Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Access to Reproductive Healthcare Services and Severe Fetal Impairment Abortion (Amendment) Bill: Northern Ireland Human Rights Commission

3 June 2021

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Paula Bradshaw
Mr Jonathan Buckley
Mr Gerry Carroll
Mr Alan Chambers
Ms Órlaithí Flynn
Ms Cara Hunter
Ms Carál Ní Chuilín

Witnesses:

Mr Les Allamby	Northern Ireland Human Rights Commission
Miss Rhyannon Blythe	Northern Ireland Human Rights Commission
Dr David Russell	Northern Ireland Human Rights Commission

The Chairperson (Mr Gildernew): I welcome Mr Les Allamby, the chief commissioner of the Human Rights Commission. Good morning, Les. Can you hear me OK?

Mr Les Allamby (Northern Ireland Human Rights Commission): I can hear you fine.

The Chairperson (Mr Gildernew): I also welcome Dr David Russell, the chief executive. Can you hear us OK, Dr Russell?

Dr David Russell (Northern Ireland Human Rights Commission): Yes, Chair. Thank you.

The Chairperson (Mr Gildernew): I also welcome Miss Rhyannon Blythe, the director of legal, research and investigations and advice to government. Good morning, Rhyannon. I hope that I have pronounced your name correctly and that you can hear me OK.

Miss Rhyannon Blythe (Northern Ireland Human Rights Commission): Yes. Thank you, Chair.

The Chairperson (Mr Gildernew): There will be a fair bit of overlap between the two items that the commission is here to give evidence on, so, in order to aid our time for briefings today and if members are content, I will ask the commission to start by briefing the Committee on its report on access to reproductive healthcare services and its submission to the Committee on the Severe Fetal Impairment

Abortion (Amendment) Bill. After that, we can allow questions from members on both those issues. I think that that is the best way to proceed.

Les, are you content to lead on briefing the Committee? After that, we will go to questions and answers.

Mr Allamby: Yes, I am. Good morning and thank you for the invitation to brief the Committee. I will start with the monitoring report and provide a brief backdrop and recap.

Following complaints to the Committee on the Elimination of Discrimination against Women (CEDAW) in 2010, it decided to conduct an inquiry into abortion law and its impact in Northern Ireland. That inquiry report was published in 2018, concluded that the old law created grave and systemic violations of human rights and made a number of recommendations, including that women should be provided with access to quality abortion and post-abortion care in all public health facilities and that a mechanism should be established to advance women's rights, including through monitoring authorities' compliance with international standards. It also stated that enhanced cooperation between the Department of Health and the commission should be ensured. It is fair to say that the recommendations went beyond access to abortion: they were wide-ranging and looked at access to sexual reproductive health services more broadly. Those recommendations were endorsed by the UK Government through the Northern Ireland (Executive Formation etc) Act in July 2019, which placed a duty on the Secretary of State to implement the recommendations in full by 31 March 2020 and to decriminalise abortion by 21 October 2019 unless the Northern Ireland Executive, which were in abeyance at the time, had been restored.

That was the basis on which we commenced our monitoring initiative; it was part of the recommendations. It involved meeting those responsible for providing the service across all five health and social care trusts, meeting all the royal colleges of midwives, nurses, gynaecologists and obstetricians, GPs, the Public Health Agency (PHA), the Health and Social Care Board (HSBC), the Regulation and Quality Improvement Authority (RQIA), the Department of Health, the NIO, the Pharmaceutical Society, unregulated providers, the Coroners Service and a number of pro-choice and pro-life organisations. We also held a round-table discussion with civic society organisations, including those who supported the reforms and those who were avowedly against them.

The inquiry and monitoring were very detailed in order to see what was happening on the ground. We found that a service was initially commenced in early April 2020 in two trusts on behalf of all five trusts and in all the trust areas by June 2020. However, by June, the service was confined to an early medical abortion service of up to nine weeks and six days, with referrals coming from Informing Choices and emergency surgical arrangements being provided through the Belfast Health and Social Care Trust. Those services were being provided through the transfer of staff from other sexual and reproductive healthcare services that were either in abeyance or facing reduced demand due to the pandemic. None of the services was being commissioned or funded by the Department of Health, and Informing Choices was providing the referral service without any additional financial support. The Department of Health had provided no guidance, public information or other tangible support for the service. The trusts said to us that they were used to managing risk and normally did so within a clear framework and operational guidance, but here they were being asked to do so without such a framework. The reality is that the service has not met the legal requirements. It has also been suspended on a number of occasions in three trusts. For example, the Northern Trust did not provide a service for three months from October 2020 to January 2021; it was suspended for a month in the South Eastern Trust from January 2021; and it has been suspended in the Western Trust for the last five weeks, and we do not know how long it will be before the service will be restored. It is also clear that, when they suspended the services, none of the trusts was able to refer women to other parts of Northern Ireland to access the service. Therefore, there has been a make-do-and-mend approach through, frankly, the heroic efforts of clinicians in trusts. For example, two of the three suspensions were because the one person who was providing the service was no longer able to do so.

There has been an early medical abortion service, in that there were 1,373 early medical abortions in Northern Ireland during the financial year 2020-21. It is also clear that significant numbers of women have been forced to travel to Britain, usually Liverpool or Manchester, for terminations, despite the pandemic and the travel restrictions. It is also clear that the number of women using unregulated services has dropped markedly. Therefore, as best as we can ascertain, the number of terminations overall has not necessarily increased substantially. Instead, women have been more readily able to access at least an early abortion service through regulated provision locally. I must emphasise that the service is not being carried out in accordance with the abortion regulations, its provision is precarious,

it is prone to suspension, and, in the near term, it can be provided only at the expense of other sexual and reproductive healthcare services, which is deeply unsatisfactory.

The Department of Health brought a paper to the Northern Ireland Executive on 3 April 2020 that sought to provide for an emergency early medical abortion service due to the pandemic. That paper's proposals could not be agreed within the Executive. A further paper was tabled on 6 May, but it was never discussed. Following the commission's recent legal challenge, there have been further attempts to get the issue discussed but without any success to date. From the papers that we received in the legal case, it is fair to say that the legal challenge has concentrated the minds of people in London and Belfast.

The key recommendations of our report are that the Secretary of State should take the required legislative action to ensure that the recommendations in the CEDAW report are fully implemented in line with Westminster legislation, that the Department of Health should commission and fund abortion services and that the Northern Ireland Executive should enable that to happen. In practice, we have gone to court once again to try to ensure that those recommendations are actioned, and it is deeply regrettable that we have had to do that. There are a number of other recommendations, but I focused on the key ones.

The second part of this morning's evidence is a consideration of the Severe Fetal Impairment Abortion (Amendment) Bill. In effect, the Bill seeks to prevent abortions from being carried out on the grounds of physical and mental impairment that amounts to a serious disability. The CEDAW inquiry held that:

> *"The Committee assesses the gravity of the violations in NI in light of the suffering experienced by women and girls who carry pregnancies to full term against their will [owing] to the current restrictive"*

— that is, the old —

> *"regime on abortion."*

Furthermore:

> *"The Committee interprets articles 12 and 16 [of CEDAW] ... read with articles 2 and 5, to require State parties to legalise abortion, at least in cases of rape, incest, threats to the life and/or health (physical or mental) of the woman, or severe foetal impairment."*

When the 2020 regulations were passed to introduce the current reform, Viscount Younger, speaking for the Government in the House of Lords, said:

> *"I remind noble Lords that the regulations can be amended in Northern Ireland should that be so wished in the future, so long as any amendment is compatible with the ECHR and compliant with CEDAW".*

The question of CEDAW's recommendations and their compatibility, for example, with the UN Convention on the Rights of Persons with Disabilities (UNCRPD) has been raised, and a joint statement was issued by the two bodies in August 2018. That statement finished by saying:

> *"In all efforts to implement their obligations regarding sexual and reproductive health and rights, including access to safe and legal abortion, the Committees call upon States parties to take a human rights based approach that safeguards the reproductive choice and autonomy of all women, including women with disabilities."*

It is fair to say that the UNCRPD approach will be to treat pregnancy and access to abortion equally, regardless of fetal impairment, and that has been the focus of the committee. It has never definitively outlined whether that should be equality within a permissive or a restrictive regime. Nonetheless, if you read the joint statement as a whole, you will see that it is clear that any arrangement should focus strongly on a women's right to personal autonomy, and this Bill does not appear to do that.

I am also very mindful that the Northern Ireland Abortion and Contraception Taskgroup's recent report outlines that Northern Ireland lacks the level of provision for prenatal testing that is available elsewhere in the UK and that that makes it less likely that severe fetal abnormality will be diagnosed at

an early stage. The reality is that, where a severe foetal impairment arises, it is normally a wanted pregnancy, and it places the woman in a particularly acute and difficult position.

The commission is also aware that the equivalent provisions in the 1967 Abortion Act are being legally challenged in the High Court in London on the grounds that they are not human rights-compliant. There is a hearing on 6 July 2021. That case is being taken in the name of Heidi Crowter. In those circumstances, we think that it might be prudent to wait to see what the courts decide in Britain before embarking on a law that removes provision in Northern Ireland.

In summary, we do not think that the current Bill is in compliance with the recommendations of the CEDAW inquiry into abortion in Northern Ireland. The Westminster Government have tasked the Secretary of State for Northern Ireland to fully implement the recommendations of the CEDAW report. While the Northern Ireland Assembly can legislate in these matters, it should do so in compliance with the CEDAW recommendations, and we do not think that it does.

Rhyannon and David, do you want to add anything? If not, we are happy to take questions from the Committee.

The Chairperson (Mr Gildernew): Rhyannon and David are indicating that they are OK at this point.

I will ask a couple of questions first, Les, and then go to Committee members. Thank you for your presentation. You mentioned that the current provision of services is a case of "make do and mend" and is unsustainable. What do you recommend needs to happen to address that immediate situation satisfactorily?

Mr Allamby: In effect, the Department of Health needs to commission and fund the service. It needs to resource the service. As I understand from our discussions with the Department, the issue here is not primarily finance or COVID. The Department has already asked for an emergency medical abortion service to be provided during the pandemic. I now understand that the Department is willing to scope out commissioning the service. The problems lies — we think that, on this issue, the Department is right — in the fact that, legally, it must bring the matter to the Northern Ireland Executive. The Northern Ireland Executive do not commission services, but, under the ministerial code, they need to give their agreement for the Department to go ahead. We are saying that the Department of Health and the Northern Ireland Executive should enable the service to happen. In the absence of that, the responsibility then falls on the Secretary of State for Northern Ireland, because the law in Britain says, effectively, that he is responsible for fully implementing the CEDAW recommendations. We think that the current service is not human rights-compliant, and those are the grounds on which we have taken the case against the Department of Health and the Executive. As for the Secretary of State, the action is based on the statutory duty laid down by Parliament in Westminster. It is worth mentioning that that duty is to ensure that the recommendations are complied with expeditiously, which, effectively, means "with some urgency". It is now 14 months since the regulations were made, yet we are still in the situation that I outlined earlier.

The Chairperson (Mr Gildernew): Thank you, commissioner. In this evidence session, you have clearly indicated that you believe that the Bill is not compliant with human rights or with the CEDAW recommendations. You referenced current screening and the levels of screening. You said that it would be prudent to await the decision in the Heidi Crowter court case in Britain. Will you elaborate a little on your thinking around that, please?

Mr Allamby: Yes. I have read some of the papers in the Heidi Crowter case, and, personally, I do not think that the case will succeed. However, I am wise enough and long enough in the tooth to know that you should always be very careful about predicting the outcome of a court case, so we should wait to see what happens. If that court case were to succeed, it would also remove the grounds for abortion in England, Scotland and Wales in cases of severe fetal impairment. Effectively, the Bill leaves a woman, usually requiring a late-term abortion, having to travel to Britain, which involves an increased risk, frankly, and causes distress. We need some certainty on whether a service will be available in Britain. I think that it still will. It makes sense to see what will happen with the legal challenge. That will also clarify the argument as to whether severe fetal impairment provisions are in compliance with the European Convention on Human Rights. We think that they are, but, ultimately, that is a matter for the courts to decide.

Mrs Cameron: Thank you, Mr Allamby and the team, for your presentation and for your attendance at the Committee this morning. We greatly appreciate your time. I have a question on each of the issues.

On the commissioning of services, there is much criticism in the report about inequality of access and the failure to commission services. Does the Northern Ireland Human Rights Commission recognise, however, that retaining early medical abortion services in the context of resources already being stretched would perpetuate new inequalities in care and support in other front-line services? Do you recognise that we cannot operate in a vacuum, ignoring the clear resourcing constraints that face our health service?

Mr Allamby: I absolutely recognise that healthcare services are under enormous pressures. From our discussions about the reasons for the full service not being implemented, our understanding is that it is not primarily an issue of finance; rather, it is an issue of political will. That is not to say that there are not costs associated with the service, but we think that early medical abortion and wider abortion services are a priority. The trusts are willing to provide the service and have managed to do what they can. We think that the CEDAW recommendations as a whole, which are about access to wider sexual and reproductive healthcare services — important services for women — should be given priority, and, in those circumstances, the commissioning and funding of the service allow the trusts to recruit the necessary staff to provide all sexual and reproductive healthcare services.

It is in our interests to have a proper service for women. In the absence of that, we expect women to travel to Britain, and a number of women still have to do that. Frankly, that is not satisfactory in normal circumstances, and it is worse to ask women to travel during a pandemic. At times, women have been asked to travel to Liverpool or Manchester to undergo a termination and then get back to Belfast all in the one day and night, because, of course, there has been nowhere to stay in Liverpool or Manchester at various times during the pandemic. In the 21st century, that is not the kind of service that we think women should have or that they deserve.

Mrs Cameron: I appreciate your response, and I fully appreciate that it is a very sensitive and difficult issue for many.

We now have the Severe Fetal Impairment Abortion (Amendment) Bill. Abortion on the grounds of serious fetal impairment perpetuates stereotypes, and the current law imposed by Westminster is at odds with the aims of promoting an inclusive and diverse society in Northern Ireland. That is why we are supportive of that Bill's intentions. How does the view that the unborn child does not have any right to life under human rights law contrast with equivalent protections under the Criminal Justice Act? Are we not sending mixed messages about the protections that we offer to the most vulnerable?

Mr Allamby: Our case, particularly in the High Court, established that the common law — the judge-made law — in Northern Ireland is the same as that in England and Wales. In essence, it is that a fetus or an unborn child has no free-standing rights. Any rights that an unborn child or fetus has are inextricably linked to those of the woman, save where statutory provision provides otherwise, and you have just given an example of where the statutory provision is. Of course, that does not preclude other statutory provision, and that is what the Bill intends to do. However, we say that it must be compatible with CEDAW, and, in this case, the CEDAW recommendations have been implemented through Westminster legislation. The UK Government have decided to take those international obligations and implement them within the framework of UK law, and that, effectively, is what the dualist approach is: in other words, the UK Government sign up to treaties, including CEDAW, but making those treaties justiciable is a matter for the Westminster Parliament. In this case, with these recommendations, that is what they have done. Therefore, we think that, while the Assembly has a perfectly legitimate right to legislate in this area, it should do so in a way that is compatible with the CEDAW recommendations in this report, which stated that, under the old law, there were "grave" and "systemic" violations of human rights. That is not to be treated lightly.

Mrs Cameron: I appreciate your response. Thank you.

Mr Buckley: Thank you, panel. First, I will outline the obvious: the DUP is resolutely a pro-life party, and we oppose the current regulations. We are interested in saving lives, not taking lives. I wholeheartedly support the position adopted by the Minister on the need for Executive agreement on what is a cross-cutting and controversial issue. I think that the intervention by the Secretary of State is deeply destabilising at this time.

The commission desires to see a definition of "conscientious objection". Do the representatives recognise the risk that restricting the exemption to direct abortion services, rather than auxiliary functions, may unduly infringe on freedom of conscience and religion?

Mr Allamby: Thanks, Jonathan. I should start by saying that the Human Rights Commission is neither pro-life nor pro-choice; it is pro-human rights. I hope that we have engaged in a very respectful debate with people from across the spectrum of views on the issue, and we entirely respect the freedom of conscience that people have about it. It is a touchstone issue for many people who are pro-choice or pro-life or those who find themselves somewhere on that continuum.

Our report on freedom of conscience found that, to date, it is not impairing the service, largely because the service is being provided by a relatively small number of clinicians and other staff, most of whom, in the absence of any guidance from the Department of Health, fall back on their professional bodies, which are the Royal College of Nursing and the Royal College of Midwives etc. We think that there should be clear guidance from the Department of Health and that that should be based primarily on the case law in the Greater Glasgow Health Board case. It may well also draw on article 9 on freedom of conscience. The trusts raised with us the point that, if a full service were to be implemented, there may be more significant freedom of conscience issues. It is clear to us that the parameters should be within the Supreme Court grounds. On questions about, for example, whether administrators and others should not even make an appointment etc, we do not think that it extends that far. It is fair to say, however, that the issue of freedom of conscience may, if the full service envisaged in the regulations is rolled out, become more of an issue. To date, it has not been an issue. It is there, and it is *[Inaudible owing to poor sound quality]* the track.

Mr Buckley: I want to put on record my concern. In my eyes, the direction of travel that some may want to take this in relation to freedom of conscience is deeply worrying. At the extreme, it could risk requiring medical professionals to perform auxiliary or support services connected with abortion against their conscience. My party and I will never support a restriction on that freedom of conscience. That is just another point. I do not whether you want to come back on it, or I can move on to the next part.

Mr Allamby: I will check whether either of my colleagues want to comment on the freedom of conscience issue. They do not, so I am happy to move on to your second point.

Mr Buckley: No problem. It relates to the Severe Fetal Impairment Abortion (Amendment) Bill. My colleague Pam Cameron outlined why we support the approach and the Bill. Do the representatives feel that there is a space for enhancing specialised care pathways for women who have received a diagnosis of fetal impairment? Is there not a real danger in viewing those women solely through the lens of abortion?

Mr Allamby: We have always been very clear as a commission that part of a woman's right to bodily autonomy is the right to carry a pregnancy to full term and to be completely and fully supported in doing so. Equally, women have the right not to do so. We think that there should be pathways for those who choose to have a pregnancy to full term, whether that is in a case of fatal fetal abnormality, severe fetal impairment or in other circumstances, and for those who choose otherwise, and they should also have proper care and aftercare. One thing remains very clear in my memory. When the CEDAW committee undertook work on its report, it came to Belfast and met people of all shades of opinion. The visit fell in the week that the paediatric pathologist, who is one of only two in Northern Ireland, resigned because of the arrangements that were having to be put in place for women and their partners to bring back fetal remains in cooler bags and in various other ways. Because she was so disturbed about the kinds of arrangements in place, she resigned after 25 years in the service. We need to move to a stage where aftercare for those who do and do not go to term is centred on the woman and her needs, regardless of the choice that she has made. To that extent, I am absolutely in agreement with you. There should not be a one-sided approach to pathways to care; all the decisions that a woman may want to make should be taken into account.

Mr Buckley: Much of the debate surrounding the Severe Fetal Impairment Abortion (Amendment) Bill has been about its impact on young people born with Down's syndrome. It is an issue that continues to cause much hurt right across the country for those families that have children with Down's syndrome who have gone on to have full and fulfilling lives and who are valued members of their family and community. The type of response and language that we see here from the Northern Ireland Human Rights Commission recommending the roll-out of early testing for conditions such as Down's syndrome makes me ask this: do you recognise the importance of ensuring that the culture surrounding such tests is supportive rather than negative? It can easily be perceived that we have now taken an approach where there is an attempt to screen out those with Down's syndrome from our society, which is wholly inadequate and wrong.

Mr Allamby: The purpose of having an early testing regime is not solely focused on Down's syndrome. There can be all kinds of other severe fetal impairment, and the earlier those are discovered, the more likely it is that the woman will get the care she needs and the time to assess her situation. In the papers for the Heidi Crowter case, there is guidance from the Royal College of Obstetricians and Gynaecologists about how to deal with those situations. There is also a joint piece of work that is about to be completed, and the British Medical Association has done work on the issue. There is a great deal of guidance on how to properly and sensitively treat those situations. I do not think we should make any assumptions about Down's syndrome; it is absolutely clear that people with Down's syndrome can lead full and fulfilling lives. I know that there is a focus on Down's syndrome, but we have to look at the wider questions. I am absolutely clear that there should be proper care and respect for women and for the difficult choices that they have to make in those situations. That should also be about recognising the value of all lives, including those of people who have disabilities and those with severe fetal impairments, in circumstances where someone chooses to go to term, and it is then about providing the appropriate care. The state should provide that care in support of families as well.

Mr Buckley: OK. Thank you, and thank you, Chair.

The Chairperson (Mr Gildernew): Thank you, Jonathan. I will now go to Gerry Carroll. Gerry, lean ar aghaidh, le do thoil.

Mr Carroll: Thanks, Chair, thanks, Les, and thanks to your team for being here.

I want to tease out the role of the Minister of Health. The report clarifies and restates the fact that he has sole responsibility for providing the abortion services under the regulations. Les, you said today that neither finance nor COVID is the reason for those services being delayed, stopped or not fully provided. That suggests that the reason for not implementing services is either because of the Minister's view on the issue or his view that it needs to be brought to the Executive. In your assessment of the regulations and the Executive's response to you, as a commission, will you clarify whether it is the Minister who has the responsibility to act and to provide those services?

Mr Allamby: Yes. One of the Northern Ireland Executive's defences, if you like, in our legal action was that they had no basis for commissioning or funding such services. We took legal advice at a very early stage. If you remember, on 31 March, which was the day that the service was to be introduced, there was a brief hiatus during which I gather a phone call was made from somewhere in the Department of Health telling the trust not to implement the service. We came to the Health Committee at that stage with the Royal College of Obstetricians and Gynaecologists, and then, fairly quickly, the Chief Medical Officer (CMO) wrote to the Royal College of Obstetricians and Gynaecologists to say that if the trusts wished to commence a service, they could.

In those circumstances, we took legal advice about whether, in fact, the matter had to be brought to the Northern Ireland Executive under the ministerial code; in other words, was it cross-cutting and controversial? The advice that we got was that the Minister of Health did have to bring it to the Executive and that it did require Northern Ireland Executive approval. I understand that, eventually, legal advice was sought from the Attorney General, and, while I have not seen the advice, I understand that the Attorney General's advice was similar to our own, which was that it is a matter that has to come to the Executive.

The problem is that it has not been able to get through the Executive. The proposal that the Minister brought was for an early medical abortion service during the pandemic; it was not for the full implementation of the service. It is only in the last few weeks that the Department has signalled that it is now going to try to set up a working group in order to effectively scope out what a fully commissioned, funded service would look like. However, it still has the caveat that that service will have to go to the Northern Ireland Executive. The Secretary of State issued the 2021 regulations about directing a service, because it is pretty clear that, by the looks of it, it will not be possible to get agreement in the Northern Ireland Executive that would allow the Department of Health to properly and fully fund and commission the service.

The amount of effort that has been made by the Minister to get the issue through the Executive is open to question, although it is fair to say that it is probably an uphill battle, given the position of the parties in the Executive on it. The reality is that getting political agreement on it will not be easy.

Mr Carroll: Thank you, Les. I want to make the point that bringing the matter to the Executive is a political decision. You do not have to comment on this, but, in my view, it has been brought to the Executive with the understanding that there probably will not be agreement. Also, given that it is controversial, while I understand that not everybody agrees with abortion or having the right to choose, the life and times survey and other surveys show that the vast majority of people here want choice.

Moving quickly on, I have a couple of other questions. On the Severe Fetal Impairment Abortion (Amendment) Bill, the commission's report references the Supreme Court ruling or decision — I am not sure which it was — about how the starting point in any discussion about rights has to be about people being able to choose what to do with their body. How dangerous is the situation that we are in or what kind of situation are we in if the state decides what people can and cannot do when getting access to healthcare, especially reproductive healthcare? Will you confirm that there is no compulsion on women to proceed with a termination if they get a diagnosis of severe fetal impairment and that the choice is up to them in *[Inaudible owing to poor sound quality]* and seeking guidance and consultation?

Mr Allamby: Our original claim was upheld, but the Supreme Court decided that we did not have the powers to take a case in our own name. We were always hamstrung by the fact that it is very difficult to ask a pregnant woman, who is already going through very difficult circumstances, to go to court on top of that. The courts gave us an indicative view that that was contrary to article 8, which is the right to private and family life and a woman's right to personal bodily autonomy. The right to personal bodily autonomy is the right to carry a pregnancy to full term alongside a right not to do so in accordance with the law. It is absolutely clear, therefore, that there should be nothing to impede a woman making a choice to carry to term if that is what she wishes to do.

Mr Carroll: I have a very quick question. There are sanctions and criminal offences in the regulations for GPs and medical practitioners. I think that the fine goes up to £5,000. Given the lack of guidance, what impact does that have on creating fear amongst GPs, obstetricians and gynaecologists in providing services and on not knowing what they can or cannot do? What impact does that have on medical practitioners?

Mr Allamby: In our inquiry, we heard some anecdotal evidence about GPs who were making it difficult to provide a service. We had some evidence — again, it was anecdotal — that the lack of guidance and clarity was causing some difficulties for GPs. We always wanted to see abortion decriminalised, but it is still a criminal offence in certain circumstances. Clinicians also have professional obligations, which include following the law. It is clear to us that there is no evidence of, for example, clinicians being cavalier in how they interpret the law when they are providing a service in the trusts; the picture is somewhat more mixed.

One problem is the lack of clear public information and guidance from the Department of Health. For example, it took some time for women to realise that there was a service that could be accessed in Northern Ireland, particularly in the first few weeks of that service existing. That was simply because no work was done on the preparation of public information so that women could understand what service they could access. That remains the case today.

Mr Carroll: Thank you, Les.

Ms Bradshaw: I thank the panel for their presentation and submission to the Health Committee. I am absolutely clear about where your paper sits on the Severe Fetal Impairment Abortion (Amendment) Bill, so thank you for the intensive work that went into that.

I do not really have any questions, but I will put on the record that I am in agreement with Jonathan Buckley. I am sure he will be surprised to hear that this morning. I agree with him that we need to ensure that the pathways for women who receive that diagnosis allow them to be supported when they want to continue to full term. As a Committee, we also need to work and to continue to look at the sensitivities around screening.

I will focus on monitoring, which you mention in your paper. In your report, you reference telemedicine and the short period in April 2020 when the British Pregnancy Advisory Service (BPAS) provided a service in Northern Ireland. You note that that ceased quite quickly because of a direction from the Department of Health. At that time, huge travel restrictions were in place, people were being asked to shield and we already knew, from police records, that incidences of domestic abuse were on the rise.

Given that that was the case, were you given any understanding of why on earth the Department of Health in Northern Ireland intervened in this instance? That is my first question. Thank you.

Mr Allamby: My understanding is that the Department of Health considered that the BPAS service was not in accordance with the law. In England, Scotland and Wales, the law was amended to allow a telemedicine service to be provided as a result of the pandemic. An unsuccessful legal challenge was made — it was maybe made by Christian Concern — to those arrangements. In Northern Ireland, we decided not to implement any legislation that would allow similar access to telemedicine. It is one of the areas that, we think, should be looked at. Again, in fairness to the Department of Health, there were certainly some legal issues with providing the telemedicine service by BPAS, and those were then dealt with in England, Scotland and Wales. That is my understanding of the backdrop to why that happened.

Ms Bradshaw: In your report, you also talk about the movement by the Department of Health in recent weeks off the back of the third round of your legal challenge on the failure to commission and fund services. You were advised that a new project team had been set up in the Department of Health in order to start to look at commissioning abortion services. You indicate that the Department said that that would take between eight to 12 months. Have you any understanding of why it will take so long, considering that a lot of the work has already been done by clinicians and healthcare professionals in that field to examine what the service could look like?

Mr Allamby: There are a number of procedures, so it will take a bit of time. We have two points to make about that. One is that you should put some interim arrangements in place in the meantime. There does not seem to be any reason why you could not, for example, properly fund Informing Choices in order to allow it continue with a referral service or make some other interim arrangements. Having looked at it, I think that eight to 12 months seems slightly prolonged. In a discussion on the court case, if we were to win — that is obviously a big "if" — how long do we think that it should take? We were very clear with the judge that, if we were successful, we would like a time frame for how long it would take to properly commission and fund a service. Frankly, we felt that a maximum of six months from the time when the work was supposed to commence would be appropriate. We think it could be delivered in a more timely fashion. In the meantime, things could be done to improve the service and to make it more stable prior to rolling it out to a footing that is completely in line with the regulations that were passed in March 2020.

Ms Bradshaw: Thank you, Les.

Ms Ní Chuilín: Thank you, Les, for your presentation, and, indeed, the panel for the paper. You will have seen the protests outside health and social care settings, which, to be frank, have been quite disturbing. When you talk about interim arrangements, do they include protecting from harassment those women and girls who access health and social care for reproductive healthcare in particular?

You partially answered my second question, Les. In anticipation of whatever the Department of Health brings forward or can bring forward, given that it is being blocked at the Executive, what would those interim arrangements look like?

Early screening does not mean screening out; it is just early screening. At the minute, women have to pay for an early scan, particularly if there are concerns about the pregnancy or its success. That is expensive. Will scans also be included in interim arrangements?

Mr Allamby: We recognise that there is freedom of assembly and freedom to protest. However, we think that can be permitted in circumstances where women are allowed to attend clinics unfettered and are not put under undue pressure. From memory — my colleagues will remind me of this — I think that there was a recommendation in the CEDAW report to the effect that, actually, the law should be amended. It is one of the few areas where the Northern Ireland Office and the Secretary of State have decided not to implement change. That is regrettable. We are not suggesting that people should not be able to protest, but it should happen in a manner that does not leave people intimidated or in fear. That has clearly not been the case in some circumstances.

You asked about interim arrangements. There are all kinds of ways those could be done. You could, for example, put funding into other sexual reproductive health services, which would then free up those who are providing the interim service, for example. You could fund, as I said, Informing Choices. There are things that you can do. You could start to ensure that early screening is available.

You raised a very valid point. In effect, the system you have at the moment is based on whether you can afford to pay for an early screening process. That raises an issue of equity based on your, if you like, income and social class etc. Those who are well off can, obviously, afford that. Those who are not well off or who do not have that kind of family and other support simply will not be able to afford it, so there will be an inequity based on your financial circumstances or social class.

Dr Russell: A couple of members raised prenatal diagnostic testing. From our perspective, it is important to emphasise that the absence of prenatal testing in Northern Ireland, combined with gestational time limits and the circumstances around the Bill before the Assembly, make, in the commission's view, that legislation incompatible with the European Convention on Human Rights and potentially in breach of article 3 and article 8 of the convention. The Bill makes human rights impractical and illusory for women in the circumstances proposed.

There is a wider issue with prenatal diagnostic testing because of what Les just said. Socio-economic inequalities are being created by what is, effectively, the current privatisation of a system. If you have the money, you can pay and get access; if you do not, you cannot. No doubt, the Committee will be fully over the issue, but the diagnostic testing available and a gestational time limit of 12 weeks, in effect, for the majority of instances, make the diagnostic testing a total nonsense. It is a pointless exercise for most women.

Ms Ní Chuilín: So, really we are creating a two-tier system in the approach to reproductive health. Middle-class women will have the means and support for interventions, whereas women from deprived communities with no access to financial support will not. That is basically the nub of it.

Dr Russell: The two-tier system already exists, and it existed before the current debate on abortion law in Northern Ireland. It has been well and truly publicised. Those who could afford it could pay for the prenatal diagnostic testing that is available in Northern Ireland privately, and, if they chose not to carry their pregnancy to term, they could afford to get on to the boat or the plane in order to access a private abortion service in England.

In part, the regulations have addressed travel because there is the free England pathway. We do not think that that is compatible. However, not making diagnostic testing available on demand under the NHS in Northern Ireland perpetuates an inequality that already exists.

Ms Ní Chuilín: Yes, so it is working-class women who are failed again, frankly.

Ms Hunter: I thank the panel for being here. Your contributions and comments are most welcome, and I am grateful that you are here.

I acknowledge the important point that you touched on, Les, about telemedicine. I am based in a rural constituency, and it is important to say that, throughout the pandemic, there has been that layer of complexity with having to travel. I have often mentioned the barriers that women in rural areas experience with any kind of healthcare, including reproductive healthcare. Certainly, over the past year or so, it has been difficult to access contraceptives, especially long-term contraceptives like IUDs. In what ways do you think telemedicine will help to alleviate those barriers for rural women and girls and tackle those concerns in order to ensure that rural women have the right to privacy?

Mr Allamby: The arrangements that were introduced in England, Scotland and Wales were about enabling women to take the second set of pills at home, for example. In addition, it is absolutely clear to us that if you live in a rural area, accessing services is more difficult. One of the things that came up time and again in our research was that a number of women were concerned about attending clinics because Northern Ireland is a small village, and if you turned up and were seen by staff or other people in the services, they would know about your business, which you may well want to keep private.

The applicant in our case is an interesting example. She is a woman who lived in the Northern Trust area. Her pregnancy was unexpected, and she had a supportive partner. She was quite shocked to discover that there was no service in the Northern Trust and was placed in a position in which she was asked to travel instead. The issues for her were that, first, she living in a small place and at a time when there was a lockdown in Liverpool and Manchester so she would have had to ask for time off from work suddenly, and, secondly, she was living in a close-knit family in a rural area and would have suddenly disappeared to England. Those issues would have thrown up considerable questions like, "What on earth is going on?" or "Why are you travelling to England in this circumstance?" She was left

in a position of not wanting others to know about her personal circumstances. She was very aware of her privacy, and, in the end, she went down the unregulated route. You still have to pay for the unregulated route — it is not massively expensive, but she was very conscious that she was lucky enough to be able to afford it — but she was in the position where, if something had gone wrong, she would have had to present herself to an emergency department and, again, almost certainly reveal her circumstances. She did not have the backing of an NHS service, and even though everything went fine for her, she found it very stressful and difficult. That would occur whether you live in a rural or urban area, but, in a rural area, you have even more sense of the issues involved with revealing your personal circumstances in your immediate surroundings.

There are issues about accessing services rurally. For example, the Western Trust clinic was based in Derry, but the Western Trust covers a very broad area, and you may have had to travel a significant distance to attend that clinic when it was in place. You are quite right to point out that rural services are quite a significant issue.

Ms Hunter: Thank you, Les. I have another question about adequate screening and equipment, and Carál raised this point as well. I did some research and found that it costs £573 to access the IONA test privately. I will wait until the next agenda item to raise that further, but thank you for talking to us. Your response about a lived experience was very helpful. Thank you.

Mr Chambers: Commissioner, I am pleased that you have placed on record the fact that the Health Minister has to go to the Executive to get their approval before he can implement anything on abortion services. Some people have found that hard to accept, but the Minister has said that all along. Indeed, many people have challenged that view. I am glad that that has been placed on the record.

With abortion services at the moment, I hear whispers about people suggesting that perhaps the Minister allows his own views on abortion, whatever they may be, to interfere with his ministerial responsibilities to deliver services, but I certainly see nothing in your report that suggests that, commissioner.

Mr Allamby: I have met Robin on a number of occasions during this process. He has always been very open and honest about his views on the matter, but he has also shown propriety in our discussions and has been consistent that the matter has to go to the Northern Ireland Executive. We agree on that. How hard he is pushing it at the Northern Ireland Executive is another matter, and whether it would have made a difference if he had is open to debate. However, it is perfectly legitimate for him to say, "This matter has to go to the Northern Ireland Executive".

Mr Chambers: You comment, commissioner, about how hard he may be pushing the matter in the Executive. Do you have any indication or evidence that he is not pushing hard to have the Executive come to an agreement, or is that just a personal view that you hold?

Mr Allamby: The issue is that he brought a paper in April, but it did not reach agreement. He brought a paper again in May. The question, I suppose, becomes this: when that paper was not considered in May 2020, how strongly did he push for it to be discussed after that? I do not know the machinations of the Northern Ireland Executive, but I can say that the Minister of Health seems to have done a good job on a number of fronts, and he has been very firm in making sure that public health issues have got onto the Executive's agenda during the pandemic. There is plenty of evidence of the Minister pushing strongly to ensure that public health issues are discussed at the Executive. In this case, the paper did not get an airing, despite its having been with the Executive since 6 May. I do not know the machinations or why that is. That is all the information that I can offer.

Mr Chambers: OK. Thank you, commissioner.

Mr Allamby: Chair, I have rather monopolised the session. Does David or Rhyannon want to say anything? Have I missed anything?

The Chairperson (Mr Gildernew): David and Rhyannon are indicating that they are OK.

Mr Allamby: Great. Thank you, Chair.

The Chairperson (Mr Gildernew): Commissioner, David and Rhyannon, thank you very much for both of your reports to the Committee. They are very helpful. Thank you for your attendance this

morning and for assisting us on the provision of services and on the Bill that the Committee is considering. We appreciate your input, and I wish you all the very best. Thank you for coming this morning, and good luck to you all.

Mr Allamby: Thanks, Chair.