage to the health of any person, which would meet the circumstance of discovery or risk of genital mutilation.

**Advocacy**

Patient advocacy has been defined as:

Informing the patient of her rights in a particular situation, making sure she has all the necessary information to make an informed decision, supporting her in the decision she makes, and protecting and safeguarding her interests.

(Clark 1982)

A patient should have complete freedom of choice. This means they have the right to both accept and reject the advice of health care professionals, no matter how good or how necessary that advice and those directions are. It lays great emphasis on caring and makes the nurse first and foremost accountable to the patient. (Clay 1986)

These views are adequate in most care situations, but in the context of female genital mutilation actually appear to support the cultural self-determination argument. It is important therefore for nurses to approach the role of
advocate with a depth of knowledge of the complex issues involved and analyse each situation in the light of their legal and professional responsibilities. Due to the stressful nature of this role, there is a requirement for managerial and clinical support of the nurse, possibly through clinical supervision (Butterworth & Faugier 1992).

The Code of Professional Conduct (UKCC 1992) clearly states the advocate role of the nurse in Clause 1, who:

... must act always in such a manner as to promote and safeguard the interests and well-being of patients and clients.

Clauses 5, 6 and 7 within the code, which clarify the duties of the nurse with regard to this issue, state that the nurse must:

Work in an open and co-operative manner with patients, clients and their families, foster their independence and recognize and respect their involvement in the planning and delivery of care.

Work in a collaborative and co-operative manner with health care professionals and others involved in providing care, and recognize and respect their particular contributions within the health care team.

Recognize and respect the uniqueness and dignity of each patient and client, and respond to their need for care, irrespective of their ethnic origin, religious beliefs, personal attributes, the nature of their health problems or any other factor.

These parts of the code appear very pertinent to the subject of female genital mutilation. The nurse is given clear guidelines to work from, which should be incorporated into policies and ensure that nurses, while always caring for the best interests of the patient, are also aware of the legal and cultural ramifications of the situation in which they are involved.

DISCUSSION

Research suggests that female genital mutilation is more widely practised in the UK than had previously been thought (Dorkenoo & Hedley 1992). It is defended by the ethnic groups concerned on grounds of culture and tradition. Many health care/social care workers shy away from the problem because of its racist and cultural overtones (Sone 1992). It does, however, constitute child abuse and is outlawed by the Prohibition of Female Circumcision Act 1985. The Act may be used to prosecute medical practitioners who operate illegally in private clinics, but only as a last resort used against the family.

Child protection legislation can be used to protect girls at risk. The approach should be to discourage the practice through education and child protection, using the law as a last resort. The key players are workers in health care, social services, education and within the communities.

CONCLUSION

The aim of this paper has been to clarify the major issues for nurses around the subject of female genital mutilation. This has included examining the procedure, the associated medical problems, the cultural justifications and the legal concerns. These issues impact upon the role of the nurse in a variety of care settings, in relation to the duties of confidentiality, consent and advocacy. Guidance is given regarding professional responsibilities within specific clauses of the UKCC Code of Professional Conduct, which may clearly be related to caring for patients in this context.

The care of these children, women and the families concerned can be enhanced by increasing awareness of the subject and by assisting with the development of clear policy guidelines.

Barriers exist to open discussion of this sensitive issue in the light of the fear of overriding the culture of ethnic minority groups, and the difficulties of the obvious sexuality link. However, there are many international conventions which prohibit the practice but which are difficult to enforce.

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