

Women and Equalities Committee

Oral evidence: [Abortion Law in Northern Ireland](#), HC 1584 (ii)

Thursday 24 January 2019, Derry/Londonderry

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[Watch the meeting](#)

Members present: Mrs Maria Miller (Chair); Tonia Antoniazzi; Sarah Champion, Angela Crawley; Vicky Ford; Jess Phillips.

Questions 158–215

Witnesses

[I:](#) Dr Goretti Horgan, Deputy Director, ARK, Dr Fiona Bloomer, Reproductive Health Law and Policy Advisory Group, Emma Campbell, Co-chair, Alliance for Choice, and Grainne Teggart, Campaign Manager for Northern Ireland, Amnesty International UK.

Written evidence from witnesses:

- [Alliance for Choice](#); [Alliance for Choice](#)
- [Amnesty International UK and the Family Planning Association](#)
- [ARK](#)
- [Reproductive Health Law and Policy Advisory Group](#)

Examination of witnesses

Witnesses: Dr Goretti Horgan, Dr Fiona Bloomer, Emma Campbell and Grainne Teggart.

Q158 **Chair:** Good evening. Thank you for coming along at this hour to talk to us. I am not sure whether this hour is incredibly convenient or incredibly inconvenient, but we are very grateful either way. You know the work that we are doing as a Select Committee looking at the issue of abortion laws in Northern Ireland. Our objective is very simple: it is to give people in Northern Ireland the opportunity to have their voices heard. Our remit is to make sure that Government are doing what they should be doing in terms of their international obligations. That is the context, which I know you are aware of. You know that my colleagues, all MPs, will be asking questions. If you have something to add, please do so, but do not feel obliged to contribute. We anticipate being just an hour, if that is all right, so succinctness will be greatly appreciated. Sarah Champion is going to start us off.

Q159 **Sarah Champion:** First, thank you again for coming. My question is about your personal opinions. How do you think the law on abortion is working in Northern Ireland?

Emma Campbell: I don't think it is working. That is my fundamental answer. I think the law has a chilling effect on medical professionals and is acting as a mechanism of social control. If we are giving 19-year-old women criminal charges for accessing abortion pills online, while they were saving up try to travel to England, I do not understand how in any context that means any law is working.

Chair: I am being reminded by Jess Phillips, stage right, that we need to be cautious about sub judice, so if you could avoid discussing specific cases that are currently before the court, I would be grateful.

Grainne Teggart: It is not working at all. A statistic from the Department of Health in Northern Ireland published yesterday showed that only 12 women accessed terminations lawfully here. At the same time, during a similar period, approximately 900 women travelled to mainly England for those services, so the law is not working. While those women were able to travel and avail themselves of the free access, and that is a welcome form of remedy for some, we have to remember the position of women unable to travel, and that includes women in particularly vulnerable situations, such as domestic violence, women who do not have confirmed immigration status, or women who simply have other children and do not have childcare and therefore cannot travel.

So, no, the law is not fit for purpose. Its stated aim is to prevent the termination of pregnancies, and it is not doing that, because women will always find a way to circumvent the law. In increasing numbers, women



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are also going online and accessing these pills, and they are risking prosecution in doing so. Prosecutions are a reality in Northern Ireland. The chilling effect of prosecution means that women who are accessing pills are reluctant to seek medical care if and when they need it. So not only is the law not working, but it is extremely harmful to women who need this form of healthcare.

Dr Horgan: I would have to agree. The law is not working. In fact, it used to work better. Twenty years ago, there were about 80 abortions every year in Northern Ireland. Now there are only 12, and that is precisely because of the chilling effect since devolution. Since devolution, doctors are being told that they have to consider whether they will end up with life in prison if they carry out abortions.

It used to be the case that if a woman was ill—pre-eclampsia, high blood pressure, renal problems, any of those things—she had a chance, at least, of getting an abortion here in the local hospital. That is no longer the case and now we are having to put sick women on the plane, and that is absolutely wrong. Even the very limited law that there is, is not working, and as others have said, that means that women either travel or they risk prosecution. Also, as our research is discovering, they are even risking not going to the hospital when they think maybe they ought to go to the hospital if they use the pills.

Dr Bloomer: I would also agree with that. The law clearly is not working. It is not working for those who are seeking abortions and it is not working for health professionals either. The work that I have done with colleagues and with health professional bodies has shown the chilling effect of the law and how that impacts on their practice, and also the unevenness of how polices are rolled out and how that impacts on them as professionals, and makes them very reluctant to even mention abortion.

Q160 **Sarah Champion:** Again, in your personal opinion—this is a topic that clearly polarises the population and politicians—what legal reform do you think the public would accept at this point?

Emma Campbell: Initially, when we had people who came forward with diagnoses of FFA, the public were incredibly supportive of making some sort of change. That was about eight or 10 years ago. When they prosecuted, and started raiding workshops as well as my home and the homes of my colleagues to look for abortion pills, and when they started arresting people, the public became acutely aware of what criminalisation really means. Until the public saw how hard the law came down on people, they thought it did not really matter because people could just go to England. But as soon as you start criminalising women, it brings a certain level of fear within communities. As people have said, women are then scared to go to their doctors if there is too much bleeding after an abortion medication.

The only remedy is to put abortions back into the hands of the healthcare profession, to get away from criminalisation. I think the public would support that. There is plenty of evidence to support the view that even



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DUP voters are in support of taking abortion out of the legal system and into the healthcare system.

Q161 **Sarah Champion:** Would you agree?

Grainne Teggart: Yes, very much so. I would challenge the assumption that it is polarised among the public here. You would be hard-pressed to find another issue where the public has so consistently favoured change. Amnesty has commissioned polls, which have been independently carried out, including after the referendum in the Republic of Ireland, and they showed very clearly that not only in Northern Ireland but across the UK, at least seven in 10 people support reform of our law—not limited reform, but decriminalisation and wider access to this healthcare. As Emma has rightly stated, people recognise the harmful consequences of healthcare being treated as a criminal justice matter and not what it is, which is a healthcare and human rights issue.

If we consider for a minute what would be acceptable and where the public and the political parties are here, in about September 2018 there was a joint statement signed by the leader of Sinn Féin on behalf of the party, the leader of the SDLP—it is a conscience matter there—the leader of Alliance Party, for which, again, it is a conscience matter, and the UUP justice spokesperson. It explicitly and unambiguously called on the UK Government to decriminalise abortion. That is, if you like, the most current call that we have from political parties here to Westminster to intervene, because they recognise the harmful effects of the law. Decriminalisation is also supported by the Green party and People Before Profit and other parties. So not only do the public favour change, but our politicians favour change. We are in a situation where we have not had a devolved Government for two years.

Quite simply our message is this: women cannot wait, and we will not accept women's rights being sacrificed for political expediency. This change is long overdue and we need to see Westminster delivering this. This inquiry should be one route to getting a change that is much needed.

Q162 **Chair:** What are the doctors doing to make that happen?

Grainne Teggart: In terms of the change?

Chair: You have just called for the medical profession to act. What are they doing? Fiona said this situation is not working for doctors, so what are they doing to try to change things?

Grainne Teggart: I think doctors, as Fiona said, are feeling the chilling effects of the law, but they are also obviously practising, so on day-to-day targets they are not advocates. They are not advocates and they are obviously not out lobbying. The other Royal Colleges, like obstetricians and gynaecologists, the BMA and others all support decriminalisation. The Royal College of Midwives also supports decriminalisation. We have brought delegations from different political parties from Westminster to



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Northern Ireland to meet with medical professionals on this, as well as women impacted by the law and political parties and so on. They have been very clear that they want to see decriminalisation, and also a framework for access.

Emma Campbell: If you look at medical colleges, even within the United Kingdom, the Royal College of GPs is the most conservative on this issue, whereas the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Nurses all broadly come out in support of decriminalisation across the whole of the UK and Northern Ireland.

Dr Horgan: What should a law look like?

Q163 **Sarah Champion:** What would the public accept?

Dr Horgan: First of all, I have to echo what Grainne said, especially on it not being a polarised issue here. When we go on the streets, have stalls, take up petitions, write letters and things like that, we have people queuing to sign up. We get virtually no abuse. We have had the occasional personal coming along, obviously, just as you would in England or Scotland or Wales, saying they do not agree with this, but the overwhelming majority make that very clear.

As for our studies, the Northern Ireland life and times survey is like the British social attitude survey. It is a full survey with everybody's different ethnic backgrounds and everything. 71% of people here said that they did not believe that abortion should be part of the criminal law, and said that it should be medically regulated. The exact same proportion said that no woman should face prosecution or face prison for causing her own abortion. 63%, almost two thirds, said it is a woman's right to choose. They are very close to the figures that you get in England, Scotland and Wales.

On this notion that there is something different about Northern Ireland, look, for example, at the number of people who give birth outside of marriage here. Here in the city of Derry/Londonderry, or in Belfast, about six out of 10 births are outside of marriage. Casual sex is as casual as it is in England, Scotland or Wales. This notion that women here or the people here are a different breed is just not true.

Dr Bloomer: I think there is a myth that there is this split, but in fact if you look at all the survey evidence—the Northern Ireland life and times survey or the survey of trade union members, which I led on—about 10% of respondents in those surveys are clearly anti-abortion, and the rest are in favour of some type of reform. The myth has been allowed to fester because, for instance, in our media both sides are given equal airtime. It is presented as a black-and-white issue.

I have been researching this for 10 years. The change over the last 10 years has been significant. We have had particular high-profile cases that have served as a trigger point. You have to step back. In terms of talking



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about abortion, for instance, our children and young people are delivered either no sex and relationship education or deeply flawed sex and relationship education. There is an organisation in Northern Ireland called Love for Life. It has visited over 70% of post-primary schools in Northern Ireland and key to its ethos is an anti-abortion view. Our young people are being provided with a very slanted view of abortion, and that leaves them with being unable to know how to articulate their views or other opinions. The only time they might learn about abortion is GCSE religion, where they are talking about it purely from the ethical issues.

Work by Alliance for Choice that I have done research on has looked at, for instance, women in community settings, and an evaluation of a training programme where we had a legal specialist who went in and talked to the women about all sorts of issues. They looked at the history of the law and what had changed over time. When you provide women with a safe space and the opportunity to look at all of those issues, they will then be able to articulate what their opinions are and also be able to identify, "I used to think that because I was brought up in this particular framework of thinking that abortion was bad, or that I could not be a person of faith and be pro-choice". I think when you provide those spaces for women to look at the law and policy and how our country has shaped that, it gives them the freedom to express their views on it away from the myths that we have about abortion.

Q164 Jess Phillips: The working group on fatal foetal abnormality made a series of recommendations, as I am sure you all know, including on a change to the law on abortion in those cases. If these proposals were adopted, what impact do you think that would have?

Emma Campbell: I would agree with other people on this panel that the changes would not go nearly far enough. We know that fatal foetal anomaly cases are a very small percentage of the number of women who need access to abortion healthcare. The danger with introducing these measures only is that there would be some kind of public perception that abortion had been dealt with, and we would be left with another 10 years of trying to campaign for any further access.

Q165 Jess Phillips: You do not buy the argument that opening the door—

Emma Campbell: No. I think there is a very good local example in the UK with the Isle of Man. The Isle of Man introduced measures in terms of widening access where there had been rape or sexual crimes over 10 years ago, but no women were able to access that, in reality, and women were still travelling to England. It is very easy to look at our neighbours and say that that absolutely does not work as a method of changing the law.

Dr Horgan: It is worth looking at what is happening in the south at the minute. Just last week, a woman was refused an abortion for reasons—in the south it has to be a fatal foetal abnormality for people to have an abortion. After 12 weeks, you are not allowed to have them for reasons of disability, general disability. The doctor said that it was not necessary.



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It was a fatal foetal abnormality. It was one of the ones that would normally be seen as fatal, but the doctor said that there was a possibility that the baby might live beyond 12 weeks, and their definition of a fatal foetal abnormality is that it will die before it is 12 weeks old, so the woman has had to go to England.

Grainne Teggart: The key point linked to that is that in the south, there is still criminalisation of healthcare professionals. As long as criminalisation remains, it will continue to compromise the care of women, because among medical professionals, you will always get those who do not feel comfortable, or do not feel able to make decisions if there is unclarity in terms of what the law is.

There are any amount of examples where countries and regions have attempted exception-based legislation and it has not worked, including for those who the exceptions were meant for, including women, for example, who would experience FFA pregnancies, and they have not been able to access those services. If we get to a point where we have abortion decriminalised so that it is regulated like any other form of healthcare—I think it is ridiculous that we have having to say that in 2019—from that we can start to look at what the free work for access should be. Fourteen weeks is the Isle of Man example. There are other international examples —Sweden, Canada and other countries. It would be at that point that we look at what would best work for our context. Regional context is very important.

Q166 **Jess Phillips:** Who would look at that at the moment?

Grainne Teggart: Westminster.

Dr Bloomer: Can I comment on the point about floodgates, because that is something that is bandied about? Again, it is a myth about abortion. If you look worldwide, the countries that have the highest abortion rates tend to be the ones that have the most restrictive laws, because they also tend to be countries where there is poor access to contraception, and poor sex and relationship education. The countries that have low abortion rates are those with the most liberal regimes and, in contrast to that, good access to sex and relationship education and good access to contraception. We need to take it in the round. It cannot just be reforming the abortion law and leaving it at that. We need education for our children and young people so there are wraparound services.

We also need to ensure that the medics are getting appropriately trained. For instance, Queen's medical school has a module on reproductive health, and all the students know that that is taught by someone who is anti-abortion. They have set up an organisation in the university called Medical Students for Choice, so that they can supplement the very, very limited education they are getting on abortion, and they can supplement themselves as a society.

Q167 **Jess Phillips:** Is there not a standard on what they should be learning to be doctors? Presumably if you train as a doctor at Queen's you can come



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over and work in Birmingham Queen Elizabeth Hospital. Is there not just a standard that is adhered to here?

Dr Bloomer: The particular aspect that they have on abortion is very, very limited. Because of the extreme limitation on numbers here, they are not able to see abortions being performed.

Q168 **Jess Phillips:** Of course. So there is a training deficit?

Grainne Teggart: Emma has talked about the percentage of cases that we are talking about. Absolutely, those situations are particularly tragic, but there will always be a reason why a woman needs an abortion, and the point is that it should be a matter for each individual woman and her doctor, not police and judges, which it is for as long as it remains a criminal justice matter.

Emma Campbell: I would also quickly like to make a point on the skewed perception of polarisation. We have to remember who has the ear of the most powerful political party in Northern Ireland. That is not necessarily clear—who gets the ear of the DUP. An example is some of us in the Alliance for Choice were asked to support the Marie Stopes clinic when it was open, to try to help people in and out through the protestors, and during that time the DUP Health Minister openly said in a local newspaper that he was a close personal friend of the clinic protestors. I don't think you would be allowed to get away with that if you were the Health Minister in the rest of the UK. I think that is a point to be made about who gets the ear of the media and who gets the ear of people in power.

Q169 **Vicky Ford:** The question about medical professionals ties into what Jess was just asking.

Just to carry on what Fiona was saying, do you think medical professionals are clear about how they advise and treat patients in the current law?

Grainne Teggart: No, absolutely not.

Q170 **Vicky Ford:** None of you think that? Who do you think is responsible for ensuring that there is clarity for the medical professionals in the current law?

Grainne Teggart: The Department of Health has a responsibility to deliver guidance which is fit for purpose and clarifies which terminations are lawful, and that does not currently exist. Guidance exists, but it is not clear enough; it does not provide clarity to medical professionals.

Q171 **Vicky Ford:** Do you think there is enough guidance from their professional bodies?

Grainne Teggart: From their professional bodies across the UK, yes, but in terms of the local situation, the professional bodies can only say so much until the Department is clear about it.



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Q172 **Vicky Ford:** You see a piecemeal approach by different hospitals?

Grainne Teggart: By different trusts. In Amnesty's "Barriers" report we described it as a postcode lottery. Depending on the health trust a woman lives in, she may or may not be able to access a lawful termination. In some trusts, they will just consult with their solicitors, and they are ultimately taking a legal decision, rather than one that is based on the woman's healthcare and wellbeing.

Emma Campbell: Our current campaign for Alliance for Choice is to write to Richard Pengelly, because even though he has been pressed by us previously and by other MLAs, he still refuses to issue any guidance on what medical practitioners here can recommend even as pathways to England. So there has been a refusal to even do that up until this point. Yes, I think it is currently—

Q173 **Vicky Ford:** Is it clear to you—sorry to interrupt—that he is the person responsible, or is there a lack of clarity about who is responsible?

Emma Campbell: They have absolutely said that if they were able to, legally, it would be their responsibility, but they have said in response so far that because it is currently illegal in Northern Ireland, they cannot possibly offer guidance to medical professionals.

Grainne Teggart: When free access came in for women in England, we wrote to the Department of Health straight away and asked that the guidance be updated. Seemingly, the bottom line response we were getting from the Department of Health was, "The law here has not changed, therefore there is no need to update the guidance." I had written back and said, "With respect, that misses the point," because the law here has not had to change for the working environment; for the medical professionals, it has changed considerably. If a woman goes to her GP and asks even about these services that are available in England, they will not know. Many of them do not. That is part of the problem, because there is not the proper guidance, and with the Department of Health refusing that, you are reliant on organisations like Alliance for Choice or FPA and others who are filling that gap, and that is obviously not acceptable.

Q174 **Chair:** Before I bring Angela in, have any of you and your organisations considered pursuing doctors, rather than pursuing politicians to get the current law implemented? It is not illegal to have an abortion in Northern Ireland in certain circumstances, but we have seen the numbers go through the floor because of the way medics are choosing to interpret that, for whatever reason. I am interested that nobody has thought about pursuing that. I was thinking that if there were doctors in England who were not delivering healthcare that was available in other parts of England, some people might choose to report them to their regulatory authority and say that they were not actually delivering the service they should. Is that something you have considered?



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Dr Horgan: If you look at the current guidance, it says specifically to doctors, "Before you perform an abortion, be aware of the fact that if it is an illegal abortion you are performing, you can face life imprisonment."

Q175 **Chair:** That would be the same in England.

Dr Horgan: Yes, but the fact that the guidance starts with that message to doctors—

Q176 **Chair:** Yes, but, with respect, that is the same for any doctor in the United Kingdom: if they do something illegal, they could face life imprisonment. Why is it that in this instance nobody has chosen to challenge the doctor's interpretations?

Emma Campbell: I think it would rely on a woman who is desperately needing that particular medical professional's help to pursue that case. None of us here could do that on behalf of anyone else. That is relying on somebody who is in the middle of going through a very difficult time.

Q177 **Chair:** Amnesty takes—

Emma Campbell: After the fact. You cannot expect somebody in the middle of that kind of very delicate medical treatment to suddenly say to this doctor, who they have placed their full medical care and trust in, in the middle of all that—pregnant women do not even do it when they—

Q178 **Chair:** Complaints about the medical practice can happen after the fact; I am just surprised there is not that—

Grainne Teggart: No, there are, and, again, I know we cannot discuss current cases and so on, but I can say without being specific that there are civil cases under way against health trusts, and against the Department of Health in Northern Ireland. There is one in particular from a woman who should have lawfully qualified for a termination, but no one would sign her off. I would look at this just through the lens of if you are in an environment where doctors have reinforced and official guidance from the Department of Health of the threat of prosecution, you cannot necessarily blame doctors for going, "Well, am I going to risk that?" It's not ideal. Of course women are suffering as a consequence, and that is all of our primary concern, but our medical practitioners are operating in a very hostile and difficult climate, which again reinforces the need for decriminalisation.

Emma Campbell: There is only one doctor in the whole world who ever stuck his head above a parapet and risked arrest, and that was Dr Morgentaler in Canada. He eventually secured decriminalisation of abortion in Canada, but it took him the best part of 30 years. We are asking medical professionals to do that. We have medical round tables; we have midwives, nurses, medical students, doctors and psychiatrists on that round table that we currently speak with, but they are still worried about the professional circumstances that might impact on their career. We have to keep those e-mail lists private.



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Grainne Teggart: Also, it is a higher bar the doctors have to prove. They have to prove that the woman's life was at risk, not just the woman's mental state. It is how the long-term serious physical risk is interpreted. and if they do not have the current guidance, then what do you do?

Q179 **Angela Crawley:** In the absence of an Assembly in Northern Ireland, who do you think should be responsible for ensuring the law on abortion is effective?

Emma Campbell: Westminster. Even if the devolved Government was effective, it is in the ECHR report that devolution should be no barrier to people accessing their human rights properly.

Grainne Teggart: Even if we did have function in devolved bodies, which we have not had for two years, the Secretary of State still has specific powers to intervene in transferred matters. What we have seen, unfortunately, is the Secretary of State hiding behind the devolution argument as justification for this. Parliament at any time could repeal an Act of Parliament. Parliament right now could repeal sections 50 and 59 of the Offences Against the Person Act (OAPA). The Secretary of State can also be active in the Department of Health in Northern Ireland now to look at freedom for access, what that should look like, and what can be possible in Northern Ireland. All of these things could be done. There is an urgent need for them—women are suffering—but they are not being done. We need to see Westminster exercising the powers that they have.

Even if devolution was in place, it has never relieved Westminster of their responsibilities to women here.

Emma Campbell: There was also a precedent in 2004: the Civil Marriage Act was extended to Northern Ireland, yet somehow women are left behind.

Dr Horgan: Always. It is also the case that in 2014, when the Assembly were refusing to pass what is the 2012 Welfare Reform Act—and so this is when the Assembly were sitting—Theresa May threatened to impose it if the Assembly did not pass it. In fact, the Assembly collapsed briefly, and part of the reason it collapsed briefly in 2015 and came back with the Stormont House agreement, which agreed to give legislative consent to Westminster, was because of those kind of threats. It was not a human rights issue—well, there was a human rights issue but in the wrong direction.

I think it is also worth saying, because childhood and family poverty is one of my areas, that when you look at Northern Ireland, we have never served children here properly. On the one hand, they keep on saying that we are different from the rest of the UK, but we treat children worse; we do not have children centres here—it never took off the way it did in Britain. This, I think, is why we continue to say that Westminster has to act. We believe that the Assembly is incapable of acting.



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I will give you an example. We do not have a funded childcare strategy here in Northern Ireland. We do not have a gender strategy. We do not have an anti-poverty strategy. We do not have a sexual orientation strategy—any of those strategies. Those policies involve ideological differences between the two main parties, the DUP and Sinn Féin. That has meant that they are unable to even agree a simple policy—not legislation; just a simple policy on those things.

Q180 **Jess Phillips:** You do not have funded childcare?

Dr Horgan: No.

Q181 **Angela Crawley:** Just to play devil's advocate here, we have heard that if the UK Government were to repeal sections 50 and 59 of the Offences Against the Person Act, that would create a void, because it is not the 1967 Abortion Act. What would you say to that?

Grainne Teggart: That is where the framework of access that we have been referring to should come into play. That is where the Secretary of State could be directing at the minute. She could be directing the Department of Health to look at that. Depending on the political party she may speak to in Northern Ireland, you will have some, for example Sinn Féin, who will want to see what they call all round alignment, so they would motion a request for the first 12 weeks and so on. All of those conversations can and should be happening in parallel to that legislative change.

There is current precedent for Westminster intervening, if you like, or legislating on devolved matters. We have seen that the Secretary of State has already gone through legislation around the public appointments and so on, which is the most recent Bill. It seems to be that there is a bit of selectivity and a pick and mix approach to which devolved issues Westminster will act on.

Q182 **Chair:** One could quite strongly argue that public appointments is a slightly different issue from abortion.

Grainne Teggart: It is absolutely. One could therefore argue that abortion is the more urgent of the two of them.

Emma Campbell: Also there is no vacuum, because technically abortions are already provided in Northern Ireland. There are already healthcare pathways; there is already the expertise. When the Marie Stopes clinic was open in Belfast, medical staff could be found to staff that clinic. NICE—I cannot remember full acronym—is working on guidelines for the whole of the UK, which, if 50 and 59 were repealed, would apply in Northern Ireland as well. We also have the Infant Life Preservation Act 1929 and the Bourne judgment, which both guard against anything post 24 weeks. Like my colleagues here, I think there is no possibility of a vacuum here.

Q183 **Chair:** We have to deal with the political world as it is, not necessarily as we would like it to be, and the fact is the Westminster Government will



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not introduce direct rule. I am a little puzzled: I could take out from what you have said this evening that you would rather have the perfect than something that might help some of the women we have spoken to today. Or am I misunderstanding you? The idea of decriminalising abortion would be very controversial in the Westminster Parliament, and you may be aware that we are dealing with two quite controversial issues there at the moment. Why would you not just want to try to make the current law bite, rather than holding out for something that, quite frankly, would be difficult to see on the legislative agenda for the next two to three years? Why are you resistant to just trying to make the current law bite?

Emma Campbell: The last two times that this issue has been debated in the House of Commons, there has been an overwhelming majority of support for this to happen, for section—

Q184 **Chair:** No; you misunderstand the reality of getting legislation through, versus having a debate.

Grainne Teggart: There is legislation currently; the Government has published the draft bill. As I understand it, it will not be moved until after summer recess. The Domestic Violence Bill could potentially be a vehicle under the Offences Against the Person Act.

Q185 **Chair:** I am sorry; a lot of people would think it would not be exactly the right way to try to introduce something that was such a major reform.

Jess Phillips: Also the extent of the Domestic Abuse Bill is currently England and Wales.

Chair: On dealing with the world as it is, rather than a world that we might all like, why would we not try to fix what we have? It is clear in the past that it has worked very imperfectly, but it has worked much better than it does at the moment.

Dr Horgan: For 40 years now, we have been trying to get some improvement on abortions rights.

Q186 **Chair:** Yes, but things have gone backwards.

Dr Horgan: It has gone backwards, frankly, because of devolution. I have to say that there is no other explanation for it. That is when we saw it going backwards. I am originally from the south, and when I moved up here, one of the first things that I was involved in was a tribunal. It was an international tribunal held in Belfast to look at abortion rights here. We had women coming in and saying that if you had money you could get an abortion without any problem at all, not for any particular reason other than just because you needed one. About the same time, we knew that we were having to put sick women on the plane from here.

Making the current law bite was always going to mean that there was just going to be one law for the rich and another for the poor. That really does not solve the issues, because if you look around this city, for example, have you seen the levels of child poverty here? There are some areas



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where seven out of 10 children grow up in poverty. Think about what that means.

The idea that you are saying, "Let's have a law that will allow women with money to get abortions. Everybody else will have to take their pills from the internet, and take their chances with prosecution or whatever" is just—I think it is experience; you think, "We are not going down that road again."

Emma Campbell: On the numbers, there is a very low estimate—that 1,000 women a year since 1967 have travelled. That is not a law that ever adequately dealt with anything.

Q187 **Chair:** I suppose the thing that is deeply concerning is women who potentially face quite serious health problems as a result of fatal foetal abnormalities. We have heard a little bit about that today. That really concerned me. They should be getting help under the law but are not. What can we do to change that tomorrow?

Grainne Teggart: They should absolutely be getting help, as should women in domestic violence situations, obviously. They are vulnerable as well. There are different reasons why women—

Q188 **Chair:** What can we actually do to change that?

Grainne Teggart: I outlined what sort of change I think needs to happen. We are talking about the real politics of this. Of course, we have to be mindful of the political environment that we are in and the fact that there are other issues that are dominating and potentially compromising progress, but we also have to consider the legislative basis and the international human rights obligations that Westminster is under here. On signing up to the various relevant treaties that the UK Government has, it is not merely fancifully signing up; it is undertaking to put in place domestic measures that are compatible with those human rights obligations and those bodies have been very clear in their calls to the UK Government, it is not exception based, it is decriminalisation of abortion.

Q189 **Chair:** The sense I get is that a number of years ago women with severe fatal foetal abnormalities would have got help. At the moment, some get help in some hospitals. How can we get back to where it was before that everybody got help or did that never really exist, Dr Horgan?

Dr Horgan: That never really existed but it was the case that it was not just if you had a fatal foetal abnormality; if you had any kind of foetal abnormality then depending on where you lived you had a good chance of getting an abortion. These abortions, they are illegal, so when the Department of Health clarified what the law is here, it said that while abortion is legal if a woman's life or health was severely at risk, that does not include abortion for reasons of foetal abnormality. It is not just for fatal foetal abnormalities that we need to change the law. We have here in Ireland a very high rate of congenital abnormalities. I have interviewed



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women in this town who have buried five children because of a genetic abnormality.

Q190 **Jess Phillips:** What is the reason for the genetic abnormality? I come from a place with high levels of genetic abnormality, but I cannot—

Dr Horgan: It would be very similar reasons. Small gene pool, but also poverty, frankly. A combination of poverty and a small gene pool.

Q191 **Sarah Champion:** Chair, can I follow on from your question. I do not know why it is not landing, but I do not think it is landing.

Looking at the last 10 years, the number of legally carried out abortions is dropping dramatically. From the evidence I have heard, one of the key things is this letter that went to medical practitioners. On dealing with the legislation as it is now, it is imperfect, but it is something that you have. Would very clear guidance from the Department of Health outlining the a list of 500 or 5,000 conditions that would be classified as abnormalities where it would be legally okay to carry out an abortion get back to the law as it is intended? We could do that, rather than having this chilling effect that we have heard about on medical practitioners, or as the Chair said, rather than looking at pursuing individual medical practitioners. What about a letter from the British Medical Association to all its signed-up doctors saying, "This is what we expect, and these are your duties. We will give you cover under the law, because doing it in these circumstances is legal"? Will that help, or do you think it has now gone so far that unless you have a complete overhaul of the law, there is no point trying anything else?

Emma Campbell: I think Grainne's point of it noticeably getting worse makes it very clear that we need Westminster intervention in order to sort out the mess. The reality is asking if we want an FFA law—

Q192 **Sarah Champion:** Sorry, can I clarify the clarification? I understand that the reality is that is not going to happen in the short term, whereas guidance could be issued by the end of the week, for example.

Grainne Teggart: Do you mean the guidance would say—if we consider the Bourne exception around a physical and mental risk to the woman—that there would somehow be a letter or a guidance—

Q193 **Sarah Champion:** That is exactly what that meant.

Grainne Teggart: Which would say that if a woman had a pregnancy with one of these 500, or however many, conditions, they could be brought under a risk to their physical and mental health? No, I don't think that would work. I think when you have had medical professions who have been operating in a climate of fear to this extent, no.

Q194 **Sarah Champion:** It is all or nothing for you?

Grainne Teggart: It is not that it is all or nothing for me. Our position on this has come through extensive research, working very closely with



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medical professionals as well as women impacted by the law. We agree that change absolutely needs to happen, but the existing law will only permit so much. Of course, aside from anything else, it has taken years to get the not fit for purpose guidance that we currently have, and that is ever-evolving. As and when new conditions and so on are discovered, are we going to keep adding those into the guidance and still not have the legislative change, which is really what we need to get to?

Q195 Chair: There is a very good example: euthanasia in England and Wales. I do not know how that is dealt with in a devolved manner. There was a very real concern about people being put in prison for helping loved ones to die, and there was Crown Prosecution Service guidance issued to say that it would not be in the public interest to prosecute. It was very simple, and a very similar issue—very emotive. Parliament voted for the change.

Dr Bloomer: I believe this goes beyond just issuing guidelines. The stigma within institutions in terms of dealing with termination of pregnancy is significant.

Let me give you a snippet of how severe that is. I had a gynaecologist that works in a hospital in Northern Ireland come to interview me, because she was doing her Masters in medical law and she was doing it on abortion in Northern Ireland. She said she could not tell any of her colleagues what the topic of her dissertation was. She was warned by her mentor, "Don't tell anybody that this is the topic of your dissertation, because you will immediately be under suspicion over what you are actually doing in your practice". That is the level of stigma and fear among medical professionals in a lot of units.

Grainne Teggart: I hope this is relevant to what you mentioned: again, without naming names, one woman that I work with very closely on this asked whether we could do guidance or law—all these questions were asked—and the then DUP Health Minister gave her a letter that basically said that the legal advice was clear that guidance could not achieve this, and that legislative change was needed, which is why this particular woman and other women are fighting through the courts to have their right vindicated. We have had that clarification. Those questions have been asked, is what I am saying, and the legal opinion has been given.

Q196 Sarah Champion: Could we get a copy of the letter?

Grainne Teggart: Absolutely.

Dr Horgan: Do you think the idea of having some kind of a statement to say there will be no prosecutions would help initially? It does mean, of course, that women will continue to have abortions outside of the law, so if you are comfortable with women continuing to have those abortions, then it could help. I think in Scotland, for example, in relation to the age of criminal responsibility that there was something similar done where Scotland has increased the age of responsibility. That would certainly help.



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Emma Campbell: There is the question: if you are saying that this law will not be prosecuted, then what is the law for? We are obviously here because we believe very strongly that the law perpetuates a certain culture and that culture is what prevents women getting the medical access they deserve. That culture, provided by the law, is what prevents medical professionals giving the care that they need. We know this is not an easy question. If it was easy you would not need an inquiry.

Q197 **Jess Phillips:** There are many laws that do not change culture, though. There are many laws that do not affect our culture.

Emma Campbell: There is a great deal of worldwide medical evidence that shows that abortion as a particular example is one area where the law very much changes the culture. We also know that ratification of various guidelines with the law remaining the same does not change what the medical professionals think they can offer. I think we understand as well, because we have all been campaigning on this for a very long, that this is not going to be an easy fix, but we certainly did not understand this to simply be an inquiry into FFA.

Q198 **Chair:** It is not. Let's be really clear about the terms of this inquiry; it is not about changing the law in Northern Ireland. We do not have the remit to do that. It is looking at the Government's responsibilities for international treaties and giving people the opportunity for voicing their opinions. In doing this, what I think we have been quite concerned about as parliamentarians is that individual's lives could be being put at risk because medics are not using the law. I do not care who I tell, either; I am not going to stop looking at that, because I think that is wrong. It does not matter whether or not it is devolved. That is why we focused on that particularly.

Dr Bloomer: I think that is one of the reasons why Marie Stopes opened their clinic for three years—because they recognised that they could operate within the law and offer women terminations, for women that had either been unable to access or unwilling to go and ask their GP because they did not know what the GP's reaction would be. In terms of the interpretation of the law, it depends on the context of the environment. Marie Stopes obviously had that environment that they were happy to work within the law and interpret it in a particular way. In other settings, it is clearly not the case.

Emma Campbell: There is no way any guidelines are going to be able to stop women who buy the pills online or worry about being prosecuted. They are not presenting at accident and emergency rooms because, as previously shown, medical staff will report them to the police. I do not think guidelines are going to change that, unfortunately.

Chair: Have we covered everything?

Q199 **Jess Phillips:** I have one question. Obviously Amnesty is an international organisation and you are academics. Are there any organisations that are



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pro-choice and offer advocacy and advice funded through the public purse in Northern Ireland?

Emma Campbell: There is only the FPA. They do sexual health education programmes, and in the last decade they have had that work in schools cut. We believe that has been a political decision.

Q200 **Jess Phillips:** If I could find an organisation that had not had a cut, I would give you—

Emma Campbell: I should clarify that another pro-life organisation then won the contract that they used to have.

Q201 **Jess Phillips:** You all repeatedly say the void has to be filled with organisations, and that is the case UK-wide for the victims of domestic violence or sexual violence for women's issues generally. It is the voluntary sector, but the state recognises its responsibility and usually does fund those one way or another.

Grainne Teggart: The FPA is the only known directive service that there is in Northern Ireland.

Dr Horgan: I would say obviously the various medical organisation bodies are much better than—

Jess Phillips: Yes, that was my experience.

Q202 **Tonia Antoniazzi:** Earlier, we heard that not all women were getting the same amount of guidance that they were getting in England and Wales, and possibly Scotland. The UK advice that is given to all mothers—"This is what will happen at this stage, and you will be tested for that"—those tests are not happening in Northern Ireland. Is there some work around that that we could do to provide them with guidance, or do you know of a reason why they do not state on their guidance that certain tests are not available in Northern Ireland?

Emma Campbell: I have a two year-old, so I was pregnant fairly recently, and you get a massive book, a pregnancy book. On I think it is page 14 or whatever, you get four pages of what you should eat when you are pregnant. Then you get a tiny paragraph on your 20-week anomaly scan and what you should do if any issues arise—it is a tiny paragraph. I know, because I used to live in England and my friends had children around the same time, that their passageway through maternal healthcare looked very, very different from mine. As somebody who was over 35 when I was pregnant, I should have been offered a Down syndrome test as standard. You are not obliged to take it, but I was not even offered the test. I had a friend who was offered the test, and she was in the Ulster Hospital, but I was in a Catholic maintained hospital, and I was not offered the test.

Q203 **Jess Phillips:** You do not have a triple blood test?

Emma Campbell: I did not get any tests.



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Q204 **Jess Phillips:** No amniocentesis offered?

Dr Horgan: It is offered, but in a very vague way.

Grainne Teggart: Some are offered, I think is the point. It varies, depending on the health trust, and maybe even the hospital within that health trust. It varies considerably. We think the void of information is a particularly critical point, because we know of different cases. I have spoken to any amount of women in cases where there is a serious foetal anomaly, and even in those circumstances, they are not being given information as to options, or even as to what the condition, whatever has been diagnosed, means. Women are going away and having to research and look at that themselves.

Q205 **Tonia Antoniazzi:** This is UK-wide standardised material. It should be the same.

Grainne Teggart: We do not have that triple test. It is not standard; it is absolutely not.

Q206 **Jess Phillips:** So it varies. When you say they are not giving you options, when I had my triple test, it was not that it was an option.

Grainne Teggart: Not even being offered.

Jess Phillips: It was just, "This is what you do" sort of thing.

Q207 **Vicky Ford:** That goes into an interesting path about comparing the offer. I just want to go back to what you were talking about earlier—whether more clarity on what is involved and "We will not prosecute you if you are acting within the law" might help. I do not know who the right medical regulator is that is linked to the BMA; I do not know if it is the Royal College or the GMC. If there was more clarity on them as the professional bodies, what would be the type of cases that would lead you to consider that the woman's life could be at risk? On top of that, if there was clarity that if you were operating within those cases, you definitely would not be prosecuted, would that help? Is that a sort of step? I know it is not going as far as some of you would want, but would that help?

Grainne Teggart: I am not a lawyer, but I think if you are meeting with lawyers you would ask about the legal enforceability, because I have serious question marks over that. If you look at the history of the attempts to issue guidance in Northern Ireland, they have nearly always been subject to judicial review. Therefore I have no doubt that if there were attempts to do that, we would just be through the courts, and meanwhile you would have medical professionals who could push back and say, "Not until this is settled".

Q208 **Vicky Ford:** What lawyers have said to us is that if you have a woman who thinks her life is going to be put at risk by delivering this child who has a foetal abnormality, for example, or because she was raped and might be suicidal or whatever, then if she believes she has been denied that, she should take it to court, and then once it has gone through the



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court, she can have an abortion. I am thinking they just miss it entirely. You cannot stretch out your pregnancy indefinitely; the baby is going to come.

Grainne Teggart: You were talking about, for example, women who try to bring themselves under the law for mental health grounds. That is extremely difficult. I am thinking of one woman in particular—again, I know we cannot name names—who should have qualified on mental health grounds. She had a long and very serious history and still could not be signed off and was told, “No psychiatrist in Northern Ireland will sign you off”. I do not think guidance is going to remedy that.

Q209 **Chair:** Did you recommend that she then report that doctor to his professional body?

Grainne Teggart: I am not sure of whether I can say; she is one of the ones who are taking the civil case.

Q210 **Chair:** Would you, in a theoretical manner, then urge people to report individual doctors for not—

Emma Campbell: If someone has gone through that experience, to then ask them to prolong that traumatic experience by dragging it through some sort of procedure like that is obviously hard.

Q211 **Chair:** Unfortunately, unless we have evidence of wrongdoing, it is really difficult to get change. At every step I am finding it difficult to identify. We have case studies, but trying to show—

Dr Bloomer: Surely the evidence should be that the woman has told you what happened.

Chair: We have lots of case studies showing how the current law does not work for that individual woman, but then how we remedy it is causing me some headaches. You can try to take these things to court, which is very difficult because of the timeframe involved. Trying to register that there is an inconsistency in the way—

Dr Bloomer: It is additional pressure on the woman. If you were, for instance, involved in something like a tribunal—even an employment tribunal where you potentially have the support of your trade union—taking something like that is a lengthy and stressful process. If you add on to that then the trauma of whatever has happened during that pregnancy—whether the woman has been denied a termination and had to continue the pregnancy on for 10 weeks waiting for the foetus to die, or whether she has scrabbled around to try to find the money to travel to England to have that termination before the policy change happened—it is an unrealistic expectation to put that on the woman on top of everything else that she is going through.

Q212 **Chair:** Having had three pregnancies, in which I did not have to experience the things we have been talking about, I understand that.



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However, reflecting on euthanasia, it has been really as a result of individuals pursuing change that we have reached where we are today.

Emma Campbell: We did have individuals who went to the Supreme Court and it was the Attorney General that questioned the standing of the case of the Northern Ireland Human Rights Commission. That is the kind of barriers you are facing in terms of bringing a legal case.

Grainne Teggart: Potentially, you again put the responsibility on an individual woman to go back to court. One is doing that next week, supported by Amnesty and others.

Dr Horgan: It is also notoriously difficult frankly to get doctors if you go to the GMC or whatever. Even where there is a clear breach of the doctor's medical duties, it is very difficult to prove that. I think that doctors here would have some very good defences with how unclear law is. The courts have said the law is too unclear for anybody to be able to operate it. The fact we have the 1967 Criminal Justice Act means if a woman comes to them and says she has cause for an abortion they have a legal duty to report her or face a prison sentence themselves. I would not want to advise any woman to complain about her doctor here because she would be going down a road that was leading nowhere because there will be so many defences for the doctor.

Chair: A very final question, and then we must wrap up.

Q213 **Vicky Ford:** Westminster law set the rules for the Northern Ireland Human Rights Commission. You have just mentioned that case was thrown out because it was questionable whether or not it had the ability to take the case on behalf of society. If we in Westminster change the rules and give it that power to take that case does that—

Grainne Teggart: In short, yes. We need a Human Rights Commission that can take cases absolutely as a body. Yes, we do need that because obviously the Supreme Court, our only human rights body, then was neutered and, yes, the Secretary of State should immediately remedy that.

Forgive me for my directness in all of this, because I am conscious of time, but it feels like in all of this—talking about guidance and talking about what might be possible in the short term—we are missing the wider point here that there is a very urgent and grave situation here for women. It is not about tinkering around the edges. Westminster does have responsibilities here and they should be prioritising women's rights and legislating for change. Women should not have to be fighting through the courts. We should not have to be looking at all these ways to try to make law that predates the lightbulb fit for purpose. We should have 2019 laws for 2019 healthcare. That is all I will say on that.

Q214 **Sarah Champion:** From a personal point of view I am not disagreeing with that at all. What I am trying to do is find a practical way, through



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steps, to get to that point. Sometimes that means you have to make small compromises that are really frustrating, appeasement almost.

Grainne Teggart: Hopefully we have been clear that guidance will not deliver that.

Dr Horgan: I really say look at the south of Ireland. I honestly thought that is what the south of Ireland would do—they would bring in abortion for cases of rape and stuff like that. However, they went the whole way, and they did that because they realised that the only way you can look after women who are pregnant as the result of rape is if you allow them to make decisions themselves.

I have a daughter who is now 30-odd who is severely disabled. The number of women I know who have had abortions for reasons of disability—not that they were pregnant with a disabled foetus, but because they had disabled children and really had no choice. With what they have to do to go to England, and the military operation they have to undertake to get their disabled children looked after while they go to England, those women will not be helped by any of the tinkering that you are doing. There are so many women. We talk about the difficult cases but an awful lot of the everyday cases are really difficult cases that would break your heart if you actually knew the whole story.

Emma Campbell: I understand you are quite distracted with Brexit, but arguments around Brexit are about whether the vote was democratic, respecting the referendum, so on and so forth. What we are faced with in Northern Ireland currently, especially around the abortion law, is a clear democratic deficit where we are not being properly represented, we are not being properly looked after. Even the people who voted for the party that speaks for Northern Ireland in Westminster are not being properly represented by the views of the politicians there and I think that is a very clear breach of democracy.

Grainne Teggart: In terms of the chain, we are isolated now in these islands. We are the only part of the UK, Ireland and surrounding islands where we have this legislation so we need to remedy that.

Q215 **Chair:** I think we probably do need to close at this point. I do feel obliged to say that the views you have expressed here are not consistent with all of the views we have had expressed to us. We have had very strong views expressed that these are issues that should be decided by the Northern Ireland Assembly. Of course our legal ability to get involved in this does not give us the power to do the things you have talked about. We do not have the devolved power to make these sorts of laws. You are asking us to do things that are well beyond the scope of this Committee.

Yes, we do hear it loud and clear, what you are asking, but it is not right to think that we are able to act in the way we have talked about, because the remit of this Committee is very much curtailed by devolution, and until that changes that will be the political fact.



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Grainne Teggart: I am aware of what the Committee can and cannot do legally on this. At the end of this there will be a report that makes recommendations to a Department that can drive forward legislative change and so it is through that lens we are speaking about the recommendations and the change we would like to see.

Emma Campbell: Also, our frustration comes from a place of quite regularly having to take calls from women in very desperate situations. You can understand we do not often have the opportunity to express this, so thank you.

Chair: That is why we were very delighted that you were very willing to come along and to have your voices heard here today. You can absolutely rest assured that they have been heard very loud, very clear and with an enormous amount of sympathy from us. Can I thank you for eating into your Thursday evening? I apologise for that but it is incredibly generous of you to give your time and to come in and talk to us. Thank you so much. We really are indebted to you for your time.

I am going to close this session now. I am going to remind colleagues we have another hour and a half travelling ahead of us so if we swiftly move towards the reception I would be grateful. Thank you all very much.