RESPONSE OF THE COUNCIL FOR PUBLIC AFFAIRS OF THE PRESBYTERIAN CHURCH IN IRELAND TO THE NORTHERN IRELAND OFFICE CONSULTATION ON A NEW LEGAL FRAMEWORK FOR ABORTION SERVICES IN NORTHERN IRELAND

DECEMBER 2019

General Comments

1. The Presbyterian Church in Ireland (PCI) has over 217,000 members belonging to 535 congregations across 19 Presbyteries throughout Ireland, north and south. Included in our membership are many medical and health professionals who will be directly affected by the introduction of this new legal framework, and families who have personal experience of the range of issues covered by the consultation. The Council for Public Affairs is authorised by the General Assembly of the Presbyterian Church in Ireland to speak on behalf of PCI on matters of public policy, and met on Thursday 10 December to consider this response. We welcome the opportunity to respond to the Northern Ireland Office consultation on a new legal framework for abortion services in Northern Ireland. In preparing our response we have also engaged with medical and health professionals within our membership.

2. PCI recognises that the issues raised by this consultation are not only sensitive but cut across the lives and personal experiences of women and their families who have faced a crisis pregnancy situation in the past, or who may do so in the future. While this consultation is guided by an ideal of reducing barriers to abortion, we believe the proposals have the potential to remove a significant number of safeguards which provide protection for women and girls who might consider abortion as a way of addressing their pregnancy crisis. It is also worth noting that the pregnancy is often not the crisis itself, but rather the crisis is about the circumstances around the pregnancy, which precipitate the consideration of a termination.

3. This is not simply a theological or academic exercise for the church as many of our ministers, and others in congregations, have journeyed alongside women and families who have experienced a pregnancy crisis and been presented with difficult decisions. That continues as they support those who care for loved ones born with a disability. As a denomination we are actively considering how we can better support women and their families who face these challenges.

4. While the consultation document specifically states that views are not sought on “the ethics of the matter of abortion” it is important to state that consideration of abortion and, matters relating to it, are indeed matters of ethical, as well as legal and pastoral concern. We therefore wish to state at this stage that this response reflects our current position on abortion as laid down by resolution of the General Assembly, the highest decision-making body of the Church, as this sets the framework for our response. Any change in the Church’s position on abortion can only come through resolution of the General Assembly, and there are no plans to seek a change to the current position.

5. The current position of PCI was established in 1985 when a resolution was agreed "*that the General Assembly accept the position that human life begins at conception and therefore believe that from that moment the human embryo should be treated in a manner in accordance with full human dignity*."

   The General Assembly revisited the issue in 2016 when a report was received that stated the following in relation to:

   a. necessary intervention to preserve the life of the woman and where there is a real and serious adverse effect on her physical or mental health, which is either long term or permanent:

      "… It is only extremely rarely a case of either mother or baby dying. It is a case of either mother and baby dying or the baby alone dying. In that situation, direct action with the intention or foreseen effect of taking the life of the unborn baby is justified.

   b. fatal fetal abnormality:

      "*… in refusing to take the life even of the child doomed shortly to die, simply on the grounds of its serious or fatal malformation, we pay proper homage to our co-humanity, honour its Creator and respect the sadly malformed creation… whatever the rights of the mother, they reach their limit when it comes to taking the life of the child."*

   c. pregnancy as a result of sexual crime:

      "…*since we are dealing with innocent human life, there is no suggestion here of the propriety of taking life beyond the stage of implantation on the grounds that a sexual crime has been committed."*

6. During the passage of the Northern Ireland (Executive Formation etc) Act 2019 through all its stages in the Houses of Parliament PCI consistently expressed its view that matters relating to abortion provision should be respected as devolved issues, and did not agree with the introduction of significant cultural and societal change in this manner.

7. While we understand that a legal duty has now been placed upon the Secretary of State to change abortion law in Northern Ireland, we continue to strongly oppose these changes and engaging with this consultation in no way indicates tacit agreement with them. Additionally we express concern that these proposals take a maximalist view of what is required by the CEDAW Report[1] rather than a minimalist approach that would more accurately reflect the particular circumstances of Northern Ireland. Our aim in responding is to ensure that the new legal framework for abortion services here provides a context where abortion provision is safe, legal, and most importantly rare. We are also conscious of the need to engage sensitively and fully with the issues raised and do so as set out below, along the lines of the number questions offered in the consultation paper.

[1] Report of the Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW/C/OP.8/GBR/1) published on 6 March 2018

Question 1: Should the gestational limit for early terminations of pregnancy be:

- **Up to 12 weeks gestation (11 weeks + 6 days) – NO**
- **Up to 14 weeks gestation (13 weeks + 6 days) – NO**

8. Provision of abortion services in any jurisdiction not only impact women, but also their families and the wider community, along with those involved in the medical and healthcare provision. The framework for introducing abortion services here should therefore ensure that provision is safe, legal and most importantly rare.

9. The recommendations of the 2018 CEDAW report, upon which section 9 of the Northern Ireland (Executive Formation etc) Act 2019 is based, indicate that abortion provision should be linked to a 'threat to the pregnant woman's physical or mental health'. The proposal for 'unrestricted access for early terminations, so that termination of pregnancy is available without conditionality, where a pregnancy has not exceeded 12 or 14 weeks gestation' goes far beyond this requirement. We therefore recommend that early terminations are linked to a meaningful assessment of the woman's physical and/or mental health.

10. The argument for unrestricted access up to 12 or 14 weeks is that this would cover instances where the pregnancy is the result of sexual crime so that victims of sexual crime would not be required to give evidence or prove the connection between the sexual offence and the pregnancy. However we are concerned that providing abortion services without conditionality might have the unintended consequence of allowing sexual crime, or domestic abuse, to go undetected, or provide the conditions where a woman might be coerced to seek an abortion and not have the opportunity to alert a health or medical professional to their situation.

11. The CEDAW report has no requirements with regard to time limits for accessing abortion services. Our recommendation therefore is that gestational limits for accessing early terminations should be as low as possible, but never exceeding 12 weeks (11 weeks + 6 days). A gestational limit of not more than 12 weeks is common in other European countries and anything over this would create a significant differential with the Republic of Ireland. Such a situation may encourage women to travel across the border to access abortion services.

12. A scan assessment should be mandatory to ensure accurate dating of the unborn child. We also recommend a 'cooling off' period (currently 3 days in the Republic of Ireland) to allow women time to weigh up all the options, avail of appropriate non-directive counselling and consider the implications of making this life-changing (and life-ending) decision.

13. We therefore suggest that providing abortion services without conditionality is not safe for women, while the lack of any framework to determine the legality of the abortion also creates difficulties. Unrestricted access up to 12 or 14 weeks does not meet the criteria that abortion provision should be rare, and a cooling off period should be introduced.

Question 2: Should a limited form of certification by a healthcare professional be required for early terminations of pregnancy? – YES

14. Abortion is a life-changing, and in our view a life-ending, procedure and therefore certification should be mandatory. It is our view that this certification should be undertaken by two doctors who can make a meaningful assessment of the perceived threat to the physical and/or mental health of the woman.

15. Certification should take account of a number of elements including:

    a. Confirmation of the gestational stage of the unborn child;
    b. Reason for the abortion linked specifically to the physical or mental health of the woman; and
    c. Confirmation that pre-abortion counselling has been offered to the woman.

16. It is regrettable that no statistical data will be collected with regard to accessing early terminations. It would be very unusual for such a significant and controversial piece of social legislation to be introduced without rigorous monitoring of the impact. Data captured through certification could, and should, be used to:

    a. guarantee compliance with the legislation;
    b. determine the age of those accessing early terminations;
    c. the gestational stage at which the termination occurred;
    d. detect numbers of repeat abortions; and
    e. identify appropriate policy responses to the systemic reasons that cause women to seek an abortion.

Question 3: Should the gestational limit in circumstances where the continuance of the pregnancy would cause risk of injury to the physical or mental health of the pregnant woman or girl, or any existing children or her family, greater than the risk of terminating the pregnancy, be:

- **21 weeks + 6 days gestation – NO**
- **23 weeks + 6 days gestation – NO**

17. The CEDAW report, which forms the basis of these policy proposals, does not require any reference to be made to any of the woman's existing children, or her family, when provision of abortion services is being considered at any gestational stage. There is no requirement for the provision of services for these reasons up to these limits and we are concerned that this would in effect permit unrestricted abortion up to 22/24 weeks.

18. Should the Secretary of State be minded to permit abortions up to 22 or 24 weeks in these circumstances it is our recommendation that this should be linked to a meaningful assessment of physical and/or mental health. We therefore suggest that:

    a. the terms 'real and serious' be used to qualify the health assessment; and
    b. the health assessment is undertaken by two doctors one of whom must be a specialist in the area which poses a risk of injury to physical and/or mental health (e.g. a psychiatrist).

19. That notwithstanding, we again state our position that gestational limits for abortion should be as low as possible, and not more than 12 weeks. October 2019 guidance from the British Association of Perinatal Medicine (BAPM) advocates for resuscitation of babies born at 22 weeks which, in any case, would mitigate against the higher limit of 24 weeks suggested here.

20. We are concerned that these proposals have the potential to create a significant differential with the provision of services in the Republic of Ireland, opening up the possibility that women may travel to Northern Ireland to access a more liberal abortion regime than might otherwise be available to them. We note that these proposals are also more liberal than those found in many other European countries.

Question 4: Should abortion without time limit be available for foetal abnormality where there is a substantial risk that:

- **The foetus would die in utero (in the womb) or shortly after birth – NO**
- **The foetus if born would suffer a severe impairment, including a mental or physical disability which is likely to significantly limit either the length or quality of the child's life – NO**

21. We recognise that these circumstances are amongst the most difficult for pregnant women and their families to deal with, as the unborn baby with a fatal diagnosis, or a diagnosis of severe fetal impairment, is very much wanted and eagerly anticipated. These situations are also areas of pastoral concern within our congregations, and ministers and those involved in pastoral care often journey with women and their families who are affected in this way.

22. At paragraph 3(b) above we state the Church's position, as agreed by the General Assembly in 2016, that we cannot endorse abortion on the grounds of serious or fatal malformation of the unborn child. Therefore, our answer to both proposals is no.

23. We understand that a recent High Court ruling[2] will have an impact on situations where there is a substantial risk that "the foetus would die in utero (in the womb) or shortly after birth", but note that this ruling deals with fatal foetal abnormality only. Any change in the law should therefore be tightly restricted to these cases. The Department of Health/Department of Justice joint report of the Working Group on Fatal Fetal Abnormality[3] specifies the types of conditions that might be covered by the term. There is no similar clarity within these proposals.

24. We question the assumption that aborting a pregnancy is the best option in these circumstances. In many cases of birth defects where a child is carried until the point of birth, parents (and potentially other family members) can, when presented with suitable palliative care options, be afforded precious time with their babies, and have options as to how their babies might spend their final moments.

[2] https://judiciaryni.uk/sites/judiciary/files/decisions/Ewart%27s%20%28Sarah%20Jane%29%20Application_0.pdf

[3] https://www.health-ni.gov.uk/sites/default/files/publications/health/report-fatal-fetal-abnormality-April-2018.pdf

25. We recognise the increased support that is now available in some Health Trusts through bereavement midwives who can make contact with women whose unborn babies are diagnosed with life-limiting conditions in utero. It is our recommendation that support services such as these should be properly resourced across all trust areas, and not subject to a postcode lottery.

26. We note that the CEDAW report recommends legalising abortion in cases of "severe fetal impairment, including fatal fetal abnormality without perpetuating stereotypes towards persons with disabilities." It is our view that the proposals here, which allow for a subjective judgement to be made on the quality of life of a baby with a severe impairment, do perpetuate stereotypes towards persons with disabilities and we do not agree with this approach.

27. We note the Concluding Observations on the Initial report of the United Kingdom of Great Britain and Northern Ireland of the United Nations Committee on the Rights of Persons with Disabilities (UNCRPD) from October 2017 which states the following:[4]

> "The Committee is concerned about perceptions in society that stigmatize persons with disabilities as living a life of less value than that of others and about the termination of pregnancy at any stage on the basis of fetal impairment.
>
> The Committee recommends that the State party amend its abortion law accordingly. Women's rights to reproductive and sexual autonomy should be respected without legalizing selective abortion on the ground of fetal deficiency."

28. Unlike CEDAW, the UNCRPD is a binding treaty within EU, and therefore UK, law. We therefore question why the CEDAW report has been allowed to be given legal standing over and above that of the UNCRPD.

29. We are concerned about the potential for a range of minor conditions to fall under this definition, as we note that there is no indication of what might be included under the auspices of 'severe fetal impairment'. We are also concerned about the potential for significant negative societal and cultural change in attitude towards people with disabilities. In this regard we are surprised to note that the Equality Screening Document assesses that the new framework will have a 'minor' impact on equality of opportunity based on disability. It is our view that these proposals have the potential to have a profoundly negative impact on perceptions of disability, and in turn on equality of opportunity for people of all ages who are disabled.

30. It is vital that parents, and other family members where appropriate, are given all the available options with regard to fatal and severe abnormality, allowing them to make informed choices. Where a severe abnormality has been identified an appropriate specialist in that field must be afforded the opportunity to provide a medical assessment.

[4] Committee on the Rights of Persons with Disabilities: Concluding Observations UK (2017) [pars. 12 & 13]

Question 5: Do you agree that provision should be made for abortion without gestational time limit where:

- **There is a risk to the life of the woman greater than if the pregnancy were terminated – NO**
- **Termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant women or girl – YES**

31. We recognise that the law must allow for terminations where it is medically necessary to save the life of the woman, and believe that the previous legal framework and guidance in Northern Ireland provided the necessary protections in this regard. We suggest amending the first part of question 5 to read 'There is a *real and serious* risk to the life of the woman greater than if the pregnancy were terminated'. Such instances will be rare as detailed in the consultation document itself.

Question 6: Do you agree that a medical practitioner or any other registered healthcare professional should be able to provide terminations provided they are appropriately trained and competent to provide the treatment in accordance with their professional body's requirements and guidelines? NO

32. 'Healthcare professional' is an undefined term, potentially covering a wide range of specialities. Abortions should only ever be carried out by registered and trained medical practitioners i.e. doctors, ideally in the area of obstetrics and gynaecology, so that any complications or emergencies are managed effectively and safely.

Question 7: Do you agree that the model of service delivery for Northern Ireland should provide for flexibility on where abortion procedures can take place and be able to be developed in Northern Ireland? NO

33. We are concerned about the lack of clarity regarding a regulatory framework and inspection regime for provision of abortion services in Northern Ireland. This means that 'flexibility' in this context remains undefined. Does it create the potential for abortion services to be provided in schools or universities? If so we do not agree that this should be the case. Standards and safeguards should be as high as possible.

34. In that regard we recommend that the regulations place a specific duty on the Department of Health in Northern Ireland to introduce a regulatory regime for the new legal framework for abortion services here which includes provision for inspection of locations where abortions will take place.

35. We are also concerned that there appears to be no assessment of the impact of the introduction of these services against current provision of gynaecology beds and services. At the same time there appears to be no assessment of whether there are sufficient medical and health professionals available in this speciality to ensure safe service provision for women.

36. Later terminations may present with a higher rate of complications and it is our view that they should only be carried out in an acute hospital setting with appropriate levels of medical expertise, aftercare and theatre facilities.

Question 8: Do you agree that terminations after 22/24 weeks should only be undertaken by health and social care providers within acute hospitals? YES

37. While we oppose the introduction of these proposals, acknowledging that the law obliges the Secretary of State to develop a framework for abortion provision in NI, we understand the rationale for proposing that late terminations should only be undertaken by health and social care providers within acute hospitals to ensure safety for the woman, but also to provide protection where there is a possibility of the baby being born alive. We would go further and suggest that abortions should be brought into the acute hospital environment from at least 18 weeks due to the higher risk of complications. We also again refer to the October 2019 guidance from the BAPM which advocates for resuscitation of babies born at 22 weeks.

Question 9: Do you think a process of certification by two healthcare professionals should be put in place for abortions after 12/14 weeks gestation in Northern Ireland? YES

Alternatively, do you think that a process of certification by only one healthcare professional is suitable in Northern Ireland for abortions after 12/14 weeks gestation (owing to perceived higher levels of conscientious objection)? NO

38. In the case of any ethical, moral or potentially contentious issue it is normal medical practice for more than one professional to make a final decision so there is less likelihood for clinical error, complaint, or legal challenge. It is our view that abortion is a life-changing, and life-ending procedure, and so to provide safety for women availing of the service, and protection for medical professionals providing the service, two medical professionals should be involved. Withdrawal of ventilation would require the certification of two doctors, and we view the provision of this service in the same light.

39. Reducing this to only one 'health professional' would leave no meaningful checks and balances. In other areas of medicine it is recognised good practice to have another professional not directly linked to the case to assess the facts of the case and associated risks. The standard in the rest of the British Isles is for two doctors to provide certification. What is being proposed here would be a significant departure from standard practice. Additionally there is no evidence cited to back up the claim that there are likely to be a larger number of people making the case for conscientious objection than elsewhere in the UK. Even if this is the case it is for the NIO and the Department of Health to produce a model of service delivery that protects the right of all those tasked with delivery of this framework to conscientiously object, whilst ensuring patient safety.

40. Two healthcare professionals should be more clearly defined as two doctors, with one being a specialist in the appropriate area e.g. neonatology or psychiatry

Question 10: Do you consider a notification process should be put in place in Northern Ireland to provide scrutiny of the services provided, as well as ensuring data is available to provide transparency around access to services? YES

41. We recommend that the notification process is applied to all terminations, including those that take place up to 12 or 14 weeks. A notification process as described is vital to:

    a. ensure that all abortions provided under the new framework fall within the limits of the law;
    b. understand if the model of service delivery is working effectively;
    c. allow decision-makers to plan and budget appropriately for service delivery;
    d. protect the public by allowing for scrutiny;
    e. promote transparency;
    f. provide for monitoring and regulation;
    g. ensure that anyone employed in caring for women have the requisite qualification and skills; and
    h. provide appropriate information for research and statistical purposes.

42. The regulations should specify:

    a. how often reports on the provision of abortion services should be made;
    b. what should be contained in such reports; and
    c. that these reports must be published annually and be easily accessible to the general public.

Question 11: Do you agree that the proposed conscientious objection provision should reflect practice in the rest of the UK, covering participation in the whole course of treatment for the abortion, but not ancillary, administrative or managerial tasks? NO

43. We are of the view that statutory protection of conscience is essential but that this definition is too narrow an interpretation and assumes that those who object are a problem to be solved. Although conscientious objection is not the sole preserve of people from faith backgrounds, it is likely that most conscientious objection will come from people of faith. We are therefore surprised that the Equality Screening document assumes a 'minor' impact on religious belief when significant questions on the basis of a presumed religious conscientious objection form part of the consultation document.

44. We are also concerned that there may be no legal protection against dismissal for those who object to participating in any part of the provision of the abortion service, and are aware anecdotally of health professionals who feel that the introduction of this legislation leaves them with no option but to leave their profession altogether. More clarification is required with regard to possible dismissal, being removed from professional registers, or even litigation if a medical or health professional refuses to be involved in an abortion procedure or any care prior to, or following, the procedure itself.

Question 12: Do you think any further protections or clarifications regarding conscientious objection is required in the regulations? YES

45. Article 9 of the European Convention on Human Rights provides protections for the right to freedom of thought, conscience and religion, which includes the right to manifest religion or belief in 'practice and observance'. It is unclear how the Secretary of State expects to mitigate for Article 9 rights.

46. Limiting conscientious objection to the whole course of treatment for the abortion, but not ancillary, administrative or managerial tasks, has the potential to create a 'glass ceiling' in regard to career progression for those already employed in areas that will deal with the provision of abortion services. We believe that this will also create a 'chilling effect' and may discourage those who are considering entering such professions. Conscience should be protected throughout the entirety of the procedure and across all administrative and managerial tasks. It should also be future-proofed to provide protection when changing jobs, or moving between Health Trusts.

Question 13: Do you agree that there should be provision for powers which allow for an exclusion or safe zone to be put in place? NO

47. We recognise that women and girls who attend a location to find out information about abortion services, or to access those services, can often be vulnerable and experiencing some form of mental distress. We deplore any situation where a woman seeking a termination, or medical staff involved in the provision abortion services, are harassed or subjected to behaviour which would compound their distress.

48. However we suggest that existing legislation around harassment and anti-social behaviour may be sufficient to deal with the small number of issues that may arise and we endorse the use of such statutory powers to manage any illegal activity. The rights of peaceful protestors should not be diminished because of the actions of a small number who may break the law.

Question 14: Do you consider there should also be a power to designate a separate zone where protest can take place under certain conditions? NO

46. There should be freedom to protest, and freedom to share opinion in a reasonable, lawful and peaceful manner. This is not harassment. While women must have a clear path to access services that is not physically blocked, others should be able to be exercise their fundamental right to a reasonable expression of opinion. We would however deplore any situation where a woman seeking a termination, or medical staff involved in the provision of abortion services, are harassed or subjected to behaviour which would compound their distress.

Question 15: Have you any other comments you wish to make about the proposed new legal framework for abortion services in Northern Ireland?

47. We are disappointed that the consultation has been framed in such a way that the term 'child' in a quotation from the Criminal Justice Act 1945 has been replaced with the term 'fetus'. This implies a bias towards a particular policy direction.

48. We are concerned that there is little within these policy proposals to protect and support women. For example there is no mention of non-directive counselling provision to ensure that women can make an 'informed choice'; neither is there provision for non-directive post-abortive counselling. A duty should be placed on the Department of Health to make provision for non-directive counselling. There are also no protections specified in relation to abortions accessed by coercion, and no mention of support for women to help them continue with a pregnancy and support and raise their children if they subsequently decide not to proceed with an abortion.

49. We are equally concerned that no separate consideration has been given to the particular needs of girls who are under the age of 18, and deemed to still be children in the eyes of other state providers, or of women and girls who lack capacity for decision making.

50. We are disappointed that the consultation does not address how a diagnosis of foetal abnormality is disclosed to a pregnant woman, nor specify the counselling and support required having received such a diagnosis.

51. Against the backdrop of the current, and increasing, extreme pressures on the NHS, we are concerned that this new legal framework for abortion services in Northern Ireland has the potential to place additional strain on a system that is at break-point. We are hugely concerned that the system will not be ready to implement these changes as required by 31 March 2020. There is no assessment of which services will be detrimentally affected to make room for these provisions. For example, the waiting list for gynaecology inpatient was over 5000 at the end of September 2019. It is likely that this new framework will have a negative impact on those waiting times.

Rev Daniel Kane (Convener of the Council for Public Affairs)

Rev Trevor D Gribben (Clerk of the General Assembly)