



Northern Ireland
Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Severe Fetal Impairment Abortion (Amendment) Bill:
Both Lives Matter; Christian Action Research and
Education Northern Ireland;
Evangelical Alliance Northern Ireland;
Presbyterian Church in Ireland

17 June 2021

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Members present for all or part of the proceedings:

Mr Colm Gildernew (Chairperson)
Ms Paula Bradshaw
Mr Jonathan Buckley
Mr Gerry Carroll
Ms Órlaithí Flynn
Ms Cara Hunter
Ms Carál Ní Chuilín

Witnesses:

Ms Dawn McAvoy	Both Lives Matter
Ms Sarah Pike	Christian Action Research and Education Northern Ireland
Mr David Smyth	Evangelical Alliance Northern Ireland
Ms Grace Cahoon	Presbyterian Church in Ireland
Miss Karen Jardine	Presbyterian Church in Ireland
Mr Stephen Lowry	Presbyterian Church in Ireland

The Chairperson (Mr Gildernew): I welcome Miss Karen Jardine, who is the Presbyterian Church in Ireland's (PCI) public affairs officer. We are also joined by two parent representatives, Ms Grace Cahoon and by Mr Stephen Lowry.

We are also joined by Ms Sarah Pike, who is the early human life policy officer with Christian Action Research and Education NI (CARE NI); Ms Dawn McAvoy, who is co-founder of Both Lives Matter; and Mr David Smyth who is head of the Evangelical Alliance here in the North.

I sincerely welcome all of you to our Committee meeting. It is a large panel, and that will provide its own challenges for how we manage the session. Given the technological limitations, we will conduct the meeting as best we can.

I will begin with you, Karen. I ask you for some short initial remarks and to advise how those will be given, and then we will go to questions from members.

Miss Karen Jardine (Presbyterian Church in Ireland): Thank you, Chair, and I thank the Committee for the opportunity to speak with it. I will speak briefly, then hand over to David Smyth and then to Stephen and Grace. That will be our presentation. Hopefully, Sarah and Dawn can then be brought in during the question and answer session.

At the start, I acknowledge the professionalism and compassion shown by the witnesses who appeared before the Committee in the previous session on this complex subject, which, as the Chair said, requires compassion from us all.

We really appreciate the work of the Committee and our locally elected representatives taking the time to hear a range of views on local legislation. We want to thank you for doing that work, which is difficult at times.

The Bill before us removes from law the principle that prospective disability is a reason to terminate pregnancy at any gestational limit. Recognising that law shapes culture, some of the evidence that we have heard this morning reflects the culture that exists in Northern Ireland. We would like to talk about how that culture might change, say, over the next 10 or 20 years, with regard to what we see happening elsewhere in the UK.

I will hand over to David, who will make some brief remarks.

The Chairperson (Mr Gildernew): Thank you, Karen. Go ahead, David, please.

Mr David Smyth (Evangelical Alliance Northern Ireland): Thank you, Karen.

The Chairperson (Mr Gildernew): Sorry, David. Just before you start, it is particularly important, given the size of the panel that we have, that I ask everyone who is not speaking to try to ensure that they are on mute. It is also hugely beneficial if people can use headsets. I realise that not everyone has access to one but, if people have headsets, that helps with the sound. I just want to make those few remarks. Sorry, David. Carry on.

Mr Smyth: No problem. Thank you very much. Good morning, Committee.

I want to acknowledge at the start that nobody stands nowhere: there are no neutral opinions here. We all come with our beliefs and values, be they socialist, capitalist or whatever they may be. I believe that everyone who is present on these screens this morning is concerned with justice, equality, compassion and freedom. However, we might define those quite differently, and even be offended by each other's definition of justice or compassion. The questions for you, as a Committee, are definitely medical and legal, but there are questions that medicine and law alone cannot answer; deeper questions about what it means to be a human being. We represent many religious beliefs this morning, but it is not just about beliefs but how we shape them, for the people whom we represent, into the practical actions of care, support, solidarity and walking with people in difficult situations.

It is entirely legitimate and proportionate to advocate for the protection of both lives in legislation. Under UN convention and EU law, there is no absolute right to abortion, and admittedly there is no absolute right to life. Therefore, a wide margin of appreciation is given to member states to decide their laws in this area based on cultural values. That comes from the case of *Vo v France*.

The law that was brought into Northern Ireland in 2019 and the regulations of 2020 are of a maximalist nature, basically transplanting the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) agreement into local legislation. Many countries take a more minimalist approach. It is entirely legitimate and proportionate that a legislature with devolved responsibility for abortion could decide to acknowledge and protect both women and unborn children in those circumstances to some degree. In the UK Supreme Court judgement of 2018, Lord Mance said:

"in principle a disabled child should be treated as having exactly the same worth in human terms as a non-disabled child".

That is also the consistent theme of the United Nations Committee on the Rights of Persons with Disabilities, expressing concerns about the stigmatising of persons with disabilities as living a life of less value than others and about the termination of pregnancy at any stage on the basis of fetal abnormality, and recommending that states amend their laws accordingly. Both law and medical care across the UK and these islands already acknowledge the continuity of care pre- and post-birth. That is why, if a child in the womb suffers medical negligence or malpractice, they have until three years after their 21st birthday to bring legal proceedings. The adult is legally recognised as one and the same person as the baby who was in the womb.

That brings me to my final point. I am someone with a cleft lip and palate. I was interested to listen to the previous discussions, and I note the Committee's and clinicians' concern that there is a perception out there that abortions are happening solely on the basis of a cleft lip and palate or a club foot. My understanding from the data is that that has happened in the past. In 2003, a legal case was brought specifically about that issue by Joanna Jepson. I would be encouraged if the Committee today would state its support for a Bill, like was brought to the UK Parliament last year, that would specifically stop or prohibit abortion based on those grounds so that there is no confusion out there. It would be really helpful for the public to know that.

At this point, I will hand over to Grace. Thank you so much.

The Chairperson (Mr Gildernew): Thank you, David. Go ahead, please, Grace.

Ms Grace Cahoon (Presbyterian Church in Ireland): Thank you for the opportunity to speak today. I am a mother of two: James, who is six, and Harry, who is 18 months and has Down's syndrome. It was a shock when we heard that Harry had Down's syndrome after a relatively straightforward pregnancy. Harry was in hospital for a period of time following his birth, and, during that time, we tried to get our heads round the news. How would we share it with friends and family? How would everyone react? How would we tell his brother? Thankfully, immediately after Harry's birth, we were surrounded by positivity and encouragement, and we continue to be. We worry about the future at times, but what parent does not? We have a happy, strong, determined little boy who is adored by his brother, who just sees him as Harry or, in his words, "his best brother". Down's syndrome does not define who Harry is and what he will become. At 18 months, he is already striving to achieve and amazes us every day with how much he is learning and developing.

I am proud to sit here today representing many of the other amazing children and families we have met on our journey so far, many of whom echo the thoughts that I am sharing today. I know, from personal experiences that I have heard about, that not all women, particularly those in England, who have had prenatal or postnatal diagnosis of Down's syndrome for their baby have had the positive response from medical professionals that we, thankfully, experienced. I am concerned that this law will reinforce discrimination against Down's syndrome in Northern Ireland and that our culture will begin to change. When a parent is told that there is a possibility of a diagnosis of a disability such as Down's syndrome, they should not lose any rights as a result. This is about equality. We live in a society that constantly talks about equality and inclusivity, yet here we are, taking away the rights of a baby like Harry before he or she is even born. My older son would be protected after 24 weeks. My youngest could have been terminated right up to birth. Why? Do we want to live in a country where Down's syndrome and other disabilities are seen with such negativity and fear? How would a change in the law impact adults and children with a disability? It would make them feel equal and help them know that their lives are valued.

Thank you. I will now hand over to Stephen.

The Chairperson (Mr Gildernew): Thank you, Grace. Go ahead, please, Stephen.

Mr Stephen Lowry (Presbyterian Church in Ireland): Hi, everybody. Good morning. Thanks to the Committee for the opportunity to speak. I have been asked to share some lived experience as a parent of a child with a disability. My wife and I found ourselves thrust into the world of disability when we became parents to our daughter Rose. Rose was born with severe mental and physical disabilities. We did not plan it. We did not choose it. I notice that the term "bereavement" has been used already this morning, and I guess that, in hindsight, that is fairly true. We entered into a grieving process, perhaps for the child we did not have. Perhaps we grieved over the life that we could no longer live, and maybe we grieved the perfect child and the perfect life. Maybe "grieve" is a fair enough term, because it is painful to learn suddenly a lesson that usually requires time — a lesson that we all will learn: that the perfect life and perfect child are fallacies and that, in life, there are no peaks without valleys.

If there is one thing that I want to express this morning to the Committee, it is that what is often seen as a tragedy is not. We think that it is, because disability cuts across the grain of our hopes for perfection. Disability can be seen as an intruder into how we expect our lives should be or how we want our lives to be, but I have been asked to share my experience this morning, and my honest experience is as far from a tragedy as can be. My experience is not a tragedy; it is more of a love story. Being a special needs parent has brought me into a world of emotions that were previously unknown. Grace has just said that all parents worry, but there is a worry that is unique to special

needs parents — I will go so far as to say an angst — and it is disingenuous to deny that. However, there is also a tremendous joy in my world of special needs, and it is equally disingenuous to deny that. That joy is in the same cup as the angst; it is a cocktail, and I have to drink them both. I encounter that joy in myself. I see it in my wife and in other special needs parents and caregivers. It is evident in Rose's school. It is a joy that I think is rooted in the act of caring. It is a joy that comes from the act of kindness and even an exercised offering of kindness over a lifetime. It is a joy that I believe comes from a focused life of caring for the vulnerable and of giving dignity to the very least. I have found a profound sense of meaning and life purpose in those things through disability.

I fully understand why a diagnosis of disability is seen as tragic, and a term that has been used already this morning was "the unthinkable". I see the difficulty in asking people to accept something that they do not want, but my experience is one of a very welcome tragedy and a very welcome disruption to a perfect life. My experience is a sorrowful joy. My story is not a tragedy, but it is a love story. Thank you for listening.

The Chairperson (Mr Gildernew): Thank you, Stephen. I will turn to members' questions now, and first of all myself. As a clarification, I know that I certainly referred to bereavement. When I said that, I meant actual bereavement, either post-birth or pre-birth. I am not for a second suggesting that anyone would see a diagnosis of disability in itself as a cause. I agree with you, Stephen, on that. I know very many people with disabilities, many of whom, in fact, I work with on the all-party group on disability. They are some of the best advocates and activists and some of the most able people. I think that it is very often our society that disables people, rather than people themselves, because of support and accessibility and all those issues. I know people and have people in my own family circle with Down's syndrome, who are some of the greatest and most fun, able and lovable people who thoroughly enjoy life. I do not have any issue with that.

One of the key things I want to explore is the panel's experience of support and what support has been available to allow people to continue with pregnancies which present particular issues for which additional support may be needed. We heard in the earlier session about a lack of psychological support at times. Are there other areas of support that you would like to flag up or indicate as potentially positive or where there have been negative experiences as a result of services not existing?

Karen, can you generally field the questions to whoever you fell is most appropriate? We want to be clear and to get a substantive answer, with something additional only if is additional. We do not have time to go to everyone on each question, unfortunately.

Miss Jardine: Absolutely, Chair. I will make one brief comment and then, perhaps, hand over to Dawn to reflect on that. The Presbyterian Church in Ireland has consistently called for better support and care around perinatal hospice care and some of the services that were described earlier — even that link between the hospice and the hospital and the psychological support for families and mothers. We are fully supportive of finding the extra resource and funding for that. That is, maybe, a question about where is best to invest our time and resources. I will ask Dawn to come in on that.

Ms Dawn McAvoy (Both Lives Matter): Thank you, Karen. I repeat what has already been said: thank you for the opportunity to be here today. It is privilege. Both Lives Matter campaigns broadly on the issue of abortion. Speaking specifically to the Bill, our concern was to take a back seat; we wanted to support the disability campaigners who were taking the lead. There is obviously a connection to abortion and its discriminatory aspect precisely because disabilities are singled out differently. Able-bodied babies are protected in law.

From our perspective, hearing the voices of those living with disabilities and their parents was of primary importance. To add to what Grace and Stephen have so powerfully shared, we have a number of stories on our website from women who received a fetal diagnosis and were similarly concerned and faced pressure to terminate. I am very aware of the previous medical contributions. This is not about judging particular individual medics, and, certainly in the context of Northern Ireland, we recognise that wonderful care is offered, but we have to listen to the stories of women who have reiterated that they felt pressure to terminate when they faced a diagnosis. I have three stories today that speak exactly to the assumption within the medical profession that they should terminate. One concerns Down's syndrome, and the other two do not. The first case was a Down's syndrome diagnosis, and surgery was required post-birth. The parents were asked whether they wanted to have surgery. When they said that they did — "Of course, because he's our little boy" — the consultant said, "He may be your little boy now, but one day he's going to grow up to be a great big monster".

Story two is from two university professors and concerns a significant neurological condition. Part of their story is about the power dynamic that they faced and the pressure that they faced for four months to terminate a baby that they had said that they did not want to terminate. They were told by the medical professionals, "It's morally unethical to bring a child into the world who is going to have so many needs and won't have anything to contribute". Their little daughter lived for five years, but the distress of those conversations continues to live with them. They feel that it is really important to get that story into the public square.

The third story concerns a genetic condition that was picked up not pre-birth but post-birth. When the family were talking about future pregnancies, the consultant who was working with them said, "The risk is one in four for a similar condition, but don't worry; we can test it, and, if it has it, we'll get rid of it for you". I am not suggesting that every medic responds in such a way to a diagnosis of disability, but that speaks to the assumption that terminating is the moral or the best option. Very often, from the perspective of the families we have talked to, no other alternative is talked about, or it is simply, "Terminate or go away and deal with it on your own". There is very much a need for more support. There is a need for personalised pathways of care. There is a need for appropriate language to be used for parent-centred information, not scary medical language. We know, as has been said, that, out of the pregnancies where a fetal diagnosis of Down's syndrome, for example, is received, in GB 90% of those parents choose to terminate. However, elsewhere around the world, where comfort care and good support services are on offer, up to 90% of parents choose not to terminate. That speaks to the very real need for better support and care pathways.

Finally, if we think exclusively about Down's syndrome for a minute, there is a problem in the UK with termination for Down's syndrome outweighing the continuing of the pregnancy because of the lack of alternative support. We know that, in the UK, £16 per person is allocated to Down's syndrome, of which £11 is spent on screening, with only £5 being spent on research. The vast majority of the funding goes towards screening. We know that, as has been said, the vast majority of those who find out that they have a diagnosis of Down's syndrome pre-birth will choose to terminate. Our concern is that that eugenic culture does not come into Northern Ireland. We do not have a culture in which it has ever been possible to discriminate against disability pre-birth. As Lord Shinkwin said, before the law changed, Northern Ireland was the safest place in these islands to be diagnosed with a disability pre-birth. As much as we take on board what the previous contributors have said, but there is a problem with eugenics in medicine in the UK. That cannot be allowed to come into Northern Ireland.

The Chairperson (Mr Gildernew): Thank you, Dawn.

Mr Buckley: I thank the panel for the presentations. There were some emotive stories. I share the approach of justice and compassion that David outlined.

I have questions for Dawn and Sarah to begin with. Why do you believe that this Bill is needed? What difference do you think the Bill will make to the families of those living with disabilities in Northern Ireland? How do you think this Bill will help pregnant women?

Ms Sarah Pike (Christian Action Research and Education Northern Ireland): Thank you for inviting us to speak. I am sorry that my colleague Rebecca, who is more local to you, was not able to make it. On the need for the Bill, I am really aware, reading some of the submissions, that practitioners have said that they do not recognise the stories coming from women in England about the pressure that they felt to terminate. I am really glad about that. As Karen said, we know that law shapes culture, and we are aware that a number of women in England and Wales face really difficult situations. The BBC reported on Emma Mellor, a woman who faced a situation where she was asked by her doctors about termination at 38 weeks. She said:

"the doctors made it really, really, really clear that if I changed my mind on the morning of the induction to let them know, because it wasn't too late."

A number of Down's syndrome charities produced an excellent report. They did some research on the experiences of women in England and Wales, and they said that 69% of women who received a positive diagnostic test result for Down's syndrome were offered a termination when the result was given. That speaks to a culture. Regardless of how non-directly that is offered, it is really distressing for some women. They do not want to have those conversations on their antenatal journey. This Bill is important for those women. We do not want women in Northern Ireland to face the same distressing conversations during their pregnancy.

Ms McAvoy: I will add to that, Jonathan. I talked about the Bill to a friend of mine who lives with severe physical disabilities. When I first mentioned it, his immediate response was, "Would that law apply to me?". Those voices are why the Bill matters; it is about how it is received by people who are living with disability when they realise that. For example, a family that I know has three children. Two have disabilities, and one does not. The mummy also has disability that would be classed as severe. From her perspective, two of her children are not protected in law in the way that the other one is. The Bill matters in that way; it sends a clear signal that disability discrimination pre-birth is not permitted.

We know that disability discrimination pre-birth is connected to post-birth discrimination. It is the fear of what the lived life will look like or of what it will not be able to look like. One of those stories was that the born child will not have anything to contribute. That is a really dangerous path to go down when we measure someone's worth in how they are able to contribute. How do we measure that? Is it a financial contribution?

For example, again, with Down's syndrome, I have three able-bodied daughters, and I would wish that they reported similar feelings of happiness, joy and satisfaction with their lives and how they look as, we know, Down's syndrome people respond when they are asked. Around 99% of people with Down's syndrome indicate that they are happy; 97% like who they are; and 96% like how they look. How do we determine whether life is worth living? How do we determine suffering? How do we determine pain? Unfortunately, legislation that permits abortion for disability sends a signal that those lives, being lived, are not worthy in the same way that able-bodied lives. That is why this law matters.

Mr Buckley: Thank you. I am not going to put words in your mouth, but, from what I have heard from the presentations, I think that many of you would agree that your overwhelming thought is that the culture that exists among the medical professions is that, for the most part, pushing termination is the only option. In that regard, we have had presentations from paediatricians and, just before you, the Royal College of Obstetricians and Gynaecologists, who would say that that is not the culture at all and that a choice is offered to women, even right up to birth. Sarah, I think that you mentioned a case right up to induction. What is your response to the medical professionals who tell us that that just does not happen?

Miss Jardine: There is a culture in Northern Ireland, which has been shaped by the laws, that determines how those circumstances have been dealt with up to this point. The CEDAW report and the 2020 legislation have changed that culture completely. We are, maybe, not talking about what might happen tomorrow or next week or next month, but we are talking about 10 or 20 years down the line and about establishing a set of norms where abortion is seen as, maybe, the first port of call rather than the last resort. What the medics were talking about this morning was the case of last resort. I will ask Grace to reflect on that and Sarah may have some comments as well.

Ms Cahoon: Our entrance into the world of Down's syndrome in the last year and a half has probably opened my eyes to this more. Through various support groups that I am in, women have shared their experiences of being asked repeatedly at appointments. When they have said that termination is not something that they are considering, they have been put under pressure. A personal friend was put under so much pressure that she did not have any more scans with her first child and did not have any scans with her second and third children. That is the reality for women, particularly in England, where abortion has been available.

My fear, as a parent with a child with Down's syndrome, is that that will become our culture in Northern Ireland. It is, maybe, not happening as much here, but I am aware of girls who have not had positive responses when they have had a diagnosis of Down's syndrome. The information that they were given was outdated. One family that I know who have a child with a disability were told that she would never walk or talk. That was when the mummy was pregnant, when emotions are already running high. She was told that the child would never walk, would never talk and would never call her mummy "Mummy". That is a horrendous thing to say to somebody during pregnancy. That little girl went on to walk and talk and do amazing things.

While it might not be happening in Northern Ireland just as much as it is in England or Scotland, as our situation changes, and, as Karen said, looking 10 or 20 years down the road, it would be a terrible thing. Lord Shinkwin, as we talked about, said that Northern Ireland was one of the safest places for an unborn baby. We would hate it to turn into somewhere that is not safe. It is happening here, however, and it will probably happen more, I feel, if this Bill is not put in place. It would be a sad situation for children coming into the world with disabilities to be seen differently and for parents to be

made by medical professionals to feel anxieties during pregnancy that were not previously there. My concern, as a parent is that, as Karen said, the culture will start to change as time moves on.

Mr Buckley: Can I just respond —.

The Chairperson (Mr Gildernew): Thank you, Grace and Sarah. Respond briefly, please, Jonathan.

Mr Buckley: What would you say, Grace, to those who say that, on one side, it is OK to advocate for a pro-life position but that there simply are not services for disabilities following the birth? What is your view on that?

Ms Cahoon: We entered into this world during COVID, so it may have been a different experience. We have a team of professionals who are very involved with Harry and very supportive of his development, as well as supporting us. A lot more is happening now than in years gone by, specifically in relation to Down's syndrome. There are a lot of very active support groups in Belfast. Support is there. There probably could be more, but if we go down this road and take the journey into encouraging people, in a positive way, not to consider abortion and to continue with pregnancies, the support will be there.

As an Executive, as a country and as people like us, who are parents, we need to look at that and at the ways that we can support families more. There is definitely support, but, as a country, we could put more into that as we move forward, giving people more time and attention and immediate care following hospital and during the diagnosis period. We had excellent care for our child. We had unbelievable care in the hospital. There was psychological support for our family and, after that, practical support for Harry. That definitely needs to be looked at, and more could definitely go into it.

The Chairperson (Mr Gildernew): Thank you, Grace. Were you looking to come in on Jonathan's previous point, Sarah?

Ms Pike: Yes. In relation to the comment that this just does not happen, I point back to the research. Studies have found that, of the women who received the high-chance screening result for Down's syndrome, 50% were offered terminations, despite having already said that they did not want that. I do not want this to be an attack on clinicians; that is really not what it is. Clinicians are in a really difficult position, because their role is to support women to make informed choices, and one of the legal choices in these cases is termination right up to term. In a sense, it is their role to let women know that that is an option, but that is distressing for many women who do not want to think about termination during their pregnancy, and particularly not in the late stages. They find that really upsetting. I think that you will be meeting a representative from Don't Screen Us Out later. That organisation has an open letter that has been signed by more than 1,500 people with Down's syndrome and their families, expressing concerns about the law as it stands currently and speaking in support of this Bill. A significant number of people are really concerned about the impact of the Bill.

Some of you might be aware that there was a storyline in 'Emmerdale' about parents choosing to terminate a pregnancy when there was a high-chance screening result for Down's syndrome. That kind of storyline is really upsetting for children and adults with Down's syndrome and their families. As that is legal, that is, in a sense, a legitimate storyline, but it is really upsetting. The Bill will be really important to stop those kinds of things happening.

Mr Buckley: Thank you.

The Chairperson (Mr Gildernew): Thank you, Sarah. Thank you, Jonathan.

Mr Buckley: I do not know whether any members are indicating that they want to come in. I would [*Inaudible owing to poor sound quality*] come in at the end.

The Chairperson (Mr Gildernew): I have an indication from Carál Ní Chuilín. Go ahead, Carál.

Ms Ní Chuilín: Thank you for your testimony and, indeed, for your written testimony to the Committee. Some of you referred to listening to the previous contributors from the Royal College of Obstetricians and Gynaecologists, and some have acknowledged that the experiences of women who felt almost coerced into considering a decision of termination were more prevalent in England and Wales, but some local women felt that that was also the case for them. My concern, even from listening to the two

clinicians this morning, is that it is quite obvious that they are trying to give as much support to women regardless of the decision that they are making. I want your views on that. If the Bill is not passed, what difference would it make to your campaign? Thank you.

Miss Jardine: Thank you, Carál, for your question and for taking the time to listen to us. One of the comments made by one of the previous contributors was that many women and their families, when they are well informed, choose to continue with a pregnancy that may result in baby not living for very long once it is born. Some of the focus was on the very difficult cases, rather than the cases that we are talking about today. It is the cultural shift and the potential for change over the next 10, 20 and 30 years that we are concerned about. I will bring in David to speak about that.

Mr Smyth: One of the concerns that we have is about what many of us see as literal dehumanisation, which does not do anything to address the structural inequalities and injustices that young people growing up in the world with disabilities will face. It does not alleviate poverty and it does not tackle the core roots of many of the problems.

Carál's question about the campaign was very helpful. Regardless of whether the legislation passes, we want to see much better support services for women and their families and for people who are growing up with disabilities. It is important to say that, in the same way that there are different world views, there are sometimes different end goals. Sometimes, there is the accusation that people only care about this because they only care about ending abortion. It is no secret that we would like to see further changes to the law because it does not strike the right balance in protecting both lives as far as it could. However, for the Churches that we represent and many others, and as shown by Grace and Stephen's testimony today, it is not just a belief that we abstractly throw out; we are working on the ground to support families with disabilities. There is a long way to go on that, but this is not a ruse, and we want to be up front about both aims.

It is also important that some of those who are campaigning against the Bill are clear that they want to see abortion, in any and every circumstance, up to term. It was helpful to point out that abortions in cases of cleft lip and palate would not be supported, but clarity on some of that is helpful rather than the sloganeering that we sometimes fall into.

To reiterate that point, we have concerns about long-term culture change. Offering abortions in cases of disability does not address many of the concerns about the structural and systemic issues that those who are living with a disability face, such as respite care and special educational needs education. The list could go on and on.

Miss Jardine: Chair, could I bring in Stephen to speak for a couple of minutes? Stephen has a role in PCI on the services that we provide for people with disabilities, so maybe he could speak for a couple of minutes about that.

Mr Lowry: Thanks, Karen. I have a role in PCI as the convener of disability services. We have a council for social witness, and I was giving a report on my role there. As we were getting our thoughts together about arguing for the dignity of life and the dignity of people with disabilities, it struck me that it is not just talk or something that we say as a theory or principle. The Presbyterian Church owns and runs four residential care homes for adults with learning difficulties, and they provide either full-time residential or respite services. Those are fully funded and staffed by PCI. We take it seriously, and it matters to us.

The Chairperson (Mr Gildernew): Jonathan, you indicated that you would like to come back in at the end for another question if time allowed. No other members have indicated that they want to ask a question, so go ahead with another question. This will be the final question.

Mr Buckley: It has been a very helpful session. I wanted to maybe get a different perspective on it. Is Dawn still with us? *[Pause.]* No, she is not. I specifically wanted to ask her a question.

The Chairperson (Mr Gildernew): Clerk, can you advise if Dawn is still on the call?

The Committee Clerk: She was, but she has gone off again. We will try to get her back as soon as possible.

Mr Buckley: It is OK. My question was specifically about Both Lives Matter and its campaigning. If she is not there, it is fine, Chair. Thank you.

The Chairperson (Mr Gildernew): OK. Thank you. I want to thank every member of the panel for taking time this morning to come to the Committee and for contributing their written and oral evidence. I wish you all the very best in the time ahead in campaigning for the supports that are so badly needed by everyone. Some of the people on the call are in that position, and we should look at how we can provide better support in the longer term. That is clear and has emerged clearly from the discussions.

Thank you, panel, and all the very best good luck for the time ahead.