Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Termination of Pregnancy Guidance: DHSSPS Briefing

29 January 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:

Ms Zoe Boreland	Department of Health, Social Services and Public Safety
Dr Margaret Boyle	Department of Health, Social Services and Public Safety
Mr Alasdair MacInnes	Department of Health, Social Services and Public Safety
Ms Eilís McDaniel	Department of Health, Social Services and Public Safety

The Chairperson: I welcome Eilís McDaniel, the director of family and children's policy in the Department of Health, Social Services and Public Safety (DHSSPS); Dr Margaret Boyle, a senior medical officer; Mr Alasdair MacInnes, who is from the social services policy group; and Zoe Boreland, who is a nursing officer in the Department. You are familiar with the procedure, so I will hand over to you to make a 10-minute presentation. We will then open up the meeting for questions and comments.

Ms Eilís McDaniel (Department of Health, Social Services and Public Safety): Thank you, Madam Chair, for the opportunity to provide information to members. I apologise that you got the paper that you requested very late in the day. I hope that we will be able to answer any of your questions as fully as possible during the evidence session.

When we last appeared before the Committee on the subject of termination of pregnancy, we were still assessing and analysing the consultation responses. Since then, we have provided you with a summary of those responses, which is also available online for the public. It is worth reminding the Committee that the Department received 86 responses to the consultation from a wide range of interested groups. Although the draft was heavily criticised, the consultation was successful in the sense that consultees responded with great clarity and provided us with an enormous amount of helpful information. The document was criticised for being too pro-choice, and it was criticised for being too pro-life. This subject generates very different views — polar opposite views, in fact. It will

satisfy neither those who seek to introduce the Abortion Act 1967 into Northern Ireland nor those who think that abortion is wrong in every circumstance.

Abortion in Northern Ireland is governed by criminal law. The formulation of the law and the case law that is developed means that it is not possible to give absolute clarity in a guidance document as to whether any given medical procedure is legal. In Northern Ireland, abortion is lawful in very limited circumstances. The nature of those circumstances is such that every case must be evaluated by a health professional, based on his or her clinical judgement. An enormous amount of responsibility is put in the hands of health professionals as they strive to produce, within the law, the best outcomes for women. It is important that the guidance that we produce assists health professionals to make decisions within the confines of the law. They are the people at the front line, dealing with pregnant women who, for whatever reason, face a choice that may be incredibly painful for them and their families. It is equally important that the guidance empowers professionals to act decisively within the law, based on the clinical circumstances that they face. We want to ensure that women, no matter where they are from in Northern Ireland, are able to access services that meet their clinical needs.

The difficult circumstances around this subject became evident in a number of media stories that ran last year, with which the Committee will be familiar, and they served to personalise and put human faces and voices to the subject. We want to produce guidance that is consistently applied to ensure that the health and social care system provides a comprehensive assessment, effective healthcare when it is required and information to help pregnant women in very difficult and often traumatic circumstances.

Before I discuss the details of the issues that were raised and the way in which the Department intends to address them, it is worth repeating that the guidance cannot change the law. The Department of Justice (DOJ) is responsible for the criminal law, and I understand that the Justice Minister intends to consult on the issue of lethal foetal abnormality. Although health officials have engaged with the Department of Justice on the matter of potential changes to the law, we cannot answer questions about its proposals. Those are matters for the Minister of Justice or his officials to comment on when their proposals are finally firmed up.

When we were last at the Committee, we explained that we had broken the responses down into seven broad categories. With your agreement, I intend to take members through each issue in turn and indicate how we intend to deal with the issue in the revised guidance.

The first category is the law on termination of pregnancy. Although the consultation made it clear that the guidance could not change the law and that there were no proposals to change the law, a number of responses suggested that it should be changed. Although we will update the guidance to reflect the current understanding of the legal position and will acknowledge the DOJ proposals, we do not intend to address the issue of legislative change in the revised guidance. The document was much criticised for its perceived punitive tone and threatening language, which was described as having a chilling effect on health professionals. The purpose of the guidance is to clarify the law for health professionals and to ensure that it is understood that a failure to comply with the law on abortion is a criminal offence; in other words, the penalty for non-compliance is severe, punishable by life imprisonment. Nevertheless, as a Health Department, we are clear that health professionals must act at all times in the best interests of their patients and respond effectively to their medical needs. We want health professionals to treat their patients confidently, in good faith and on the basis of a professional assessment of a woman's individual circumstances. As the guidance is aimed primarily at health professionals, we will seek to use medical terminology throughout the document.

The second broad category of responses relates to the mental health grounds for a termination. There were mixed views on the proposal that a consultant psychiatrist should examine a woman who could be considered for a termination on mental health grounds. We have considered the matter again and acknowledge that health professionals regularly make assessments of mental health in many areas of practice and that, although a psychiatrist can make an assessment on the state of a woman's mental health at a moment in time, he or she is unlikely to be able to predict the long-term impact of mental health problems that result from a pregnancy. Furthermore, the General Medical Council (GMC) guidance stresses the need for doctors to work in their professional capacity and to seek specialist opinion when it is necessary. We accept that it is probably a health professional who knows a woman's history and prognosis; it may not be a consultant psychiatrist.

We have taken all those factors into account and given consideration to whether we can achieve a less prescriptive approach to who can assess a woman's mental health. We will maintain the advice that two doctors should be involved in the assessment and management of the woman and advise

that doctors should seek the most appropriate specialist help in any particular case, in line with GMC guidance that they should work within their competence at all times.

The consultation highlighted the issue of lethal foetal abnormality. We have received legal advice that confirms that, if the life or long-term physical or mental health of a woman is not threatened, a pregnancy involving a lethal foetal abnormality is not grounds for a termination in Northern Ireland. Minister Ford has indicated that he will consider that issue. We will pay close attention to any action that is taken by the Department of Justice.

The third category of responses relates to the recommendation in the guidance that any termination procedures should be certified by two doctors. Although we note that the law in Northern Ireland does not require two doctors to certify, we were struck by comments from the two sides of the debate. Those who were pro-life perceived that the requirement protected the foetus. Those who were pro-choice saw it as a level of protection for the doctor. Both sides of the debate saw the benefit of the proposal. On that basis, we intend to retain the recommendation, with a focus on the need to work within professional competence and capacity and seek specialist help in circumstances in which it is actually necessary.

Responses in the fourth category relate to conscientious objection and the ability of a woman to seek a second opinion. In a Northern Ireland context, the issue of conscientious objection is complex. Unlike other parts of the UK, there is no statutory right here for staff to conscientiously object, although limited rights exist in European human rights law. Despite the lack of statutory basis, there was broad agreement that staff should not be forced to participate in procedures to which they object on moral grounds. There is also broad agreement that, in an emergency situation, when the life of a woman is in immediate danger, the needs of the patient should override conscientious objection on moral grounds. We intend to reconsider the issue of conscientious objection to reflect the broad agreement on the issue. We will need to consider the particular Northern Ireland context whereby, as the law stands, any and every termination will, by definition, take place only when there is a threat to the life or health of the woman.

One issue that came to light during the consultation was a woman's right to clarity when she is being told that she cannot access a termination in Northern Ireland and that a decision has been made on medical and not moral grounds. GMC guidance already requires doctors to refer women whom they will not treat on moral grounds to a colleague who can treat them. That is different from and in addition to the working assumption that a patient should normally have access to a second opinion if he or she disagrees with the doctor. Several consultees suggested that a woman should have a right to appeal clinical decisions and that there should be an appeals mechanism. It was also suggested that institutions should have a right to conscientiously object to carrying out terminations. We do not believe that that is possible in the context of the current law in Northern Ireland.

The fifth category of responses relates to the provision of counselling services. That drew particular criticism and will need careful consideration. Two very distinct issues emerged. First, some respondents queried what information can be provided to women on services available elsewhere that are not legal in Northern Ireland. That includes the grey area that was debated at length in the media at the end of last year. Secondly, some respondents sought clarification on the support that women should receive before or after receiving a termination, whether carried out here or elsewhere, and whether it is legal to provide support in those circumstances in Northern Ireland. We are clear that it is not illegal to provide information on services available outside Northern Ireland, nor is it illegal to travel overseas or to accompany someone who travels overseas, even if it is known that she is travelling to receive a termination that may not be legal in Northern Ireland. However, the courts in Northern Ireland have not ruled on whether it is lawful to advocate or promote — that is, to encourage or arrange for someone to have a termination. We will make it clear in our revised guidance that that has not been tested in court, that, in the absence of current law on the subject, it remains a grey area and that practitioners should be mindful of that fact.

We will clarify that all women should, at any stage of the decision-making process, be offered appropriate counselling by Health and Social Care (HSC). We will clarify that all women, regardless of whether they receive a termination in Northern Ireland or elsewhere, should be offered the full range of Health and Social Care services that they are assessed as needing.

The sixth major area that attracted comment in the consultation is the collection and sharing of information. The guidance proposed a new system to collect information. There was broad agreement that, as long as confidentiality is assured, additional information collection is acceptable. The intention is to collect data on the grounds for a procedure and where it took place. That appears

to be relatively straightforward as far as HSC premises are concerned but may require legislative change to access data from private clinics.

The section of the guidance that deals with the legal requirement for staff and others to report crime received much negative comment. As I mentioned, the guidance does not change the law. However, we are aware that the prominence and tone given to the requirement of the criminal law may directly impact on patient confidentiality. There is also some evidence that it has impacted on trust within health teams. Several consultees suggested that women could be reluctant to seek help if they are concerned about their privacy or fear prosecution. We are considering how that is handled in the guidance, its prominence and its presentation, including the tone that is used. It potentially impacts patient confidentiality, which was referred to in the consultation responses.

As a Health Department, our concern is to ensure that women receive the lawful treatment they need, whatever the circumstances. We will redraft the guidance to reflect the comments we received on the subject and will draw from GMC comments and guidance.

The matter of abortifacient drugs being accessed through the Internet was raised in this context particularly and was specifically mentioned by the Committee when we appeared before it last year. We will raise the prominence of that issue and seek to provide more detail on the legal position.

Finally, the seventh major area raised concerns about equality and human rights. That covered not only section 75 issues but UK treaty obligations. The only section 75 issue identified was the potential differential treatment of staff with religious views and their ability to conscientiously object. Many respondents mentioned that the law in Northern Ireland is discriminatory and suggested that, because of the law here, the UK is in breach of several treaty obligations. We do not intend to comment on the impact of Northern Ireland criminal law on treaty obligations.

A number of European Court of Human Rights (ECHR) judgements on legal certainty, the provision of information and the right to appeal were brought to our attention. It is the Department's view that the guidance complies with human rights standards.

You will be aware of a number of other issues. They include the prominence of sections on sexual offences and the need to ensure patient consent. There was support for those sections being removed from the guidance on termination of pregnancy on the grounds that the reporting of sexual offences is principally a matter for safeguarding guidance and that the principle of consent is integral to the provision of healthcare and is covered in guidance on the subject. We are minded to remove the sections and to refer to specific guidance on those matters, perhaps in either a footnote or an annex. That concludes my presentation to the Committee.

As I said, despite the criticism that the draft guidance received, there was a genuine attempt to listen to the broad range of divergent views on this very difficult subject. The views raised in the consultation have been extremely helpful to the Department, and I thank anybody who took the time to respond formally. We are happy to have the opportunity to discuss the matter with the Committee, and we welcome your questions. I am glad to say that, this time, we have medical and midwifery colleagues with us who will be able to address any clinical issues that may arise as we discuss the consultation responses. Thank you very much.

The Chairperson: Thank you. The Department's response refers to the wording of the law and the fact that it is 160 years old. There is a suggestion that the wording of a 160-year-old Act means that health professionals may be criminalised for managing a complex issue. It would appear to many that a law that is 160 years old will be open to interpretation.

I take on board your point about the legislation being outside the remit of the guidance, but the Minister had at one stage suggested that consideration of the issue of fatal foetal abnormality may be within the current legislation. It would seem to many that forcing a woman to continue with an unviable pregnancy to full term and labour, if that is not her wish, could result in psychological distress or damage and is not in the interests of anyone. I specifically want your views on that and would suggest that those circumstances would fall into the category of managing a complex issue.

I note that, throughout the presentation, you said very clearly that this is not about legislation, which is being looked at elsewhere, but that the guidance would be updated. Will the Minister or the Department consider the issue of fatal foetal abnormality further and possibly look at ways in which the guidance could include scenarios, perhaps not definitely, in which fatal foetal abnormality would or should be considered, or has that simply been ruled out?

Ms McDaniel: Given the level of interest expressed in the issue and the very human stories that emerged late last year, the Minister took legal advice. The purpose of his seeking that advice was to establish whether the guidance could deal with the subject of lethal foetal abnormality. The clear legal advice stated that dealing with the issue would require a change in the law, so a process of engagement with the Justice Minister was started. We now know that the Justice Minister intends to pursue a potential change in the law by way of consultation. I think that we are very clear in the guidance that, where there is a risk to —

Dr Margaret Boyle (Department of Health, Social Services and Public Safety): You raise the issue of lethal foetal abnormality and the potential impact that that might have on some women's mental health. The legal advice is clear that, when there is a diagnosis of a baby or a foetus having a lethal abnormality that has an impact on a woman's mental health that is likely to be long-term or permanent, such a case would fit within the current legal framework in Northern Ireland. When the continuation of a pregnancy is not going to endanger a woman's life or have a significant long-term impact on her physical or mental health, it is outside the law in Northern Ireland and not lawful to terminate.

The Chairperson: Is there a responsibility or requirement for the guidance to reflect scenarios? As was said, we are dealing with a complex issue, so, for the sake of clarity, should the guidance list or outline scenarios?

Dr Boyle: We have to provide guidance within the current law. That law allows a termination when a woman's life is in danger or when a continuation of the pregnancy is likely to have a significant and long-term impact on her physical or mental health. For any woman who meets those conditions, for whatever reason, it would be legal to terminate such a pregnancy. When a woman knows that she has a foetus that has a lethal abnormality, and it is clear that she wants to terminate the pregnancy for that reason, and there are no other overriding issues that would have a significant and long-term impact, such cases are outwith the law.

We can certainly look at making some reference to that, but, as Eilís said, the Justice Minister has indicated that he will bring a paper on lethal foetal abnormality to the Executive concerning the situation in which a lethal foetal abnormality or continuation of the pregnancy would not have any significant impact on a woman's health.

The Chairperson: I absolutely accept that that is the current legislative position. I am trying to ascertain the Department's requirements for ensuring that the guidance is absolutely clear. We acknowledge that we are dealing with a very complex issue, so I think that there is room to list specific scenarios clearly, which would include lethal foetal abnormality.

Ms McDaniel: As Margaret said, we need to avoid medical professionals being in a position whereby, in a case of lethal foetal abnormality, there is absolutely nothing that they can do in Northern Ireland, and we need to await the Justice Minister's outcome. If it can be demonstrated that there is a longer-term impact on a woman's mental health, we need to address that and make it clear in the guidance, if that is what you are referring to.

The Chairperson: I am picking up that the Department's remit on the guidance will be considered further.

Ms McDaniel: Given the spotlight on the subject, there is an absolute onus on us to provide clarity.

The Chairperson: The language used in the guidance is also an issue. In our previous session in October, we noted that the language was described as aggressive, patronising and unhelpful. That was made very clear by a number of respondents and medical professionals. You noted at that session that the Chief Medical Officer and the Chief Nursing Officer did not sign off or even see the guidance. Can you confirm that that is the case?

Ms McDaniel: I do not think that we said that the Chief Medical Officer and the Chief Nursing Officer did not sign off on the guidance. I think that what I said was that both, as members of the working group established to draft the guidance, would certainly have had a very strong input.

The Chairperson: Sorry, my notes — I can check it in Hansard — state that the Chief Medical Officer and the Chief Nursing Officer did not proof the document.

Ms McDaniel: I think that it was the way in which the question was phrased: "Did they proof the document?".

The Chairperson: Did they or did they not?

Ms McDaniel: I do not think that it is for the Chief Medical Officer or the Chief Nursing Officer to proof a document. They need to provide their medical advice.

The Chairperson: Sorry, we are dealing with guidance to assist clinicians and the medical profession. Is it not irregular that they would not proof a document?

Ms McDaniel: Maybe it is my understanding, in departmental terms, of the word "proof". The Chief Medical Officer and the Chief Nursing Officer would certainly have had a huge input to the development of the guidance.

On the subject of tone, I think that, in October, I made the point that it was never our intention to be threatening in any way. However, perception is everything, and, if it was construed that the language used in the guidance was threatening, we will certainly seek to avoid that as much as possible in the revision.

The Chairperson: I am going to labour this point a bit. It is not a debate about what is meant by proofing; we all know what proofing is. The issue is whether they signed off on it, and I am not getting an answer.

Ms McDaniel: It is fair to say that they will have signed off on it up to the point at which they provided their input — absolutely they will have signed off on it. A final proofing exercise may have been undertaken by policy officials, for example, to make certain that absolutely everything was in order, format-wise and in any other way. It is fair to say that the Chief Medical Officer and the Chief Nursing Officer would have signed off on the document up to the point at which they had provided input to it.

The Chairperson: Can the Committee have that clarified?

Ms McDaniel: OK.

Mr Beggs: In its response, the Royal College of Nursing (RCN) highlighted that, in relation to patient confidentiality, were nurses to follow the guidance they would:

> *"commit a flagrant breach of the fundamental principle of patient confidentiality, as set out in the Code published by the statutory regulatory body, the Nursing and Midwifery Council, and which could lead to the nurse's removal from the register."*

My question to the Chief Nursing Officer is this: were you aware of the wording in the document that would have caused nurses to have breached their code of practice, resulting in their removal from the register?

Ms Zoe Boreland (Department of Health, Social Services and Public Safety): All nurses are governed by the Nursing and Midwifery Council (NMC) code of conduct, which requires them to treat patient confidentiality as an absolute. That is what we would expect practitioners to do.

Mr Beggs: Were you aware of the wording in the consultation document that would have meant that a nurse would have breached the code of practice, which would have resulted in a nurse being removed from the register? If so, did you make your officials aware of it?

Ms Boreland: I do not understand your question.

Mr Beggs: I am trying to get to the bottom of how wording could be used that could cause nurses to be removed from the professional register if they were to follow the draft guidance. Surely that is a very basic failing in the draft guidance that went out?

The Chairperson: I am sorry, Roy; I should clarify that Ms Boreland is not the Chief Nursing Officer.

Ms Boreland: I am not sure of the context of that; I would need to look at the RCN's response to establish the context.

Mr Beggs: I am sorry; you are the Department's nursing officer, is that correct?

Ms Boreland: Yes, I am. I would need to look at the statement in which the RCN said that.

Ms McDaniel: It is a statement of fact that a failure to comply with a code of conduct could lead to someone being removed from a professional register, subject to consideration by the relevant committee. That is a statement of fact.

Ms Boreland: There has always been a conflict in the NHS code of confidentiality between addressing patient confidentiality and that which needs to be disclosed in the public interest. The whole debate is around the issue of when things are not lawful or when there is proof that something has occurred that is not lawful.

Mr Beggs: I just do not understand how that could have got into the draft guidance. Did the medical officials sign it off before it went to the Minister's office, and then it changed? Did that happen, Ms McDaniel?

Ms McDaniel: I cannot say with absolute certainty what happened. I took up post a very short time ago, so I was not involved in the drafting of the guidance in any way. I have become involved post-consultation, and responses have come into the Department. It is now my responsibility to produce a set of revised guidance, taking account of what came out of the public consultation. I cannot answer your question directly with any degree of veracity at all. However, if you want us to come back to you on that matter, we will be happy to do so.

Mr Beggs: Can you assure us that the next set of guidance will meet the requirements of the basic codes of conduct for nurses and doctors?

Ms McDaniel: Absolutely. That is a must. The guidance cannot run contrary to established codes of conduct for medical staff and professionals.

The Chairperson: I find it very irregular that, irrespective of people's positions and length of time in post, we cannot clarify the sign-off process for guidelines that were so important and were so heavily criticised by the medical profession. We now hear that the nursing officer here is not even aware of the RCN response or has not read it.

Mr Alasdair MacInnes (Department of Health, Social Services and Public Safety): There is a contradiction in several areas, including with gunshot wounds and knife wounds, between the obligation to report a crime and the obligation to treat a patient in confidentiality. It is not just in this area. They exist uncomfortably in the guidance. It is not a mistake. The codes of practice are quite clear that you must respect the confidentiality, and the guidance in the GMC more or less says that you have to make a judgement on whether it is in the interests of the general public to reveal whether a crime has taken place or to respect confidentiality.

The Chairperson: Sorry, Alasdair, my point is in relation to Roy's point that the response was, "I am not aware of that". I find that irregular. I find it irregular that the RCN response has not been examined in more detail.

Ms Boreland: I need to clarify that I am aware of the code and of the responsibility on nurses to protect confidentiality. However, I am also aware that, under the code, nurses have to work within the law. As Alasdair said, the section that this relates to is when there is that difficulty of whether they are aware of a situation where there has been something unlawful.

The Chairperson: Can I be very direct? Have you read the RCN response?

Ms Boreland: Yes, I have.

The Chairperson: Part of the response document that we received was about medical professionals suggesting that the draft guidance introduced a level of doubt rather than clarity. In my view, that is a

damning indictment of the fact that the whole purpose, as I stated earlier, of the guidance was to provide that clarity for clinicians. So, having accepted that, does the Minister or the Department accept that the document needs a fundamental rethink?

Ms McDaniel: If it is not providing the clarity that it is intended to provide, we will absolutely need to look at the guidance again, and we are doing exactly that at the minute. I have given you an idea about how we intend to respond to some of the issues that were raised. I will say this again: we want to provide clarity. If we have not provided clarity, that suggests to me that a revision is absolutely needed. Whether or not it is a fundamental rewrite remains to be seen. I do not think that it requires a fundamental rewrite, but it certainly needs revision.

The Chairperson: Finally, can you explain why the earlier drafts from 2009 or 2010 or thereabouts, which were subject to scrutiny by the courts as well, were not simply amended in light of that scrutiny? Two fairly minor amendments were proposed. Why were those guidelines not adopted?

Mr MacInnes: A new Minister came in with his own views. He let the Department know his views, and the Department changed the document.

The Chairperson: OK. Thank you for that.

Mr Wells: Ms McDaniel, can I take it that the procedure is simply to interpret the law properly as it stands and does not in any way seek to change the present law in Northern Ireland?

Ms McDaniel: It cannot change the current law. It is a matter of interpretation of the law and providing clarity about what the law actually means.

Mr Wells: I should have said before I started questioning that I am vice-chair of the all-party pro-life group and have very strong personal feelings about the matter, just in case you were not aware of that. What is procedure when you go through the consultation period through to the final conclusion?

Ms McDaniel: It is the Minister's intention to clear the revised guidance through the Executive again. Given the nature of the subject — it is a controversial matter, and the fact that people have come before you several times now indicates that it is a controversial matter — it will go back to the Executive again for final clearance before it is finally published.

Mr Wells: Who has the final say on whether the guidelines are published or not?

Ms McDaniel: It will go to the Executive for approval for publication. Ultimately, it is an Executive decision whether or not to approve.

Mr Wells: You know that a previous set of guidelines introduced by Mr McGimpsey was taken to judicial review by the Society for the Protection of Unborn Children, and the basis of the judge's decision to overturn the guidelines was a lack of proper allowance for freedom of conscience by those, including many of my relatives who are in the health profession, who would never want to be in the position of terminating the life of any child. Do you believe that the present guidelines properly reflect that judgement?

Ms McDaniel: It deals with the issue of conscientious objection and acknowledges that there should be an allowance made for those who want to conscientiously object. There are some peculiarities in Northern Ireland, in the sense that most determinations that take place here will probably happen in emergency situations. So, it may reduce the scope to conscientiously object. I think that needs to be made clear in the document, and it will be made clear in the revised document.

Mr Wells: You have led into my next question because you alluded to this issue. Could it be that someone who has profound moral objections, rather than religious objections, to the termination of life could be forced to terminate that life because of the medical situation in which the mother finds herself?

Ms McDaniel: If it was an emergency situation. I will ask Margaret to come in here.

Dr Margaret Boyle: I would hope that we would never get to that position, but if you have a mother whose life is in immediate danger and someone does not intervene to save her life there and then, there is the likelihood that she and the foetus will die. If that situation were to present itself, I would like to think that there would be some other clinician who could take over the role of managing the mother, but, theoretically, you could be faced with the situation that there might not be someone else there, and they may well have to intervene.

Mr Wells: There have been 6·7 million abortions in Great Britain since 1967, and 162 fell into that category. So, the chances of that set of circumstances being encountered in Northern Ireland are very slim indeed.

Dr Margaret Boyle: Should that happen, I would like to think that there would be another health professional in the hospital at that point in time. I hope that the scenario that you have painted would not arise, but, theoretically, it is possible.

Mr Wells: Well, then, I am slightly dubious as to whether the guidelines cover every eventuality where someone of a very profound Christian background could technically be placed in the position of doing something that he or she could never, in conscience, do. However, as I said, the chances of that happening are very slim.

Last week, you published the statistics for abortions in Northern Ireland, and the total was 51, 50 of whom were from Northern Ireland. What you did not do — it is important that we know this to see the extent of the problem — is explain the difference between abortions and evacuations. There was a situation that I came across in my own family quite recently of a stillborn child who was dead in the womb, and that child, for very obvious reasons, had to be evacuated from the womb. That, to me, is not an abortion; it is a medical procedure. With regard to the 51 abortions that have been totalled per trust area, what do they constitute? The reason why this is relevant is that it indicates the law as it presently stands.

Dr Margaret Boyle: Yes, I am aware of the statistics that were published. Those would be terminations of pregnancy within Northern Ireland that met the current legal framework. They would not include the situations that you described, where the foetus was dead and had to be delivered. That would be a stillbirth. There are other situations. We talk about spontaneous miscarriage or spontaneous abortion. Obviously, it does not include any of those, so it would be those where there was a medical reason to terminate the pregnancy.

Mr Wells: Yet the figures published on 6 August 2012 did include those spontaneous abortions and evacuations as part of the overall figure. There is no breakdown in the figures that you have now given us to indicate how many of those that a reasonable person would not consider to be abortions there were.

Dr Margaret Boyle: If I understand you correctly, there was a time when the figures that were published were, we thought, around 80 terminations of pregnancy per year. An audit established that some of the procedures were not being coded correctly. An audit was done of the coding going back about four or five years, and the figures were then revised, and there were around 40-ish, or figures in the low 40s, that were true terminations of pregnancy. The other subgroup that would have made up the numbers was people who may have had a miscarriage — a spontaneous abortion — and had gone into hospital for some management, were discharged and were re-admitted because some of the products of conception were still there.

It is the coding convention that requires it to be coded in that way, and those were coded as part of medical abortion, but they were separate and different from the terminations of pregnancy. That is a UK-wide coding convention that applies across all reasons for admission and diagnoses. We could ask our information colleagues whether they could get that information for you.

Mr MacInnes: Those figures are available.

Mr Wells: That is helpful and gets round that issue.

Allied to and combined with the publication of the guidelines was a commitment that an explanation would be given to the Department of the reasons for every one of the abortions carried out within the

guidelines. In that case, that is the 51 that we are talking about. That has not happened, yet it was promised to run in tandem with the publication of the guidelines. What has happened there?

Dr Margaret Boyle: One of the things we said was that that should happen in tandem with publication of the guidelines. We would probably envisage a care pathway for women, because each and every case will be individual and assessed on its own merit. When the guidance is published, one of the parts of full implementation of it would be the collection of more detailed information. That is a change to what has been in place and was part of the consultation.

Mr Wells: But the guidance has been published. Are you talking about the final version rather than a draft?

Dr Margaret Boyle: Yes, rather than a consultation, it will be the final version.

Mr Wells: Why was it not possible to publish that information in combination with the draft guidance that is before us?

Dr Margaret Boyle: One thing that the consultation consulted on was enhanced data collection around the individual cases of termination of pregnancy.

Mr Wells: But how does the Department know that those 51 terminations were carried out in line with existing guidance if there is no publication of the information to show why the termination was carried out in the first place?

Dr Margaret Boyle: Every practitioner has to practise within the law. Each individual trust has to ensure that the services that it delivers are within the law. It is the responsibility of the trusts and individual health professionals to practise —

Mr Wells: But how do you know that a doctor is reading the guidelines correctly?

Dr Margaret Boyle: I do not think we can ever —

Mr Wells: If he does not tell you why he did it, how on earth do you know whether he interpreted the guidelines correctly? It is shrouded in mystery.

Ms McDaniel: And that is why we are proposing to enhance the system of data collection, so that we do know.

Mr Wells: In reply to a question for written answer that I posed to the Minister in early 2012, we were told that, from the next quarter, there was going to be a publication of statistics on abortions that would indicate how each abortion tied in with existing guidelines. That did not happen. We are still here 18 months later, and it has not happened.

Ms McDaniel: The guidelines do not exist at present. We issued a draft for consultation, and, until we finally publish, the guidance does not exist.

Mr Brady: Thank you for your presentation. You have answered some of the questions that I was going to ask about the conscientious objection. In the 162 cases that Jim mentioned, it becomes more of a moral dilemma than a moral decision, because the choice has to be made. You said that if that situation arises, somebody has to make a decision if the mother's life is in imminent danger.

I have a couple of other things. With regard to the consultant psychiatrist and the two doctors, there is a difference between assessing mental health and actually diagnosing it. I would imagine that, as part of a doctor's training, they would have some training in that area, but not necessarily specialist knowledge. If a doctor is not sure, presumably he or she would seek a further opinion. It seems that it may portray a lack of trust, in a sense, of the medical profession, because you have all those layers of checks and balances. That may be an issue.

Some international human rights organisations have expressed some concern because there are issues where, for instance, somebody may become pregnant through a criminal act, whether that is rape or incest or whatever. Those issues need to be addressed, and there is the possibility that they

have not been fully addressed in the guidelines. The other point that has been made already is that the guidelines are to provide clarity, rather than doubt, but, in my view, they seen to introduce more doubt than clarity to the medical profession. Do you have any comments on that?

Dr Margaret Boyle: You raised the issue about the role of mental health assessment and the psychiatrist and whether it should be other doctors and what sort of training they have. You are quite right when you say that all doctors, as part of their training, will have training in mental health assessment. For example, GPs will do mental health assessments quite regularly in their practice, and that can be different from managing someone who has a significant mental illness. The same would go for obstetricians, who, as we know, probably see quite a lot of women with postnatal depression, so there is an element of mental health assessment etc there. The General Medical Council requires all doctors to work within their competence, and if they feel that they do not have the sufficient knowledge and expertise for whatever the clinical issue might be, they should seek help from someone who has expertise in that area. That goes for all branches of medicine, not just in this particular area. I hope that that answers your question.

Mr Brady: There is the issue of the criminal aspect.

Mr MacInnes: The law on the criminal aspect is the same as in GB. It is still regulated by the 1861 Act. That could be changed if the Minister of Justice were minded to take it forward. The guidance cannot really address it, because, in itself, it is not grounds for termination.

Mr Brady: If, for instance, that person were going to suffer psychological trauma, presumably that would fall into the category of mental health assessment and the diagnosis.

Mr MacInnes: Absolutely.

Mr Brady: There is a follow-on from that.

Mr Beggs: On that issue, there has been discussion in the summary of responses on the issue of whether a consultant psychiatrist would be required. Has there been any conclusion from the Department? Has it accepted the general medical view that has come from the responses?

Ms McDaniel: I think that we have accepted that we will certainly not make it a requirement.

Dr Margaret Boyle: We have given it a lot of consideration, given the views that have been expressed by the consultees.

The Chairperson: I want to pick up on the point about the international commentary around human rights. Collectively, whether it is a remit of the legislation or not, we should be concerned if there is a concern that the guidelines may not be compliant with international rights human law, particularly, as Mickey Brady outlined, in relation to a criminal offence where a women undergoes rape or incest. I think that we should not shirk our responsibilities on that.

We certainly want clarification from you on the sign-off of the guidelines by the Chief Medical Officer or the Chief Nursing Officer. We request that clarification in writing from you. Given the enormity of this and the need to get the guidelines right, it would be appropriate for the revised guidelines to be brought back to the Committee in advance of them being taking to the Executive to allow us to fully implement our scrutiny role.

Just for clarification, Eilís, before you go, you indicated that the issue of lethal foetal abnormality may be referred to in the guidelines. Is that my understanding of what you said?

Ms McDaniel: Given everything that has happened, it is essential that it is referred to in the guidance.

The Chairperson: OK. I appreciate that. Thank you for your time and clarification.