C1/2020/0822

IN HER MAJESTY'S COURT OF APPEAL IN ENGLAND

CIVIL DIVISION

ON APPEAL FROM THE DIVISIONAL COURT (Claim CO/1402/20202)

(SINGH LJ AND CHAMBERLAIN J)

APPEAL AGAINST REFUSAL OF PERMISSION FOR JUDICIAL REVIEW

BETWEEN:

R (CHRISTIAN CONCERN)

Claimant/Appellant

-v-

SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE

Defendant/Respondent

GROUNDS OF APPEAL and SKELETON ARGUMENT IN SUPPORT OF AN APPLICATION FOR PERMISSION TO APPEAL FROM THE COURT OF APPEAL TO THE SUPREME COURT

Reference in square brackets in bold, are to the draft judgment paragraphs.

The Court of Appeal has erred in holding that the following grounds of appeal should be dismissed:

Ground 5(a) The decision is *ultra vires* s. 1 of Abortion Act 1967 [35 – 50]:

1. By refusing to admit relevant and admissible evidence, namely the statements of Kevin Duffy and the second statement of Dr Gardner, the court was driven to conclusions [40 – 50] that would be unsustainable if this evidence had been admitted.

2. The court found that the second statement of Dr Gardner and statements of Kevin Duffy were inadmissible because their evidence was immaterial, as the court's role was "to adjudicate on the lawfulness of the decision under challenge" **[5].** With respect, their evidence was anything but immaterial, as it went to the heart of the matters to be adjudicated on.

3. The statement of Dr Duncan suggested that in order for an Early Medical Abortion (EMA) to take place, the entirety of the process would consist of a video consultation with a non-Registered Medical Practitioner (RMP), backroom discussions between the medical professionals, and a prescription simply handed over in the clinic. The Divisional Court was materially misled by Dr Duncan's evidence, hence the relevance of Mr Duffy's evidence (Duffy first witness statement para 10 – 17 and 32). Consequentially, the findings by the Court **[40 – 50]** are in error.

4. Whilst it is right that **[41]** "in each case context is vitally important" it does not follow that simply because there are radical developments in medical science and new "prevailing conditions", that legislative interpretation should become so expansive that the original statute is left with little or no meaning. The general principle of statutory interpretation is that any delegation of legislative power to the Executive, is to be interpreted *restrictively. R (The Public Law Project) v Lord Chancellor [2016] UKSC 39 at 23.*

5. The Court concluded that **[43]** the Claimant's submissions failed to "reflect what has been the reality of practice for some years." However, developments in medical practice, whilst they may be commonplace, do not become lawful for that reason alone, especially if they are a departure from long established practice, and are poor practice. Whilst the 2014 Department of Health Guidance envisaged a discussion by phone or webcam, this was *with an RMP*. A fortiori, the dangers of relying solely on phone/video call by a non-RMP, are clearly legion (Gardner second statement para 4).

6. The Court placed too great a weight on the Royal College of Obstetricians and Gynaecologists' (RCOG) 2020 guidance, in particular, that in order to determine Gestational Age (GA), primary reliance should be placed on the mother. Whilst in many cases this might be sufficient, the removal of an in-

person attendance at a clinic removes an important safeguard for the foetus and the mother (Duffy 1st statement para 26]. There is now evidence that women whose gestational age is clearly past 10 weeks have obtained EMA and this has on occasion resulted in death (Duffy 2nd statement para 37 and 38). Whether the EMA was obtained by way of dishonesty or ignorance is irrelevant. There was relevant and admissible evidence of the same that should have been before the court (Duffy second statement paras 37 – 40). In the alternative, it is unconscionable that the burden of diagnosis falls to the patient, even if this is the view of the RCOG.

7. If the court had permitted the evidence of Mr Duffy the Court would not have been able to come to the erroneous conclusion that **[44]** "technology has obviated the need for personal attendance at a clinic by a woman seeking an assessment for EMA." The evidence was that although phone consultations are an important feature of modern medicine, until the recent pandemic it was still routine for [Duffy 1st statement, para 12] "women presenting for an EMA to be clinically assessed for suitability, including an ultrasound scan and blood tests." Marie Stopes UK states on its website that after the remote consultation the woman will attend a clinic and on that visit will have an assessment which covers the ultrasound scan, her general health, blood pressure check, blood tests, and tests for sexually transmitted infections (STIs). It goes on to say, "We will assess how many weeks pregnant you are using ultrasound scanning."

8. The court conflated the permission granted to woman to take the first pill at home under 2018 approval, with the far more general approval in 2020 for *all stages* of an EMA to take place at home **[45 and 46].** It does not follow that simply because there has been no successful challenge to the 2018 approval that all stages of an EMA can and should take place at home. This reasoning fails to acknowledge the many other steps that all the main UK providers of EMAs took prior to the pandemic. The analogy drawn to prescribed medication being handed over by a nurse, is flawed. There is simply no comparison. Mifepristone is not a 'medicine', it has no healing properties, but instead causes the death of the foetus and there are multiple risks to the mother (Gardner 1st statement para 6) and therefore its administration has, and should be, tightly regulated. The proper comparator would be the administration of methadone by a pharmacist.

9. The court comments that **[47]** "there is no good evidence before this court upon which to begin to find that the nature and effect of the first pill is such as to render the same unsafe to be taken in a home." It is unclear why the court needed this to be evidenced, it is a matter of common sense that a drug that causes the death of a foetus and which might be administered to a woman in a state of coercion (as recognised by Lord Bethel and the Secretary of State) would be unsafe to take at home. The effects of mifepristone were set out in the Claimant's facts and Grounds from the outset and no challenge was made [Statement of Facts para 52]. In addition, the court needed to look no further than the Northern Irish High Court judgment of *JR76 [2019] NIQB 103*, the effects of Mifepristone are noted to cause a miscarriage [para 22], the contraindications for both drugs are listed at [para 31 and 56]. Whilst it is now possible for misoprostol to be taken at home, until the approval it remained important for the drug to be administered from the clinic for the aforementioned reasons as the contraindications for the drugs were more likely to manifest after ingestion of mifepristone.

10. Whatever the purported purpose of the Approval was, what is relevant is the actual means and effect. Following analysis of this, consideration is to be given as to whether the Approval falls within the original legislative purpose. The claimant concedes that the stated purpose was **[48]** "in the context of a public health emergency…to ensure the continuance of the protection of the health of women." However, the means to effect this purpose had many consequential dangers which the court makes no reference to: risks of coercion (Gardner 1st statement para 33), risks of an abusive relationship (Lord Bethel page 212 joint bundle), increased risks of medical complications through the removal of clinical safeguards (Duffy 1st statement para 10 – 17).

11. The court found that the RMP **[49]** "remains in charge throughout the procedure" but failed to explain how. There is no answer to the Claimant's submission that once the pills have been posted to the woman, the RMP has no control. The RMP has no power to recall the pills or to ensure that they are taken in a timely manner. To suggest misoprostol is similar to other drugs is a non-sequitur. There was no response to the Claimant's submission [skeleton argument in support of appeal para 17] that "it is difficult to see exactly what

treatment any of the doctors are undertaking, under the analysis of the Divisional Court, aside from a remote signing of the HSA/1 and the prescription. It is the doctor's role in the administration of drugs, not just in the prescription, that determines whether the treatment is "by a RMP"."

12. Therefore, the Court erred in its analysis of *"terminated by a registered medical practitioner"* in s. 1(1) of the Abortion Act 1967. Where pregnancy is terminated by self-administration of a drug, after an e-consultation with a clinician (not necessarily a doctor) and the HSA/1 being signed off by a doctor resulting in the prescription being posted to a patient; the pregnancy is not *'terminated by an RMP'*: *RCN v DHSS* [1981] AC 800*; Doogan v Greater Glasgow and Clyde Health Board* [2014] UKSC 68*; British Pregnancy Advisory Service v Secretary of State for Health* [2011] EWHC 235 (Admin)*; JR76* [2019] NIQB 103. *SPUC Pro-Life Scotland v Scottish Ministers* [2019] CSIH 31 is clearly distinguishable from this case.

Grounds 6 (a) the decision is contrary to the legislative purpose of the 1967 Act (Padfield) [51 – 56]

13. The Court erred in holding that the decision was consistent with the legislative purpose to ensure that abortions are carried out with proper skill and in hygienic conditions.

14. Lord Keith in RCN at 835 found: "policy and purpose of the Act which was directed to securing that socially acceptable abortions should be carried out under the *safest conditions attainable*." [Emphasis added].

15. Whilst Parliament did not **[55]** "stipulate where abortion must be carried out", it does not follow that anywhere will do. It is an over-simplification to suggest that the class of place must be 'safe and suitable' simply for the purposes of taking the 'medication' alone. In fact, there is far more involved in an EMA than just 'taking the medication', there are substantial dangers to woman when none of the EMA procedure takes place at a clinic; supra [9].

16. In any event, there is insufficient justification for a departure from *RCN* [Lord Diplock at 928] "treatment must be carried out in a National Health Service hospital (or private clinic specially approved for that purpose by the minister)."

17. The court observes that the stated purpose of the 2020 Approval was to **[56]** "meet a public health emergency" and therefore this cannot frustrate the purposes of the 1967 Act. Again, the stated purpose is only a single consideration and is not ultimately determinative *per se*. If the unintended side-effect of the Approval is the removal of important safeguarding measures, an increase in deaths etc, these are important factors to be considered in the equation. However, there is no evidence that the court properly considered these countervailing considerations.

Grounds 5(b) and (c) [57 – 61] Failure to admit Hansard under *Pepper v Hart*

18. From Hansard, it is unquestionably the case that the purpose and policy of s. 1(3A) for *Padfield* purposes was to enable the Secretary of State to allow other already regulated places to carry out abortions e.g. GP surgeries. It was never intentioned to permit major reform of the substantive regulatory framework through the legalisation of self-administered home abortions.

19. *Pepper v Hart* evidence is admissible to ascertain the legislative purpose of s. 1(3A), and shows that the power was conferred on the Secretary of State to enable a designation of safe and hygienic places such as GP surgeries, and expressly not of 'home'. The Divisional Court has failed to consider the Hansard record in the context of *Padfield* argument.

20. The Court erred in refusing to admit *Pepper v Hart* evidence. The cases cited under Ground 5(a) above, demonstrates that there is an ambiguity in the words *"terminated by a registered medical practitioner",* and especially in reconciling s. 1(3A) with that requirement; so that the *Pepper v Hart* test is met. The court found that no assistance was needed from Hansard as **[60]** "the meaning was determined, namely that the RMP is in charge of the termination but it is not required to take part in every aspect of the process". This finding is derived from *RCN,* however the House of Lords finding was predicated on the abortion taking place in a hospital (Lord Diplock at 928). As the approval relates to a non-clinical setting this dictum does not assist the court.

21. The constant advances in abortion procedure and medical practice have, in part, caused the ambiguity, hence the constant litigation at the Highest Judicial levels.

It is self-evident that language is ambiguous hence the need for recourse to Hansard.

22. The words of s. 1(3A) prima facie confer an extremely wide discretion on the Secretary of State; the literal interpretation by the Divisional Court (para 48) and adopted by the Court of Appeal **[60]** would suggest an almost unfettered discretion. Therefore, there must be implied limits and to resolve this ambiguity a recourse to Hansard is required in accordance with *Pepper v Hart*.

23. By adopting the Divisional Court's approach to the consideration of Hansard, the Court of Appeal has repeated the same error. The statement of Ken Clark MP should not be read in isolation, but rather alongside the mover of the amendment, Mr Key MP. Ann Widdecombe MP suggested that the amendment was "a paving measure - even if it is not intended as such - for self-administered home abortion", the author of the amendment (Mr Key MP) immediately responded "That is not the intention and, quite inadvertently I am sure, my hon. Friend has been *very misleading*.". "The intention" clearly referred to the legislative intention of the provision. Ken Clark MP then stated that the intention of the legislation was to enable an approval of places like GP surgeries. The Divisional Court and the Court of Appeal undertook no analysis of Ken Clark's comments in context, which gave an unequivocal assurance that (1) Miss Widdecombe was mistaken, (2) that the amendment only envisaged administration of the pill "in closely regulated circumstances", and (3) the power might only be used to designate regulated, doctor-run places like GP surgeries but not unregulated places like home.

24. Hansard plainly resolves any dispute over the meaning of s. 1(3A). the suggestion that there could be an approval of all "homes of a pregnant woman" was unequivocally ruled out by the amendment's mover and by the responsible Minister.

Ground 6(b) failure to admit Pepper v Hart evidence to ascertain the legislative purposes of s1(3A)

25. The legislative purpose is not clear and recourse to *Pepper v Hart* was paramount.

Michael Phillips

Counsel for the Claimant/Appellant

23 September 2020