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THE CRIMINAL LAW ON ABORTION:

Lethal fetal abnormality and sexual crime

RESPONSE TO THE CONSULTATION

AND

POLICY PROPOSALS

April 2015

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INTRODUCTION

Background

1.1. This document has been produced in response to the Department's consultation on abortion law, which closed on 17 January 2015. It aims to provide readers with an overall summary of the responses received, along with a more detailed look at individual submissions from key interest groups and representative organisations and bodies. Finally, the paper aims to address the primary concerns raised and recommends a way forward. While we have made every effort to reflect faithfully the range of opinion provided, we could not record every point made by respondents.

Overall summary of responses

1.2. The following figures give an overview:

- there were **712** individually written responses. **579** of these opposed change, **133** supported change;
- there were **65** responses from representative organisations and interested groups. **47** of these supported change, **18** were against;
- there were **921** letters opposing change written in support of seven lobby campaigns which may have been organised by individual churches or faith groups;
- there were **23,622** petition signatures opposing change. The petition, called Project Love, was organised by Every Life Counts Ireland. It was made up of **18,000** postcards, delivered to the Department by Precious Life; a further **2,197** sent directly to the Department and **3,425** signatures to the electronic version of the petition on a website called CitizenGo.org.

Although it was not possible in all cases to confirm that the respondents lived in Northern Ireland, the above figures nevertheless include all responses.

Views expressed

1.3. The Department's consultation paper asked respondents to consider the case for changing the law by creating exceptions to the abortion offences in the Offences Against the Persons Act 1861, so that a woman who wished to terminate a pregnancy where a lethal fetal abnormality was diagnosed could make that decision and her medical practitioner could carry out the procedure without either of them being liable for criminal sanction.

1.4. The paper also asked for views on the inclusion of a right of conscientious objection for medical and nursing staff.

1.5. The responses spanned a range of opinion falling into five broad categories. These categories were:

Against any change

- The petition signatures, the various lobby campaign letters and over 500 of the individually written replies all fell within this group.

Qualified support for a change on lethal fetal abnormality

- Two of the churches were prepared to countenance a change to include lethal abnormality but only with judicial oversight of decisions, and where there was no feticide involved. Others *against change* also asked for this if the law should be changed.

Full support for a change on lethal fetal abnormality

- A number of groups, including a major proportion of the medical bodies, were in favour of the objective as set out in the consultation paper, albeit with some different views on the best method of achieving it.

Support for enhanced extension to include <u>serious</u> abnormality and rape and incest

- A number of other respondent organisations in support of change wanted to include cases of serious, not just fatal, abnormality and rape and incest.

Extension of the Abortion Act 1967 (the 1967 Act)

- Some political parties not in the Assembly argued for this option, along with Alliance for Choice and the NUS-USI.

Sexual Crime

1.6. The paper also asked for views on whether and, if so, how, the law should be changed to enable a similar decision and similar procedure in cases where a pregnancy was the result of sexual crime. However, the paper did not contain recommendations to change the law in this way, due largely to the complexities and potential difficulties in framing such a law. The intention was to seek views on the case for change and how any change might be accommodated. The response to the consultation did not provide sufficient detail as to how the law might be reformed or framed in this respect, so concrete proposals have not been possible at this stage. Many of the questions in part two of the consultation paper remain unresolved. There is, nevertheless, a summary of responses and part two conclusion in Chapter 9. Part one focuses solely on abortion in cases of fetal abnormality.

Criticisms of the consultation paper and process

1.7. In the responses there were a number of criticisms levelled at the Department about the content and style of the paper and the handling of the process. The Department would like to take this opportunity to respond to some of these criticisms.

Curtailing debate

1.8. Prime amongst those groups and individuals opposing change was the criticism that the Department tried, in the wording of the paper, to curtail debate and discussion on the wider issue of the protection of life before birth, the rights of the unborn child and the moral and ethical issues attached to this subject. The presentation of the paper was seen as portraying a biased position in favour of the woman and her right to choose. The Department's position was intended to be understood that, ***in the context of lethal fetal abnormality***, the law should not criminalise abortion in that limited context, that we also needed to examine the case for change regarding sexual crime, and that the desire was to ensure that responses were relevant to these limited sets of circumstances.

Excluding responses

1.9. Fears were also expressed that the Department would pick and choose responses to the consultation and ignore those it considered to be outwith the

specific proposals. This has not happened. All responses received have been included in the summary section at the start of this chapter.

Language

1.10. There were also criticisms expressed in relation to the language used and the terminology. The Department recognises the sensitivity of the subject and understands that there will be different views and perspectives on how to present such a sensitive issue. However it was interpreted, the intention was to use factually accurate terms with no emotive or subjective language.

Illustrative cases

1.11. A number of responses opposing any change to the law also criticised the use of a particular case, that of Sara Ewart, to illustrate the need for change. Such responses thought that it was inappropriate to make proposals for changing the law on the basis of one particular case, and others thought that there should have been examples given of cases where a woman had had a positive experience through carrying the pregnancy to term.

1.12. As the case of Sarah Ewart was already well known and in the public domain, it was included in the paper to illustrate the consequences faced by women who would wish to terminate a pregnancy in circumstances of lethal fetal abnormality. The proposal in the consultation paper is about a change to the criminal law to enable a woman to have an abortion in these limited circumstances. It does not in any way affect the rights of women who do not want to have this option. The proposal seeks to except from criminal sanction a small number of specific cases in defined circumstances. It seeks to enable, not to impose. It is in recognition that for some women, like Sara Ewart, there is a need to accommodate, in Northern Ireland, a different path.

Context

1.13. One further point is worth emphasising. The subject matter of this consultation is ***the criminal law alone***. It is not possible for the Department to make recommendations or proposals in relation to matters outside of its remit. As the subject of abortion also encompasses health issues, this is recognised as a

limitation. This was obvious from many of the responses that criticised the paper for not addressing abortion as a health matter and for seeming to ignore issues such as perinatal hospice care and the important provision of palliative care and treatment for babies born who may not survive. It is not that these issues are considered unimportant or irrelevant, simply that they are not matters which the Department of Justice has any authority to address and therefore cannot have a place in proposals for changing the criminal law. How the clinicians, doctors and nurses practice their duties in relation to any patient, including where a termination occurs, is a matter for the Department of Health, Social Services and Public Safety (DHSSPS), Health Trusts and professional bodies. It is not a matter that can be dealt with in the criminal law and is therefore outside the scope of this consultation.

Content of responses

1.14. The major issues raised by respondents were:

Against change:

- the proposed change for lethal abnormality gives no recognition to the rights of the unborn child;
- the right to life extends to the unborn child;
- there is an equal right to life for both mother and unborn child;
- there is always a possibility of misdiagnosis;
- doctors cannot predict with accuracy how long a baby will survive;
- such a change will lead to ‘abortion on demand’;
- there will be abuse of the legislation and the ‘lethal’ diagnosis will lead to incremental extension to include circumstances where the anomaly is not lethal;
- the rule that a diagnosis must be made by two doctors will not provide a sufficient safeguard as it has been shown not to be effective for decisions taken under the 1967 Act in the rest of the United Kingdom;
- abortion does not help the psychological effects of dealing with lethal fetal abnormality;
- there can be no consensus around which abnormalities are lethal – doctors would differ in their approach;

- there would be pressure put on women to have abortions where anomalies were diagnosed;
- such a change to the law would change the basis of abortion from 'indirect' (as a result of intervention to prevent risk to the life/health of the woman) to 'direct' (as a result of a condition of the fetus);
- there should be increased funding and emphasis on palliative perinatal care, counselling/neonatal intensive care;
- there could be an unequal impact on Catholic mothers who would be put under pressure to have abortions against their will and beliefs;
- if the law changed, there should be a judicial safeguard in legislation which would require every case to be referred to the High Court for permission to terminate a pregnancy in these circumstances;
- if the law changed, conscientious objection should extend to institutions rather than just individuals;
- if the law changed, the right of conscientious objection should be made available in respect of all participation except possibly post procedure nursing care.

In favour of change:

- the current law directly contravenes Article 3 of the European Convention on Human Rights (ECHR). This Article prohibits torture and inhuman and degrading treatment or punishment;
- abortion is not and should not be solely a justice issue. Abortion is a medical procedure and women's health is at risk when access to legal abortion is denied;
- the law should also have provision for abortion in cases of fetal abnormality which may not necessarily be lethal;
- women belonging to vulnerable and disadvantaged groups are required to access care through the public system and in practice '*disproportionately suffer the harms of the chilling effect brought on by criminalisation'*;
- women in Northern Ireland should have the same access to reproductive health care as women in the rest of the United Kingdom;

- punitive provisions imposed on women who undergo abortion should be removed;
- to force continued pregnancy under these circumstances would leave many women and young girls 'physical and mental wrecks';
- women who have to travel to England for a termination may need to bring their baby's remains back to Northern Ireland for burial or cremation, or even to have a post mortem examination carried out which may benefit them in a future pregnancy;
- some ethnic minority groups have an increased chance of carrying a fetus with a neural tube defect that includes fatal abnormalities such as anencephaly, hydranencephaly and iniencephaly;
- women facing a diagnosis of severe or lethal abnormality must be treated with the same compassion whether they elect to carry on with the pregnancy or they are so distraught that they feel unable to do so;
- women who can't afford to travel may purchase illegal abortifacient drugs via the internet and then are unwilling to disclose this fact to healthcare staff due to the threat of criminal sanctions being imposed. This can affect their healthcare;
- there should be a clear declaration that procurement of a termination under the circumstances of severe congenital abnormalities is a recognised part of good clinical practice, where the patient wishes;
- where a fetus is not expected to survive after delivery there are real risks posed to a patient's health if carried to term;
- termination of pregnancy should be able to be accessed in a local hospital, preferably at the hospital where the woman has commenced her antenatal care;
- the duty to report information about a crime as set out in section 5 of the Criminal Law Act (NI) 1967 needs to be addressed as a matter of urgency as nurses are being asked to breach patient confidentiality.

1.15. Part one looks in more detail at all of the arguments and views on abortion for fetal abnormality. Chapter 2 looks at the responses from the medical professional bodies and practitioners. Chapter 3 provides a detailed analysis of

responses from organisations and interest groups who wrote opposing change. Chapter 4 details the views from those bodies and groups in support of change. Chapter 5 gives an overview of responses from organisations to the specific consultation questions. Chapter 6 details the range of views put forward by individual respondents, both from those in favour of change and those against. Chapter 7 looks at the petition and lobby campaigns. Chapter 8 sets out how the policy on fetal abnormality has been developed in light of the responses and details the legislative proposals. Chapter 9 looks at the responses to part two of the consultation paper on pregnancy resulting from sexual crime. As already mentioned, sexual crime is covered separately because the consultation did not make proposals in this respect. Rather, it sought views on a particularly complex set of questions and the Department hopes it is helpful for the reader to see the responses grouped together.

Terminology and language

1.16. As a result of responses to the consultation paper, we have altered some of the terminology used in further developing the proposals. There was some discussion in responses about the most relevant word to use when describing a serious fetal abnormality which would be unlikely to sustain life for more than a short period outside the womb. The summary in this document will show that the term ‘fatal’ is used frequently, as is the term ‘lethal’. Our interpretation is that both words are synonymous and are defined as ‘causing or capable of causing death’ or ‘sufficient to cause death’. However, it appeared that the word ‘fatal’ may have been more widely used and the preferred term, so, as a result of this, we have changed the wording used in our policy proposals (see Chapter 8) from ‘lethal’ to ‘fatal’, although there is no change of substance associated with this revised term.

1.17. We have tried throughout the paper to ensure consistency of terminology, but recognise that this may not always be possible. We have also provided a glossary of terms as an annex to the paper which we hope will be of assistance to the reader. We have not, however, sought to define terms that have been used in individual responses.

PART ONE

LETHAL FETAL ABNORMALITY

CHAPTER 2

RESPONSES FROM ROYAL COLLEGES, HEALTH AND SOCIAL CARE TRUSTS AND MEDICAL ORGANISATIONS

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RESPONSES FROM ROYAL COLLEGES, HEALTH AND SOCIAL CARE TRUSTS AND MEDICAL ORGANISATIONS

Royal Colleges

The Northern Ireland Committee of the Royal College of Obstetricians and Gynaecologists (NICRCOG)

2.1. NICRCOG began its response by stating that the Royal College believe that women should have access to safe abortion services across the United Kingdom but it recognises the sensitivities involved and local resistance towards the law being extended to Northern Ireland.

2.2. NICRCOG summarises its overall position by saying that pregnant women facing a diagnosis of severe or lethal abnormality must be treated with the same compassion whether they elect to carry on with the pregnancy or they are so distraught that they feel unable to do so.

2.3. It also maintains that the latter group do not suffer from a psychiatric illness and therefore to suggest that they need psychiatric referral is both inappropriate and upsetting to them as it becomes a form of unjustified categorisation. It may however be in their best interests that they have a termination of pregnancy.

Fetal abnormality

2.4. NICRCOG believes that there are circumstances where the diagnosis of a severe or lethal abnormality may threaten a woman's mental health, seriously, adversely, for a long time and without her having a certifiable mental illness. It must be recognised first that these are wanted and often"planned pregnancies. While some mothers may cope with the diagnosis and carry on with the pregnancy, the diagnosis for others may be more than they can bear. NICRCOG believes that both these groups of women must be treated with humanity and compassion. At times, that may involve termination of the pregnancy.

2.5. NICRCOG submit that there are at present three, rather than two, options open to the woman pregnant with a baby with abnormalities as described in para. 4.19 and 4.20 of the consultation paper. As well as continuing with the pregnancy or travelling to England for a termination, the third is to have a termination in Northern Ireland on the basis of a mental health assessment. This was acknowledged by DHSSPS in its evidence to a Judicial Review in 2003, however it also said that DHSSPS was unable to give any advice or guidance which would assist a practitioner in deciding whether in a particular case it would be lawful for him to carry out the termination of a pregnancy. NICRCOG therefore believes that legislation to clarify further this area would remove the problems outlined in the last sentence and allow equity to all mothers across Northern Ireland.

Views on options in the consultation paper

Option 1

2.6. NICRCOG rule out option one as creating problems and leading to accusations of eugenics.

Option 2

2.7. This is also ruled out as it is not therefore possible to draw a line in relation to survival time.

Option 3

2.8. Option 3 is similar to the current law on what is ‘unlawful’ which is not defined and is open to interpretation in evolving circumstances which seems to match the apparently conservative, yet compassionate, situation in Northern Ireland.

Option 4

2.9. NICRCOG believes that the best way forward is to use a statutory definition, alongside the safeguard that the assessment should be made by two medical practitioners. The suggestion is that a person would not be guilty of an offence relating to abortion when a pregnancy is terminated if two registered medical practitioners are of the opinion, formed in good faith, that a fetal condition has been

assessed as lethal (sufficient to cause death) and that continuance of the pregnancy would be likely to have a detrimental effect on the health of the mother.

Conscientious objection

2.10. Given the limited circumstances in which abortion would be lawful, even with amendment as discussed, NICRCOG believes that those women who are having a termination of pregnancy in keeping with the law should be managed by a team in which there is no dissension. Any right of conscientious objection should apply only to the administration of abortifacients or the use of instruments and should exclude those occasions where there is a threat to the life of, or of grave permanent injury to the physical or mental health of, the woman. Following their administration the woman should be considered to be in the same situation as any other experiencing a miscarriage and thus there should be no further conscience related exception. It also concurs with the unanimous decision of the Supreme Court in the case of Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland) [2014] UKSC68 handed down 17 December 2014 (the Supreme Court judgment).

Other issues

2.11. NICRCOG is also concerned about the potential conflict between patient confidentiality and central recording of data. It should suffice that confirmation (a) of numbers of terminations of pregnancy, (b) that they were carried out in accord with the guidance and (c) under what aspect of the legislation (risk to life of mother, severe risk to physical or mental health of mother, in relation to lethal fetal abnormality) are returned centrally. Given the small numbers of terminations of pregnancy in Northern Ireland, it is not appropriate that any potentially identifiable information could ever be released into the public domain.

Royal College of Midwives (RCM)

2.12. RCM represents over 90% of practising midwives in Northern Ireland and has consulted widely with members in formulating its response. It welcomes the clear statement in the introduction that this consultation deals with the legal and clinical aspects of abortion and is not concerned with ethical or moral issues related to this subject.

2.13. It welcomes the recognition in paragraph 1.1 of the consultation paper that if a woman chooses to terminate a pregnancy on the basis of fetal abnormality she should be enabled to have the termination carried out in Northern Ireland rather than requiring to travel to England or elsewhere and pay for travel, accommodation and to have the procedure carried out privately.

2.14. It is concerned however that the proposed legislation is confined to the issue of 'lethal' fetal abnormality, and does not consider the possibility of abortion for cases of serious, but not immediately lethal, abnormalities. Given the advances in diagnostic techniques during the last decade, women are now able to be informed with a high degree of certainty of serious fetal abnormality when they present for an anomaly scan at approximately 20 weeks gestation. It is reasonable for women to assume that if there is something seriously wrong with the fetus then they will be offered the same options for care and treatment as those women living in Great Britain.

2.15. RCM points to the 'two tier' system whereby access to abortion in cases of serious fetal anomaly is available to those women who can pay for treatment elsewhere but not to women in poorer socio-economic circumstances.

2.16. RCM also points out that the situation is further complicated for those women who are forced to travel to England for a termination but wish to bring their baby's remains back to Northern Ireland for burial or cremation, or even to have a post mortem examination carried out which may benefit them in a future pregnancy. There are a number of women who choose to travel to Great Britain to have feticide carried out before returning to Northern Ireland to give birth to their baby.

2.17. RCM points out that case law in Northern Ireland has established that the 'right to life' of the pregnant woman has a wider interpretation than merely her existence – it provides for the termination of pregnancy where the woman may be left a 'physical or mental wreck' if she continues with a pregnancy and there is no legal obligation to afford the unborn fetus an equal right to life.

Views on options in the Consultation paper

2.18. RCM does not agree that any proposed legislative change should be restricted to cases of lethal fetal abnormality. In its view termination should also be available for those women with a diagnosis of serious fetal abnormality. RCM do not, therefore, support option 1 or option 2 as they are based on unsustainability of life.

2.19. RCM sees the proposal in option 3 to permit the attending physician to determine the limits within which a condition may be described as 'lethal' as more sympathetic to the needs of women carrying a fetus with a diagnosis of serious or lethal abnormality. It allows for a wider interpretation of what is to be considered 'lethal' i.e. whether a particular anomaly will be immediately lethal, or will lead to an early demise. RCM accepts that this may result in individual cases requiring a court ruling, however it is seen as the most acceptable of the options offered and is more likely to meet the needs of women requesting an abortion on the grounds of fetal anomaly.

2.20. Option 4 deals only with those conditions where the fetal condition has been assessed as being incompatible with life. It fails to address the issue of other congenital, degenerative conditions which mean that while not immediately lethal, the child will eventually succumb to an untreatable, life-limiting condition.

Conscientious objection

2.21. RCM welcomes the Supreme Court judgment that the right to conscientious objection extends only to those who are directly concerned in the provision of treatment to women undergoing abortion. The right of conscientious objection should be limited to direct participation in the process of abortion and all other care both before and after a termination of pregnancy should be exempt from any such right.

Other issues

2.22. RCM reports a growing concern about the threat to health and wellbeing of women, who, without access to abortion services in Northern Ireland, and without the financial means to travel to Great Britain to access safe, legal abortion services, are purchasing illegal abortifacient drugs via the internet. These women are often very

reluctant to disclose this fact to healthcare staff due to the threat of criminal sanctions being imposed. There is no mention in the consultation paper of any change in the legislation that will enable these women to feel that it is safe for them to provide this information to those caring for them, and it would be helpful if this issue were to be considered in taking the legislation forward.

Royal College of General Practitioners Northern Ireland (RCGPNI)

2.23. RCGPNI is the professional body for General Practitioners and has 1,361 members, 1,023 of whom are active. The College therefore represents approximately 80% of the GP workforce in Northern Ireland.

2.24. RCGPNI points out that in its response to the DHSSPS consultation on draft guidelines on abortion, it included advice on the risks posed to women carrying fetuses affected by anencephaly. It is the College's view that a woman carrying a fetus with a lethal abnormality such as anencephaly should be allowed to terminate their pregnancy, if they choose to do so. This recommendation is made on the basis that the fetus would not be expected to survive after delivery and the real risks posed to the patient's health if the fetus was carried to term.

Views on options in the consultation paper

2.25. RCGPNI supports the legalisation of abortion for lethal fetal abnormalities as some conditions contain risks for the patient's health if brought to full term. They give as an example, anencephalic pregnancies which have a higher incidence of polyhydramnios (increased liquor volume) which causes increased discomfort and incidence of preterm labour. They also point out that anencephalic fetuses are unable to fully flex their necks and thus have a higher rate of caesarean delivery. Caesarean deliveries have an inherent risk to the woman's health and impact on future pregnancies due to an increased risk of subsequent uterine rupture.

2.26. RCGPNI also stresses that it fully respects a woman's wishes and if women carrying a lethal fetal abnormality pregnancy desire to carry to term, full support should be given to the woman during this distressing time.

2.27. Of the options discussed in chapter 4 of the consultation paper, RCGPNI supports option 4 as being a clear and practical option. The College feels a

designated Northern Ireland centre would be helpful where this assessment could be carried out by suitably trained consultants.

2.28. RCGPNI feels that the proposals should mention genetic issues, such as Edwards' Syndrome, as the current proposals could be mistaken as providing undue emphasis on physical abnormalities.

Royal College of Nursing (RCN)

2.29. The RCN response is informed by the expert professional views and judgment of RCN members and staff in Northern Ireland, collated through an open member consultation meeting held on 12 December 2014 and via individual written submissions made by members. The response has been endorsed by the RCN Northern Ireland Board, the elected body responsible for the governance of the RCN in Northern Ireland.

Views on options in the consultation paper

2.30. RCN believes that, of the four available options set out in the consultation paper, option 3 offers the most effective resolution. However, RCN questions whether "lethal fetal abnormality" is the appropriate term to be used in this respect. It refers instead to the extract from the 2013 United Nations Convention on the Elimination of Discrimination Against Women (CEDAW) monitoring report of "serious malformation of the fetus" and that this phrase is echoed in the summary (paragraph 3.14 on page 23) of the views of the Northern Ireland Human Rights Commission (NIHRC). Although the submission doesn't say outright that this is the RCN's preferred terminology we are assuming that that is the case. RCN accepts that attempting to define in law that which is deemed to be "lethal" (or "serious") could be problematic. The key issue is that sufficient information must be made available to the woman and discussed openly with her in a non-judgmental manner, such as to enable her to reach her own informed decision and then to support her and advocate for her on the basis of the decision she has taken.

Conscientious objection

2.31. RCN believes that the framing of the legislation around this issue must make it clear that the right to conscientious objection exists solely in relation to the procedure(s) that constitutes the act of termination of pregnancy. The recent decision in the Supreme Court Judgment has reinforced this legal principle and RCN believes that it should apply equally in Northern Ireland.

Other issues

2.32. There is, however, one further related legal anomaly that RCN has raised concerning the statutory duty to report information about a crime as set out in section 5 of the Criminal Law Act (NI) 1967. The College says it needs to be addressed as a matter of urgency. Paragraph 2.7 (iii) of the most recent (2013) version of the DHSSPS draft guidance on termination of pregnancy states that: "*A person who has knowledge of the carrying out of a procedure which is not lawful in Northern Ireland and who has information which is likely to be of material assistance in securing the apprehension, prosecution, or conviction of any person in relation to that unlawful procedure is under a duty to give that information, within a reasonable time, to the police. If that person fails to do so without reasonable excuse, he or she may be liable, upon conviction to a maximum penalty of ten years imprisonment."*

2.33. RCN says in its submission that this statement is unacceptable. It means, for example, that a registered nurse attending a woman who has accessed medical termination drugs via the internet and then requires aftercare is expected to breach the fundamental principle of patient confidentiality. The duty of confidentiality also derives from common law and statute law. If the nurse declines to commit such a breach, she or he risks being jailed for up to ten years. RCN emphasises that this is a serious violation of the sanctity of the patient-client relationship that is at the very heart of health care. RCN cannot and will not allow its members to be subjected to such threats and be placed in such an impossible dilemma.

Royal College of Psychiatrists in Northern Ireland (RCPsych in NI)

2.34. The submission on behalf of RCPsych in NI acknowledges the complex and difficult issues and states that the opinions expressed will not represent the views of all members. The submission also states that the evidence base in relation to the psychological outcomes of termination of pregnancy is unclear and describes outcomes as ranging from none to severe.

Views on options in the consultation paper

2.35. RCPsych in NI notes that it is essential that the medical practitioners advising the mother of any prognosis of lethal abnormality are absolutely confident in their diagnosis and that they provide evidence based advice in relation to potential outcomes of decisions the mother will make.

2.36. RCPsych in NI notes that the process may be fraught with difficulty as there are problems with definition. This applies across all the options, including option 4. Assessment criteria could include fetuses which have the potential to survive. This could lead to unworkable legislation.

2.37. The terminology in paragraph 4.21 introduces ambiguity - in particular the use of the terms ‘substantial risk’ and ‘unlikely to survive birth’ and ‘unlikely to be capable of maintaining vital functions after birth’. A clearer definition of these terms would be helpful. The document makes no recommendation as to the expertise, seniority, independence or training of the two medical practitioners nor does it describe on what basis an assessment would be made in paragraph 4.22.

Conscientious objection

2.38. RCPsych in NI says there is a clear duty to act in an emergency to save life. However it is important that the right of staff to conscientious objection to participating in abortion is upheld in the instances of lethal fetal abnormality where there is no immediate risk to the life of the mother. There should therefore be no coercion or obligation for any professional to participate in the process directly. However all staff should continue to be involved, irrespective of conscientious objection, in the other aspects of the woman’s care including the management of physical and mental health conditions, both before and after a termination.

Health and Social Care Trusts

The Consultants in Maternal and Fetal Medicine, Department of Fetal Medicine, Royal Jubilee Maternity Service, Royal Group of Hospitals, Belfast

2.39. The consultants welcome this consultation and the clarity that the proposed legislation would provide in the area of lethal fetal abnormality. They emphasise that in everyday practice they care for pregnant women where the fetus has been diagnosed as having a lethal abnormality. This is an exceedingly difficult time for parents who are distressed and are in grief.

2.40. Their submission states that making a diagnosis of lethal abnormality is often straightforward and quickly determined by ultrasound and give examples such as in the case of complete posterior urethral valve obstruction. They say that at other times it will be strongly suspected at ultrasound and subsequently confirmed following investigations and an abnormal result, for example in the case of Trisomy 13.

2.41. They also describe more complex cases where other members of a multidisciplinary team (such as medical geneticists, radiology) may be necessary in helping to make a diagnosis, for example in the case of lethal skeletal dysplasia, or rare genetic conditions which are considered to be incompatible with survival. The diagnosis will sometimes only be made following the results of further more detailed investigations, such as genetic tests including microarrays.

2.42. Also, they point out that within the fetal medicine department and as a point of good medical practice, patients are seen by two different medical practitioners and on two separate occasions.

2.43. A well-established multidisciplinary team (fetal medicine specialists, medical genetics, neonatology, paediatric surgery, other paediatric specialities including neurosurgery, fetal cardiology, radiology including fetal MRI and midwifery) works together to give parents detailed information, provide counselling and to support these women through their pregnancy and delivery.

2.44. They also report that occasionally an earlier delivery prior to term is indicated to facilitate delivery and to reduce maternal morbidity. They give examples of hydranencephaly or large fetal tumours– where the dimensions of the affected area become so large that it makes delivery by Caesarean section difficult. Additional surgical incisions into the uterine wall are frequently required to deliver the baby and this confers an increased risk in any future pregnancy, including that of uterine rupture.

View on options in the consultation paper

2.45. The consultants believe that option 1 is not practical as it would be impossible to provide a list of all possible lethal abnormalities.

2.46. Option 2 would lead to inequitable decisions being taken. For example, different fetuses with the same abnormality (which is considered to be lethal) may die at different times. For some, the fetus may die in utero. For others, the fetus may die during labour but prior to delivery. For others, the baby may die within the first few minutes of birth or the first hour of birth. Irrespective of the time of demise, the underlying lethal abnormality is the same. Compassion and palliative care are the cornerstones of treatment for these infants, until they succumb.

2.47. The consultants do not feel that option 3 would provide enough clarity and would lead to further uncertainty and distress for pregnant women where a lethal abnormality has been diagnosed.

2.48. The consultants believe that the best way forward is option 4. In defining lethal, they suggest the following - that a fetal condition has been assessed by medical practitioners as being lethal (or incompatible with life), where a clinical judgment has been made during the pregnancy that there will be no intervention performed routinely after birth. They agree that the assessment should be made by two medical practitioners. They propose that a person would not be guilty of an offence relating to abortion when a pregnancy is terminated if two registered medical practitioners are of the opinion, formed in good faith, that a fetal condition has been assessed as lethal and that continuance of the pregnancy would be likely to have a detrimental effect on the health of the mother.

Conscientious objection

2.49. The consultants believe that the right of conscientious objection should apply only to the administration of abortifacients or the use of instruments and not to other aspects of the woman's care. They concur with the recent Supreme Court Judgment.

Clinical Director, Belfast Trust

2.50. A Clinical Director for Obstetrics & Gynaecology, Neonatology, GUM and Sexual & Reproductive Health introduces his personal submission (not on behalf of the Trust) by stating that there is a need to make thoughtful and well planned legislative changes within this area to achieve a position which offers support to women and families during an extremely difficult circumstance. "For those who have had experience of supporting parents through very difficult situations where the law as it applies in Northern Ireland was extremely unhelpful."

Views on options in the consultation paper

2.51. Option 4 is seen as providing the most pragmatic position. Current diagnostic tools allow for identification of lethal conditions. Decisions could also be supported by a multidisciplinary approach by experts to make a clear determination that no intervention can be offered after birth to improve chances of survival.

2.52. Judgments taken by two medical practitioners is the only sensible and practical approach.

Conscientious objection

2.53. Healthcare professionals should have a right to object, however, this right should not be absolute in that, where there is a risk to the life of the mother then the woman's right to life takes precedence over the right of a health care professional to exercise a conscientious objection to participation in abortion.

Consultant and Clinical Lead for Genetic Medicine, Clinical Director, Surgical & Specialised Services, Belfast Health & Social Care Trust

2.54. This Clinical Geneticist routinely sees individuals and families affected by genetic disorders, and discussions with these families frequently touch upon issues of reproductive risk, i.e. the risks of children being born with serious and often fatal abnormalities.

2.55. As part of the United Kingdom Clinical Genetics community, the professional advice given in these circumstances reflects best practice in this area, and it is the opinion of this specialist that the legal framework in Northern Ireland is ‘woefully inadequate’ in dealing with serious genetic and congenital abnormalities.

2.56. Prenatal diagnostic techniques have improved immeasurably since the 1967 Act, and the rate of progress has become even faster in recent years with the advent of Next Generation Sequencing and other modalities that allow for identification of many serious genetic abnormalities during pregnancy.

2.57. The consultant highlights that many couples at risk of having a baby with a serious genetic disorder undertake pregnancies that are very much wanted, yet the prospect of having a child with a similar condition to their previous affected child, or to affected children in their wider family, fills them with dread. It is his opinion and that of the vast majority of his colleagues in Genetics and Obstetrics that prenatal diagnosis and termination of affected pregnancies should be available to these families without the need to travel to England. He stresses that this is not "abortion on demand", nor is it devaluing the lives of disabled people - families live in the real world, and a legal system needs to protect professionals and especially families and patients in very trying circumstances.

2.58. The clinician recommends a clear declaration that procurement of a termination under the circumstances of severe congenital abnormalities is a recognised part of good clinical practice, where the patient wishes.

2.59. The definition of lethal should be exactly the same as Lord Justice Girvan interpreted the law in relation to the Bourne Judgment: either it will definitely/very likely cause death, or there is a risk of real and serious adverse effect on physical or

mental health, which is either long term or permanent. This would seem to be in the spirit of the existing law.

2.60. The best way is to allow clinical judgment to decide when a fetus is not compatible with life. This cannot be down to a list which cannot keep pace with clinical advances or with changes in prenatal screening policy.

Conscientious objection

2.61. There should be a right to conscientious objection but this must be coupled with a duty imposed upon HSC Trusts that offer obstetric services that the service (including counselling) can be supplied in a timely manner without further imposition on the woman. If this cannot be guaranteed at a Trust level, it must be guaranteed at a Northern Ireland level. There should be no opt-out clause for routine good clinical care. Pre and post procedural care should NOT be included in a conscientious objection clause. These are aspects of normal clinical care and should be offered to everyone. The right must be restricted to the procedure itself.

South Eastern Heath and Social Care Trust

2.62. The Trust response represents the voice of medical, midwifery, nursing and other professional teams who have informed this response.

Views on options in the consultation paper

2.63. The Trust considers that options 1 and 2 are not feasible and the amendments to the legislation from these options would be undermined and unworkable. Option 3 has the potential to cause ambiguity which may result in delay and uncertainty for women.

2.64. The Trust agrees with the principle outlined in option 4. However, the word 'survival' must be defined and clarified as it may be open to interpretation.

2.65. The Trust says that it supports women on a weekly basis carrying a fetus with a lethal abnormality and is committed to providing that support to women who wish to continue with their pregnancy. Its obstetric, midwifery, paediatric and neonatal teams have developed supportive services to provide this care and treatment. The Trust is, however, also concerned for the women who do not wish to carry forward a

pregnancy in the case of a lethal fetal abnormality. This is a much needed change to the law for this small number of women.

Northern Ireland Committee of the Faculty Of Sexual And Reproductive Health Care, Western Health and Social Care Trust

2.66. The Committee stressed the importance of ensuring that any process to decide what is a "lethal anomaly" should both support doctors to act in their patients' best interests and also be able to make the decision in a timely manner to avoid additional unnecessary distress for the parents through a prolonged process. The termination of pregnancy should be able to be accessed in a local hospital within Northern Ireland certainly, preferably at the hospital where the woman has commenced her antenatal care.

2.67. No time limit should be set on how long the fetus could be expected to survive post-delivery. Many cases will be straightforward and a clinical decision not difficult: in these cases a single clinician should be able to make the diagnosis. There may be other cases where the clinician looking after the woman would like to seek advice from their colleagues. In these circumstances an expert panel consisting of the consultant in fetal medicine, a geneticist, a paediatric metabolic consultant and any other clinician deemed appropriate for the case should be able to assess the request quickly, preferably within a 48-72 hour window, and give an opinion as to whether termination is a reasonable option.

Northern Health and Social Care Trust

2.68. The Trust notes that obstetricians, midwives and nurses will welcome clear and unambiguous guidance that assists practitioners in providing women and their families with the appropriate support and guidance to deal with what is often a very difficult and traumatic time in their lives. Recent high profile cases reported in the media have highlighted the difficulties surrounding clinical decision making in the absence of clear guidance.

2.69. The Trust states the importance of recognising that if a woman chooses to terminate a pregnancy on the basis of fetal abnormality she should be enabled to have the termination carried out in Northern Ireland. The current situation of women

being required to travel to England or elsewhere is not conducive to her health and well-being.

Views on options in the consultation paper

2.70. The Trust states that advances in diagnostic medicine and antenatal screening for women means that they are now informed with a high degree of certainty of serious fetal abnormality when they present for an anomaly scan at either their maternity unit or the regional fetal medicine unit.

2.71. The Trust states that women should be seen by experts in the field of fetal medicine and, following diagnosis, two medical practitioners should determine whether the diagnosis meets the requirements of the legislation for termination.

2.72. The Trust is supportive of option 4 which would allow for lawful termination of pregnancy in cases where a fetal condition has been assessed by medical practitioners as being incompatible with life, and a clinical judgment is made during pregnancy that there will be no intervention after birth, because no treatment can be offered to improve the chances of survival.

Medical Organisations

The British Medical Association Northern Ireland (BMA NI)

2.73. BMA NI is both a professional association and a trade union which represents the medical profession in Northern Ireland across all branches of practice. The BMA has155,000 members world-wide, and 75% of doctors and medical students in Northern Ireland are members. BMA NI believes abortion legislation in Northern Ireland is a matter for the public and the politicians of Northern Ireland and not for the medical profession to decide upon.

Views on options in the consultation paper

2.74. BMA NI supports the recommendation of option 4, that lethal fetal abnormality should be “based on clinical judgment”. This should be supported by clear clinical pathways.

2.75. The following should be taken into account:

- many fetal abnormalities will be identified at the first and second routine ultrasound scan. In some cases it will not be known until after the second routine scan that there is a fetal abnormality; the condition of the fetus may deteriorate; or there may be a late diagnosis of a maternal infection that is known to cause fetal abnormalities. Even when tests are available earlier in pregnancy, some women do not present for antenatal care until late in their pregnancy, delaying the timing of diagnosis. There may also be technical difficulties with a scan, for example because of the positioning of the fetus that requires a repeat scan later on; and
- after a diagnosis has been made, women should be given time to understand the nature and severity of the fetal abnormality, and should be offered specialised counselling where appropriate.

General Medical Council (GMC)

2.76. GMC felt that the differences between the four options were somewhat blurred: all the options would rely on a degree of clinical judgment; and the distinction between a fetus having ‘a lethal abnormality’ and being ‘incompatible with life’ was unclear.

2.77. Its concern about option 4 is around the assessment that a condition is ‘incompatible with life because no treatment can be offered to improve the chances of survival’. The GMC points out that, if the chance of survival could be improved from ‘nil’ to 5% with treatment, that would increase the risk that different medical practitioners might reach different conclusions.
It suggests the following formulation:

- if ‘lethal’ and ‘incompatible with life’ are seen by Northern Ireland healthcare practitioners as having the same meaning, perhaps the Act could use the phrase which is most widely used and provide a definition;
- a definition will be necessary whichever term is used; a condition may not be incompatible with life of any kind, but certainly incompatible with continuing life – ie more than a few minutes, hours or even days of life – and it will be necessary to make this distinction in order for the law to be clear;

- the Act could include examples of those lethal abnormalities that would qualify for an exemption from the criminal law, but not attempt to provide an exhaustive list (eg 'Lethal fetal abnormality includes, but is not limited to, anencephaly, xxxx, …');
- two medical practitioners must agree that the condition in an individual case can be considered to be lethal (or incompatible with life, whichever term is decided on).

2.78. If such an approach were attractive, GMC suggests that the Department might want to explore whether it could be supported by national guidance from the Royal Colleges of Obstetricians and Gynaecologists, and Paediatrics and Child Health.

2.79. To define a 'lethal fetal abnormality' in legislation in terms of what would be judged by a doctor to be in the child's best interests if that child were to be born might cause confusion. However, if this approach is taken, GMC wonders if it may be helpful to consider its guidance for doctors on end of life care for neonates, where it says the following:
'*If, when considering the benefits, burdens and risks of treatment (including resuscitation and clinically assisted nutrition and hydration) you conclude that, although providing treatment would be likely to prolong life, it would cause pain, or other burdens that would outweigh any benefits and you reach a consensus with the child's parents and healthcare team that it would be in the child's best interests to withdraw, or not start the treatment, you may do so*.'

Conscientious objection

2.80. The scope of conscientious objection is not specifically addressed in GMC guidance on personal beliefs and medical practice. However, it does expect doctors who have a conscientious objection to a procedure requested by their patient (and to which that patient is entitled) to comply with certain guidance in the best interest of the patient.

British Association for Counselling and Psychotherapy (BACP)

2.81 BACP would strongly advise that if there is a change in law to allow women to choose to have a termination in the circumstances where a fetal condition has been assessed as being incompatible with life, due regard must be made to the emotional and psychological impact that making such a decision might have on the woman and her partner/family. It is imperative that all women considering a termination in such circumstances should be offered counselling by trained and qualified therapists belonging to a professional body such as BACP. Providing good pre and post abortion counselling is a preventative measure and cost-effective, as dealing with issues of grief, bereavement and loss may prevent the onset of post-abortion depression.

CHAPTER 3

RESPONSES FROM ORGANISATIONS AND INTEREST GROUPS OPPOSING CHANGE

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Introduction

3.1. Ten representative churches and faith groups, six pro-life groups and two political parties wrote in opposition to any change to the law on abortion. All argued that the right to life of the unborn child would be removed by any proposal to change the law to allow for abortion in cases of fatal fetal abnormality. Summaries of their responses are set out in this chapter.

Church and faith groups

The Caleb Foundation

3.2. The Caleb Foundation introduces itself as an umbrella lobby group which seeks to reflect and articulate the views of mainstream evangelical Christians in Northern Ireland. In its view no change should be made to liberalize the existing laws.

3.3. In its response, it says that there should be no change to the current law on abortion. It suggests that there is always a possibility of misdiagnosis. Doctors cannot predict with accuracy how long a baby will survive.

3.4. It notes anecdotal information set out by a report produced by www.anencephalie-info.org/index.php in which parents reported their experience of anencephaly babies. This described the experience of parents as showing that:

7% died in utero.

18% died during birth.

26% lived between 1 and 60 minutes.

27% lived between 1 and 24 hours.

17% lived between 1 and 5 days.

5% lived 6 or more days.

3.5. Caleb also does not accept the assertion that 'lethal fetal abnormality' is incompatible with life. The fetus is already alive. In particular, option 4 in the consultation paper gives no legal definition of 'incompatibility with life' that lies at the heart of the proposals. It leaves the entire life and death of an unborn baby in the hands of doctors and entirely subject to what may well be a faulty prognosis. The Foundation also states that it is very sad that the consultation paper takes a line which virtually robs the child of any rights.

Conscientious objection

3.6. No change should be made to liberalize the existing laws. The Foundation believes that, when it comes to the provision of publicly funded services, the right for conscientious objection across government ought to be upheld and would propose it as a much wider principle than the narrow issue of abortion. For that reason it is proposed that one change that ought to be considered is to allow for the right of conscientious objection within the existing provisions.

Catholic Bishops of Northern Ireland

3.7. The Catholic Bishops say that such a change fails to give any consideration to the right to life of the unborn child.

3.8. The Catholic Bishops emphasise that it has always been the teaching of the Catholic Church that the lives of both a mother and her unborn child are sacred by virtue of their common humanity and therefore require equal protection under the law. Their submission states that the direct and intentional termination of an unborn child denies the humanity and inherent dignity of that child in the womb and violates the most basic human right of all, the right to life, whether or not the child has a life limiting condition.

3.9. A law that authorises the direct and intentional killing of an unborn child, regardless of his or her medical condition or the circumstances of his or her conception, is completely lacking in any authentic juridical validity and therefore possesses no morally binding force.

3.10. The Catholic Bishops see the proposed outcome to be a deliberate attempt to remove from unborn children with a life-limiting condition the protection that they

currently possess under the law. They state unequivocally that it is wholly unacceptable to attempt to decriminalise a direct and intentional act aimed at terminating the life of an unborn child on the grounds that the child's lifespan is limited by a serious medical condition such that the child will not, if born, survive.

3.11. Instead of changing the law on abortion, there should be increased funding and emphasis on palliative perinatal care, counselling/neonatal intensive care.

3.12. Also, a full Equality Impact Assessment is needed to assess the impact on Catholic mothers who would be put under pressure to have abortions.

Conscientious objection

3.13. If the law was to change, conscientious objection should extend to institutions rather than just individuals.

Christian Action Research and Education (CARE) in Northern Ireland

3.14. CARE in Northern Ireland opposes introducing new legislation to allow for lawful termination of pregnancy in cases where a fetal condition has been assessed by medical practitioners as being incompatible with life, because of both practical and ethical concerns.

3.15. The reasons for this were as follows:

- there is always a possibility of misdiagnosis. Doctors cannot predict with accuracy how long a baby will survive;
- a diagnosis of lethal abnormality is subjective and unreliable. It will be impossible to review and enforce in law;
- there will be abuse of the legislation and the 'lethal' diagnosis will lead to incremental extension to include circumstances where the anomaly is not lethal. The rule that a diagnosis must be made by two doctors will not provide a sufficient safeguard as it has been shown not to be effective for decisions taken under the 1967 Act in the rest of the United Kingdom;
- the Department is using 'hard cases' to make 'bad law', and there are no examples of positive experiences where women have given birth in circumstances of lethal fetal abnormality;

- there is no evidence that abortion helps psychological effects of dealing with lethal fetal abnormality;
- there can be no consensus around which abnormalities are lethal – doctors would differ in their approach;
- there would be pressure put on women to have abortions where anomalies were diagnosed;
- there should be increased funding and emphasis on palliative perinatal care, counselling/neonatal intensive care.

Conscientious objection

3.16. CARE said that there should be no change to the law on abortion in Northern Ireland but in those incidents where abortions are conducted under the current law the conscientious objections of all medical staff should be respected.

Christian Concern and the Christian Legal Centre (Christian Concern)

3.17 Christian Concern does not agree that the law in Northern Ireland should be changed to permit abortion on the grounds of lethal fetal abnormality, or in the event of rape and other sexual crime. It supports the balanced approach of the current law which provides robust and strong protections for the life, well-being and health of both the mother and the unborn child. The reasons given were:

- in relation to lethal fetal abnormality, there is always a possibility of misdiagnosis. Doctors cannot predict with accuracy how long a baby will survive;
- there is also the likelihood of abuse of the legislation and the 'lethal' diagnosis will lead to incremental extension to include circumstances where the anomaly is not lethal;
- the rule that a diagnosis must be made by two doctors will not provide a sufficient safeguard as it has been shown not to be effective for decisions taken under the 1967 Act in the rest of the United Kingdom;
- the Department is using 'hard cases' to make 'bad law';
- there are no examples of positive experiences where women have given birth in circumstances of lethal fetal abnormality;

- there is no evidence that abortion helps psychological effects of dealing with lethal fetal abnormality;
- such a change to the law would change the basis of abortion from 'indirect' (as a result of intervention to prevent risk to the life/health of the woman) to 'direct' (as a result of a condition of the fetus);
- there should be increased funding and emphasis on palliative perinatal care, counselling/neonatal intensive care.

Conscientious objection

3.18. If the law was to change, the right of conscientious objection should be made available in respect of all participation except post procedure nursing care.

Christian Medical Fellowship (CMF)

3.19. CMF does not support a change in the law in Northern Ireland to permit the abortion of those with fetal abnormalities incompatible with life. The reasons given mirror those of CARE in Northern Ireland and Christian Concern. These were:

- there is always a possibility of misdiagnosis. Doctors cannot predict with accuracy how long a baby will survive. A diagnosis of lethal abnormality is subjective and unreliable;
- it will be impossible to review and enforce in law. The phrase "unlikely to be capable of maintaining vital functions"' is particularly open to a breadth of interpretation. There are many congenital conditions that could fit this description but that are eminently treatable;
- there will be abuse of the legislation and the 'lethal' diagnosis will lead to incremental extension to include circumstances where the anomaly is not lethal. The rule that a diagnosis must be made by two doctors will not provide a sufficient safeguard as it has been shown not to be effective for decisions taken under the 1967 Act in the rest of the United Kingdom.
- the Parliamentary Inquiry into Abortion for Disability 2013 found a strong presumption from doctors in England, Scotland and Wales that parents with disabled babies would choose to have them aborted. This leads to subtle or more direct pressure being placed on parents who were either unsure or did not want to have an abortion;

- there is no evidence that abortion helps psychological effects of dealing with lethal fetal abnormality;
- there would be pressure put on women to have abortions where anomalies were diagnosed;
- there should be increased funding and emphasis on palliative perinatal care, counselling/neonatal intensive care.

Conscientious objection

3.20. CMF is not in favour of any changes to the existing law in NI. Where abortions are carried out under the terms of the existing law, it believes that there should be provision to respect conscientious objection for all clinical staff engaged at any stage of the process, as per the General Medical Council guidelines.

Evangelical Alliance Northern Ireland

3.21. Evangelical Alliance does not support the proposed changes to the law on abortion in Northern Ireland in the case of lethal fetal abnormality. Evangelical Alliance advocates for the life and dignity of each woman and unborn child. The current law is unique to Northern Ireland and strikes a delicate balance between protecting the life and wellbeing of the mother and her unborn child.

3.22. Evangelical Alliance's position of not supporting a change in the law is based on a theological, ethical, legal and medical understanding of what is being proposed. Instead it would support clarification of the existing law through guidelines and improvement in pregnancy crisis care.

3.23. In terms of the proposal, it stated:

- there is always a possibility of misdiagnosis. Doctors cannot predict with accuracy how long a baby will survive;
- the Department is using 'hard cases' to make 'bad law'; there are no examples of positive experiences where women have given birth in circumstances of lethal fetal abnormality;
- there is no evidence that abortion helps the psychological effects of dealing with lethal fetal abnormality;

- such a change to the law would change the basis of abortion from ‘indirect’ (as a result of intervention to prevent risk to the life/health of the woman) to ‘direct’ (as a result of a condition of the fetus).
- if the law was to change, there should be a judicial safeguard in legislation which would require every case to be referred to the High Court for permission to terminate a pregnancy in these circumstances.

Conscientious objection

3.24. If the law was to change, the right of conscientious objection should be made available in respect of all participation except post procedure nursing care.

Fellowship of Independent Methodist Churches in Northern Ireland

3.25. The Fellowship of Independent Methodist Churches believes that life begins at conception and there is no medical, scientific or biblical evidence to suggest that such a life is anything less than human life. The following points were made:

- there is always a possibility of misdiagnosis. Doctors cannot predict with accuracy how long a baby will survive;
- the consultation paper does not define lethal fetal abnormality or who the practitioners should be. Should they have particular expertise, training or qualifications? Will a post mortem be carried out on these babies to confirm the diagnosis?
- the Department is using ‘hard cases’ to make ‘bad law’; there are no examples of positive experiences where women have given birth in circumstances of lethal fetal abnormality;
- there would be pressure put on women to have abortions where anomalies were diagnosed;
- there should be increased funding and emphasis on palliative perinatal care, counselling/neonatal intensive care.

Conscientious objection

3.26. In all cases of moral and ethical legislation there should be the right of conscientious objection to cover all associated procedures and duties. A person should have the right to practice according to their conscience or faith.

Free Presbyterian Church of Ulster

3.27. The Free Presbyterian Church as a church body seeks to adhere to the teaching of Scripture as found in the Ten Commandments on the preservation of life from the time of conception until natural death. Similar arguments were made:

- there is always a possibility of misdiagnosis. Doctors cannot predict with accuracy how long a baby will survive. The Church states that '*in the consultation there is the desire to murder the unborn children upon the basis of a judgment made by two medical practitioners who have a very real chance of getting it wrong'*;
- there will be abuse of the legislation and the 'lethal' diagnosis will lead to incremental extension to include circumstances where the anomaly is not lethal. The rule that a diagnosis must be made by two doctors will not provide a sufficient safeguard as it has been shown not to be effective for decisions taken under the 1967 Act in the rest of the United Kingdom;
- the Department is using 'hard cases' to make 'bad law', and not giving examples of positive experiences where women have given birth in circumstances of lethal fetal abnormality;
- the pregnant women carrying a child with a *"fatal fetal abnormality"* will be pushed into having an abortion without adequate advice and time being given. Abortion is portrayed as a quick-fix solution. However, abortion for many has left them suffering from depression and a sense of guilt that they may never get over.

Conscientious objection

3.28. The Church does not support a change to the law. However in the case that abortion is legislated for in these circumstances it is vital that a statutory conscientious objection clause is introduced.

Presbyterian Church in Ireland

3.29. In the view of the Presbyterian Church in Ireland, the criminal law should not be changed to allow for abortion in cases of lethal fetal abnormality, because it regards the right to life itself as of higher importance than any rights of personal choice.

3.30. In offering its response, the Church points out that it is also very conscious of the crucial role of the DHSSPS in providing the necessary guidelines for the medical profession in these matters, and is greatly concerned that these have not yet been agreed.

3.31. A diagnosis of lethal abnormality is subjective and unreliable. It will be impossible to review and enforce in law. The definition of 'lethal' is difficult, and clinical judgment on this condition by (as yet) unspecified medical practitioners would be an inadequate legal basis if the law were to be changed.

3.32. If the law was to change, there should be a judicial safeguard in legislation which would require every case to be referred to the High Court for permission to terminate a pregnancy in these circumstances. This would give added protection to the medical practitioners involved, as well as giving added public assurance that the law was being strictly followed.

3.33. The Church would also would regard it as very unwise for any new legislation to be introduced without full public assurance from DHSSPS and the relevant health authorities that the best possible perinatal and postnatal care would be made available to the mother, whatever her decision.

Conscientious objection

3.34. Should the law be changed to permit abortion in any of the circumstances outlined in the consultation paper, the church would be very greatly concerned if the right of conscientious objection for anyone involved was to be limited or dis-allowed.

Reformed Presbyterian Church of Ireland

3.35. The Reformed Presbyterian Church of Ireland says that, within its world view, the question of the legality of abortion in cases of lethal fetal abnormality is a non-starter, and that God determines the days and circumstances of our lives. They make the following points:

- there have been instances in which medical diagnoses of lethal fetal abnormalities have been wrong and healthy children have been born. Aborting children in such instances would be analogous to miscarriages of justice leading to the execution of the death penalty on innocent parties;
- the church would be deeply concerned if "lethal" and "incompatible with life" were defined in ways that encouraged the inference that "*life for a short period post-partum is not valid life worthy of legal protection"*;
- there will be abuse of the legislation and the 'lethal' diagnosis will lead to incremental extension to include circumstances where the anomaly is not lethal. The rule that a diagnosis must be made by two doctors will not provide a sufficient safeguard as it has been shown not to be effective for decisions taken under the 1967 Act in the rest of the United Kingdom.

3.36. The Church does not support any of the four definitions of lethal fetal abnormality contained in the consultation paper. In particular, it considers that option 4 merely fudges the issue of what constitutes lethal fetal abnormality.

Conscientious objection

3.37. The Church does not agree that the law should be changed to allow abortion in respect of lethal fetal abnormality. However, if there were such a change made to the law then it would want a right of conscientious objection as described in question 17. The law should never compel people to act against conscience on matters as profound as the ending of human life.

Pro-life groups

Choose Life Ministry

3.38. Choose Life Ministry is a '*life affirming, educational ministry which seeks to educate, equip and enable the Evangelical Church in particular, the wider society as a whole, on the complex subject of abortion. We have been established since 2006. Our aim is to help Churches reach out to those in our community who have been affected by a past abortion experience.*'

3.39. Choose Life puts forward the following points in relation to abortion for lethal fetal abnormalities:-

- doctors can be wrong in their diagnosis;
- no-one can predict how long a baby will live after birth;
- post abortion trauma is greatly compounded in women who have aborted for fetal abnormality;
- in carrying on with the pregnancy, women who have parented children with life limiting conditions are without regret;
- grieving is a natural process once the child is born. With abortion, it is a completely abnormal grief - a forbidden and disenfranchised grief;
- women protect themselves from the long term detrimental effects of post abortion trauma, (which are psychological, physical, emotional and spiritual) by carrying on with the pregnancy;
- there are extensive resources out there to advise parents on many fetal abnormalities including anencephaly and how to proceed with the birth and subsequent funeral;
- counselling and support is very important;
- women have said that medical staff who dealt with their perinatal hospice care, empowered them as women. Instead of feeling that their child was a monster and they as a woman were a burden, they made them feel special and loved;
- no matter the reason for the abortion, women are still damaged by it;
- it is not the travelling to England or elsewhere that is the trauma in abortion - it is the abortion itself;

- using dehumanising language about the pre born child is not appropriate. Women find it offensive;
- women will not choose abortion when they are given time to think and love and support.

Every Life Counts (ELC)

3.40. ELC describes itself as '*a support network for parents whose children were diagnosed with a severe or sometimes fatal condition while in the womb. We are working to make better support and care available throughout Ireland, North and South and to ensure every child has a right to life, however short that life is*.'

3.41. ELC believes that:

- perinatal hospice and palliative care should be offered to parents who find out during pregnancy that their baby has a life-limiting condition. Support should be made available to families and incorporated into standard pregnancy and birth care, and be made available in maternity hospitals and units in Northern Ireland. In practical terms, perinatal hospice care requires that obstetricians, nurses, chaplains, neonatologists, social workers, bereavement counsellors and even photographers work together to ensure that parents are given the gift of time with their children;
- parents need real information and not '*the dreadful mis-information that is currently being given to parents and to the public regarding life-limiting conditions. For example, parents are told their baby is 'incompatible with life' - which is a judgement and not a medical opinion. They are told that abortion is a better option because the baby will not make it until birth, and will suffer after birth*.';
- the most common conditions can have survival rates much longer than expected;
- whatever the condition, the time parents can have with their children is hugely rewarding and tremendously important for healing. In contrast, research suggests that substantial numbers of women who undergo abortion in these circumstances suffer post-traumatic stress.

3.42. In conclusion, ELC submits that there must be better provision of perinatal hospice care in every hospital in Northern Ireland; and that instead of a change in the law on abortion there should be a change in the services provided.

Life Northern Ireland (Life NI)

3.43. Life NI introduces itself as an organisation that has existed in Northern Ireland for over 30 years, its main objective being to provide care and support and counselling for those facing unexpected pregnancy or needing help during pregnancy or after having a baby. The organisation believes in the sanctity of life from conception, which leads to respect and care being afforded at every stage in life. It also offers counselling for those women or family members who need assistance or counselling following an abortion.

3.44. Life NI is opposed to any change in the law which would enable a life to be ended on the basis of any of the four options in the consultation paper.

3.45. Life NI says that the term "incompatible with life" is an inappropriate and loaded term to use. It proposes an alternative approach to changing the law on abortion. It seeks to *'change the mindset of the medical profession when faced with such dilemmas. Instead of approaching the situation from an entirely hopeless viewpoint captured by the epithet "incompatible with life", a caring and empathetic approach to the parents, especially the mother, to value whatever time is left to her with her baby and to offer her every medical care available during that time. This is the model offered by peri-natal hospice care and is one which puts mother and baby at the forefront, rather than seeing disposal of the baby as the optimum solution. It is a solution which values the mental health of the mother by allowing nature to take its course and ensures that no regrets are stored up for the future.'*

3.46. Life NI believes that many women who are faced with a diagnosis that their baby has a brief life expectancy, are too quickly pointed in the direction of prematurely terminating that life without being offered either counselling or alternatives.

3.47. Life NI also suggests that there may be merit in further researching whether there is any connection between some life-limiting conditions and remedial health

care of mothers-to-be, e.g. in regard to folic acid and conditions affecting the neural tubes.

3.48. Life NI notes that it would be very concerned for the care that would be provided to those parents who decide to continue with the pregnancy until its natural end. '*What exactly does no medical intervention mean? What if the predicted outcome is much less serious than originally anticipated? Can the first medical opinion be overridden? In trying to "fix" one problem many additional problems may arise.'*

Conscientious objection

3.49. In response to the questions on conscientious objection, Life NI believes that there should be no attempt to legislate in the way suggested. However in the event of a change to the law, it believes that the right should cover participation in all treatment related to abortion including pre and post procedure nursing care.

Precious Life

3.50. Precious Life is completely opposed to the Department's proposals to amend the criminal law on abortion in Northern Ireland. It calls on the Government of Northern Ireland to ensure that the unconditional right to life of all human beings is respected, and that all children, before as well as after birth, receive equal protection in law, policy and practice, regardless of their disabilities or the circumstances of their conception.

3.51. Precious Life submits that the terms 'lethal' and 'incompatible with life' are ambiguous and medically meaningless terms. It says that '*the choice of such terms is used to dehumanise unborn babies with disabilities and life-limiting conditions. The choice of such ambiguous terms is also to reassure the number of medical professionals who would rather have unfettered discretion in deciding when an unborn baby is 'incompatible with life', that they can freely diagnose and carry out an abortion without fear of prosecution.'*

3.52. Precious Life suggest that the practice of abortion in Britain leads to the conclusion that abortion in 'certain limited and clearly defined circumstances' in legislation eventually leads to abortion on demand in practice and that there is no

reason to believe that criteria, ‘incompatible with life’, will only be restricted to ‘lethal fetal abnormalities’.

3.53. The organisation points out that the Bruce Inquiry, a Parliamentary Inquiry into Abortion on the Grounds of Disability in July 2013, revealed that there was a strong presumption from doctors that parents with disabled babies would choose to have them aborted. This led to a huge amount of subtle or direct pressure being placed on parents who decided not to abort.

3.54. The submission also says that ‘*abortion harms mothers too’* as ‘*women who abort their disabled unborn babies are at high risk for symptoms of severe post-traumatic stress and intense grief such as anxiety, depression, and emotional pain impacting marital intimacy, communication and trust.’*

3.55. Precious Life points to the need for perinatal hospice care as invaluable in that it allows for a continuum of supportive care from the time of diagnosis. *‘Parents and families are able to spend precious time with their children, both while the baby is in the womb, and then for hours, days and sometimes weeks months and even years after birth.’* It also provides examples of the benefits of perinatal hospice care.

Precious Life concludes that:

3.56. ‘*Rather than convincing a mother in such a vulnerable state that she can choose to be responsible for her unborn baby’s death, we must push healthcare professionals to provide for both their patients.’*

‘There is no ‘pressing need’ for abortion in cases of a prenatal diagnosis of a life-limiting disability. Rather, what women and their babies need in these tragic cases is perinatal hospice care.’

Pro- Life Campaign (PLC)

3.57. The Pro Life Campaign, based in Dublin, describes itself as a non-denominational human rights organisation, drawing its support from a cross-section of Irish society. The Campaign promotes pro-life education and defends human life at all stages, from conception to natural death. It also campaigns for resources to support and assist pregnant women and those in need of healing after abortion.

3.58. PLC refer to an article in the British Journal of Obstetrics and Gynaecology which reports that there is "*no agreed definition of a 'lethal fetal or congenital malformation and no agreed list of conditions that might fit this description*." They also refer to a survey of perinatal management which says, in summary, that the use of terminology like 'lethal' or 'fatal' fetal abnormalities '*is used for a heterogenous group of conditions to imply an ethical conclusion rather than to present a clear prognosis: it obscures rather than aids communication and counselling.*' PLC concludes that this terminology diminishes, if not removes entirely, the ability of a woman in these circumstances to make informed decisions about the management of her pregnancy and care of her offspring.

3.59. PLC states that the Department '*proposes deliberate foeticide on the basis of assertions by ill-informed medical practitioners. This would constitute a radical departure from the doctor's primary duty to do no harm, and from the duty to practice evidence based medicine insofar as is possible.'*

3.60. The submission also says that no mention was made of perinatal palliative care in the consultation paper. It says '*This is astonishing, given that this is the gold standard, offered in our leading maternity hospitals. Where it is clear that a baby will have a very short time to live, perinatal palliative care offers a safe and caring environment for the couple and their baby. There are initiatives in this jurisdiction to establish a dedicated perinatal hospice.'*

Conscientious objection

3.61. PLC says that if the Department's proposals become law in Northern Ireland, it '*considers it critical that provision is made also for the exercise of conscientious objection by hospital personnel, as is the case in the 2013 Protection of Life During Pregnancy Act in this jurisdiction.'*

Society for the Protection of Unborn Children (SPUC)

3.62. In its submission, SPUC states that it is an independent education, research, advocacy and lobby group with active members throughout Britain and Northern Ireland, committed to affirming, defending and promoting the inherent value of human life from the moment of conception until its natural end. It emphasises that it is opposed to the intentional killing of unborn children through abortion, whether by

chemical or surgical means (including the use of drugs and devices to cause abortion of the early embryo) as medically unnecessary and morally unjustifiable.

3.63. SPUC emphasises that, even if the Department's proposal was drafted with enough precision to permit only a small number of abortions of the most profoundly disabled children, the taking of one innocent human life can never be morally justified. They believe that the right to life, that is the right not to be killed, is the fundamental right, shared by all members of the human family, regardless of their health, abilities, the circumstances of their conception or any other distinction. Their view is that the Department proposes to violate this right, which has been recognised by the Universal Declaration of Human Rights (UDHR), the ECHR and the Convention on the Rights of the Child.

3.64. The Executive summary to the SPUC submission provides a clear view of the content of the submission. It begins by saying that the Department's recommendation to allow the abortion of children judged to be "incompatible with life" is seriously flawed. It believes that a lack of clarity surrounding the use of the term means that the resulting law would:

- be applied in an arbitrary manner;
- increase pressure on parents to abort seriously ill children;
- facilitate widespread exploitation;
- lead to a gradual expansion in the number of children considered unworthy of legal protection.

3.65. SPUC also believes that there is no proven medical benefit to abortion. It quotes that over 1,200 studies document the ways which abortion damages women's health and research into the effects of abortion is being published continually. Evidence shows that when an abortion is undertaken for reasons of fetal disability the psychological after-effects can be particularly traumatic.

3.66. SPUC also says that during the passage of the 1967 Act it proved impossible to overcome the complex legal problems surrounding the issue of abortion on grounds of rape, statutory rape, lack of consent and mental capacity. It says that the Department has been unable to show how it would resolve these difficulties.

3.67. The SPUC submission goes on to say that perinatal hospice care applies the principles of palliative medicine to babies diagnosed with life limiting conditions and provides help and support for families in this painful situation. Abortion is never a genuinely compassionate response to a crisis pregnancy; perinatal hospice care is indeed such a response.

3.68. SPUC says that the present law in Northern Ireland does not place any less value on the life of a disabled child, even if that life is tragically short. It therefore rejects the legalisation of a lethal form of discrimination based upon a child's disability or the circumstances of conception.

Conscientious objection

3.69. SPUC says that a person's right to conscientiously object to killing innocent human beings is absolute. To help or facilitate in the killing of the child in utero is co-operation in an intrinsically evil act. Conscientious healthcare workers should not be asked to be an accessory to killing the innocent.

Political parties

SDLP

3.70. In the introduction to its submission, the SDLP reiterates the Party's long held policy position regarding abortion, which is that it is a pro-life Party with a long standing and consistent position on the protection of the life of the unborn child. It says that, as decided by Party Conference, the SDLP is totally opposed to abortion and to any extension of the 1967 Act to Northern Ireland. This remains the Party's position and it has been consistent in its continued opposition to abortion.

3.71. The submission also puts forward the criticism that the approach adopted in the consultation paper restricts a wider debate in the context of the health options and/or provisions available to any mother in the situation of lethal fetal abnormality. It says that this is primarily a health issue and should be addressed within that context with a particular focus on adequate counselling and psychotherapy support services for women directly affected by such pregnancies. It makes the point that women must be fully supported by the health service throughout their pregnancies, in coping with and addressing the medical and other difficulties that will arise.

3.72. The Party's submission contains a number of specific criticisms of the recommendation in the consultation paper. These are:

- the particular proposition canvassed in this paper to abort a baby suffering from a lethal fetal abnormality is similar (including an unlimited time limit) to Section 1 (1) (b) of the 1967 Act;
- option 4 is an attempt to define clinical judgment. It is the SDLP's view that it is neither clear nor precise. It is based on a subjective clinical judgment, not an objective assessment. It is no clearer than the other options considered by the Department to be uncertain or lacking in clarity and which have thereby been rejected by the Department as worthy of support;
- there is no difference between option 4 and Section 1(1) (b) of the 1967 Act. In reality this proposal is targeted at anencephalic babies. Those babies are in reality severely disabled babies with an extremely limited life span. What is the difference, therefore, between this proposal and Section 1(1) (b)? What is achieved by aborting the baby? The alternative is to be preferred of permitting the baby to be born and giving the mother and family the option of holding the baby and nursing it through to its natural death and letting the natural grieving process take place.

Conscientious objection

3.73. The SDLP is supportive in principle of the introduction of a statutory right to conscientiously object to participate in a medical procedure to terminate a pregnancy in Northern Ireland in non-life-threatening circumstances affecting the mother, if the law were to change as to permit a termination to take place in the event of a lethal fetal abnormality.

3.74. The submission concludes that there is no right to abortion under the ECHR and that a wide margin of appreciation is granted in the area of abortion law, thereby permitting the Assembly to determine the law on abortion. Options 1, 2 and 3 are unacceptable for the reasons provided in the paper. Option 4 is also unacceptable for similar reasons given its own uncertainty and lack of clarity. If adopted and made into law it could open up the way for a wider application of abortion in Northern Ireland. The consultation has also ignored the well recorded democratic consensus against abortion that exists within Northern Ireland and the Assembly.

TUV

3.75. TUV sets out in its introduction the guiding principles of the response:

- belief in traditional family values as one of the founding principles of the Party;
- it is a pro-life Party and passionate supporter of the life of unborn children and opposes the extension of the 1967 Act to Northern Ireland. Legislation introduced in other parts of the world to allow for abortions on medical grounds has effectively led to abortion on demand. The present situation in Great Britain is a prime example of this;
- where it comes to tragic cases where the mother's life would be in danger the life of the mother should take precedence over that of the unborn child.

3.76. The submission states that lawful termination is possible where there is a real and serious risk to a woman's physical or mental health, which is either long term or permanent. Thus, the mother whose mental health is so damaged by carrying a child with fatal fetal abnormality can at present avail of lawful termination within Northern Ireland. In the view of the TUV this is sufficient.

3.77. TUV further states that:

- parents who are told their child has a potentially fatal abnormality could feel pressurised to have an abortion if the law is changed in Northern Ireland;
- while medical advances have made it possible to tell much more about a child prior to birth it is very possible to misdiagnose a condition;
- regardless of what the Department says, tampering with the laws as presently constituted will open the door to abortion on demand;
- individual beliefs of medical practitioners on abortion could colour their judgment on whether an unborn child has a potentially lethal abnormality.

Conscientious objection

3.78. TUV does not believe that the law in Northern Ireland should change and rejects all of the proposals put forward in the consultation. It does say that if proposals were followed through it would be imperative that a conscience clause exists for medical practitioners.

CHAPTER 4

RESPONSES FROM ORGANISATIONS AND INTEREST GROUPS SUPPORTING CHANGE

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Churches

4.1. The Church of Ireland and the Methodist Church in Ireland both provided submissions to the consultation which set out very clearly the value both Churches place on the right to life of the unborn child, but also recognised that in some very specific circumstances, there may be a need to terminate a pregnancy.

The Church of Ireland

4.2. The Church of Ireland submitted its response within the context of the Church of Ireland's Position on Abortion, adopted from a Lambeth Conference resolution stating:

'In the strongest terms, Christians reject the practice of induced abortion or infanticide, which involves the killing of a life already conceived (as well as a violation of the personality of the mother) save at the dictate of strict and undeniable medical necessity'.

4.3. The Church of Ireland's submission sums up its position as recognising that there are (regrettably) exceptional circumstances of strict and undeniable medical necessity where an abortion should be an option (or more rarely a necessity) whilst also concerned to avoid a situation whereby legislating for such exceptions provides a 'back door' to widespread abortion, to which the Church is strongly opposed.

4.4. As a result, the Church's submission offers qualified support for allowing abortion in cases of lethal fetal abnormality. The qualifications are that:

- de-criminalisation should only be to the extent of expediting birth and providing perinatal care and support. The Church would not support feticide;
- option 4 should be used in making an assessment of lethal abnormality based on clinical judgment;

- lethal should be defined as a condition that is incompatible with life outside the womb or in the immediate period of time following birth.

Conscientious objection

4.5. The Church believes that this should apply only to those involved in the direct provision of care.

The Methodist Church in Ireland (MCI)

4.6. The MCI begins its submission by stating its belief that life is a precious gift from God and recognising the value of every life and that there is a special responsibility to care for those who are weak and vulnerable. This care clearly precedes birth.

4.7. MCI believes that abortion should only be considered in rare and extreme cases and a number of these are already provided for under current Northern Ireland legislation. It recognises the increasing pressure on the Northern Ireland Assembly to bring forward legislation to widen provision for abortion and points out that failure to do so could result in judicial reviews or case law which could be more permissive than carefully drafted legislation which the Northern Ireland public has had the opportunity to consider. The Bourne judgment in 1938 is cited as an example of this. As a Christian church, MCI's preference is that no unborn child would be aborted but it recognises that carefully drafted and very specific legislation may afford greater protection to more unborn children than case law would.

4.8. In particular, MCI states:

- when a diagnosis of lethal fetal abnormality is made, parents should have access to counselling and detailed information on the choices available to them, including the benefits of continuing with the pregnancy until at least an early induced delivery with the opportunity of saying goodbye to their baby and grieving in the natural way;
- there should be no presumption from doctors that parents with disabled babies would choose to have them aborted. It may be outside the scope of the Department to guarantee this mind-set but there should be discussion with DHSSPS as no parent should be put under any pressure;

- babies with lethal abnormalities delivered through induced labour before term, should be allowed to die naturally after birth, preferably in their parents arms.

4.9. Whilst it may be a matter for the DHSSPS rather than the Department, MCI calls for proper provision of perinatal hospice care in Northern Ireland.

4.10. MCI state that safeguards are important to protect medical practitioners taking difficult decisions regarding the viability of a fetus and performing abortions in good faith, but they are also important to try to ensure that legislation permits no more than that which was intended. Therefore, MCI believes there needs to be a judicial safeguard where a judge, in the family court, should approve the request of the two doctors for a termination.

4.11. MCI would also want a statutory requirement to notify all abortions under this legislation, with sufficient detail of the fetal condition to allow audit of the application of the law and compliance with any guidelines produced by DHSSPS to support its implementation.

Conscientious objection

4.12. MCI also believes in a right of conscientious objection to all staff.

Political parties

4.13. Two Northern Ireland Assembly political parties, Sinn Féin and the Green Party, responded in favour of a change to the law to allow for termination of pregnancy in cases of lethal fetal abnormality. Anna Lo, Alliance MLA also submitted an individual response in favour of change. Other political parties who responded in support of more fundamental change were the Workers Party, the Progressive Unionist Party, the Labour Party of NI and the Socialist Party.

Sinn Féin

4.14. Sinn Féin states in its submission that it is not in favour of the extension of the 1967 Act to Northern Ireland. The Party opposed and voted against it when proposed in the Assembly and that remains its position.

4.15. Sinn Féin also states that it would support legislation, which would make provision for abortion services in instances of pregnancies arising from rape, incest and sexual abuse and that the Sinn Féin leadership will bring a motion before the Party's Ard Fheis, which would further incorporate situations in which a pregnancy has been determined to have a fatal fetal abnormality. (This motion was subsequently passed at the Ard Fheis in March 2015).

4.16. It also states that it believes there is a case to consider in relation to whether it is appropriate to invoke the criminal law for terminating a pregnancy. Criminalisation of women is particularly tenuous in circumstances where the condition of the fetus is not compatible with life and in scenarios of sexual abuse.

4.17. It acknowledges the practical difficulties the current law presents for a woman who, following a medical diagnosis that the baby she is expecting is suffering from a fatal abnormality and will not survive, makes the difficult decision that she cannot continue with the pregnancy.

4.18. It further believes in cases where a woman finds herself in a similar situation but wishes to continue with the pregnancy, she should be fully supported in that decision and all efforts should be made to ensure appropriate care and consideration.

The Green Party in Northern Ireland

4.19. The Green Party considers that to continue to deny, in law, access to abortion in circumstances involving lethal fetal abnormality directly contravenes Article 3 of the ECHR. This Article prohibits torture and inhuman and degrading treatment or punishment. The United Kingdom is a signatory to the convention on Human Rights and must uphold these rights for its citizens and residents.

4.20. The Party agrees that the law should allow for abortion in cases of lethal fetal abnormality by using current clinical judgment and medical diagnosis to decide when a fetus is not compatible with sustaining independent life outside the womb.

Conscientious objection

4.21. The Party also stated that conscientious objection in Northern Ireland should follow the Supreme Court judgment. Northern Ireland should follow this ruling.

The Labour Party in Northern Ireland (LPNI)

4.22. Overall, the LPNI states a belief that the consultation paper does not go far enough, only allowing for abortion where the fetus may have a fatal abnormality. It is clearly not possible to have a fit for purpose consultation on the issue of abortion where the question of reproductive rights is not at the centre. In addition, the Party states that abortion is not and should not be an issue for the Department. Abortion is a medical procedure and women's health is at risk when access to legal abortion is denied.

4.23. LPNI believes that the law should also have provision for abortion in cases of fetal abnormality which may not necessarily be lethal to the fetus.

Conscientious objection

4.24. Where provision for conscientious objection is to be made, LPNI is concerned that the right of a medical practitioner to refuse to become involved in legal abortion procedures should not override duty of care. The right to conscientious objection should not prevent medical staff referring women to other medical providers of abortion, neither would it be acceptable for healthcare professionals to refuse to provide aftercare for those who may have had an abortion.

Progressive Unionist Party (PUP)

4.25. The PUP acknowledges that this is a positive step against Northern Ireland's restrictive abortion laws, but states that the consultation is very narrow and does not go far enough to offer equal rights to citizens of Northern Ireland as those available to citizens living in Scotland, England and Wales.

4.26. The PUP fully agrees that the law should allow for abortion in cases of lethal fetal abnormality. Given the limited options provided with regards to lethal fetal abnormality, it would support legislation within this framework that includes option 2: 'sustainability of life', which would provide pregnant women with a choice of

terminating a pregnancy not only if the fetus would not survive to term, but also if the baby would be unlikely to survive after birth. The PUP ultimately feels that clinical judgment is the best way to decide when a fetal condition is not compatible with life.

Conscientious objection

4.27. The PUP believes that individuals with deeply held beliefs and objections to abortion should have a right to refuse to provide this form of healthcare should they wish. They argue, however, that people in need of any medical treatment should receive non-judgmental, non-biased advice from all involved in the process.

The Socialist Party

4.28. The Socialist Party states in its submission that while the recommended changes to allow women access to abortions for lethal abnormality and sexual crime are welcome, it doesn't go far enough.

4.29. The Department's consultation seeks to bring forward legislation that would enable pregnant women in cases of lethal fetal abnormality to decide to terminate a pregnancy and to have this procedure done in Northern Ireland. This would undoubtedly lessen the burden that women in such circumstances have to bear and would be a positive development.

4.30. The Party states that any improvement in access to safe and legal abortions in Northern Ireland must be welcomed. However, it is clear that the current debate isn't going far enough. The immediate step required is for the Assembly to extend the 1967 Act to Northern Ireland and allow access to free, legal and safe abortion under the NHS.

The Workers Party

4.31. The Workers Party believes that legislation should be introduced with immediate effect to enable women to avail of free and full access to abortion and that in the case of Northern Ireland the mechanism which can most readily and expeditiously facilitate access to abortion rights is the immediate extension of the 1967 Act to Northern Ireland. Women should have equal access to reproductive healthcare as is available in Great Britain. The Workers Party believes that it is

crucial to place women at the centre of the debate. Criminalising abortion harms individual women with unwanted pregnancies.

4.32. The Workers Party also recognises that women who are pregnant should have all appropriate options available to them. Women who opt to continue with a pregnancy in the event of the tragic circumstances of lethal fetal abnormality should be afforded all the appropriate treatment and care to enable them to do so. There should be sufficient care, secular counselling and support for women who wish to continue to full term. Women should neither be compelled to terminate a pregnancy in circumstances where the woman has no wish to do so, nor should a pregnant woman be compelled to continue with a pregnancy where it is her choice to terminate the pregnancy.

4.33. The Workers Party rejects the narrow compass of the terms of reference set out in the consultation and is firmly of the view that rather than creating exceptions or exemptions in the criminal law on abortion the Assembly should legislate for the immediate extension of the 1967 Act to Northern Ireland.

Anna Lo MLA – making this response as an individual MLA

4.34. Anna Lo states that international human rights standards provide for abortion in cases of severe fetal abnormalities and where a pregnancy is a result of sexual crime, therefore anything less than this would not be human rights compliant. She also says that no international or regional human rights body has ever recognized the fetus as a subject of protection under international human rights treaties.

4.35. Her view is that recent publicised cases of fatal fetal abnormality have highlighted the fact that the needs for termination are not straightforward and the woman's circumstances must be sympathetically considered. To force a pregnant woman to carry out a full term pregnancy, knowing that her child could not survive is nothing short of barbaric. Whilst some mothers make the decision – which is their right - not to terminate in the case of fatal fetal abnormalities, the same right should be accorded to women who decide to terminate the pregnancy. It is her view that women should have access to all the support and information they need and under

no circumstances should they be made to feel the shame, stress, isolation and financial burden as a result of the current law on abortion, when already dealing with complex and often traumatic circumstances.

4.36. She recommends that the term ‘severe’ fetal abnormality is used in legislation and option 3 – no statutory definition provided; this would then permit the medical practitioner to decide whether a condition could be defined as severe.

Conscientious objection

4.37. Anna Lo supports conscientious objection providing there is no risk to the woman’s life or an immediate risk to her health and must also only apply to the abortion procedure itself – not pre and post procedure care.

Reproductive healthcare organisations

Family Planning Association (FPA)

4.38. FPA is concerned that the proposals are limited to lethal as opposed to serious, but not immediately lethal, abnormalities. Through its counselling service it knows the unacceptable distress and trauma placed on women who are faced with serious and/or immediate lethal fetal abnormality. Should they choose to end their ‘much wanted’ pregnancy the emotional and mental health consequences are dire as they are forced to leave Northern Ireland, and the healthcare professionals who have cared for them during their pregnancy, to obtain the procedure elsewhere. Such action incurs costs of around £2,000 which must be secured within a very short space of time to meet the legal time limit of 24 weeks. For many women this involves borrowing from family and friends or taking out loans at ludicrous interest rates. Some simply can’t raise the money so are forced to continue with the pregnancy. Therefore access to abortion becomes a class issue – only available to those who can afford it. This degrading and inhumane treatment of women must end.

Conscientious objection

4.39. The Supreme Court judgment details when conscientious objection is applicable or not, therefore it would seem sensible to follow the definitions in this ruling.

British Pregnancy Advisory Service (BPAS)

4.40. This submission states that:

- BPAS welcomes the acknowledgement that Northern Irish women have abortions and the proposal that some of these women will be able to access care at home;
- it is inhumane to force pregnant victims of sexual violence to travel to England to access abortion care.

4.41. As a charity that provides abortion care for Northern Irish women with diagnoses of fetal abnormality, BPAS is relieved that some of these women may finally be cared for at home while disappointed that so many will continue to be forced abroad, with all the distress that entails.

4.42. BPAS acknowledges that the Department does not wish to provide abortion care for women in Northern Ireland beyond a set of extremely limited circumstances. However it is possible that in retaining this narrow focus it will prevent practical change for some of the women these proposals are designed to help. By limiting access to abortion to those circumstances where death of the baby shortly after birth is a certainty, women with a diagnosis where death is probable but not definite, and for whom there is a small chance treatment may prolong the life of their child will be excluded. Life-sustaining treatments may often be available that by definition improve the chances of survival, but they will not be pursued when parents and medical staff believe the distress they cause outweighs the benefits. If there is any chance that the abnormality is compatible with life, however small that chance may be and however high the toll of intervention may be for that individual infant when born, doctors in the climate of Northern Ireland will err on the side of caution. Paragraph 4.22 of the consultation paper makes clear that the same opinion must be reached by two practitioners to avoid prosecution, so the threat of criminal sanction for doctors working in this area looms large. To give doctors the confidence they

need to help women in these appalling circumstances, BPAS would suggest that the definition of “lethal” is taken in its natural meaning to include conditions capable of causing death, as well as causing death.

Conscientious objection

4.43. BPAS refers to the Supreme Court judgment which upheld NHS Greater Glasgow & Clyde Health Board’s appeal and dismissed the extremely broad definition of ‘participation’ in treatment proposed by Doogan and Wood. If the proposal to care for women with lethal fetal abnormalities at home in Northern Ireland is indeed enacted, it is essential that any conscientious objection provisions are not so broad that they can be used by anti-abortion staff to prevent healthcare services offering that care. Any conscientious objection provision must be balanced with the rights of women in need of care.

Brook Northern Ireland (Brook NI)

4.44. Brook NI states that it has provided clinical sexual health services to young people in Northern Ireland since 1992, this has included pregnancy testing and working with young people who have been the victims of sexual crimes.

4.45. Brook NI welcomes the creation of an exemption in the criminal law on abortion, to provide for termination of pregnancy in cases of lethal fetal abnormality.

4.46. When young people attend for their 20 week anomaly scan they may be informed at that time if there is serious fetal abnormality: it may not be apparent that it is lethal at this point but may become so later on. The narrowness of the definition of ‘lethal’ is of concern.

4.47. Young people should have their abortion in their hospital of choice within Northern Ireland. Young people are particularly concerned about confidentiality and abortion in Northern Ireland is identified in extremely negative terms by a small but vociferous number of people. Offering a choice of hospital not only responds positively to the above sentence but also allows hospitals to employ clinicians with the requisite training in order to offer the highest quality of care to young women.

4.48. While lethal may be defined as fatal or deadly it can also mean dangerous and harmful. If it is defined as fatal or deadly does this mean within the womb, within 24

hours of birth or within a week or 2 weeks? A clinician making that ethical decision (which medical practitioners make all the time) falls into option 3 and allows for a more varied elucidation of the presenting condition. There are protocols currently agreed by the Faculty of Sexual and Reproductive Health and the Royal College of Obstetricians and Gynaecologists which could be used as a basis for clinicians in Northern Ireland.

Conscientious objection

4.49. The Supreme Court judgment would be best followed for this situation.

The International Federation of Abortion and Contraception Professionals (FIAPAC)

4.50. This organisation, with headquarters in Vienna, points out that restrictive abortion laws do not reduce abortion rates. Women from Northern Ireland have no option but to travel and pay for the procedure elsewhere. Significant numbers of women are now obtaining the abortion pill over the internet, but are less likely to avail themselves of medical back-up should there be any complications. It also offers the view that the real problem is the lack of guidance and that fetal anomaly already falls under the mental health component of existing case law.

4.51. FIAPAC believes that issuing guidelines to explain the current position of case law would be better than creating new highly specific statute law. If, however, this is considered by the Assembly to be the best way to proceed, then they would support option 4.

Conscientious objection

4.52. FIAPAC is concerned that if it were to be permitted then access to specialised abortion care could be blocked.

Trade unions

Irish Congress of Trade Unions (ICTU)

4.53. The ICTU submission reports that 36 trade unions and Councils of Trade Unions affiliate to ICTU in Northern Ireland representing members across public and private sector workplaces. Representing almost a quarter of a million people, ICTU is the largest Civil Society organisation in Northern Ireland. There is a total membership of 211,800 in Northern Ireland.

4.54. ICTU puts on record its support for the Amnesty International campaign 'My Body My Rights' and the submission made by Amnesty International to the consultation. It further endorses the submissions made by the Committee for the Administration of Justice and the Royal College of Midwives, which is the professional and trade union organisation for the majority of midwives working in Northern Ireland. These submissions make clear the Human Rights Framework which contextualises the consultation as well as issues facing workers in the health sectors.

4.55. ICTU welcomes the consultation and the opportunity it provides to change the restrictive and discriminatory laws in relation to abortion in Northern Ireland.

4.56. It agrees that the law should be changed to allow for abortion in the case of lethal fetal abnormality and where pregnancy is the result of rape, incest or sexual crime. It believes that the consultation does not go far enough and that it should consider termination for women with a diagnosis of serious fetal abnormality. This would be compliant with Human Rights standards.

Conscientious objection

4.57. It endorses the Royal College of Midwives submission to the consultation. In particular it agrees with the comments in that submission in relation to conscientious objection and agrees that the Supreme Court judgment should provide the basis for conscientious objection in Northern Ireland.

Unite

4.58. This submission was made on behalf of Unite trade union's Irish women's committee. Unite is the largest trade union in the United Kingdom and Ireland with over one and a half million members.

4.59. Unite believes the law should allow for abortion in cases of lethal abnormality and this would be best achieved through clinical judgment. Lethal should be defined as incompatible with life and Unite believes the best way is to allow clinical judgment to determine when a fetus is not compatible with life.

Conscientious objection

4.60. Unite believes there should be a right to conscientious objection for those who participate in treatment for abortion in respect of lethal abnormality and sexual crime. This should be confined to the actual procedure which results in termination and not cover all treatment which includes pre and post procedure care.

NIPSA

4.61. NIPSA states that it is the largest trade union in Northern Ireland representing over 45,000 members employed across the whole of the public service and a significant number of members in the voluntary sector. It recognises the diversity of opinion amongst its membership and says that policy expressed in its submission has been agreed through the democratic procedures for making policy at the NIPSA Annual Delegate Conference.

4.62. NIPSA states that evidence gleaned from the Northern Ireland public would concur with and support NIPSA's view that the current law relating to the termination of pregnancy in Northern Ireland breaches core international human rights instruments and standards through the denial of women's human rights to exercise control, freedom and choice in their sexual and reproductive lives. In taking this position it wishes to put on record its support for the Amnesty International campaign 'My Body My Rights' and their submission to the consultation. It also endorses the submissions made by the Irish Congress of Trade Unions, the Committee for the Administration of Justice and the Royal College of Midwives.

Belfast & District Trades Union Council (B&DTUC)

4.63. B&DTUC is a federation of trade union representatives living or working in the Belfast area which forms a linkage between unions and acts as an interface between the trade unions and the local community. Its submission supports the views already put forward in the above summary of the submission by ICTU.

National Union of Students (NUS-USI)

4.64. NUS-USI believes that the changes are not going far enough in that they should deliver full reproductive choice for women on abortion. The fact that new legislation could be created is a positive step forward, yet further change needs to be delivered as soon as possible to ensure choice for women. NUS-USI strongly believes that politicians and government ministers can provide a pro-choice position while retaining the full integrity of their own personal religious beliefs. Having a pro-choice stance allows people to make their own decision.

4.65. The submission goes on to say that politicians should represent every person in their constituency and not simply make decisions based on their own personal beliefs.

4.66. In terms of definitions of lethal fetal abnormalities, it would favour option 4 (clinical judgment of incompatibility with life) as outlined in the consultation paper as the best definition. It is also essential that DHSSPS provides legal guidelines to ensure that there is clarity and to protect healthcare professionals as well as the person involved. NUS-USI agrees that the best way is to allow clinical judgment to decide when a fetus is not compatible with life.

Conscientious objection

4.67. The right of conscientious objection should be confined to involvement in the actual procedure and it should not cover participation in all treatments related to the abortion, like pre and post procedure care as this would be totally unacceptable.

Human rights groups

Amnesty International UK

4.68. Amnesty sets out in some detail the human rights grounds on which it maintains there is a need to change abortion law in Northern Ireland. The submission says that international human rights bodies have repeatedly criticized the criminalization of abortion and recognized that the criminal regulation of abortion impedes women's access to lawful abortion and post-abortion care. Amnesty considers that criminal law governing this form of women's healthcare and the ongoing failure of the DHSSPS to publish termination of pregnancy guidance contributes to a chilling factor, giving rise to reluctance amongst medical professionals to provide abortion services within existing Northern Ireland law.

4.69. United Nations (UN) treaty bodies have recognized the discriminatory effects of criminal regulation whereby women belonging to vulnerable and disadvantaged groups are required to access care through the public system and in practice disproportionately suffer the harms of the chilling effect brought on by criminalisation.

4.70. On lethal fetal abnormality, Amnesty says that no international or regional human rights body has ever recognized the fetus as a subject of protection under international human rights treaties. It says that Governments have been held accountable for not ensuring that abortion is available in cases when the life or health of women and girls is in danger, in cases of fatal fetal impairment and in cases of rape or incest.

4.71. Amnesty refers the Department to the fact that in all the individual complaints filed to the UN human rights bodies on failure to ensure access to abortions, the Committees found human rights violations, including the rights to equality and non-discrimination, the right to privacy and the right to be free from torture and other cruel, inhuman and degrading treatment. These cases involved denial of access to abortion in cases of rape and in a case of fatal fetal abnormality.

4.72. Amnesty recommends that the term 'severe' fetal abnormality is used in legislation and option 3 – no statutory definition provided; this would then permit the medical practitioner to decide whether a condition could be defined as severe.

Conscientious objection

4.73. Amnesty recommends that the Department make clear in law and accompanying guidance that:

- the right to conscientious objection is not absolute and would not apply in cases where there is a risk to the woman's life or an immediate risk to her health;
- a woman's right to life, health and dignity must always take precedence over the right of a health care professional to exercise conscientious objection to participation in an abortion procedure;
- conscientious objection should only be permitted insofar as the woman seeking care can still be guaranteed timely and appropriate quality care;
- the right to conscientious objection must also only apply to the abortion procedure itself – not pre and post procedure care.

The Northern Ireland Human Rights Commission (NIHRC)

4.74. The Commission considers that the current law on abortion is incompatible with articles 3, 8 and 14 of the ECHR, and is therefore seeking a declaration of incompatibility from the Court pursuant to section 4 Human Rights Act 1998. In particular Article 3 prohibits inhuman or degrading treatment; Article 8 provides a right to respect for a person's private and family life and Article 14 ensures freedom from discrimination in the exercise of ECHR rights. The Commission also quotes other human rights law which is engaged.

4.75. The Commission reiterates its advice from November 2013 in its paper 'Advice to the Department of Justice and the Department of Health, Social Services and Public Safety: the law on termination of pregnancy in Northern Ireland' that the Department should introduce legislation to the Northern Ireland Assembly to remove the criminal sanctions that prevent access to termination of pregnancy in Northern Ireland in circumstances of serious malformation of the fetus, rape or incest. In that paper the Commission advises that the law on termination of pregnancy in Northern Ireland violates the International Convention on Civil and Political Rights (ICCPR) article 7. It advises that the law also falls within the scope of ECHR, articles 3, 8 and 14 and is open to challenge on these grounds. The Commission also noted the

commitment of DHSSPS to issue guidance in this area to clarify the existing law. The Commission recalls, however, that a change in the law is required and advises that the law in Northern Ireland be amended to provide for termination of pregnancy within this jurisdiction on grounds of rape, sexual abuse (incest) and in cases of serious malformation of the fetus.

Committee on the Administration of Justice (CAJ)

4.76. The submission from CAJ introduces itself as an independent human rights organisation with cross community membership in Northern Ireland and beyond. It was established in 1981 and lobbies and campaigns on a broad range of human rights issues. It says that CAJ seeks to secure the highest standards in the administration of justice in Northern Ireland by ensuring that the Government complies with its obligations in international human rights law.

4.77. In July 2013 CAJ responded to the DHSSPS consultation 'Guidance on the Termination of Pregnancy: The Law and Clinical Practice in Northern Ireland.' In this response it reiterated the requirement of legal certainty in relation to abortion law and policy in Northern Ireland. In this submission it raised concerns that the proposed DHSSPS guidance had been drafted in a way which made the document less likely to meet the requirements of legal certainty and more likely to be susceptible to litigation. CAJ notes that as clear guidance has still not been progressed, DHSSPS continues to remain in breach of these requirements.

4.78. CAJ welcomes the Department's consultation on the criminal law on abortion and supports the proposal to enable abortion in the cases of fatal fetal abnormality.

4.79. CAJ draws attention to human rights jurisprudence and urges that the changes in the law are progressed to support women who need to attain safe and legal abortion in the instance of fatal fetal abnormality and sexual crime.

Equality Commission for Northern Ireland (ECNI)

4.80. ECNI is of the view that the consultation should have considered, among other things, the issue of women in Northern Ireland having the same access to reproductive health care as women in the rest of the United Kingdom. It should also

have considered amending the abortion law to remove the punitive provisions imposed on women who undergo abortion.

4.81. ECNI is disappointed that a full consultation on abortion that considers the above matters has not been issued. It says that the Department will be aware that CEDAW in its Concluding Observations on the United Kingdom in 2013 recommended specifically in relation to Northern Ireland, that:

"the State party should expedite the amendment of the anti-abortion law in Northern Ireland with a view to decriminalise abortion. The State party should also ensure that legal abortion not only covers cases of threats to the life of a pregnant woman, but also other circumstances such as threats to her health and in cases of rape, incest and serious malformation of the foetus."

4.82. It is essential that the Department ensures that all proposed changes to the law are compatible with human rights law. ECNI stresses that support for any changes to the criminal law on abortion is subject to such changes being considered compatible with human rights law. It therefore awaits the outcome of the application for judicial review brought by the NIHRC in this regard.

4.83. As regards lethal fetal abnormality, it notes that although such a change to the law would permit greater choice for women in those difficult circumstances, clearly women may equally decide, and should be free to decide, not to have an abortion. It will also mean that women in Northern Ireland will not have to travel to Great Britain and pay the associated costs, and experience the additional stress, of having an abortion on this ground carried out privately outside Northern Ireland. This has a particular impact on women with low incomes or from disadvantaged communities who may face difficulties in meeting those costs.

4.84. In addition, whilst outside the matters considered in the consultation paper, ECNI stress the need to develop clear guidance and information for both women and health professionals on their rights and responsibilities under abortion law. ECNI is aware that DHSSPS consulted (2013) on 'Guidance on the Termination of Pregnancy: The Law and Clinical Practice in Northern Ireland' but that to date revised final guidance has not been issued.

Conscientious objection

4.85. ECNI supports the Department's proposal to consider how, in the event of changes in the criminal law relating to abortion, a right of conscientious objection might be included.

The Equality Coalition

4.86. The Equality Coalition is convened by the Committee on the Administration of Justice (CAJ) and UNISON. It is a network of over 80 Non-Governmental Organisations (NGOs) from across the nine equality categories within section 75 of the Northern Ireland Act 1998. The Equality Coalition provides a forum for unity between all sectors when campaigning for equality, while allowing for the diversity of its members' work and views.

4.87. The Equality Coalition supports the proposals in the consultation paper, as agreed by members at the meeting dated 17 December 2014. However, in taking this position, it also draws attention to human rights jurisprudence, as outlined in a number of other submissions. It urges that the changes in the law are progressed to support women who need to attain safe and legal abortion in the instances of fatal fetal abnormality and sexual crime.

Pro-choice groups

Alliance for Choice (AFC Belfast)

4.88. AFC Belfast is an organisation that campaigns for the extension of the 1967 Act to Northern Ireland. It is made up of women and men who reflect the diverse population of Northern Ireland and who want to see equality and self-determination for women. In its submission, AFC Belfast considers that the proposed legislative change, while welcome for those directly affected by it, does not go far enough and fails, once again, international human rights standards.

4.89. AFC Belfast says that the document seems to be concerned about further regulating an already highly restrictive process. Nowhere are the emotional consequences for women highlighted. It could be argued that women who wish to terminate as a result of fetal abnormality or sexual crime are already covered under the current legislative frameworks. To force continued pregnancy and motherhood

under these circumstances would leave these women and young girls ‘physical and mental wrecks.’

4.90. The submission also points out that if the legislation is amended to legalise abortions for fetal abnormality and sexual crime, the responsibility still lies with DHSSPS to provide clinical guidelines for health professionals.

4.91. AFC Belfast say that the 1967 Act allows for termination at any gestation if there is a substantial risk that there is a serious fetal abnormality. It is a matter of clinical judgment and accepted practice that clinicians are best placed to determine the scale of fetal abnormality and they should have the flexibility for clinical judgment in individual cases. AFC Belfast is recommending that a similar approach is adopted for Northern Ireland.

4.92. AFC Belfast also cites cases where women who have to travel to England for a termination may wish to bring their baby’s remains back to Northern Ireland for burial or cremation, or even to have a post mortem examination carried out which may benefit them in a future pregnancy.

4.93. AFC Belfast also cites a number of opinion polls and surveys which indicated broad support amongst the general public for improved access to abortion services in Northern Ireland.

Queen’s University Belfast (QUB) Pro-Choice Society

4.94. This reply advocates decriminalization of abortion, as in Canada, or extension of the 1967 Act.

4.95. Lethal should be defined as a condition that threatens the fetus in utero or the healthy life of any subsequent child. The term ‘lethal fetal abnormality’ should also include anything which threatens the physical or mental well-being of the pregnant woman.

4.96. The Society believes that definition of the term ‘compatible with life’ should be made, in each case, by the pregnant woman with the advice of her medical practitioner. The medical professional can explain risks and probabilities based on

current research. They cannot however decide whether a woman is capable of continuing a pregnancy that will end in utero, at birth, shortly thereafter or within a few years of birth.

Conscientious objection

4.97. There should be a right to conscientious objection for those who participate in treatment for abortion as covered within the 1967 Act, Section 4. There should be opt-out of treatment '*necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman*.' It should not cover pre and post procedure care or other indirect duties.

Disability groups

Disability Action

4.98. Disability Action describes itself as a Northern Ireland charity working with and for people with disabilities to provide information, training, transport awareness programmes and representation for people regardless of their disability; whether that is physical, mental, sensory, hidden or learning disability. As a campaigning body, it works to bring about positive change and serves 45,000 people each year.

4.99. In relation to the definition of lethal fetal abnormality, it says that option 4 in the consultation paper would appear to provide the clearest context for any proposed change in legislation.

4.100. Disability Action suggests that the Department consider the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and the United Nations Convention on the Rights of the Child (UNCRC) as well as CEDAW in its Human Rights considerations. It also says that there has been no evidence provided on any possible equality or human rights impact, and this should have been included within the consultation paper.

Mencap in Northern Ireland

4.101. Mencap says in its submission that it is a voluntary organisation which works alongside and represents the interests of people with a learning disability and their families. Mencap believes in the dignity and value of everyone with a learning

disability and is committed to ensuring that people with a learning disability are listened to, valued equally and included.

4.102. Mencap believes in a woman's right to choose. It also believes it is essential, however, that parents are offered full, fair and balanced information which is positive about disability, and that there should be guidelines and standards put in place to ensure consistency of practice across Northern Ireland.

4.103. Mencap agrees that there must be a clear, objective and factual definition of lethal fetal abnormality to protect all those affected by this diagnosis and agree that option 4 provides medical professionals with protection. The legislation should also ensure that women, their partners and wider family have access to the information and support they need to make an informed decision when they receive a diagnosis of lethal fetal abnormality.

Women's groups

Women's Aid Federation Northern Ireland

4.104. Women's Aid describes itself as the lead voluntary organisation in Northern Ireland addressing domestic and sexual violence and providing services for women and children. In 2013-14, 999 women and 747 children sought refuge. 59 women in refuge were supported during their pregnancies and 15 babies were born to women in refuge.

4.105. Women's Aid agrees that the law should allow for abortion in cases of lethal abnormality. In such circumstances, it is cruel and unnecessary to force a woman to carry a fetus to term when that fetus is not able to survive. Given the severe negative impact of carrying a fetus to term with no prospect of survival, society has a moral duty to prevent such a scenario, in the interests of the health and wellbeing of women who are faced with this terrible situation.

4.106. Women's Aid also believes that the law should not just allow abortion in these circumstances, but that there should be sufficient clarity in law and guidance to facilitate such decisions to be made by medical practitioners. It is vital that medical practitioners are able to make such decisions in an environment where they have no fear of criminal sanction in the event that they have to deliberate on a

complex or borderline case. For this reason Women's Aid are of the view that option 4 would be the option that is most fit for purpose and a sensible way of implementing this change of law.

Conscientious objection

4.107. Women's Aid supports the development of clear rules and guidance, recognising that some medical practitioners may wish to refuse to perform an abortion if it conflicts with their personally-held beliefs, and it acknowledges that they should have the right to do so.

4.108. They consider there is a responsibility on both the Department and DHSSPS to develop law and guidance which ensures that conscientious objection is facilitated, that no woman is ever denied a legal abortion as a consequence of the conscientious objection of a medical practitioner, and that clear procedures are put in place in all relevant public health facilities to ensure that both the rights of women and conscientious objectors are accommodated.

Women's Regional Consortium (WRC)

4.109. WRC consists of seven women's sector organisations who have come together to provide a voice for women from disadvantaged and rural areas and support efforts to tackle disadvantage and social exclusion.

4.110. WRC would like to make clear their view that consulting on the provision of abortion with a view to possibly restricting free and equal access to this essential medical procedure is tantamount to consulting on torture under European and International Human Rights Standards.

4.111. It also noted that as a health issue, the lack of input from DHSSPS was seen as making the consultation somewhat redundant. It was felt by many focus group attendees that to be consulted on this issue as justice matter only was a violation of the right to appropriate health care.

4.112. Despite this criticism, the Consortium recommended that option 4 be used with the amendment that only one medical professional needs to diagnose the lethal fetal abnormality and that a second opinion need only be sought where questions

were raised. Formal guidance should also be issued in line with the GMC in the rest of the UK.

Conscientious objection

4.113. The Consortium believes that conscientious objection should be granted only in cases where there is no direct risk to the life of the woman or her health. There should be robust guidance developed that ensures duty of care is paramount and safeguards need to be put in place to ensure women do not fall victim to the point that it denies their access to the services available. A woman's right to life, health and dignity should always take precedence over the right of medical professionals to conscientiously object. Finally, conscientious objection should only apply to the direct procedure of abortion and should not encompass pre and post procedure care of patients undergoing termination of a pregnancy.

Belfast Feminist Network (BFN)

4.114. BFN is a pro-choice community collective representing the views of over 1400 people, committed to providing an open and inclusive space for discussions of gender inequality in Northern Ireland.

4.115. In its submission, BFN highlighted the invisibility of trans people in this area of policy making, explaining that trans people face barriers and stigma generally when accessing healthcare and their experiences of abortion must also be considered.

4.116. BFN believes that every woman should have access to a free, safe and legal abortion if she has made the choice that the pregnancy is unwanted. This should be available in the context in which the prevention of unwanted pregnancies is prioritised through family planning and sex education.

4.117. While BFN welcomes the proposal to change the law it is concerned that it is restricted to discussion of lethal fetal abnormality and believes that allowance for abortion in cases of serious malformation of the fetus should be included.

4.118. Option 4 is considered the best approach by allowing clinical judgment to decide when a fetus is not compatible with life. BFN considers this would provide a clear statutory framework within which medical professionals can be sure that the choice of termination is within the law – '*crucially important for medical professionals*

currently operating in an unclear statutory framework as a consequence of DHSSPs's resistance to publishing guidelines for practitioners'.

4.119. BFN considers that the requirement for two clinicians is a result of the climate of fear within which medical practitioners operate and there are very few other medical decisions in which this is required. The judgment of one medical practitioner should enable a woman to have an abortion. Publication of comprehensive and women- centred guidelines by DHSSPS would enable judgments to be made without fear.

Ethnic minority groups

The Northern Ireland Council for Ethnic Minorities (NICEM)

4.120. NICEM is an independent non-governmental organisation. As an umbrella organisation, it represents the views and interests of black and minority ethnic (BME) communities.

4.121. NICEM notes that it has been illustrated that almost 70% of the population is in support of allowing the ending of a pregnancy in additional situations to those currently permitted. It also notes that, on the issue of the availability of medical procedures to end a pregnancy, BME communities may be particularly adversely affected by the excessive restrictions that currently exist. It states that a number of factors related to the issue of ethnicity mean that the current system for criminalising abortion in Northern Ireland disproportionately affects individuals with an ethnic minority background.

4.122. Research suggests that some ethnic minority groups in the United Kingdom have an increased chance of carrying a fetus with a neural tube defect, a collection of defects that include fatal abnormalities such as anencephaly, hydranencephaly and iniencephaly. This is linked in part to the fact that BME individuals in the United Kingdom disproportionately suffer from Type-2 Diabetes, which in turn is a risk factor for carrying a fetus with a neural tube defect.

4.123. It is also the case that the monetary aspect of current legal arrangements for criminalising medical procedures for ending pregnancy disproportionately affects some BME individuals.

4.124. In its submission, NICEM also says that it is evident not only that there is a strong international human rights case for changing the law to allow pregnancies to be ended where the fetus is inflicted with a fatal abnormality, but also that the current system of denying women the opportunity to end such pregnancies has the potential to inflict significant psychological trauma on those who must carry such pregnancies to term.

4.125. NICEM recommends that legislation be introduced or amended to allow pregnancies where the fetus is afflicted with a fatal abnormality to be ended, if the pregnant woman so elects.

Conscientious objection

4.126. NICEM recommends that any future legislative change to the criminal law on procedures for ending pregnancies allow for medical personnel to conscientiously object to direct involvement in a procedure that is taking place for purposes additional to those allowed under the current law. However, it is also recommended that legislative provisions be explicit in preventing conscientious objection from interfering with a woman's ability to obtain a legal procedure in a timely and convenient manner, in line with international law and guidance.

Black and Minority Ethnic Women's Network (BMEWN)

4.127. BMEWN is a women-led organisation that advocates for change on issues affecting black and minority ethnic (BME) women in Northern Ireland.

4.128. BMEWN states that the fact that a woman does not have the choice to end a pregnancy in situations of fatal abnormality has the potential to cause a great deal of trauma, as the experience of birthing a stillborn child has a profound psychological impact. Delivering a baby with a fatal abnormality may cause additional distress within certain minority cultures. While it is acknowledged that some women may draw comfort from the process of completing the pregnancy and saying farewell to their child, others are left traumatised by this experience. Consequently, it is important that women be given a choice in this situation, so that they may decide what is best for them.

Others

Humanist Association of Northern Ireland (HUMANI)

4.129. Humani introduces itself as the largest free-thinking organisation in Northern Ireland, seeking to represent the views of the 180,000 people who have no religious beliefs.

4.130. Humani supports the extension of the 1967 Act to Northern Ireland. However, its response is confined to the specific questions posed in the consultation paper.

4.131. On lethal fetal abnormality, Humani believes that the law should allow for abortion. It also agrees with the Department's preferred option that two medical practitioners should make a clinical decision about the condition of the fetus being incompatible with life. However, clinical judgment should also include taking account of the views of the parents. If the parents want to carry on regardless that has to be respected too.

4.132. Humani would define lethal as meaning when the child has no chance of life either at all, or for very little time, outside the mother. It should also cover instances where the child would have no quality of life at all even if it were to live several months or years in exceptional circumstances such as in cases of anencephaly where this is no chance of development of the child.

Conscientious objection

4.133. Humani believes that all health and care professionals have a duty to care for all people according to their needs, before, during and after any medical treatment such as abortion.

CHAPTER 5

OVERVIEW OF RESPONSES FROM ORGANISATIONS AND INTEREST GROUPS TO CONSULTATION QUESTIONS

CHAPTER 5

OVERVIEW OF RESPONSES FROM ORGANISATIONS AND INTEREST GROUPS TO CONSULTATON QUESTIONS

Introduction

5.1. The previous chapters summarise responses by organisations. The reader might also find it helpful to see the responses grouped under the specific questions set out in the consultation paper. The responses are shown by organisational grouping. Not all organisations addressed all questions.

Lethal fetal abnormality

Q: Should the law allow for abortion in cases of lethal fetal abnormality?

Church and faith groups

5.2. Most were against any change to the law. The Church of Ireland recognised that in circumstances of strict and undeniable medical necessity the care that medical professionals need to give may result in the termination of a pregnancy. The response did ask for further clarity and did emphasise that expediting birth and providing perinatal palliative care is consonant with the Church's understanding of the value of the life of a baby with a lethal abnormality. The Church continues to have objections to feticide as a form of termination in cases like this.

5.3. The Methodist Church in Ireland would prefer that no unborn child would be aborted but recognises that carefully drafted and very specific legislation may afford greater protection to more unborn children than case law or judicial review.

Disability groups

5.4. Mencap believes in a woman's right to choose but considers it essential that parents are offered full, fair and balanced information which is: positive about disability; explains all the options; and facilitates contact with other parents who have gone through a similar experience. Medical and healthcare professionals must also provide comprehensive, positive support whether the decision is to terminate or to proceed with the pregnancy.

5.5. Disability Action is supportive of the proposed change in the law, but this did not constitute an organisational view on abortion in the wider context.

Ethnic minority groups

5.6. NICEM and BMEWN supported the proposal. NICEM highlighted the following: the serious psychological impact on a woman forced to continue with a pregnancy where there has been a diagnosis of lethal fetal abnormality; research which suggests that some ethnic minority groups in the United Kingdom have an increased chance of carrying a fetus with a neural tube defect: their view that the current law on abortion is discriminatory against those with a BME background, as BME individuals are more likely to come from a deprived background and are unable to fund travel to Great Britain for an abortion in these circumstances.

5.7. BMEWN also highlighted that delivering a baby with a fatal abnormality may cause additional distress within certain minority cultures. For example, under Islamic tradition, a baby must draw breath in order to receive the azãn and be acknowledged as a Muslim. Without this acknowledgment, the baby is unlikely to be buried in a Muslim cemetery. Consequently, continuing with a pregnancy and developing a bond with a baby, knowing that it may go unacknowledged in death by the family and wider community, can be a source of great distress to the pregnant woman.

Human rights groups

5.8. NIHRC welcomes the proposal but considers that legislation should be introduced to provide for termination of pregnancy where there has been a diagnosis of serious malformation of the fetus. It advises that failure to provide this constitutes a violation of ICCPR, article 7 and also falls within the scope of ECHR, articles 3, 8 and 14 and is open to challenge on these grounds.

5.9. Amnesty welcomes the proposal but recommends that the term ‘severe’ rather than ‘lethal’ is used in legislation.

5.10. CAJ, the Equality Coalition and the ECNI support the proposal. ECNI support was subject to such a change being compatible with human rights law and awaited the outcome of the judicial review brought by NIHRC. It also recommended that the

Department ensure its approach is in compliance with the UK Government's obligations under the UNCRPD.

Political parties/MLAs

5.11. The Workers Party, the Socialist Party, the PUP and LPNI all welcomed the proposal to change the law, seeing it as a positive step against Northern Ireland's restrictive abortions laws. All considered that the proposal did not go far enough and recommended the extension of the 1967 Act to Northern Ireland.

5.12. The Green Party and Anna Lo MLA (responding as an individual MLA) supported a change in the law. Sinn Féin did not state a definitive position but advised that the Sinn Féin leadership would bring a motion before the Party's Ard Fheis to support legislation allowing termination in cases of lethal fetal abnormality. This motion was subsequently passed at the Ard Fheis in March 2015.

5.13. The SDLP and the TUV are opposed to any change in the law. The TUV stated that, as lawful termination is possible where there is a real and serious risk to a woman's physical health, which is either long term or permanent, this is sufficient.

Royal Colleges, Health and Social Care Trusts and Medical Organisations

5.14. There was clear support for a change to the law from all in this category, although both the Royal College of Midwives and the Royal College of Nursing would support a provision which enabled women to terminate a pregnancy as a result of serious, rather than lethal, abnormality. The Royal College of Psychiatrists and the British Association for Counselling and Psychotherapy did not put forward a definitive answer to this question.

Pro-choice groups

5.15. Abortion Rights and Alliance for Choice Belfast supported the right of a woman, who decides not to continue with a pregnancy due to a fatal fetal abnormality, to be able to access a safe, legal abortion in Northern Ireland. Abortion Rights went on to state their support for complete bodily autonomy in relation to abortion, regardless of the reasoning behind the choice.

5.16. QUB Pro-Choice Society supported the proposed change but thought it should not be limited to cases of lethal fetal abnormality.

Pro-life groups

5.17. All stated their opposition to the proposal.

Reproductive healthcare groups

5.18. Both Brook NI and FPA welcomed the proposed change, though Brook NI is concerned at the narrowness of the definition of lethal. FPA expressed concern that the proposal does not extend to serious as well as lethal fetal abnormalities.

5.19. BPAS welcomed the proposal but was concerned that the extremely limited context of the proposal could lead to the exclusion of women with a diagnosis where death is probable but not definite.

5.20. FIAPAC supported the proposed change, if it helped to give some clarity to the law. It is its view that the current interpretation of the law is having a chilling effect on medical practitioners. However, it considered that guidelines on the current position in the development of case law on abortion would be preferable to creating highly specific legislation.

Trade Unions

5.21. All supported a change in the law.

5.22. ICTU, NIPSA and B&DTUC further stated their support for the view put forward in the Royal College of Midwives submission to the consultation that termination should be available for those women with a diagnosis of serious fetal abnormality. NIPSA and B&DTUC called for the full decriminalisation of voluntary abortion in all cases.

5.23. B&DTUC took the opportunity to point out that restrictive abortion laws and practices and barriers to access to safe abortions are gender-discriminatory.

Women's groups

5.24. The Women's Regional Consortium; Women's Aid; QUB Feminist Society and the Belfast Feminist Network all support the proposal. BFN thought that the proposal should extend to serious malformation of the fetus.

Others

5.25. The Humanist Association of Northern Ireland (Humani) supports the proposal.

Q: If so, how is this best achieved?

Church and faith groups

5.26. For most groups there was no support for a change to the law so this question became irrelevant. The Church of Ireland response said that option 4 was the best way to provide for terminations of pregnancy in situation of lethal fetal abnormality. The Methodist Church in Ireland was of the same view.

Disability groups

5.27. Mencap and Disability Action both considered option 4 presented the best way forward.

Human rights groups

5.28. Amnesty considered that option 3 represents the best way forward

Political parties/MLAS

5.29. The Worker's Party, the Socialist Party, the PUP and the LPNI considered that the 1967 Act should be extended to Northern Ireland.

Royal Colleges, Health and Social Care Trusts and Medical Organisations

5.30. NICRCOG and the consultants in the Department of Fetal Medicine at the Royal Jubilee Maternity Service would prefer new law to decriminalise abortion when a fetal condition is lethal and two medical practitioners are of this opinion and that the continuance of the pregnancy would likely have a detrimental effect on the health of the woman. Both the RCM and the RCN favour option 3 in order to allow for serious as well as lethal abnormalities. The BMA says that the diagnosis of lethal

abnormality should be based on clinical judgment and that this should be supported by clear clinical pathways. The Clinical Director of the Belfast Trust says that with current diagnostic tools, the majority of fetal conditions should be identifiable by medical practitioners as being incompatible with life. Decision making could be supported by a multidisciplinary approach to make clear that no intervention after birth can be offered to improve chances of survival. The NI Committee of the Faculty for Sexual and Reproductive Health Care says that termination should be able to be accessed in a local hospital, preferably where the woman has commenced her ante-natal care. The SEH&SC Trust recommends a framework that is women-centred, and provides full information which is confirmed by two medical practitioners. Care pathways should be developed regionally to ensure consistency of care and treatment. The NH&SC Trust recommends that the woman is seen by experts in the field of fetal medicine and following diagnosis two medical practitioners are involved in determining whether the termination meets the requirements of the legislation.

Pro- choice groups

5.31. Abortion Rights considered that this was best achieved by removing abortion from the criminal law and recognising it as a medical procedure requiring the consent of one doctor.

5.32. QUB Pro-Choice Society suggested two possible models:

- following the Canadian model and decriminalising abortion completely which would allow the medical profession to work without the threat of legal sanction and their actions would be limited by the best interests of the woman;
- extension of the 1967 Act to Northern Ireland

5.33. Alliance for Choice Belfast supported a similar approach to the 1967 Act.

Pro-life groups

5.34. As the respondents in this category were opposed to the proposal, this issue was not addressed.

Reproductive healthcare groups

5.35. The FPA considered that the woman, together with the doctors involved in her care, should make the decision whether to continue with the pregnancy and that, should she decide to have an abortion, it should be available in the hospital where she has received ante-natal care.

5.36. Brook NI considered that women who have chosen to have an abortion should be able to have it in the hospital of their choice in Northern Ireland, particularly where they have concerns about confidentiality and the extremely negative views about abortion by a small but vociferous number of people.

5.37. FIAPAC considered that guidelines on the current position of case law would be preferable to highly specific legislation. In the absence of guidelines they considered option 4 presented the best way forward.

Trade Unions

5.38. NUS-USI considered this was best achieved by changing the law to allow choice for all women.

Women's groups

5.39. Women's Aid believes this can best be achieved through option 4, but with a clear commitment from DHSSPS to support medical practitioners in implementing the law in a manner that has the least negative impact on women faced with this situation.

5.40. BFN considered that option 4 as presented in the consultation paper presented the best way forward. It would provide a clear statutory framework within which the medical professionals can be sure that the choice of a termination is within the law – crucially important for medical professionals currently operating in an unclear statutory framework as a result of DHSSPS resistance to publishing guidelines for practitioners.

Others

5.41. Humani agreed that option 4 presented the best way forward. In providing background to its ethos, Humani stated their support for the extension of the 1967 Act to Northern Ireland but confined its response to the specific questions posed in the consultation paper.

Q: How would you define lethal?

Church and faith groups

5.42. The Church of Ireland said that lethal should be defined as a condition that is incompatible with life outside the womb or in the immediate period of time following birth.

Disability groups

5.43. Disability Acton considered that the definition in option 4 provided the clearest context for any change in the law. Mencap thought that the option 4 definition provided medical professionals with protection, but suggested that the Department talk directly to parents who have experience of this diagnosis about the best option and terminology used to convey the diagnosis in a sensitive, clear and non-judgmental way.

Human rights groups

5.44. Amnesty recommended legislation to allow abortion in cases of severe fetal abnormality and considered that no statutory definition should be provided. This would permit the medical practitioner to decide whether a condition could be defined as severe.

5.45. ECNI agreed that it is essential to have a clear and unambiguous definition of lethal fetal abnormality so as to provide legal certainty and clarity for both women and medical practitioners. ECNI rejected option 1 as it would be impossible to complile a definitive list which took account of future conditions and/or medical advances. However, they did not consider it within their expertise to comment on feasibility of the remaining options discussed in the paper.

Political parties/MLAs

5.46. The TUV and SDLP view the definition provided in the consultation paper too broad and imprecise and consider that it has the potential to legalise abortion across a wider spectrum than that envisaged in the paper. They see this as an inherent danger in any proposed abortion legislation.

5.47. The Green Party considers that decisions on whether a fetus has a lethal abnormality should be for clinical judgment and medical definition and diagnosis.

5.48. LPNI consider the term ‘incompatible with life’ ambiguous and failing to provide clarity on the range of medical reasons that would fall within the scope of the proposal. They believe that the law should provide for abortion in cases of fetal abnormality that may not necessarily be lethal to the fetus.

5.49. Anna Lo MLA recommended the use of the term ‘severe’ fetal abnormality and that no statutory definition is provided, thus allowing the medical practitioner to decide whether a condition could be defined as severe.

5.50. PUP favoured the definition proposed in option 2 of the paper: ‘sustainability of life’.

Royal Colleges, Health and Social Care Trusts and Medical Organisations

5.51. NICRCOG would define lethal as ‘sufficient to cause death’.

5.52. RCGPNI thinks that option 4 is suitable – ‘incompatible with life’

5.53. Both the RCM and RCN would not restrict the legislative change to cases of lethal fetal abnormality.

5.54. The consultants in the Department of Fetal Medicine at the Royal Jubilee Maternity Service, suggest that lethal should be defined as stated in option 4 - incompatible with life and where a clinical judgment is made that there will be no intervention performed routinely after birth.

5.55. The Clinical Director of the Belfast Trust also agrees with option 4.

5.56. The Northern Ireland Committee of the Faculty for Sexual and Reproductive Health Care says that in reality, no-one can give a definitive answer about length of survival, therefore informed clinical judgment is crucial.

5.57. The South Eastern Trust uses ‘sufficient to cause death’ and should be based on the current best evidence and agreed by two medical practitioners with the woman.

5.58. The Northern Trust agrees with option 4.

Pro- choice groups

5.59. Abortion Rights did not support using a specified measure of sustainable life as the deciding factor for a termination.

5.60. QUB Pro-Choice Society proposed the definition of a condition that threatens the fetus in utero or the healthy life of any subsequent child. The definition should also include anything which threatens the physical or mental well-being of the pregnant woman.

Pro- life groups

5.61. Every Life Counts and Precious Life considered the terms ‘lethal’ and ‘incompatible with life’ ambiguous and medically meaningless. Precious Life stated that the choice of such terms is used to dehumanise unborn babies with disabilities and life-limiting conditions; and their use is to reassure the number of medical professionals who would rather have unfettered discretion in deciding when an unborn baby is ‘incompatible with life’.

5.62. Life NI finds the term ‘incompatible with life’ insulting and hurtful, devaluing the unborn child. It considers the term so broad as to be capable of referring to children with disabilities who survive the birth process, leading to a discriminatory attitude towards children who have such disabilities and to a decline in the level of clinical care they are given. This view was echoed by SPUC.

5.63. Pro-Life Campaign considers that, as many babies born with these conditions have been reported to live for months or even years, the use of the terms ‘lethal’ or ‘incompatible with life’, diminishes, or removes entirely, the ability of a woman in

these circumstances to make informed decisions about the management of her pregnancy.

Reproductive healthcare groups

5.64. The FPA considered it clinically difficult to give a definitive definition of lethal if it was being strictly interpreted in relation to survival outside the womb. It was not in favour of a list of abnormalities or survival times.

5.65. Brook NI thought it preferable not to define lethal, allowing for a more varied elucidation of the condition of the fetus.

5.66. BPAS expressed concern that, if there is any chance that the abnormality of the fetus is compatible with life, however small that chance may be and however high the toll of intervention may be for the baby when born, doctors in the climate of Northern Ireland will err on the side of caution. It suggested that the definition of lethal should include ‘capable of causing death’.

5.67. FIAPAC, in the absence of guidelines on current case law, favoured option 4 definition.

Trade Unions

5.68. NUS-USI favoured the definition as outlined in option 4. It considered it essential that DHSSPS provided legal guidelines to provide clarity and protection for both healthcare professionals and the woman having the abortion.

Women’s groups

5.69. Women’s Aid stated that lethal should mean ‘no reasonable prospect of survival.’ However, it considered it is for those with expertise in this area to make the decision on whether a case is lethal. There should be sufficient clarity in law and guidance to ensure that medical practitioners are able to make such decisions in an environment where they have no fear of criminal sanction, where the decision is in a complex or borderline case.

Others

5.70. Humani defined lethal as meaning when the child has no chance of life either at all or for very little time outside the mother. It should also cover instances where the child would have no quality of life at all even if it were to live several months or years in exceptional cases such as anencephaly, where there is no chance of development of the child.

Q: Do you agree that the best way is to allow clinical judgment to decide when a fetus is not compatible with life?

Church and faith groups

5.71. The Church of Ireland response agreed that the most prudent way was for clinical judgment to be exercised within a clear statutory framework.

Disability groups

5.72. Mencap suggested that the decisions made by medical professionals should be transparent and audited, with written justification of the clinical judgment. They also recommended the production of best practice guidelines and the provision of training on: the full range of options, bereavement and family counselling and; UNCRPD.

Human rights groups

5.73. Groups in this category did not comment on this question.

Political parties/MLAs

5.74. The SDLP considered that clinical judgment was subjective and that the proposal was lacking in clarity.

Royal Colleges, Health and Social Care Trusts and Medical Organisations

5.75. All agreed that clinical judgment is crucial. The RCN noted that the key issue is how and by whom the judgment is made, communicated and recorded. Others said that in some straightforward cases one clinician could make the diagnosis but in others a team of specialists may be required. The South Eastern Trust said that the woman must always be central to the decision making. Also mentioned as an

additional safeguard were improvements which have taken place to the Clinical Coding for Termination of Pregnancy which has the potential to assure public confidence around such decision making.

Pro-choice groups

5.76. Abortion Rights, QUB Pro-Choice Society and Alliance for Choice Belfast consider that the decision to terminate a non-viable pregnancy should be taken by the pregnant woman with appropriate, non- biased, guidance from medical practitioners. Ultimately it should remain the woman's choice.

Pro-life groups

5.77. Life NI considers that clinical judgment, even when backed up by a second opinion, is subjective, potentially inaccurate and ultimately becoming an 'exercise in box ticking'. SPUC added that it would lead to a gradual expansion in the number of children considered unworthy of legal protection. While other respondents did not address the question specifically, this was reflective of the views expressed in this category.

Reproductive healthcare groups

5.78. Brook NI and FPA both considered that Northern Ireland clinicians should follow the same protocols as their clinical colleagues in the rest of the United Kingdom, which have been approved by the Faculty of Sexual and Reproductive Health and the Royal College of Obstetricians and Gynaecologists.

Trade Unions

5.79. NUS-USI and Unite agreed that clinical judgment should decide when a fetus is not compatible with life.

Women's groups

5.80. WRC and BFN felt that the protocol for two medical opinions on the diagnosis was unnecessary. WRC took the view that, potentially, it could leave the door open for those with a conscientious objection to being involved in abortion processes: to sabotage a case where a lethal fetal abnormality was present in order to prevent the choice of abortion being offered.

5.81. BFN considered that the proposal was the result of the culture of fear in which medical professionals currently operate. Both WRC and BFN stressed the need for clear guidance for medical professionals, if they are to have the freedom of clinical judgment without the fear of legal action looming over them. WRC thought that the guidance, developed in consultation with relevant medical professionals, and with the full support of the DHSSPS, should be in line with existing GMC guidance. BFN were of the view that guidance should be published by DHSSPS.

5.82. BMEWN considered that clinical judgment by two medical practitioners was the best way to proceed but considered that the initial decisions should not be immutable. It suggested that the legislation should provide for the ability to appeal decisions, but that it should ensure determinations are made promptly and well in advance of the expiry of any gestational term limit for termination.

5.83. Women's Aid agreed with the reasoning behind the proposed requirement for two doctors to make a clinical judgment on lethal fetal abnormality but urged that any legislation makes provision for one doctor to be able to make such a decision in emergency situations without fear of sanction.

Others

5.84. Humani agreed that two medical practitioners should make a clinical decision about the condition of the fetus being incompatible with life. However, the views of the parents should also be respected.

Conscientious objection

Q: Should there be a right to conscientious objection for those who participate in treatment for abortion in respect of (i) lethal fetal abnormality and (ii) sexual crime?

Q: Should that right be confined to involvement in the actual procedure which results in termination(e.g. giving the abortion medication, carrying out or assisting in the surgical procedure)?

Q: Should the right cover participation in all treatment related to the abortion, including both pre and post procedure nursing care?

Q: Should it also cover all associated, but not direct duties, such as supervising and supporting other staff, and delegating tasks to staff involved in the provision of care to patients undergoing medical termination at any stage of the process?

Church and faith groups

5.85. The positions of the individual Church and faith groups are summarised in chapters 3 and 4. Briefly, some Church and faith groups against a change in the law offered views on this point. The Caleb Foundation would favour conscientious objection within the existing arrangements. The Catholic Bishops of Northern Ireland felt that conscientious objection should be applicable to organisations as well as to individuals. CARE in Northern Ireland felt that under the current law the conscientious objections of medical staff should be respected. Christian Concern said that conscientious objection should be respected except in post procedure nursing care. CMF believes that under the terms of the existing law, there should be provision to respect conscientious objection for all clinical staff at any stage of the process. The Evangelical Alliance felt that if the law were to change, the right of conscientious objection should be respected except in post procedural nursing care. The Fellowship of Independent Methodist Churches said that a person should have the right to practice according to their conscience or faith. The Free Presbyterian Church of Ulster said that if the law was changed, it would be vital that a statutory conscientious objection clause is included. The Presbyterian Church in Ireland

would be greatly concerned if the right of conscientious objection for anyone was to be limited or disallowed. The Reformed Presbyterian Church of Ireland said that if the law was changed it would want a right of conscientious objection as described in question 17.

5.86. The Church of Ireland believed that conscientious objection should apply only to those involved in the direct provision of care. The Methodist Church in Ireland believes in a right of conscientious objection to all staff.

Ethnic minority groups

5.87. NICEM supported conscientious objection to direct involvement in the abortion procedure but stressed that legislative provision should not interfere with a woman's ability to obtain an abortion in a timely and convenient manner.

Human rights groups

5.88. Amnesty considered that conscientious objection must only apply to the abortion procedure itself, and that it should be made clear in law and guidance that the right to conscientious objection is not absolute and would not apply in cases where there is a risk to the woman's life or health. It should only be permitted where the person seeking care can still be guaranteed timely and appropriate quality care. A woman's right to life, health and dignity must always take precedence.

5.89. ECNI considered that the inclusion of a right to conscientious objection can have a number of beneficial outcomes, providing legal certainty and clarity for employees and employers. However, any exception to the law must be narrowly defined and objectively justifiable. It needs to be clear who can avail of the right; in relation to what services/treatment the right applies; and how a conscientious objection will be established. The exercise of a conscientious objection must not prevent women from accessing services to which they are legally entitled. The conscientious objector must be under an obligation to refer the case to a professional who does not share that objection.

Political parties/MLAs

5.90. The Workers Party has concerns about the parameters and extent of conscientious objection, and that, if provided for, it may be used to restrict or diminish access to free and safe abortion or to make such facilities and care undeliverable. It considers it essential that active measures are in place to ensure access to abortion. If this guarantee cannot be given, the right to conscientious objection should not be available.

5.9.1 Sinn Féin, the Green Party and Anna Lo MLA support the right to conscientious objection, confined to involvement in the actual procedure.

5.92. Sinn Féin considers that extension of this right to pre and post procedure, and to associated duties, could be at odds with established medical ethics that require medical professionals to treat the patient in front of them without distinction. To create a distinction risks the wholly inappropriate criminalisation of women whose actions are within the law. However, informal accommodation of staff preferences should be respected where practically possible but this cannot be allowed to take precedence over the rights of patients or to extend to the right to regard all terminations as illegal and all participants as suspect. Both Sinn Féin and the Green Party consider the Supreme Court judgment as an appropriate template.

5.93. Anna Lo MLA commented that a woman's right to life, health and dignity must always take precedence over the right of a health care professional to exercise conscientious objection to participation in the procedure.

5.94. PUP supports conscientious objection but stresses that people should receive non-judgmental non-biased advice from all involved in the process.

5.95. LPNI voiced concern that the right to conscientious objection, which should not extend to aftercare, should not override duty of care, nor should it prevent medical staff referring women to other medical providers of abortion.

5.96. In the event of a change in the law, the SDLP and TUV are supportive of statutory conscientious objection. SDLP notes the Supreme Court's restrictive interpretation of 'treatment' in relation to participation in an abortion procedure. It considers that any proposed legislation on conscientious objection in Northern

Ireland should be on a wider maximalist basis, so as to meet the existing concerns of medical professionals.

Pro-choice groups

5.97. Abortion Rights and QUB Pro-Choice Society consider that conscientious objection should apply only to the act of administering an abortion (as in the 1967 Act) and consider it crucial that conscientious objection does not override the duty of care medical professionals have to patients. Nor should it extend to the provision of pre or post procedure nursing care or to any associated duties. In this context, the clarity provided in the Supreme Court judgment was welcomed.

5.98. QUB Pro-Choice Society voiced concern that extension of conscientious objection beyond participation in the procedure would imply a moral judgment on the woman and not on the act of abortion itself. Refusal of treatment based on moral or religious objection is a very dangerous precedent to set with some obvious sectarian, racist and homophobic outcomes if extended beyond provision of abortion.

5.99. Both organisations stressed that conscientious objection should not be allowed to extend to the provision of information on abortion.

Pro-life groups

5.100. Life NI referred to the Supreme Court judgment and objected to its narrow interpretation of 'participation'. They stated that any legislation in Northern Ireland should robustly ensure that the right to conscientious objection should be extended to: participation in abortion; involvement in the procedures of securing or surrounding an abortion; the process of authorising or assisting in making arrangements for someone else to be so involved and; supervising the procurement of an abortion. The right should also specifically cover situations relating to authorisation and referral.

5.101. SPUC also pointed to the Supreme Court judgment but highlights its acknowledgment that a state employer still had an obligation to respect the Article 9 ECHR rights of their employees. It considered ideological advocates of a woman's right to freely choose abortion make freedom of conscience subservient to their

ideological demands and goals and state that healthcare workers should not be asked to be an accessory to ‘killing the innocent’.

5.102. Pro-Life Campaign considered that in all cases, other than medical intervention or treatment necessary to save the life of the woman, the right to conscientiously object must be afforded to hospital personnel.

Reproductive healthcare organisations

5.103. Brook NI and FPA considered that the definitions in the ruling of the Supreme Court judgment, of when conscientious objection is applicable or not, should be followed.

5.104. Both also considered that the right to conscientious objection should not be extended to pre and post procedure care or to any associated duties. In their view, the woman’s right to appropriate care takes precedence over the healthcare professional’s right to conscientious objection.

5.105. BPAS supported the right to conscientious objection, stating that vulnerable women should not be treated by those who are unable to provide non-judgmental care. They pointed to the Supreme Court judgment and stated that it is essential that any conscientious objection provisions are not so broad that they can be used by anti-abortion staff to prevent healthcare services offering pre and post abortion care. There must be limits to the rights of conscientious objection in order that one individual’s rights do not take priority over another.

5.106. FIAPAC was concerned that if conscientious objection were to be permitted then access to abortion could be restricted. If it were to be allowed then it must be subject to onward referral and timely delivery of the abortion service.

Trade Unions

5.107. NUS-USI would like to see the conscientious objection provisions in the 1967 Act being used as the definition for Northern Ireland. Its view is that DHSSPS should provide clear guidance to professionals, without delay. The right to conscientious objection should be confined to involvement in the actual procedure and should not cover participation in all treatments related to abortion.

Women's groups

5.108. WRC and BFN considered that conscientious objection should not extend to cases where there was a risk to the woman's health or life, nor should it apply to pre and post procedure care of patients undergoing a termination. Strict guidance would be needed which made clear that the highest standard of care should be given to all patients and that neglect of patients should be taken very seriously. Freedom of conscience should never restrict access of patients to available services. BFN stressed the importance of referral of the woman to an appropriate medical practitioner. It also recommended a transparent mechanism through which women can raise any concerns with DHSSPS or the GMC over their treatment by a conscientious objector. They pointed to the Supreme Court judgment as a useful template.

5.109. Women's Aid considered that there was a responsibility on the Department and on DHSSPS to develop law and guidance which, while facilitating conscientious objection, ensured that no woman is ever denied a legal abortion and that clear procedures are put in place in all relevant public health facilities to ensure that both the rights of women and conscientious objectors are accommodated. Conscientious objection should not be used to prevent others from dispensing their duty to perform a legal abortion.

Others

5.110. Humani believe that all health and care professionals have a duty to care for all people according to their needs, before, during and after any medical treatment.

CHAPTER 6

RESPONSES FROM MEMBERS OF THE PUBLIC

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Responses which oppose change

6.1. Of the 579 individual, non-lobby, responses which were against changing the law to allow for abortion in cases of lethal fetal abnormality, there were common themes.

6.2. Many responses expressed their disappointment that the Department was trying to limit the scope of the consultation by stating that it did not seek to open up a debate on the wider issues of abortion law – issues labelled as 'pro-choice' and 'pro-life'. Some respondents considered that since the paper conveyed the impression that the proposals were about accommodating choice – the choice to legally avail of procured abortion, then that premise naturally entailed discussion about the value of pre-born life itself, and the fundamental question of the right to life of the unborn.

6.3. Belief in the sanctity of human life was referred to in a number of responses and that using different terms for the unborn child, such as embryo or fetus, could not disguise the fact that the discussion was about the destruction of the life of an unborn child. Some thought the Department, by its use of these terms, was being disingenuous, pointing out that, during ante-natal care or when a mother is undergoing a scan, the midwife does not refer to a fetus but to a baby. This was considered indicative of bias on the part of the Department. There was no acknowledgment in the consultation paper that the unborn child is a living human being from the moment of conception; that all children have the right to be born, regardless of their abilities and that abortion discriminates against the most vulnerable and innocent by depriving them of life.

6.4. Some respondents took issue with the reference in the paper to the 'pressing need' for change. Two cases were cited as examples and in the view of some, this did not demonstrate a need: that the claim was not substantiated by a body of research. A common phrase used to illustrate this view was that 'hard cases make bad law'. There was concern that no counterbalance was given by providing

evidence from women who had continued with their pregnancy after receiving a diagnosis of anencephaly.

6.5. Common to all responses was the view that any change to the law in Northern Ireland would lead to ‘abortion on demand’ or an incremental increase in the use of abortion as has been seen in England and Wales following the introduction of the 1967 Act. Others took this wider and considered that wherever in the world the law on abortion has been liberalised abortion on demand has followed.

6.6. In discussion of the proposal, many found the reference in the consultation paper to ‘no possibility of medical intervention or treatment after birth’ disturbing, and interpreted this as meaning that the baby would be left to die. *It should be clarified that palliative care is given to the baby. Where a clinical judgment has been made that a fetal condition has been assessed by medical practitioners as being incompatible with life, it means that no medical intervention can be offered at birth to improve the chances of survival.*

6.7. Almost without exception respondents stressed the need for resources for the provision of peri natal hospice care, for counselling and support services and for spiritual support from hospital chaplains. Some were of the view that, as a society, we needed to do much more to help women to enable them to make ‘pro-life’ choices.

The consultation questions

6.8. Understandably, the majority of those who opposed any change to the current law on abortion did not address the follow up questions in the consultation, taking the view that discussion of these issues was not relevant once their position on abortion in cases of lethal fetal abnormality had been stated. However, some did address specific questions.

Q: Should the law allow for abortion in cases of lethal fetal abnormality?

6.9. A predominant reason given for opposing abortion in these circumstances was the possibility of misdiagnosis. General references were made to babies who had been born healthy after their mothers had received a diagnosis that the baby they were carrying had a lethal abnormality. Many letters referred only to knowing

someone to whom this had happened. Lobby letter 7 (at Annex C) makes reference to specific examples.

6.10. Another predominant theme was the reference to the harmful effects of abortion on the mental health of the mother, which respondents considered had been ignored in the paper. Many responses, including the lobby letters, considered that the risks of abortion to the mental and physical health of the woman had not been adequately addressed in the consultation. Some responses expressed the view that abortion increased the risk of mental illness, depression and suicide, giving references to research which was stated to confirm this view. One response referred to research which had shown a link between abortion and higher rates of Post-Traumatic Stress Disorder. (No references to the research were given.) Another referenced research by David Ferguson, Professor of Psychology, University of Otago, Christchurch, New Zealand which, the letter states, reveals that abortion is an independent risk factor for the onset of mental illness and found that abortion was linked to higher rates of depression, anxiety, drug and alcohol abuse and suicidal behaviour.

6.11. A doctor specialising in Intensive Care Medicine and Anaesthesia considered that undertaking a medical procedure to prematurely end the life of a terminally ill baby is unlikely to be the least invasive or least distressing option for baby or mother. It deprives mother and baby of a natural death, ‘the precise opposite of what those of us who work with terminally ill patients aim to achieve’.

6.12. Many respondents echoed reasons detailed in lobby letters including:

- a change in the law as proposed would increase the pressure on mothers, who might otherwise have carried a baby with a diagnosis of incompatibility with life to term, to have an abortion;
- it would pave the way for any fetal abnormality as grounds for abortion;
- it would set a dangerous precedent and establish the principle that a disabled child no longer has an absolute right to life.

6.13. One response pointed out that it is incorrect to say that these cases are not covered by the law in Northern Ireland. Under current case law, abortion in these

circumstances is available where there is a risk of a serious adverse effect on the mother's physical or mental health.

Q: If so, how is this best achieved?

6.14. As respondents were opposed to any change in the law, this issue was not addressed.

Q: How would you define lethal?

6.15. The views expressed were as follows:

- use of the term 'lethal fetal abnormality' was unhelpful. It was considered that by its use the Department sought to disassociate the issue from the fact that the taking of a human life was being discussed. It was suggested that a preferable term would be ' unborn child with severe life-limiting conditions'; another considered that the definition overlooked the fact that the baby is already living and is consequently endowed with transcendent dignity and intrinsic worth;
- 'lethal' should apply only where the child dies in the womb;
- any legislation must be limited to strict interpretation of 'incompatibility with life'. The definition must not be allowed to become blurred into matters of poor prognosis over the longer term or measures of the quality of life. If the law was changed, then a definition of the sustainability of life should be included, otherwise the timeframe could be extended beyond recognition;
- with advances in medical science, particularly in the area of antenatal surgery, conditions that may be 'incompatible with life' in 2015 might well be treatable within the next few years. Attempts to tighten the working definitions will only prove to make life increasingly difficult for medical professionals making decisions in these cases;
- to say there could be no intervention after birth is to ignore the rapid advances made in treatments for all kinds of previously untreatable conditions;
- the term 'fatal' was more appropriate as many children are born with life threatening conditions that could be described as lethal – whether the condition will result in loss of life after months or years. It was considered that

use of word ‘lethal’ opened the door for many more conditions to be brought within the scope of the proposed legislation;

- concern was expressed that the term ‘lethal’ was too subjective and could be misinterpreted. No time frame was set on the term for survival after birth and yet some babies can live for days, weeks or longer. In some responses anecdotal evidence was given of a child who had lived with anencephaly until the age of 3; one made reference to a child who lived to the age of 12;
- because the definition in the paper does not specify a duration for ‘life’ or ‘survival’, the proposal would open the way for termination in the case of handicaps where short-term life and survival are possible but not long-term life. Many conditions under the purview of the consultation proposals would permit life and survival for some hours, days, weeks or months after birth. Thus the disadvantage said in the consultation paper to apply to option 2 applies equally to option 4, there being no guidance proposed for the relationship between the definition of lethal and the possible duration of life, or by which the definition of lethal may be objectively assessed. There can be no definition of lethal that removes uncertainty;
- one respondent considered that no definition would adequately address the issues, setting their comment in the context of their perception of the continuing focus in the courts on the definition and redefinition of words in legislation;
- a number of respondents expressed concern about the impact any definition might have in the future in terms of care for the elderly or terminally ill. It was considered that ‘incompatible with life’ was a misnomer - in essence the baby had a terminal illness. Reference was made to recent attempts to legalise euthanasia which had been rejected by legislators. The view was expressed that no lower standard of ethics should be applied to the baby ‘in utero’. The attempt by the Department to define what comes with the scope of the proposal ‘doesn’t bode well for wider society’.
- ‘no likelihood of sustained life’ (para 9.6 of the consultation paper) is an impossibly broad definition and invites the question ‘sustained for how long?’ Sustainability of life is open to such a broad range of interpretations that it becomes almost meaningless.

Q: Do you agree that the best way is to allow clinical judgment to decide when a fetus is incompatible with life?

6.16. The lobby responses were against the use of clinical judgment by two medical practitioners for abortion in cases of lethal fetal abnormality. The common theme in these responses was that this had proved an insufficient safeguard in England and Wales and Scotland. Many made reference to a practice there of doctors pre-signing abortion forms and expressed concern that any change in the law here would lead to similar practices and open the flood-gates to 'abortion on demand';

6.17. Where other individual responses addressed this issue, the views expressed were as follows:

- doctors should not be sole arbiters of the decision. Legal consultation on the decision should be required;
- clinical judgment is no guarantee of the appropriate application of the law; the way is left open to 'decisional drift' leading to more liberal interpretation;
- decision making needs to be scrutinised;
- legislation will only be as strong as the two most pro-abortion medical practitioners that are consulted;
- the decision should be made by a panel of experts. This view was echoed by another respondent who suggested that a Multi-Disciplinary Team meeting should be held (obstetricians, neonatologists, paediatricians and midwives) to make a clear determination that no intervention after birth can be offered to improve the chances of survival;
- any assessment on the likelihood of survival by medical practitioners should be free from any real, or perceived, conflict of interest. There was concern that doctors from organisations such as the Marie Stopes Clinic may not be as objective in making such assessments as a Health Service doctor might be;
- a lack of confidence in the professionalism of some doctors was expressed. If change was introduced, then there should be consequences for those who abuse the laws – e.g. immediately struck off;
- difficult clinical judgments are made frequently by health care professionals but traditionally these have been carried out in furtherance of the objective of preserving life. The Department is proposing to rely on fallible predictions to

trigger a procedure that will deliberately and definitively end the life of an innocent person;

- members of the medical profession should not be allowed, or trusted, to be gatekeepers in any plan to change the law. This respondent stated that babies with abnormalities which are not lethal are currently being aborted on the grounds that the woman will suffer deep psychological distress if the pregnancy continues. A judgment, the response states, often made on the basis of one meeting with a woman or couple who have just been given devastating news but where the majority of the women have not had previous history of any mental health problems;
- doctors can only make a prediction of death, there is no absolute certainty.

Personal experiences

6.18. Some of those who were opposed to a change in the law gave accounts of their personal experience of having babies who had been diagnosed with lethal fetal abnormalities. These letters recounted how precious was the brief time spent with the baby after birth; how the baby was loved and remembered as a member of the immediate and wider family circle; and how these memories, and the ability to have a funeral for their baby, helped in the grieving process. This view was echoed in some responses from midwives, who, while acknowledging the all consuming grief felt by the parents in these cases, did not consider that abortion would ease the disappointment, pain and loss. A predominant view was that abortion was not an easy option: that it interfered with the grieving process.

6.19. One respondent wrote of the birth of his niece who was diagnosed with Edward's syndrome (trisomy 18).

'*My sister and her husband were aware of her condition before birth. After birth the hospital confirmed the diagnosis and was unable to offer any intervention to preserve her life. I had the honour to be present at her baptism in the hospital unit. I held her in my arms. I was wearing a shirt and could feel her responding to the warmth I was providing while she was out of her baby unit. She survived only a few days but she was my niece. I had the further honour of being present when she died a few days later. Her sisters know she was a sibling and loved and still love her. The family and my niece bonded together*.'

6.20. A couple wrote of being told that their baby had anencephaly. They were advised to have a termination but chose to continue with the pregnancy.

'Our baby,… had the opportunity to be loved even if he didn't live in this world. He was able to get a name, have a proper funeral, be acknowledged as a baby – he is the second child in our family. He did not live any days on this earth but he is a very precious memory to our family and he will be in our hearts forever.'

Conscientious objection

6.21. Responses to these questions, where given, were set clearly in the context of opposition to any change in the law. The majority of responses were of the view that the scope of conscientious objection should extend beyond participation in the abortion procedure, to pre and post procedure care and to those involved in indirect duties. Some however, were mindful of the need for women to be provided with professional and compassionate care. The views expressed were:

- it is imperative that no person is obliged to co-operate in the procurement of an abortion;
- grave concern about the Supreme Court judgment. It was considered important that legislative provisions in Northern Ireland are sufficiently robust to withstand dilution under judicial scrutiny;
- the law should be as wide as possible and should never seek to compel anyone within the medical profession to act contrary to their beliefs;
- the right to conscientious objection should extend to auxiliary staff, cleaning staff, civil servants, social workers, chaplains, health visitors, hospital visitors etc;
- the strongest possible protection should be given to those with a conscientious objection;
- the right of conscientious objection is already supported by the General Medical Council and in one sense should not require special legislation to uphold it. To do so might suggest that without it, there is no general right of conscientious objection available to medical practitioners unless it is specifically enshrined in legislation;
- an anaesthetist wrote that if asked to provide anaesthesia for patients undergoing termination of pregnancy, he would consider this to be unethical, the facilitation of murder and could not, in conscience, take part. A desire to protect the unborn child should not be punishable in law;
- it would be obscene to threaten people with penalties or loss of employment for refusing to participate in abortion;
- the right to conscientious objection is recognised by the Catholic Church as an essential right that should be acknowledged and protected by civil law. The

right to refuse to take part in the phases of consultation, preparation and execution of actions designed to terminate human life should be guaranteed;

- there should be reasonable accommodation for medical and support staff indirectly facilitating abortions;
- conscientious objection should extend to participation in the process of abortion, including recommendation, preparation and procedure, but all staff should continue to be involved, irrespective of conscientious objection, in the other aspects of the woman's care e.g. managing physical or mental health conditions, both before and after an abortion;
- a midwife considered that the views of those required to work in this extremely complex and sensitive area should be considered, but the right of conscientious objection should be limited to direct participation in the process;
- Trusts should have clear protocols in place where staff who have a conscientious objection can transfer the care of the patient;
- we as a society must respect how deeply some people hold their views on the value of human life.

Responses in support of change

6.22. Of the 133 responses which were in favour of a change in the law there were a number of issues common to the replies.

6.23. There were a number of complaints that the consultation did not open up discussion on the wider issues, considering that a debate was long overdue on the provision of legal and safe abortion in Northern Ireland. The view was that it is not possible to have a debate on the termination of a crisis pregnancy other than within the framework of a woman's right to choose.

6.24. Another criticism was that the consultation was too 'fetus-centric'. The purpose of the consultation was to better meet the needs of women in extremely distressing circumstances and yet the document did not reflect this. There was little focus, in the proposal, on concerns about the woman's health, mental well-being or safety.

6.25. Many put forward the argument that, in law, women are equal citizens and are able to make their own decisions regarding their health, their bodies and their future. They could think of no other instance in which there is a public debate on an adult woman's ability, or right, to make her own decisions. In this context, several respondents stressed the point that changing the law did not mean that women in these circumstances would have to have an abortion; pro-life campaigners speak as though women will have to have an abortion. Choice should be given to the woman after discussion with medical professionals and her family. Not every woman will make the same decision but it is not for government to make that decision for her.

6.26. Some responses focused on the need for separation of church and state, being of the view that religious belief had no place in legislation regarding women's health and economic welfare and expressed concern that religious organisations might impact negatively on the proposed change.

6.27. Respondents in favour of change also referred to the cruelty and inhumanity involved in not enabling a woman to have an abortion in these circumstances. A response from a retired paediatrician with over 40 years experience in the field of paediatrics stated '*the Executive has a moral obligation to care for women, and also families who often are unable to plead their case effectively. … the very idea that a*

… woman …is forced to carry a grossly imperfect fetus to term is completely immoral..'

6.28. Others considered it barbaric to force a woman to carry a baby to full term knowing there is no hope of life and considered it in contravention of Article 3 ECHR which prohibits torture and inhumane and degrading treatment or punishment. Access to safe and legal abortions was considered a fundamental right in line with the recommendations of the CEDAW Committee. The right to terminate in circumstances of fetal abnormality should be the reflection of a humane society.

6.29. One respondent wrote:

'*Terrible that a woman who receives the most awful news that her baby is not going to survive should receive this news and then just be sent home to wait for her baby to die…… How can she expected to live a normal life whist wondering each day if that is the day her baby will die. Being forced to suffer this against her wishes is cruel and torturous*.'

6.30. Others considered the current situation gender discriminatory with women as the resulting disadvantaged group. Those from lower socio-economic groups or those unable to travel are even more disadvantaged – some respondents stated the cost of travel to England or Scotland for an abortion would be around £2,000, which would have to be found within a short period of time before the 24 week deadline imposed by private abortion clinics. Women with financial means are able to circumvent the law in Northern Ireland by travelling elsewhere, yet women belonging to vulnerable and disadvantaged groups who are unable to travel abroad are unable to access services which are legally obtainable by those who can afford it or who live in other parts of the UK. The situation is further complicated for these women who may wish to bring their baby's remains back to Northern Ireland for burial or cremation, or to have a post mortem examination carried out which may benefit them in a future pregnancy. The failure of the Assembly to deal with this was regarded as both discriminatory and hypocritical and needed to be addressed.

6.31. Many regarded abortion solely as a health issue and contested that it should not be a criminal issue. In this context, several people expressed disappointment that DHSSPS had not been involved in the consultation, regarding it as an abdication

of responsibility and a demonstration of clear disregard for women's health. Some made reference to the fact that abortions in the circumstances referred to in the consultation could be accessed in Northern Ireland under the Bourne judgment but that DHSSPS draft guidelines had taken away all decision making from the medical profession. The guidelines were regarded by some respondents as tantamount to a threat. Concern was expressed that, if change was introduced, DHSSPS would attempt to hamper access to abortion.

The consultation questions

Q: Should the law allow for abortion in cases of lethal fetal abnormality?

6.32. The main theme of responses in favour of a change in the law was a disappointment in the limitations of the consultation. Views expressed were as follows:

- scope of permissibility of abortion should be widened to include cases where two clinicians consider that if the child were born it would suffer such serious adverse physical or mental abnormalities as to be seriously handicapped;
- abortion should be available for severe physical or mental handicap, and where it is determined that continuing the pregnancy would create a risk to the woman's life or would cause serious longstanding harm to her physical or mental health. This should be without referral to a psychiatrist or her being stigmatised as having a mental illness;
- given the advances in diagnostic techniques, women are now able to be informed with a high degree of certainty of serious fetal abnormality when they present for an anomaly scan at approximately 20 week gestation. Many of these woman can access the same information as women elsewhere in the United Kingdom and can access information on the internet. It is reasonable for them to assume that they will be offered the same options for care and treatment as those women living in Great Britain;
- situating an 'exemption' within the current model of criminalisation of women seeking abortions and medical practitioners carrying out such abortions risks having a chilling effect on the provision of any lawful abortions in NI. The lack of clarity in the law means that women who should be lawfully entitled to abortions in Northern Ireland due to risk of serious and long term mental or physical harm or a risk of life must travel to United Kingdom or Europe to pay for abortion services that should be available through NHS in Northern Ireland;
- enforced continuation of pregnancy following a diagnosis of lethal fetal abnormality is potentially very harmful to a woman's physical and mental health and creates a serious risk of exacerbating an already traumatic experience;

- right to abortion should be extended to other circumstances which make impending motherhood a potentially damaging experience to the woman's physical or mental wellbeing;
- women should have the right to free, safe abortions, otherwise some may risk their health by purchasing online abortifacients;

6.33. However, some responses stated clearly their view that abortion should only be allowed in these limited circumstances;

- where the fetus is diagnosed as incompatible with life, the rights of the mother and the effects of carrying on with the pregnancy full term, should she not wish to do so, should take precedence;
- abortion should only be available where the fetus is not viable.

Q: If so, how is this best achieved?

6.34. While few respondents addressed this question specifically, option 4 was considered the best way forward.

6.35. Some considered that the 1967 Act should be implemented in Northern Ireland, bringing it into line with the rest of the United Kingdom.

6.36. One respondent considered that option 3 – no statutory definition provided – was the best way to proceed. In their view this would permit the medical practitioner to decide whether a condition could be defined as severe.

Q: How would you define lethal?

6.37. The majority of respondents agreed with the definition provided in option 4. However, some respondents made the following suggestions for an alternative definition:

- any combination of circumstances that obstetricians agree will lead to the death of the baby;
- death before or shortly after birth or anything that could lead to severe medical concerns for the mother and could potentially cause her death before, during or after birth;
- where the fetus could survive to term but could not survive outside the womb;

- where the fetus will not survive to term or will die within one year of birth;
- deadly, mortal, causing or capable of causing death;
- that the baby is unlikely to survive to term or for more than a few hours after birth;
- some respondents considered that ‘severe fetal abnormality’ would be more appropriate, with the definition informed by medical experts on a case by case basis, not specified in statute. Any legislative change should not obstruct this medical assessment. Guidance on what should be considered lethal/severe should be issued by medical bodies, such as General Medical Council and/or the Royal College of Midwives or DHSSPS rather than being set out in statute. It would therefore have the flexibility to change and adapt over time in line with medical advances;
- simple definitions of the term lethal are provided by the Oxford and Collins dictionaries, namely ‘sufficient to cause death’ or ‘able to cause or causing death’;
- definition should be extended to cover circumstances where extreme measures must be taken to improve the chances of the fetus surviving without guarantee;
- the Royal College of Obstetricians and Gynaecologists refer to fetal abnormality and this should be the term used;
- any definition should be flexible enough to allow for presently unforeseen circumstances to be brought into the exemption case with as little trauma as possible for the pregnant woman.

6.38. Other comments expressed concern for the application of the legislation within the proposed definition:

- legislative definition should not be developed. It should be left to the judgment of medical experts;
- particular reference was made to the chilling effect of the criminal law on medical practice – doctors may be unsure of when they can lawfully provide terminations;

- as no guidance is offered on ‘incompatibility with life’, to charge clinicians with the application of such a test is inappropriate. The proposal did not deliver the necessary clarity.

Q: Do you agree that the best way is to allow clinical judgment to decide when a fetus is not compatible with life?

6.39. A range of views were given:

- a response from a consultant paediatrician who has spent his professional career caring for premature and sick newborn infants addressed the issue in some detail, setting his comments in the context of his Christian faith. He considered that it was essential that consensus be achieved in the practical interpretation of this terminology (including professional and lay involvement) and incorporated into guidelines for practice. To ensure that such judgments take account of the relevant current medical evidence, such guidelines should include the responsibilities of those doctors with respect to the medical evidential basis on which the diagnosis and prognosis are made. The guidelines should also include reference to the necessary expertise of the doctors involved. It was his view that such guidelines would provide an important safeguard against unethical practice or ‘mission creep’ into a wider range of conditions, for example where abnormalities may be detected which have the potential to shorten or impair life, or are likely to require medical intervention or treatment for their management after birth;
- two obstetricians should decide if a fetus has a potentially lethal condition or one which will result in severe physical or mental handicap;
- one respondent considered that there must be an agreed and prescribed template for completion by respective specialists and this must be subject to some form of regional audit procedures within clearly defined periods. It should be a legislative requirement that the results of such an audit be placed in the Assembly library;
- a prevalent view was the importance of the woman (and where appropriate her partner) being included in all discussions so that she had a firm understanding of the risks involved and of all the options available to her. Safeguards should be in place to ensure that the clinical assessments carried

out by medical practitioners are done in a way that recognises the woman's particular vulnerability and powerlessness at such a time. It was considered important that a holistic care package was put in place to ensure that a woman is supported with the full range of services over the course of this period from the clinical assessment of lethal fetal abnormality, through to her decision to continue with the pregnancy or seek a termination, and the aftermath of that decision. It was not considered enough to decriminalise abortion in these circumstances - there was a need to work with DHSSPS to ensure that women are properly supported over the course of this period and afterwards;

- some concern was expressed at the need for two clinicians, taking the view that it might lead to delay. It was considered that deliberation between the pregnant woman and one clinician was sufficient;
- a panel of medical experts, consisting of a minimum of three, should look at situations on a case by case basis;
- physicians who have registered a conscientious objection to providing medical care relating to an abortion should not be allowed to take part in the decision.

Personal experiences

6.40. Respondents wrote movingly of their personal experience of babies who had been diagnosed with lethal fetal abnormalities.

6.41. One couple were told their baby had a condition which was incompatible with life. They were told that, born alive, their baby had insufficient lung tissue to be ventilated. All that could be done for the baby would be pain relief. The respondent says that the option of termination would have been helpful. It was their view that this would have been easier for the baby than to be forced through the trauma of birth.

'*In my mind it would probably have been easier for [the baby] to be terminated in the womb than be forced through the trauma of birth and then have the misery of gasping for breath but not having lungs to fill with air. Any parent wants to protect their child from harm; so in circumstances such as this, to me, a termination is an act of love*….'

Their baby was stillborn a few days after diagnosis but the legal position he and his wife faced added to their distress.

'*My wife wondered about her right to take the decisions she felt would be best for both her and our baby – to essentially prevent in the only way possible our baby from suffering any further unnecessary pain*.'

6.42. A minister wrote to share his experience of providing pastoral care to a couple who had received a diagnosis of gross abnormality of their much wanted baby. After a time of intense pressure during which the mother was on the point of mental collapse, the couple decided that an abortion was the right course of action. On learning that a termination of the pregnancy could not be provided in Northern Ireland, and that the doctors could be open to the charge of procuring an abortion if they referred the couple to doctors in the UK, the couple travelled outside Northern Ireland where a procedure was performed which involved injecting the baby's heart. They then travelled back to Northern Ireland where the mother was induced. Out of this experience it is his view that there should be provision for the termination of a pregnancy on the grounds of gross abnormality of the fetus or if the fetus has no realistic chance of life.

‘*Never have I seen more distressed parents, never have I felt more pastoral pressure…. The whole situation was made much worse due to the current law in Northern Ireland.’*

Conscientious objection

6.43. Almost all respondents who were in favour of a change in the law, also favoured allowing for conscientious objection but limited to those involved in direct participation in the abortion procedure. The predominant view was that the right of conscientious objection should not extend to pre or post procedure care. Other views included:

- the right of conscientious objection should only be in relation to the prescribing or administration of abortifacients or the use of instruments;
- it should extend to all treatment related to an abortion in these specific circumstances, including pre and post procedure care together with all associated duties, such as supervising and supporting other staff and delegating tasks to staff involved in the provision of such care. However, a doctor who holds a conscientious objection should make sure the patient has enough information to arrange to see another doctor who does not hold the same objection. (Consultant paediatrician);
- every Health and Social Care Trust should provide an abortion service staffed by those without an objection to the service;
- a very prevalent concern was that conscientious objection should not prevent doctors from referring the woman to another doctor who is known not to have a conscientious objection. One respondent considered that there should be an explicit legal obligation to do so, particularly important in NI where there is a strong Christian religious ethos which influences the public sphere;
- care must be taken that doctors who choose to provide abortions are given our strongest support against pro-life activists;
- in the interests of the women having the procedure, they will be very vulnerable and it would not be best practice for them to be cared for by staff who disapprove of them;
- if the abortion has been legally performed and the conscientious objector has not been required to assist directly or indirectly in the actual procedure, then they would simply be providing medical care to an individual about to undergo or recovering from a legal medical procedure, which should be regarded in the same way as any other medical procedure;

- to suggest that general care should not be provided to women who are seeking or have sought an abortion is to stigmatise a category of patients within the medical facility as being undeserving of the same high standard of care as those who are receiving non-abortion related general care;
- Important that the protection of conscientious objection should apply to individuals and that it should be made clear that there would be no protection of institutional conscientious objection.

6.44. A few, however, were against conscientious objection in any circumstance, giving the following reasons:

- medical professionals should prioritise the needs and wishes of their patients rather than their moral standing or faith. Job and opinion should be separate and no-one should be denied healthcare or have their treatment compromised because of a medical professional's personal views;
- doctors and staff working in gynaecology should understand it may be part of their role. They are there to support the medical needs of the whole population, not just those who hold their particular religious beliefs. Staff should carry out their duties without making moral judgments;
- people need to do the job they are paid for or change roles;
- conscientious objection should not be permitted for terminations in these circumstances as it has not been present for instances where pregnancies must be terminated due to a risk to the woman's life. As such it promotes the idea of types of deserving abortions and neglects to consider the woman's position.

Other issues

6.45. One respondent expressed concern at the idea of central collection of data on terminations of pregnancy. The numbers of patients will be small and thus patients may be identifiable. To ensure that patient confidentiality and anonymity is not breached the respondent suggested that figures alone are submitted by maternity units.

CHAPTER 7

PETITIONS AND LOBBY CAMPAIGNS

CHAPTER 7: PETITIONS AND LOBBY CAMPAIGNS

Introduction

7.1. As outlined in chapter 1, there were **921** letters opposing change written in support of seven lobby campaigns.

7.2. There were also **23,622** petition signatures opposing change. The petition, called Project Love, was organised by Every Life Counts Ireland. It was made up of **18,000** postcards, which were delivered to the Department by Precious Life; a further **2,197** sent directly to the Department and **3,425** signatures to the electronic version of the petition on a website called CitizenGo.org.

7.3. Although it was not possible in all cases to confirm that the respondents lived in Northern Ireland, the above figures nevertheless include all responses.

7.4. As recorded in chapter 8, the lobby campaign letters and the petition, along with the individual responses which opposed change, show that 25,140 people in total registered their opposition to a change to the law. This is 1.8% of the adult population in Northern Ireland.

The petition

7.5. The petition was entitled 'Project Love' and was organised by Every Life Counts Ireland. It comprised a series of postcards with six individual stories and photographs. A letter to the Justice Minister appeared on the reverse side rejecting the Department's proposals to amend the criminal law on abortion. It also called for better provision of perinatal hospice care in every hospital in Northern Ireland and requested that the Health Minister is made aware of this submission.

7.6. **20,197** responses were received using the pre-formatted cards produced by Every Life Counts Ireland. **18,000** of these were delivered to the Justice Minister's Office in Castle Buildings on 19 January 2015. The remainder were posted to the consultation response address either individually or in batches. Examples of the pre-formatted cards can be found in annex C at the end of the document.

7.7. Project Love cards also formed the basis of a petition posted on www.citizengo.org. **3,425** electronic signatures were received.

Lobby campaigns

7.8. Other lobby responses, in the form of pre-prepared letters, were also received, again either individually or in batches. For some responses, people used the pre-prepared letters as a template, copying the content verbatim or using parts of one letter as the basis of their response. There were seven different lobby letters:

Lobby 1 - **331** responses received. 155 with NI addresses; 176 with no address.

Lobby 2 - **121** responses received. 104 with NI addresses; 17 with no address.

Lobby 3 - **273** responses received. 264 with NI addresses; 9 with no address.

Lobby 4 - **25** responses received. 16 with NI addresses; 9 with no address.

Lobby 5 - **17** responses received. 16 with NI addresses; 1 with no address.

Lobby 6 - **133** responses received. All from NI.

Lobby 7 - **16** responses received. 14 with NI addresses; 2 with no address.

Pastor Bell's petition gathered **5** electronic signatures, all with NI addresses.

7.9. Copies of the lobby letters and Pastor Bell's petition are provided in Annex C at the end of the document.

CHAPTER 8

POLICY DEVELOPMENT AND LEGISLATIVE PROPOSALS

CHAPTER 8: POLICY DEVELOPMENT AND LEGISLATIVE PROPOSALS

Summary of evidence

8.1. As a result of responses to the consultation from a range of bodies and organisations, and developments more widely, the Department believes there is sufficient evidence to suggest that a case has been established for a limited legislative change to the law and that there is substantial support to make such a change.

8.2. In particular, the evidence from medical practitioners and professional bodies clearly shows that women in these circumstances need to have an option to terminate the pregnancy for their own health and wellbeing. The responses made reference to the risk of injury to physical or mental health that such a pregnancy can have. Many supported the right for women to make a decision on what was best for them and made clear that whatever the decision was, their primary duty as medical practitioners was to provide the best clinical, medical and nursing care, either to support the woman in carrying the pregnancy to term and, where applicable, providing optimum palliative and nursing care for the baby after birth, or in enabling a woman to have a safe termination with the associated optimum medical and nursing care.

8.3. The concerns expressed by those who opposed change were also considered carefully. Responses to the most common of these concerns are set out later in this chapter. However, the most fundamental point is that, in the limited circumstances of a fetal abnormality which is likely to cause death either before birth, during birth or in an initial period after birth, the Minister‘s view is that the health and wellbeing of the woman must take priority, that the law should be clear and offer certainty, and that women in Northern Ireland should be permitted to decide in these circumstances. Although the case law arising from the Bourne judgment may intend to include, or have the effect of including, circumstances such as these, the proposed statutory change to the law will make it beyond doubt and provide clarity to both the pregnant woman and her medical team that, if she decides that it is in her own best interest for the sake of her health and wellbeing to terminate the

pregnancy, then it is lawful for such a procedure to be undertaken in Northern Ireland.

8.4. It is also the case that for those women who want to continue with their pregnancy, the proposed change will have no impact or effect on such a decision. Medical and nursing care will continue to be provided. The Department noted the many references in the consultation responses which sought improvements in perinatal hospice provision. However, this is a matter for the Health Minister, not the Justice Minister.

8.5. In direct response to the consultation 65 submissions were received from groups representing a major cross section of interested parties. Of these, 47 were in support of changing the law to a greater or lesser extent, including all the relevant medical and nursing professional bodies, reproductive healthcare groups, human rights organisations, trades unions, political parties and others. There were also 133 replies from individual members of the public who wished to see change.

8.6. There have also been two public opinion polls which suggest that a majority of the population are in favour of change. A Belfast Telegraph poll in October 2014 suggested that 58% of people wanted abortion laws liberalised. One commissioned by Amnesty International showed that 60% of people think the law should make access to abortion available where the fetus has a fatal abnormality. There has also been political support for change in these circumstances from Sinn Féin, the Green Party and some individual MLAs from those parties where members will vote according to their own beliefs.

8.7. In addition, the Department has taken note of views and evidence provided by interested parties through public statements and published documents in the context of ongoing public interest and heightened media awareness. For example, the personal contribution to the issue provided by Cathal O hOisin at the launch of the Amnesty report ‘Barriers to Accessing Abortion Services’, and the input of Samina Dornan, Consultant in Obstetrics, and Robin Ashe, Chair of the NI Committee of RCOG, on the issue of accuracy of diagnosis.

8.8. Against this, 18 organisations objected to any change. These were churches and faith groups, two political parties and organisations such as Precious Life and

SPUC. There were also 579 individual replies rejecting change. The Department also received a postcard petition opposing change, organised by Every Life Counts Ireland, with 20,000 signatures. A similar campaign hosted on the CitizenGo website added over 3,000 signatures. There were also 921 letters submitted as a result of seven lobby campaigns.

8.9. The responses to the consultation, along with the lobby campaigns and the petition, show that 25,140 people in total registered their opposition to a change to the law. This is 1.8% of the adult population in Northern Ireland. We have noted carefully the views of these respondents and we have attempted to address their concerns later in this chapter. Against this, 47 out of 65 organisations representing many and varied groups across society were in support of a change. We also noted the results of public opinion surveys carried out on behalf of the Belfast Telegraph and Amnesty international.

8.10. The Minister notes, and is mindful of the fact, that responses in favour of change and responses against were submitted from the perspective of sincere and genuinely held views, whether professional, political, religious, moral or ethical. The Minister believes that all views are to be respected in a democratic society and that for some organisations and individuals any change in the law would be unacceptable from their perspective. This is understood and respected.

8.11. The Minister has, however, to make a decision on proposals for reform. He has carefully balanced the issues and his proposals are set out in this chapter.

Addressing concerns

8.12. A number of issues were raised in consultation responses by those who have moral and ethical positions which would prohibit abortion in any circumstances.

There is always a possibility of misdiagnosis. Doctors cannot predict with accuracy how long a baby will survive.

8.13. There are a number of responses raising concerns about the likelihood of ‘Doctors getting it wrong’ or not being able to predict how long a baby will survive.

8.14. Whilst acknowledging that medical diagnosis cannot be flawless, the evidence presented to the consultation by all the medical bodies points to a high degree of

accuracy in diagnosing fetal anomalies. The responses told us that advances in recent years in prenatal diagnostic techniques have improved immeasurably, and the rate of progress has become even faster in recent years with the advent of Next Generation Sequencing and other modalities that allow for identification of many serious genetic abnormalities during pregnancy. We also heard that making a diagnosis of lethal abnormality is often straightforward and quickly determined by ultrasound while at other times it will be strongly suspected at ultrasound and subsequently confirmed following investigations and an abnormal result, for example in the case of Trisomy 13. The RCM said that '*given the advances in diagnostic techniques during the last decade, women are now able to be informed with a high degree of certainty of serious fetal abnormality when they present for an anomaly scan at approximately 20 weeks gestation*'.

8.15. The evidence from both the medical professional bodies and individual practitioners who submitted to the consultation does not, therefore, support the view that there is a high prevalence of misdiagnosis.

8.16. The concern that Doctors can't predict accurately how long a baby will survive is also acknowledged. It is accepted that the proposed clinical assessment at the point of diagnosis cannot predict with chronological accuracy the exact amount of time a baby may live if born with a fatal condition. The assessment does not ask for this as it could never be given. The threshold is determined by both (a) the likelihood of death occurring in utero, at birth, or at an early point after birth, that is, it is more likely than not that one of these outcomes will occur, and (b) the fact that, after birth, there is no medical treatment available to improve the condition and sustain independent life.

8.17. The likelihood of cases such as anencephaly falling outside of the above framework is illustrated by figures published by the Northern Ireland Statistics and Research Agency[1]. In the ten years to 2013, there were 27 live births of babies with this condition. 22 died within one day of birth, four died within one week and one within 28 days. It is therefore clearly the case that, even when only looking at the

[1] Number of Deaths with Anencephaly1 recorded as the Underlying Cause of Death, 1999-2013: Demography & Methodology Branch, NISRA

small number of live births with this condition, it is likely to prove fatal in the initial period after birth.

Such a change will lead to 'abortion on demand' and there are insufficient safeguards to affirm that the conditions of the legislative provisions are met.

8.18. As a result of the narrowly defined terms of the proposed legislative change, concerns expressed about 'opening the floodgates' to abortion 'on demand' are understood but, we believe, unfounded. The Methodist Church and Church of Ireland recommended that a judge, in the family court, should approve the request of the two doctors for a termination. They cited that practice under the 1967 Act appears to have led to abortion on demand.

8.19. Evidence from all the medical professional bodies and the practitioners would point to this being unnecessary. The limited set of circumstances for a termination is well defined and understood by the medical profession. Contrary to what has been put forward by a number of respondents, the parameters of the proposed legislative framework under consideration cannot be compared to the much wider provisions of the 1967 Act in the rest of the United Kingdom and suggestions that this law has led to abortion on demand. There has been no evidence provided to back the assertion that the same would happen here as a result of the proposed change. The statutory position here would be clear – abortion would only be available in the event of a serious fetal anomaly being detected prenatally where the prognosis, agreed by two suitably qualified medical practitioners, is that the condition is likely to cause death either before, during, or in the initial period after, birth. The safeguard is clear. Where there is an ability to treat the condition, this statutory exception will not apply. The clinical assessment must be that there is no medical treatment which can be offered to substantially improve the chances of survival. Outside of the statutory exception, the Bourne principles will continue to be applied. There is no interpretation of this proposed limited change which would allow for a reasoned comparison with the provisions of the 1967 Act.

There is no evidence that abortion helps the psychological effects of dealing with lethal fetal abnormality.

8.20. Responses to the consultation from pro-life groups and supporting petitions relied heavily on this argument. However, respondents from the medical professional bodies made the point very strongly that denying abortion in these circumstances to women who wish to terminate a pregnancy can cause a risk of serious harm to her mental health. It was also very much recognised, however, that there must be mechanisms by which support and care is provided at this difficult time and information given to any woman in order that she can make a decision which is best for her wellbeing, either to continue with the pregnancy, with full medical support and nursing care, or to terminate the pregnancy and have the same medical and nursing support for that decision.

There would be pressure put on women to have abortions where anomalies were diagnosed.

8.21. Many of the churches and faith groups, along with the pro-life organisations gave this as a reason not to change the law. Again, there is no evidence to back this assertion. The medical bodies were clear in their submissions. Their desire is to provide all women with the best treatment possible and with the most compassion in what are very tragic cases. For example, the NICRCOG submission stated that '*while some mothers may cope with the diagnosis and carry on with the pregnancy, the diagnosis for others may indeed be more than they can bear (cf. para 1.3 Consultation Document). The NICRCOG believes that both these groups of women must be treated with humanity and compassion. At times, that may involve termination of the pregnancy.*' The RCM said that '*any decision should be made following discussion with the team caring for her and after she has been offered objective counselling. It is our experience that very many women, when given all of the facts, will choose to continue with their pregnancy and they will be provided with all the care and support necessary to assist them in coping throughout their pregnancy and following the birth of their baby.'*

Human rights are being ignored

8.22. As documented in the previous chapter, we received responses from human rights bodies and from a number of other respondent organisations citing their belief that the current law on abortion in Northern Ireland is outwith international human rights obligations, and will only be compatible with those obligations if a change is made to decriminalise abortion in cases of serious fetal abnormality and for pregnancies as a result of sexual crime. At the same time, NIHRC has been granted leave by the Court for a judicial review of the current law. The hearing is scheduled to take place in June 2015.

8.23. The Department acknowledged in the consultation paper that there were human rights concerns, but felt that these concerns did not constitute an outright breach of ECHR obligations.

Developing the legislative proposal

8.24. Having taken all of this into account and having acknowledged the moral and ethical position of those groups and individuals that do not want any change to the law, the Department believes that the weight of evidence and the content of the arguments, rather than the number of signatories to a petition or lobby campaign, seem largely to favour a move to clarify the law so that women would be able to access services for a termination of pregnancy in circumstances of fatal fetal abnormality where continuing with the pregnancy would have a detrimental effect on their health and wellbeing. The following evidence from medical practitioners and professional bodies illustrates the evidence provided:

NICRCOG said:

'There are circumstances where the diagnosis of a severe or lethal abnormality may threaten a woman's mental health, seriously, adversely, for a long-time and without her having a certifiable mental illness. It must be recognised first that these are "wanted" and often "planned" pregnancies. While some mothers may cope with the diagnosis and carry on with the pregnancy, the diagnosis for others may indeed be more than can bear (cf. para 1.3 Consultation Document). The NICRCOG believes that both these groups of women must be treated with

humanity and compassion. At times, that may involve termination of the pregnancy….. A person should not be guilty of an offence…..if two medical practitioners are of the opinion, formed in good faith, that …..continuance of the pregnancy would be likely to have a detrimental effect on the health of the mother'

RCGPNI said:

'It is the College's view that a woman carrying a foetus with a lethal abnormality such as anencephaly should be allowed to terminate their pregnancy, if they choose to do so. This recommendation is made on the basis that the foetus would not be expected to survive after delivery and the real risks posed to the patient's health if the foetus was carried to term.

'The RCGPNI supports the legalisation of abortion for lethal fetal abnormalities as some conditions contain risks for the patient's health if brought to full term. For example, anencephalic pregnancies have a higher incidence of polyhydramnios (increased liquor volume) which causes increased discomfort and incidence of preterm labour. Anencephalic foetuses are unable to fully flex their necks and thus have a higher rate of caesarean delivery. Caesarean deliveries have an inherent risk to the woman's health and impact on future pregnancies due to an increased risk of subsequent uterine rupture.'

Consultants in the Department of Fetal Medicine at the Royal Jubilee Maternity Service proposed:

' that a person would not be guilty of an offence relating to abortion when a pregnancy is terminated if two registered medical practitioners are of the opinion, formed in good faith, that a fetal condition has been assessed as lethal and that continuance of the pregnancy would be likely to have a detrimental effect on the health of the mother.

RCM said:

'The RCM reports a growing concern about the threat to health and wellbeing of women, who, without access to abortion services in Northern Ireland, and without the financial means to travel to GB to access safe, legal abortion services are purchasing illegal abortifacient drugs via the internet. These women are often

very reluctant to disclose this fact to healthcare staff due to the threat of criminal sanctions being imposed. There is no mention in the consultation of any change in the legislation that will enable these women to feel that it is safe for them to provide this information to those caring for them, and it would be helpful if this issue were to be considered in taking the legislation forward.'

RCN said that it:

' urged legislators and policy-makers to reflect on whether it is really acceptable in the second decade of the twenty-first century for the legal position on the termination of pregnancy in Northern Ireland to be almost entirely dependent upon two pieces of legislation dating back respectively 154 years and 70 years. The RCN believes that there is an obligation upon those charged by the people of Northern Ireland with creating and upholding the legal framework in which life is conducted here to ensure that it is modern, relevant and fit for purpose. This consultation marks a significant step forward in this respect.'

8.25. In summary, opinion expressed by NICRCOG and the consultants in the Department of Fetal Medicine at the Royal Jubilee Maternity Service, felt that the existing law, supported by guidelines, needed to allow for termination of pregnancy in cases where fetal abnormality results in a detrimental effect on the health of the woman.

8.26. Others recognised, acknowledged or supported the policy objective to change the law to enable women to make an informed choice as to a termination without the requirement that continuing with the pregnancy would result in a risk to her mental or physical heath which is serious and either long term or permanent.

8.27. Some argued that the objective of providing choice in those circumstances should extend to serious but not immediately fatal abnormalities where, for example, a serous genetic disorder would adversely affect the woman, her family or existing children.

8.28. The existing case law provides for termination of pregnancy only to protect the woman against the risk of physical or mental health issues which are real and serious and long term or permanent. However, there may be cases when there is a risk of damage to a woman's health through carrying a pregnancy in these

circumstances which is assessed not to meet this high threshold and which may therefore be outside of the current legal parameters for a termination. As a result, the proposal to make this exception part of the statutory law is sound. From evidence provided to the consultation it is clear that women faced with these circumstances can experience a variety of reactions and, whereas those who decide it is best for them to continue with the pregnancy are accommodated and supported in this decision, and those who may face a risk of serious harm also find that their health can be protected under the existing law, there are others who may not fall within either of these groups but who face trauma, distress, and possible financial hardship, because they cannot access the health service they require.

The proposed legislative framework for fetal abnormality

8.29. The proposed law would therefore provide for a statutory exception, in addition to the existing case law exceptions, to the criminal offence of abortion in the following circumstances:

- where a diagnosis has been made of a fetal abnormality which is likely to prove fatal and the continuance of the pregnancy would be likely to have a detrimental effect on the health and wellbeing of the woman;
- in relation to a diagnosis of a fetal abnormality which is likely to prove fatal, an assessment must be made by two suitably qualified medical practitioners, in the field of obstetrics, fetal medicine or genetics, whichever is the most appropriate to the case, that the condition is likely to cause death either before birth, during birth or in an initial period after birth, and, in the event of a child being born alive, there would be no medical treatment, other than appropriate palliative and nursing care, which could be offered to treat the condition in order to substantially improve the chances of survival.

8.30. It would be made clear that:

- every woman in these circumstances, where such an assessment has been made, must be given an opportunity to decide freely whether to terminate the pregnancy or continue to the point of natural delivery;

- where a woman decides to continue with the pregnancy she should receive suitable medical care to enable her to do so;
- where a woman decides to terminate the pregnancy she should receive suitable medical care to enable her to do so.

Conscientious objection

8.31. There was general support for a clause to provide for conscientious objection. Many of the groups advocating no change to the law did say that, if the proposals were to become law, then it was imperative that medical staff had a right not to participate on grounds of conscience. The Caleb Foundation and CARE proposed that there should be a right within existing case law provisions. Christian Concern argued for the need for any conscience clause to expressly cover both direct and indirect activities that facilitate the abortion procedure both prior to and post abortion (except post-termination nursing care), including the supervision of staff who perform abortions and the booking of terminations. The Christian Medical Fellowship also said that, where abortions are carried out under the terms of the existing law, it believed that there should be provision to respect conscientious objection for all clinical staff engaged at any stage of the process.

8.32. Evangelical Alliance proposed that the concept of reasonable accommodation would seem like a common sense way to frame such a clause. In relation to the extent of this accommodation, most people holding such an objection would likely object to being a part of pre-procedure care and the termination itself. They presume that many people would be willing to provide treatment post-termination when the purpose shifts to medical care of the woman. *'However the very notion of conscientious objection is a very subjective and personal thing. Abortion touches deeply held principles and beliefs and we would want no one to be forced to provide care where they felt they were complicit in an act of killing. Similarly we would want no woman to feel that they might receive compromised care from someone who felt forced into that situation.'*

8.33. Many referred to the judgment by the Supreme Court in the Doogan and Wood case brought by two midwives from the Southern General Hospital in Glasgow, which ruled in favour of a narrow interpretation of participation in treatment, defined

as actually taking part, in a “hands-on” capacity, in the treatment or performing the tasks involved in the course of treatment. Those not in support of a change to the abortion laws felt that it would be necessary to frame the conscience clause to allow for a wider interpretation of participating in treatment.

8.34. In addition, the Catholic Bishops proposed that the clause should extend to institutions rather than just individuals.

8.35. Views from the medical professional bodies also supported the right not to participate in terminations if the law was changed, but were largely in favour of the interpretation made by the Supreme Court judgment. NICRCOG said it should apply only to the administration of abortifacients or the use of instruments and should exclude occasions where there is a threat to the life of, or grave permanent injury to, the woman. Consultants in Maternal and Fetal medicine at the Royal Jubilee Hospital said the same and the RCM and RCN made a similar case.

8.36. BMA NI also supports the right of doctors to exercise a conscientious objection and would welcome such a clause. However, it recommends that this clause is extended beyond fetal abnormality and sexual crime and applied to other legal abortions that are carried out in Northern Ireland.

8.37. GMC states that it does not have a role in determining the law but makes similar provision in its own guidance for doctors to opt out of providing a particular procedure because of their personal beliefs and values, as long as this does not result in direct or indirect discrimination against individual patients or groups of patients, and provided that this opting out does not result in substantial delay to the patient accessing appropriate care.

8.38. RCN said that ‘*The argument that Northern Ireland law only currently permits termination in cases where the woman’s life is in danger and therefore, because the right of conscientious objection does not pertain to these circumstances in any eventuality, such a right does not need to be defined in Northern Ireland, is unsustainable. The RCN therefore welcomes the fact that the Department of Justice is now proposing to do what the DHSSPS should have done many years ago and legislate on this matter*.’ It also says that it is essential that the law makes it clear that the right to conscientious objection exists only in the very specific procedures

directly related to the act of termination, as recently reinforced in the Supreme Court judgment. However, it also argues for the right to extend to all terminations.

8.39. There were many responses advocating the need for any right to be carefully qualified, for example, Amnesty said that:

> '*a right to conscientious objection is not absolute and would not apply in cases where there is a risk to the woman's life or an immediate risk to her health. A woman's right to life, health and dignity must always take precedence over the right of a health care professional to exercise conscientious objection to participation in an abortion procedure.'*
>
> RCM echoes this:
>
> *'this right should not be absolute and that in any event where there is a risk to the life of the mother then the woman's right to life takes precedence over the right of a health care professional to exercise a conscientious objection to participation in abortion.'*
>
> NICRCOG also said:
>
> *'Any right …..should exclude those occasions where there is a threat to the life of, or of grave permanent injury to the physical or mental health of, the woman.'*
>
> A consultant in Genetic Medicine said:
>
> *'Yes, but this MUST be coupled with a duty imposed upon HSC Trusts that offer obstetric services that the service CAN be supplied in a timely manner without further imposition on the woman.'*
>
> Sinn Féin submitted:
>
> *'A reasonable accommodation of conscientious objection cannot be allowed to take precedence over the rights of patients whose circumstances meet the legal criteria from any misguided hostility or neglect.'*

Options

8.40. There are, therefore, a range of responses to the questions on conscientious objection as follows:

- there should be a right not to participate in any abortion in Northern Ireland, including abortions under the current law;
- the right should extend to institutions rather than individuals;
- there should be a right to object if the law is changed for fatal abnormalities;
- there should be a right not to participate in any treatment connected to termination of pregnancy;
- there should be a right not to participate in any treatment except post termination nursing and medical care;
- there should only be a right not to participate directly in the administration of abortifacients or use of instruments.

Proposal for legislation on conscientious objection

8.41. Having taken into account the views expressed in response to the consultation, there would seem to be a clear body of opinion in favour of a clause to allow for conscientious objection, with many responses pointing to the need for this to be a qualified right which will provide women with an appropriate standard of health care. The Department also recognises the importance of the responses from the professional medical bodies whose front line members will be affected by any change to the law. With these factors in mind, and taking account of the Supreme Court judgment, it is proposed that there should be a clause which would allow for a right of conscientious objection in respect of any termination of pregnancy, except where there is a risk to the life of the woman or of injury to her physical or mental health which is likely to be either long term or permanent. The extent of the right will be limited to direct participation in the procedure for termination, either medical or surgical, as distinguished from the ordinary nursing and pastoral care of the patient.

Other issues

8.42. RCN highlights a further legal issue which it believes needs to be addressed as a matter of urgency. It points to paragraph 2.7 (iii) of the most recent (2013) version of the DHSSPS draft guidance document which refers to the duty contained in section 5 of the Criminal Law Act (NI) 1967 to report to the police information about a serious criminal offence: “A person who has knowledge of the carrying out of a procedure which is not lawful in Northern Ireland and who has information which is likely to be of material assistance in securing the apprehension, prosecution, or conviction of any person in relation to that procedure is under a duty to give that information, within a reasonable time, to the police. If that person fails to do so without reasonable excuse, he or she may be liable, upon conviction, to a maximum penalty of ten years imprisonment.”

8.43. RCN says that this is an unacceptable position. It means, for example, that a registered nurse attending a woman who has accessed medical termination drugs via the internet and then requires aftercare is expected to breach the fundamental principle of patient confidentiality, as set out in the Nursing and Midwifery Council Code, and which could lead to the nurse’s removal from the register. The duty of confidentiality also derives from common law and statute law. If the nurse declines to commit such a breach, she or he risks being jailed for up to ten years. The RCN point out that this is a serious violation of the sanctity of the patient-client relationship that is at the very heart of health care. The RCN *‘cannot and will not allow its members to be subjected to such threats and be placed in such an impossible dilemma. This wholly unacceptable state of affairs is the direct consequence of the enduring failure of the Northern Ireland Executive and Assembly to fulfil their statutory duties by legislating on this matter.’*

8.44. RCM refers to ‘*a growing concern also about the threat to health and wellbeing of women, who without access to abortion services in Northern Ireland, and without the financial wherewithal to travel to GB to access safe, legal abortion services are purchasing illegal abortifacient drugs via the internet. These women are often very reluctant to disclose this fact to healthcare staff due to the threat of criminal sanctions being imposed. There is no mention in the consultation of any change in the legislation that will enable these women to feel that it is safe for them to provide*

this information to those caring for them, and it would be helpful if this issue were to be considered in taking the legislation forward.'

8.45. Section 5 of the Criminal Law (NI) Act 1967 places a duty on a person to provide information to the police if he knows or believes that a serious offence has been committed and has information which is likely to be of assistance in making someone amenable for the offence. Failure to do so, without reasonable excuse, is an offence.

8.46. The Department will consider this issue separately and respond to the Royal Colleges in due course.

PART 2

SEXUAL CRIME

CHAPTER 9

RESPONSES ON SEXUAL CRIME

CHAPTER 9 RESPONSES ON SEXUAL CRIME

Abortion following a sexual crime

9.1. Part two of the consultation paper sought views on abortion in circumstances involving sexual crime. Specific proposals were not included in the consultation paper. A range of questions were set out which were intended to help the Department better understand the issues relevant to any potential change in the law in this regard. These were:

Q: Should the law also provide for abortion to be choice in the event of rape?

Q: Should the law allow abortion only for women who have been victims of rape?

Q: Should the law allow for abortion for victims of other sexual crime, such as sexual activity with a person under the age of 16, abuse of a position of trust, unlawful sexual activity with a vulnerable adult?

Q: Should the law provide for abortion in cases of familial sexual activity with a person under 18, and sex between adult relatives?

Q: Should it be necessary to have made a compliant to the police before accessing a termination?

Q: Does this need to be time limited?

Q: Should a police report be required and what would this say?

Q: how would all this be achieved to allow for an early termination and is this an issue?

Q: Or should the exemption apply with no requirements, other than a declaration to her medical practitioner by the woman, that the pregnancy is the result of a sexual crime committed against her?

Q: In the case of incest, who is going to determine when an incestuous relationship has occurred and how is this proved?

Q: In other words, how could we ensure that the law would work as intended, has no unintended consequences and that there would be legal certainty in these cases?

9.2. A range of views have helpfully been given in the consultation responses.

9.3. Please note that the views expressed on part two issues do not necessarily indicate the consultee's views on part one issues or other related matters. Given that the Department recognised that sexual crime required specific consideration, part two responses are brigaded together in this chapter. We hope this is a helpful approach. We would note that some organisations which are against any change in the law went on to point out the legal complexities. Where that is the case, the organisation's general view on whether the law should be changed is included in the summary below for clarity.

The organisational responses

9.4. The following organisations responded to part two of the consultation and their views are summarised below.

Disability groups

Disability Action

9.5. Disability Action make no specific comments but say they would have preferred that the Department had brought forward clear options for comment. They do however make reference to the Concluding Observations of the UN Committee on the Rights of Persons with Disabilities in relation to Article 12.

Church and faith groups

Caleb Foundation

9.6. The general response is that abortion after a rape could be a further ordeal, adding further emotional stress. The Foundation suggests that there is evidence which supports this, although this is not referenced in the document.

9.7. The Foundation makes the following points against legislation in this area: that if a baby may be killed because of the circumstances of their parenthood, that is fundamentally wrong; and that it would be wrong to put a baby to death for reasons of ethnicity or religion, and to do so because the father is a criminal is no less

unacceptable. The response includes biblical references. Adoption is favoured where a mother feels unable to keep the child.

9.8. The response points to two issues relevant to the construction of any criminal law in this area: cases where an allegation of rape is unfounded and; cases where an abortion has taken place and a defendant is subsequently found not guilty.

Catholic Bishops of Northern Ireland

9.9. The response begins with the teaching of the Catholic Church that the lives of both a mother and her unborn child are sacred by virtue of their common humanity and therefore require equal protection under the law.

9.10. The response says that "*Part II contemplates a complete surrender of ethical principles in favour of the mother's freedom to choose a termination of her pregnancy. The Catholic Church utterly opposes such a proposal, and reiterates the principle of the dignity of the unborn child and his/her mother*."

9.11. An intentional termination of an unborn child denies the humanity and inherent dignity of that child and violates the right to life. This remains true regardless of the circumstances in which the child was conceived. The trauma and distress experienced by a victim of a sexual crime is acknowledged but it is never morally justifiable to abort an unborn child. It should not be assumed that a mother who has a child following a rape could not, under any circumstances, accept and raise the child. Some will chose to give the child up for adoption.

9.12. The response goes on to say that consideration of the law on abortion in part one of the consultation has been based on a medical model whereas part two seeks views on the introduction of "freedom of choice" which regards the perceived needs of the mother as being paramount. Such a change goes beyond the 1967 Act, which does not provide for termination in cases of rape or sexual assault. The Department has not offered any empirical rationale for a "freedom of choice" model.

Christian Action Research and Education (CARE) in Northern Ireland

9.13. CARE in Northern Ireland does not support any change in the current law. From a practical perspective, it would be unworkable and unenforceable.

9.14. The response replies to the questions posed in the consultation. There would need to be a formal complaint to the police. An investigation would have to follow, culminating in a police report delivered in a "very tight frame" if an abortion was to be a possibility. In practice this would be difficult to achieve. It would not be necessary to change the law for the "extremely rare" occasion when a woman becomes pregnant after a rape. The response suggests that "the little evidence there is, finds that most women in this situation actually choose to keep their baby." They point to figures released by Rape Crisis Network Ireland in 2013 which indicate that 17 of 90 women who were pregnant following rape chose to have a termination.

9.15. CARE in Northern Ireland refer to the following statistics: of 192 women interviewed who had become pregnant after rape or incest, nearly all (80%) who had an abortion regretted it. Over 90% would discourage other victims of sexual violence from having an abortion. Of the women who carried to full term, not one expressed regret about her choice.

9.16. The response notes that abortion does not remove the violence perpetrated against the women. Research has found that those who had an abortion said it compounded the trauma. Support and resources are more appropriate including support from family, friends, and counsellors.

9.17. CARE in Northern Ireland say that any change in relation to rape or incest would lead to pressure to expand the exemptions for other difficult situations and there would be "no logical reason to deny this" if abortion were permitted for rape and incest. They also refer to the views of children and adults born following a rape and that they need protection under the law too.

9.18. In the case of other sexual crimes, determining when a crime has occurred is complex and sensitive and would be time dependent if an abortion were requested.

9.19. The response goes on to say that "abortion is not the best solution for most women" and refers to the findings of a Counsellor for sexual assault victims: two-

thirds of women who continued their pregnancy developed more positive feelings towards their unborn child as the pregnancy progressed. Abortion does not bring healing to a victim of sexual crime.

9.20. In relation to incest, determining when and if an incestuous relationship has occurred is complex and sensitive and would be time dependent if an abortion was requested. Incest is not a term under the criminal law in Northern Ireland and would need to be clarified.

Christian Concern

9.21. The terms of the consultation are criticised in the response. Christian Concern would not support a change in the law. Recognising the pain and trauma suffered by victims of sexual crime, abortion is not the answer. It cannot undo the crime committed and it would create a second innocent victim. The response says the appropriate and compassionate response would be to provide better care, specialist counselling and support for victims, to invest in better awareness raising work for young people, and preventative work which educates young men on issues surrounding sexual crime, human rights and violence against women.

9.22. Adoption is a life-affirming option and should be promoted.

9.23. The response says that evidence shows that most women who become pregnant as a result of a sexual crime do not opt for a termination.

9.24. The response concludes that if the law is changed, it will be difficult to prevent a further weakening of the law. Once choice is permitted in some instances, it will not be possible to justify restricting choice in other cases.

Christian Medical Fellowship

9.25. This response says that it is difficult to see how a law that allowed abortion in cases of rape or non-consensual sex, or where pregnancy resulted from sex with a family member could be framed. Highly restricted access may be deemed too narrow, while increased accessibility may 'inevitably lead to unplanned pregnancy being 'labelled' coercive or non-consensual, producing little short of abortion on demand, even if this was not intended.'

9.26. There would be problems also in defining the circumstances relevant to a new law.

9.27. Pregnancy resulting from rape is ‘very rare’. There are two victims: the mother and the fetus. Both deserve protection. Adoption and fostering are more healthy alternatives. Most women who become pregnant through rape or incest did not want an abortion; and other research has found that those who had an abortion said it increased and compounded the trauma. Abortion does not solve the problem.

9.28. Women need sensitive support and a safe environment to consider their options with holistic support, accurate information and resources to meet their needs.

9.29. A change in the law is not supported, any such provision would be unworkable and would lead to a process of incremental extension.

Church of Ireland

9.30. The Church of Ireland recognises that sexual crime is a gross violation. Early access to emergency support, counselling and care (which may include emergency contraception) is the preferred pathway. A change in the law is not advocated in respect of sexual crime. The Church affirms the value of life of both the mother and her unborn baby. Although not in favour of a change in the law, the Church would support adequate resources being made available to help all victims of sexual crime to report this and to receive all the support required. It would have favoured a fuller analysis of this issue in the consultation.

Evangelical Alliance

9.31. Evangelical Alliance response sets out its position generally, beginning with these words: ‘we refuse to be drawn into a false dichotomy which pits a woman’s rights against those of her child.’

9.32. Evangelical Alliance does not support the introduction of abortion on the specific grounds of sexual crime. Its preference is to see clarification of the existing law through guidelines and it would also wish to see comprehensive and tailored pathways of care for each woman who is facing a pregnancy crisis.

9.33. The remainder of the response sets out the Evangelical Alliance's position in detail, beginning with theological arguments, its moral perspective, and commentary on the law. Evangelical Alliance believes that changing the law would cross a rubicon in Northern Ireland from indirect to direct abortion. It is also concerned that this may be the start of a shift towards broader changes in the law.

9.34. The work of the Rowan Sexual Assault Referral Centre (SARC) is commended. Good physical and psychological medical care, healing and restoration are preferred. The law should not redress sexual crime with another crime. They note that in other jurisdictions, rape and sexual crimes are not explicit grounds for abortion and they go on to say that this is because there are many problems with proof of this in a requisite timescale and they point to other potential difficulties including: consent; age and relationship; definitions of crimes which would be relevant to any change in the law and, mental capacity to consent to sex.

9.35. Evangelical Alliance does not believe there is a need for the law to change and would favour preventative work on the wider cultural issues around rape and sexual crime, human rights, and violence against women. The Rape Crisis Network Ireland statistics mentioned above are referenced.

Fellowship of Independent Methodist Churches

9.36. The response says that the consultation has advocated a pro-choice position while denying a voice to those who would advocate a pro-life position. Changes to the law would not be supported.

9.37. The response says that the life and welfare of a fully human person, albeit not yet born, is entirely absent and the sole concern is that of the expectant mother. The idea that the baby should or may be killed because of who one of their parents was is wrong. It is possible that a woman might get over the rape but never get over the abortion. Evidence suggests that those who abort after rape often suffer emotional turmoil and depression.

9.38. The response goes on to say that there is a very real possibility that some women would claim they had been raped when that was not the case. Proving rape in law may be a lengthy process, delaying the abortion, or the child may be aborted with no legal grounds. Adoption is an option. A change in the law is not supported.

Free Presbyterian Church of Ulster

9.39. Sexual crime is acknowledged as a problem in society and one which is not talked about sufficiently. The response suggests that 'the sexualisation of women within the music culture and within the media makes them the target of the most depraved of crimes in society.'

9.40. The response says there is a need for stricter sentences in relation to these crimes. It commends those facilities that provide counselling and help for those affected and the work that has been done in relation to human trafficking.

9.41. The response does not support a change in the law. Love, care and compassion are needed, abortion is not the answer. Killing the unborn child cannot correct the crime. The child is as much as a victim as the mother. Further trauma is suffered if an abortion takes place after a sexual crime.

9.42. The response refers to the Rape Crisis Network Ireland statistics referenced in other responses.

Presbyterian Church in Ireland

9.43. In the opening section of the response, the Church refers to the crucial role of DHSSPS in providing necessary guidelines for the medical profession. It does not see how the consultation issues can be separated from the wider abortion debate, and notes the NIHRC judicial review.

9.44. On part two matters, the response is not in favour of any further extension of the law in Northern Ireland relating to abortion. The current law strikes a 'careful and fine balance' between the need to protect the life of the unborn and the need for care of the mother. It would be unwise to change the law without full public assurance from DHSSPS and the relevant health authorities that the best care would be made available to the mother whatever her decision. Not to have this assurance would 'steer the mother in the direction of choosing an abortion.' The consultee is also concerned that the consultation does not give assurance that any change in the law could be framed so that the desired limitations could be effectively sustained and protected.

Reformed Presbyterian Church of Ireland

9.45. A change in the law would not be supported. A child conceived as a result of a sexual crime is an innocent party. A sexual crime is a grave and traumatic violation of the victim. Abortion is also traumatic and can lead to consequences such as mental illness depression and even suicide. The preferred approach is to encourage and fund organisations that work with the victims of sexual crime and adoption agencies that care for the welfare of unwanted children.

Ethnic minority groups

Black and Minority Ethnic Women's Network (BMEWN)

9.46. This response begins with commentary on victims of sex trafficking. BME women are disproportionately represented as victims of sex trafficking; pregnancy as a consequence of sex trafficking is not uncommon, with National Crime Agency best practice informing its front line practitioners that they may encounter women who are pregnant.

9.47. The response discusses the experience of women who are refugees or are seeking asylum, saying that they have an increased chance of having experienced sexual crime at some point in their lives. An unwanted pregnancy may be inherent to their status as an asylum seeker.

9.48. Domestic violence is then discussed in the response which says that BME women are disproportionately likely to be victims of domestic abuse.

9.49. BMEWN would not support any legislative requirement to report a sexual crime to the police. Under-reporting; adding an additional burden to the victim in order to access a medical procedure; the various reasons why a woman may not wish to report and; the vulnerability of BME women as described in the response are cited as reasons against a requirement to report.

9.50. The response then makes two detailed suggestions for framing a law. These are set out in full below.

'The BMEWN recommends, therefore, that the criminal law on abortion be adjusted to allow for procedures to be conducted where the pregnancy is a consequence of

sexual crime. "Sexual crime" should be taken to refer to any act prohibited under the Sexual Offences Order (NI) 2008 that can or does result in pregnancy.

Provision should also be made to allow terminations to occur where criminal activity not explicitly covered by this act, but which may be indirectly prosecuted under other provisions, results in pregnancy. This includes practices known as reproductive coercion.'

NICEM

9.51. NICEM discusses similar issues to those discussed by BMEWN. It too touches on refugees and asylum seekers' issues, victims of trafficking, and victims of domestic abuse.

9.52. NICEM is not in favour of a woman being required to report a sexual crime to the police in order to access a medical procedure. Victims of sexual crimes have difficulty in approaching the police and these crimes are under-reported. There will be a range of reasons why a woman would not wish to report, including not wanting others to know she has been raped. Fears about the justice process may also feature. A woman may not know for some weeks after a rape that she has become pregnant. It would be unreasonable to establish a requirement that a woman should have to report the crime to the police to qualify for a legal procedure to end a pregnancy resulting from a sexual crime.

9.53. NICEM makes a specific recommendation: '*NICEM recommends that any change to the criminal law to allow for procedures to end pregnancies that result from sexual crime not be constructed in such a matter as to make a complaint to the police a prerequisite to obtaining a procedure.'*

Human rights groups

Amnesty International UK

9.54. Amnesty references the concluding observations of the CEDAW Committee in which it urged states to take measures to provide for implementation mechanisms to ensure availability and accessibility of abortion on rape and incest grounds. The advice of the World Health Organization on the provision of safe, legal abortion

services on the complaint of rape is also referenced and their recommendation mirrors this advice.

9.55. Amnesty recommends that the Department '*legislates to make abortion services available where pregnancy is the result of a sexual crime. This service should be offered to any woman presenting herself to medical staff requesting a termination of pregnancy on these grounds, without being compelled to undergo unnecessary administrative or judicial procedures, such as pressing charges against the perpetrator or identifying the rapist'.*

Equality Commission for Northern Ireland (ECNI)

9.56. In its Executive Summary, ECNI says: *'we are disappointed that a full consultation on abortion has not been issued; we support the Department's proposal to consider whether or not to make provision for abortion in the case of pregnancy resulting from sexual crime, and if so, how this would be defined and safeguarded; and we will consider further our position on the issues raised in the event of a further consultation on the same'.*

9.57. No substantive comments are made on the issues, although it is clear that ECNI would wish to comment if there is a consultation on specific proposals. The response does however include commentary on human rights issues and says '*it is essential that the DOJ ensures that all proposed changes to the law are compatible with human rights law and commentary including CEDAW. We are aware of the application for judicial review brought by the NIHRC in this regard, and await the outcome of the same.'*

Equality Coalition

9.58. The Equality Coalition is co-convened by the Committee on the Administration of Justice and UNISON.

9.59. We should point out that the Equality Coalition refer to the Department as proposing legislation to enable abortion "as a result of rape or incest (sexual crime). This does not reflect accurately the terms of part two of the consultation. The Equality Coalition expresses a view and it is therefore included here for completeness.

9.60. The consultee supports a change in the law relying solely on its response on 'human rights jurisprudence'.

Political parties/MLAs

Green Party in Northern Ireland

9.61. The Party considers the current situation to be a contravention of article 3 of ECHR. It believes the law should provide for abortion to be a choice in the event of a rape, and for abortion in the event of other sexual crimes. A victim should not be required to report to PSNI in order to avail of services. A time limit should not be put in place, as victims of sexual crime do not come forward immediately. Sexual crimes have a low rate of reporting, and a low conviction rate. Presenting to a GP should be sufficient. No other restrictions are placed upon victims of sexual violence seeking other healthcare services and restrictions should not apply to those accessing an abortion. Victims of incest should also be believed when they present to a medical practitioner.

Labour Party in Northern Ireland (LPNI)

9.62. LPNI is in favour of an extension of the 1967 Act. The response says that the law should allow for abortion to be a choice in cases of rape and instances of other sexual crime including incest. The response also says that it is important that guaranteed access for women who have been raped should be provided in a manner which allows choice at the earliest stage possible and with the least amount of trauma.

SDLP

9.63. SDLP say*: 'we note the section on sexual crime but given the absence of any specific proposals by DOJ we will not be entering into speculative debate, which raises wide ranging issues relating to the crimes of rape and incest and abortion law.'*

Sinn Féin

9.64. Sinn Féin's position is that it supports legislation which would provide for termination of pregnancy arising from a rape, incest or sexual abuse. Sinn Féin refer to levels of under reporting, attrition and traumatisation which can occur within the legal process. Consequently, Sinn Féin does not believe that the legislative provision should be contingent on initiation of criminal proceedings.

Socialist Party NI

9.65. The Socialist Party welcome the consultation but feels it could go further. As well as extending the 1967 Act, they say there is a need for real sex education and economic security so that women can have children if they choose to.

9.66. On the detail, the response agrees with the proposition in the consultation that a number of issues arise which make it difficult to construct a legal framework. Their preferred approach is to enable women to choose whether to have an abortion regardless of the circumstances which led to the pregnancy.

Workers Party

9.67. The Workers Party is pro-choice. The response refers to article 6 of the International Covenant on Civil and Political Rights and CEDAW. The Workers Party rejects *"the narrow compass of the terms of reference set out in this consultation …."*. It argues for the extension of the 1967 Act.

9.68. No specific comments are made against the questions.

Anna Lo MLA

9.69. Ms Lo's response is made as an individual MLA. She quotes from the Amnesty International survey carried out by Millward Brown Ulster, noting that: 69% thought that the law should make access to abortion where the pregnancy is the result of rape; and 68% where pregnancy is the result of incest.

9.70. Ms Lo believes abortion should be available as a choice for women who are pregnant as a result of sexual assault or interfamilial sexual activity. The woman should not be compelled to undergo unnecessary administrative or judicial procedures such as pressing charges or doing so in a time bound manner.

Pro-choice groups

Abortion Rights

9.71. The response is pro-choice generally and refers to international human rights jurisprudence.

9.72. Abortion Rights asserts support for complete bodily autonomy regardless of the reasoning behind the choice. It would not favour limiting a change in the law to rape, as it believes that continuing with a pregnancy should always be a matter of choice. Similarly in cases of sexual activity with a person under the age of 16 or with a vulnerable adult, and in cases of familial sexual activity with a person under 18 and sex between adult relatives. In all these possible examples, their position is that this is between the woman and her doctor rather than for politicians.

9.73. In relation to the questions about complaints to the police etc, Abortion Rights' position is that it should never be necessary for a victim to prove they have been a victim of rape, sexual abuse or incest in order to access an abortion.

Alliance for Choice Belfast

9.74. The Department's proposals do not go far enough. AFC Belfast refers to its concerns about the position of the judiciary on this issue, the Attorney General's role, and the *'anti-choice socialisation process that pervades Northern Ireland churches, schools and the political sphere …'*

9.5. In its General Comment section, the response says '*Indeed you could argue that women who wish to terminate as a result of fetal abnormality or sexual crime are already covered under the current legislative frameworks. To force continued pregnancy and motherhood under these circumstances would leave these women and young girls 'physical and mental wrecks'.'*

9.76. The response discusses the legal context and National Law as well as public opinion, citing surveys and research from 2008 to 2014. It touches also on the views of clinicians, citing Professor Francome's survey of 2009; and on the views of MLAs.

9.77. The response cites international commentary including the World Health Organisation report on Safe Abortion. The response concludes that the decision to

terminate should lie with the woman. It also makes the case for women to have the same access to support services, including abortion, as other women or girls in the UK. If the service can not be provided in Northern Ireland, then funding should be available to enable them to access services elsewhere in the UK.

Queen's University Pro-Choice Society

9.78. This response also enclosed with it a petition signed by almost eight hundred students, lecturers and tourists on campus. The Society considers that the law should provide for abortion in the event of rape. The 1967 Act allows for this without having to specifically legislate for rape. Some women will be able to raise the child of their rapist, some will not. The best person to make the choice is the woman. The law should not be limited to rape and should cover other types of sexual crime. It should not be a requirement to report to the police as *'the police and the judiciary should have no part in individual medical procedures.'* Any time limits should be linked to the opinions of the highest medical authorities, and in relation to abortion the time limit should be '*as early as possible, as late as necessary.'* A police report should not be necessary.

9.79. Non-directive information on all pregnancies should be provided to all women as standard including information on abortion provision. This, coupled with the extension of the 1967 Act, would provide for early terminations.

9.80. A verbal declaration to a medical practitioner should be sufficient in cases of sexual crime. A victim should not have to relive their assault. If they have chosen not to press charges they should not have to go on written record and if the medical professional is unaware of the identity of the attacker they cannot be forced to give evidence in court. The woman would be aware of an incestuous relationship and can make a verbal declaration to her medical professional.

Pro-life groups

Choose Life Ministry

9.81. The response is against a change in the law and speaks from personal experiences of working with and supporting victims of sexual crime, and from seeing the aftermath of abortion.

9.82. Perpetrators of sexual crime should be punished severely. The response says *'Our perception of crime is often higher than the reality due to the media's portrayal of such crimes….. It distorts our view that rape and sexual assault are very common.'* The response says that pregnancy through rape is extremely rare but does sometimes occur.

9.83. The response sensitively includes a number of quotes from victims of rape and those conceived in rape. The response says that some women in abortion recovery had testified that they eventually got over the rape but the abortion was a further violation. They still grieved for their aborted child. Women also testified that the child brought healing to the rape.

Life NI

9.84. Life NI notes that the Department makes no recommendations, notes that there is no specific provision for abortion following a sexual crime under the 1967 Act, and refers to the consultation's references to the Bourne case. The consultee finds the reassurance that there is no intention to introduce the 1967 Act to be "hollow" when potentially an *'even more liberal situation is under consideration in this consultation document.'*

9.85. Life NI responds to the questions: no sexual crime resulting in pregnancy can justify the taking of an innocent life; and they note that a number of people who were born as a consequence of rape have spoken at public meetings, distressed that their lives are regarded as valueless because of their background. Life NI recognises the difficulties in framing any change in the law: they are concerned about the issue of proof given that convictions for sexual offences are unlikely to arise before the end of the pregnancy; and even where there is reliance on an assertion or affidavit, plus mandatory reporting, the threshold for destruction of innocent life would be low.

9.86. Life NI believes the intention of a change in law would be to make an exception to the criminal law based on misplaced compassion. If the law is changed for rape, it would follow that it would he changed for other types of sexual crime. Ultimately, it would lead to abortion on demand.

9.87. The preferred approach is for the Department and other Departments to take steps to encourage women and young girls to report any sexual crime at the earliest

possible opportunity when the best possible evidence is available. In summary, Life NI would be against a change in the law.

Precious Life

9.88. Precious Life says there are few official statistics on the numbers of women who have had abortions or become pregnant as a result of sexual crime. They refer to the Rape Crisis Network Ireland statistics referred previously.

9.89. Precious Life recognises that rape is a horrific act of violence against women and that victims need long term compassion and care. They make the following points: abortion is not an easy solution to rape and cannot undo the crime committed; people should never be ranked based on the circumstances of their conception and; loving care and counselling are vitally important.

9.90. Precious Life refer to views of those involved in counselling rape survivors: women suffering from depression, guilt and anger after rape who have those feelings compounded after an abortion. Counselling can give women time, space, practical and emotional support.

Pro Life Campaign

9.91. Pro Life Campaign does not endorse an abortion as a 'solution' to the tragedy of a sexual assault on a woman, which results in pregnancy. To offer an abortion in such circumstances ignores the fact that it involves the taking of an innocent unborn life and the exposure of the women to emotional hurt and possible psychological harm. The reality is that our willingness to offer social support is the single most important factor influencing a better psychological outcome for women in crisis after a sexual assault. The response refers to a study by Sandra Makhon, and to peer reviewed studies from Finland and New Zealand.

9.92. The response suggests that we should seek stronger sentences for rapists and real justice for those who are victims of rape.

The Society for the Protection of Unborn Children (SPUC)

9.93. SPUC would be against a change in the law and refers to the debates on the 1967 Act. The response says that it proved impossible in 1967 to overcome

complex legal problems surrounding the issues of rape, statutory rape, consent and mental capacity. As the Department has not shown how these issues would be resolved, it is a futile exercise to seek views from the public.

9.94. SPUC refers to International law being relevant to these issues. Specifically, it refers to the prohibition on the death penalty for pregnant women. It concludes that a change in the law to allow abortion of children conceived through criminal sexual activity violates the child's right to life and punishes the child for the crimes of others. It also refers to evidence that abortion has serious consequences for the physical and psychological health of women.

Royal Colleges, Health and Social Care Trusts and Medical Organisations

British Medical Association Northern Ireland (BMA NI)

9.95. BMA NI submission says that when doctors are acting in difficult circumstances they can only act in the best interests of their patients. Doctors should not be put in a position of determining whether a sexual crime has occurred. If there is a change in the law in this respect, clear clinical guidelines would be needed.

Clinical Director, Belfast Trust

9.96. This response is in favour of a change in the law in respect of rape cases, although the word 'option' is preferred to 'choice'. The law should not be limited to rape cases as this is too difficult to define and is a matter for the courts. Doctors can only deal with the clinical situation presented by the patient. It is not always practical to report to the police. This would be desirable but should not impact on a clinician's ability to care for the patient. The woman's declaration should be sufficient. Legal certainty on whether a sexual crime had been committed would take too long. Doctors would have to rely on the word of the patient as they do in all other aspects of medical practice.

Consultants in Maternal and Fetal Medicine, Department of Fetal Medicine, Royal Jubilee Maternity Service Belfast

9.97. This submission sees no need to alter the law and that the present law covers this as set out in the Bourne judgment. The response feels that it is not appropriate or possible for clinicians to adopt a role that should properly be undertaken by a jury.

General Medical Council

9.98. GMC states that cases of pregnancy following rape or other sexual crime may be covered by cases where *'the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family'.* This wording is taken from the 1967 Act.

9.99. GMC does not believe that a woman should be required to make a complaint to the police. They would not support a change in the law which required a doctor to be required to determine whether such a complaint has been made in deciding whether a termination would be a legal option in her case. Nor do they believe it is the doctor's role to gather or assess criminal evidence before providing treatment.

9.100. The doctor's primary concern is the patient's care. If the patient is in distress, to then require that patient to make a complaint to the police or show evidence that a complaint has been made would affect the timeliness of access to termination (if judged legal in her case). It might hamper the doctor's ability to address the patient's needs and it may impact on the woman's trust in the medical profession. Similar concerns are set out in relation to the other questions in part two of the consultation paper.

9.101. In relation to the question of guarding against unintended consequences, GMC states that anonymised reporting on the women obtaining abortion on the grounds set out in the consultation may satisfy public concern.

Northern Health and Social Care Trust

9.102 The Trust response is in favour of the law providing for abortion to be a choice in the event of rape and that it should also enable choice in relation to other types of sexual crime. Medical, nursing and midwifery staff would be aware that not all

sexual crimes are reported to the police. Guidance would be needed to enable appropriate care within the confines of the law and engagement with SARC and social services would be needed. It is not within the remit of health professionals to ascertain criminal activity. The woman's relationship with her professional often enables disclosure of personal information such as sexual crime. The Isle of Man approach is not favoured.

Northern Ireland Committee of the Faculty of Sexual and Reproductive Health Care Western Trust

9.103. The Trust recognises that this issue is not straightforward in terms of framing the law. It considers that the law should provide for an abortion to be a choice in the event of rape and should also provide for choice in relation to other types of sexual crime. Opinion varied on the requirement to report to the police: some thought there should be no requirement; others felt that some type of reporting would be required.

9.104. Ideally, sexual crime would be reported within hours or days but this is not the reality. Women do not report for a variety of reasons, and some may feel that accessing services should not hinge on this. Reporting to a doctor or health care practitioner should be sufficient. Action before the pregnancy exceeds 12 weeks would be preferable but this is not always possible. SARC may be in an ideal position to assist women although it should be noted that hormonal emergency contraception and intrauterine emergency contraception are available. It would also be important that the medical profession and the public should be educated to know that reporting sexual crime would be taken seriously.

9.105. A declaration to a medical practitioner is seen as a possibility, although this could be subject to abuse and/or some practitioners would not feel able to provide a declaration for this purpose.

9.106. Generally speaking, the complexities are for the lawmakers to consider and answer.

Royal College of General Practitioners Northern Ireland (RCGPNI)

9.107. RCGPNI notes that cases of sexual assault and incest are distressing for victims and would welcome "any legislation" which supports women who have suffered in this way. It welcomes the work of SARC which offers Post Coital Contraception (PCC) and notes that PCC is readily available in Northern Ireland.

9.108. RCGPNI recognises the complexity of defining sexual crime and would welcome legislation. However, RCGPNI members have a diverse range of views on abortion and it was not possible for a consensus view at this time. In its summary section, RCGPNI says '*the college supports any legislation which supports women who are the victims of sexual crime. The college is unable to give a consensus view on whether abortion is justified in these circumstances.'*

Royal College of Midwives Northern Ireland (RCM)

9.109. RCM first notes the provision of health care services to women who have been subjected to a sexual assault. The legal context for such cases outside of Northern Ireland is also noted.

9.110. RCM believes in equitable access to services for women or girls who become pregnant as a result of sexual crime. Many such crimes are not reported to the police, and not all women are able to use the SARC services. Some women may conceal the pregnancy until birth is imminent. RCM would not favour the Isle of Man approach which requires an affidavit and is overly restrictive in other ways.

9.111. There should be consistency across the UK in relation to accessing healthcare treatment for women or girls pregnant as a result of rape or incest, and if a termination is not available in Northern Ireland then appropriate funding should be available to access treatment elsewhere in the UK.

Royal College of Nursing Northern Ireland (RCN)

9.112. RCN outlines the responses it has made to the consultations undertaken by DHSSPS and notes that it is a matter of concern that definitive guidance has not yet been published.

9.113. RCN concludes that women who are pregnant as a result or rape, sexual assault or familial sexual activity where the woman is aged under 18 should have the legal right to access a termination of pregnancy; and the only viable way which, for these purposes, the rape or sexual assault can be evidenced is on the basis of the woman's own judgment and notification.

9.114. In response to the questions, RCN note the different situation in England, Wales and Scotland and believe the same 'principle' should apply in Northern Ireland law, with the same provision that it should not be necessary to have to prove that a woman is suffering from serious and intractable mental health before she is able to access a termination.

9.115. RCN concludes that a right to a termination should exist in relation to all types of sexual crime. However, no specific view is given in relation to pregnancy deriving from consensual sex between adult relatives. More information would be needed.

9.116. RCN feels there are two broad options in respect of reporting requirements. These are: proof that the pregnancy derives from a sexual crime or; an approach to allow the woman to determine that she had not consented to sex. RCN favours the latter. The response references PSNI and CJINI statistics to make the point that the first option is neither 'practical or ethical'. Nor should determination be made by a medical practitioner. RCN believes that the number of women who would misuse this is small, and that, even so, that would be preferable to the current situation where rape victims are denied an abortion in Northern Ireland.

9.117. RCN also express concern that the woman's voice is missing from the consultation.

Royal College of Obstetricians and Gynaecologists

9.118. The response refers to the relevant law. In relation to alleged sexual assault, the response points to the Bourne Judgment and concludes that there is no need to alter the law as it thus stands, and sees no evidence that it has been altered in subsequent cases. The response goes on to say'*"the judgment of a medical practitioner will always depend on their history from and examination of, the individual woman. It is not possible to inflict on a gynaecologist a quasi-judicial role properly undertaken by a jury'.*

Royal College of Psychiatrists in Northern Ireland (RCPsych in NI)

9.119. RCPsych in NI welcomes the consultation and it refers to its submission to the DHSSPS consultation on its Draft Guidance.

9.120. The evidence base in relation to the psychological outcomes of termination of pregnancy is unclear and describes outcomes as ranging from none to severe. RCPsych in NI agrees that the issues are extremely complex and may be very different to those in the case of a pregnancy where the fetus has a fatal abnormality. Women who have been the victim of a rape often require urgent and empathetic care. They should be encouraged to seek help immediately and the focus of care should be on supporting the woman in dealing with the trauma of sexual assault.

9.121. RCPsych in NI says there is very limited evidence available on the potential impact of a pregnancy occurring as a consequence of rape on a woman's mental health and in particular the likelihood that a continuation of the pregnancy would lead to suicide. It references a report entitled 'Induced abortion and mental health: a systematic review of the evidence – full report and consultation table with responses' dating to December 2011. It says '*The report, which was based primarily on epidemiological studies, also comments on the overall poor quality of research in this area and concluded that the rates of mental health problems for women with an unwanted pregnancy were the same whether they had an abortion or where the pregnancy went to term.'*

South Eastern Health and Social Care Trust

9.122. The Trust sets out three principles that should be applied in the event of a pregnancy as a result of rape or incest: a woman centred approach; the pregnancy is treated in a compassionate and timely manner; and the focus of the legislation must be to reduce the suffering of a pregnant victim of such a crime.

9.123. The response goes on to note the complexity of the issues and that the scenarios discussed in the consultation are rare in this Trust.

Reproductive healthcare groups

British Pregnancy Advisory Service (BPAS)

9.124. BPAS says that the development of a sexual crimes exception is important but legally problematic if not considered as part of a wider liberalisation of the law to take account of a woman's physical and mental health. Sexual crime is already traumatic and the State should not require of her anything which adds to that. The primary concern should be the health and wellbeing of the patient/victim. If a decision is made to end a pregnancy in these circumstances, barriers should not be put in the way. Having to disclose the crime before the woman is ready to discuss it may add to the trauma. The only workable solution is that the medical profession should accept the woman's account.

Brook NI

9.125. Brook NI provides sexual health services to young people in Northern Ireland including pregnancy testing, and works with young people who have been the victim of sexual crime.

9.126. Brook NI are in favour of a change in the law to provide for abortion to be a choice in the event of rape and other sexual offences. Brook NI do not believe that it should be necessary to make a complaint to police or for a medical practitioner to declare that the pregnancy is the result of a sexual crime. In the case of incest, Brook NI refers to the role of the Safeguarding Board in answer to the consultation question of who could determine when an incestuous relationship has occurred. In relation to the question about ensuring a change in the law could work as intended,

Brook NI say that a decision to offer a termination should be cognisant of the difficulties faced by young women in this situation.

Family Planning Association (FPA)

9.127. FPA notes the CEDAW position in its response. It believes the law should provide for abortion to be a choice in the event of rape and in respect of other sexual crimes too. From their experience, women should not be required to report to the police before accessing a termination. This is because: some women do not trust the court situation and feel their reputation will be on trial; as a legacy of the Troubles, some women do not trust PSNI; some women are frightened of further violence from the perpetrator (including if he is involved in paramilitary organisations) and; some women simply want to forget the experience as soon as possible.

9.128. FPA would not be in favour of a time limit or of a requirement for a police report. A declaration to her medical practitioner should be sufficient. In the case of incest, a healthcare professional who suspects an incestuous relationship should follow statutory safeguarding policies and procedures in respect of the welfare of children and vulnerable adults.

9.129. In summary, a change in the law should not be problematic if appropriate policies and procedures are followed, although a prompt response will be essential to ensure that abortion is not delayed.

International Federation of Abortion and Contraception Professionals (FIAPAC)

9.130. FIAPAC consider that rape and familial sexual activity are already covered quite clearly by case law in Northern Ireland and reference the Bourne judgment. They see the problem as '*lack of clarity and guidance and fear of prosecution that leads doctors to interpret the law in a most conservative manner'.*

9.131. FIAPAC is of the view that there is no need to change the law. Instead, clear guidance from DHSSPS is required so that doctors can confidently interpret existing law.

9.132. Requirements including police reports would make the law more restrictive. Requiring rape victims to have reported their experience to police before they qualify for abortion is a barrier to access which risks further traumatising the rape survivor.

Trade Unions

Belfast and District Trades Union Council

9.133. The NIHRC Judicial Review is noted, and B&DTUC records its support for the Amnesty International campaign “My Body My Rights” and the submission made by Amnesty International to this consultation. It endorses the submission made by CAJ and RCM.

9.134. B&DTUC supports a number of points set out in the Amnesty International response: that restrictive abortion laws are gender-discriminatory; the demand for full decriminalisation of voluntary abortion subject to safeguards and in line with human rights standards; freedom of choice for women without specifically promoting abortion, as advanced by the Parliamentary Assembly of the Council of Europe; all health services should be consistent with the human rights of women and; abortion should be legal when a pregnancy results from rape and other sexual crimes.

Irish Congress of Trade Unions

9.135. ICTU takes a similar position to the B&DTUC, by recording its support for the Amnesty International campaign “My Body My Rights” and the submission made by Amnesty International to this consultation. It endorses the submissions made by the CAJ and the RCM.

9.136. The consultation is welcome but does not go far enough.

9.137. The response draws on the Amnesty submission in a similar way to the response given by the B&DTUC. In conclusion, ICTU say: we agree that the law should be changed to allow for abortion in the case of lethal fetal abnormality and where pregnancy is the result of rape, incest or sexual crime.

NIPSA

9.138. NIPSA's submission begins with recognising the diversity of opinion amongst its membership and refers to its procedures for making policy at the NIPSA Annual Delegate Conference.

9.139. As with other responses, NIPSA references the Millward Brown Ulster research. The Department's consultation is welcomed but NIPSA feels it does not go far enough. International and domestic human rights organisations are referenced including the NIHRC and CEDAW positions.

NUS-USI

9.140. The consultation is welcome but does not go far enough. It is essential that victims and their rights are at the centre of any law and that it works effectively for them. Politicians and Ministers can provide a pro-choice position while retaining the full integrity of their own personal religious beliefs.

9.141. Choice should be available in the event of a rape but choice should be available for all women in any event. A change in the law should not be limited to rape and should allow for other sexual crimes. The Millward Brown research is referenced at this point. A victim should not have to report the matter to the police before accessing a termination. It is essential that women are believed. The process should not be time limited as many women may not want to engage with the police. A declaration to a medical practitioner that pregnancy is the result of a sexual crime should be sufficient. Similarly, healthcare professionals can determine that incest has happened: victims must be listened to.

9.142. The law should be amended for victims of sexual crime and should not involve significant bureaucracy.

Unite

9.143. Unite is of the view that the law should provide for abortion to be a choice in the event of rape but they did not agree that the law should be limited to rape alone. Unite would favour the law being amended for victims of all sexual crimes listed in part two of the consultation. Unite were not in favour of there being a requirement to report the crime to the police, nor should reporting be time bound. Unite believe that

a declaration to a medical practitioner would be sufficient and that this should be a matter of trust between a woman and her medical practitioner.

Women's groups

Belfast Feminist Network

9.144. BFN commends the opening of the SARC centre in 2013. They are of the view that equal support should be provided to women who choose to continue with a pregnancy as a result of sexual violence and women who choose not to.

9.145. Their preferred approach is legislation governing abortion which ensures access for all women and girls in all of the situations outlined in the consultation including children below the age of consent, women experiencing domestic violence and victims of trafficking. It would not be in favour of a model like the one in place in the Isle of Man. Reporting to police or signing an affidavit should not be a pre-requisite. They believe this model would delay the process and could result in the woman having to undergo a more complex and invasive procedure. The Department is urged to bring forward a legislative proposal. The word of the woman should be trusted. As an alternative, in recognition of the profoundly negative impact sexual violence can have, they propose that women should have the choice of abortion *'if the continuation of the pregnancy involves a greater risk to the health of the woman than a termination.'*

Women's Aid

9.146. Women's Aid believe that the law should provide for abortion to be a choice in the event of rape. The trauma following a rape can be exacerbated by the prospect of being forced to become the mother of a rapist's child.

9.147. While Women's Aid are encouraged by the development of support services such as the SARC and the 24 Hour Domestic and Sexual Violence Helpline, these services are not an alternative to the option of abortion. They also believe that those organisations practicing in this field could provide additional information on numbers of women who become pregnant as a result of rape.

9.148. Women's Aid find the part two consultation approach to be completely unacceptable and the issue must be addressed as a matter of urgency.

9.149. Addressing the remainder of the consultation questions, Women's Aid say: other sexual crimes have lack of consent in common, whether this stems from age, inability to give informed consent, or extreme power imbalances. In such cases, it is crucial that women and girls have the option of abortion so that they are not forced to bear the lifelong consequences of sexual crime. Many women in these circumstances may not desire an abortion. Choice is the issue given that a sexual crime has denied them autonomy.

9.150. Women's Aid is extremely concerned that reporting to police is even being considered in the consultation. They say this would be a barrier to most victims being able to access an abortion if the law was changed. They set out their reasons for advancing this point including: the fear of not being believed; feelings of shame and self-blame that victims often experience; being too traumatised to engage in the process of reporting the crime and; the majority of sexual assaults perpetrated by someone the victim knows. They point also to the difficulties in securing a successful prosecution and to ongoing suspicion of the police and justice agencies which continues to persist in some parts of the community. Women's Aid also say that the process of coming to terms with a sexual assault is a longer process than seen in other crime types. Women would have a short timeframe to make a decision about an abortion in these circumstances if the law was changed, therefore any law in this area must be fit for purpose.

9.151. In summary, Women's Aid say: '*We believe that the basis of this policy should be that women who disclose rape should be believed, and that any form of scrutiny or cross-examination of these women would equate to re-victimisation of a traumatised victim.'*

Women's Regional Consortium

9.152. The response feels it is important to put sexual crime in context: the lack of prosecutions and convictions and the "rape culture" in Northern Ireland. PSNI has made improvements in their handling of rape reports but more work needs to be done. In 2010 there were 380 reported sex crimes, 212 put forward by PPS, and 88 convictions. The following year saw an increase in reporting to 440 but with convictions falling to 78.

9.153. This is relevant to the question of legal certainty for rape and the response sets out some questions relevant to this, for example: how can you prove rape in order to access abortion when the legacy of rape crime in Northern Ireland is so poor despite massive increases in reports?

9.154. The response refers to the legacy of the conflict in Northern Ireland, where rape or sexual crime is perpetrated by paramilitary groups or supporters.

9.155. The response concludes that rape and sex crimes are an infringement of basic human rights and refers to various international bodies such as the World Health Organisation and CEDAW and their positons that women should have access to abortions based on their complaint of rape.

Others

Police Service of Northern Ireland

9.156. The PSNI response sets out some of the issues which would require legislative clarity, concludes that the issues are complex and that they would require to be precisely addressed in any proposed legislation (given that it may fall to PSNI to investigate whether an abortion was legal under a new law).

9.157. The following issues are posed in the form of questions in the PSNI response and potential solutions are not offered.

- would abortion be permitted in any case where sexual assault is alleged? If so, where the victim of the rape is a child, who could give the consent to the abortion?
- where sexual activity is not denied but the issue is one of whether there was consent, would abortion be permitted solely on the basis of the allegation?
- will the legislation require that the alleged crime has been reported to the police?
- would an abortion based solely on a declaration to a medical practitioner be lawful?
- what would be the position if an allegation is not upheld or indeed withdrawn?

9.158. The Department notes that it is not PSNI's role to offer policy solutions to these issues but we welcome the fact that PSNI has drawn attention to the need for any law to be precise.

Humanist Association of Northern Ireland (Humani)

9.159. Humani believes that the law should allow a woman to choose to have an abortion in the case of all forms of sexual crime. As few obstacles as possible should be placed in the way as this can add to the trauma she has already suffered.

9.160. A woman should not have to make a report to the police as she may wish to keep the pregnancy a secret. She may be in fear of being harmed by a family perpetrator. Women should be given as much support as possible in coming to a decision about an abortion. Humani would therefore recommend a regulated scheme of advisors or counsellors and medical practitioners to handle such cases.

Responses from members of the public

Responses which oppose change

9.161. The replies which were opposed to a change in the law for cases of lethal fetal abnormality were opposed to any change in the law relating to abortion where pregnancy is as a result of sexual crime. Some expressed even more concern about the possibility of extending abortion to such cases. The majority of replies expressed abhorrence at instances of sexual violence and stressed that compassion, appropriate support and comfort must be provided to victims. The views expressed in responses were as follows:

- it is wrong to punish the unborn baby because of the circumstances of its conception;
- children conceived in rape are human beings worthy of dignity and respect;
- why should an innocent child pay for the sins of the father;
- it would be a perversion of justice to do fatal violence to the unborn child as a result of another person's unacceptable conduct;
- sanctions ought to target the perpetrator of the impugned act and not the innocent life;
- there are two victims – the woman who has been raped and the fetus conceived as a result of the rape. Both deserve protection under the law;
- care, counselling, and holistic support are more positive ways of helping a mother in a crisis pregnancy;
- adoption should be facilitated and better resourced;
- there is a need for more pregnancy crisis centres; better advertising of action to be taken in the event of rape; and of the availability of emergency contraception to prevent conception;
- time and resources should be invested in: a multi-disciplinary approach to help in sex education which also focuses on human values and; support and care for those who have faced trauma through sexual crime;
- surviving children of rape have given moving testimony of their gratitude to their mother for allowing them to live;
- abortion can compound the trauma already experienced by women who go through rape. It may simply add to a sense of guilt. Many have found it was

better for them to allow the baby to be born: abortion has left many feeling guilty for the rest of their lives;

- figures released by Rape Crisis Network Ireland in 2013 were referenced - 75% of the women they had contact with who became pregnant through rape chose not to seek an abortion;
- the Bourne judgment already covers these circumstances, allowing review on a case by case basis.

9.162. Some responses addressed the specific questions though set their views clearly in the context of opposition to any change in the law.

9.163. On whether the sexual crime should be reported to the police, some respondents recognised the difficulty in framing the law. However, the consistent views were:

- it was essential that any decision to terminate a pregnancy is supported by a complaint having been made to the police;
- being charged with a crime is one thing, being found guilty is another. The crime needs to be proved in a court of law. On this point there was an acceptance by respondents that this was a slow process. The issue of how this might be achieved within time constraints was not addressed other than the view that a time limit of no later than 12 weeks gestation must be set;
- in cases of incest, some thought there should be a formal record either with police or social services.

9.164. On the issue of whether there should be no requirements other than a declaration to her medical practitioner by the woman, that the pregnancy is as a result of a sexual crime, it is clear that the majority of respondents considered this was not sufficient or acceptable. The predominant views were:

- GPs are not trained to take forensic histories, photos etc;
- the questions give the impression that abortion is being offered as a choice when an allegation of rape has been made. Safeguards need to be put in place that show a rape has taken place;

- no health professional could make a decision on termination on the basis of a declaration by the woman to her medical practitioner in the absence of any evidence;
- there is too great a potential for abuse: false allegations of rape are frequent – a false allegation of rape might be seen by some as a convenient way to end an unplanned pregnancy;
- increased accessibility will inevitably lead to any unplanned pregnancy being labelled coercive or non-consensual, leading to 'abortion on demand.'

Responses in support of change

9.165. While the majority of respondents who supported a change in the law for cases of lethal fetal abnormality considered that abortion should be provided for in cases of sexual crime, there were exceptions. There was also a view expressed that there should be no immediate rush to introduce further legislative change – better to adopt an interim approach with monitoring of how any changes to the law in regard to lethal fetal abnormality work in practice.

9.166. Rather than amend the law, some thought that there was a need to highlight that emergency contraception is available from pharmacies, GPs and family planning services, as well as the SARC. Advice on steps that need to be taken in the event of rape or sexual crime should be clearly displayed in GP surgeries, hospitals, out-patients, schools, colleges, universities, and voluntary services offices.

9.167. There were a number of issues common to the replies:

- the law should facilitate terminations as a result of any unwanted, unlawful and non-consensual sexual activity;
- it should not be considered acceptable to transfer the consequences of one person's decision on to another without consent – by forcing a woman to carry a fetus conceived by sexual crime is precisely what occurs;
- a number of responses made reference to the recommendations of the CEDAW Committee and that women in Northern Ireland should have access to safe and legal abortions as a fundamental right;
- to deny access to abortion in these circumstances directly contravenes Article 3 of the ECHR;

- the consultation shows the inability of our society to cope appropriately with sexual crime – it is vital that those who have been raped can access abortion at the earliest stage and with the least amount of trauma.

9.168. On the issue of whether abortion should be allowed for other sexual crimes, views were as follows:

- law should allow for abortion only in cases of rape. In cases of pregnancy resulting from other criminal sexual activity, the existing principle of termination due to severe adverse effects on the physical or mental health of the woman would apply;
- the definition of rape should not be restrictively interpreted to correspond with Article 5 of the Sexual Offences (NI) Order 2008 but should cover a wide range of sexual offences and situations of coercion, vulnerability and where active consent may be lacking;
- all offences under the Sexual Offences (NI) Order 2008 should be included;
- sexual crimes fall under the Bourne judgment. Lack of clarity and the absence of guidelines has had a chilling effect on how medical professionals act. There was concern that, whatever change was introduced, access to abortion would still be hampered. It was suggested that the Bourne judgment could be included in the law: that if it's the opinion, in good faith, of two medical professionals the Bourne amendment applies, the abortion should be accessed.

9.169. On the issue of whether the sexual crime should be reported to the police, a number of respondents considered that this should not be a requirement. It was considered that a declaration to her medical practitioner by the woman should be sufficient. Other views on this issue included:

- a requirement for a police report would put the victim off seeking an abortion and add to an already traumatic situation;
- asking the woman to prove her victimhood and the legitimacy of her right to an abortion will further expose her to abuse and humiliation;

- pressing charges, identifying the rapist or providing forensic evidence should not be required;
- a network of trained advocates should be available to assist the competent individual to arrive at the appropriate decision for themselves and the unborn baby;
- the interface with the proposed Mental Capacity legislation needs to be carefully considered particularly in relation to best interest and safeguards for those over the age of 16 who lack capacity to make decisions.

9.170. However, others felt that some verification that a sexual crime had taken place was needed:

- there are challenges in establishing that a sexual crime has taken place without the time for a proper legal process – the requirement should be that a reasonable person looking at the evidence would believe that a rape has taken place;
- a declaration to a medical practitioner would be unworkable and would take a medical practitioner outside their field of professional competence;
- a declaration by the woman to her medical practitioner could be supplemented by a sworn statement;
- sexual crime has a very low reporting rate. Much needs to be done to address this so as to instil confidence in victims to come forward before legal restrictions to health and aftercare should ever be enforced;
- declaration alone would lead to complaints from those with pro-life views that abortion would effectively be ‘on demand’;
- making such an allegation is very serious and if there is no requirement to report the sexual crime, it might be too easy to say the pregnancy was as a result of a sexual crime as a way to obtain an abortion;
- necessary for GP to report the allegation to the police. This would protect medical practitioners if there was an allegation made that an abortion had been performed without any allegation of a sexual crime;
- in cases where it involves a person under 16, the decision should be made between the child in question, the parent/guardian and 2 doctors. Police would be involved to ascertain the rape took place;

- in cases of incest, some wondered if a DNA test could be carried out. Others considered that a declaration to the GP was sufficient. No corroboration should be required.

9.171. Few addressed the issue of how verification might be achieved to allow for an early termination, or, if there should be a time limit, how timely reporting mechanisms might be achieved. Comments were as follows:

- early termination is preferable, less traumatic and safer medically; strong reasons why the discussion should not be framed within the criminal justice framework but a medical one;
- if it is not possible to establish the facts within the necessary time frame, abortion for these cases should not be legalised;
- a report should be made to the police within an 8 week time limit to allow for a termination within 12 weeks;
- a time limit is necessary as late term abortions are not a desirable outcome
- termination should be allowed up to 20 weeks, later where the mother's health or life is at risk;
- there should be no time restriction. Women may need time to process physical and psychological issues before they can decide whether they want to continue with pregnancy or not.

9.172. On how legal certainty could be ensured, many respondents considered that this was impossible in any situation. All that could be done was to make the law as foolproof as possible. Some thought that if legal certainty could not be achieved then it might not be possible to change the law. Others thought that the risk of criminal sanction already acts as a safeguard against abuse of the law and has a chilling effect on how and when lawful abortions are carried out in Northern Ireland. Guidance from the Public Prosecution Service; the General Medical Council; the Royal Colleges of Midwives and Nursing and; DHSSPS should supplement legislation. If changes are implemented it was suggested that they should be carefully reviewed to provide some assurance that there were no unintended consequences.

Policy consideration

9.173. The consultation paper recognised the complexities and the potential difficulties in seeking to frame a law in relation to abortion following a sexual crime, should that be the preferred policy approach. Specific questions were included in the consultation and the Department is grateful that respondents have engaged with these questions where possible.

9.174. Very little detail emerged from the consultation exercise on how the law might be reformed or framed in this respect. Respondents, generally speaking, answered briefly to the questions about the law without giving detailed suggestions for reform. This reflects the complexity of the issue.

9.175. The responses were varied but can be summarised as falling into the following broad groups:

- against a change in the law generally, meaning they were against a change in the law in respect of sexual crime;
- against a change in the law generally, but who offered comments on the complexities of this issue;
- in favour of a change in the law but who felt that the detail of this was outside their competence at the framing stage;
- in favour of a change, but would not wish to take decisions about whether a sexual crime or criminal act had taken place;
- who would welcome a change in the law on sexual crime but would prefer to see a broader, 1967 type approach.

9.176. The organisations' views and personal responses were universally in favour of support for women and girls who are pregnant following a sexual assault. Many praised the work of those who provide support services; some felt that improvements could be made in the overall provision of support.

9.177. Some responses drew attention to the situation of those who are born following a sexual assault and the need for their voices to be heard and valued.

9.178. Some commented that an abortion in these circumstances cannot undo the sexual crime, while others felt this was entirely a matter of choice for the woman.

9.179. A number of responses commented on the impact that an abortion following a rape can have on the health and well-being of the woman, but there was a range of views on this point. There was a very helpful range of references to studies and research throughout the responses.

9.180. In terms of proposals for framing a new law, very little emerged from the consultation but a number of specific issues were highlighted. Firstly, the difficulties in requiring a report to the police both in terms of the effect this may have on the woman and on the difficulties in overlaying a criminal justice process into the timeframes for medical intervention should the woman wish to have an abortion. There was no support for a system similar to the one in place in the Isle of Man. Many responses, particularly from the medical professions, felt that the woman's word was all that could be required and that it would be outside the doctor or healthcare professional's remit to be satisfied that a crime had occurred. A number of responses said that this approach would or could be subject to abuse.

9.181. At this stage, the Department is of the view that the complexities of the issues are such that it is not possible to make detailed proposals at this time on whether and how the law might be reformed specifically to cover cases where a woman is pregnant resulting from a sexual crime. Many of the original questions set out in part two of the consultation paper remain to be resolved before policy proposals could be formulated. The Department will consider further but does not intend to bring forward legislative proposals in relation to part two in this Assembly mandate.

ANNEX A

Glossary of terms

The Department is aware that the subject of abortion is a sensitive one and people will have differing views on use of terms and language. With this in mind, the paper aims, where possible, to use factually accurate terms and language which is not emotive, subjective or inflammatory. The following glossary explains some of the terms used and illustrates that different words do not in certain cases indicate different meanings.

Abortifacient

An abortifacient is a drug that induces abortion and is widely used to terminate pregnancies usually up to 9 weeks gestation. Common abortifacients used in performing medical abortions include mifepristone often used in conjunction with misoprostol.

Abortion/termination of pregnancy

The above terms have both been used in response to the consultation and both should be read interchangeably as describing a procedure to terminate a pregnancy in the circumstances of the policy under discussion.

Fatal fetal abnormality

This term describes a condition of the fetus which is likely to cause death either before birth, during birth or in an initial period after birth.

Although we have tried to be consistent with terminology, the responses to the consultation used a variety of terms. The following are all used in the paper and should be taken as having the same meaning as the term described above:

Lethal/terminal/fatal

Anomaly/condition/abnormality

Fetal/foetal

We have chosen to use the spelling ‘fetal/fetus’ but there will also be instances where ‘foetal/foetus’ will appear in quoted extracts. The fetus is the term used to

describe prenatal development from the end of the second month of pregnancy until birth.

ANNEX B

REPRESENTATIVE ORGANISATIONS

Abortion Rights

Alliance for Choice, Belfast (AFC Belfast)

Amnesty International UK (Amnesty)

Anna Lo MLA – personal response/ not on behalf of Alliance Party

Belfast & District Trades Union Council (B&DTUC)

Belfast Feminist Network (BFN)

Black and Minority Ethnic Women's Network (BMEWN)

British Association for Counselling and Psychotherapy (BACP)

British Medical Association NI (BMANI)

British Pregnancy Advisory Service (BPAS)

Brook NI

Caleb Foundation

Catholic Bishops of Northern Ireland

Choose Life Ministry

Christian Action Research and Education in Northern Ireland (CARE in Northern Ireland)

Christian Concern and Christian Legal Centre (Christian Concern)

Christian Medical Fellowship

Church and Society Commission of the Church of Ireland

Committee for the Administration of Justice (CAJ)

Consultant and Clinical Lead for Genetic Medicine, Clinical Director, Surgical and Specialised Services, Belfast Health and Social Care Trust

Consultants in Maternal and Fetal Medicine, Department of Fetal Medicine, Royal Jubilee Maternity Service, Royal Group of Hospitals, Belfast

Disability Action

Equality Coalition

Equality Commission for Northern Ireland (ECNI)

Every Life Counts

Family Planning Association (FPA)

Fellowship of Independent Methodist Churches Northern Ireland

Free Presbyterian Church of Ulster, Government and Morals Committee

General Medical Council (GMC)

Green Party in Northern Ireland

Humanist Association Northern Ireland (Humani)

International Federation of Abortion and Contraception Professionals (FIAPAC)

Irish Congress of Trade Unions (ICTU)

Labour Party in Northern Ireland (LPNI)

LIFE NI

Mencap in Northern Ireland (Mencap)

Methodist Church in Ireland

National Union of Students (NUS-USI)

Evangelical Alliance Northern Ireland

NIPSA

Northern Health and Social Care Trust (Northern Trust)

Northern Ireland Committee of the Faculty of Sexual and Reproductive Health Care, Western Health and Social Care Trust (Western Trust)

Northern Ireland Council for Ethnic Minorities (NICEM)

Northern Ireland Human Rights Commission (NIHRC)

Precious Life

Presbyterian Church in Ireland

Progressive Unionist Party (PUP)

Pro-Life Campaign

PSNI

Queen's University Pro-Choice Society (QUB Pro-Choice Society)

Reformed Presbyterian Church of Ireland, Public Morals Committee

Royal College of General Practitioners Northern Ireland (RCGPNI)

Royal College of Midwives Northern Ireland (RCM)

Royal College of Nursing Northern Ireland (RCN)

Royal College of Obstetricians and Gynaecologists, Northern Ireland Committee (NICRCOG)

Royal College of Psychiatrists in Northern Ireland (RCPsych in NI)

SDLP

Sinn Féin

Socialist Party

Society for the Protection of the Unborn Child (SPUC)

South Eastern Health and Social Care Trust (South Eastern Trust)

The Workers Party

Traditional Unionist Voice (TUV)

Unite

Women's Aid Federation Northern Ireland

Women's Regional Consortium (WRC)

OTHERS

Ballee Presbyterian Church, Ballymena

Catholics for Choice

Centre for Health, Law, Science and Policy. University of Birmingham

Christian Democratic Party

Christian Institute

Public Morals Committee of the Congregational Union of Ireland

Cookstown Independent Methodist Church

Covenant Theological Seminary, Ireland

Crossgar Presbyterian Church

Dungannon Independent Methodist Church

Public Morals Committee, Evangelical Presbyterian Church

Killicomaine Evangelical Church, Portadown

Kirk Session of 2nd Presbyterian Church, Randalstown

Lisburn Independent Methodist Church

Lisburn Reformed Presbyterian Church

Newtownabbey Free Presbyterian Church

Newtownards Reformed Presbyterian Church

Northern Ireland Legal Services Commission

QUB Feminist Society

Racecourse Medical Group

Sean Brady, Archbishop Emeritus of Armagh

Soroptimist International, Bangor

Tuesday's Child

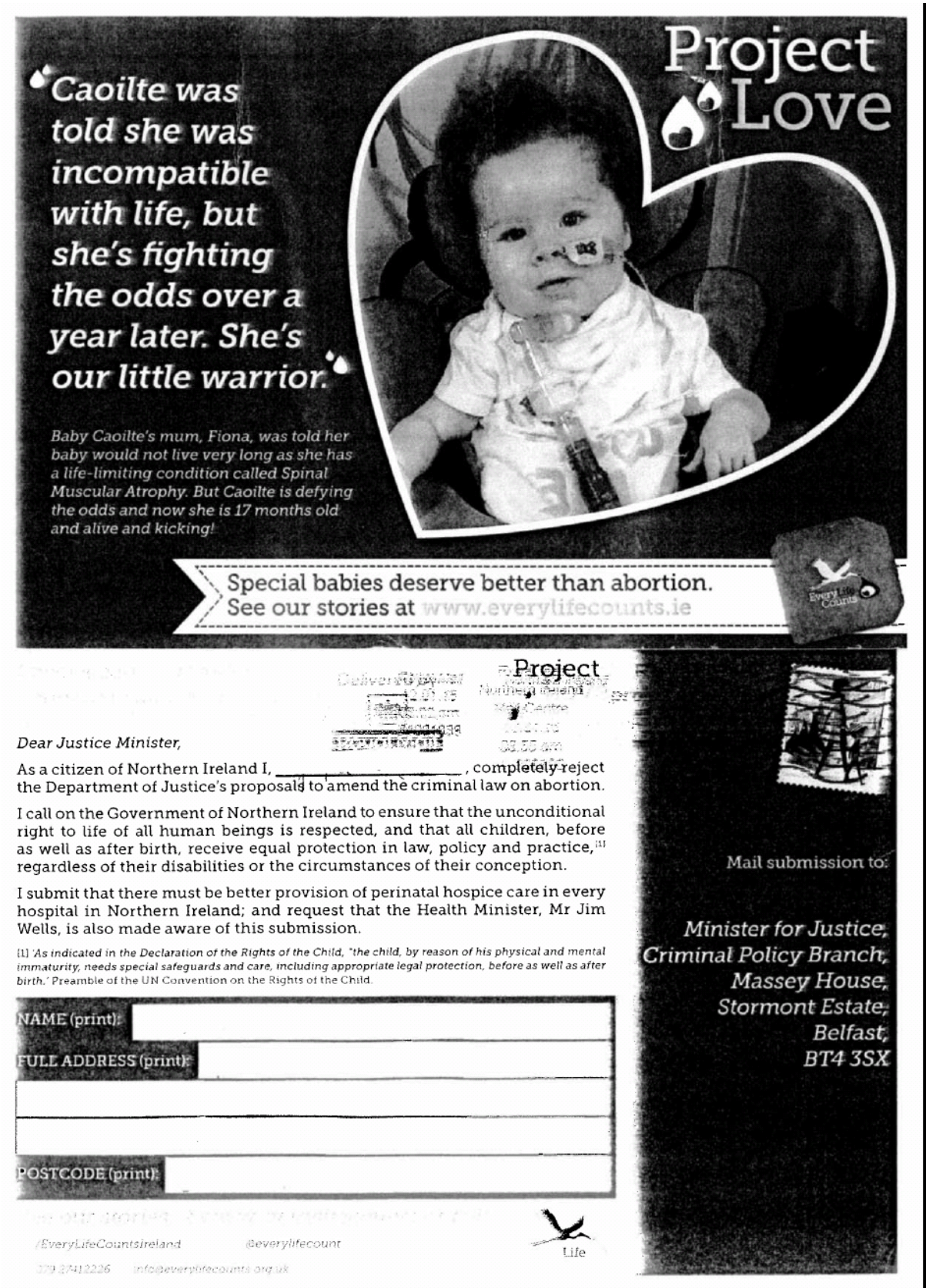
Union Theological College, Queen's University Belfast

William Tyndale Memorial Free Presbyterian

Youth for Life

ANNEX C

PETITION AND LOBBY CAMPAIGNS



Project Love

"Clodagh Treise brought nothing but love; nothing but joy."

Derbhille with Baby Clodagh, who was diagnosed with Trisomy 13, also known as Patau's Syndrome, and lived for 33 days after she was born.

Special babies deserve better than abortion.
See our stories at www.everylifecounts.ie

Project

Dear Justice Minister,

As a citizen of Northern Ireland I, _____, completely reject the Department of Justice's proposals to amend the criminal law on abortion.

I call on the Government of Northern Ireland to ensure that the unconditional right to life of all human beings is respected, and that all children, before as well as after birth, receive equal protection in law, policy and practice,[1] regardless of their disabilities or the circumstances of their conception.

I submit that there must be better provision of perinatal hospice care in every hospital in Northern Ireland; and request that the Health Minister, Mr Jim Wells, is also made aware of this submission.

[1] *'As indicated in the Declaration of the Rights of the Child, "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.'* Preamble of the UN Convention on the Rights of the Child.

Mail submission to:

Minister for Justice,
Criminal Policy Branch,
Massey House,
Stormont Estate,
Belfast,
BT4 3SX

NAME (print):

FULL ADDRESS (print):

POSTCODE (print):

/EveryLifeCountsIreland @everylifecount

079 27412226 info@everylifecounts.org.uk

Life

Project Love

Some people only dream of angels, we held one in our arms. We love you, Myla Faith. xxx

Charlene, Gareth and family with Baby Myla Faith who was diagnosed with Trisomy 18 and lived for 1 hour and 55 minutes after she was born.

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Criminal Policy Branch,
Massey House,
Stormont Estate,
Belfast,
BT4 3SX

Project Love

Poppy Grace was my little princess. I thank God every day for the 8 precious days I got to spend with her.

Christina with her baby Poppy Grace, who was diagnosed with a very rare condition called Neu-Laxova Syndrome (NLS) and lived for 8 days.

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Belfast,
BT4 3SX

Project Love

"Lily Rose was compatible with love and joy - and she had a life inside me for 32 weeks."

Gemma and David, with their baby Lily Rose who was diagnosed with Trisomy 18 who lived for 32 weeks in her mummy's womb.

Special babies deserve better than abortion.
See our stories at www.everylifecounts.ie

Project

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Life

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Minister for Justice,
Criminal Policy Branch,
Massey House,
Stormont Estate,
Belfast,
BT4 3SX

Project Love

"Abby Angela's short life was cherished, protected and loved in my arms."

This is Baby Abby Angela, who was diagnosed with anencephaly, with her mummy Anne. She lived for two precious hours after she was born.

Special babies deserve better than abortion.
See our stories at www.everylifecounts.ie

Every Life Counts

Project

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Life

Mail submission to:

Minister for Justice,
Criminal Policy Branch,
Massey House,
Stormont Estate,
Belfast,
BT4 3SX

Lobby 1

David Ford MLA

I wish to affirm my opposition to any changes in the abortion law as outlined in the consultation document. I believe there is sufficient protection to the life of the mother in the existing abortion law in Northern Ireland and should not be tampered with as this could lead to further liberalisation down the road.

I wish to comment on the following questions:-

Question 2

I oppose the changing of the law in cases of lethal foetal abnormality as it is well known that the medical profession can get the diagnosis of an unborn baby wrong.

The proposals could then be seen as allowing healthy babies to be aborted when it turns out that the aborted baby was healthy.

The proposal to have two doctors involved is not a sufficient safeguard as we already know in the UK under the 1967 Abortion Act was abused in the pre-signing of forms.

The proposals are unclear in regard to an unborn baby's whose condition may be seen as incompatible to life yet the department gives examples of these baby's living for weeks or months after being born.

Questions 6-9 ask if the law should be changed to allow abortion in cases of rape or other sexual crimes ?

I oppose the changing of the law as women need support and love, no an abortion.

This may be a great trauma for women in such situations but we must be reminded that the unborn child also who is innocent of all this has a right to life.

It is well documented that abortion increases the risk of mental illness and may even lead to suicide or depression.

Adoption should be promoted in cases where sexual crimes have occurred instead of the law allowing the life of the baby to be ended.

Question 17 Ask if the law should be changed to allow conscientious objection for those who would be expected to participate in abortion of lethal foetal abnormality and or sexual crime?

If the proposals were to be allowed then those professionals who are asked to participate in the abortion then those professionals should have a right of conscientious objections.

The 1967 Abortion Act in the mainland protects freedom of conscience.

No law should ever compel people to act against their conscience in such important moral issues as abortion.

Please reply to this if it is as portrayed to be a consultation exercise.

Hope the comments are helpful.

Lobby 2

Dear DOJ

In light of the above consultation to end Saturday 17th January, I am writing to request of the Department of Justice, that the current abortion laws for Northern Ireland should not be changed.

All unborn children share an equal right to life. There should be no liberalisation of our abortion laws.

Disabled babies are amongst the most vulnerable people in our society. They need legal protection before as well as after birth.

The killing of babies because they are disabled or terminally ill is a fatal form of discrimination. Our current law protects disabled children and it should continue to protect them.

Disabled babies need to be cared for not killed by abortion.

Parents of disabled children need genuine support not legal permission to kill their unborn babies.

Don't change the abortion laws.

Lobby 3

Dear Sir

Re: Public consultation on the Criminal Law on Abortion:

Lethal Foetal Abnormality and Sexual Crime.

The proposes liberalization of Northern Ireland's Abortion Law purports to offer a compassionate and simple solution to very complex and difficult problems, while ignoring the fact that abortion is anything but a compassionate response to the most valuable and innocent by depriving them of life. It also ignores the lasting physical and psychological damage that abortion does to mothers.

The 1967 Abortion Act in England and Wales was predicated on similar compassion and has become a classic example of the law of unintended consequences, where the legal restraints imposed are routinely ignored by many physicians. The proposed changes to the law in relation to lethal foetal abnormality will inevitably lead to pressure on mothers to see their babies as damaged good rather that the terminally ill, but valued child that they are. It will also pave the way for a situation where all foetal abnormality is a legitimate ground for abortion and further illustrates the maxim that 'hard cases make bad law.'

All children have the right to be born, regardless of their abilities or the circumstances of their conception. Our laws should protect all babies equally. Mothers in crisis pregnancies need genuine support. If this proposed new law is implemented by the Northern Ireland Assembly, it will greatly increase the pressure on a mother in a crisis pregnancy to abort her child.

I strongly urge that the law is not changed.

Yours sincerely,

Regarding the Department of justice's Consultation on the proposed changes in Northern Ireland's Abortion Laws: This letter can be used to submit your opposition to such proposed changes. The letter must include your name and address as anonymous submissions will not be considered and can be posted or emailed (access .public@dojni.x.gsi.gov.uk). The Consultation ends on Saturday 17th January. You should also send the same letter to each of the six South Antrim MLAs. Addresses of their Constituency Offices are below and the suggested letter is below/over the page.

Addresses to send letters:

Criminal Policy Branch,

Department of Justice,

Massey House,

Stoney Road,

Belfast, BT4 3SX.

MLA's	Party
Pam Cameron	
Parliament Buildings, Stormont, Belfast BT4 3XX	DUP
Trevor Clarke	
1 Lough Road, Balloo, Antrim BT41 4DG	DUP
David Ford	
Unit 2, Glengormley, Newtownabbey BT36 6HL	Alliance
Paul Givan	
5-7 School Street, Ballyclare, BT39 9BE	DUP
Danny Kinahan	
39a High Street, Antrim BT41 4AX	UUP
Mitchell McLaughlin	
2 Main Street, Randalstown BT41 3AB	Sinn Féin

Lobby 4

Dear Justice Minister

As a citizen of Northern Ireland I wish to express my objection to the proposals to amend the criminal law on abortion.

I do so on the following grounds.

Lethal Foetal Abnormality

- A baby with 'lethal foetal abnormality' is a living human being.
- A baby with 'lethal foetal abnormality' is a disabled human being.
- A baby with 'lethal foetal abnormality' is a human being with a terminal illness.

I do not accept that these circumstances justify the 'putting down' of that human being. I do not believe that it is either safe or proper to grant the power to make that decision to any group of people. Where there is a person with a disability or terminal illness, love and respect coupled with specialist or palliative care is the way to care for them.

Sexual Crime

We note again that the life and welfare of a fully human person, albeit not yet born, is entirely absent and the sole concern is that of the expectant mother. We hold this to be a very serious wrong. The idea that a baby should. or may, be killed because of either who one of their parents was or because of the circumstances surrounding their conception is fundamentally wrong.

Conscientious Objection

While calling for no change in the law in NI yet it is my belief that in all cases of moral and ethical legislation there should be the right of conscientious objection to cover all associated procedures and duties. A person should have the right to practice according to their conscience and faith.

I would therefore call upon the government to ensure the unconditional right to life of all children. I ask that the preamble of the UN Convention on the rights of the child, "that the child by reason of his physical and mental immaturity needs special safeguards and care, including appropriate legal protection before as well as after birth" be respected. I therefore completely reject the department of Justice proposal to amend the criminal law on abortion.

Your sincerely

Proposed changes to NI Abortion Law

Mr David Ford MLA, Justice Minister for NI has announced proposals to amend the criminal law on Abortion in NI. Full details can be found at www.dojni.gov.uk - public consultations.

He is required by law to hold a public consultation before it can proceed. **This consultation period ends 17 January 2015**.

The proposal is to enable abortions to be carried out in NI where there has been a diagnosis that a foetus has a lethal abnormality and will not be capable of surviving for any length of time outside the womb. Secondly it will enable abortions to be available to women who have been victims of sexual crime i.e. rape or incest.

It is the Biblical teaching that

- Life begins at conception.
- Human life is sacred.
- All children are a gift from God.
- All children have rights both before and after birth.
- The weak and most vulnerable deserve special care and protection.

An unborn child is a human being. It may be disabled, with a short life expectancy but it deserves better than abortion. Many parents who have experienced this distressing situation, but have kept their baby have spoken of the comfort and positive experience to hold it and care for it, even for a few hours or days.

Many prominent and successful persons have been born as a result of sexual crime. No child should be punished or killed because of the sin of a parent. Two wrongs do not make a right.

Where abortion laws have been liberalised history and experience proves it has either been exploited, or any loophole, flexibility or uncertainty to expand the grounds for abortion has led to a floodtide of abortions.

It is important that all who are pro-life and seek the welfare of the unborn child should write or email the Justice Minister and other MLAs before 17 January 2015. (details overleaf).

Lobby 5

Mr David Ford
Minister of Justice
Criminal Policy Branch
Department of Justice
Massey House
Stoney Road
Belfast
Bt4 3SX

Dear Mr Ford

Re Public Consultation on the Criminal Law on Abortion:
Lethal Foetal Abnormality and Sexual crime

I am upset to learn of the proposed changes to the current Abortion Laws in Northern Ireland.

As you are aware, Article 2 of the Declaration of Human Rights details the Right to Life and imposes an obligation on the State to protect the right to life and prohibits the State from intentionally killing. At the same time, Article 14 of the Declaration requires there be no discrimination in the application of human rights on any grounds.

Therefore, all children have the right to life, to be born regardless of their abilities or the circumstances of their conception. Our current laws recognise that and **should not** be changed.

All unborn children share an equal right to life. Disabled babies are amongst the most vulnerable people in our society and they need legal protection to ensure their right to life is upheld and that they are not subjected to discrimination, with fatal consequences. Women in crisis pregnancies need help to care for their babies, not a legislative basis to help to kill them.

I am therefore writing to you as a resident of Northern Ireland in your capacity as Minister of Justice, to request that you do all in your power to represent my strongly held belief that the proposed changes to the Abortion Laws in Northern Ireland will violate the right to life and introduce discriminatory practice with fatal consequences and therefore our current laws **should not** be changed.

Yours sincerely

Lobby 6

Criminal Policy Branch
Department of Justice
Massey House
Stoney Road
Belfast
BT4 3SX

Dear Sir/Madam

Responses to the Department of Justice Consultation on amending 'The Criminal Law on Abortion: Lethal Foetal Abnormality and Sexual Crime"

Please find attached my responses to the questions as set out in the above mentioned consultation paper in Part IV, chapter 11, Anne A.

Yours faithfully,

Name: _____

Address: _____

Signature: _____

Date: _____

Annex A

QUESTIONS FOR RESPONDENTS TO CONSIDER

Lethal foetal abnormality

1. Several options have been put forward in chapter 4 to create an exemption in the criminal law on abortion, to provide for termination of pregnancy in cases of lethal foetal abnormality. The Department has set out its preferred option for defining what is meant by 'lethal' and ensuring that the law will apply only to such cases. The paper seeks views from respondents.

    - **I DO NOT BELIEVE THAT THERE SHOULD BE ANY EXEMPTION IN THE CRIMINAL LAW ON ABORTION. THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE. ALL LIFE SHOULD BE AFFORDED THE SAME RIGHTS REGARDLESS OF THE PHYSICAL AND/OR MENTAL CONDITION OF THE UNBORN CHILD.**

2. Should the law allow for abortion in cases of lethal foetal abnormality?

    - **NO.**

    THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.

3. If so, how is the best achieved?

    - **THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

4. How would you define 'lethal'?

    - **Not applicable as THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

5. Do you agree that the best way is to allow clinical judgment to decide when a foetus is not compatible with life?

    - **ABSOLUTELY NOT. THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

Sexual Crime

6. Should the law also provide for abortion to be a choice in the event of rape?

    - **NO. THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

7. Should the law allow abortion only for women who have been the victim of rape?

    - **THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

8. Should the law allow for abortion for victims of other sexual crime, such as sexual activity with a person under the age of 16, abuse of a positon of trust, unlawful sexual activity with a vulnerable adult?

    - **NO. THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

9. Should the law provide for abortion in cases of familial sexual activity with a person under 18, and sex between adult relatives?

    - **NO. THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

10. Should it be necessary to have made a complaint to the police before accessing a termination?

    - **THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

11. Does this need to be time limited?

    - **THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

12. Should a police report be required and what would this say?

    - **THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

13. How would all this be achieved to allow for an early termination and is this an issue?

    - **THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

14. Or should the exemption apply with no requirements, other than a declaration to her medical practitioner by the woman, that the pregnancy is the result of a sexual crime committee against her?

    - **THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

15. In the case of incest, who is going to determine when an incestuous relationship has occurred and how is this proved?

- **THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

16. In other words, how could we ensure that the law would work as intended, has no unintended consequence and that there would be legal certainty in these cases?

    - **THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

Conscientious Objection

17. Should there be a right to conscientious objection for those who participate in treatment for abortion in respect of (i) lethal foetal abnormality and (ii) sexual crime?

    - **THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

18. Should that right be confined to involvement in the actual procedure which results in termination (e.g. giving the abortion medication, carrying out or assisting in the surgical procedure)?

    - **THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

19. Should the right cover participation in all treatment related to the abortion, including both pre and post procedure nursing care?

    - **THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

20. Should it also cover all associated, but not direct duties, such as supervising and supporting other staff, and delegating tasks to staff involved in the provision of care to patients undergoing medical termination at any stage of the process?

    - **THE LAW SHOULD NOT BE CHANGED TO ALLOW FOR A TERMINATION UNDER ANY CIRCUMSTANCE.**

Lobby 7

CONSULTATION ON ABORTION 2014
http://www.dojni.gov.uk/consultation-on-abortion-2014

Criminal Policy Branch
Massey House
Stormont Estate
Belfast
BT4 3SX

QUESTIONS FOR RESPONDENTS TO CONSIDER

Lethal foetal abnormality

1. Several options have been put forward in chapter 4 to create an exemption in the criminal law on abortion, to provide for termination of pregnancy in cases of lethal foetal abnormality. The department has set out its preferred option for defining what is meant by 'lethal' and ensuring that the law will apply only to such cases. The paper seeks views from respondents.

2. **Should the law allow for abortion in cases of lethal foetal abnormality?** No, the child has a right to be given every chance of survival. I would highlight that there have been multiple cases of parents refusing an abortion despite being advised their child had no chance of survival, and the child was born and survived (see examples given in my response to question 5). It is therefore clear that the wording used to describe Option 4 in para 4.1 as "clear and precise" are completely erroneous and should be deleted. Further, considering that this error prone option "offers the best way to proceed", according to para 4.18, one can only conclude that we should not proceed. How many children's lives must be sacrificed to give this "choice"?

3. **If so, how is this best achieved?** N/A.

4. **How would you define 'lethal'?** It is impossible, even "professionals" who have tried to make judgment on this have been proven wrong multiple times as I outline in my response to Q5. In any case, just because an infant is ill, even if he is terminally ill that does given anyone the right to kill them.

5. **Do you agree that the best way is to allow clinical judgment to decide when a foetus is not compatible with life?** Absolutely not, clinical judgment has been proven wrong so many times in the past. I outline a few examples below.

    - Melanie & Damien Sheenan, who were told at their 20 week scan that the child had fatal foetal abnormalities. The couple were then put under immense pressure to have an abortion and were told that the brain was not formed and the spine was not formed etc. The couple endured many

phone calls to tell them how many days and weeks they had left to their 24 week cut off. When they went to appointments, they were introduced as "the couple who were coming with the pregnancy against medical advice." Causing them much pain and anxiety – they were made feel they were doing something terribly wrong by wanting to keep their baby. Despite all this, baby Joshua was born healthy and well.

- Robyn & Adam Wilson were advised to abort their son after a 12 week scan revealed there was a chance he would be born with a life limiting illness. They refused the abortion and recently celebrated little Harry's second birthday.

- Sara Fisher & Scott McMahon were advised by doctors to abort little Jacob, after his twin sister Emie died when she was born at 21 weeks and six days due to an infection. But Jacob was born 8 days later at 23 weeks (1 week before the legal threshold for abortion) and just 12 hours before doctors would have demanded a final decision on whether to terminate the pregnancy. Five months later he was deemed healthy enough to leave the hospital.

- Vicky Davies and Gavin Wilson were told that their little one had CDH, and his stomach organs were in his chest. Doctors advised an abortion, but mum of 4 said "I knew I just had to give him a chance of survival". Little Samuel Wilson survived and is doing well. His mum said her other children "love him to bits and would come and stay the weekend so see him". She said "I want to raise awareness of CDH and show people that it is not all negative, your baby can survive this".

    - Rachel Davies, was advised there was a 10% chance her baby would survive when she was diagnosed with Oligohydramnios – meaning her unborn son was surrounded by too little amniotic fluid. The first time mum refused to listen to doctors who said "this baby will die, the best think you can do is terminate it". She continued with the pregnancy; she said "I could feel my baby was alive, he was moving, how could I get rid of him". Rachel kept a detailed journal of her pregnancy, and said "when Alfie is older, I shall give it to him, it will be a testament to how much we wanted him and how hard we fought to bring him into the world."

    - Jennifer Kehoe and her husband John, from Kildare were told their baby has a congenital heart defect and a rare brain disorder and would have little chance of survival outside the womb. Their daughter Louise, now 3 years old, defied the odds. Jennifer and John said they they felt "judged" for not choosing an abortion. Three year old Louise has come through three heart operations, but her congenital development is normal and she is expected to lead a long and normal life.

In all these cases and many more, medical experts have erroneously advised the parents to kill their child yet the child has survived. Why has no such case

been noted in the consultation paper? If a house was about to be demolished by explosives and someone said “wait, I think there might be a child in there”, who in their right mind would detonate the explosion. Children have a right to live, no matter how small their chance of survival, they have a right not to be killed.

Sexual Crime

6. **Should the law also provide for abortion to be a choice in the event of rape?** No it should not; just because the Father is a rapist, is not a valid reason to kill a child. For example Gary Moore was conceived through rape, his grandparents advised his mum to abort him and threw her out of the house because she refused. This highlights the potential additional pressure and pain such a law would place on victims of rape. Again why have no such cases been included in the consultation? I would ask that the consultation be revised to include such cases to ensure a fully rounded picture is presented, and avoid potential criticism that the consultation presents a lopsided view of the issue.

7. **Should the law allow abortion only for women who have been the victim of rape?** This question is outside the stated scope of the consultation as outline in the introduction, quote: “The subject matter of this consultation paper is strictly focused on two aspect of the criminal law on abortion. Firstly, it looks at whether the law should enable abortion in cases where there is a diagnosis in pregnancy and the foetus has a lethal abnormality.

   Secondly, it addresses the issue of whether abortion should be available to women who have become pregnant as a result of sexual crime. It is not a debate on the wider issues of abortion law.”

   As such I would ask for its removal.

8. **Should the law allow for abortion for victims of other sexual crime, such as sexual activity with a person under the age of 16, abuse of a position of trust, unlawful sexual activity with a vulnerable adult?** No, again bestowing the death penalty on a child because of the transgressions of its Father is unfair in the extreme and completely unjust; the little one has done nothing to deserve death.

9. **Should the law provide for abortion in cases of familial sexual activity with a person under 18, and sex between adult relatives?** No, why should the child be put to death for something he had no control over? If someone brings genetic difficulties to the discussion, I would be very afraid of where this path will lead, because it would seem to be going in the same direction as Nazi eugenics.

10. **Should it be necessary to have made a complaint to the police before accessing a termination?** Killing the child is not right no matter what the father did, this question is irrelevant and should be re-worded or removed.

11. **Does this need to be time limited?** From the moment of conception the child is fully human, and its life should be protected. To draw a line in the sand anywhere else from conception, to birth or indeed after birth is "playing God". I would draw your attention to a paper in the Journal of Medical Ethics, entitled, '**After-birth abortion:** why should the baby live?' which argues that filling a newborn baby should be "permissible in all the cases where abortion is, including cases where the newborn is not disabled." The authors of this paper, Alberto Giubilini of the University of Milan and Francesca Minerva of Melbourne University, argue that,

    (i) "both foetuses and newborn do not have the same moral status as actual persons",

    (ii) "the fact that both are potential persons is morally irrelevant".

    (iii) and thirdly, they write that, "adoption is not always in the best interest of actual people."

    To summarise they say: newborn babies are not actual people therefore, killing them is not immoral. The arguments marshalled by these ethicists' are not new, they are just an extension of the current argument that undergrids the murder of babies within the womb to cater for their killing outside of the womb. If we accept the ideas on personhood that are held by those who advocate abortion, there is no ethical reason to stop carrying out abortions at the arbitrary point of birth.

    The moment we assume the dangerous position of setting up as the arbiters of who is human and who isn't, this is the calamitous vet inevitable end. Once we declare that all human life is not sacred, the rest is just drawing random lines in the sand. Such barbarity is the only logical outcome once you accept that you can kill a child.

12. **Should a police report be required and what would this say?**

    This question is getting into the administration of the proposed change, and is predicated upon an acceptance of the proposed change. The question should be re-worded to avoid this. With or without a police report, abortion is not acceptable.

13. **How would all this be achieved to allow for an early termination and is this an issue?** This question is getting into the administration of the proposed change, and is predicated upon an acceptance of the proposed change. The question should be re-worded to avoid this.

14. **Or should the exemption apply with no requirements, other than a declaration to her medical practitioner by the woman, that the pregnancy is the result of a sexual crime committed against her?** This has the potential to open the floodgate to abortion on demand, as happened in England for example when the law was changed to allow for abortion "If the life of the mother would be placed in greater danger if she were to continue

the pregnancy that if she were to have an abortion". It is established medical opinion, borne out by statistics, that any full-term pregnancy does put the physical and mental health of the mother at some risk, albeit very small, thus this can be used as a reason by anyone who wants an abortion. In the same way, the above proposal would permit an abortion for any women willing to tell a lie.

15. **In the case of incest, who is going to determine when an incestuous relationship has occurred and how is this proved?** Again this question appears to point towards the introduction of Eugenics, ie, its ok to kill the child because it is likely to have poor quality genetics' because of incest. It is frightening that such a question is even included in this questionnaire. I would refer you to the history of Nazi Germany as a case study of where it leads.

16. **In other words, how could we ensure that the law would work as intended, has no unintended consequences and that there would be legal certainty in these cases?** A consideration of the intended consequences (i.e the killing of innocent children), should suffice to convince any right thinking person to abandon any idea of such a law.

Conscientious objection

17. **Should there be a right to conscientious objection for those who participate in treatment for abortion in respect of (i) lethal; foetal abnormality and (ii) sexual crime?** The right to conscientious objection should apply across the board, no person should be required to participate in the killing of an innocent child in any capacity whatsoever**.**

18. **Should that right be confined to involvement in the actual procedure which results in termination (e.g giving the abortion medication, carrying out or assisting in the surgical procedure)?** The right to conscientious objection should apply across the board, no person should be required to participate in the killing of an innocent child in any capacity whatsoever.

19. **Should the right cover participation in all treatment related to the abortion, including both pre and post procedure nursing care?** The right to conscientious objection should apply across the board, no person should be required to participate in the killing of an innocent child in any capacity whatsoever.

20. **Should it also cover all associated, but not duties, such as supervising and supporting other staff, and delegating tasks to staff involved in the provision of care to patients undergoing medical termination at any stage of the process?** The right to conscientious objection should apply across the board, no person should be required to participate in the filling of an innocent child in any capacity whatsoever.

Pastor Bell Petition

From:

Sent: 08 November 2014 18:35

To: Access to Justice (Public)

Subject: 5 new people signed: Do NOT change the law on abortion in N.Ireland

5 new people recently signed Pastor Bell's petition "The Department of Justice (N.Ireland): Do NOT change the law on abortion in N.Ireland" on Change.org.

There are now 5 signatures on this petition. Read reasons why people are signing, and respond to Pastor Bell by clicking here:

http://www.change.org/p/the-department-of-justice-n-ireland-do-not-change-the-law-on-abortion-in-n-ireland/responses/new?response=1bfe8e359ec0

Dear The Department of Justice (N.Ireland),

Do NOT change the law on abortion in N.Ireland

Sincerely,

5.

4.

3.

2.

1.