

Women and Equalities Committee

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

Friday 25 January 2019, Belfast

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[Watch the meeting](#)

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

Questions 216–338

Witnesses

I: Amanda Patterson, Head of Criminal Policy Branch, Department of Justice Northern Ireland; Dr Michael McBride, Chief Medical Officer, Department of Health Northern Ireland; Alasdair MacInnes, Family and Children's Policy Directorate, Department of Health Northern Ireland.

II: Dawn Purvis, former Chief Executive, Marie Stopes Belfast; Karen Murray, Director for Northern Ireland, Royal College of Midwives; Dr Paul Coulter, Christian Medical Fellowship.

Written evidence from witnesses:

- [Christian Medical Fellowship](#)
- [Marie Stopes UK](#)
- [Northern Ireland Office](#)
- [Dawn Purvis](#)
- [Royal College of Midwives](#)

Examination of witnesses

Witnesses: Amanda Patterson, Dr Michael McBride, and Alasdair MacInnes.

Q216 **Chair:** Good afternoon. Thank you for taking the time to come in front of the Women and Equalities Select Committee session this afternoon. This is a public evidence session, so we welcome people in the gallery and those who might be listening online. I remind you that because this is a public evidence session, we are subject to rules around sub judice. I would very grateful if you do not to refer to live cases that are in front of the court in a way that would be inappropriate.

As you know, the Women and Equalities Select Committee is undertaking an important inquiry into abortion in Northern Ireland as a result of the CEDAW report, with our responsibility being to scrutinise the UK Government on their adherence to international agreements and also to give the people of Northern Ireland the opportunity to have their voices heard. This is an important part of that process.

Thank you for being here and we look forward to a productive session. We will be finishing just before 3 o'clock. We are very short on time, so if I could ask you to be mindful of that in your responses. As usual, members are going to ask a series of questions, but before we do that, could I ask you to give your name and your title?

Amanda Patterson: Amanda Patterson. I am the Head of the Criminal Policy Unit in the Department of Justice.

Dr McBride: Michael McBride, Chief Medical Officer for Northern Ireland.

Alasdair MacInnes: Alasdair MacInnes, abortion policy in the Department of Health, Northern Ireland.

Chair: That is wonderful, thank you very much. Jess is going to start with the questions.

Q217 **Jess Phillips:** Hello. Whose responsibility is it to address the violations of human rights that the Supreme Court and CEDAW Committee have identified in the current law? We will start with Amanda.

Amanda Patterson: There would certainly have been a responsibility on the Assembly to look at that, if there had been a declaration of incompatibility, which there is not as yet. But at the minute, I am afraid that the Department of Justice is not able to do anything, given that we do not have a Justice Minister, we do not have an Executive and we do not have an Assembly.

Q218 **Jess Phillips:** In light of that, whose responsibility is it?

Amanda Patterson: I cannot really give you an answer on that. All I can tell you is that the Department of Justice is no longer able to do anything without the guidance and direction of a Minister.

Q219 **Jess Phillips:** In normal times, it would be the Department of Justice



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and currently it is a vacant position?

Amanda Patterson: Yes. The position of the Department of Justice at the minute remains as it was more or less two years ago when we last had policy guidance from a Minister. The position remains that we have to stay with that policy. We were a part of the interdepartmental group that looked at fatal foetal abnormality. The policy at that point was a recommendation that the law should be changed, but nothing has happened since then.

Dr McBride: It is not within my professional remit to advise on legal matters. I am not in a position to do that, but I think it is fair to say that we are in somewhat—to quote a term often used—uncharted territory. In the absence of an Executive and respective Ministers, it does leave us in a somewhat challenging position in what options are available should there be such a determination.

Q220 **Jess Phillips:** Amanda has already referred to the working group. That working group recommended the change of the law in fatal foetal abnormality in times when the Assembly was in session. Is it a case that it needs ratifying again? Why can't that continue now?

Dr McBride: The working group was established in July 2016. It made its recommendations to the then Department of Health and Department of Justice Ministers in October 2016. It did recommend a change in the law in relation to women who were diagnosed with a pregnancy with a fatal foetal abnormality. With the fall of the Executive, no progress was made in relation to that then recommendation to Ministers.

Q221 **Jess Phillips:** Alasdair, we obviously want to hear from you as well. Are there any other instances with similar working groups where the recommendations have fallen in the lack of an Assembly? I understand that you can only answer from within the remit of your own Departments.

Amanda Patterson: I am sure there are.

Q222 **Jess Phillips:** It is on us to go and look at that, but do you know of any where there was a working group decision made that has been taken forward since the Assembly has not been sitting?

Amanda Patterson: I do not know.

Dr McBride: Can I ask for clarification? Is this in relation to this particular area?

Jess Phillips: No, towards anything, as a general principle.

Alasdair MacInnes: I am not aware of any, but there may well be some.

Jess Phillips: We can look into that.

Dr McBride: There are clearly issues in relation to new policy, legislation that we wish to take forward for policy and strategies. I gave evidence to



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the Northern Ireland Affairs Committee fairly recently in relation to that. We obviously have limitations. We are not Ministers, but we will look at the Northern Ireland (Executive Formation and Exercise of Functions) Act 2018, which has recently been passed, and the extant guidance that we will receive for the powers that we have to progress those areas, which we have not been able to progress in the absence of Ministers.

Q223 Jess Phillips: Alasdair, if the change in the law that was recommended by the working group is to come into practice, does it need a vote in the Assembly?

Alasdair MacInnes: It would need legislation and the Assembly agreement, yes.

Q224 Chair: But are there any aspects of those recommendations that do not require legislation? Your answer intimated that there might be, Michael.

Dr McBride: Yes. I think the latter section, section 5 of that working group report, did recommend steps that could be taken in relation to improving the information and support for women who find themselves in this very difficult set of circumstances. That was contained within the report and advice to Ministers, so I think there are elements—

Q225 Jess Phillips: That is non-legislative?

Dr McBride: It is not legislative, but there are aspects of that. As you will be aware, the issue of termination of pregnancy in Northern Ireland is extremely contentious. It is probably within the confines of the ministerial code as cross-cutting, that it is high profile and controversial, and therefore in all likelihood would require Executive consideration if not Executive approval. It is not for me to advise on legal matters but I would anticipate that the advice would be that it would require at least consideration by the Executive, at least a note.

Q226 Jess Phillips: Is that specifically because it is about abortion? Let's say there had been a dental working group and there had been recommendations that are non-legislative about changes in practice to the way that children go to the dentist, for example. Do you think that that is more likely to go through while there is not an Executive?

Dr McBride: I know the general point that you are making and I do not think it is a reasonable comparison, if I might say so respectfully. But I think that in those circumstances, where it is a matter that is not as controversial or high profile, that work would be progressed.

Q227 Jess Phillips: It is the controversy of the issue that stops progress?

Dr McBride: I think the matter is one that is high profile, it is contentious and it is most probably covered, I would anticipate, by the ministerial code, but others may have a—

Q228 Jess Phillips: Amanda, from a health perspective, do you think that controversy potentially stands in the way? Would you allow controversy



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in other areas to stand in the way of health provision?

Amanda Patterson: I can't answer you on the health application at all.

Chair: Alasdair might be able to.

Jess Phillips: Alasdair, sorry.

Alasdair MacInnes: I suppose what I was thinking is that this is an area where there is not a very agreed position from the Assembly. If there was unanimity across the Assembly, it might look at the Executive Functions Act and think about going forward, but we do not have that.

Dr McBride: We do not have a clear steer. As officials, we don't. As I say, we cannot anticipate what incoming or future Ministers may determine in this matter.

Q229 **Vicky Ford:** We have received evidence from the Royal College of Obstetricians and Gynaecologists that the 2013 circular to healthcare professionals left them, "feeling vulnerable in relation to providing abortion in cases where there is a serious risk to the physical health of the mother, concerned about what constitutes 'a real and serious risk' and they no longer have confidence to practise as before". Do you accept that this is the view of the frontline professionals and do you think it is clear to health professionals exactly what the circumstances are in which they can perform an abortion within the law in Northern Ireland?

Dr McBride: I have heard those views. I respect and understand those concerns in relation to the 2013 guidance. The 2013 guidance was superseded by the March 2016 guidance, which I think provided much more balanced advice to clinicians on those albeit limited circumstances where the termination of pregnancy in Northern Ireland was lawful. I think that we have moved beyond the 2013 guidelines. They were a product and they were approved by the Executive at that time and they were consulted upon.

Alasdair MacInnes: I think we need to make the point that the 2013 guidance was a draft guidance. It was consulted on. It was never issued and it should not have been acted upon. The 2016 guidance was a direct descendant following the consultation responses and reacted to what was said about the 2013 consultation.

Q230 **Chair:** You do not think it is right to say that doctors no longer have the confidence to practise as before? Do you think that is an incorrect statement, it is inaccurate?

Dr McBride: I do not doubt that those were the views that were expressed. I think the fundamental issue here that is more relevant is the issue and findings of our fatal foetal abnormality working group and the views of the RCOG, which were expressed in that, where doctors expressed the view that, in their professional opinion, they were unable to fulfil their duty of care for women in these very challenging circumstances. For a professional body to relay to me, as Chief Medical



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Officer, that doctors and other health professionals feel that they are not able to fulfil their duty of care because of the legislative position in Northern Ireland is a matter of significant concern. It is a matter that, as Chief Medical Officer, I have significant concerns about.

Q231 **Vicky Ford:** Could you just repeat who said that to you?

Dr McBride: The Royal College of Obstetricians and Gynaecologists has made that very clear. That is why we made recommendations to Ministers that there was a need to change the law.

Q232 **Chair:** If you, as Chief Medical Officer, have been told that doctors, who obviously have a Hippocratic Oath and are a regulated sector, are unable to fulfil their duty of care, what is your professional obligation? Setting aside the politics and policy, what is your professional obligation as Chief Medical Officer in terms of your reaction to that?

Dr McBride: My professional responsibility is very clear. I have a professional responsibility to advise Ministers in relation to the circumstances that doctors find themselves in in Northern Ireland, the fact that they do not feel that they can fulfil their duty of care or provide adequate care to meet the health needs of women with a diagnosis of fatal foetal abnormality who have decided that they cannot continue with a pregnancy. It is a very difficult set of circumstances that health professionals are being put in and I think it is the responsibility of those who legislate in any jurisdiction to ensure that that situation is addressed.

Q233 **Vicky Ford:** The working group suggested that you need to have a change to the law, not just clear guidance on how to interpret the law in those cases.

Dr McBride: Guidance will not address these issues. What this requires is an examination of the law in Northern Ireland and a change to the law in Northern Ireland if we are to address the circumstances, that we can fulfil and meet the needs of women, in the limited circumstances that I was asked to look at, which was when there was a diagnosis of fatal foetal abnormality, and to allow doctors and other health professionals to fulfil their duty of care.

Q234 **Chair:** But in the absence of somebody who is a Minister in the Northern Ireland Assembly, in the absence of that individual for you to advise, who do you now advise? Your job as Chief Medical Officer does not cease because there is not an Assembly, so who does your advice now go to?

Dr McBride: In the absence of Ministers, my advice will be provided to respective permanent secretaries in the Department of Health and Department of Justice. There are limitations in what officials can do in the absence of Ministers. The Department of Justice, as we have heard from Amanda earlier, is not in a position where it can act on advice to take forward proposed amendments to legislation. There is no mechanism to do so in the absence of Ministers.



Q235 Chair: Sorry to interrupt you again, Vicky, but if doctors are unable to fulfil their duty of care—and we have been hearing examples where, in my untrained view, you are putting people's lives at risk—what happens then? We cannot ignore it. If it was in another area, for instance if cardiac operations were being done in such a way that it was killing people, what would you do then?

Dr McBride: We have to be clear that where there is a risk to the life of a woman that is covered within the extant legislation in Northern Ireland and health professionals can act in those circumstances. The guidance is very clear: if there is a risk to the life of a woman, that takes priority over any other consideration. Doctors and other health professionals have an obligation and a duty of care to act in the best interests of women in those circumstances or if there is a serious risk of adverse impact on physical or mental health, that risk is likely to be long term or serious. Where there is a risk to life, there is no impediment to act.

The difficult situation that we find ourselves in is when women with a diagnosis of fatal foetal abnormality feel unable to continue with that pregnancy. In that very difficult set of circumstances, there is a range of potential obstetric complications and other complications that not only impact on the risk for the woman in that pregnancy but potentially on other pregnancies as well. Within the extant legislation in Northern Ireland, it is not possible for health professionals to act to seek to terminate the pregnancy if that is the conclusion of the assessment of what is in the medical best interests of the woman and that has been the informed choice that she has made.

In those circumstances, I do not have any power to act other than to make very strong representation to respective Ministers, which we did back in October 2016. We were unequivocal about the action that we felt needed to be taken at that time. Unfortunately, the Executive has fallen and we have been unable to progress it since that time.

Q236 Vicky Ford: Do you think that women and girls who are seeking an abortion are receiving adequate support and advice by medical professionals? Especially, do you think there is adequate support, advice and care for women and girls who are pregnant as a result of rape, incest or carrying a baby that has been diagnosed with a fatal foetal abnormality?

Dr McBride: That was a matter that we covered in our working group report. The simple answer to that is no. The report made a number of recommendations about how we could improve that. During the course of that work, our colleagues in the Public Health Agency, the Northern Ireland equivalent to Public Health England, met with a number of women who had found themselves in this situation and their partners. Similarly, I met with a number of women and it was quite clear that the provision of information, the support, emotional, psychological, both when the diagnosis was made and in relation to the aftercare, should a woman determine to proceed with a termination of a pregnancy outwith this



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jurisdiction, needed to improve. There are proposals that we developed to improve those aspects of the care that was provided.

Q237 **Vicky Ford:** Who do you think should provide that? Who should fill that gap?

Dr McBride: There are aspects of it where we have sought advice as to whether or not we can progress. There have been a constantly changing set of circumstances. We produced a report and recommendations to Ministers; we had draft leaflets and information for women in this circumstance. There then was the working group that was to consider recommendations of whether the law should change. That made recommendations that the law should change. The information was not produced at that time because there were clear recommendations to Ministers for a change in the law.

Subsequently now we have the situation whereby we have provision of services in other jurisdictions and we have sought legal advice as to whether or not we can include reference to that in relation to any information that we provide. The advice on that is not straightforward and we still await definitive legal advice on whether that is possible.

This is an extremely complex situation. Certainly within Health we cannot fix it with guidance and information leaflets. This requires an examination of the law of Northern Ireland and a consideration of whether the law in Northern Ireland needs to change.

Q238 **Vicky Ford:** What we have heard though, just to drill down on this, is very patchy differences. We have heard evidence from a woman who has been diagnosed with a severe fatal foetal abnormality for her child being told at one hospital, "We can help you" and then going to another hospital, "No, we can't help you". There is patchiness.

Chair: Inconsistency is the word I would use.

Vicky Ford: That is a better phrase.

Dr McBride: Yes, I heard that too. The guidance that we published in March 2016 made very clear our expectations of the health and social care sector and the trusts in that regard. The Public Health Agency has developed proposals about how we might better co-ordinate that care. We have no steer and have had no steer from Ministers, because the Executive collapsed, and there were clear recommendations within section 5 of the FFA working group as to whether Ministers were minded to support that. That was a priority, that it should be funded to provide the level of care that one would reasonably expect and to reduce the very fundamental issues about variability in the levels of advice and support provided.

Q239 **Chair:** Can I drill down on that to another level? You have a combined role of Chief Medical Officer and Chief Executive of the Belfast Health and Social Services Trust. Is that correct?



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Dr McBride: No, it is not, thankfully not for some years. My period of double-jobbing came to an end in February 2016, from recollection.

Q240 **Chair:** But you still have that experience. What we have heard about is inconsistency, particularly in the legal advice that is provided. No, what has been put to us is that there could well be inconsistency in the legal advice that has been given to different trusts about the lawfulness or not of conducting certain activities, information giving relating to abortion. Do you think that would be the case? If it were, how would you, as Chief Medical Officer, advise trusts so that you do not have an inconsistency in the interpretation of the law? I think that would fall squarely into your job.

Dr McBride: I am not certain that it necessarily would. I certainly have not heard the issue of inconsistency in legal advice being raised.

Q241 **Chair:** It has been raised with us at least three times.

Dr McBride: It has certainly not been raised with me and nor was it raised in investigations or in any of our work. As Chief Medical Officer, I need to confine my comments to matters that I am competent to advise you on. Legal matters and legal considerations would really be outwith my remit.

The guidance makes clear our expectations of the arrangements that trusts have in place to support health professionals in these difficult circumstances, with a system of accountability to ensure that terminations of pregnancy are carried out within the law in Northern Ireland, a monitoring system that we have for ascertaining the number of terminations of pregnancies carried out and the reasons why. The guidance also makes clear the advice and support that should be available to health professionals, including legal advice.

Q242 **Chair:** Alasdair, if it is not Dr McBride's job to ensure consistency in the application of the law, whose job is it?

Alasdair MacInnes: It is not Dr McBride's job to give advice on the law, no, but I suppose the thrust of it—

Chair: No, in the application of the law, not the law. It is important that you understand it is not the law itself, it is the application of the law so that we have consistent clinical standards.

Alasdair MacInnes: The law is not crystal clear. It goes back to 1861, so anything we do is an interpretation of that following from judgments that are made in court. The point of the guidance was that the emphasis was placed on a doctor with a woman in front of them and they made a decision based on the clinical circumstances of the woman. We in the Department cannot second guess what the doctor saw or what advice he sought.

Q243 **Chair:** But if inconsistencies have been found, who are they reported to and how do you resolve those inconsistencies? It happens all over,



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doesn't it? There are inconsistencies in every part of the United Kingdom and then they will be looked at and that will be resolved, because we do not want an inconsistent health service.

Dr McBride: Maybe Amanda might be able to provide some steer on this, but ultimately the law is the law.

Q244 **Chair:** I am talking about inconsistencies. I am not talking about the law.

Dr McBride: The interpretation of law is ultimately a matter for how the courts apply it. I know that you are talking at a different level about advice to trusts on the law. The guidance that we produced in March 2016 was very clear about the law in Northern Ireland and attempted to provide a clinical framework—your point, Jess—for decision-making within the law in Northern Ireland. Over and above that, I am not aware of any significant gaps in that guidance that would require legal interpretation, unless of course there was emergent case law as a result of court cases for the appropriate interpretation.

Q245 **Chair:** Amanda, do you recognise what I am talking about with different trusts taking legal advice on the lawfulness of advising people about abortions and that that differs trust by trust or do you think that is not correct?

Amanda Patterson: I am trying to find out exactly what sort of advice we are talking about and what sort of inconsistencies. Is this inconsistencies surrounding whether a trust or whether a person accesses a termination of a pregnancy or is it about information and advice?

Q246 **Chair:** Whether or not a medical professional can undertake a termination. There seem to be some trusts that are more likely than others to be—

Jess Phillips: To be brave and to have legally less risk-averse advice, presumably.

Amanda Patterson: That is an interpretation by separate trusts of the guidance that has already been published by the Department, yes.

Q247 **Chair:** Is that something, Amanda, that as a civil servant you would be keen to be aware of and that you would be able to look at? This is the application of the law. It is not about changing the law; it is whether or not trusts are being correct in their interpretation of the law.

Amanda Patterson: Sorry, I would have to give you back to my public health colleagues.

Alasdair MacInnes: There is not a formal system of assurance and accountability that comes through to the Department from the trusts and this has not been raised as an issue.

Q248 **Chair:** If it was raised as an issue, would you then look at it?

Alasdair MacInnes: We would look at it.



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Q249 **Chair:** As civil servants. You would not need a Minister to look at that, would you?

Amanda Patterson: But the trusts have not raised it themselves.

Alasdair MacInnes: If a trust thought there was a problem, it absolutely should raise it.

Dr McBride: It is interesting. I am struggling to get my head around some of the specifics, but we have a central business service organisation that provides legal advice to all of the trusts.

Chair: Yes, we know.

Dr McBride: So I am struggling to understand why there may be inconsistency in the legal advice.

Chair: So are we, Michael, because we know that. It has been explained to us.

Q250 **Vicky Ford:** What we are being told—and I go back to the testimony we have heard from some women—is that in one hospital a senior consultant is saying, “We could help you with this”, and this is the case where the baby was going to die, and in another hospital a senior consultant is saying, “No, never possible.”

Chair: “We do not do that here.”

Vicky Ford: Why do we have this inconsistency, whether that is the legal advice or the different approach by the ethics committee or different individuals? Do the numbers hold out? When you look at the dozen cases last year, are they happening more in one trust than in other trusts? Are they spread around or is it just not clear?

Dr McBride: I do not know the answer to that, but certainly we can get that information for you.

Chair: There are only 12.

Dr McBride: Yes. I think we also need to bear in mind that there are some trusts that provide regional services and will deal with more complex pregnancies and, therefore, that might slightly skew those figures.

What you are describing there, to my mind, does not sound like a disparity in legal advice but a difference in clinical judgment about the application of the extant legislation. It strikes me that it is an interpretation of whether or not the grounds are met that the impact on a woman’s physical or mental health is serious and real and likely to be long term and permanent.

Vicky Ford: Maybe we can send you home to think about it, if you could. We have been told that in some cases it is suggested that it is different legal advice being given as well as different clinical judgment.



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Q251 **Jess Phillips:** There is a woman there—and it happens all the time that we are given different doctors' opinions—who is being told clinically a different diagnosis about carrying a baby that will certainly die for a further 15 unnecessary weeks; what will that do to that woman? Clinically speaking, as the Chief Medical Officer, I am not asking you to pass your opinion on that particular case but are you not concerned that the perception of the guidance is causing bad clinical decisions?

Chair: Or very different clinical decisions.

Dr McBride: I think it is a more fundamental issue. That is not the guidance, it is the law. The guidance is based on the law in Northern Ireland. No amount of guidance can change the law of Northern Ireland.

Q252 **Jess Phillips:** No, it is not an issue about the guidance.

Chair: It is the inconsistencies.

Jess Phillips: As the Chief Medical Officer, do you have grave concerns about the different levels that are being caused because of concerns about the chilling effect and so on and the effect that is having on clinical decisions being made?

Dr McBride: I have already expressed my concerns in relation to the law in Northern Ireland. As a result of the work that we undertook as part of the FFA working group, our recommendation to then Ministers was that the law should change. Clearly that remains my view. I think there is a reasonable expectation in any jurisdiction that health professionals should be able to act in the medical best interests of patients and that they should do so without fear of acting outwith the law. It is clear from the work that we did that the current situation in the current law in Northern Ireland does not and causes its health professionals to have fundamental concerns about their ability to fulfil their duty of care. They have a concern with the current law—and it is in the report itself—that it places an undue burden on the health and wellbeing of women in Northern Ireland.

Q253 **Angela Crawley:** The thing that we are hearing repeatedly is the chilling effect. I think you have expressed concerns that practitioners have come to you, as the Chief Medical Officer, expressing concerns about their ability to act, but because of that women are basically saying that as well as the healthcare system already having a postcode lottery, they feel that there is even more of an inconsistency between one healthcare trust and the next. What recommendation would you make to whoever you believe should be held accountable at this present moment to improve that?

Dr McBride: The guidance also makes it clear that every individual case needs to be judged as an individual case. We resisted, I think correctly, trying to put in an exhaustive list of those circumstances where a termination of pregnancy would be lawful. The purpose of the guidance was to ensure that women in Northern Ireland could avail of a termination of pregnancy where it was lawful to do so. We can't, through



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the guidance, change the law, but it is a matter for concern where there is inconsistency in the interpretation of that or the application.

That confidence—because I think it is about confidence in healthcare professionals—is only likely to be addressed when they feel there is absolute clarity in relation to the law in the range of a very complex set of circumstances. Their feeling is that there is not that clarity, as Alasdair has said, in relation to the 1861 Act or the 1945 Criminal Justice Act or as to how those have been interpreted subsequently.

The other point I would make, and I think this is an important point, is that the guidance also makes clear that while there is no statutory or legislative requirement, where a woman is dissatisfied with or requests a second opinion every effort should be made to facilitate that second opinion. As Jess has said, there may be different interpretations of the clinical circumstances.

Q254 Vicky Ford: From the testimonials we have heard, I do not think it has been clear to any one of those women who have come to us and given testimony, especially on FFA cases, that they could have asked for a second opinion. I do not think that ability is at all clear, whatever the processes or pathways or support.

Dr McBride: It is very clear in the guidance and it is very—

Vicky Ford: It may be very clear in the guidance, but we have heard from a woman who experienced this less than six months ago and was crying out for a second opinion and had been given one opinion at one hospital and another opinion at her local hospital and then could not get back to the other one. Just again, if you could take that away.

We have also received evidence that women and girls who are seeking an abortion are sometimes not being given information about funding the treatment in England. Do you think there is a gap in the advice of how to find that pathway to England? If there is a gap, who should fill it?

Dr McBride: I think it is section 5.11, section 5.14 within the draft guidance that makes very clear that there is no impediment at all for health professionals to advise of services that are available in another jurisdiction but would be unlawful in this jurisdiction, absolutely none. I use the word—and I hope it is not misinterpreted—but there is nothing to prevent a health professional signposting or making a woman aware of services that are available in other jurisdictions should she determine that a termination of pregnancy is the right course for her in a pregnancy, given a particular set of circumstances. It is crystal clear in the guidance; it could not be clearer.

However, what has never been tested in the courts in Northern Ireland is whether it would be lawful to advocate or promote—that is, to refer—a woman to services in another jurisdiction where they are lawful, where it is unlawful for those services to be provided within Northern Ireland. That has never been tested.



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Q255 **Chair:** Is it clear that it is not unlawful to signpost someone to the Family Planning Association?

Dr McBride: The guidance is very clear. There is absolutely no impediment. The guidance made this crystal clear in March 2016 and I am surprised that there are still any concerns in that respect.

Q256 **Chair:** Given that we have heard overwhelming confusion, what could you do as a civil servant to make sure that confusion does not persist?

Dr McBride: I am very happy to take that away and consider that, but this has been a matter that has been, since 2001, 2004, to the fore of public and wider societal debate in Northern Ireland. It has been to the forefront of interaction with health professionals, my interactions with health professionals, the Chief Nursing Officer's interaction with health professionals and respective Royal Colleges. I struggle to understand why there would be a gap in an individual professional's awareness of—

Q257 **Chair:** But if there is a gap, Dr McBride, you would be able to fill that gap, would you not?

Dr McBride: The other thing I would add—and this is an important point—is that as a doctor I have a professional duty to ensure that I am aware of relevant guidance, up-to-date evidence of best practice so that I can assure myself of my competency and ability to deliver the best possible care I can. There is a responsibility on all health professionals, not just on the Department but on health professionals, to ensure that they familiarise themselves with appropriate guidance so that they are best placed to provide the best support.

Chair: You are neatly taking us on to Tonia's question there.

Q258 **Tonia Antoniazzi:** Thanks for that. You were saying about there being crystal-clear guidance in 2016 and that it is your duty as a doctor, but whose responsibility is it to regulate healthcare professionals in ensuring that they have given the correct advice and treatment about abortion, including advice on travelling to other parts of the UK and Ireland?

Dr McBride: Like every part of the United Kingdom, health professionals are regulated by their professional regulator, whether that is the General Medical Council or the Nursing and Midwifery Council. I know you are talking to the General Medical Council later this afternoon. Good medical practice guides me in my responsibilities as a doctor to ensure that at all times I act in the best interests of my patients. To act in the best interests of my patients requires me to ensure that I keep my skills and knowledge up to date. That includes familiarising myself with extant guidance and evidence-based practice.

Q259 **Tonia Antoniazzi:** It would be up to the individual to refer the doctor, the medical professional, to the GMC?

Dr McBride: That is a different sort of angle on it. If there are fundamental concerns about the professional practice of an individual



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health professional, the public does and can refer any health professional to their professional regulator.

Q260 **Chair:** If an individual went along to their doctor and asked for advice on abortion and was told that that was not legal in Northern Ireland and the individual felt that the pregnancy was going to cause them lasting psychological damage, would that doctor be acting within their own professional regulatory conduct or not?

Dr McBride: Again, it is very difficult, and the information you have provided as to what you mean by psychological damage, because the legislation does not refer to psychological damage.

Q261 **Chair:** But would you expect that individual doctor to give information to that patient?

Dr McBride: Absolutely, and the guidance is clear about not only the accuracy of the information that is provided but that that information needs to be provided in a timely manner and that would include—

Q262 **Chair:** If it is not, that would be potentially a professional problem?

Dr McBride: It certainly would be. If a doctor has a conscientious objection against something that is covered in the guidance, as a doctor if I have a conscientious objection, we have a professional duty and a responsibility—and good medical practice and GMC guidance is very clear on this—to say to the patient, “I have a conscientious objection in relation to abortion, termination of pregnancy, but I also have a professional duty to you to ensure that I refer you and facilitate and support you in taking advice from another health professional. That is my duty”.

Q263 **Chair:** If you do not do that, it would potentially be a breach of your professional ethics standards.

Dr McBride: It would, and it would be a case of my not putting the best interests of the patient first.

Q264 **Chair:** How many cases of that sort of reporting do you have in Northern Ireland on an annual basis?

Dr McBride: I am not aware of any, and none have been brought to my attention, but if they were matters that were brought to the attention of the General Medical Council, we would not necessarily be advised unless there were substantive issues that were determined or there was some restriction in practice or other action deemed appropriate by the GMC.

Q265 **Chair:** Sticking with regulatory standards for a moment, we were talking about the inconsistencies between hospital trusts and the evidence that has been brought to us. If that were to happen in England, the CQC would look at that, because it has a duty to ensure a good standard of care in all hospital trusts. I understand in Northern Ireland it is the RQIA that looks at these sorts of regulatory issues. Is that correct?



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Dr McBride: Yes, although then the legislation and the rules and responsibilities are—

Q266 **Chair:** No, I am talking about the consistent application of the current law. Are you aware that the RQIA is looking at the inconsistencies between hospital trusts on abortion?

Dr McBride: I was trying to say there is an important point here, which is that the 2003 legislation and the regulations that establish the Regulation and Quality Improvement Authority differ from the legislation in England and differ from the legislation in Scotland. RQIA does not regulate health and social trusts in Northern Ireland.

Q267 **Chair:** What do they do?

Dr McBride: They regulate the independent sector providers under the Independent Sector Regulations and they inspect, under the broad umbrella of clinical social shared governance, on a series of themed and specific reviews.

Q268 **Chair:** Who makes sure that trusts are doing what they should do with taxpayers' money?

Dr McBride: We do as a Department. Trusts in Northern Ireland are an arm's length body of the Department.

Q269 **Chair:** Shouldn't the Department, therefore, be looking at whether or not the trusts are using taxpayers' money properly?

Dr McBride: As I was going on to say, the accountability line is to the Department. As the guidance makes very clear, there are specific expectations of trusts in this regard about the equity of service provision. Trusts have a statutory duty to enquire of the population that they serve and to ensure that the service that they provide meets the needs of that population, to ensure that the services under their duty of quality are consistent and that those services are provided within the law.

Q270 **Chair:** If you are brought evidence that there are inconsistencies, how many times do you do investigations of these sorts of inconsistencies on an annual basis? It will not just be in the case of abortion. The CQC will look at my local hospital on a regular basis to make sure it is doing things right in A&E, maternity care, in all sorts of places. Do you do that sort of systematic review?

Dr McBride: We have a process of systematic reviews that RQIA undertake, but they are not—

Chair: No, you as a Department.

Dr McBride: We as a Department, no. We have a series of inspectorial procedures on a range of unannounced and announced inspections within trusts, for instance on issues of healthcare-associated infections and a range of other matters. We hold trusts to account in relation to their performance on a range of matters.



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Q271 **Chair:** Given that you have expressed your very deep concern about the situation with regards to abortion and the law and you have heard that we have been given quite a lot of concerns about a lack of consistency in the application of the law between different trusts, is this something that you think you should be looking at as a Department to make sure that taxpayers' money is being used in a consistent way?

Dr McBride: We can look at specific examples that you wish to provide, but on the issue that I think this conversation and discussion stemmed from, those are not inconsistencies that have been drawn to the immediate attention of the Department. If those inconsistencies or differences were drawn to our attention, we would consider the most appropriate action to take.

Q272 **Chair:** We will certainly write to you on that. Before we go on to our last question, can I ask another question, which is about pathways? Throughout our conversations in recent weeks, we have heard a lot of discussion about the importance of supporting women who may be either choosing to continue with a pregnancy or being forced to consider a termination of a pregnancy. There has been quite a lot of concern about whether or not the pathways for those individual women are very clear. Is this something that you have some sympathy with, that there might be some work to do to make those pathways clearer?

Dr McBride: I am conscious that I am hogging all the discussion here but, yes. We made very clear in the recommendations to Ministers from the FFA working group that we felt that there were improvements that could be made, particularly in relation to women with a diagnosis of fatal foetal abnormality who have decided to continue with their pregnancy. But we were very clear, and the advice that we had from those who informed the working group was that those were only modest improvements and could not address the very fundamental issues for women who had determined that the course of action that they wished to pursue was a termination of that pregnancy.

Q273 **Chair:** For me "modest improvements" would be at least an improvement. What is stopping you as a civil servant implementing pathway improvements, given that would not require legislative consent in any way? What is stopping that happening?

Dr McBride: I think that there is a significant number of priority areas within health and social care and there are significant resource constraints right across the piece.

Q274 **Chair:** It is resource constraints that would stop you from doing that?

Dr McBride: That would be one factor. There is also a number of issues that are undoubtedly within the advice and support that we would wish to provide that remain matters of contention, I would suggest.

Q275 **Chair:** But those that are not contentious, just—



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Dr McBride: For some of those, we did not have a clear steer from the then Ministers or the then Executive.

Q276 **Chair:** But pathways are not things Ministers get involved in. Having been a Minister, you would never get involved in something operational like that. This is very much what civil servants advise you on.

Dr McBride: It is, but in this matter there are very strongly polarised views and very strongly held views in Northern Ireland. I think it is very likely that efforts that could be reasonably made to seek to take what would seem reasonable steps to improve care and support may in themselves become extremely contentious.

Q277 **Angela Crawley:** Amanda, what role, if any, do you think the police and criminal justice system should have in investigating or prosecuting abortion or suspected abortion in the case of stillbirth? That was quite a longwinded question.

Amanda Patterson: Yes. In what respect?

Angela Crawley: In the first instance, the view that abortion, if you take one interpretation of the law, is a criminal act, what role do you think the police or the criminal justice system should have in investigating or prosecuting?

Amanda Patterson: I cannot give you an answer on what I think the law should have or should not have, but at the minute the current law provides criminal offences for termination of pregnancy.

Q278 **Angela Crawley:** Would the police or justice system act on those?

Amanda Patterson: Yes. If there is a criminal offence, the police have a duty to investigate. That is basically—

Q279 **Angela Crawley:** Would they do that in the case of a stillbirth?

Amanda Patterson: I am not sure that that is the same thing. There is a criminal offence around abortion but for stillbirth I am not sure what that—

Angela Crawley: No. Sorry, that is just the question I have been looking at.

Dr McBride: I think what you might be referring to there is the requirement in Northern Ireland to refer stillbirth to coroners and for the coroner to consider whether or not there is a need to investigate. That was a Court of Appeal ruling in 2013. I know that other jurisdictions, if they have not moved to that position, are considering moving to that position. There is no doubt that we still have significant improvements to make on the rates of stillbirth in the United Kingdom compared to other European countries, although we are making improvements. I think that might be caught up in that, but it would be at the discretion of the coroner as to whether or not a coroner's investigation would be required



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in the case of stillbirth. I do not know if that helps clarify the basis of the question.

Angela Crawley: That is helpful, thank you.

Q280 **Chair:** It is always important for us as a Select Committee to know that there are going to be many different points of view. We are not here just to say one set of views is right and one set of views is wrong; it is to gather those views together. But I think what struck us about this is the level of inconsistency and confusion and I am struggling to think of another inquiry we have done where that is so prevalent. I will give you two examples. One is that women are able to go to Great Britain for an abortion, but there seems to be considerable confusion as to whether or not when they come back they will lawfully be able to ask for aftercare, and if individuals take a medicalised abortion pill, whether or not they will be able to get aftercare in that instance. Why do you think there is such a level of confusion here?

Dr McBride: If I am honest, Chair, I find that really difficult to understand. I keep coming back to that the March 2016 guidance was very clear about our responsibility as a health and social care system to provide counselling, emotional care and support at the time of diagnosis, irrespective of what a woman's decision was, and that we give that in a way that respects the individual woman's views, that is non-directional and that we have responsibilities as a system to provide aftercare. It is very clear that that is a requirement. I struggle, to be honest, with the view and perception that sometimes there is, somehow or other, some uncertainty as to whether that view—

Q281 **Chair:** It may be that some people are putting that forward because it assists their case for change. That may well be what is happening, but your obligations as civil servants are to make sure that the current policy is implemented and that does not go away simply because there is not an Assembly. What will you be doing to make sure that there is no confusion in communication? Our Department of Health in England has to do that all the time to make sure that people are clear about health policies, that they communicate. What are you doing to make sure that people are not confused about the care that they can get in Northern Ireland on abortion?

Dr McBride: The action that I took back in 2016 was to request that the Public Health Agency and the Health and Social Care Board, our commissioning organisations, undertook a piece of work to seek to address those issues that you are referring to with pathways and information leaflets and resources and support. They did that work in the course of 2016, 2017. What we then had was the working group established, the potential for the change in the law, the Executive falling and no clear clarity or certainty about when the Executive or Ministers would come back. It has been very difficult in circumstances whereby a matter is high profile, contentious and cross-cutting for us to progress in



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the absence of clear direction from the Executive or direction from Ministers at the time when they were in office.

Q282 **Chair:** But the law has not changed, so you have to uphold the law as it is now. Why can't you simply go forward with the communications programme about what the law is now, particularly given the fact it might be doing people harm?

Dr McBride: The circumstances have changed, as we said, with the provision of termination of pregnancy in Scotland, England and Wales. We actively have sought legal advice as to whether the guidance that has been developed and the information and support resources that have been developed by the Public Health Agency can be updated to include that. Otherwise I think we would stand accused of putting out incomplete information. It is not clear at this point whether we can lawfully provide that information.

Q283 **Chair:** How can you get that to be clearer? How can we help you on making that clearer?

Alasdair MacInnes: We have asked for legal advice and we are awaiting legal advice. On the clarity point, with the guidance that was issued in 2016 we were steered into whether we needed to produce guidance by a judge in 2004. It took us 12 years to get in the great position that it was not judicially reviewed; we had many judicial reviews. The guidance is quite explicit on all of the things you have raised. You have asked about confusion. One of the areas of confusion is that we still hear back that the guidance was issued in 2013 and it was not. On the point I made earlier on, the guidance makes it clear that abortion is legal in certain circumstances in Northern Ireland. That is a clinical decision, so different lawyers will advise different things, but it fundamentally comes down to a doctor and their patient.

Q284 **Chair:** In my experience, though, lawyers do not give one point of view, do they? Is seeking legal advice really just kicking it into the long grass?

Dr McBride: We have sought legal advice from the Departmental Solicitor's Office. It is not just taking a variety of sources of advice; we are taking and seeking resolved legal advice for the Department.

Q285 **Chair:** When will you finalise that and be able to tell us what that advice is?

Dr McBride: When we receive the advice. I do not have a timeframe for that. I think it reflects the complexity of this.

Q286 **Chair:** Is it so complicated?

Dr McBride: I am not a lawyer, so I cannot advise on the complexity, but it is more complicated than you might think. The position, as I understand it—I am not legally qualified—is that it has not been formally tested as to whether or not it is lawful for the system in Northern Ireland at any level to advocate or promote those services that are lawful in



another jurisdiction but are unlawful in this jurisdiction. It has never been tested in court.

Q287 **Vicky Ford:** To drill down on a couple of things, the FPA, which is funded in Northern Ireland, have told us that some doctors will refer to them and some will not—inconsistency—so that would be one area that I would ask you to look at.

We have also been told by BPAS that of the women who have travelled to England to have abortions, over 95% of them are self-referring, they are not even touching their GP, and that the women who travel to England are far more likely to end up having a surgical procedure, not a medical procedure, with all the risks that a general anaesthetic surgical procedure brings. They made the point that this is a far less safe process for women and that there is health inequality between Northern Ireland and GB. My question about the advice and support that is given to women is: why are some GPs referring to FPA and some not? How does one get that information to women to stop them having to turn up in England for late abortions that are more likely to be surgical with all those risks?

Dr McBride: Very quickly, because I know we are short of time, there should be no impediment to any health professional referring into a service that we commission.

Chair: Clearly there is.

Dr McBride: We do provide funding to the Family Planning Association in Northern Ireland. On referral to services in England, I come back to the point that now it is not clear whether health professionals can formally refer into those services and whether it would be lawful to do so or whether it would be complicit with an act that is unlawful in this jurisdiction but is lawful in the other jurisdictions.

Q288 **Chair:** That is why people are not going to their GPs.

Dr McBride: I cannot speak for individual cases but there is no impediment to health professionals providing the advice as to what services are available or saying, "Here is a telephone number" and referring to other sources of information, internet or whatever else, but a health professional cannot refer to abortion services.

Q289 **Chair:** You indicated that you were not surprised that women were not going to their GPs. Why weren't you surprised?

Dr McBride: Well, not going to their GP, but I think you said that referrals were 95% self-referrals, which is consistent with the fact that GPs are not making referrals because we have not provided that advice and cannot provide that advice.

Q290 **Vicky Ford:** They are even saying they have not been to their GP first; they have not got a phone number from their GP; they are not even touching the GP.



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Dr McBride: The final point I want to make, because I think this is an important point, is the risk. This was highlighted in our working group. You are absolutely correct, they are dealing with very fundamental concerns about the risks to women in a pregnancy because they are presenting later for termination of a pregnancy, with the complications particularly associated with fatal foetal abnormality, with polyhydramnios or other potential obstetric complications, a higher percentage of complex surgical terminations with risks to women and risk with subsequent pregnancies.

There is a compelling clinical consideration here as to whether or not the current situation with the law in Northern Ireland is having a disproportionate impact on the health and wellbeing of women in Northern Ireland. That was clearly the view of the RCOG and other professionals that were contributors.

The final point is that I think there is a legitimate question to be asked as to whether it is equitable, proportionate, to put in place a disproportionate resource in facilitating the women travelling outside of Northern Ireland to have a termination of pregnancy, separated from their families and friends and support networks, when in actual fact the issue that we are trying to address is a fundamental one of the law as it exists in Northern Ireland pertaining to termination of pregnancy.

Q291 **Jess Phillips:** You have said a number of times that whether or not you can make a referral has not been tested in the law. There has been no test for that.

Dr McBride: In the courts, yes.

Q292 **Jess Phillips:** In the courts, yes. Would you worry about sending out a letter, for example, that made it clear that you are allowed to give out advice, even on a conscience issue you are allowed to say, "I am sorry not me, but here is a number of somebody who could help you"? When you say that these things have not been tested in the law, do you worry about you being in trouble with the law?

Dr McBride: Personally, no. Where I think I have a responsibility as Chief Medical Officer, however, is to women in Northern Ireland and the responsibility to provide advice to help professionals that ensures that they practise within the law and do not expose themselves to risk. I cannot duck that responsibility and, therefore, I need to be confident, with the advice of colleagues and expert legal advice, that the advice I provide is balanced and measured.

Q293 **Chair:** I thank you hugely for your candour today but you have said, Dr McBride, that the current situation on abortion laws in Ireland risks women's health. You have also said that medics, doctors, are "unable to fulfil their duty of care". Do you think this reaches a threshold, at a time when you do not have an Assembly in Northern Ireland, for those who are sitting in Westminster to act?



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Dr McBride: I was afraid you were going to ask me that.

Chair: In your professional opinion as the Chief Medical Officer here—I find it difficult that you have been so candid with us and you have used words that I did not expect you to use like “unable to fulfil their duty of care” and “risks to women’s health”—as a medical professional, are you worried that unless somebody who should be filling the void left by the Assembly acts, you are not doing your job properly?

Dr McBride: The words I used are words that are reflected within the FFA working group report. They are there and those recommendations and that advice were put into the public domain by the permanent secretaries of the Department of Health and Department of Justice because they felt there was a public interest to be met by putting that information in the public domain. Professionally I am comfortable that advice we provided to Ministers of a clear need to consider fundamental changes to the law in Northern Ireland has not been able to be progressed from October 2016. That is a matter, as Amanda and Alasdair have said, outwith our control. In the absence of an Executive and a legislature, due consideration needs to be given as to whether that is a tenable situation. A quote from the report—as everything I have said this afternoon—is that the current position was not tenable.

Q294 **Chair:** The current position is not tenable?

Dr McBride: That is the view of health professionals.

Q295 **Chair:** It is a view of health professionals. It is a view that has been echoed not only by you but by permanent secretaries via—

Dr McBride: They have put the report into the public domain in the public interest on a FOI request.

Q296 **Chair:** In the absence of the Assembly, who would be the most appropriate person to act, Dr McBride?

Dr McBride: That is probably not a matter for me to advise upon.

Q297 **Chair:** It is a factual thing. Is it the Department of Health in England or is it the Secretary of State for Northern Ireland or is it the—surely there are other issues that in the absence of the Assembly you, as a set of civil servants, have had to refer to Westminster?

Amanda Patterson: There is nowhere else we can go as the Department of Justice. We have nowhere else to go.

Q298 **Chair:** What if women started to die as a result of the policy here, what would you do then?

Dr McBride: If we could come back to that, the point I was going—

Chair: I would rather you didn’t, because it is pretty serious.

Dr McBride: I think that clearly this is a matter that previously and actively has been under consideration by the Parliament in Westminster.



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There have been a variety of private Members' Bills that have been proposed in terms of—

Q299 **Chair:** Yes, but nobody in Westminster has been saying that doctors are unable to fulfil their duty of care or that there are risks to women's health.

Dr McBride: All of that information is in the public domain.

Chair: No, sorry, the situation in England.

Dr McBride: Sorry, the situation in England. I would find it difficult to see the circumstances, in this particular case, where women would die as a consequence of the current law in Northern Ireland. The guidance is clear and the law is clear on that: where it is a matter of preservation of the life of a woman then no one should delay or fail to act.

I am not aware of situations that have been so serious in the complications that might arise that have had an impact of the order that you have described. It comes back to the mechanism by which, in the absence of a legislature, we would address any recommendation on the need to change the law. We do not have an Executive, we do not have Ministers and we do not have a legislature. No matter how we look at this, indeed looking at it within the confines of the Executive Formation and Functions Act, even that and any associated guidance that issues, does not seek to make us Ministers and it would be wrong for it to seek to do so.

Q300 **Vicky Ford:** Could I check with Amanda, do you think the Secretary of State has the power legally to change this law, either the Secretary of State for Northern Ireland or the Secretary of State for Health?

Amanda Patterson: I do not think there is an impediment to the UK Government acting, but the Northern Ireland Office has given a written submission that sets out their position so I do not need to say more.

Chair: I know that we could continue this discussion and I am sorry we have already overrun by a few minutes. I apologise for that. Thank you again for your time—I know you are busy people—and also for being so very frank. We really appreciate that. Thank you very much.

We are now having another panel, so if I could ask you to exit stage left and ask for our second set of panel witnesses to join us.

Examination of witnesses

Witnesses: Dawn Purvis, Karen Murray and Dr Paul Coulter.

Q301 **Chair:** Thank you for joining us for the second panel this afternoon. We are being livestreamed. We are very grateful to you for coming in front of us today. The Women and Equalities Select Committee is undertaking an inquiry into the UK Government's obligations under CEDAW in relation to access to abortion in Northern Ireland. We are also looking to give the



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people of Northern Ireland the opportunity to have their voices heard on this hugely important issue.

We are grateful to you, our panel of medical experts, for coming before us today. Before we start with our questions, can I just do two things? The first is to remind you that because we are being broadcast you should be careful about discussing live cases for fear of falling foul of sub judice laws. Also, could you say your name and the organisation you represent?

Dawn Purvis: Yes, my name is Dawn Purvis and I am a former director of Marie Stopes in Ireland.

Dr Coulter: My name is Paul Coulter, I am representing the Christian Medical Fellowship.

Karen Murray: I am Karen Murray, I am the Northern Ireland Director for the Royal College of Midwives.

Q302 **Angela Crawley:** What is the view of healthcare professionals in Northern Ireland on the healthcare guidance on abortion?

Dawn Purvis: Following on from the last session, I listened very closely to Dr Michael McBride and I was quite struck that he is not aware of the inconsistencies in provision of abortion care for women across Northern Ireland. The inconsistency not only relates to different health trusts but to different clinicians within the same health trust.

From my own experience, I have had women come to me where previously the consultant they were under would have provided a termination for them in cases of fatal foetal abnormality, for example, but when the draft guidance came out in 2013 and did the damage and caused that chilling effect and the fear, that same consultant refused to offer termination of pregnancy. I have had women come to me where they have been seen by a consultant who offered them a termination of pregnancy, but that consultant went off on holiday and they were seen by a consultant in the same trust who said, "What are you talking about, we do not offer terminations here. Who told you that and where do you think you could get it?" There is a real inconsistency across healthcare professionals and I would say GPs in particular.

With obstetricians and gynaecologists, it is based on who you know and not what you know. The pathway is not clear. For GPs who have to refer to an obstetrician, if I can describe Northern Ireland when it comes to general practitioners and doctors in general, we are a village, we are that small and everyone knows everyone else. There is a fear for women approaching their own GP who is often a family GP and women are concerned about confidentiality and maybe someone else in the family getting to know. But I have also had women come to me where they have approached their GP to ask for an abortion or they ask for information on abortion where they have been shown the door, where the GP has said, "It's not legal here, get out". They have come to me in



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floods of tears and I said to them they are not allowed to do that, they have to refer you on to someone else. If they have a conscientious objection, they have to refer you to someone else. They are not allowed to do that but it does not matter.

Dr Coulter: I think our members have expressed some of their concerns about clarity of the guidance, but when the 2016 guidance, which has already been referred to in evidence to you, is looked at it is very clear. My reading of it is that it is very clear. It needs to be consistently applied and clear across the board.

Our members are also identifying some other concerns to us. They include the sense that there could be a better informed consent. There is a concern that there is not good or clear information about what is entailed in abortion procedures for women who are considering travelling, for example. I am aware there is not clarity in some of the language that is available in Great Britain about that. There is also a sense that there could be improvement in perinatal palliative care, that there could be an improvement in provision for women who are going through with their pregnancy where their child is not expected to live long and some more privacy, better facilities, better care around that.

The biggest concern our members have is that should there be any change in the law, they would be very concerned about conscience issues. That is not just for medics. We are a medical association but we do have members who are nurses and midwives and we would like to see conscience provisions for all healthcare professionals should the law change. That is not our preferred position; we do not believe there needs to be a change in the law.

Karen Murray: One of the difficulties—and I know there was quite a lot of discussion in the previous panel and everyone was referring to the 2013 guidelines—is because the 2016 guidelines came out very quietly. I also think that the issues raised in the 2013 guidelines create the situation of fear. While the 2016 guidelines appear more measured, they have not taken away the key elements and, therefore, that fear still exists. Midwifery members are very unsure about how to react when they come into contact with women who may have travelled in for an abortion, may have presented in a maternity unit with bleeding, and they still feel very much that it is difficult to ask questions. If a woman presents and she is bleeding, they are very uncertain about asking questions because they are uncertain about the answers they are going to get and how they would deal with those situations.

Q303 **Angela Crawley:** That was going to be my next question. Do you think that women and girls in Northern Ireland seeking information about abortions receive adequate information and treatment by medical professionals?

Karen Murray: I think the information is not what it should be. We could have much stronger information. I concur with Dr McBride who



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mentioned the work the PHA had carried out in developing leaflets for various scenarios, but those leaflets have never come into the public domain. I take on board his point about the difficulties of the topic area, but certainly there is information there already although there are still some minor amendments. It has been co-produced with women and it would be helpful if that information was made more readily available.

I also pick up the issue of clear pathways of care that Dr McBride mentioned. A woman who presents requesting termination of pregnancy hopefully meets a minded professional who will go through the procedures and identify the organisation to put her in contact with. There needs to be a pathway where the woman can access that organisation, have an organised termination of pregnancy in GB but has a pathway that allows her to return to Northern Ireland with a package of care and she doesn't arrive back in Northern Ireland completely unsure of where to go for support. We have members who report situations—and it invariably happens at night time or on a Saturday evening—where they have women who present as obstetric emergencies, bleeding, and it is difficult to ascertain what the cause has been, the pathway of care that woman is on and negotiate the best routes for them to access continuation of care.

Dawn Purvis: Since women have been able to travel to England, Scotland and Wales for free, safe, legal abortion, the Department of Health has failed to issue any guidance, instruction or information for women on how they access that service. It goes back to the draft 2013 guidance that created such a fear. You heard Dr McBride say—and it hasn't been tested but it is an issue—about providing information and advocating or promoting abortion. There is no legal impediment to providing information.

There was a little tête-à-tête at the time between our Attorney General and our Director of Public Prosecutions. The Attorney General's stamp was all over the draft guidance in 2013 and the Director of Public Prosecutions at the time made a statement to say that there is no legal impediment to providing a woman with information on abortion that is legal in another country. There is a grey area around advocacy and promotion in relation to information, but what we are seeing from the Department of Health is they are not bothered with providing information.

Dr Coulter: I think it is very important that there is joining up of care and we know that is a challenge across healthcare provision. If women are returning from England they ought to have the proper information that will be transferred. What we say as healthcare professionals is that properly informed consent is so important. We believe in a non-paternalistic approach. It is important that people have the full information they need, so the transferring of information within the system is incredibly important. It is also important that there is clear



information and people know the decisions they are making. We are concerned that is not the case, not just here but elsewhere as well.

Q304 Vicky Ford: You have spoken about some of the gaps in the pathway and gaps in the treatment; turning up Friday night or Saturday morning is someone coming back from having an abortion presumably. There are also gaps in the treatment, for example for somebody who is pregnant with some form of a FFA and seeking advice. If there are gaps, who should fill them? Whose responsibility is it to make sure they are filled?

Karen Murray: There are probably two levels to that question. If someone is presenting, I would like to think that I, as a professional, would give the best information I could, based on my knowledge and understanding of the situation. If a woman has a conversation with a midwife, that midwife should be able to provide appropriate advice and information about where to seek guidance, whether it is to the FPA or BPAS, on the free availability in GB. I think there is a professional obligation there to be clear about what advice you can give and it would be helpful if we had some steer from the Department about the advice and certain information that we can share.

There is something there about making sure that we have well-designed, co-produced leaflets, information, an ability to get informed consent that can be used. There are the two things. There is a professional responsibility for what you can do and there is the departmental responsibility for making sure that we facilitate it by having in our hands the information that we can pass forward.

Dawn Purvis: There is a fear among many clinicians and healthcare professionals that if they have a bunch of leaflets on their desk from the FPA or Marie Stopes or BPAS that somehow they are breaking the law and they will be judged or reported for having those information leaflets there. You have taken evidence where GPs have refused to refer a woman to the FPA. I had a similar experience when I was at Marie Stopes, trying to work with sexual health clinics across Northern Ireland and they refused to engage, never mind take leaflets, even though we provided an integrated sex and reproductive health service. There is a massive fear that comes from the criminalising attitude of the powers that be and the failure to produce any clear guidance for healthcare professionals, nurses, doctors, and midwives, working in this area.

The impact on women is horrendous. You have met women, you have spoken to women. I worked in a clinic where we saw women coming in from the age of 12 to the age of 52. A 12 year-old who had become pregnant as a result of sexual assault had to travel—the police travelled with her—to a clinic in England to have a termination. We could not treat her in Northern Ireland because the law said we could not treat her. The police had to go with her, one had to attend the actual surgical procedure in order to seize what they call the product of conception for evidence, and then they travelled back with her. That is inhumane treatment of a young child who did not have a passport, had never left the country and



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she had been removed from family, friends and everything else to go through that.

Q305 **Chair:** Dr Coulter, do you recognise this?

Dr Coulter: I am not familiar with this particular case.

Q306 **Chair:** No, not that particular case but this inconsistency of GPs' advice. As Dr McBride was saying, it is very clear the GPs have a professional and ethical responsibility to provide this information, yet we have been hearing they haven't. Do you recognise that?

Dr Coulter: What I am hearing from our members is that there are concerns about inconsistency with the availability of information and even with the guidelines. It would be a good thing if the guidelines—not made clear, they are clear in themselves—were made readily available and folks were reminded of them. It is important that the information that is there needs to be from the Department not from the various organisations who are involved in abortion provision outside this jurisdiction or through many other organisations, including our own. It needs to be departmental guidelines or information that is clear and impartial, uses clear and appropriate language. I certainly would welcome that and our practitioners would welcome that.

Q307 **Vicky Ford:** There seems to me to be a few different issues on these guidelines. First, there is not enough knowledge about what the existing guidelines are. Secondly, do we need to have more detail on those guidelines so that doctors and medical professionals feel more confident in the decisions they are taking rather than being risk averse and just saying, "I am not going to give you any advice, I am going to walk away from this"?

Karen Murray: On the advice, it would be useful if there was a departmental steer and clear information coming out of the Department that could be shared by health professionals and it would be very clear.

Q308 **Vicky Ford:** What sort of information?

Karen Murray: I think about the availability, who the key contacts are and the provision of post-abortion care when a woman returns. There is something about having clear advice about that. That would give health professionals more confidence in sharing that. I agree with Dawn that in Northern Ireland it is a difficult topic. It raises lots of issues so those conversations can sometimes be difficult even within teams because of differences in views. There is something about needing to have very open conversations about it as well.

Dawn Purvis: I will give you an example of the guidance and the impact of the guidance. In 2012-13 there were 51 terminations carried out in HSE establishments in Northern Ireland and last year there were 12. I know Dr McBride and others are saying how clear the guidance was in 2016; the damage was done in 2013. I am sure you have heard about Sarah Ewart and her case, which was 2013. I want to talk about the



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publicity in 2013. Sarah asked for a termination and was told by her doctor she could not have one and that was after the draft guidance had come out. If it had happened previous to that I am sure she would have been treated.

Q309 Jess Phillips: I want to come back to what Dr Coulter was saying about not necessarily wanting the leaflet managed out or to be passed out. Would you and your members carry a document from the Family Planning Association? It is not associated with performing abortions in other jurisdictions, so would they give it out freely?

Dr Coulter: If it is going to be required to be carried and signposted by all healthcare professionals, it needs to be something that is produced by the Department.

Q310 Jess Phillips: The Family Planning Association is funded by the Department.

Dr Coulter: I think it is the Department that has a responsibility to give clear information and the associated organisations, the Public Health Agency and—

Q311 Jess Phillips: Would your advice to your members be that you want them to be giving out the advice?

Dr Coulter: In a situation like this where there are two lives present there are clear ethical issues. Those issues should not be sidestepped. It would be paternalistic for me to assume what the patient thinks about that. They should be encouraged to think in wholeness and fullness about the whole issue.

Q312 Jess Phillips: Paternalism is a big concern of mine as well. However, and I do not know if you were in the last evidence session, the current guidance states that if you have a conscience issue you express that you have a conscience issue—this has happened to me so I know that this is the case also in GB—and, “Here is the number of somebody you can call”. Is that currently the advice you give to your members to follow?

Dr Coulter: We do not give advice to our members on what they should follow in that situation. However, I think those guidelines are signed.

Q313 Jess Phillips: They are clear?

Dr Coulter: I think they are clear.

Q314 Chair: Following up on that before Tonia comes in, it is clear from what Dr McBride said that GPs have to do that. It is not an option. They have to give that information and if they are not in a position to give that information, they are professionally bound to refer to somebody else. What view does the General Medical Council take of GPs who do not do that?

Dr Coulter: Are you asking me or the GMC?



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Chair: I am asking you as a doctor, what view does the General Medical Council take if doctors do not do that?

Dr Coulter: I could not comment directly on that. I cannot speak either for the GMC and I cannot speak for—

Chair: As a practising doctor?

Dr Coulter: I am not currently practising but I represent an organisation of doctors who are. In every consultation between a patient and a doctor there is a relationship and there is a context of trust. Some patients will often ask about complex issues and they will be expressing various views and emotions. It is very difficult to legislate about every detail of a conversation that will happen in that context. I certainly understand the guidance and I do not think our members would have an issue with that. Patients have a right to a second opinion; they have a right to go to somebody who can give them the advice and the information.

Q315 **Chair:** You recognise that?

Dr Coulter: I recognise that and our members would recognise that.

Q316 **Tonia Antoniazzi:** Going on to the advice on treatment about abortion, including advice on travel to other parts of the UK and Ireland, you talked about pathways and information that was given. Who regulates the healthcare professionals to ensure that this advice is being given? Should it be the Department of Health? Is anybody currently regulating it?

Karen Murray: From the perspective of midwives, the professional regulation comes from Nurses and Midwives but it is all in the code. The code is very clear about how we interact with women in the case of midwives—that the advice we are giving should be impartial and we should respect a woman's perspective and a woman's choices. From the perspective of the Nursing and Midwifery Council, it is the key question it would regulate.

Dr Coulter: Dr McBride addressed this in part earlier. From a medical perspective, the General Medical Council regulates the actions of trusts and healthcare generally, not the RQIA, so it is the standard of care. However, in Northern Ireland at least there is also an arms-length body, the Patient and Client Council, which is there to help and support any patient or client of health and social care. There is a complaints procedure and that organisation can help them with that. It can also help them access information. I think it is good that is available and that would be another avenue for people.

Dawn Purvis: It is not regulated by any professional body. It is left to individuals to deal with it as they like and that is the stark reality of the situation.

Q317 **Tonia Antoniazzi:** Thank you, Dawn. The working group report recommended a change in the law for FFA. That is two years-old now. What needs to happen now for the recommendations from the report to



be implemented?

Karen Murray: I think all of us would prefer a Northern Ireland Assembly, an Executive in place with Ministers who would listen to the debate, read the report and understand what the recommendations were. The difficulty is that is not in place, I think you had quite a long discussion about this in the previous session. There is no Assembly and the situation has gone on for such a long time that we are getting to a point where something needs to be done by somebody, whether that is escalated up to the Secretary of State or up to Westminster. Outside my role as a health professional, as an individual I think we are at a point where there needs to be action taken. We need to move the situation forward and it is not looking as if we are going to have an Assembly in the near future.

Q318 **Chair:** Karen and Paul, as medical professionals—albeit you are not practising at the moment—are you able to agree with Dr McBride that at the moment you and the people who do jobs like you are unable to fulfil their duty of care to women? Would you agree with that, Karen?

Karen Murray: I think it has been very difficult for us. We interact on a regular basis with women who are struggling in very difficult circumstances, who wish to make decisions but find that very difficult to do. It is not possible for every women to travel. For some women that is not going to happen either financially, because of family commitments or just the situation they find themselves in. Midwives are left in the position of trying to support these women in a framework that makes it difficult.

Q319 **Chair:** Paul, would you agree that your members are unable to fulfil their duty of care?

Dr Coulter: I have a difficulty with the language in the sense that it does not include the duty of care to the second patient in that situation. Even the language that you use today, for example, I think is misleading in the sense that I do not think the term “fatal foetal abnormality” is the best term. If we are talking about conditions that have a limitation on the child’s life, that is not the diagnosis of the mother. As I said earlier, if a woman has a diagnosis of FFA it is not the woman’s diagnosis, it is the diagnosis of the child. Therefore, I think we have a duty of care to both. That duty of care is to respect and recognise the right to life of the child and to maximise the dignity of the child, and at the same time to maximise the mother’s wellbeing. That must involve looking at the risks that are entailed in abortion as well as the risks to the mother of continuing the pregnancy and also her dignity, and then the professional integrity of the professionals as well.

It would be a huge change for healthcare professionals to be involved in ending human life rather than prolonging, preserving and enhancing human life. That is not something that I and others were expecting to be part of when we took our oaths at the beginning of our time. It is a very



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big change at an ethical level. Those three reasons lead me to the conclusion that I do not think the law should change on this.

Q320 **Chair:** Do you think you can undertake your duty of care to patients perfectly happily at the moment?

Dr Coulter: I think the current law in Northern Ireland strikes that balance of the lives of both the unborn child and the mother. The provision that is there is unlike the situation that was there before the referendum in the south, as we have heard already today, where if the mother's life is at serious and clear risk there is provision for a termination of pregnancy. That is an impossible situation, as every case of FFA is. There ought to be support and compassion but I do not believe a change in the law is the best response to that.

Q321 **Jess Phillips:** To pick up on what you said, you think women should be told what the risks of abortion are. What are the risks?

Dr Coulter: I did not say women should necessarily although, of course, informed consent means that should be available to them. Even healthcare professionals are weighing that up. We gave a written submission to the Medical Fellowship that details those from peer-reviewed published evidence. There is an increased rate of mental health issues for a woman struggling with a prior mental health history, and possibly for others, and a small but real risk of subsequent preterm births. Future breast cancer is possible, but the risk of it is disputed and that needs further research. There is also a small but real risk of physical complications from the abortion.

Q322 **Jess Phillips:** Breast cancer is one of the risks?

Dr Coulter: That is one where there are contrary opinions. The references are in our submission.

Q323 **Jess Phillips:** You would want women to be told of those risks?

Dr Coulter: Informed consent means that should be available. A woman in a crisis situation cannot necessarily process all of that, but also when the current law is applied concerning the mother's health, all of these things are taken into account: the risks to her of both continuing with the pregnancy and of a termination.

Q324 **Jess Phillips:** What do you think are the risks of a woman travelling after a termination?

Dr Coulter: I am sorry, I cannot comment.

Q325 **Jess Phillips:** You are not sure about that?

Dr Coulter: I am talking about whether the law should change here currently in Northern Ireland. I do not think the issue of so-called fatal foetal abnormality and life-limiting conditions is solved by a change in the law.



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Q326 **Chair:** Dawn brought up one particular case that I am afraid has stayed with me, which is the idea of a 12 year-old being asked to travel abroad. Would you think that is a correct application of the current law?

Dr Coulter: She was being asked by whom to travel? Sorry, I was not sure.

Dawn Purvis: The law here does not provide for her to have an abortion in Northern Ireland so she had to travel to England.

Dr Coulter: It is not a healthcare professional who is asking her to travel to England to have an abortion.

Q327 **Chair:** You do not think that would be a reasonable request?

Dr Coulter: That is not an issue for a healthcare professional here in the sense they are not advising her to go.

Dawn Purvis: It is an issue for the law here.

Dr Coulter: It is an issue for the current situation with the law. I am not totally sure of your question.

Q328 **Jess Phillips:** Can I clarify the organisation you are here to represent? It is very tricky because you are here to represent an organisation. I see the word "doctor". I do it all the time, my brother has a PhD and I constantly—

Dr Coulter: I am a qualified doctor; I am just not currently practising.

Q329 **Jess Phillips:** You are just not practising; you are qualified?

Dr Coulter: Yes.

Q330 **Jess Phillips:** You stopped when?

Dr Coulter: I am here speaking for an organisation that has 6,000 members so I am not sure of the relevance—

Q331 **Vicky Ford:** Sorry, I just do not know what your own experience is or how you are chosen—

Dr Coulter: I am not speaking from personal experience but I am speaking for an organisation.

Q332 **Vicky Ford:** Possibly you were added so we did not get a brief on your organisation. I know what the Marie Stopes Clinic is. I know what the midwives are. I do not have an understanding of when you last practised, whether or not your own experience was in this area or a different area. You are no longer on the GMC register. Therefore I do not follow—

Dr Coulter: No, I am no longer on the GMC register personally and I do not have experience practising obstetrics. I am speaking for the Christian Medical Fellowship, which has over 5,000 doctors who are members



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across the UK, including over 250 in Northern Ireland, 800 medical students and 400 nurses.

Q333 **Vicky Ford:** How many in obstetrics?

Dr Coulter: I cannot answer that. I can find it and—

Vicky Ford: That would be helpful, how many at the moment are involved in—

Dr Coulter: I have spoken directly to obstetricians in Northern Ireland about this issue as part of my preparation for today.

Q334 **Jess Phillips:** In that case, maybe less so Dawn but certainly for Karen and Paul, what do you feel about the potential that one of your members has been involved in what has been a stillbirth, not necessarily at full term but preterm potentially—we heard about cases of stillbirth yesterday at 32 weeks and 33 weeks—and those being scrutinised by security forces and police? Have you heard of any cases like that?

Karen Murray: We certainly would have had members who have been to coroners courts on the back of a stillbirth, because the legislation has changed and most of those are now referred to the coroner. The coroner makes a decision as to whether or not they require a review. We have had midwives who have been through that process, often because there are more than likely issues or questions about the care that was provided antenatally or during labour. There are none that I am aware of that have been purely because there is a question over the reason for the stillbirth and the potential for—

Q335 **Jess Phillips:** Do you think the law on abortion in Northern Ireland played any part in any of those cases?

Karen Murray: I could not say.

Q336 **Jess Phillips:** Dawn, you were nodding.

Dawn Purvis: Yes, because I have heard of a number of cases where people who are opposed to women having choice or having terminations have intervened in maternity hospitals, accusing healthcare professionals of helping women who have taken abortion pills and who have delivered a baby that has been beyond the gestational limit for abortion. I know of cases where that has happened.

Q337 **Jess Phillips:** What do you think brought about the role of the criminal justice system investigating or prosecuting in the case of suspected stillbirth?

Dr Coulter: I really do not have any other comment to add. It is the professional beliefs of the medical professional.

Q338 **Chair:** Can I thank you all for being here today. I think we could have gone on all afternoon. It is such an important topic and it is so full of detail. We are really grateful to you for coming in front of the Committee.



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Dawn, do you want to come in?

Dawn Purvis: I wanted to add one thing, if I may. I know we focused a lot on the working group of the Department of Health and foetal abnormality and the recommendations on that. Even looking at implementing those recommendations does not go far enough when you are faced with a woman who really does not want to be pregnant and does not want to be forced to continue with that pregnancy for whatever reason.

When I was in the clinic we saw many women who we could not help because the law here prevented them from having help. Those are women from the Roma community, the Travelling community, who are in domestic violence situations. One woman came in with a boot mark on her face where she had been constantly battered and raped by her abusive partner over the Christmas period. She cannot leave Northern Ireland to have a termination. The law here does not help those women. What do we say to a woman who does not want to be pregnant?

Chair: You make this point helpfully.

Dr Coulter: Can I just comment on that? From polling in the population and also among the medical professionals, there is not an appetite in Northern Ireland for a change in the law for abortion effectively on demand. I do not believe it is the answer even for the very difficult cases. I understand that, but I am saying there needs to be a compassionate and supportive response and a change in the law is not the solution.

Dawn Purvis: Abortion on demand is—

Dr Coulter: I am not saying there is abortion on demand. I am saying that is not what people want purely at the mother's choice.

Dawn Purvis: Abortion on demand does not exist anywhere. Nobody can walk in, slap her hand on a desk and say, "I want an abortion now". It does not happen.

Dr Coulter: I am sorry, I did not mean to imply it does.

Chair: Thank you all very much indeed. We are now going to close this evidence session. Thank you very much to the people who have been in the gallery as well.