



Reproductive Health Law and Policy Advisory Group

A joint initiative between Queen's University Belfast, Ulster University and Manchester Metropolitan University

Report

Moving Forward From Judicial Review on Abortion in Situations of Fatal Foetal Abnormality and Sexual Crime: *The Experience of Health Professionals*

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Author Details: Dr Kathryn McNeilly (QUB) k.mcneilly@qub.ac.uk, Dr Claire Pierson (Manchester Metropolitan University) c.pierson@mmu.ac.uk; Dr Fiona Bloomer (UU) f.k.bloomer@ulster.ac.uk.

Introduction

The Reproductive Health Law and Policy Advisory Group is a joint initiative between Queen's University Belfast School of Law, Ulster University School of Criminology, Politics and Social Policy and Manchester Metropolitan University. Its founding members are Dr Fiona Bloomer (UU), Dr Kathryn McNeilly (QUB) and Dr Claire Pierson (MMU), all of whom have extensive research backgrounds in the area of law and policy pertaining to issues of reproductive health. The Advisory Group was established in early 2016 to provide expertise and knowledge on policy and legal matters related to reproductive health; to facilitate discussions and knowledge transfer between academics, policy and law makers, health professionals and stakeholder groups; to provide advice on legal and policy reform.

Over the period March-June 2016 the Advisory Group undertook a number of roundtable discussions with professionals working in the area of abortion in Northern Ireland. This report follows one such roundtable discussion with healthcare professionals which took place on Friday 3rd June 2016 as part of the international Abortion and Reproductive Justice: The Unfinished Revolution II conference hosted by Ulster University on 2nd-3rd June. Representatives from RCOG, RCM, RCN and a number of specialist practitioners working across the Health Care Trusts in Northern Ireland and Great Britain took part in the roundtable discussion. The aim of the roundtable was to explore key issues affecting healthcare professionals following the 2015 High Court judicial review decision which deemed the current legal framework governing abortion in Northern Ireland incompatible with human rights commitments in relation to fatal foetal abnormality and pregnancy following sexual crime, and to consider ways of moving forward which would be of benefit both to women and professionals working in the area.

The roundtable provided a unique opportunity for a range of healthcare professionals to share their experiences and a number of recurrent issues were indeed apparent. In this report these issues are elaborated on and presented as offering a starting point for reform. The report is divided into four sections. In section one some terminology and statistics regarding abortion in Northern Ireland and the issues of fatal foetal abnormality and sexual crime are outlined. In section two the relevant legal framework and the 2015 judicial review decision are overviewed. Following this, section three presents a summary of the key issues that arose as part of our roundtable discussion with healthcare professionals in June 2016. Finally, section four outlines a number of recommendations that are put forward by the Advisory Group for moving forward following judicial review as informed by roundtable discussion with healthcare professionals.

1. Definitions and Setting the Scene

What Does the Term Fatal Foetal Abnormality (FFA) Mean?

FFA is understood as a clinical judgment of incompatibility with life “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” (Department of Justice (DOJ), 2015:137). It is this definition which the DOJ seeks to adopt in new legislation.

The emphasis on clinical judgement is also reflected in advice from the Royal College of Obstetricians and Gynaecologists (RCOG) in guidance published for practitioners in England, Scotland and Wales. This document notes that “an assessment of the seriousness of a fetal abnormality should be considered on a case-by-case basis, taking into account all available clinical information” (RCOG, 2010).

What Does the Term Sexual Crime Mean?

The following definitions are extracted from the DOJ proposals published in April 2015:

- Sexual crime is a generic term, which includes rape and incestuous offences, but which describes a broader range of offending behaviour, some of which may lead to pregnancy.
- Rape is defined by the absence of consent to the sexual act, except where the victim is under the age of 13 when the offence of rape is committed, with no requirement to establish lack of consent.
- Illegal sexual activity- All sexual activity with a child under the age of 16 years is illegal and a criminal offence. For children aged 13 to 15, the offence of rape requires that a lack of consent is proved.
- Those aged 16-18 may also be considered vulnerable and subject to sexual exploitation.
- Sexual activity with a child family member is also considered a criminal offence as too is sexual activity with a vulnerable adult. Incest is no longer used as a legal term, but is now referred to as familial sexual abuse.
- Sexual activity between consenting individuals, where one is over 16 and the other party is over 18, is also criminalised, but the range of relationships covered is confined to parent, grandparent, siblings, half siblings, uncle, aunt, nephew or niece.

Moving Forward From Judicial Review on Abortion in Situations of Fatal Foetal Abnormality and Sexual Crime: *The Experience of Health Professionals*

In the proposals issued in April 2015 the DOJ state that legislation allowing for abortion on the grounds of sexual crime is complex and that framing this in law is problematic. The department took the decision not to make concrete proposals on this matter.

Abortions Data from the Department of Health (Northern Ireland)

Monitoring data on abortions carried out on the NHS in Northern Ireland is collated by the Health and Social Care Trusts and then published by the Department of Health on an annual basis.

What Does This Data Tell Us?

- This data indicates that during the reporting periods 2006/07 to 2014/15 an average of 39 abortions were carried out per year on NHS premises (table 1 below).
- The majority of these were carried out on women aged 30+.
- Whilst data is collated on other variables such as which health trust the abortion was carried out in and country of origin the small numbers within each category are not sufficient for statistical analysis (DHSSPSNI, 2016).

Table 1: Abortion Data for NHS Northern Ireland – Age profile

Year	24 & Under	25 – 29	30 & Over	Total
2006/07	7	15	35	57
2007/08	12	9	26	47
2008/09	9	8	27	44
2009/10	6	9	21	36
2010/11	7	10	26	43
2011/12	8	4	23	35
2012/13	14	11	26	51
2013/14	4	8	11	23
2014/15	3	7	6	16

Those unable to obtain an abortion on the NHS obtain abortions by other means:

- Unknown numbers **self-abort at home** having accessed the abortion pill (also referred to as medical abortions) from internet-based providers such as Women on the Web and Women Help Women (Bloomer and O’Dowd, 2014).
- Unknown numbers also obtain medical abortions (up to 9 weeks 4 days gestation), within the current legal framework, from **Marie Stopes International** in its sexual health clinic in Belfast (Bloomer and Hoggart, 2016).
- Unknown numbers travel to **elsewhere in the EU**, with studies in the Republic of Ireland suggest this could be 6% of all residents who obtain abortions (IFPA, 2016).
- An average of **1075 residents per year travel to England** (Bloomer and Hoggart, 2016).
- The **cost of accessing abortion** ranges from £70 from internet providers to £600 –£2000 for those who travel to England (this includes clinic fees and flights/ferry costs) (fpani et al, 2010). Such costs create a significant burden to women

Moving Forward From Judicial Review on Abortion in Situations of Fatal Foetal Abnormality and Sexual Crime: *The Experience of Health Professionals*

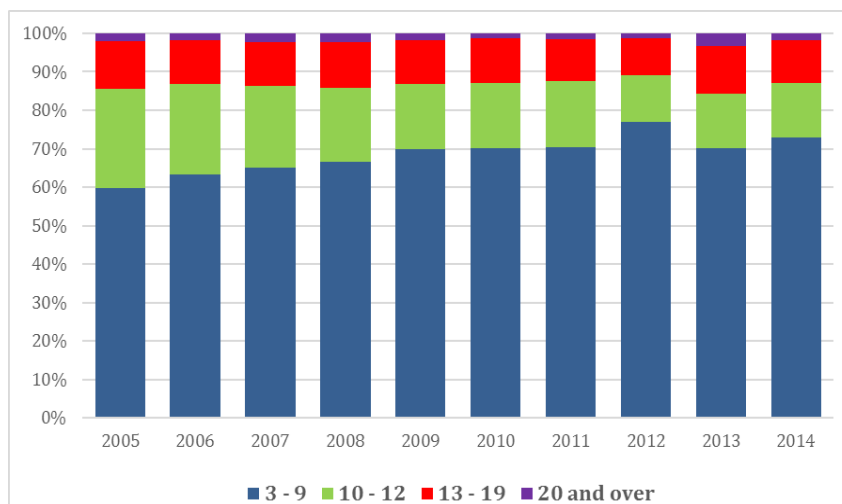
with low incomes and can also lead to delays in obtaining an abortion, thereby increasing its cost. (Rossiter, 2009). Additional costs may be experienced by those wishing to bring foetal remains home for burial or cremation (or an autopsy) at a cost of approx. £400 (Bloomer and Hoggart, 2016).

Abortion Data from the Department of Health (England and Wales)

In terms of those who travel to England data provided to the Department of Health (England and Wales) by abortion providers provides insight into the profile of those who travel and the gestation time (weeks of pregnancy) at which the abortion is carried out (Bloomer and Hoggart, 2016).

- The data indicates that a wide range of ages travel to obtain abortions in England.
- The majority of those who travel are in a relationship (married / civil partnership / with partner).
- In terms of ethnicity the category white / Irish is typically the most frequent ethnic group chosen, with white / British in second place.
- The data collated by the Department of Health does not categorise abortions carried out as a result of sexual crime. Thus no data is available on abortions carried out under these grounds.
- Most abortions are within the time period of **3-9 weeks gestation**, with overall almost 90% within 12 weeks gestation (Chart 1).
- Of particular note are the very small percentages of abortions carried out at later gestations. These are largely thought to comprise cases of foetal abnormality which is often diagnosed at 20 weeks gestation.

Chart 1 Gestation (weeks) Northern Ireland residents who travel to England (2005-2014)



A recent development in the consideration of issues related to FFA have been statistics released on **stillbirth rates** in the UK. These indicate that the Belfast Trust has the

highest stillbirth rate in the UK. Data is not routinely published on how many of these relate to FFA however it is estimated to be around 30% of stillbirths (Irish News, 2016). It is important to note that the high stillbirth rate in Northern Ireland is partially attributable to lack of provision for abortion in cases of fatal foetal abnormality. In the rest of the UK many pregnancies affected by lethal abnormalities would go on to be terminated. While not every woman in Northern Ireland would choose termination in the context of fatal foetal abnormality, the option is not available and many of these pregnancies are continued, leading to stillbirth.

In what follows below we present case studies of those who have decided to end a pregnancy following a diagnosis of FFA and those who have made the same decision following a sexual crime. The cases serve to provide insight into the issues faced by those seeking abortions.

Case Studies: Fatal Foetal Abnormality

The case studies below are extracted from a pilot study underway by researchers Hoggart (Open University) and Bloomer (Ulster University).

“A couple pregnant with twins with fatal foetal anomalies needed support. They tried everything to receive care in NI they wanted to have a funeral for their babies, they wanted to bring the babies’ home for an autopsy so they could be aware for future pregnancies. This couple were very young and even though they had the support of their families they were barely able to raise £100”. (Bloomer and Hoggart, 2016)

Families who wish to have an autopsy or burial after an abortion in England have to organise bringing the foetal remains home, this might include using specialist services (at a cost of approx. £400), a parcel courier or bringing the remains in their hand-luggage if flying / or in own car.

“In one recent case a young couple sought an autopsy after an abortion following FFA, the autopsy was arranged via the clinic in England to take place at a hospital in Belfast. The couple carried the foetal remains in their hand-luggage. Their flight arrived back in Belfast after the autopsy office had closed. The clinic staff in England tried to arrange where they could leave the foetal remains that evening. A member of the clinic staff contacted the hospital and was passed around several departments before she spoke to midwife who suggested the couple could bring the foetal remains to the labour ward. It was pointed out that was perhaps insensitive and an alternative meeting point was suggested” (Bloomer and Hoggart, 2016)

Case Studies: Sexual Crime

The case studies below are extracted from evidence submitted to the Judicial Review in 2015 (Judicial Review, NIQB96, 2015). These cases illustrate the issues faced by those who are pregnant following sexual crime and decide to end the pregnancy.

“Client B had been raped by her partner with whom she had endured a domestically abusive relationship. She already had children and did not want any more. She was not able to have a lawful abortion in Northern Ireland and was distressed on learning that she would have to travel to England. Her distress was compounded by the fear that her partner would find out and react violently to her decision to seek a termination. Despite this, she travelled outside of Northern Ireland and underwent the termination.

Client C was 13 years old. She had been impregnated by a relative as a result of familial sexual abuse. She was beyond nine weeks and four days when she attended MSNI. The matter was reported to the PSNI. She still had to travel outside Northern Ireland in a frightened and distressed condition due to her later gestation. The “products” of the conception had to be retained for evidence in event of prosecution.”

2. The Current Legal Framework and Judicial Review

The Current Legal Position

Abortion is currently a criminal offence in Northern Ireland unless carried out in good faith to preserve the life of the woman or prevent long-term serious effect to her mental or physical health. This position is laid down in the following legal framework:

- Abortion before 28 weeks:
Offences Against the Person Act 1861 ss 58-59 read alongside case law authority stemming from *Bourne* [1939] 1 KB 687 which established procurement of abortion in good faith to be lawful if it were for the purposes of preventing the woman becoming a “physical or mental wreck”.
- Abortion after 28 weeks:
Criminal Justice Act (NI) 1945 s 25(1).

However, there are a number of **problems** with this legal framework which make it unsatisfactory:

- **Lack of clarity on ‘physical or mental wreck’ as per *Bourne*.**

More recent case law elaborating on this term engages women who are either minors or suffer from mental disability. See, for example, *Northern Health and Social Services Board v F and G* [5³³7] NI 6⁰²; *Northern Health and Social Services Board v A and Others* [5³³8] NIJBI; *Western Health and Social Services Board v CMB and the Official Solicitor* [1995].

- **Serious criminal consequences which affect medical provision of lawful abortion within the law.**

Procurement of an abortion carries a sentence of up to life imprisonment. There is no requirement that the defendant be pregnant themselves, meaning that health care professionals, family members, etc. may be prosecuted for assisting with or carrying out an abortion.

Evidence suggests this leads to a reluctance on the part of medical professionals in Northern Ireland to exercise judgment and carry out abortion which may fall within law for fear of prosecution. For example, in *Northern Health and Social Services Board v F and G* [5³³7] NI 6⁰², a case involving pregnancy due to sexual crime against a minor, even though the termination was determined as lawful the minor was still required to travel to England for the procedure due to what was described as ‘the reluctance of obstetricians in Northern Ireland to carry out the operation.’

Since 2000 the Police Services of Northern Ireland have investigated over 30 cases of individuals suspected of procuring an abortion. In April 2016 a 21-year-old woman was convicted under the 1861 Act for procuring her own abortion via the purchase and use of abortion medication. She received a suspended prison sentence.

2015 Judicial Review and How It Impacts the Law

In November 2015 the Northern Ireland High Court heard a judicial review application from the Northern Ireland Human Rights Commission challenging the legality of the current legal framework for abortion in cases of serious malformation of the foetus, fatal foetal abnormality and pregnancy due to sexual crime on human rights grounds (*The Northern Ireland Human Rights Commission's Application* [6459] NIQB³⁰).

What was involved?

- The High Court ruled that prohibition of abortion in cases of fatal foetal abnormality and sexual crime (up until date when foetus becomes capable of existing independently) violated UK human rights commitments, specifically the right to private and family life under **Article 8** of the European Convention on Human Rights.
- Limited remit of this case: the High Court decision made clear that the remit of this decision was not to consider prohibition of abortion generally.
- Under section 3 of the Human Rights Act 1998 the court has a duty to read all primary and secondary legislation in a way that is compliant with rights under the European Convention of Human Rights.
- After further submissions the Court found it was not possible to read the present legal framework in a way that protected Article 8 and so section 4 of the Human Rights Act 1998 was used to issue a **declaration of incompatibility** which places the onus on the legislature to remedy the incompatibility through legislative reform.
- This was a significant move by the Northern Ireland High Court, **one of only 30 declarations of incompatibility** made across the UK since 2000, one of two made by Northern Irish courts.

What are the consequences of the case?

- **The Northern Ireland Assembly now has the onus** to introduce reforms.
- Following rejection of amendments to the Criminal Justice Bill (in February 2016) women experiencing fatal foetal abnormality and pregnancy due to sexual crime **remain unable to access these services in Northern Ireland**. Abortion in these situations remains a criminal offence with a sentence of up to life imprisonment unless falling within the *Bourne* exception.

How Does This Case Fit With Wider EU/International Human Rights Frameworks?

- There is no 'right to abortion' in international human rights law. However, the European Convention on Human Rights and UN Treaties such as the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention Against Torture

support broad access to abortion services. As early as 1999 bodies such as the Committee on Economic, Social and Cultural Rights have called for reform of the current legal position in Northern Ireland.

- When considered in relation to the European human rights framework, **the Northern Ireland High Court decision is not radical, but represents a straightforward following of jurisprudence of the European Court of Human Rights** e.g. *Tysiac v Poland* [2007] ECHR 219, *A, B and C v Ireland* [2010] ECHR 2032, *RR v Poland* [2011] ECHR 828 and *P and S v Poland* [2012] ECHR 1853. In these cases the European Court of Human Rights has found restrictive legal frameworks for abortion incompatible with rights such as the Article 8 right to privacy and the Article 3 right to be free from torture, inhumane or degrading treatment or punishment.
- While the Northern Ireland High Court found incompatibility on Article 8 grounds alone, argument could be made, following the European jurisprudence above, that the current legal framework also violates Article 3 through potential criminalisation of a victim of crime in cases of abortion due to sexual crime.

3. The Experience of Northern Ireland Healthcare Professionals

The following reflects the issues and themes that emerged from the June 2016 roundtable session with healthcare professionals reflecting on the 2015 judicial review and related relevant issues.

Experiences of Working Within the Current Legal Framework

Healthcare professionals who participated in the June roundtable across medical specialisms and geographical area expressed a general view that working within the current legal framework for abortion in Northern Ireland is very difficult. Particular difficulties emerge surrounding clarity on the law, communication amongst professionals and the impact and effects of the current legal framework on healthcare professionals.

The view was expressed, and agreed on across participants, that the most recent guidelines published in 2016 by the Department of Health, Social Service and Public Safety on the provision of legal abortion in Northern Ireland were useful, and a marked improvement on the previous draft guidelines issued in 2013. However, professionals indicated that a 'chill factor' or a 'climate of fear' brought on by the 2013 draft guidelines was still present and affecting healthcare professionals' work in this area. A general feeling of caution or hesitancy surrounding abortion was identified as having increased since the early 2000s, culminating with the last Departmental guidelines published in draft form in 2013 which were framed in a punitive manner. While the 2016 guidelines are less punitive and provide welcome instruction on the whole, work still needs to be done to address the 'chill factor' surrounding provision of abortion in Northern Ireland. Healthcare professionals are very conscious of the fact that the current legal framework holds possibility to criminalise them in the course of their work.

While participants did identify the 2016 guidelines as an improvement in assisting healthcare practitioners carry out their work it does appear, however, that complete clarity on the legal framework surrounding abortion in Northern Ireland has not yet been achieved. A significant reason for this is attributable to inadequate communication of the contents of the guidelines across departments and Health and Social Care Trusts as well as to all levels of staff, especially junior staff. Significant differences in approach still arise across the five Health and Social Care Trusts in Northern Ireland. For example, one issue that emerged in the course of discussion was the perception that in order to be deemed a 'mental or physical wreck' and thereby fall within the *Bourne* exception a psychiatrist's diagnosis of a mental health condition was required. While the most recent guidelines make clear that this is not the case, some professionals continue to work under this assumption. Standardisation on this issue is required to ensure that lawful abortion provision is not being withheld by imposing additional requirements which are not part of the legal framework. This lack of communication not only leads to misinformation and a further reluctance to offer lawful abortion services, but also a lack of consistency of healthcare services for

Moving Forward From Judicial Review on Abortion in Situations of Fatal Foetal Abnormality and Sexual Crime: *The Experience of Health Professionals*

women across the province. On the issue of mental health assessment, it was also noted that a divide exists amongst Obstetricians. Some feel very capable to assessing mental health and making an assessment as per *Bourne*, while others, usually those younger in their practice, feel ill equipped to make such an assessment without specific training on the issue.

An additional issue raised in relation to the current legal framework and guidelines on it pertained to abortion medication. There is increased awareness of abortion medication which may be purchased online. The prosecution of two women in Northern Ireland for purchasing and/or using such medication in 2016, and the one conviction which has followed to date, has moved debate on substantially. The legal framework and guidelines for healthcare professionals must reflect this and deal with the related issues comprehensively. Such changes should be introduced as soon as possible in order to assist healthcare professionals with this difficult issue which has received much publicity and provoked much concern.

Overall, discussion reflected the view that the current legal framework pertaining to abortion in Northern Ireland remains complicated and has not yet been adequately communicated to achieve parity of provision, despite improvements made by the most recent Departmental guidelines. Particular issues arise in relation to fatal foetal abnormality and sexual crime where, following recent judicial review, clarity on this issue is urgently required. It was noted that the 2016 guidelines did not address such issues or the recent judicial review decision.

Pathways for Abortion Provision and Care

A second theme arising in roundtable discussion was pathways for abortion provision and care. Where a woman is seeking an abortion which cannot be provided in Northern Ireland healthcare professionals expressed concern surrounding lack of official and standardised pathways, in particular relating to fatal foetal abnormality. Such a lack of pathways has the consequence of heightening practical and emotional difficulties for women. To a significant extent pathways for women seeking abortion on the grounds of fatal foetal abnormality are colloquial – dependant on who the healthcare professional in question can put the woman in contact with and, in turn, what healthcare professional and Health and Social Care Trust the woman is receiving care from. Again while participants suggested the situation has improved in recent years, it is still not possible to make a direct referral for a woman to seek abortion provision in Great Britain. Standardised NHS pathways on this issue are required, and are indeed currently being considered.

Related to the lack of official and standardised pathways for abortion provision, participants identified a lack of aftercare support for women who do choose to seek a termination outside Northern Ireland. Because women in Northern Ireland generally seek abortion at a later stage – given the legal and practical obstacles that must be surmounted – the need for an aftercare pathway is even more important. Pathways

which are integrated into NHS care would allow a woman to return to Northern Ireland and seek aftercare from her local Health and Social Care Trust.

In relation to women who travel outside Northern Ireland to seek abortion on grounds of fatal foetal abnormality specifically, there is currently no pathway for returning foetal remains home for burial or autopsy. Women and/or couples are often required to transport remains themselves in harrowing circumstances such as via picnic coolers, in hand luggage, or via private courier. This lack of a standardised pathway raises significant ethical concerns, causes additional trauma and difficulty at an already harrowing time and leaves women and their families without a significant practical support provision. Pathways for return of foetal remains could also be created within a standardised NHS frame. Participants expressed awareness that work to create such a pathway, accompanied by counselling, is currently under consideration.

Related to the concern regarding current lack of pathways for returning foetal remains, difficulties were also highlighted in relation to the legal aspects of foetal remains and information regarding disposal which is causing considerable distress. Women and families appear to be receiving inaccurate and/or incomplete information regarding possibilities to take tissue home for burial in Northern Ireland and there is a general lack of awareness of disposal options and arrangements which appears to stem from a lack of understanding regarding the legal position of foetal remains.

Fatal Foetal Abnormality

The issue of fatal foetal abnormality was raised in a number of forms throughout discussion. Participants at the roundtable expressed the general view that healthcare professionals' judgments should be trusted on this issue. In particular, it was stressed that there is no clinical definition of fatal foetal abnormality nor any list of approved illnesses or conditions that exist to lead a foetus to fall within this category. However, a judgment that a foetus has a fatal abnormality will only be made where healthcare professionals are completely sure that the foetus stands no chance of independent life. The abnormalities which lead a foetus to fall within this category are life-threatening and do not relate to foetuses with abnormalities which are non-life threatening. Participants expressed concern regarding the adequacy of current practices surrounding fatal foetal abnormality that included long waiting times to see a consultant, requiring later travel if a termination in Britain is pursued, as well as recovery times in Northern Ireland being longer due to later travel.

Post-Mortem Practice Surrounding Stillbirths

Considerable concern was expressed by roundtable participants regarding current practices in Northern Ireland surrounding stillbirths. A change in practice in 2013 now requires all stillbirths to be reported to the coroner. This departs from practice surrounding adult deaths where if a medical practitioner can certify the death as being due to a natural cause it is not reported to the coroner. The view was expressed that if a stillbirth death appears to be due to natural causes there is no need to report it to the

coroner. It appears that the reason for stillbirth reporting is to determine whether the stillbirth is due to feticide.

In this context parents of a stillborn child have the option to consent to an autopsy or, failing this, a coroner's inquest will be opened. While many parents do consent, those who do not have been subject to police investigation which, until recently, involved uniformed police officers coming into the maternity ward to gather evidence and question the parents due to protocols surrounding cot deaths being followed *in lieu* of tailored stillbirth protocol. The police have acted to change their practices and now enter the ward out of uniform, however, concern was raised that police involvement in these issues is inappropriate generally, and that current practices violate the privacy of parents. Concern was also raised regarding whether parents' consent to an autopsy could be considered true consent in a context where they are aware that a coroner's inquest will be opened if consent is not given.

It is important to note that not all healthcare professionals participating in the roundtable were aware of this practice, again raising issues surrounding effective communication and clarity on procedures in this area. Investigation of stillbirths being used in such a way in Northern Ireland was raised as another abnormality surrounding abortion and related medico-legal frameworks in the province; routine reporting of stillbirths to the coroner does not appear to be a practice that happens regularly in other jurisdictions and is not the appropriate arena to look at stillbirth deaths given the potential it holds to take power away from parents, including their say over what happens to tissue.

Interestingly, despite the change of practice following judicial review in 2013, there also appears to be a number of stillbirths in Northern Ireland that are not receiving an autopsy at all. It is unclear whether these stillbirth deaths are not being reported, whether they are being written up as natural, and why the coroner is not pursuing autopsy in these cases. This again points towards a divergence in practice across Health and Social Care Trusts and a lack of transparency and communication regarding coroner decision-making.

4. Recommendations

A number of recommendations can be drawn from the above discussion which the Reproductive Health Law and Policy Advisory Group suggests as starting points for moving forward on the issue of abortion in Northern Ireland following 2015 judicial review.

Recommendation One: The (diverse) experience of healthcare professionals and thorough knowledge of practice on the ground must underpin reform

The Advisory Group recommends comprehensive legislative reform to reflect the High Court's determination that the current prohibition of abortion in cases of fatal foetal abnormality and sexual crime is incompatible with human rights commitments. In considering the specific shape this reform should take in addition to taking account of the needs of women the views of healthcare professionals must be at the forefront, and their diverse experiences of working within the current framework considered. It is not possible to approach reform of this area from a legalistic standpoint alone, nor dependent upon the views of a small number of healthcare professionals. Rather, reform should reflect a wide awareness of, and responsiveness to, practices of healthcare on the ground and the everyday needs and difficulties that surround it. This should include engagement with a range of medical practitioners across specialisms, levels of expertise and discipline. Only through thorough exploration of practice on the ground may provisions that benefit those most directly impacted by the current legal framework be devised.

Recommendation Two: Ongoing work is required to communicate guidelines to healthcare professionals while also acknowledging the limitations of guidelines to address the root of the problem

While some work to address concerns of healthcare professionals can be undertaken through the issuing of guidelines, the Advisory Group stresses that this is not enough in and of itself. This fact is demonstrated through problems that remain following publication of the most recent 2016 guidelines, in particular problems surrounding effective, widespread communication of the content of these guidelines and gaps that still remain, including a failure to address issues surrounding fatal foetal abnormality and sexual crime. These issues need to be tackled in order to provide guidance that is adequate and comprehensive and in addition to undertaking thorough communication of the guidelines, regular refresher training on the most up to date guidelines should be undertaken. However, it is also necessary to acknowledge the limitations of guidelines in addressing the root of the problems facing women, families and healthcare professionals in this area. Guidelines cannot change the law and are not enough on their own to remedy the 'chill factor' that healthcare professionals have experienced in recent years in relation to abortion provision. An overhaul of the current legislative position is needed in order to reassure health care professionals and better assist them in their role. The onus is on the Northern Ireland Assembly to act as opposed to relying on Departmental guidelines, useful though they are, to do the work of legislative reform or to work under the assumption that the most recent set of guidelines has remedied

Recommendation Three: Pathways must be created as a matter of urgency

While work remains ongoing on the creation of pathways surrounding abortion within the healthcare service in the interim women and families continue to receive inadequate care in this area. Work to create official pathways for abortion care and aftercare between Northern Ireland and Great Britain are necessary and needed as a matter of urgency. This relates to all women who seek abortion, however, particular concerns arise in relation to women seeking abortion in cases of fatal foetal abnormality which requires additional pathways to minimise the practical and emotional burden on those required to travel to access abortion provision in these circumstances. While legislative overhaul is the Advisory Group's primary recommendation, the significant obstacles that women from Northern Ireland face within the current legal framework could be greatly reduced in the interim with the creation of pathway provisions that are attentive to the specific and varied needs of women who seek abortion services.

Recommendation Four: Revise current practice relating to stillbirth deaths to reflect the privacy rights of parents

Current practice surrounding investigation of stillbirth deaths in Northern Ireland is extremely problematic and is in need of review to consider its impact as experienced by families. The present position which requires parents to consent to autopsy or be subject to a coroner's inquest holds potential to be distressing and intrusive. The lack of transparency surrounding practice in this area also requires review. The Advisory Group recommends that experiences of current practice in this area be investigated with special attention to concern for the privacy of parents.

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