Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Guidance on Termination of Pregnancy in Northern Ireland: DHSSPS Briefing

22 October 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:

Mr Alasdair MacInnes	Department of Health, Social Services and Public Safety
Ms Eilis McDaniel	Department of Health, Social Services and Public Safety
Mr Paul Skillen	Department of Health, Social Services and Public Safety

The Chairperson: I welcome Eilis McDaniel, the director of family and children policy; Alasdair MacInnes, the head of the family policy unit; and Paul Skillen from the family policy unit. You are very welcome to the meeting. We are aware that the summary of responses document has not yet been completed. That is the information that has been relayed to us. However, given that the Minister has stated that he intends to bring guidelines to the Executive within — it was said publicly last week — a number of weeks, it seems reasonable for the Committee to assume that the Department is aware of the key issues that have been raised in the consultation process. Therefore, the Committee would like you to take us through the key issues that were raised. We understand that a final decision on what will be in the guidelines is a matter for the Minister. At this stage, the Committee is simply asking you to brief it on the key issues that have been raised. If you are in a position to advise us of how the Department intends to respond to the outcomes raised, we would welcome that as well. However, we understand that, on some of the issues, it may be a ministerial decision. We also ask you to advise us of when the summary of responses document will be completed and when it will be sent to the Committee. Maybe you could give us a timeline for that. I ask you to make your presentation.

Ms Eilis McDaniel (Department of Health, Social Services and Public Safety): Thank you very much, Chair. The Department is grateful for the opportunity to provide information to the Committee on the recent public consultation exercise on the draft guidance document for health professionals on the termination of pregnancy in Northern Ireland. I apologise that we were not able to get a written briefing to you in advance of today's meeting. Developments in recent weeks have shown how difficult this issue can be and how important it is to ensure that there is clear guidance for health professionals on the matter. Guidance is required to ensure that medical professionals are empowered to make decisions within the law and based on the medical circumstances that they face. It also ensures that women, no matter where they are from in Northern Ireland, are able to access services to which they

are legally entitled. I will begin by making a brief statement, after which we are happy to take questions from members.

The Department ran a 16-week public consultation exercise until 29 July seeking opinions on the draft document, which was entitled 'The Limited Circumstances for a Lawful Termination of Pregnancy in Northern Ireland: a Guidance Document for Health and Social Care Professionals on Law and Clinical Practice'. In total, the Department received 86 responses from a wide range of interested groups, including various royal colleges that represent health professionals, health and social care trusts, individual doctors, groups with an interest in human rights law, groups that could broadly be called pro-life, and groups that could broadly be called pro-choice.

It is important to recognise that the purpose of the public consultation was to seek views on the guidance document that we are here today to discuss with you. The public consultation was not on whether the law on the termination of pregnancy as it is currently framed in Northern Ireland should be changed.

It is also important to note that the draft guidance currently has no status and is simply a consultation document at this stage. Significant work has taken place in the two months since the consultation closed to consider all the issues raised by consultees. A document summarising those issues will be published on the Department's website shortly, and we will provide members with a copy once it has been agreed with the Minister.

Before I highlight the issues raised in the consultation process, it is important to acknowledge that the Minister has indicated his intention to bring revised guidance to the Executive at an early stage, certainly by the end of this year. We are not currently in a position to indicate what may or may not be included in the final guidance document. However, given the gravity of events in recent weeks, it is clear that any views that have been aired will be fully considered in the drafting process for the revised guidance. Furthermore, consideration will be given to any advice provided to the Minister since the consultation exercise has closed, such as any advice provided by the Director of Public Prosecutions.

I will now take members through the views that were raised in the consultation. They can be broken down into seven broad areas. The first is the law in Northern Ireland. As I mentioned, the public consultation was not on whether the law should be changed. However, the issue of the law and its representation in the document was raised by a large number of consultees. Some consultees stated that the law should be liberalised. Others felt that it should be updated to reflect medical advances. Some were content that the law should remain as it currently stands. Members will be aware of the recent media coverage on lethal foetal abnormality and the debate about whether it should be a ground for termination of pregnancy. Changing the law to cover that issue, as well as instances of rape and incest, was raised in the consultation.

Concerns were raised by respondents about the representation of the law in the document, with many stating that the tone and terminology was inappropriate for medical professionals. Examples included the use of the term "mother" instead of "woman" and "child" instead of "foetus". It is important to note that the document can merely reflect the law as it stands in Northern Ireland. It may be an opportune moment to remind members of the law as it has been interpreted by the courts here: it is unlawful to perform a termination of pregnancy unless it is necessary to preserve the life of a pregnant woman or there is a risk of a real and serious adverse effect on her physical or mental health that is either long-term or permanent. In any other circumstances, it is unlawful to perform such a procedure in Northern Ireland.

The second issue raised was mental health grounds for a termination. The draft guidance document recommends that a consultant psychiatrist should be involved in any assessments in that area. Respondents noted that that recommendation has no basis in law. It was highlighted that a consultant psychiatrist can assess a patient's current mental health but may not be the most appropriate person to assess the long-term effects of a given situation on a woman's health. That may require specialist medical expertise on the condition of the woman and the foetus. Some consultees noted that compelling a woman to undergo a full psychiatric assessment may in itself result in mental distress for the woman. Consultees stated that the effects of lethal foetal abnormality on a woman's mental health are not fully explored in the document.

The third issue related to certification by two doctors. The draft guidance document recommends that two doctors should certify a termination where possible, while acknowledging that this may not be possible in emergency circumstances. Some consultees said that there was no basis in law for this requirement and stated that one doctor was appropriate. Others recognised that an additional doctor

can bring with them additional skills and experience to any assessment that is taking place. Some respondents felt that this recommendation offered protection to a foetus in relation to the application of the law, and others felt that it offered a degree of protection to the doctors involved in a decision to terminate.

The fourth issue was conscientious objection and second opinions. The issue of conscientious objection raised a considerable range of views. Many respondents felt that the section did not adequately address the issue at hand and noted that there is no legal basis on which to conscientiously object in Northern Ireland. In Great Britain, the right to conscientious objection is set out in the Abortion Act 1967. There was recognition by some respondents that, in an emergency situation, health professional staff cannot conscientiously object to taking part in a procedure and that protecting the life of the pregnant woman will always be the overriding concern. Ensuring that a woman has access to a second opinion and having a framework to handle any disputes that may arise was raised by human rights organisations, and reference was made to European Court rulings.

The fifth issue was the provision of counselling services. The section of counselling services received considerable engagement in consultation. Respondents highlighted the importance of non-directional counselling for women and the need to ensure that they can access a full range of psychological services. Some felt that any reference to religious support services was inappropriate. The issue of whether it is appropriate to provide advice to someone on abortion services outside Northern Ireland was raised in relation to this section, and members will be aware of this issue from recent media coverage. Consultees referred to European Court cases and stated that it is not illegal to provide such advice and that it is not a grey area, as the guidance claims. The recent comments from the Director of Public Prosecutions on this matter have, I think, been very helpful and will be taken into consideration in the redrafting of the guidance.

The sixth issue related to patient confidentiality and data collection. The issue of a proposed new system of data collection was raised in the consultation. Respondents highlighted the need to ensure that patient confidentiality was protected in any system implemented and needs to take into account the small number of terminations undertaken in Northern Ireland in any given year. Some consultees suggested that statistics should be collected from statutory and non-statutory organisations, and others recognised that any data collected could be used to inform policy decisions and to ensure that there are adequate resources to meet the needs of women in these circumstances. Medical professionals raised concerns regarding requirements on them to disclose information on terminations that might be illegal, such as those resulting from drugs purchased on the internet, and the impact that this could have on patient trust and care.

The seventh issue related to equality and human rights. A range of views was raised in relation to the section 75 implications of the document and the matter of human rights in general. Some respondents stated that the law places a financial pressure on women from lower socio-economic groups in relation to their ability to access services that are readily available in Great Britain. Some stated that the law acted as a restrictive barrier for women in accessing terminations. A number of organisations stated that the document failed to take into consideration European Court rulings on human rights in this area, and reference was made to comments by the UN Committee on the Elimination of Discrimination against Women in relation to termination of pregnancy services in Northern Ireland. It was noted that HSC staff with a religious belief may be impacted on in relation to their ability to conscientiously object.

It is clear that there is a wide range of opposing views on the termination of pregnancy and that there is a broad range of key issues for any guidance document that is produced to address. Without exception, there were opposing views on every issue raised in consultation, and that highlights the difficulty of the issue and the need to take account of different opinions where possible. We clearly have not got it right yet, and we will endeavour to provide the clarity that is required. The purpose in issuing the guidance is to provide medical professionals operating in difficult, emotional and traumatic circumstances with the clarity that they require. There is an onus on the Department to provide them with that.

The views raised in consultation are helpful for the Department, and we thank everyone who formally responded. All responses are being considered in the drafting of any future guidance document. As I said, we are happy to have the opportunity to speak to members today. However — this is a final plea on my part — none of the three of us is medically trained; none of us is a doctor. We work in the Department's policy area that deals with producing the guidance document, and we would find it difficult to answer questions that may require some level of medical expertise. Thank you.

The Chairperson: Thank you for that, Eilis. First, I note that the issue of foetal fatal abnormality was raised in the consultation process.

Ms McDaniel: It was raised as an issue, yes.

The Chairperson: Therefore, may we have a bit of clarity around whether lethal foetal abnormality is likely to be included in the guidelines as grounds for termination?

Ms McDaniel: No final decisions have been made on that. The guidance is limited in the sense that it can state only the law as it is and make abundantly clear the circumstances that apply when a termination can be undertaken in Northern Ireland. It was raised as an issue in consultation. We have to take account of the fact that it was raised in consultation. We have to take account of the fact that it has now been raised in a very public way over the past couple of weeks, and, of course, we will need to consider how that is reflected in the final document that we produce. I think that that is as much as I can say on that point.

The Chairperson: I am sure that you are well aware of the very human side and public dimension to this issue, and given the engagement by families and Minister, is there clarity? Is there guidance? Given that there were some very human timelines, is there consideration given to the here and now of this issue?

The Chairperson: We were all struck by the very human nature of the issues raised recently. I think that how we deal with some of the cases that were brought to our attention recently is outside the scope of this guidance, but any future guidance that is produced will consider how we reflect the issue of fatal foetal abnormality. However, we have to take account of some of the personal cases that faced us all in the past couple of weeks. I do not think that this guidance is going to address issues for the individuals concerned, but it will need to consider how it addresses that issue for individuals who may be in such circumstances in the future.

The Chairperson: OK. I will use a different approach. Were the guidelines to be removed from the current equation for people working in policy, would that provide more clarity for the medical profession, individuals and families?

Ms McDaniel: The removal of the guidance? Are you asking me would people behave differently — be able to behave differently — if the guidance did not exist?

The Chairperson: I am asking what difference it would make if we were to revert to another policy piece in advance of the guidance being worked up? Would it actually provide more clarity?

Ms McDaniel: I am not certain that it would. I am saying today that this was raised as an issue in consultation. It has been thrown into even sharper relief because of the publicity around it in recent weeks, and we will need to take account of how we present that in a future document. The purpose of the document is to provide clarity to medical professionals who find themselves in these very difficult circumstances. As I said, there is an onus on the Department to ensure that we provide absolute clarity to people working in the medical profession, and we will place a focus on that particular issue; we are duty-bound to do so.

The Chairperson: In the absence of that guidance — if those guidelines were removed — would lethal foetal abnormality be recognised in current legislation as grounds for termination?

Ms McDaniel: I will rely on my colleagues. I am fairly new to this policy area, so I will point to either Paul or Alasdair to assist me. The law does not permit termination of pregnancy on the grounds of foetal abnormality. That is abundantly clear. However, if a lady is in circumstances that are clearly impacting either on her mental or physical well-being in the long term or permanently, it can absolutely be taken into account. Nevertheless, the law is the law. At the minute, it does not permit termination on the grounds of foetal abnormality.

The Chairperson: Can I just probe that a bit with regard to mental capacity. What would be the assessment process around that?

Ms McDaniel: That is a matter for medical professionals. Every woman's case will be different. It has to be dealt with on a case-by-case basis, and a medical assessment needs to be made. Those who are trained to undertake medical assessments need to decide in an individual's case whether lethal foetal abnormality and carrying a child through to full term in those circumstances would impact on her mental health well-being on a long-term or permanent basis. That is as much as I can say. It is a case-by-case issue; it is a matter for medical professionals, and it is a matter of professional judgement.

Mr Alasdair MacInnes (Department of Health, Social Services and Public Safety): The law here dates from 1861, and it has only been developed by case law. The last main bit of case law on this was in 1938. Therefore, we are dealing with quite a long time ago. In the absence of guidance, you would be asking a doctor to make a legal assessment based on laws that are 160 and 60 or 70 years old. As Eilis has explained, the purpose of guidance is to try to give doctors something more up to date and clear. It is a work in progress. We have consulted, and we got a major response from organisations and the public. We have picked up an awful lot of information from the consultation, and that was the purpose of the consultation.

The Chairperson: You referred to the useful clarity from the Director of Public Prosecutions (DPP) on Friday, which will, in your words, "be taken into consideration". Are you suggesting, or is there an inference to, what the director said last week, which was that he could see no criminal offence of aiding and abetting in counselling someone or procuring for them a termination in England? Is that the Department's view now?

Ms McDaniel: I have said it. I think that the DPP's contribution was particularly helpful on that subject. It has been referred to in the media as the grey area, and his contribution was incredibly helpful on that point. The DPP met the Minister last Friday. He has made a public contribution, and he has done that with the Minister face to face. We need to take account of what he said as to how the final document should be framed on that point.

The Chairperson: So, is it the Department's view that what the director said last week was accurate?

Ms McDaniel: It is very difficult not to agree with what he said. He basically said that you cannot aid or abet something and face the force of the criminal law in relation to something that is not a criminal act in another jurisdiction. So, it is very difficult to disagree with that point. How we actually reflect that in the final guidance document will be the issue.

The Chairperson: Following on from that, in your view, why did a number of health professionals in organisations such as the Royal College of Nursing and others raise concerns that providing assistance, in whatever shapes that might be, could be a criminal offence? In your view, why was there that lack of clarity? Following on from that, why did the Department and, indeed, the Minister — I know that you cannot answer for him — not consult the DPP until the end of last week?

Ms McDaniel: I cannot explain why that was not done. All I can say is that it was not done in advance of the document being finalised for public consultation. Now that it has been done and the contribution has been made, I think that we need to make as much of that as we possibly can, take account of what the director has said and provide the clarity that medical professionals require. What we were attempting to do was to draw a distinction between advising and counselling on the availability of services outside the jurisdiction and actively promoting or advocating that women go to England to have an abortion. That was the purpose of including that in the document: we were drawing a distinction between the two things. I think that that is probably better reflected in how the DPP has framed it.

The Chairperson: OK. Finally, the guidelines from 2009-2010 — before my time here — were widely consulted on, and there is a suggestion that health professionals are referring to those. There was a judicial review, and two issues were identified. From the Department's point of view, would it not have been simpler to address those two issues than to have a completely new process?

Mr MacInnes: The short answer is that there was an election, and we got a new Minister.

The Chairperson: OK. There was no appetite to — I am taking this from your response — look at the two issues that were identified, so there was a new process.

Mr MacInnes: I would not say that it was a new process. The Minister brought his views to the table and considered the issue afresh.

Ms McDaniel: That is the case in many areas of policy. New Minister, new eyes, new views, and policy gets revisited on that basis.

Mr Gardiner: After I ask my question, I have to go to another Committee that started 20 minutes ago.

The Chairperson: Sure.

Mr Gardiner: Can you comment on Professor Jim Dornan's statement on 17 October that the 2009 McGimpsey guidelines should have been retained but with the two minor modifications that were suggested by the judicial review process? Can the guidelines be reinstated now?

Ms McDaniel: I think that that relates to the same issue. We have explained why we issued a further document for consultation that looked a bit different from the one that Professor Dornan referred to in his 17 October statement. The new Minister of Health decided that we would do things slightly differently from how they had been done previously.

Mr Gardiner: So you are saying that the present Minister deleted it completely?

The Chairperson: I think that we have heard, Sam, that, ultimately, that is what happened — that there was, if you like, a new ministerial approach to the issue. That is the answer that we have been given.

Mr MacInnes: If I said that, I have maybe misled you slightly. It is not as though we started from scratch. There was clearly a document there that had been in front of the courts, and which the Assembly had considered. A new Minister is not obliged to come in and —

Mr Gardiner: I can appreciate that, but we want to do what is right.

Mr MacInnes: I think that we would certainly all agree with that.

Ms McDaniel: The comments of Professor Dornan will be taken into account — as will the other 86 comments made by organisations or individuals in response to consultation — in the redrafting of the guidance for final issue.

Mr D McIlveen: First of all, on that grey area, there are examples of other European states where somebody can be convicted for an offence that is illegal in their own country but is not illegal in the country that they visit. There is some precedent set for that, so I can understand why it is a grey area. I do not think that it is as black and white as some people have been making it out to be.

I found your contribution very helpful, but I am just a bit confused about the consultation. The first of the seven points was about the law. Forgive me if I am totally missing the point, but my understanding is that the law on abortion is actually under the auspices of the Minister of Justice.

Ms McDaniel: That is correct. Our Minister has recently been on record as saying that. It is criminal law. It is within the body of criminal law in Northern Ireland, which falls to the Minister of Justice. The Minister of Justice has recently made an announcement too, particularly on the point about fatal foetal abnormality. He has indicated that consideration perhaps needs to be given to whether we have drawn the line in the right place on that particular issue. So, I think that it is widely accepted that it is a criminal law matter and, ultimately, a matter for the Minister of Justice, in consultation with his Executive colleagues, to deal with.

Mr D McIlveen: So, taking that to its logical next point, any Health Minister — regardless of who he or she is or what political party they are connected to — can effectively issue whatever guidelines they want, but if they fall outside of the law then the guidelines are not really worth the paper that they are written on. Is that a fair enough assessment?

Ms McDaniel: The guidelines have to absolutely reflect the law. There is no scope for the Minister to put something into guidelines that is not in keeping with what the law requires. That is not in the Minister's gift to do, and we have made that abundantly clear, as has the Minister.

Mr D McIlveen: That is really helpful; thank you.

Mr Beggs: I note some of the comments from the Royal College of Midwives and the nursing profession. There seems to be great concern among their members. The Royal College of Midwives was not involved in the latest consultation process at all, is that correct?

Ms McDaniel: Not involved in the consultation? It certainly —

Mr Beggs: Sorry, in the drafting of the guidance that was issued for consultation.

Mr MacInnes: No organisations were involved in the drafting of the current document. My understanding is that it has slightly misinterpreted a response to an Assembly question stating that there had been a lot of consultations. We intended to say that, since 2004, there have been a lot of consultations, and I think that they have picked it up slightly wrong. That is my understanding, anyway. Certainly, no other organisations were involved in the drafting.

Mr Beggs: Was that wise, given that the Royal College of Nursing (RCN), in its response, indicated that a registered nurse would essentially be in breach of their code of conduct and would risk their position on the register if they were to follow? So, there are some fundamental failings in the draft guidance. Do you accept that?

Ms McDaniel: That is the point of consultation.

Mr Beggs: Do you not think that fundamental things like that should be ironed out before you go to consultation?

Ms McDaniel: That could be argued, but the counterargument is that we produce documents for consultation, go to consultation, invite comments from organisations such as the royal colleges and take account of what they say in response to that. Where we get things wrong — we have acknowledged that there are some things there that we have possibly got wrong — that will be taken account of in the finalisation of the document.

Mr MacInnes: I think that it is worth repeating that there is hardly a paragraph in the draft guidance on which there was not somebody who agreed and somebody who disagreed. It is always going to be a compromise between two quite polarised views.

Mr Beggs: Let us move on. I understand that, in 2004, following an appeal to the Court of Appeal, it was accepted that the Department had to produce guidance. Obviously, the 2009 guidance was subsequently issued and heavily consulted on. Can you clarify its status? What guidance has been in place each year since that was produced? I am told that there is no guidance at the moment. Is that correct? Is there no guidance at all? Was there any period when there was guidance?

Mr MacInnes: Paul may correct me on this. There was a period, I think, in 2009 when there was guidance out briefly, but it was withdrawn following judicial review. You are correct that, at the moment, there is no guidance.

Mr Beggs: Was it that two aspects of it were withdrawn?

Mr Paul Skillen (Department of Health, Social Services and Public Safety): Yes. Interim guidance was issued following the legal challenge in November 2009.

Mr Beggs: So that had ongoing status as the guidance for professionals at that point.

Mr Skillen: Following that, the interim guidance was redrafted, with those two sections replaced, in July 2010. That was subsequently put out for public consultation.

Mr Beggs: And what status did that have at that time?

Mr Skillen: It was still a consultation draft, essentially.

Mr Beggs: At what point — to be very specific — was there guidance for medical professionals working in this area?

Mr Skillen: From March 2009 to November 2009.

Mr Beggs: Would you agree that, given the judicial review, there should have been an urgency to try to ensure that any problems were addressed? In effect, in the absence of approved guidance, the professionals look to the draft guidance that exists at any time. They take their steer from that. Is that correct?

Ms McDaniel: I accept your point about urgency. The Department is on record as attempting to get guidance in place over a significant period of time. However, that has been subject to challenge after challenge, which has made the task nearly impossible. It is clearly the case that professionals need guidance in this area. That is what we are in the process of trying to produce at the minute. However, you can see that it is not an easy issue to resolve. There are views and counter views, and the responsibility of the Department is to take all of those into account and to somehow reach some form of accommodation or compromise position. That is what we are attempting to do.

Mr MacInnes: An organisation has already made public that it intends to have the next set of guidelines judicially reviewed.

Mr Beggs: Do you accept the fact that it would have been wise to continue with the extensive set of guidelines, which had robustly survived judicial review other than in two discrete areas, and to simply finalise the rest of the regulations? Would that not have been a wise decision?

Mr Skillen: In 2009, that interim draft went out without those two sections — on conscientious objection and counselling — being redrafted. That interim guidance, which had been approved by the court, was subject to further legal challenge at that time. So, it is a very contentious issue. Ultimately, that is where it leads. It is very hard to produce such guidance without litigation following.

Mr Beggs: My final point is about the language used in the document. Health professionals say that the language is:

"aggressive, patronising and unhelpful to health and social care professionals".

How does the Department of Health produce language like that? I quote from the Royal College of Nursing response. How does the Department of Health manage to use language on which members of the caring profession comment like that?

Ms McDaniel: I will answer that, and Alasdair may wish to support me. I do not think that it was the intention of anybody in the Department to use language that was unhelpful. "Intimidatory" was one of the other words used to describe it. It was certainly not intended that the language would be aggressive in any way. Now that those points have been made in response to consultation, we will need to take account of and address them.

Mr MacInnes: The points were raised, and they exist in law. You could argue that a health professional should have all of the information available. We probably worded it wrongly, but, as other people have said, nothing in this is black and white.

Mr Beggs: Given the recent statement by the Director of Public Prosecutions, did you not think to engage with him earlier?

Ms McDaniel: In retrospect, that probably would have been a good thing to do. I can only say that it was not done, and we will now take account of what he has said more recently, both publicly and in his meeting with the Minister.

Mr Brady: Thanks for your presentation. The college of midwives mentioned that the guidelines did not deal at all with the fact that women have access to drugs from the internet that can induce an abortion. Its worry was the after-effects of that. It seems to me that, in the current world that we live

in, all sorts of drugs are easily accessible from the internet. Its concern was the after-effects of that, which GPs, hospital A&Es and so on will have to deal with, and how that will impact on people who are presenting having taken the drugs and, presumably, having had the induced abortion. It seems that there is a huge gap. Already in the North, there have been cases of people getting drugs. In one particular case that was highlighted a couple of years ago, a young man got drugs from the internet and took his own life. That seems to me to be a huge gap, and we are dealing with a very sensitive area. I do not think that anybody is denying that, and it needs to be dealt with sensitively. Civil servants are not necessarily noted for the sensitivity of their language, and that is not a criticism but a statement of fact. Is it the intention that the internet issue will be dealt with in the guidance or whatever other guidance may be issued? Undoubtedly, that is something that will increase and become more common.

Mr MacInnes: It is not something that we ever really thought about in the current guidance. The intention is that any medical professional will treat a patient in a non-judgemental way, so you should treat the condition and certainly not make judgements behind that. The internet is increasingly coming to the fore, and it is something that we will specifically have to address in the future.

Mr Brady: The midwives were raising the issue of whether it would be incumbent on the medical professional who was dealing with the aftermath to report to the police, for instance, that someone had put themselves into that situation. It may or may not be dealt with under the law or, indeed, the guidelines that have been issued.

Mr Skillen: Ultimately, the primary concern has to be for the patient.

Mr Brady: Absolutely, but, if a health professional has particular issues around the use of such drugs and the whole abortion issue in general, they may feel that it is incumbent on them to report to a health authority or, indeed, a legal authority. Therein lies the predicament.

Mr MacInnes: Yes, I suppose that it does. The professional codes of practice suggest that patient confidentiality is important, and I absolutely agree. I can only say that, in this area, the consultation has been very helpful in pointing out some of the issues. When this process started in 2004, there was not as much internet around.

Mr Brady: I understand that, but the point is that it has been raised, and I think that it is important for the Department to deal with it specifically and not leave it out.

Mr MacInnes: Absolutely.

Mr Brady: We talked a lot about grey areas. Those drugs are accessible and available. Indeed, that is happening, and presumably it will happen more and more regularly, so it needs to be dealt with.

Ms McDaniel: It was raised in consultation. We absolutely need to take account of it, and I think that we need to seek legal advice on that point to ensure that the final document reflects it properly.

The Chairperson: I have one final question to ask for clarity, and it is related to a point that Roy Beggs made. Concern has been raised by a number of organisations, including the Royal College of Midwives and the Royal College of Nursing, about the language that was used. They go as far as suggesting that the guidelines were flawed, inadequate and misconstrued and that some of the language was patronising. Your response was that, ultimately, the guidelines were based on the current legal framework. Leaving aside the judicial review that identified the two issues in 2009, were the same issues raised in the 2009 process?

Mr Skillen: It is fair to say that there has been increased engagement generally across all issues. The last consultation received about 30 formal responses, whereas this time we have received 86. I am not 100% sure on the specifics of the issues raised. People are considering the document more in light of recent events.

The Chairperson: The point that I am making is that the language is very strong for healthcare professionals to be using about guidelines that are produced by the Department. I am trying to tease out whether those concerns existed on the previous guidelines. Roy wants to make a final comment.

Mr Beggs: I am just curious about what brought about that change in language. Were the concerns not there in previous consultations? In particular, I would have thought that the Chief Medical Officer and the Chief Nursing Officer would know about such an obvious thing as a breach of a code of conduct by a nurse. How did such language manage to get through the process in the Department when there are key personnel in place to specifically look after significant members of the health service in Northern Ireland?

Ms McDaniel: The intention was to provide as much clarity as possible. Often, that demands that you tighten the language that you use. But, we are accepting, based on the comments that we have received, that we probably have not got the language or the tone quite right. There is scope to reflect the law accurately in a way that does not make someone feel that they are being intimidated by what the guidance is saying.

Mr Beggs: Was that not the intention during the previous consultation in 2009?

Ms McDaniel: Yes, it has always been about providing clarity. What we tried to do this time around, and my colleagues can add to what I say if they want to, was provide absolute clarity on what the law requires. That involved some tightening of language, but we need to look at how well we did or did not do that and to take account of what people say. I have already said that it would never have been the Department's intention to intimidate or act in a way, through guidance, that was considered to be aggressive. If that is how the guidance has come across, we need to take account of that.

The Chairperson: Just so I am very clear, would the guidance not have been proofed by the Chief Medical Officer or Chief Nursing Officer before it was issued for public consultation?

Ms McDaniel: Alasdair can come in on this point, but the guidance would have been produced with the input, support and advice of a number of people in the Department. That would have included medical input, nursing input, policy input from people like ourselves and legal input, because if you are presenting a document that intends to reflect what the law does or does not permit, legal advice is required. So, there would have been a range of inputs to the production of the guidance, and that certainly will be the case going forward.

Mr Beggs: Was it only proofed on the legal side? Was it proofed by the other senior officers?

Ms McDaniel: I said that there would have been medical input and nursing input.

Mr Beggs: Would it have been proofed by them? Would they have had an opportunity to comment on the final version?

The Chairperson: The question is whether the Chief Medical Officer saw it and proofed it in advance of its publication.

Ms McDaniel: He certainly would have provided input. Whether or not he had the final document to proof, I cannot say with absolute certainty. He or medical advisers in the Department would have had input into what appeared in the guidance that was issued for consultation.

Mr MacInnes: It was cleared by the Executive before it was issued.

The Chairperson: I suggest that input and proofing a document as it is about to go out are different things.

I thank the three of you for your attendance and participation. We will reflect on the information that we have been given today and no doubt will be back in contact.