IN THE HIGH COURT OF JUSTICE

QUEENS BENCH DIVISION

ADMINISTRATIVE COURT

URGENT APPLICATION FOR PERMISSION FOR JUDICIAL REVIEW

BETWEEN:

Her Majesty the Queen

(on the application of CHRISTIAN CONCERN)

Claimant

-v-

Secretary of State for Health and Social Care

Defendant

Index of documents submitted with the Claim Form

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Judicial Review
Application for urgent consideration

In the High Court of Justice Administrative Court	
Claim No.	
Claimant(s) *(including ref.)*	R (Christian Concern)
Defendant(s)	Secretary of State for Health and Social Care
Interested Party(ies)	

This form must be completed by the Claimant or the Claimant's advocate if exceptional urgency is being claimed and the application needs to be determined within a certain time scale.

The claimant, or the claimant's solicitors must serve this form on the defendant(s) and any interested parties with the N461 Judicial review claim form.

To the Defendant(s) and Interested Party(ies)
Representations as to the urgency of the claim may be made by defendants or interested parties to the relevant Administrative Court Office by fax or email:-

For cases proceeding in

London	**Fax:** 020 7947 6802 **email:** administrativecourtoffice.generaloffice@hmcts.x.gsi.gov.uk
Birmingham	**Fax:** 0121 250 6730 **email:** administrativecourtoffice.birmingham@hmcts.x.gsi.gov.uk
Cardiff	**Fax:** 02920 376461 **email:** administrativecourtoffice.cardiff@hmcts.x.gsi.gov.uk
Leeds	**Fax:** 0113 306 2581 **email:** administrativecourtoffice.leeds@hmcts.x.gsi.gov.uk
Manchester	**Fax:** 0161 240 5315 **email:** administrativecourtoffice.manchester@hmcts.x.gsi.gov.uk

You must complete sections 1 to 5 and attach a draft order.

SECTION 1 Reasons for urgency

The Defendant's decision, of which the public has had no advance notice, came into force with immediate effect. It is likely that, pursuant to that decision, unlawful abortions will be taking place within days rather than weeks, and may well be taking place already. That entails serious risks to the health and well-being of the patients (see the expert evidence at p.p. [ref] of the bundle), and that the protection given in law to the life of unborn children is not complied with. It is therefore necessary to consider this claim as a matter of urgency.

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SECTION 2 Proposed timetable

2.1 How quickly do you require the application (Form N463) to be considered?
This will determine the timeframe within which your application is referred for consideration.

a)	☑	Immediately **(within 3 days)** – indicate in hours (eg. 2 hours, 24 hours etc.)	72	Hours
b)	☐	Urgently **(over 3 days)** – indicate in days (eg. 4 days, 6 days etc.)		Days

2.2 Please specify the nature and timeframe of consideration sought.

a)	☐	**Interim relief** is sought and the application for such relief should be considered within		Hours/Days
b)	☑	**Abridgement of time for AOS** is sought and should be considered with	3	Hours/Days
c)	☑	**The N461 application for permission** should be considered within	10	Hours/Days
d)	☑	**If permission for judicial review is granted,** a substantive hearing is sought by	7 May	Date

SECTION 3 Justification for request for immediate consideration

Date and time when it was first appreciated that an immediate application might be necessary.

Date: 30 March 2020 Time:

Please provide reasons for any delay in making the application.

Despite the urgency of this matter, the Claimant and its solicitors believed that compliance with the pre-action protocol might resolve or narrow down at least some of the issues, and ultimately save time.

Pre-action letter was sent on 1 April 2020; the response was requested by 8 April. Regrettably, at the time of filing this application, no response has been received.

What efforts have been made to put the defendant and any interested party on notice of the application?

A very detailed pre-action letter was sent to the Government Legal Department on 1 April 2020.

SECTION 4 Interim relief *(state what interim relief is sought and why in the box below)*

A draft order must be attached.

Please see attached draft order for (a) directions and (b) specific disclosure

SECTION 5 Service

A copy of this form of application was served on the defendant(s) and interested parties as follows:

Defendant

☐ by fax machine to
Fax no.
time sent
time

☐ by handing it to or leaving it with
name

☐ by e-mail to
e-mail address
newproceedings@governmentlegal.gov.uk

Date served
Date
16 April 2020

Interested party

☐ by fax machine to
Fax no.
time sent
time

☐ by handing it to or leaving it with
name

☐ by e-mail to
e-mail address

Date served
Date

I confirm that all relevant facts have been disclosed in this application

Name of claimant's advocate
name
Michael Phillips

Claimant (claimant's advocate)
Signed

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Judicial Review
Claim Form

Notes for guidance are available which explain how to complete the judicial review claim form. Please read them carefully before you complete the form.

In the High Court of Justice Administrative Court	
Help with Fees - Ref no. (if applicable)	H W F – –

For Court use only	
Administrative Court Reference No.	
Date file	

Seal

Is your claim in respect of refusal of an application for fee remission? ☐ Yes ☑ No

SECTION 1 Details of the claimant(s) and defendant(s)

Claimant(s) name and address(es)

name
Christian Concern

address

Telephone no. **Fax no.**

E-mail address

Claimant's or claimant's legal representatives' address to which documents should be sent.

name
Andrew Storch Solicitors

address
Citygate
95 Southampton Street
Reading,
RG1 2QU

Telephone no.
01189 584407

Fax no.

E-mail address
a@andrewstorch.co.uk

Claimant's Counsel's details

name
Michael Phillips

address
Citygate
95 Southampton Street
Reading, RG1 2QU

Telephone no.
07973953971

Fax no.

E-mail address
michael@michaelphillipslawyer.co.uk

1st Defendant

name
Secretary of State for Health and Social Care

Defendant's or (where known) Defendant's legal representatives' address to which documents should be sent.

name
Government Legal Department

address
102 Petty France
Westminster
SW1H 9GL

Telephone no. **Fax no.**

E-mail address
newproceedings@governmentlegal.gov.uk

2nd Defendant

name

Defendant's or (where known) Defendant's legal representatives' address to which documents should be sent.

name

address

Telephone no. **Fax no.**

E-mail address

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SECTION 2 Details of other interested parties

Include name and address and, if appropriate, details of DX, telephone or fax numbers and e-mail

name

address

Telephone no.

Fax no.

E-mail address

name

address

Telephone no.

Fax no.

E-mail address

SECTION 3 Details of the decision to be judicially reviewed

Decision:

The Abortion Act 1967 - Approval of a Class of Places

Date of decision:

30 March 2020

Name and address of the court, tribunal, person or body who made the decision to be reviewed.

name

Mark Davies, Director, Population Health

address

Department of Health and Social Care
39 Victoria Street
London
SW1H 0EU

SECTION 4 Permission to proceed with a claim for judicial review

I am seeking permission to proceed with my claim for Judicial Review.

Is this application being made under the terms of Section 18 Practice Direction 54 (Challenging removal)? ☐ Yes ☑ No

Are you making any other applications? If Yes, complete Section 8. ☑ Yes ☐ No

Is the claimant in receipt of a Civil Legal Aid Certificate ☐ Yes ☑ No

Are you claiming exceptional urgency, or do you need this application determined within a certain time scale? If Yes, complete Form N463 and file this with your application ☑ Yes ☐ No

Have you complied with the pre-action protocol? If No, give reasons for non-compliance in the box below. ☑ Yes ☐ No

Have you issued this claim in the region with which you have the closest connection? (Give any additional reasons for wanting it to be dealt with in this region in the box below). If No, give reasons in the box below. ☑ Yes ☐ No

Does the claim include any issues arising from the Human Rights Act 1998?
If Yes, state the articles which you contend have been breached in the box below. ☑ Yes ☐ No

Articles 2 and/or 8

SECTION 5 Detailed statement of grounds

☐ set out below ☑ attached

SECTION 6 Aarhus Convention claim

I contend that this claim is an Aarhus Convention claim ☐ Yes ☑ No

If Yes, indicate in the following box if you do not wish the costs limits under CPR 45.43 to apply.

If you have indicated that the claim is an Aarhus claim set out the grounds below, including (if relevant) reasons why you want to vary the limit on costs recoverable from a party.

SECTION 7 Details of remedy (including any interim remedy) being sought

1. Certiorari to quash the Approval
2. a declaration that, notwithstanding any such Approval, a self-administration of abortion drugs at home does not satisfy the requirements of s. 1 of Abortion Act 1967.
3. Further and other relief
4. Costs

SECTION 8 Other applications

I wish to make an application for:-
1. To expedite the claim
2. Specific disclosure

SECTION 9 Statement of facts relied on

Please see attached

Statement of Truth

I believe (The claimant believes) that the facts stated in this claim form are true.

Full name Michael Phillips

Name of claimant's solicitor's fir Andrew Storch Solicitors

Signed _____ Position or office hel Consultant

Claimant ('s solicitor)

(if signing on behalf of firm or company

SECTION 10 Supporting documents

If you do not have a document that you intend to use to support your claim, identify it, give the date when you expect it to be available and give reasons why it is not currently available in the box below.

Please tick the papers you are filing with this claim form and any you will be filing lat .

☐ Statement of grounds	☐ included	☑ attached
☐ Statement of the facts relied on	☐ included	☑ attached
☐ Application to extend the time limit for filing the claim for	☐ included	☐ attached
☐ Application for directions	☐ included	☑ attached
☑ Any written evidence in support of the claim or application to extend time		
☐ Where the claim for judicial review relates to a decision of a court or tribunal, an approved copy of the reasons for reaching that decision		
☑ Copies of any documents on which the claimant proposes to rely		
☐ A copy of the legal aid or Civil Legal Aid Certificate *(if legally represented)*		
☑ Copies of any relevant statutory material		
☑ A list of essential documents for advance reading by the court *(with page references to the passages relied upon)*		
☐ Where a claim relates to an Aarhus Convention claim, a schedule of the claimant's significant assets, liabilities, income and expenditure.	☐ included	☐ attached

If Section 18 Practice Direction 54 applies, please tick the relevant box(es) below to indicate which papers you are filing with this claim form

☐ a copy of the removal directions and the decision to which the application relates	☐ included	☐ attached
☐ a copy of the documents served with the removal directions including any documents which contains the Immigration and Nationality Directorate's factual summary of the case	☐ included	☐ attached
☐ a detailed statement of the grounds	☐ included	☐ attached

Reasons why you have not supplied a document and date when you expect it to be available:-

Signed _____ Claimant ('s Solicitor)_____

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Statement of Facts Relied on
and
Grounds for Judicial Review

References in square brackets are to the page numbers in the bundle submitted with the Claim Form.

Essential reading: Application for urgent consideration **[3-5]**; Statement of Facts and Grounds **[12-35]**; Expert report of Dr Gregory Gardner **[213-225]**,

Introduction

1. This is an application for permission for judicial review against the '*Approval of a Class of Places*' under s. 1(3) and s. 1(3A) of Abortion Act 1967, dated 30 March 2020 and signed by Mark Davies, the Director of Population Health at DHSC **[38-39]**. The decision was published at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876740/30032020_The_Abortion_Act_1967_-_Approval_of_a_Class_of_Places.pdf

2. The effect of the decision is to approve "the home of a pregnant woman" as a class of places where an abortion may be carried out under s. 1 of the 1967 Act.

3. *Christian Concern* is a pro-life, non-profit campaigning NGO. Further details of the Claimant's involvement of abortion issues over the years are given in paras 67-68 below.

Factual background

4. S. 58 of the Offences Against the Persons Act 1861 provides:

Administering drugs or using instruments to procure abortion.

Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and being convicted thereof shall be liable to be kept in penal servitude for life.

5. S. 59 provides:

Procuring drugs, &c. to cause abortion.

Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanor, and being convicted thereof shall be liable to be kept in penal servitude

6. S. 1 of the Abortion Act 1967 has decriminalised abortions in England and Wales subject to a number of requirements. One of those requirements is that "*any treatment for the termination of pregnancy must be carried out in a hospital vested in the Secretary of State for the purposes of his functions under the National Health Service Act 2006 or the National Health Service (Scotland) Act 1978 or in a hospital vested in National Health Service trust or an NHS foundation trust or in a place approved for the purposes of this section by the Secretary of State*".

7. In late 1980s, the pharmaceutical industry developed a new method of abortion, effected by administration of a drug known as Mifepristone (which kills the foetus), and some 48 hours later, another drug known as Misoprostol (which expels the dead foetus from the mother's womb). It thus became technically possible for the abortion procedure, or parts of it, to take place at home, and/or to be carried out by the pregnant woman herself. Nevertheless, such course remained illegal under s. 1 of the Abortion Act 1967, which requires that an abortion is carried out (a) by a registered medical practitioner (b) in a place approved by or under the Act.

8. *Human Fertilisation and Embryology Act 1990* introduced various amendments to s. 1 of Abortion Act 1967, including the insertion of s. 1(3A), which provides: "*The power under sub-section (3) of this section to approve a place includes power, in relation to treatment*

consisting primarily in the use of such medicines as may be specified in the approval and carried out in such manner as may be so specified, to approve a class of places."

9. The record of the parliamentary debate on that amendment is to be found in *Hansard, vol. 174, columns 1178-1222, 21 June 1990* **[40-56]**. For an explanation of context, see witness statement of the Rt Hon. Ann Widdecombe at **[210-212]**. The amendment (No 29) was introduced by the Conservative MP for Salisbury, Mr Robert Kay, and supported by the then Health Secretary, the Rt Hon. Kenneth Clarke. In the course of that debate, the following relevant exchanges took place:

> ***Miss [Ann] Widdecombe [MP for Maidstone]****: [...] Amendment No. 29 gives the Secretary of State powers to enlarge the classes of premises that will be licensed. I believe that that is merely a paving measure—even if it is not intended as such—for self-administered home abortion.*
>
> ***Mr. [Robert] Key [MP for Salisbury]****: It has been brought to my attention that what my hon. Friend has just said appears in the whip issued by the pro-life group. That is not the intention and, quite inadvertently I am sure, my hon. Friend has been very misleading. [...]*[1]
>
> ***Mr [Kenneth] Clarke [the Health Secretary]:*** *[...] My hon. Friend the Member for Maidstone mistakenly suggested that the abortion pill will be given out and taken home. First, no such pill is yet licensed here. It will not be licensed unless the Committee on Safety of Medicines is satisfied when the application is made that it should be licensed. Such a pill would be administered only in closely regulated circumstances under the supervision of a registered medical practitioner.*
>
> *A question was asked earlier about what type of premises would be used for administering such a drug. It is possible that the pill could be administered in a GP's surgery under the supervision of a registered medical practitioner. The patient would still have to return two days later to be given the pessary.*
>
> *All that my hon. Friend the Member for Salisbury seeks to ensure is that, if such a drug is licensed, the Secretary of State will at least have the power in primary legislation to approve the places and circumstances in which it might be used. If we do not address that matter this evening and if the drug is licensed in a year or two, there will be a private Member's Bill on every Friday for several years about whether the circumstances in which the drug is administered should be changed. It is for the House to decide.*[2]

[1] Column 1195 **[49]**

[2] Columns 1200-1201 **[53]**

10. The power to approve a class of place was in fact never used until 2017 in Scotland and 2018 in England (see below); in particular, there has been no 'class approval' for GP surgeries. Private hospitals and clinics were always approved individually, and placed under the rigorous regulatory regime of the Care Quality Commission (prior to 2008, the Healthcare Commission). According to the written evidence submitted by the Department of Health to the House of Commons Science and Technology Select Committee in September 2007, para 9, "*Since the passing of the Act in 1967, the Department of Health has always taken the view that outside of the NHS only independent sector hospitals or clinics can obtain Secretary of State approval. The current definition of an approved place is an independent sector place registered with the Healthcare Commission under the Care Standards Act 2000. These must be subsequently approved under the Abortion Act by the Secretary of State for Health. All places must re-apply for approval every four years.*" **[58]**

11. The Defendant's *Required standard operating procedures* (RSOPs) include the *Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion)*, November 2013 **[62-95]**, identifies a rigorous procedure which is necessary to ensure that each individual place is suitable for abortions.

12. In 2017, the Scottish Ministers approved "the home of a pregnant woman" as the class of places where the second drug, Misoprostol, can be administered, provided that that woman had already attended an appointment with a doctor at an approved place, had taken Mifepristone there (thereby killing the foetus) and was prescribed Misoprostol to be taken as a follow-up. On 27 December 2018, the Defendant issued a similar 'Approval' in England ("the 2018 Approval") **[98]**.

13. In February 2020, Rt Hon. Sir Edward Leigh, the MP for Gainsborough, filed a parliamentary written question: "*To ask the Secretary of State for Health and Social Care, with reference to his Department's guidance allowing misoprostol to be taken at home, what steps he has (a) taken and (b) plans to take in the next six months to ensure that (i) misoprostol is only given to the woman who wish to use it, and (ii) there is appropriate screening to ensure women are not being compelled to take misoprostol against their will; and if he will make a statement.*". The Minister (Caroline Dinenage) replied:

Medical abortion is a two-stage process which requires the administration of Mifepristone followed by Misoprostol to successfully complete the procedure. Misoprostol can only prescribed for home use when the woman has requested an early medical abortion and given her informed consent after being assessed by two doctors as meeting the legal grounds for termination of pregnancy as set out in the Abortion Act 1967. The first stage, Mifepristone, must continue to be administered in an National Health Service hospital or an approved independent sector clinic.

Safeguards are in place under the Department's required standard operating procedures (RSOPs) for independent sector abortion providers to identify women and young girls who may feel coerced or endangered and enable them to raise their concerns in confidence. Guidance produced by the Royal College of Obstetricians and Gynaecologists outlines best clinical practice for medical abortion at home and safeguarding vulnerable women and young girls and is available at the following link: https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf ***[99]***

14. Following the outbreak of Coronavirus in March 2020, the Government introduced wide-ranging extraordinary measures designed to discourage people from travelling and social interaction. In a television address to the nation in the evening of 20 March 2020, the Prime Minister gave an "instruction" to all people not to leave their homes except for several defined purposes, including getting medical help. A few hours before that broadcast, the government's web-site gov.uk published a document purporting to be an Approval of a class of places under s.s. 1(3) and 1(3A) of the Abortion Act 1967, dated 20 March 2020 **[100]**. The document was materially identical to the subsequent decision challenged in this judicial review claim. Its purported effect was to approve "the home of a pregnant woman" as a class of places for the abortions which take place by self-administration of ***both*** Mifepristone and Misoprostol.

15. The same evening, several pro-life groups, including the Claimant, published highly critical comments about this dramatic change of the law being effected in this manner and at such a time. **[101-102]**.

16. The following morning, the document was removed from the government's web-site, and replaced by in inelegantly worded, evidently rushed notice:

"The information on this page has been removed because it was published in error.

"This was published in error. There will be no changes to abortion regulations." **[103]**

17. On 25 March 2020, two members of the House of Lords, Baroness Bennett of Manor Castle and Baroness Barker, proposed an amendment to the Government's Coronavirus Bill which would modify the requirements of the Abortion Act 1967 during the Coronavirus epidemic. Part of the amendment was to the same effect as the 'Approval' challenged in the proposed judicial review claim, and worded in virtually identical terms:

Health Secretary's purported Approval, 20 March 2020 [100]	**Baroness Bennett's amendment, 25 March 2020 [139]**	**Health Secretary's Approval, 30 March 2020 [38]**
This approval supersedes the approval of 27 December 2018. *The Secretary of State makes the following approval in exercise of the powers conferred by section 1(3) and (3A) of the Abortion Act 1967:* *Interpretation* *1. In this approval –* *"home" means, in the case of a pregnant woman, the place in England where a pregnant woman has her permanent address or usually resides or, in the case of a registered medical practitioner, the place in England where a registered medical practitioner has*	*Insert the following new Schedule—* *"ABORTION PROVISION* *1 (1) References in this Schedule to sections are to sections of the Abortion Act 1967 ("the 1967 Act").* *(2) In this Schedule—* *"Registered medical practitioner" means a person on the Register of the General Medical Council established by the Medical Act 1983;* *"Registered nurse or midwife" means a person on the Register of the Nursing and Midwifery Council, with the meaning given to it by Article 5(5) of The Nursing and Midwifery Order 2001;* *"home" means, in the case of a pregnant woman, the place in England or Wales where a pregnant woman is living during the period this Schedule has effect or, in the case of a registered medical practitioner, where that individual is living during the period in which this Schedule has effect.*	*This approval supersedes the approval of 27 December 2018. This approval expires on the day on which the temporary provisions of the Coronavirus Act 2020 expire, or the end of the period of 2 years beginning with the day on which it is made, whichever is earlier.* *The Secretary of State makes the following approval in exercise of the powers conferred by section 1(3) and (3A) 1of the Abortion Act 1967:* *Interpretation* *1. In this approval –* *"home" means, in the case of a pregnant woman, the place in England where a pregnant woman has her permanent address or usually resides or, in the case of a registered medical practitioner, the place in England where a registered medical practitioner has their*

their permanent address or usually resides; *"approved place" means a hospital in England, as authorised under section 1(3) of the Abortion Act 1967, or a place in England approved under that section.* *Approval of class of place* *2. The home of a registered medical practitioner is approved as a class of place for treatment for the termination of pregnancy for the purposes only of prescribing the medicines known as Mifepristone and Misoprostol to be used in treatment carried out in the manner specified in paragraph 4.* *3. The home of a pregnant woman who is undergoing treatment for the purposes of termination of her pregnancy is approved as a class of place where the treatment for termination of pregnancy may be carried out where that treatment is carried out in the manner specified in paragraph 4.* *4. The treatment must be carried out in the following manner-* *a) the pregnant woman has-* *i) attended an approved place;*	*[…][3]* *4 (1) This paragraph has effect as an approval of a class of place by the Secretary of State under the powers granted in sections 1(3) and (3A) of the 1967 Act.* *(2) The home of a registered medical practitioner, nurse or midwife is approved as a class of place for the treatment of termination of pregnancy for the purposes only of prescribing the medicines known as mifepristone and misoprostol to be used in treatment carried out in the manner specified in sub-paragraph (4).* *(3) The home of a pregnant woman who is undergoing treatment for the purposes of termination of her pregnancy is approved as a class of place where the treatment for termination of pregnancy may be carried out where that treatment is carried out in the manner specified in subparagraph (4).* *(4) The treatment must be carried out in the following manner—* *(a) the pregnant woman has—* *(i) attended an approved place,* *(ii) had a consultation with an approved place via video*	*permanent address or usually resides;* *"approved place" means a hospital in England, as authorised under section 1(3) of the Abortion Act 1967, or a place in England approved under that section.* *Approval of class of place* *2. The home of a registered medical practitioner is approved as a class of place for treatment for the termination of pregnancy for the purposes only of prescribing the medicines known as Mifepristone and Misoprostol to be used in treatment carried out in the manner specified in paragraph 4.* *3. The home of a pregnant woman who is undergoing treatment for the purposes of termination of her pregnancy is approved as a class of place where the treatment for termination of pregnancy may be carried out where that treatment is carried out in the manner specified in paragraph 4.* *4. The treatment must be carried out in the following manner-* *a) the pregnant woman has-* *i) attended an approved place;*

[3] The proposed amendment also provided that the abortion would need to be approved by just one doctor rather than two, as required under s. 1(1) of the 1967 Act.

ii) had a consultation with an approved place via video link, telephone conference or other electronic means, or *iii) had a consultation with a registered medical practitioner via video link, telephone conference or other electronic means; and* *b) the pregnant woman is prescribed Mifepristone and Misoprostol to be taken for the purposes of the termination of her pregnancy.*	*link, telephone conference or other electronic means, or* *(iii) had a consultation with a registered medical practitioner, nurse or midwife via video link, telephone conference or other electronic means; and* *(b) the pregnant woman is prescribed mifepristone or misoprostol to be take for the purposes of the termination of her pregnancy.* *[…]*	*ii) had a consultation with an approved place via video link, telephone conference or other electronic means, or* *iii) had a consultation with a registered medical practitioner via video link, telephone conference or other electronic means; and* *b) the pregnant woman is prescribed Mifepristone and Misoprostol to be taken for the purposes of the termination of her pregnancy and the gestation of the pregnancy has not exceeded nine weeks and six days at the time the Mifepristone is taken.*

18. On 24 March 2020, one day before the amendment was introduced, the Secretary of State was asked in the House of Commons whether he would "*commit not to oppose*" that anticipated amendment, and "*reinstate the regulations that were put up for a short while on the Government website last night*". The Secretary of State replied: "*There are no proposals to change the abortion rules due to covid-19.*" **[104-133]**

19. In the course of the debate in the House of Lords on 25 March 2020 the Health Minister, Lord Bethell, opposed the amendment on behalf of the government, and relevantly stated:

> *"However, we do not agree that women should be able to take both treatments for medical abortion at home. We believe that it is an essential safeguard that a woman attends a clinic, to ensure that she has an opportunity to be seen alone and to ensure that there are no issues.*
>
> *"Do we really want to support an amendment that could remove the only opportunity many women have, often at a most vulnerable stage, to speak confidentially and one-to-one with a doctor about their concerns on abortion and about what the alternatives might be? The bottom line is that, if there is an abusive relationship and no legal*

requirement for a doctor's involvement, it is far more likely that a vulnerable woman could be pressured into have an abortion by an abusive partner.

"We have been clear that measures included in this Bill should have the widespread support of the House. While I recognise that this amendment has some profound support, that the testimony of the noble Baroness, Lady Bennett, was moving and heartfelt, and that the story of her witness from Lincolnshire was an extremely moving one, there is no consensus on this amendment and the support is not widespread. Abortion is an issue on which many people have very strong beliefs. I have been petitioned heavily and persuasively on this point. This Bill is not the right vehicle for a fundamental change in the law. It is not right to rush through this type of change in a sensitive area such as abortion without adequate parliamentary scrutiny." ***[174-175]***

20. Following the debate, the amendment was withdrawn. The Coronavirus Act 2020 was passed on the same day. Parliament went into recess on the same day, 25 March 2020. Parliament is not expected to reconvene until late April 2020 at the earliest, which may be further delayed due to the Coronavirus epidemic. In any event, its proceedings will be logistically complicated due to the epidemic, and will undoubtedly be pre-occupied by various other urgent issues arising out of the rapidly developing events.

21. On 30 March 2020, the Secretary of State published the 'Approval' document referenced above. It is that decision that is challenged in this claim for judicial review.

22. The new system introduced by the Approval carries with it significant medical and ethical risks, as detailed in the *expert report of Dr Gregory Gardner* **[213-225]**. The information about those risks was available to the Secretary of State while making the decision, or should have been available had the Defendant made adequate enquiries.

GROUNDS FOR JUDICIAL REVIEW

(1) Constitutional and/or procedural impropriety and/or improper motive

23. The 'Approval' was issued immediately after (a) the proposed reform of the abortion regulations was debated and rejected in Parliament, (b) the Ministers assured Parliament that no such reform will take place and (c) Parliament went into recess and is unable to scrutinise

the Executive in relation to this decision and its immediate consequences. In these circumstances, it is clear that the form and timing of the decision were calculated to reverse the outcome of the Parliamentary deliberations on this issue and/or to prevent the Parliament from carrying out its constitutional functions; and in any event, had those effects. In those circumstances, the decision is unconstitutional and unlawful: see *R(Miller) v The Prime Minister* [2019] UKSC 41; *R(Miller) v Secretary of State for Exiting the EU* [2017] UKSC 5.

24. The principles of *good administration* and *separation of powers* required the Executive to abstain from exercising a power (even if that power exists in law, which the Claimant does not accept in this case) in a way which usurps the proper constitutional functions of Parliament. This applies to a statutory power as much as to a prerogative power, and is a distinct requirement from the *vires* of the statute. For example, where Parliament had repeatedly debated a morally sensitive issue and took no action, the majority of the Supreme Court thought it inappropriate to intervene by making a discretionary declaration: *R(Nicklinson) v Ministry of Justice* [2014] UKSC 38. By a parity of reasoning in relation to separation of powers, the same principle applies to the Executive branch.

25. A major reform of the substantive law is a paradigm matter which the Executive should leave to Parliament, and where the Executive powers may not be used effectively to overrule Parliament. Parliament's decision to take no legislative action does not have the force of a statute, but nevertheless, must be afforded a degree of respect by other branches of government for the sake of constitutional propriety.

(2) Breach of legitimate expectation

26. The ministerial assurances given in Parliament, as set out in paras 9, 18 and 19 above, created a *legitimate expectation* that:

    a. The Defendant would not designate "a pregnant woman's home" as a class of places where abortion may lawfully take place; and/or

    b. in particular, the Defendant would not introduce such a change without first satisfying himself and/or the Parliament that there were adequate safeguards against

the risk that vulnerable woman could be pressured to have an abortion by an abusive partner.

c. In any event, no such change would be introduced without either a wide parliamentary consensus in its favour, or adequate parliamentary scrutiny and debate. In other words, the change could only be introduced by Parliament and not by the Executive.

27. (a) and (b) above are substantive legitimate expectations, while (c) is a procedural one. Important differences in legal analysis follow, and it is therefore appropriate to consider respective substantive and procedural expectations separately below.

28. A legitimate expectation arising from a ministerial statement in Parliament is, in principle, enforceable by a claim for judicial review: see *R(ABCIFER) v Defence Secretary* [2003] QB 1397 (CA); *R (Wheeler) v Office of the Prime Minister* [2008] EWHC 1409 (Admin), para 53; *Finucane's Application for Judicial Review* [2019] UKSC 7.

(a) procedural legitimate expectation

29. The responsible Ministers have given clear and unequivocal assurances that any legalisation of home abortions would require either a wide parliamentary consensus or adequate parliamentary scrutiny and debate. A necessary implication of that is that the government might only seek to introduce that reform via Parliament, and not by exercising executive powers.

30. That is a procedural legitimate expectation, which fits perfectly into the classic wording in the headnote to the Privy Council decision in *Attorney-General of Hong Kong v Ng Yuen Shiu* [1983] 2 AC 629: "*Where a public authority has promised to follow a certain procedure before reaching a certain decision, good administration requires that it should act fairly and implement its promises, so long as that does not interfere with its statutory duty.*"

31. As Lord Woolf MR explained in *R v North and East Devon Health Authority, Ex p Coughlan* [2001] QB 213, para 57, where the legitimate expectation is procedural and not substantive, the applicable test is much lower than *Wednesbury*. In this category of cases, "*it is uncontentious that the court itself will require the opportunity for consultation to be given unless there is an overriding reason to resile from it (see Attorney General of Hong Kong v*

Ng Yuen Shiu [1983] 2 AC 629) in which case the court will itself judge the adequacy of the reason advanced for the change of policy, taking into account what fairness requires."

32. It is unnecessary for the Claimant to show any detrimental reliance on a procedural legitimate expectation before being able to rely on it: see *Re Finucane's Application for Judicial Review* [2019] UKSC 7, paras 55-81, and the cases cited there.

33. A procedural legitimate expectation will be enforced in all cases unless there is "an overriding reason" for the authority to resile from its promise. In this case, the promise was broken only five days after it was given, and (to the best of the Claimant's knowledge) with now significant change of circumstances to justify it, let alone an overriding reason. Accordingly, the Court should enforce this legitimate expectation.

(b) substantive legitimate expectation

34. It is submitted that, should that be necessary, this case is capable of also meeting the more stringent test for the enforcement of a substantive legitimate expectation.

35. The Supreme Court has recently revisited the doctrine of legitimate expectation in *Re Finucane's Application for Judicial Review* [2019] UKSC 7, paras 55-81; and has confirmed a number of important principles.

36. Firstly, the test for substantive legitimate expectation is not *Wednesbury*; it is "a much more rigorous standard" of "the court's own view of what fairness requires" in the circumstances: *R (Bhatt Murphy) v Independent Assessor* [2008] EWCA Civ 755 per Laws LJ at para 35, quoted (with approval) in *Finucane*, paras 60, 62. The Defendant must satisfy the Court that his outright breach of a promise given to Parliament five days earlier, and breached just after Parliament went into recess and faced major logistical difficulties, was *fair*. Rational policy reasons will not, by themselves, suffice.

37. Secondly, detrimental reliance is relevant to a substantive legitimate expectation claim but is not a pre-requisite of it: *Finucane*, paras 62, 69-72. In this case, like in *Finucane*, the promise was made to the world at large, not to a particular group. In any event, a pro-life campaigning / pressure group such as the Claimant has undoubtedly suffered detriment as a result of the Defendant's bypassing the parliamentary procedure. Had there been parliamentary scrutiny and debate, pro-life NGOs including the Claimant could have lobbied

parliamentarians, encouraged its supporters to lobby their own MPs, made submissions to Select Committees, etc. Such activities are normal work of NGOs, whose importance in the democratic process is universally recognised. The fact that, contrary to a prior promise, the reform was introduced by an executive decision and without any advance notice to the public has made any such contributions impossible in this case.

38. For these reasons, even the substantive legitimate expectations in this case should be enforced. It is submitted that Defendant's breach of his promise to Parliament is unfair by any standard. Insofar as that is material, it has also caused prejudice to the Claimant and others.

(3) Breach of the **Tameside** *duty to make sufficient enquiries, and/or failure to take account of relevant considerations*

39. It is a precondition of lawfulness of any public law decision that the authority has complied with the *Tameside* duty to make sufficient enquiries, to obtain the information necessary to make a decision, and make a decision consistent with that information. The scope of *Tameside* duty varies greatly depending on the nature of the case. As acknowledged in the Ministerial statements in Parliament quoted above, abortion is a sensitive issue which requires a multi-factorial consideration; in these circumstances, the *Tameside* duty is wide.

40. The only precedent of an approval of class of places by the Secretary of State under s. 1(3) and 1(3A) of the 1967 Act is the Approval dated 27 December 2018 **[98]**. 'The home of a pregnant woman' was approved as a class of place where the patient can self-administer Misoprostol if, and only if, she had attended a clinic where she had been prescribed Mifepristone and Misoprostol, and had already taken Mifepristone at the clinic. That precedent indicates the scope of necessary enquiries for a decision of this nature; in particular, it is clear from the DHSC's press statement of 25 August 2018 **[96-97]** that:

    a. The DHSC announced its decision to introduce that change on 25 August 2018, 5 months before the formal Approval was issued.

    b. The press statement taken at that time makes it clear that the Department had taken "medical and legal advice" and was satisfied that the proposed scheme was "safe and legal".

c. The DHSC undertook to introduce "safeguards" and to "work closely with partners in the health system to make the changes quickly and safely".

d. The DHSC further undertook "to work with partners, including the Royal College of Obstetricians and Gynaecologists, to develop clinical guidance for all professionals to follow when providing the treatment option to patients", before the substantive change took effect.

41. The present decision is much more momentous than the 2018 decision. It removes the need for *any* face-to-face consultation between the pregnant woman and the doctor prescribing the abortion pills. It enables women to self-administer Mifepristone, which actually kills the foetus, rather than simply follow up on that irreversible step after it had been taken in a clinical setting.

42. It is clear that on this occasion, the enquiries undertaken by the Secretary of State were not comparable in scope with those in 2018, and grossly inadequate. The whole decision-making process clearly took no longer than two working days, between the categorical assurances given by Ministers in Parliament on 24-25 March that no such decision was contemplated and the information provided to the *Sunday Times* for publication on 29 March that the decision has been made **[200]**. No safeguards have been introduced, and the relevant issues not identified. Unlike the 2018 Approval, this approval is not accompanied by any clinical guidance whatsoever.

43. In these circumstances, it is evident that the Secretary of State has not made sufficient enquiries and/or has not taken account of all relevant considerations.

44. The Claimant relies on the *expert report of Dr Gregory Gardner* **[213-225]** for *examples* of concerns about the new policy which should have been identified and considered by the Defendant. Further self-evident risks include:

a. The doctor has no control as to *when* the patient will take the drugs, which may be prescribed within the 10 weeks gestation limit but taken after it has expired.

b. The risk that one woman is prescribed the drugs and then another woman uses them: the situation in *JR76* [2019] NIQB 103.

c. The risk that the prescribed drugs will be re-sold at the black market.

(4) Failure to carry out a public consultation

45. The Secretary of State was under a common law duty to carry out a consultation with various stakeholders and/or the public before making this decision, because (a) failure to consult in this case leads to *conspicuous as unfairness*, given the proceedings in Parliament the previous week; (b) there is an *established practice* of public consultations prior to any significant reform of substantive abortion law or regulations; and/or (c) in the present context, the duty to consult is part of the *Tameside* duty to make sufficient enquiries.

46. Christian Concern has made submissions in at least five major public consultations in relation to abortion over the years:

    a. Broadcast Committee Advertising Practice (BCAP) Code Review Consultation in 2009 (concerning TV advertisements of abortion services);

    b. DFID Consultation on Maternal, Reproductive and Newborn Health, 2010

    c. Royal College of Psychiatrists consultation on Induced Abortion and Mental Health, 2011

    d. BCAP consultation on post-conception advice services, 2011

    e. Written submissions and oral evidence given to House of Commons Women and Equalities Committee Inquiry into Abortion Law in Northern Ireland, 2018-2019.

47. Christian Concern would have wished to make submissions in any public consultation on the proposed 'Approval' of pregnant women's homes as a class of places for abortion.

(5) The decision is **ultra vires** *the Abortion Act 1967*

48. It is submitted that the Defendant's powers under s.s. 1(3) and 1(3A) of the Abortion Act 1967 do not extend as far as a power to designate "a home of a pregnant woman" as a class of place where an abortion may lawfully take place. That is so because:

    a. As a general principle of statutory interpretation, any delegation of legislative power to the Executive is to be interpreted restrictively: see e.g. *R (The Public Law Project) v Lord Chancellor* [2016] UKSC 39.

b. The limits of the power are not clear on the face of the statutory provision, so the *Hansard* exchanges are admissible under *Pepper v Hart* (and clearly show that the legislation was not intended to enable the S. o. S. to legalise home abortions).

c. S. 1 must be read as a coherent whole; in particular, s. 1(3) and 1(3A) must be interpreted consistently with the requirement that "*pregnancy is terminated **by** a registered medical practitioner*" (emphasis added) in s. 1.

d. The provision must be interpreted in the light of the legislative policy and purposes of the Act as a whole: *Padfield v Minister of Agriculture* [1968] AC 997.

e. The provision must be interpreted consistently with the international law. World Health Organisation defines an '*unsafe abortion*' as "*a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both*"[4]. It could not have been the intention of the Act to enable the Health Secretary to authorise unsafe abortions.

49. As detailed in para 9 above, at the time the legislation was introduced, the Health Secretary assured Parliament that it was **not** intended to enable the Executive to authorise "home abortions".

50. The possibility of such designation was discussed in academic literature at the time: *Andrew Grabb, The new law of abortion: clarification or ambiguity?,* Crim. L.R. 1991, Sep, 659-670 at 669-670. Mr Grabb wrote: "*Even if the Act could be interpreted to permit approval of such places as patients' homes, public transportation etc., this is an absurd possibility to contemplate."*

51. Further, s. 1(1) of the Abortion Act 1967 provides that an abortion may be lawful if, and only if, the "*pregnancy is terminated **by** a registered medical practitioner*" (emphasis added). That requirement is distinct from the requirement of an *approval* by two registered medical practitioners, having regard to various factors specified in s. 1(1)(a)-(d) and 1(2). The meaning of those words was analysed in great detail in *Royal College of Nursing v DHSS*

[4] *Safe abortion: technical and policy guidance for health systems, 2nd ed.* P. 18. https://www.who.int/publications-detail/safe-abortion-technical-and-policy-guidance-for-health-systems

[1981] AC 800, leaving the House of Lords divided 3-2. The minority thought that s. 1 required the act which actually caused a termination of pregnancy to be done physically by no other person than a registered doctor. The majority held that it was sufficient for the doctor to make material decisions and remain in control throughout the process while physical tasks are carried out under his direction by other medical stuff such as nurses.

52. The process envisaged by the 'Approval' dated 30 March 2020 does not satisfy that requirement in either of its interpretations in *RCN* case. The involvement of the registered medical practitioner is limited to issuing a prescription after a telephone call with a patient. There is a clear distinction in s.s. 58-59 of the Offences Against the Person Act 1861 between (a) administering drugs to procure abortion, which is an offence under s. 58 punishable by life imprisonment and (b) procuring or supplying drugs to procure abortion, which is a less serious offence under s. 59. The scheme envisaged in the Approval is that the drugs will be *supplied* by a registered medical practitioner but *administered* by the pregnant woman herself. That is outside the scope of s.1(1) of the Abortion Act 1967.

53. *BPAS v Secretary of State for Health* [2011] EWHC 235 (Admin) is a clear authority for the proposition that where the abortion drugs are prescribed by a doctor and self-administered by a woman at home, the pregnancy is **not** '*terminated by a registered medical practitioner*' within the meaning of s. 1(1) of the 1967 Act. Supperstone J gave a detailed reasoned judgment refusing a declaration which would have authorised the scheme now envisaged in the Defendant's 'Approval' as lawful under s. 1(1). In particular, Suppersote J held in paras 24-25:

> *The critical phrase in s.1(3) is "any treatment for the termination of pregnancy". "Treatment" is not, in my view, properly restricted to the act of diagnosis and the prescription of drugs or medicine. If the drugs or tablets were prescribed by the registered medical practitioner and not taken by the woman, the opportunity for treatment would have been available but it would not have been taken. The aim of the treatment, whether medical or surgical, must be the termination of a pregnancy. Termination is the consequence of the treatment; it is not itself treatment.*
>
> *The interpretation put by the Claimant on the words "any treatment for the termination of pregnancy" requires it to submit that the pregnancy is terminated by a registered medical practitioner in s.1(1) when that person merely prescribes an abortifacient drug. However termination may or may not be the consequence of the prescription. A woman may decide not to proceed to take the drug.*

54. For the avoidance of doubt, *SPUC Pro-life Ltd. v The Scottish Ministers* [2019] CSIH 31 does not apply in England and Wales. In any event, *SPUC* case concerned the 2017 designation of a pregnant woman's home as the place for one particular step during the late stage in the process of abortion in Scotland, and is readily distinguishable from this case. The 2020 Approval authorises the whole process, including the most crucial decision and the administration of the fatal drug, to take place at home.

55. Obtaining abortion drugs via internet for self-administration at home is a criminal offence; a prosecution for that offence is Convention-compatible: *JR76* [2019] NIQB 103. That is so despite the fact that the drugs are prescribed by qualified doctors via telemedicine: *JR76*, para 7. Unsurprisingly, the far-fetched argument that the pregnancy was terminated by a doctor simply because it was a doctor who prescribed the drug was not even attempted in *JR76*. The re-designation of a woman's home as a class of places by the Defendant does not change this fundamental position, because self-administration at home does not involve sufficient medical supervision nor other safeguards.

56. The effect of *BPAS* and *JR76* cases is that, notwithstanding the Approval now issued by the Defendant, the process of abortion envisaged in it remains unlawful, and indeed criminal. The paradoxical effect of the Approval is while it purports to legalise abortions by self-administration of Mifepristone at home, the Defendant has no legal power to do so, so the true legal effect of the Approval is simply an incitement of crime. For obvious reasons, such a decision is unlawful and must be quashed.

(6) The decision is contrary to the legislative purpose of the 1967 Act

57. The legislative purposes of the Abortion Act 1967 were (1) to broaden the grounds upon which abortions may lawfully be obtained; and (2) to ensure that the abortion is carried out with all proper skill and in hygienic conditions: *Royal College of Nursing v DHSS* [1981] AC 800, per Lord Diplock at 827D-E; *Doogan v Greater Glasgow Health Board* [2015] SC (UKSC) 32, para 9. The decision of 30 March inevitably frustrates (2), and is therefore contrary to the well-known public law principle in *Padfield v Minister of Agriculture* [1968] AC 997.

58. All places hitherto approved under s. 1(3) of the Abortion Act 1967 were subject to a sophisticated regulatory framework, as outlined in *BPAS v Health Secretary*, paras 5-8. That

involves registration with the Care Quality Commission (CQC), with various conditions attached to it, prior to the approval by the Health Secretary; and CQC's ongoing supervision and control.[5] The regulatory regime (like its predecessors) aims to ensure that abortions may only be carried out with proper skill, hygiene, and verification of the free choice of the pregnant woman to obtain an abortion.

59. The 2018 Approval does not change the substantive position, because it only permits a follow-up step to be taken at home after the crucial, irreversible part of the abortion has already taken place in a clinical setting which is subject to the CQC's regulatory regime.

60. By contrast, the 2020 Approval effectively permits the whole process of abortion to take place wherever in England or Wales the pregnant woman may happen to be living at the time. Self-evidently, there is no guarantee that such a place will always be safe or hygienic, or that the woman takes the pill freely and without pressure.

(7) Breach of s. 6 of the Human Rights Act 1998

61. The European Court of Human Rights has supervisory jurisdiction over the national regulation of abortion. The principle underpinning the regulation of abortion by the Court is that "*once the State, acting within its limits of appreciation, adopts statutory regulations allowing abortion in some situations*", "*the legal framework devised for this purpose should be shaped in a coherent manner which allows the different legitimate interests involved to be taken into account adequately and in accordance with the obligations deriving from the Convention.*": *A. B. & C. v. Ireland* [G.C.], no. 25579/05, 16 December 2010 at para. 214.

62. This supervisory jurisdiction is not limited to protecting the mother's rights under Article 8, but also extends to protecting the unborn child's right to life under Article 2 (although the state's positive obligation to protect the life of an unborn child is limited). Abortion is recognised as a "derogation" from the absolute protection of life under Article 2: *Vo v. France*, [G.C.], no. 53924/00, 8 July 2004, separate opinion of J-P Costa at para. 17; *Bosa v. Italy*, no. 50490/99, decision of 5 September 2002. In *H v. Norway*, a case involving an abortion which took place against the wishes of the child's father, the Court held that a state

[5] Prior to the enactment of Health and Social Care Act 2008, the places of abortion were under the no less rigorous regulatory regime of the Healthcare Commission under the Care Standards Act 2000.

not only has a duty not to take the life of a person intentionally, but also to take appropriate steps to safeguard life.[6] As such, when a government decides to permit abortion, it remains subject to the obligation to protect and respect the competing rights and interests of everyone and everything involved.[7]

63. The Court has on numerous occasions outlined a number of rights and justifications calling for a limitation on abortion:

    a. the interest of protecting the right to life of the unborn child (*H. v Norway*, *op cit.*);

    b. the legitimate interest of society in limiting the number of abortions (*Odièvre v. France* [G.C.], no. 42326/98, Judgment of February 2003 at para. 45);

    c. the interests of society in relation to the protection of morals (*Open Door & Dublin Well Woman v. Ireland*, Judgment of 29 October 1992 at para. 63);

    d. the parental rights and the freedom and dignity of the woman (*V.C. v. Slovakia*, application no. 18968/07, judgment of 08/11/2011);

    e. the interests of the father (*Bosa v. Italy*, no. 50490/99, decision of 5 September 2002);

    f. the right to freedom of conscience of health professionals and institutions based on ethical or religious beliefs (*Tysiac v. Poland*, No. 5410/03, Judgment of 24 September 2007 at para. 121).

64. It is apparent, especially from the rushed and inconsistent manner in which the 'Approval' was issued, that the Secretary of State has failed even to consider those competing interests, and in any event, has failed to protect or respect them.

(8) Irrationality

65. The decision of the Secretary of State represents a very significant change of the substantive abortion law, with massive impact on the delicate balance of competing rights and interests involved in this issue. That momentous decision was taken under the pretext of being

[6] *H. v. Norway*, no. 17004/90, Decision of inadmissibility of the former Commission of 19 May 1992 at para 167.

[7] *A.B. & C v. Ireland [G.C.]* at para. 249; and *R.R. v. Poland, no. 27617/04, 26 May 2011* at para. 187.

necessitated by the Coronavirus epidemic. It is submitted that the effect of that decision on the epidemic will be evidently minimal. The government's strategy is to reduce the *overall* amount of travel and social interaction so as to slow down the spread of the disease. In this context, the amount of travel and social interaction arising from the requirement that abortions take place in approved places is negligible.

66. The substantive liberalisation of the abortion law, and the circumvention of the democratic process, are both out of all proportion to any potential benefit to the anti-Coronavirus measures; to the extent that no reasonable decision-maker could have made that decision, and/or could have done so in this manner.

Locus Standi

67. Christian Concern is a non-profit Christian NGO, which defines its purpose as "to speak Biblical truth in the public sphere". One of its main areas of concern is the issue of sanctity of life from the moment of conception to natural death. Christian Concern has campaigned on the issue of abortion since its inception in 2008. Its activities have involved:

    a. Making submissions to every public consultation on issues with implication for abortion, as detailed in para 46 above;

    b. Organising training on abortion issues via the Claimant's training programme (Wilberforce Academy);

    c. Publications via the Claimant's publishing wing (Wilberforce Publications);

    d. Briefing parliamentarians on new legislation and bills, such as the Human Fertilisation and Embryology Act 2008, and its implications for the issue of abortions;

    e. Christian Concern was involved in in the *Right to Know* campaign in 2010, which was a parliamentary campaign aimed at securing women the offer of independent counselling before accessing abortion.

    f. Working with a large number of pro-life groups in our country on community and social projects, including helping various crisis pregnancy centres.

    g. Helping to set up a pregnancy help line.

68. Further, the Claimant's legal wing (Christian Legal Centre) has provided *pro bono* legal advice and, in many cases, secured and financed legal representation, in many legal cases involving the issue of abortion. Examples include:

    a. Christian Legal Centre is advising Centre for Bioethical Reform, in relation to the legality of promotional and election materials; and other pro-life groups in relation to their activities.

    b. *R v Sivaraman* and *R v Rajmohan* (2015): a private prosecution of doctors who were caught on camera offering sex-selective abortions. The prosecution was taken over and discontinued by the DPP.

    c. *R v Hacking.* Christian Legal Centre supported Centre for Bioethical Reform activist, Christian Hacking, in his prosecution by the Crown Prosecution Service for alleged breach of a Public Spaces Protection Order; the case against him was dropped.

    d. *Hacking v Waltham Forest Council*. Christian Legal Centre is supporting Centre for Bioethical Reform activist, Christian Hacking, in his appeal against a Community Protection Notice issued by Waltham Forest Council.

69. NGOs such as the Claimant have a recognised role in a democratic society. In particular, in a proper democratic process leading to a further reform of abortion law, the Claimant would have had a significant role to play. As indicated under specific grounds above, the Claimant was willing and able to take a number of steps to oppose the proposed reform; such activities are vital in a democratic society.

70. In any event, the Defendant's decision affects the whole country and raises issues of constitutional importance.

71. In these circumstances, it is submitted that the Christian Concern has sufficient locus to pursue this claim.

Application for disclosure

72. The Claimant seeks disclosure of:

a. all internal correspondence and documents within the Department in relation to the preparation and promulgation of the 'Approval' dated 30 March 2020;

b. any relevant correspondence with other parties;

c. any impact assessments undertaken by the Department as to:

- the likely effect of the decision on preventing the spread of Coronavirus;
- the risk that abortions will be carried out under pressure, e.g. from an abusive partner.
- the risk that abortions will be carried out in unhygienic conditions;
- the risk that abortions will be carried out without appropriate skills.

73. The Defendant is in any event under a duty of candour to give a true and comprehensive account of the decision-making process: *Secretary of State for Foreign & Commonwealth Affairs v Quark Fishing Ltd* [2002] EWCA Civ 1409 at para 50. It is at least a rule of good practice for the Defendant to comply with the best evidence rule and exhibit the relevant documents rather than given a second-hand account: see *National Association of Health Stores and another v Department of Heath* [2005] EWCA Civ 154. In these circumstances, a disclosure order will not place any excessive burden on the Defendant.

74. The disclosure of the documents identified above was requested in the Claimant's pre-action letter **[207-208]**, to which the Defendant has not replied.

75. Where an improper purpose is alleged in an application for judicial review, it is often appropriate to make a disclosure order: see e.g. *R(Jet2.com Limited) v Civil Aviation Authority* [2018] EWHC 3364 (Admin); *R (Core Issues Trust) v The Mayor of London* [2014] EWHC 2628 (Admin), para 10. This applies to this case, where an unconstitutional purpose is alleged. Disclosure is particularly appropriate because the decision-making process was so opaque and inconsistent as to be puzzling. There is at present insufficient information to establish the true and full reasons for the Defendant's decision.

76. Especially given the obvious urgency of this case, it is not appropriate to approach this issue incrementally, i.e. give the Defendant an opportunity to comply with the duty of candour and then consider whether a further order for disclosure needs to be made. The Defendant

has had notice of what disclosure will be sought, and will need to identify and consider the relevant documents in any event.

Urgency

77. The Defendant's decision, of which the public has had no advance notice, came into force with immediate effect. It is likely that, pursuant to that decision, unlawful abortions will be taking place within days rather than weeks, and may well be taking place already. That entails serious risks to the health and well-being of the patients (see the expert report at **[213-225]**), and that the protection given in law to the life of unborn children is not complied with. It is therefore necessary to consider this claim as a matter of urgency.

Relief

78. For all those reasons, the Claimant seeks:

    a. a *Certiorari* to quash the Approval; and/or

    b. a declaration that, notwithstanding any such Approval, a self-administration of abortion drugs at home does not satisfy the requirements of s. 1 of Abortion Act 1967.

    c. Costs.

    d. Such further relief that the court sees fit.

79. (b) potentially has implications not only for 2020 Approval, but also for the 2018 Approval, whose legality has not been tested in an English court. It is submitted that this should not deter the Court from making a declaration if the Court is satisfied that it is legally correct.

<u>The Claimant believes that the facts stated in the Statement of Facts and Grounds are true</u>

……

Andrew Storch Solicitors

16 April 2020

IN THE HIGH COURT OF JUSTICE

QUEENS BENCH DIVISION

ADMINISTRATIVE COURT

URGENT APPLICATION FOR PERMISSION FOR JUDICIAL REVIEW

BETWEEN:

Her Majesty the Queen

(on the application of CHRISTIAN CONCERN)

Claimant

-v-

Secretary of State for Health and Social Care

Defendant

DRAFT ORDER

UPON the Claimant's application for permission for judicial review and application for exceptional urgency, considered on papers

IT IS ORDERED THAT:

1. Time for the service of the Acknowledgement of Service is abridged. The Defendant must file serve the Acknowledgement of Service by 4 pm on 24 April 2020.
2. The application for permission is to be considered on papers on an urgent basis, and the decision on permission shall be made by 28 April 2020.
3. In the event permission is granted on papers, the Defendant must file and serve the full Response, and any evidence relied upon, by 4 pm on 1 May 2020.
4. By 4 pm on 1 May 2020, the Defendant must disclose to the Claimant:
    a. all internal correspondence and documents within the Department in relation to the preparation and promulgation of the 'Approval' dated 30 March 2020;
    b. any relevant correspondence with other parties;
    c. any impact assessments undertaken by the Department as to:

- the likely effect of the decision on preventing the spread of Coronavirus;
- the risk that abortions will be carried out under pressure, e.g. from an abusive partner.
- the risk that abortions will be carried out in unhygienic conditions;
- the risk that abortions will be carried out without appropriate skills.

5. The full hearing (or, if permission not granted on papers, a 'rolled up' hearing, with full hearing to follow immediately if permission is granted) to be listed urgently, with a time estimate 1 day, on 5 May 2020 or the first available date afterwards.

6. Costs in the case.

The Abortion Act 1967 - Approval of a Class of Places

This approval supersedes the approval of 27 December 2018. This approval expires on the day on which the temporary provisions of the Coronavirus Act 2020 expire, or the end of the period of 2 years beginning with the day on which it is made, whichever is earlier.

The Secretary of State makes the following approval in exercise of the powers conferred by section 1(3) and (3A) [1]of the Abortion Act 1967[2]:

Interpretation

1. In this approval –

"home" means, in the case of a pregnant woman, the place in England where a pregnant woman has her permanent address or usually resides or, in the case of a registered medical practitioner, the place in England where a registered medical practitioner has their permanent address or usually resides;

"approved place" means a hospital in England, as authorised under section 1(3) of the Abortion Act 1967, or a place in England approved under that section.

Approval of class of place

2. The home of a registered medical practitioner is approved as a class of place for treatment for the termination of pregnancy for the purposes only of prescribing the medicines known as Mifepristone and Misoprostol to be used in treatment carried out in the manner specified in paragraph 4.

3. The home of a pregnant woman who is undergoing treatment for the purposes of termination of her pregnancy is approved as a class of place where the treatment for termination of pregnancy may be carried out where that treatment is carried out in the manner specified in paragraph 4.

4. The treatment must be carried out in the following manner-

a) the pregnant woman has-

i) attended an approved place;

[1] Section 1(3A) was inserted by section 37(3) of the Human Fertilisation and Embryology Act 1990 (c. 37).
[2] 1967 c. 87.

ii) had a consultation with an approved place via video link, telephone conference or other electronic means, or

iii) had a consultation with a registered medical practitioner via video link, telephone conference or other electronic means; and

b) the pregnant woman is prescribed Mifepristone and Misoprostol to be taken for the purposes of the termination of her pregnancy and the gestation of the pregnancy has not exceeded nine weeks and six days at the time the Mifepristone is taken.

Mark Davies

Director, Population Health

30 March 2020

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Short, Clare

Skinner, Dennis

Smith, Andrew (Oxford E)

Smith, C. (Isl'ton & F'bury)

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Soley, Clive

Squire, Robin

Steel, Rt Hon Sir David

Steinberg, Gerry

Strang, Gavin

Taylor, Mrs Ann (Dewsbury)

Taylor, Matthew (Truro)

Thomas, Dr Dafydd Elis

Thompson, Jack (Wansbeck)

Tredinnick, David

Turner, Dennis

Walley, Joan

Wardell, Gareth (Gower)

Wareing, Robert N.

Watson, Mike (Glasgow, C)

Welsh, Michael (Doncaster N)

Wigley, Dafydd

Williams, Rt Hon Alan

Williams, Alan W. (Carm'then)

Winnick, David

Tellers for the Noes :

Miss Kate Hoey and

Mrs. Teresa Gorman.

Question accordingly agreed to.

Clause 34

Amendment of law relating to termination of pregnancy

Mr. Michael Alison (Selby) : I beg to move amendment No. 4, in page 20, line 4, at end insert

provided that the pregnancy has not exceeded its twenty-fourth week or, if the pregnancy is being terminated in accordance with section 1(1)(d) of this Act (termination because of the risk that the child will be handicapped), its twenty-eighth week'.

Mr. Deputy Speaker (Mr. Harold Walker) : It will be convenient to take at the same time the following amendments : No. 30, in page 20, line 4, at end insert--

(4) In section 5(2) of that Act, for the words from "the miscarriage" to the end there is substituted "a woman's miscarriage (or, in the case of a woman carrying more than one foetus, her miscarriage of any foetus) is unlawfully done unless authorised by section 1 of this Act and, in the case of a woman carrying more than one foetus, anything done with intent to procure her miscarriage of any foetus is authorised by that section if--

(a) the ground for termination of the pregnancy specified in subsection (1)(d) of that section applies in relation to any foetus and the thing is done for the purpose of procuring the miscarriage of that foetus, or

(b) any of the other grounds for termination of the pregnancy specified in that section applies".'.

No. 29, in page 19, line 42, at end insert--

(2A) After section 1(3) of that Act there is inserted-- "(3A) The power under subsection (3) of this section to approve a place includes power, in relation to treatment consisting primarily in the use of such medicines as may be specified in the approval and carried out in such manner as may be so specified, to approve a class of places".'.

No. 28, in page 19, line 42, at end insert--

(2A) After section 2(1) of that Act (notification), there is inserted--

"(1A) Regulations made by virtue of paragraph (a) of subsection (1) of this section--

(a) may require a certificate to include such further particulars relating to any opinion certified as the regulations may prescribe, (b) shall require any certified opinion falling within section 1(1)(d) of this Act to include an opinion as to the nature of the physical or mental abnormalities from which there is a substantial risk that the child would suffer if it were born, and

(c) shall require the practitioners or practitioner concerned to send a copy of any such certified opinion as is referred to in paragraph (b), and of any such further particulars relating to that opinion, solely to the person to whom they are required by regulations to give notice of the termination,

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and for the purposes of paragraph (c) of subsection (1) of this section such a copy is information furnished pursuant to the regulations.".'.

Mr. Alison : It will probably assist the House most if I begin with a factual background explanation of what the amendment would secure, and then argue its merits. In an important vote on 24 April of this year, when we last debated these matters on the Floor of the House, we determined by a substantial majority that the Infant Life (Preservation) Act 1929, with its well known 28-week benchmark for foetal viability, should no longer be the overall ringmaster, so to speak, in the arena of abortion. It was the crack of that ringmaster's whip, to continue the analogy, which in practice determined the operational impact of the Abortion Act 1967, because the 1967 Act incorporated no specific time limits of its own. But in disapplying the 1929 Act in its bearing on the 1967 Act, as we did in April, and in shaking off that yoke, the instinct and purpose of hon. Members and, I argue, of the Government was not to declare a time vacuum between a human conception and a human birth nine months later. It was rather to declare that the 1967 Act had come of age and could feature specific time limits in its own right and in accordance with more modern conditions.

Our purpose was manifestly not to sweep away all benchmarks but to choose between alternative benchmarks. If our original intent had been to sweep away all benchmarks, we need not have troubled ourselves with long lists of optional alternative time periods for foetal viability, ranging from 18 to 28 weeks. We could simply have had an amendment to repeal the 1929 Act.

There was no such catch-all amendment before hon. Members on 24 April last. But there was before us--properly, logically and responsibly--a proposed Government new clause in which every relevant major category of abortion had an up-to-date and specific time limit attached to it--24 weeks for the general risk of injury category, 24 weeks for the new grave permanent injury category and 28 weeks for the risk of foetal handicap category. Only the category of pregnancy where the continuance would involve risk to the life of the woman did the Government leave fully open-ended in their original new clause on 24 April.

I will not weary the House with a rehearsal of how, probably partly unintentionally, we ended up by declaring a time vacuum for important categories of abortion, enfranchising them, so to speak, across the whole nine-month gestation period up to birth.

Mr. Peter Thurnham (Bolton, North-West) : My right hon. Friend suggests that hon. Members voted unitentionally in that way. Surely we were just following the recommendations of the Brightman committee. Has my right hon. Friend read the conclusions of the House of Lords Select Committee, which recommended not only that the Infant Life (Preservation) Bill *[Lords]* should not proceed, but that there should be no upper limit in cases of foetal abnormality? The Bishop of Gloucester, a member of that Select Committee, voted for that recommendation.

Mr. Alison : I chose the word "unintentionally" deliberately, because a number of hon. Members who voted to eliminate the 28-week limit as applied to foetal abnormality were under the impression, falsely, that its elimination would not produce an open-ended and undated situation but would result in a fall-back fail-safe

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application of the 24-week limit, which the Government had written into other categories of abortion. I repeat, from the point of view of the Infant Life (Preservation) Act, that whatever others may be arguing or advocating, there was no substantive amendment before hon. Members on 24 April to repeal that Act.

Miss Widdecombe : Will my right hon. Friend confirm that the representations that we have received from hon. Members who were confused on that occasion do not come exclusively from what might be termed the pro- life side but come from all sides of the argument, including hon. Members such as my hon. Friend the Member for Bolton, North-East (Mr. Thurnham), and that the confusion that reigned that night must be put right if we are to know the will of the House?

Mr. Alison : I agree with my hon. Friend. The fact remains that that open-ended enfranchisement of a whole range of categories of abortion for the total nine-month gestation period appears now on the face of the Bill.

As at present amended, the four grounds for abortion spelt out by the Government in the original version of clause 34, with time limits specified, now feature no fewer than three which discard all time limits and allow abortion up to birth. That is about as sweeping and fundamental a reversal of the existing law as one could imagine, for the existing law allows for the destruction of a viable foetus up to birth in only one case, and that is the single dreadful contingency that one life, either that of the mother or the infant, must be forfeit. That open-ended commitment in that unique case we have extended in the way I have described.

It is because I believe that the majority of hon. Members are not content with that sweeping liberalisation--with the new

open-endedness--that my amendment has been tabled, precisely to re- establish some final points.

Mr. Kenneth Clarke : I have before me the diagram which was produced by the Leader of the House on the last occasion we discussed the issue and which, in my recollection, was used by the vast majority of hon. Members as a guide to their voting intention. It clearly sets out--in the case of the two categories where my hon. Friend's amendment challenges the no limit-- that in respect of grave permanent injury to the health of the woman, two amendments were tabled, one of which would have brought in no limit and one of which would have brought in 28 weeks. Hon. Members cast a vote in favour of no limit, and I was on the losing side. It also makes clear, in the case of substantial risk of serious handicap, the choice between no limit, 28 weeks and 24 weeks. Again, hon. Members voted for no limit.

I understand my right hon. Friend's views and, as his amendment has been selected, he is reopening the question. But is he sure that he is doing the House a service by suggesting that, in the middle of the night on the last occasion, when hon. Members were armed with three documents--there were unofficial ones also--which were guides to what they were voting on, they did not actually know the way in which they were voting? That is not my recollection of the evening.

Mr. Alison : My right hon. and learned Friend must bear two points in mind, and I am grateful to him for throwing further light on this complex area. The first is

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that the Leader of the House's famous diagram darkened counsel for a large number of hon. Members. It was erroneous in substantial and important respects.

For example, paragraph 7 of the document said :

"The effect of the ILPA is to produce a 28-week limit where the abortion is to prevent grave permanent injury to the pregnant woman's health. The new clause replicates this, providing 28 weeks instead of 24 weeks."

Where did the new clause replicate that? It did not do so on the face of the amendment as tabled by the Government. That statement was misleading and erroneous. There were others, in the junior Minister's speech, in which she misquoted letters applicable to amendments that appeared on the Order Paper, and in the guidance offered by the Leader of the House.

I must tell my right hon. and learned Friend that not only was counsel darkened by some of the advice received from the most responsible sources but when, against the wish and advice of the Secretary of State--in the case of the 28-week change--the House took a particular decision, it is not unlikely that the resulting liberalisation might have induced hon. Members to think that they should reconsider the whole gamut of amendments that ultimately resulted from the decisions that we took that night.

8 pm

Mr. Patrick Cormack (Staffordshire, South) : I entirely agree with my right hon. Friend. Does he agree that that evening of voting was the most confusing that most of us have experienced in our parliamentary careers ; and will he further agree that it tended to bring Parliament into disrepute because hon. Members were going around with three sets of papers and were totally confused? My right hon. Friend is doing the House a great service by bringing the issue back this evening.

Mr. Alison : I am grateful to my hon. Friend. I do not want to lose the sympathy and support--I am bound to desire and require it--of my right hon. and learned Friend the Secretary of State, but I trust that he will allow me my attempted defence of the inescapable human fallibilities of the highest civil service sections and sources in these difficult matters.

The effect of the amendment will be that the 24-week limit already provided for by my right hon. and learned Friend in clause 34(1)(a), in the single case of the general risk of injury category, will be extended to the grave permanent injury category of subsection (1)(b) and to the risk to life category of subsection (1)(c). Uniquely, the general 24-week limit will be raised to 28 weeks by our amendment in the case of the fourth and last category in the clause--that of possible foetal handicap.

The House will note that there is nothing innovative or radical about these new time limits. They do not tighten up on what the Government first brought forward ; rather, they echo the original 24 April draft of the Government new clause, in which, as the House will recall, 24 weeks was proposed for the new grave permanent injury category and 28 weeks for potential foetal handicap.

Mr. Terence L. Higgins (Worthing) : Will my right hon. Friend confirm that his amendment will still leave open-ended an abortion in the case of risk to the mother's life?

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Mr. Alison : I come immediately to that point. The only category that was originally open-ended in the Government's 24 April draft but to which we have attached, as to the others, the 24-week limit is that of balance of risk to the woman's life--subsection (1)(c). In the amendment, that is merely a precautionary, not an absolute, provision, because, as we know, any abortion performed in good faith for the sole purpose of saving the pregnant woman's life is not subject to any time limit under section 1(1) of the Infant Life (Preservation) Act 1929. That Act will thus continue to operate as a fail-safe mechanism in any abortion over 24 weeks.

My right hon. Friend the Member for Worthing (Mr. Higgins) may wonder why we bothered to include that limit, given that the Infant Life (Preservation) Act can override it. The reason is that there are doctors today who argue that an abortion at 12 weeks is so safe that it is actually a good deal safer than any pregnancy brought to term, so it could be argued that one was more likely to save the life of a woman if her pregnancy were never allowed to come to term and were always aborted as early as possible- -that is the logical consequence of the argument : to end all human births. So we have introduced this precautionary, 24-week limit, safeguarded by the Infant Life (Preservation) Act.

We should not deceive ourselves or mince words. To abort means to do away with, deliberately, finally and irrevocably--the word can mean nothing else. That is different from a miscarriage of a very early foetus. In that case, what nature has given, nature has taken away. It is also different from an induced or premature termination or evacuation of a more developed or viable foetus. In that case, when nature has apparently fumbled, human hands can seek to rescue. Incidentally, a termination or evacuation after viability is an induced birth. It is only an abortion if the child is deliberately killed.

My amendment, reintroducing the 24 and 28-week limits, would not affect terminations on medical grounds--for example, under clause 34(1)(b) or (c)- - provided that there was an intention to save the child if possible and not to destroy it.

The stark and dreadful import of abortion is that what nature has successfully--in spite of all hazards--launched into the orbit of life, human hands seek deliberately to arrest and destroy in

mid-trajectory. To make such a terrible intervention in the course of nature demands compellingly good reasons. The further the foetus has got off the ground, so to speak, the more vital it is that human intervention should be geared to assisting and upholding, not to arresting and destroying.

This is why Parliament is surely right to seek, across every shade of opinion, to circumscribe abortion, carefully and agonisingly, and why it is right to insist on some time limit, as the new clause, if amended, would still do, if a growing foetus had to be interrupted and destroyed. Parliament would be wise to adopt this amendment, with its reintroduction of these vital limits. The amendment is designed to circumscribe the greatest of all risks in this area : human fallibility.

Sir David Steel : We are considering four amendments, and before I deal with the main one, I want to mention the other three in passing. I have no doubt that the hon. Member for Salisbury (Mr. Key) will seek to speak to amendment No. 29, about which he has written to me, so

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I will say only that I support it and I look forward to hearing what he has to say about it and amendment No. 30.

Amendment No. 28 attempts to write into the main statute the conditions of certification that doctors may make when carrying out certain abortions. My view is that that is best left to the regulations, but perhaps the Minister will say something in answer to the anxieties of those who have tabled the amendment. I shall certainly not support it in the Lobby.

As for amendment No. 4, I was one of those who voted unsuccessfully and on the losing side in Committee on removing the 28-week upper limit and, in certain categories, allowing abortion up to birth. Were a similar amendment to be put before us again I would vote the same way, but the right hon. Member for Selby (Mr. Alison) should be aware that he is not only reintroducing the 28-week upper limit in this category ; far more seriously, he is reintroducing to abortion law the concept of the use of the Infant Life (Preservation) Act 1929. The 1967 Act contained no time limit. Instead we decided to incorporate a reference to the Infant Life (Preservation) Act 1929. I remind the House that that Act created a presumption of viability at 28 weeks but no reverse presumption of non- viability below 28 weeks. We incorporated that reference precisely because of the uncertainty at that time about precise viability.

We have seen the law in operation for 23 years, and, as everyone knows, private Members' Bills have attempted to bring in a more precise upper time limit for the carrying out of abortions. The Department of Health under successive Governments has by regulation and instruction introduced lower time limits. In Committee, we introduced a general limit on most abortions of specifically 24 weeks. That was a fundamental change to the 1967 Act and to the exceptional upper limit of 28 weeks. The House decided on a free vote that there would be no limit at all in certain categories. I know that the hon. Member for Newbury (Sir M. McNair-Wilson) attempted to suggest that there might have been some confusion. That suggestion received some support, but I have yet to meet a single Member who has said that he voted the wrong way and was confused.

Sir Michael McNair-Wilson (Newbury) rose--

Sir David Steel : If the hon. Gentleman wishes to admit to confusion, may I take that as read and pass on?

Sir Michael McNair-Wilson : Yes.

Sir David Steel : Even my hon. Friend the Member for Liverpool, Mossley Hill (Mr. Alton) writing in The Tablet of 15 May--this shows how carefully I pay attention to his words--said :

"It was suggested that at the end of the two-day marathon debate some MPs had become confused about precisely what they were voting for. Looking through the division lists I do not believe that by and large this is the case."

There is a little twist in the tail, because my hon. Friend then says :

"Some may be confused in their beliefs, but there is a fairly consistent pattern in what MPs actually did".

That is true. There may have been an odd case of confusion, but I think that the House was fairly clear, given all the guidance that was around. I wrote to everyone in my party regardless of how he voted, and not one of them voted in a way that he did not mean to.

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Mr. Alton : I am grateful to my right hon. Friend for giving publicity to The Tablet. I said that, by and large, there was no great confusion about the way that hon. Members voted. I am glad that the House has an opportunity to consider the matter again, because it raises substantive issues, not just on the matter of handicap but on the uncoupling of the Infant Life (Preservation) Act 1929 which my right hon. Friend linked to the Abortion Act 1967. He should now explain to the House why he thinks that it should not be linked.

Sir David Steel : I was in the middle of doing that, and I am sorry that I was deflected by the discussion on confusion. Even if there was minor confusion, it would not have affected the fact that the House, wrongly in my view, voted the way it did.

The amendment is an alteration to the clause which seeks to remove the Infant Life (Preservation) Act 1929 from abortion law. The reason for that is that, if we state specific statutory time limits, as we have done in this legislation, it does not make sense to recreate uncertainty by applying a totally different law on infant life preservation and incorporating it in the Bill. We would be reintroducing the element of doubt which always lay in the Infant Life (Preservation) Act. Because the 1967 Act had no statutory limits, we rested our case on the 1929 Act. Experience since then suggested that it is better, and the House has expressed the wish to put specific time limits in abortion legislation.

8.15 pm

This matter was carefully trawled by the Select Committee in the other place. Reference has been made to that. The condition "capable of being born alive", which is in the Infant Life (Preservation) Act, is the very phrase which has given rise to so much uncertainty in the minds of the medical profession. The Select Committee in the other place unanimously recommended that there should be a decoupling and that we should state clear statutory limits.

There has been only one consistent effort to secure prosecutions under the Infant Life (Preservation) Act. There were four attempts, and they were all made by Professor Scarisbrick who is the chairman of the Life organisation. Hon. Members are used to being badgered by the so-called pro-life organisations. I am pro-life and I object to being characterised as not pro -life. Perhaps it is fair enough for hon. Members to be badgered, but I object to members of the medical profession being badgered and bullied in this way. I am glad to say that all four cases were rejected by the Director of Public Prosecutions.

The amendment proposes to reinvite vexatious prosecutions in this area, and we would be wise to avoid it. In the context of the provision that applies to the handicapped, the House of Lords report says on page 18 :

"If, for example, an unborn child were diagnosed as grossly abnormal and unable to lead any meaningful life, there is in the opinion of the Committee no logic in requiring the mother to carry her unborn child to full term merely because the diagnosis was too late to enable an operation for abortion to be carried out before the 28th completed week."

That is a telling argument in favour of the decision made by the House.

While I did not support the decision to place no upper time limit on these categories, it is perfectly reasonable to support it as long as they are in extremis cases only. Earlier, we heard about a cut-off time limit in the abortion law of other countries. According to the Gunning study,

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France, the Federal Republic of Germany, Italy, Spain and Sweden have no upper limit in extremis cases of the kind that we are talking about. We are talking about a limited number of cases.

One other country which has no other upper time limit is Scotland. The right hon. Member for Castle Point (Sir B. Braine), who is the Father of the House, wisely declined to become entangled in the Scottish case. I assure him that that matter is highly relevant. The Infant Life (Preservation) Act never applied to Scotland, not even after 1967. That means that, within the kingdom, we have an example of a country whose abortion law has no upper time limit. That has certainly not been abused, because in 1988 there were seven abortions over 22 weeks and in 1989 there were five. We are talking about a small number of extremely tragic cases where desperate decisions have to be made by the medical profession.

In that connection I deplore the circular that was put round by the promoters of the amendment. It is by two gentlemen in University college, Oxford. Paragraph 3 says :

"If abortion on any of the four grounds results in the delivery of a living and viable foetus, it will be lawful to destroy it during birth for any reason at all, from harelip to hair colour." That is a gross calumny on the medical profession. I do not think that anyone practising medicine in Britain would destroy a baby during birth because the colour of the hair was wrong.

Mr. Alton : Will my right hon. Friend give way?

Sir David Steel : I will not give way. I feel strongly about this matter. The paper is there and hon. Members can make their own speeches. I find such things totally discreditable.

I shall end by quoting from Mr. David Paintin, reader in obstetrics and gynaecology at St. Mary's hospital. He was one of the original medical advisers on my team in 1967. He now says about the proposal that is before us :

"There are few circumstances in which abortion is necessary after the 24th week ; there were only 23 cases notified in this country in 1988. Most such abortions are performed because the foetus has been shown to have an abnormality that would prevent sustained life after birth or that would result in gross handicap. A small number of such abortions are induced because the woman is gravely ill and her health would be permanently harmed or she might die if the pregnancy continued. In these cases the foetus is so immature or so affected by the illness in the woman that it would not survive. If the foetus is mature enough to have a reasonable chance of survival with modern intensive care, all possible steps are taken to optimise the survival of both mother and foetus ; delivery is normally by caesarian section."

He concludes :

"A proper ethical attitude to abortion must take into account the potential humanity of the foetus"--

that was the basic principle of the 1967 Act--

"but must also consider the humanity of the woman and the circumstances which, in her view and her doctors' view, make continuation of the pregnancy inadvisable. I believe that it is wrong to force the woman to continue the pregnancy to the serious detriment of her health or to force her to carry a foetus that is severely abnormal. The sensible decisions taken by Parliament in April clarify and improve the law. In my experience, women and doctors agree that abortion after the 24th week should be performed only in the most exceptional circumstances."

I believe that the House should rest by the decision that we have taken.

Column 1186

Mr. Robert Key (Salisbury) : I rise to speak to amendments Nos. 29 and 30. Amendment No. 30 would clarify the law in relation to selective reduction. The present position, as I understand it, is that it is not clear beyond doubt whether that procedure comes within the terms of the Abortion Act 1967. Some people agree that if after selective reduction a pregnancy continues, that cannot be a termination of pregnancy within the meaning of the 1967 Act. The counter argument is that the procedure constitutes a miscarriage and that it must therefore be done under the protection of the Act. The medical literature abounds with legal cases and learned articles from lawyers trying to argue the problem through. It is clear that there is significant doubt and it is essential that that is removed. The selective reduction procedure was neither in use nor even contemplated when the legislation introduced by the right hon. Member for Tweeddale, Ettrick and Lauderdale (Sir D. Steel) was passed in 1967. However, I understand that the procedure has been in use in Britain since 1982. It involves terminating one or more foetuses in a multiple pregnancy. That procedure may be used for a number of reasons. For example, some selective reductions are done because one or more of the foetuses has been diagnosed as having a seriously handicapping condition. In other cases it may be done because carrying a high order multiple pregnancy to term may jeopardise all the foetuses or the woman's life or health. Whether it is appropriate to carry out a selective reduction is, in the last analysis, a matter for the clinical judgment of the doctor and the wishes of the woman concerned. I understand that the number of cases is likely to be small.

My explanation has been brief. I hope that whatever moral or ethical stance we take on abortion, we can accept the importance of clarity and that the procedure should be brought within the ambit of the 1967 Act and the controls that it provides.

Mr. Frank Doran (Aberdeen, South) : I take the firm view that amendment No. 4, on which I want to concentrate, is thoroughly misconceived, certainly in the way in which it was presented by the right hon. Member for Selby (Mr. Alison). It is also deliberately disingenuous because it is nothing more than an attempt to reverse a decision of the House taken by an emphatic majority in a way which is a mystery to me as a relatively new hon. Member.

We have already heard several hon. Members complain about the large number of voters on that night who were apparently misled or who misled themselves. I have never heard of such a thing from hon. Members. One of the major problems that struck me when I first came to the House was the arrogance of hon. Members who felt that they could do no wrong and always thought that they knew what they were doing ; that Parliament, in its great wisdom, is always supreme. Yet here we have a large number of hon. Members bowing before the House and admitting to the commission of a supreme error- -that they voted the wrong way because they did not understand measures properly. I wonder what their constituents will think when they are faced with legislation and issues much more complex than this, on which the majority of hon. Members have strong views, as all the debates on the issue have shown. No hon. Member can make a greater sacrifice than to admit his fallibility, as so many have done. But

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Column 1187

they are not lowering the ego quotient in this place ; it is simply a desperate attempt to reverse an emphatic decision of the House, and it should be seen in that light.

What saddens me about the efforts that have been made to reverse the votes on 24 April is the way in which many arguments have been perverted. Few of the arguments that we heard from the right hon. Member for Selby and those who support him have rested on fact. I have a copy of the paper that was referred to by the right hon. Gentleman, which purports to be a legal opinion from John Finnis, professor of law and legal philosophy, university of Oxford, and Dr. John Keown lecturer in law and co-director of the centre for health care law at the university of Leicester. I am a solicitor and well used to reading legal opinions and I am appalled at the content of that paper, which I understand was circulated to all hon. Members. The right hon. Member for Tweedale, Ettrick and Lauderdale (Sir D. Steel) has already taken issue with part of it.

It is important to look at the paper, to assess the arguments with which it presents us. For example, it is suggested in the first paragraph that an interpretation of the clause that was passed by the House on 24 April would allow abortion until birth in a wide range of cases, markedly altering the existing law, which allows the destruction of a viable foetus only to save the mother's life. Only the most asinine of lawyers would interpret in that way a clause that is specific about the legal requirements before it is permitted to operate.

For example, according to clause 34(1)(b), it must be shown "that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman". That is a severe legal test, as are the other tests. Clause 34(1)(c) says :

"that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated".

That again is an extremely serious legal test, and if any doctor failed to satisfy it, he could be prosecuted. Finally, clause 34(1)(d) says :

"that there is a substantial risk that if the child were born it would suffer from such physical abnormalities as to be seriously handicapped."

Doctors operating in that area know of the attempts to examine their work by the so-called pro-life or, as I prefer to call them, anti-abortion organisations. Their work has been handicapped. I do not want to attack the integrity of our medical profession, which is what the right hon. Member for Selby and his supporters have done. They do an excellent job in difficult circumstances. It is sometimes a difficult and tasteless job. But to make their job that much more difficult by suggesting that the medical profession would willy-nilly ignore those strict provisions in the Bill, which I hope will become an Act, is unacceptable and a smear on the medical profession. For example, it is suggested in the paper that some doctors will interpret the onerous conditions that apply to them as including a hare lip or a cleft palate. That is pure scaremongering, which is appalling coming from a professor of law and a lecturer in law.

Mr. Alton : My right hon. Friend the Member for Tweeddale, Ettrick and Lauderdale (Sir D. Steel) refused to give way on that point, and as it has been cited a second time, it is important to clarify it. Doctors at Guy's hospital recently advertised for mothers who would otherwise be

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having abortions on grounds of cleft palate to come forward in order to carry out operations in the womb. As much as we may be grateful for progress in medical science, does not the hon. Gentleman accept that if those are the sort of reasons being given by doctors for performing abortions, it is perfectly acceptable for Professor Finnis to quote them in his letter?

8.30 pm

Mr. Doran : It is perfectly acceptable for Professor Finnis to quote such examples in context. However, we have instead the bald statement that in the view of that learned professor, the justification for terminating pregnancies is being interpreted in the way that he suggests. That is unacceptable, and his paper bears little resemblance to what I suppose was meant to be an objective assessment of how the Bill will operate. The paper goes on : "If abortion on any of the four grounds results in the delivery of a living and viable foetus, it would be lawful to destroy it during birth for any reason at all, from harelip to hair colour." That is an outrageous statement from practising lawyers, let alone a professor of law at one of our principal universities.

I am not sure what is intended by that alleged interpretation, but if an aborted foetus is found to be alive and is by medical opinion thought capable of sustained survival and is effectively viable, then I as a lawyer should have no hesitation is saying that the destruction of that foetus would be criminal.

Scaremongering of the type that I quoted, by two apparently respectable individuals, is outrageous and has produced a contrary response in me.

Ms. Harman : They ought to be reported to the Law Society or to the Bar Council.

Mr. Doran : My hon. Friend says that they should be reported, but it is unlikely that either of those two gentlemen has even practised real law. Certainly there is no suggestion of that in the opinion that I quoted.

As the right hon. Member for Tweeddale, Ettrick and Lauderdale pointed out, the medical profession has adapted to the 1967 Act as it has progressed, and the Scottish experience is worth bearing in mind and examining. Any lawyer offering an opinion should look at current practice, particularly when it is so close

to home.

I circulated a paper written by one of my constituents, Professor Allan Templeton, professor of obstetrics and gynaecology in Aberdeen. I shall read out part of his paper because it is important to record the professional medical view on a provision similar to that passed on 24 April, which I hope will become law. It has operated in Scotland since 1967.

It is not a case of widespread abuse of the 1967 Act, of abortions being performed willy nilly, on request, and of reasons for them being invented afterwards. It is not a case either of abortions being performed for trivial reasons--and the suggestion that they have occurred because of the risk of cleft palates or hare lips is intended to trivialise the medical decision. Instead, it is a case of establishing a body of principle related to the obligations that a medical practitioner has to his patients and to the law of the land, which is currently the Abortion Act 1967. Professor Templeton says :

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"It has been accepted in obstetric practice for some time that pregnancy should be terminated, regardless of the gestation, if the mother's life is at risk. Such a situation is not infrequent in obstetric practice, associated with such conditions as pre- eclampsia, abruption and placenta praevia. Similarly, it is accepted that the diagnosis of a lethal foetal abnormality is, if the mother so desires, an indication to terminate the pregnancy, regardless of the gestation. The classification of the procedure can vary. For example, we recently terminated a pregnancy"--

at Aberdeen royal infirmary--

"of 27 weeks' gestation, at the mother's wish, because of the diagnosis of renal agenesis, a condition which results in absence of the kidneys and is incompatible with life This is a clear example of current recognition that the age of viability is somewhat less than 28 weeks, and probably nearer to 24 weeks. The point here is that doctors have developed self-imposed guidelines that have emerged from their experience of current clinical practice. Thus, the perception has grown that it would be quite inappropriate for a variety of reasons to terminate pregnancies approaching the age of viability for reasons other than where the mother's life is at risk or there is a lethal"--

and Professor Templeton emphasises lethal--

"foetal abnormality. This self-imposed, unwritten code of practice is evident on scrutiny of recent figures."

Professor Templeton gives figures for the number of late terminations in 1987, 1988 and 1989. In 1987, there were in Scotland 11 terminations over 22 weeks ; in 1988, seven terminations ; and in 1989, five terminations. That is not a story of abuse of the law or of an apparent latitude that the measure passed on 24 April will allow elsewhere in Britain.

The law is being observed responsibly, and that will continue. I have no reason to believe that doctors in England and Wales are any less responsible than those in Scotland. For that reason, I hope that all right hon. and hon. Members will oppose amendment No. 4 and will base their decision on how to vote on the facts--and not in response to the scaremongering tactics that have been evident so far today.

Miss Widdecombe : I am grateful for the opportunity to speak to this group of amendments and to my own amendment No. 28. The law currently states that a doctor should abort on the ground of disability only if the child runs a substantial risk of having a disability and if the disability itself is serious, yet there is no method of checking on the various disabilities that are the reasons why abortions are performed. When an abortion is undertaken the forms that are returned often show that it was performed not because of a disability but for a different reason. If we are to draw a distinction between handicapped and healthy children, the time has come for a ready check on the disabilities that are deemed to be so severe that the child is to be killed after viability and not be allowed to survive.

When the hon. Member for Liverpool, Mossley Hill (Mr. Alton)--who on this occasion is my hon. Friend--moved his original Bill, he clearly stated that there was evidence that doctors were aborting in the case of harelip, cleft palate or club foot. At that time, we were not debating abortions for disability up to birth but abortions within the limits of the 1929 Act. When the hon. Member for Mossley Hill made those statements, he was ridiculed. The same sort of reply was given then as we heard tonight--that such claims are a slur on the medical profession, which would never do such a thing. However, there is no

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means of extracting from the Secretary of State for Health whether such a practice would arise, because there is no obligation in an abortion to submit to the Secretary of State a clear definition of the disability involved.

In case anyone doubts that abortions have been carried out for the reasons cited by the hon. Member for Mossley Hill I will refer to a letter that I received from Anthony Rowsell, a consultant plastic surgeon at Guy's hospital, who is responsible for performing the pre-natal surgery, for which we are all very grateful, on unborn children with minor deformities. He wrote in defence of his work because he misunderstood my remarks in Committee, thinking that I was attacking pre-natal surgery. He informs me that mothers not only have abortions but that they are routinely offered. That should be a cause of worry because the legislation says that abortions should not be offered routinely in the case of minor defects but that there should be a substantial risk of serious disability.

If, as hon. Members on the other side of the argument frequently contend, the medical profession has nothing to hide, and the Act is working well, there could be no possible objection to asking the profession to tell us how often it routinely aborts for a minor defect. If we have a requirement that the nature of the disability should be specified on the form, we shall be able to see whether doctors are aborting for spina bifida, hydrocephalus and cystic fibrosis or for harelip and club foot. I cannot see any objection to giving that information.

If the House tonight confirms its decision--I sincerely hope and believe that it will not--that we are going to abort for disability until birth, even if the circumstances are rare, we have a sovereign duty, not merely a right, to check on the nature of the disability which is the reason for the abortion being carried out.

Ms. Harman : I intervene on the point that the hon. Lady made about Guy's hospital. I am not familiar with the letter that the plastic surgeon wrote to her, but I presume that he is not in the regional genetic investigation department, which is run from the hospital. Guy's serves many of my constituents, and I had my babies there. For my last pregnancy I had amniocentesis and I went through the entire counselling procedure. It was never suggested to me that the discovery of an abnormality such as harelip or club foot should be grounds for considering a termination. It was made clear to me, as a patient, that the object of counselling and investigation was to discover whether there was a serious abnormality. In the process they might discover minor abnormalities, but that would not mean counselling for an abortion. The hon. Lady should be careful before she continues in that vein.

Miss Widdecombe : I shall be careful, because I have ample evidence, including that letter from Guy's, which I have in my hand, that it is, or was, routine to offer abortion for minor defects. If we need any proof of that, think of the police investigation into the case of the King's college baby. I shall raise that case later when I discuss the amendments tabled by the hon. Member for Salisbury (Mr. Key). We know that in that case the disability was not serious, it was not life threatening, it would not cause the child to be crippled, to have restricted physical movement or restricted mental agility. Yet, an abortion--it was not an abortion, but a selective reduction, which is one of our dinky terms for fratricide--was carried out at twenty-seven and half weeks.

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If the medical profession has nothing to hide, it cannot object to filling in the forms and doing it on time. Why does the Department tolerate a situation in which more than 300 of those forms were returned more than six months late in the past year?

Mr. Thurnham rose--

Miss Widdecombe : I shall give way later.

I shall now turn to the important amendment, No. 4, tabled in the name of my right hon. Friend the Member for Selby (Mr. Alison). I regret the passing of the Infant Life (Preservation) Act 1929 from the Abortion Act. I should like to digress briefly before you call me to order, Mr. Deputy Speaker, on what I believe to be one of the most serious effects of removing that Act--now, for the first time since 1929, we have no long-term law in place.

One of the greatest achievements of the 1929 Act was that it was drawn up when medical science was nothing like it is now, and the Act stood the test of 60 years. The reason why it stood the test of time was that it was drawn up with a long-term view in mind. It did not give 28 weeks as a limit for abortion. It said that 28 weeks was a rebuttable presumption. The guiding principle of the 1929 Act was the capability of a child to be born alive. As viability came down gradually from 28 weeks to 24 weeks, children between the ages of 24 and 28 weeks of pregnancy effectively enjoyed the protection of the 1929 Act.

8.45 pm

I mention that fact to the Secretary of State because it is important that the point is not overlooked during the debate. It is a pity that the amendment standing in the name of my right hon. Friend the Member for Castle Point (Sir B. Braine) was not selected, and it is important that his argument is not overlooked. If, in two years' time, the medical profession turns round and says, "We have improved incubation techniques to such an extent that we can now keep alive 40 per cent. of 22-week-olds and a few more 23-week-olds", what protection will there be in law for them?

Mr. Kenneth Clarke : I am sure that the hon. Lady understands that no one has repealed the Infant Life (Preservation) Act 1929. The only effect of what the House has done is that the Act does not now apply to cases provided for by the Abortion Act. The effect of the amendment is to apply two pieces of legislation to the same operation, in some cases with very confusing results. The House voted before for the Abortion Act to have limits, or no limits, and for those cases to disapply the Infant Life (Preservation) Act. The Act still applies to non-Abortion Act cases.

If the hon. Lady's second question was "What will happen if medical science moves on," if the Royal College of Obstetrlcians and Gynaecologists agrees that 24 weeks is too high a limit, the House could come back and review the Abortion Act limit which we have just set in the light of medical knowledge. That does not mean that we would start applying two Acts and reducing them both. The Infant Life (Preservation) Act has been set aside for Abortion Act cases, largely to ensure that there is clarity in the law, in line with the votes which the House cast last time on the Abortion Act limits.

Miss Widdecombe : I am grateful to my right hon. and learned Friend for confirming two things. First, no long-term protection exists under the law and we would

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have to come back to the House to decide again. I thought that the purpose of the grievous dissension and wrangling in the past few months was a clear long-term law, so that it would not be necessary to have such parliamentary upheaval at regular intervals. If we do that, surely it is essential to build in a legal protection so that we do not have to come back to say, "Look, the situation has changed."

As a result of the decoupling of the Acts, the House has inadvertently removed protection from viable children under the 24th week, removed long- term law and made it certain that, at some time, we shall have to return to the vexed business of time limits. I certainly do not think that that is desirable, and I have said so in public on numerous occasions.

All hon. Members should understand that that is the effect of removing the Infant Life (Preservation) Act. I appreciate that it has not been repealed, but decoupled, and I do not want to be critical of my right hon. and learned Friend the Secretary of State, because he and his Department have been most helpful in the past few months, assisting us with whether an issue was valid or technically cohesive. However, for the past year I have issued challenge after challenge about the observation of the Infant Life (Preservation) Act. For example, why was a lethal injection given if there was no possibility that a child could be born alive in the first place? I gave several other instances. The Secretary of State admitted that it did not work particularly well. Instead of tightening up and policing the Act properly, his answer to the failure of difficulties in observing the Infant Life (Preservation) Act was to remove the Act altogether.

Mr. Kenneth Clarke : I fail to follow my hon. Friend. Obviously neither of us wishes to interrupt--

Mr. Deputy Speaker : Order. Will the Secretary of State please desist from turning his back on the Chair? Will he please address the Chair?

Mr. Clarke : The pleasure of looking in your direction, Mr. Deputy Speaker, will enable me to turn towards the Chair.

Amendment No. 4 decouples the Infant Life (Preservation) Act in respect of abortions carried out under 24 weeks. However, my hon. Friend's point is irrelevant. The amendment maintains the position--which is not as troublesome as she claims--that as medical science moves on, the House will reduce the limit from 24 weeks. However, her amendment still decouples the Act. She is using the Act to introduce confusion into the law by making the Infant Life (Preservation) Act and the Abortion Act both apply above 24 weeks in certain cases and 28 weeks in others.

Miss Widdecombe : I am grateful to my right hon. and learned Friend, although he did not offer any elucidation.

I said at the beginning of my speech that it was digressing a little to refer to babies under 24 weeks' gestation, but I want to get it clearly on record that there is no longer long-term protection for them.

Let me examine what we have agreed in regard to disability. I do not want to discuss again whether there was confusion. Although hon. Members may have understood clearly enough the instructions and description of any particular amendment, the interdependency and interrelationship between various amendments became more

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difficult to work out. When they decoupled the Infant Life (Preservation) Act, they thought that, under the guidance of the Secretary of State, they were simplifying a difficult legal situation and producing an administrative device to make things tidier rather than, as a result of the previous failure to write in limits, removing completely any protection for disabled children right up to birth.

When I introduced my Bill I was quite happy to exempt disability, as did the hon. Member for Liverpool, Mossley Hill (Mr. Alton) when he presented his Bill. But we did not mean that we would exempt disability up to birth ; we meant that we would exempt it up to the limit of the Infant Life (Preservation) Act. The removal of the Infant Life (Preservation) Act effectively meant that there would be exemption up to birth.

I feel very strongly about the matter, as does my hon. Friend the Member for Bolton, North-East (Mr. Thurnham), and I shall take an intervention from him in a moment. However, it is a gross insult that disabled people could switch on their televisions and radio at any hour of the day or night during the past few months and hear politicians arguing about whether they have the right to be born. We would not offer that insult to any racial or religious group, so we should not offer it to disabled people. It is wrong.

When a disabled child is born, that child has the full protection of the law. It does not matter how gross the disability, how handicapped the child embarks on life or how grievous are the effects of that handicap on the mother and the family. At that point the child has the full protection of the law. However, a few hours or even a few minutes earlier, according to the letter of the law, the child does not have that protection. I have stood up in the House time and again and argued that the right that we extend to a child in an incubator should be extended to a child of identical age in the womb. I never thought that the day

would come when I would have to stand here and argue in the House of Commons, the mother of Parliaments and the centre of civilisation, that it is wrong not to extend the same protection to a child a few hours before birth as applies to a child that has been born prematurely and already enjoys the full protection of the law. It is wrong, morally repugnant and an insult to the handicapped.

Mr. Thurnham : My hon. Friend has been issuing challenges and talking about duties. The effect of the amendments would be that more severely handicapped children would be born. My hon. Friend is in favour of more severely handicapped children being born. The other day I heard that she had said that if she had a handicapped relative she would give up her job to look after that person. What is she waiting for? There are thousands of severely handicapped children in institutions whose families cannot look after them. Why does she not adopt one? Is she afraid that a social services committee would not give approval for her to be a mother?

Miss Widdecombe : That last comment shows the degree of desperation prevailing on the other side of the argument. When hon. Members have to resort to personal abuse, it is quite clear that they have no argument. I must tell my normal hon. Friend the Member for Bolton, North East that there is a queue of people waiting to adopt

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Down's syndrome children. Are we now saying that Down's syndrome is a cause for abortion up to birth although there is a queue to adopt those children? That queue consists of couples, not single people like myself who could not provide a father. I believe that the best start in life for handicapped children is to have two parents.

Mr. Alton : I support entirely what the hon. Lady is saying. I reiterate that if the state were not prepared to provide homes for disabled people and if there were no adoptive parents, many people in church and voluntary organisations, including the Bishops of England and Wales, have made it absolutely clear that they would provide homes for any disabled person.

Miss Widdecombe : I am most grateful to the hon. Gentleman for that comment.

Mrs. Ann Winterton (Congleton) : Does my hon. Friend agree that the intervention by my hon. Friend the Member for Bolton, North-East (Mr. Thurnham) was somewhat cheap to say the least? He has raised that point during every debate on the subject. I should like to put on record how much I admire and respect his wife who, for seven days a week, cares for their severely handicapped adopted child. However, it does the hon. Gentleman's reputation no good to raise the matter because we know that he is extremely active in the House, in his constituency and as an entrepreneurial business man. So he cannot undertake the very duties that he challenges other hon. Members to undertake.

Miss Widdecombe : I am grateful to my hon. Friend, but we should not argue about each other's personal capability or willingness to undertake those duties. That would not be profitable.

Many members of the Society for the Protection of Unborn Children and of LIFE and many others have adopted handicapped children but do not make a public parade of it. They also deserve respect. It is not confined to one side of the argument.

I deal now with the Finnis letter and the statement that it is possible to terminate for disability before birth. The 1929 Act was introduced--as can be checked in the Hansard of the time--precisely to fill the lacuna of the Offences Against the Person Act 1861 which did not protect the child during the process of birth. That is on record and is a matter of legal history. I do not draw any pictures of doctors aborting during birth ; I am saying that the 1929 Act filled that lacuna, but the removal of the Act reinstates it. Those who share the views expressed by the hon. Member for Mossley Hill and I will vigorously oppose the amendments tabled by my hon. Friend the Member for Salisbury. Amendment No. 30 proposes to bring selection reductions under the Abortion Act. I am not sure that the amendment is technically viable because it refers to a miscarriage. A miscarriage is not an abortion and it is not a selective reduction or a stillbirth. When a woman has a miscarriage she loses her child. In a selective reduction, the child is left in the womb until birth occurs naturally of its surviving siblings. In the King's college baby case, there was selective reduction at 27 weeks for a mild form of handicap. One twin was allowed to live, but the other was killed in the womb by an injection of potassium chloride.

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9 pm

I do not use, and have never used, the term "murder". I do not think that it is helpful to do so and it causes much guilt and grief for women who have had abortions. But when at 27 weeks one twin is allowed to survive and the other is deliberately killed with a lethal injection, I cannot think of another term to use.

Dame Elaine Kellett-Bowman : When I was carrying our first child I did not understand why my husband suddenly lost two stone in a fortnight. He did not tell me for many years that he had been told by the doctor that I was expecting one baby with two heads. In this day and age, those delightful children, who have twins of their own, would have been aborted.

Miss Widdecombe : I am most grateful to my hon. Friend. We daily read stories of parents who have been given the wrong

information--although perhaps not as horrendous as that--by the medical profession, whose children go on to lead normal, healthy and fulfilled lives. That is a genuine error of the medical profession ; it never deliberately gives misinformation.

If selective reduction is to be governed by the Abortion Act, it will be made legal, even after viability has occurred. We now have no time limits, for example, for reductions for disability. Viable children in the womb could be killed quite legally. But that is not always done, even for serious or minor disability. When a woman discovers in the early stages that she is having a multiple birth--quite often these days, as a result of being overimplanted through IVF techniques ; the doctor creates the situation which he solves by selective reduction--how does she choose? If there is nothing wrong with them but there are simply too many, how does she choose? On the grounds of sex, hair colour, colour of eyes? What is the deliberate killing of children in those circumstances called? If that is to be called abortion, when it is not--it certainly is not a miscarriage--we are going down a dangerous path.

Amendment No. 29 gives the Secretary of State powers to enlarge the classes of premises that will be licensed. I believe that that is merely a paving measure--even if it is not intended as such--for self-administered home abortion.

Mr. Key : It has been brought to my attention that what my hon. Friend has just said appears in the whip issued by the pro-life group. That is not the intention and, quite inadvertently I am sure, my hon. Friend has been very misleading. When I spoke, for all of three minutes so that we could hear arguments from all hon. Members, in the cause of brevity I did not refer to amendment No. 29. My hon. Friend has been speaking for 30 minutes, and with the leave of the House I shall later seek to explain her misleading argument.

Miss Widdecombe : I shall take my hon. Friend's hint and begin to curtail my remarks. I said not that he had deliberately set out to create that, but that it would be the effect. If the Secretary of State is finally able to allow self-administered abortion at home, through RU486 or whatever else is developed, there will be legalised back-street abortions with precious little counselling or control. That will be the ultimate effect.

We are told that Scotland has never experienced any problems, despite not having the Infant Life (Preservation) Act 1929. Scottish medical practice is governed by the

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General Medical Council and the ethics committee. Its ethics are based on English law. That point has been made by a number of Ministers in different circumstances. Now that the English law is being changed, there is

no reason to suppose that there will not be very late abortions. If the amendment spoken to by my hon. Friend the Member for Bolton, North-East is passed, more disabled children will be born. The amendments that have already been agreed to will lead to an increase in the number of abortions. My hon. Friend the Member for Bolton, North-East admitted as much tonight, even though he may not have intended to do so.

The ILPA has resulted in the removal of legislation that has been on the statute book for many years. We shall be making a distinction, up to birth, between disabled and healthy children. If the other amendments are passed, they are likely to end up as home abortions and as selective reductions.

I apologise for addressing the House on the subject at such length, but it is important.

Several Hon. Members rose--

Mr. Deputy Speaker : Order. There is little time in which to discuss these important issues. A number of hon. Members wish to take part. Therefore, brief speeches will be in order.

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Ms. Richardson : I listened carefully to what the hon. Member for Maidstone (Miss Widdecombe) had to say about disabled foetuses. She shows great concern for disabled people, so I was surprised when it was drawn to my attention that the hon. Lady voted against the last report of the Select Committee on Social Services on community care. All hon. Members want the interests of carers to be safeguarded. However, the hon. Lady was the only member of the Select Committee to vote against the report. That is extraordinary, especially when one remembers that she has expressed support for the handicapped and the need for the House to think about how Parliament and the Government can help the disabled.

The subject with which we are dealing amounts to a re-run of what happened on 24 April. That is extremely distressing. I have been a Member of Parliament for about 15 years. I cannot recall another occasion when cool, decisive decisions have been taken and then, six to eight weeks later, reversed because, it is said, many hon. Members did not know what they were doing. A few hon. Members may have been confused ; it was, in many respects, a confusing evening. For about two and a half hours we were trooping through the Division Lobbies. However, I was extremely pleased and surprised to see that hon. Members seemed to know what they were doing. I did not find that hon. Members were saying to one another, "Gosh, I don't know what I'm voting about tonight. Should I be in this Lobby? Oh, no, I am in the wrong Lobby." That did not seem to be happening.

Dame Elaine Kellett-Bowman : The hon. Lady was not in the same Lobby that I was in. Her side of the argument suddenly withdrew the tellers in their Lobby, which admittedly threw our Lobby into confusion. There was a quick succession of votes and the fact that the hon. Lady's Lobby suddenly withdrew tellers on a Division on one amendment threw people into confusion.

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Ms. Richardson : The hon. Lady is apparently saying that something that we did on our side of the argument threw her side into disarray.

Dame Elaine Kellett-Bowman : We had gone into the Lobby to vote for something and then suddenly, quite unaccountably, the hon. Lady's side of the argument withdrew their tellers.

Ms. Richardson : I am very sorry, but this is the House of Commons and I should have thought that hon. Members were used to reading the Order Paper to know what they were doing. The hon. Lady's comments are quite an admission. It is not our job to say, "Stop, are you sure you know what you're doing? Are you sure that you really want to withdraw this?" I am not suggesting that the hon. Lady is stupid, because I am sure that she is not. I am really sure about that. I honestly believe that by and large, with possibly a few exceptions--one or two hon. Members have admitted that they were in the wrong Lobby on the wrong occasion--hon. Members knew what they were doing. The fact that the clause stand part debate was carried by such an overwhelming majority and that hon. Members stayed to the very end to register their votes must be significant. Nearly two months later, we are effectively having a re-run of that issue.

Dame Elaine Kellett-Bowman : And you have lost.

Ms. Richardson : The danger is that we shall undo what we did less than two months ago. I do not know whether the hon. Member for Lancaster (Dame E. Kellett-Bowman) can recall an occasion when the House has taken two different stances within such a short period. I certainly cannot recall such an occasion.

Mrs. Edwina Currie (Derbyshire, South) : Does the hon. Lady recognise that some of us knew what we were doing on that night? I abstained then, and I am grateful for the opportunity to think again about the issue. Although I disagree with a great deal of what I have heard tonight and I particularly deplore the personal insults which have been flying around on both sides of the House, I have concluded that amendment No. 4 should be supported.

Ms. Richardson : Well, okay, people are entitled to change their minds. The hon. Member for Derbyshire, South (Mrs. Currie) is honest and gutsy enough to get up and say that she wants to change her mind. However, I do not believe that the House as a whole wants a re-run. If we were to take that practice to its logical conclusion, we would be re-running votes that we had taken during the week.

Mr. Cormack : Will the hon. Lady give way?

Ms. Richardson : I do not really want to give way, because I do not want to spend all the short time available to me on this constitutional issue. However, as the hon. Member for Staffordshire, South (Mr. Cormack) so ably chaired the Standing Committee on the Abortion Bill and was so kind to us, I will certainly give way to him.

Mr. Cormack : I am grateful to the hon. Lady. She was most gracious to give way.

We are dealing with this Report stage and during the passage of Bills hon. Members have the opportunity and the duty to keep thinking about the issues under discussion. I happen to believe that there was an element

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of confusion on that night of the long votes, and that we will prove it this evening. Hon. Members will vote and the Bill has not yet completed its passage through the House. What we are doing tonight is entirely constitutional and proper. At the end of this evening, we will know where we stand.

Ms. Richardson : I did not suggest that this was unconstitutional. I said that it was unusual and that I could not remember it happening before. We must remember that the Leader of the House specifically gave the House, as the Department gave the House, a clear opportunity to vote on this issue on 24 April after a full day's debate. The majority of hon. Members who participated that day--and there were many--feel that, although it is perfectly true that we are today discussing the Bill on Report, we are entitled to re-discuss issues and I acknowledge that. The fact that we had a Committee of the whole House with not just one child's guide from the Leader of the House, but child's guides all over the place meant that the House knew what it was doing. Not only hon. Members who supported my argument but hon. Members who supported the other side of the argument have expressed surprise that the whole matter should be re-run. 9.15 pm

The effect of what was passed that night was the same as the provisions of Lord Houghton's Abortion (Amendments) Bill in the other place. A considerable amount of briefing material explaining its provisions had crossed hon. Members' desks well in advance of the debate on 24 April. Some hon. Members actually tabled that Bill as a new clause so hon. Members were not unfamiliar with the arguments and proposals. The Houghton Bill was supported unanimously by the House of Lords and was based on the report of a Select Committee that had sat for two years. The members of that Select Committee took the same position as the House has taken today.

There are two reasons why the House of Lords thought that a woman's health and foetal handicap should be exempt from time limits. It is difficult to distinguish between life and health. Doctors cannot be sure whether a pregnancy will kill a woman immediately, but it could shorten her life considerably, and that must be taken into account. Pregnancy could damage a woman severely. It could put her in a wheelchair or induce illness such as multiple sclerosis. Some handicaps are so severe that the foetus cannot survive. In a dramatic case, the brain or some other vital organ may be missing. It is difficult to define the phrase

"capable of being born alive".

There have, quite rightly, been many judgments and much case law and discussion on this. The recent judgment in the Rance case, for example, has extended case law in this area. It now appears that, if a foetus is capable of drawing a few breaths, the law can regard it as viable. We must tackle that decision, because a foetus with no brain may be capable of being born alive, but it cannot survive for more than a few hours. We must face these difficult problems, and the House did so on 24 April with enormous good sense.

There is no evidence that doctors have ever performed late abortions for trivial reasons--not even in the case of the Carlisle baby, which is often referred to in the House. On investigation, it was found that there was no case to

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answer. The upshot of the Carlisle case was that the woman concerned, having had to make a terribly difficult decision, had her case investigated by the Director of Public Prosecutions and the whole thing was splashed across the British press. That woman was put through enormous agony.

I do not understand why those hon. Members who are anti-abortion cannot accept a decision that was taken by this House in good faith and with substantial votes so recently. I think that I heard those hon. Members say before 24 April that if the House had an opportunity to vote on that matter, they would accept the results of that vote. I believe that the hon. Member for Maidstone said that. I hate to say that they suggested that they would go away, but they certainly suggested that they would not raise the matter in the regular way that they have been raising it for the past several years--as I know to my cost.

Miss Widdecombe : It is the same Bill.

Ms. Richardson : Here we are, not two months later, and those hon. Members are raising the whole thing again.

I was pleased this morning to receive a copy of a letter from Sir George Pinker, the president of the Royal College of Obstetricians and Gynaecologists, which was addressed and faxed to the hon. Member for Bolton, North-East (Mr. Thurnham). It stated :

"I am writing before tomorrow's debate to confirm that the College's view would be in support of Lord Brightman's committee's findings and we would support his letter of 19th June in the Times." I am sure that hon. Members who are interested enough to be in the Chamber now will have read the letter.

Sir George Pinker continued :

"We would not like to see the Infant Life (Preservation) Act insinuated into the provisions of the Abortion Act."

That is a clear and informed decision. The House has a duty to take note-- as we usually do--of the views of the RCOG because it is composed of a large number of distinguished people.

I hope tonight that we shall decisively reject amendment No. 4, just as on 24 April we decisively decided to vote as we did. We shall support the amendments tabled by the hon. Member for Salisbury (Mr. Key). Although there is possibly a technical drafting problem with one of them, I am sure that it could be put right--

Mr. Key indicated dissent.

Ms. Richardson : I am glad to note that the hon. Gentleman is shaking his head about there being a drafting problem.

On balance, we feel that his amendments should be supported. I hope that my hon. Friends will join me in the Lobby to defeat this dangerous amendment, amendment No. 4.

Mr. Kenneth Clarke : I begin by confirming that all four of the amendments that have been selected are the subject of a free vote as far as the Government are concerned. No Whip is being applied to my right hon. and hon. Friends or--as far as I am aware--to any hon. Member. When we refer to Whips in this context, we are talking about briefs that people take from colleagues who are sympathetic to their point of view, which will help to guide them through the amendments. As this is one of our last debates at this stage of our deliberations on the Bill, I am pleased to record the fact

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that the House has so far handled the Bill with considerable care. Although there are strong feelings among hon. Members, I am sure that we all regret that a slight note of abuse has begun to creep into the debate.

Although I disagree with my hon. Friend the Member for Maidstone (Miss Widdecombe) on most of these issues--I have, however, voted with her three times this evening--I have the highest regard for the way in which she puts her case and for the strength of her convictions. Similarly, my right hon. Friend the Member for Selby (Mr. Alison) is a long-time colleague, for whose views I have the highest regard. I wish to make a few brief factual points about the three less important amendments and shall then deal as briefly as I can with amendment No. 4. First, the amendment tabled by my hon. Friend the Member for Salisbury (Mr. Key), on selective reduction-- amendment No. 30--is correctly drafted.

Mr. Frank Field : So we should be given its source.

Mr. Clarke : Some doubt has been raised about that. Secondly, the amendment would have the effect of clarifying the law as we believe it stands. The best advice that we can obtain is that selective reduction is subject to the Abortion Act 1967 but that there is considerable doubt about the matter. The effect of the amendment would be to clarify the position. The only effect of not accepting it would be to leave the law shrouded in doubt.

Mr. Alton : Will the Secretary of State explain then why the word "miscarriage" is used in the amendment when there is no miscarriage and the baby stays in the womb until it is born?

Mr. Clarke : We have taken advice from parliamentary counsel and others. The difficulty of deciding exactly what selective reduction is, when the foetus is killed inside the womb, makes the position different from that of ordinary abortion. Therefore, miscarriage is regarded as the legally correct description. I am advised that the amendment is correctly drafted to catch selective reduction. It makes it clear that selective reduction can be carried out only if the practitioner complies with the abortion legislation in whatever form it emerges from Parliament.

Amendment No. 29, also tabled by my hon. Friend the Member for Salisbury, would give the Secretary of State the power to approve a place in relation to treatment consisting primarily in the use of such medicines as may be specified. The amendment anticipates the possibility that drugs such as RU486 will be licensed and approved for use in this country. As the House knows, in France about 30,000 women have chosen that method of lawful abortion. It does not involve surgery or general anaesthesia. If that drug is ever introduced here, it will extend the range of choice available to women and to doctors who prescribe treatment. As the law stands, if no power such as that contained in the amendment is provided, it will continue to be necessary for the patient to have the drug administered in a hospital or other approved place. There is no medical reason for that. My hon. Friend the Member for Maidstone mistakenly suggested that the abortion pill will be given out and taken home. First, no such pill is yet licensed here. It will not be licensed unless the Committee on Safety of Medicines is satisfied when the application is made that it should be

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licensed. Such a pill would be administered only in closely regulated circumstances under the supervision of a registered medical practitioner.

A question was asked earlier about what type of premises would be used for administering such a drug. It is possible that the pill could be administered in a GP's surgery under the supervision of a registered medical practitioner. The patient would still have to return two days later to be given the pessary.

All that my hon. Friend the Member for Salisbury seeks to ensure is that, if such a drug is licensed, the Secretary of State will at least have the power in primary legislation to approve the places and circumstances in which it might be used. If we do not address that matter this evening and if the drug is licensed in a year or two, there will be a private Member's Bill on every Friday for several years about whether the circumstances in which the drug is administered should be changed. It is for the House to decide.

Sir Bernard Braine : Will my right hon. and learned Friend give way?

Mr. Clarke : I apologise to the Father of the House, to whom I should normally give way out of respect. However, I am sure that the House does not want me to spend so long on these three amendments that I cut other hon. Members out on amendment No. 4.

There is hardly any difference between my hon. Friend the Member for Maidstone and me on amendment No. 28. It deals with whether it should be necessary to record the handicap in the case of abortions carried out on the ground of handicap of the child. There is some point to the amendment. It would finally answer one way or the other the continual claim that abortion is carried out for a hare lip or other such condition. I share the doubts of those who say that that does not take place. My hon. Friend is convinced that it takes place, but we do not know because no one is required to notify what the handicap is. The only argument for the House to consider is how to go about recording handicap.

If amendment No. 28 is accepted, it will be necessary on the green form, a certificate which must be filled in before the operation is carried out, to specify the handicap in every case from no weeks to 28 weeks, or however many weeks we allow. I give an undertaking to the House that if that amendment is defeated the Government intend to introduce regulations to make it necessary for the nature of the handicap to be specified on the notification for a late abortion after 24 weeks. I shall not argue the point because people can reflect on that and decide which method they prefer. I believe that it will be necessary to introduce a record of the nature of the handicap.

9.30 pm

Everyone who has spoken tonight will agree that amendment No. 4 is the one that matters most. We must first be clear about the factual effect of amendment No. 4. Unlike the other three, amendment No. 4 does not relate to a new issue. My right hon. Friend the Member for Selby and my hon. Friend the Member for Maidstone are trying to reverse the effects of amendments (i) and (f) that were carried on 24 April. They openly acknowledge that that is their intention, together with the decoupling of the Infant

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Life (Preservation) Act 1929, which resulted from the acceptance of amendment (q). My hon. Friends want to reverse the combination of those three amendments.

Let us be clear what the House did on that occasion, upon which we are now being asked to reflect. The amendments introduced, without time limit, the right to an abortion on the new ground of preventing "grave permanent injury to the physical or mental health of the pregnant woman"

Recently some constituents told me that that means abortion on demand, without a time limit, up to birth. That is a travesty of the truth. The amendment deals with cases where the mother is having such difficulties, for example because of hypertension, that she is running the risk of severe permanent damage to her brain, heart, or kidneys. The doctor then feels the need to intervene to terminate the pregnancy, as he must intervene if the life of the mother is plainly threatened. The letter that was quoted in the debate has already revealed that the most reputable practitioners would attempt to do so in a way that saved the life of a viable foetus, if possible.

Dame Elaine Kellett-Bowman : Does my right hon. and learned Friend accept that in those particular circum-stances, where the blood pressure of the mother threatens to damage her kidneys, the doctor could induce the birth without killing the baby?

Mr. Clarke : In effect, that is what the doctor will try to do and that will have the effect of terminating the pregnancy. The doctor will terminate the pregnancy while attempting to save the life of the baby if he can. I believe that there will be few cases in which that will happen, but we must consider them.

On the previous occasion when we considered the Bill the House allowed, without time limit, abortions on the existing ground of the substantial risk

"that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped."

The right hon. Member for Tweeddale, Ettrick and Lauderdale (Sir D. Steel) has already said that that covers cases where the child may be capable of life and have the ability to breathe and move after birth, but have no brain. It would be incapable of sustained existence and in that case an abortion could be carried out without a time limit.

I understand how strongly and sincerely hon. Members are arguing that that decision should be reversed. Tonight, the House will vote on whether to reverse the decision to introduce no time limit on the two grounds that I have specified.

It appears that we are being asked to reconsider because people were confused on the previous occasion that we considered the Bill. I must address that point because the Leader of the House and I were responsible for the ordering of that debate and for the attempts to inform hon. Members about what was happening. I have obtained the two documents that we circulated. One was from the Leader of the House--a copious document--and, because people said that it was long and difficult, a short document was published by the Whip responsible for the Bill, my hon. Friend the Member for Derby, North (Mr. Knight), which was distributed to hon. Members on both sides of the House who wanted to know for what they were voting.

As I said in an earlier intervention, the diagram was absolutely clear. It explained that in relation to grave permanent injury to the health of the woman, amendment (f) imposed no limit, (g) would be 28 weeks, and in the case

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of a substantial risk of serious handicap, the relevant amendment would introduce no limit, compared with the 28 weeks in the Bill. The guide produced by the Whip, my hon. Friend the Member for Derby, North--it was described as an idiot guide--described amendment (f) as "Liberalising--provides no time limit in those cases where mother risks grave injury."

That was carried by 337 votes to 146, with myself voting with the majority. Amendment (i) was described in that guide as

"Liberalising--provides no time limit for abortion if child is likely to be seriously handicapped."

That was carried by 277 votes to 201. I voted on the losing side on that occasion, as did the right hon. Member for Tweeddale, Ettrick and Lauderdale, because I should have preferred 28 weeks for handicapped cases.

I checked the Division lists. My right hon. Friend the Member for Selby voted the wrong way on both occasions. Knowing his views and convictions and examining those Division lists, I am sure that he did not intend to vote the way that he did on those occasions. I cannot but help think that that is why my right hon. Friend has been asked to move the amendment, for he is the only one who appears to have voted the wrong way.

My hon. Friend the Member for Newbury (Sir M. McNair-Wilson) voted the wrong way once ; he got one wrong and one right. All other hon. Members who voted on that occasion voted then as they are speaking now. They knew exactly what they were doing, and they went down--I went down with them--by 76 votes in one Division, they had a majority of almost 190 against them in the other.

An attempt is now being made to reverse the situation--giving the House a second opportunity, as has been said--but to avoid putting the same Question for the second time, those in favour of that course are using the mechanism of the Infant Life (Preservation) Act 1929. They are bringing a confused method back into the Bill by reversing the former decision.

To reintroduce the Infant Life (Preservation) Act, as amendment No. 4 would do, would take us back to the strange feature of that Act, in that before 28 weeks it is necessary for the prosecution to prove that the child was capable of being born alive, and after 28 weeks there is a rebuttable presumption. That has always been confusing, as we all know. I do not claim that it is unintelligible to lawyers. It has not existed in Scotland, although I am sure that Scottish lawyers would have no more difficulty in understanding it than English lawyers.

If the amendment were made, taking the concept of grave permanent injury to the health of the mother back to 24 weeks--I did not vote for that on the previous occasion--the effect would be that between 24 and 28 weeks there would be an offence under the Infant Life (Preservation) Act if it were proved that the child was capable of being born alive ; above 28 weeks there would be an offence under the Infant Life (Preservation) Act unless it was shown that the child was not capable of being born alive ; and in the case of the child born with serious physical or mental abnormalities, there would be no offence if it was under 28 weeks--none of the long-term protection to which my hon. Friend the Member for Maidstone was, I think, referring when she said that she was trying to defend

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that aspect--but above 28 weeks there would be an offence under the Infant Life (Preservation) Act unless it was shown that the child was not capable of being born alive.

I have selected from a large table circumstances describing the effects of amendment No. 4 on termination under different grounds after 24 weeks. I said on the previous occasion that the legal consequence of reversing the provision in the way suggested would be unbelievably confusing. As was made clear by my hon. Friend the Member for Maidstone--the Whip for the evening, if I may use that expression--the effect for doctors would be so confusing that they would know that above 24 weeks they would be at risk from the law if they carried out an abortion in the case of proven brain damage to the woman and above 28 weeks they would be at risk from the law if the child was suffering from severe foetal handicap.

Mr. Alison : My right hon. and learned Friend is drawing our attention to this important document, which is meant to throw light on the path that we have been trying to tread in this complicated debate. The very last sentence of the last annex on the last page of the descriptive brochure issued by the Leader of the House--I refer to annex D--states :

"Where the Abortion Act set a limit of 24 weeks or less, ILPA would apply above that time limit and would put the burden of proof on the defence from 24 weeks onwards instead of from 28."

Because my right hon. and learned Friend has himself introduced subsection (1) (a), which specifies 24 weeks as one of the limited options in respect of so-called social abortions, by that very definition the ILPA has become involved on his initiative, exactly as defined in the specification issued by the Leader of the House. So my right hon. and learned Friend cannot complain that by introducing the 24 weeks to the other three subsections we are creating confusion.

Mr. Clarke : The paragraph from which my right hon. Friend is reading is the last of a series dealing with the last two amendments. It raised the question of what would happen if the House voted to decouple the Infant Life (Preservation) Act, and whether it would then be sensible to go on to vote for another amendment to reduce the ILPA to 24 weeks for non- Abortion Act cases. The sentence to which my right hon. Friend referred makes it clear that that would be logical if it were wanted. By general agreement--I remember consulting my hon. Friend the Member for Maidstone-- we did not move that amendment because nobody particularly wanted to move it, so the sentence deals with a hypothesis in which no one was interested and which was never moved--and which has not been mentioned since. It does not undermine my basic point.

Furthermore, turning to the page on which my right hon. Friend claims there is a mistake, which deals with exceptions for emergency situations, we read :"no limit (amendment i)". Three sentences below the paragraph about which my right hon. Friend complained we read : "Amendment (f), if carried, would provide that there should be no time limit to the exception on the grounds of grave permanent injury."

If this amendment is carried, the House will have flatly contradicted the two amendments that it passed by large majorities on an earlier occasion. We shall then have to decide what happens next, but I still argue that the House must come to a resolution of all those matters and of the law. Personally, I should continue to go for 28 weeks in the

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case of handicap to the child. There has been no such operation recently, but we are debating no amendment that would allow us to return to 28 weeks, so, although I lost last time, I should have left the matter there.

I do not agree with a reduction to 24 weeks when there is a risk of grave permanent injury to the mother. If doctors are dealing with a mother who will suffer grave permanent injury if her pregnancy is continued, I cannot believe it moral to make it illegal to terminate her pregnancy while doing everything possible to save the life of the child.

The House was right before ; I await the judgment of the House on a free vote later tonight.

Mr. Alton : Four amendments are before us, and before dealing with amendment No. 4, the most controversial, I should like to support the hon. Member for Maidstone (Miss Widdecombe), who spoke to amendment No. 28, which would give the House the chance to make case-specific the recommendations made by a doctor carrying out an abortion, so that we can clearly know in future debates whether an abortion has been carried out for seemingly trivial reasons.

There have been disagreements about whether abortions have occurred for reasons such as club foot, cleft palate or harelip. I suppose that to some extent we all rely on our postbags and anecdotal evidence. In one case where the child is my godson, it was recommended that the mother should have an amniocentesis test for the following child because the first had been born with a cleft palate. When she asked why she should have the test, she was told that it would be irresponsible not to do so. The woman, who is a constituent of the hon. Member for Birkenhead (Mr. Field), was then told that she would jeopardise the pregnancy if she did not proceed with the test. Of course the opposite is the case, because amniocentesis carries a 3 per cent. risk of a spontaneous abortion.

9.45 pm

The fact that a doctor would put pressure on a mother to have such a test is reprehensible. The fact that he tried to justify it by saying that an earlier child had been born with a cleft palate and that therefore the next child might have some disability shows the route down which we have gone. It is the eugenics route, a justification of abortion on the ground that in some way the baby may be born disabled.

Anyone listening to our debates and to debates outside would think that the vast majority of abortions were for disability reasons. That is not true, because 98 per cent. of all abortions are on perfectly healthy children and even 92 per cent. of late abortions are on perfectly healthy children and the disability issue does not arise. Amendment No. 28 would at least require the nature of the disability to be specified, and it would end this argument once and for all because each year we could table parliamentary questions asking the Secretary of State about the returns for that year and we would know the precise reasons for abortions.

Amendment No. 29 was tabled by the hon. Member for Salisbury (Mr. Key) and concerns the drug RU486. The Secretary of State for Health said that the amendment would pave the way for RU486 and would avoid the need for the House to return to the subject if it so wished.

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Anyone would think that RU486 was not available in Britain but that is not the case because trials have been undertaken and it is significant that the clinic chosen for the trials is in my constituency.

Clinical trials have shown that in most cases it is also necessary to administer prostaglandin. The pill has side effects such as incomplete abortion and severe bleeding in the mother. It has been suggested that the mother is more likely to suffer from post-abortion trauma after delivering a complete but dead baby. If the amendment is accepted, RU486 will become available.

It is worth bearing in mind that there has been some wide-scale experience in France. The French medical journal of 30 April says that Roussel, the company which manufactures RU486, has sent a circular to abortionists in France telling them of one heart attack and another cardiac anomaly that have occurred in a woman after she had undergone an RU486 abortion.

The company also reported knowledge of more than 3,000 further cases of less serious side effects and said that women must be assessed for risk of cardiac problems before taking the drug, that the procedures in use must be tightened, and that resuscitation equipment must be available and ready for use wherever the drug is administered. We all know that in private clinics such facilities are rarely available.

Let us be clear about the area that we are entering by paving the way in the manner that the Secretary of State has suggested. Amendment No. 30 also stands in the name of the hon. Member for Salisbury ; it deals with selective reduction. We often use euphemisms in debates to disguise what we really mean. The Lancet recently published a letter which suggested that the term "selective reduction" might be politically unacceptable to the House and suggested that it would be better to use the phrase "pregnancy enhancement".

We should be clear what selective reduction means. It means that, where there is a multiple pregnancy with too many foetuses, or where one is thought to be handicapped, the surplus or handicapped babies can be removed. A doctor using ultrasound to guide the needle stabs the heart of one of the babies and injects potassium chloride. That is usually carried out at nine to 12 weeks gestation, but in some cases--the House has already had drawn to its attention tonight the case of the King's college baby--at 27 weeks' gestation. Not years ago, but this year, a baby was aborted at 27 weeks' gestation. That case is currently the subject of a police inquiry.

Mr. Key : It is precisely because of the unclearness of the law at present and precisely because there is enormous dispute in the medical and the legal professions that I am seeking, through the amendment, to clarify the law so that the medical and legal professions know exactly where they stand. We cannot go on ducking those responsibilities.

Mr. Alton : That is precisely the point that I am making. The hon. Gentleman wants us to make legal what I believe the House should outlaw because it is wrong. At 27 weeks' gestation, the King's college baby was aborted because it was one of twins which would have been infertile for the rest of its life. In no way was that a life-threatening disability or a handicap.

Ms. Primarolo : That is not true.

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Mr. Alton : It is true. I shall give the hon. Lady further details.

Mr. Kenneth Clarke : Such an abortion would have been illegal if it did not comply with the Abortion Act. What my hon. Friend the Member for Salisbury (Mr. Key) is saying is that the abortion being graphically described by the hon. Gentleman must comply with the Abortion Act. I will not comment on the particular case, but anything of the kind that the hon. Gentleman is decribing would be unlawful.

Mr. Alton : The very reason that the Secretary of State describes is a disability. If that disability is given as the reason for an abortion, it will be perfectly legal to selectively reduce using the handicap provision right the way up to birth unless amendment No. 4 is carried this evening. Therefore, it is all the more imperative that we consider amendment No. 4 in the context of the new amendments that have been placed before the House for consideration only today. It is vital that we reverse the bad decision that was taken. Whether that was the result of confusion or whether the House knew the reason for it is immaterial. The whole point of a Report stage is so that we can reconsider matters after we have pondered them. But in the context of the other amendment on selective reduction, it is even more important that we ensure that, right the way up to birth, there is protection for the child that might otherwise be removed. In opposing amendment No. 4, various arguments have been placed before the House. One was that the letter from Professor Finnis and Dr. Keown was in some way misleading. My right hon. Friend referred to the first part of the letter, which says that abortions would be allowed until birth in a wide range of cases, markedly altering the existing law which allows the destruction of a viable foetus only to save the mother's life. Let us be clear that that is precisely what the House has authorised by uncoupling the Infant Life (Preservation) Act from the Abortion Act which my right hon. Friend the Member for Tweeddale, Ettrick and Lauderdale (Sir D. Steel) put in place in 1967. We ensure that a perfectly viable baby of, say, 23 weeks' gestation would have to be saved. Under the terms of what the House has agreed, that would no longer be the case.

The Scottish question has constantly been thrown in tonight as though that is a reason why, as the hon. Member for Aberdeen, South (Mr. Doran) and the right hon. Member for Selby (Mr. Alison) said, we in some way or other should not ensure that the law does the most to maximise the protections and safeguards for the unborn child. I took the trouble to speak to the Scottish Office during the passage of my Bill. The Infant Life (Preservation) Act did not apply in Scotland but other provisions did, and it is worth bearing those in mind. The then Solicitor-General, responding to the Corrie Bill, as it was known, in 1979, explained the law as it applied in Scotland. He said in Committee on that Bill :

"In Scotland the medical operation by surgery is essentially an assault if it is not cured by proper medical care and proper medical motivations. The motive must be a proper medical motive in the proper circumstances. The law governs late abortions."

So the law was different in those circumstances.

In this country, abortions are not regarded as an assault. Also, there are joint committees of the BMA, both Scottish and English, which together have drawn up guidelines that have been applied in England, Scotland

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Select Committee on Science and Technology Written Evidence

Memorandum 1

Submission from the Department of Health

INTRODUCTION

1. This memorandum sets out the Government's position on abortion and highlights the action the Department of Health is undertaking to improve reproductive health. The memorandum also sets out the evidence to support current policy on abortion, where appropriate.

THE GOVERNMENT'S POSITION ON ABORTION

2. The current law governing abortions (the Abortion Act 1967) in England, Scotland and Wales was introduced by a private member's bill brought by David Steel MP.

3. The introduction of this legislation was prompted by a number of factors including a strong lobby by the women's movement and political will to safeguard women by reducing the number of illegal abortions being carried out and the number of resulting deaths. The (then) Council of the Royal College of Obstetricians and Gynaecologists (RCOG) also published a report calling for a number of measures to safeguard women and to clarify the existing law.

4. In 1967 and 1990, Parliament decided, on a free vote, that abortions may lawfully be carried out in the circumstances specified in the Abortion Act. It is accepted Parliamentary practice that proposals for changes in the law on abortion have come from back-bench members and successive governments have taken the view that such matters should be decided by members voting freely in accordance with their own conscience. The Government does however have a duty to see that the provisions of the Act are properly applied until, and unless, Parliament chooses to further amend that law.

5. The Abortion Act is a reserved issue. However, the provision of services is a devolved matter. The Department of Health deals with the policy on abortion services in England only but processes the abortion notification forms, and publishes the statistics, for abortions performed in England and Wales.

CURRENT LEGAL POSITION

6. The Offences Against the Person Act 1861 (only applies in England and Wales) makes it an offence to intentionally procure a miscarriage, including for a woman to procure her own miscarriage.

7. The Infant Life (Preservation) Act 1929 (again only applies in England and Wales) makes it an offence to intentionally kill a child, capable of being born alive, before it has a life independent of its mother. It is a defence to show that the death was caused in good faith for the purpose only of preserving the life of the mother. The Act stipulates that if a woman has been pregnant for 28 weeks that shall be proof that the child was capable of being born alive. But, if medical evidence is that the foetus would be capable of being born alive, then destroying the foetus could still be an offence under the 1929 Act, regardless of the age of the foetus. The Act says 28 weeks is the age above which there is prime facie proof that the child was capable of being born alive and therefore no further medical evidence on the issue would be needed.

8. The Abortion Act 1967 creates exceptions to the offences of procuring a miscarriage and child destruction. This Act makes an abortion legal where the pregnancy is terminated by a registered medical practitioner and where two registered medical practitioners agree that the grounds specified in the Act are satisfied. The legal time limit for most abortions in Great Britain is now 24 weeks. This was reduced from 28 weeks when the Abortion Act 1967 was amended by the Human Fertilisation and Embryology Act 1990. However, there is no time limit where there is a substantial risk that the child will suffer from a serious handicap, or the pregnancy will cause grave permanent injury to the physical or mental health of the mother, or put her life at risk.

PLACE OF TERMINATION

9. Unless performed as an emergency, the Act states that all treatment for abortion has to take place in an NHS hospital or a place approved by the Secretary of State. Within the NHS, abortions have traditionally been carried out in gynaecology wards and day care units. Since the passing of the Act in 1967, the Department of Health has always taken the view that outside of the NHS only independent sector hospitals or clinics can obtain Secretary of State approval. The current definition of an approved place is an independent sector place registered with the Healthcare Commission under the Care Standards Act 2000. These must be subsequently approved under the Abortion Act by the Secretary of State for Health. All places must re-apply for approval every four years.

CONSCIENTIOUS OBJECTION

10. Except where treatment is necessary to save the life of or prevent grave permanent injury to the pregnant woman, "no person shall be under any duty ... to participate in any treatment authorised by this Act to which he has a conscientious objection". It has been the case that if medical or nursing staff have strong ethical or moral objections to abortion work they should not be obliged to take this on. Their conscientious objection should not be detrimental to their careers and appointments. Further clarity on this clause was provided in a House of Lords judgment in 1988. This found that this exemption does not extend to giving advice, performing preparatory steps to arrange an abortion where the request meets legal requirements and undertaking administration connected with abortion procedures. The General Medical Council (GMC) booklet `Good Medical Practice' states that doctors' views about a patient's lifestyle or beliefs must not prejudice the treatment they provide or arrange. If they feel their beliefs might affect the treatment, this must be explained to the patient who should be told of their right to see another doctor.

NOTIFICATION

11. The Abortion Regulations make provision for the certification of the relevant opinion of the medical practitioners referred to in the Act and the giving of notice of abortions to the Chief Medical Officer (CMO). Practitioners are required to send to the CMO a notice of each termination on Form HSA4. In England, the Regulations require that Form HSA4 be submitted within 14 days of the procedure. This notification is used by the Department as an aid to checking that terminations are carried out within the law. Form HSA4 requires detailed information relating to the procedure including the names and addresses of the doctors who certified there were grounds under the Act, gestation, method used and place of termination. Every form is checked and monitored by Department of Health officials, authorised by the CMO. The Department returns around 11,000 (approximately 5%) of forms each year due to missing information or to seek clarification on information given.

KEY STATISTICS

12. In 2006, for women resident in England and Wales:

— The total number of abortions was 193,700

— Age-standardised abortion rate was 18.2 per 1,000 resident women aged 15-44

— 89% of abortions were carried out at under 13 weeks gestation (a figure that has stayed steady over the last 10 years); 68% were at under 10 weeks

— 87% of abortions were funded by the NHS (55% of these took place in the independent sector under NHS contract, mainly by the providers BPAS and Marie Stopes International)

— 70% of abortions were performed surgically and 30% were medical abortions

— 1% of abortions were performed due to the risk that the child would be born seriously handicapped

— 2,948 performed at 20 weeks and over (1.5% of total performed). Of these, 1,262 were performed at 22 weeks and over (0.7% of total performed) and 136 at 24 weeks and over (majority performed due to fetal abnormality). 149 abortions were performed where the woman's life was at risk or to save the woman's life.

METHODS OF ABORTION

13. Different methods may be used to terminate a pregnancy, depending on duration of gestation and other circumstances relating to the individual woman. The most common method of abortion continues to be vacuum aspiration which was used in 64% of abortions in 2006. However, in recent years there has been a large increase in the use of the abortifacient drug Mifegyne (mifepristone also known as RU486). Medical abortion accounted for about 30% of the total in 2006. The proportion of medical abortion has more than doubled in the last 5 years.

14. Medical abortion takes place in two stages. First, Mifegyne is given orally in a single dose. Forty-eight hours after the pill has been taken, a prostaglandin pessary is inserted into the vagina. The effect of this is to cause the uterus, already affected by the Mifegyne, to expel the pregnancy, generally within six hours.

15. During the Committee stage of the Human Fertilisation and Embryology Bill an amendment was passed, on a free vote, giving the Secretary of State power to approve classes of place (as opposed to individual places) where specified drugs may be used to carry out abortions in whatever manner was specified in the approval. The amendment anticipated the possibility that drugs like Mifegyne would be fully licensed and be available in places other than NHS hospitals or individually approved places. It was seen as an enabling provision should experience of the drug and the climate of opinion be right for such a move.

16. Progress is now being made to determine a "class of place". Two hospitals are currently being funded by the Department to run early medical abortion services in non-traditional settings, to evaluate the effectiveness and safety of provision in these settings. One site is within a community hospital; the other is in a stand-alone unit within an acute hospital. A formal evaluation is underway to assess the safety, effectiveness and patient acceptability of providing early medical abortion services in non-traditional settings.

THE ISSUES BEING CONSIDERED BY THE INQUIRY

17. As highlighted above, the Government's role is to ensure that the provisions of the Act are properly applied. Policy on abortion, particularly, ensuring early access to services for women who have grounds for abortion under the Act, and choice of method of procedure, has developed as part of the wider Sexual Health and HIV Strategy (more detail on this is at paragraph 39-45). The documents can be found at: http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Sexualhealth/Sexualhealthgeneralinformation/DH—4002168

The scientific and medical evidence relating to the 24-week upper time limit

(a) Developments, both in the UK and internationally since 1990, in medical interventions and examination techniques that may inform definitions of fetal viability;

18. In the 1980s a working party of the RCOG, established with Department of Health encouragement and including representatives of medical and midwifery professional bodies, was set up to look at medical advances in light of fetuses surviving before 28 weeks gestation. It recommended that the age at which a fetus should be considered as viable should be changed to 24 weeks. Their report, the report on Fetal Viability and Clinical Practice 1985, was sent to all RCOG Fellows and Members.

19. In 1990, Parliament agreed by a decisive majority, on a free vote, that the Abortion Act should be amended to lower the time limit from 28 to 24 weeks gestation in line with the clearly expressed and confirmed view of the main medical and professional bodies.

20. Our understanding is that the position has not changed—both the British Medical Association (BMA) and the RCOG are not convinced there is currently a need to change the time limits.

21. The Births and Deaths Registration Act 1953, as amended, provides for the registration of babies born dead after 24 weeks gestation and this is described as the legal age of viability. Guidance from the British Association of Perinatal Medicine introduces the concept of a "threshold of viability" as being from 22 to 26 weeks gestation. The British Medical Association's briefing paper "Abortion time limits" (2005) highlighted that gestational age is not the only factor that affects the possibility of a fetus being considered viable.

22. Whilst there have been medical advances in caring for premature babies, only a small number of babies born at under 24 weeks gestation can survive. Data (published in 2005) from the EPICURE study (Extremely Preterm Infants—a population based study of study and health status), established in 1995, shows the percentage of extremely premature babies who survived to 6 years of age as 1% at 22 weeks, 10% at 23 weeks, 26 % at 24 weeks and 43% at 25 weeks. Survival to 6 years of age (where disability is known) with moderate or severe disability at those gestations is 50%, 64%, 51% and 40% respectively. The full study can be found at http://www.nottingham.ac.uk/human-development/Epicure/epicurehome/index.html

23. The Nuffield Council on Bioethics published a Report "Critical care decisions in fetal and neonatal medicine" was published in 2006. One of its conclusions was that caution is required over decisions to treat babies born up to 23 weeks, six days of gestation as most babies born at 23 weeks die or survive with some level of disability even if intensive care is given; survival and discharge from intensive care for babies born between 22 and 23 weeks is rare. The full report can be found at:

http://www.nuffieldbioethics.org/go/ourwork/neonatal/publication—406.html

24. DH has previously asked the RCOG to look at the issue of fetal pain and review the scientific evidence. The RCOG's report "Fetal Awareness, Report of a Working Party"(1997) concluded that before 26 weeks gestation the nervous system has not developed sufficiently to allow the fetus to experience pain. The report recommended further research. This was taken forward by the Medical Research Council and its advisory group's report was published in 2001. The group concluded that, although there have been some developments in research into fetal pain since the publication of the RCOG report, there is still a need for further research in many areas. The experience of pain in the unborn is still poorly understood. In particular, further research is needed to improve understanding of how the ability to feel pain develops in the fetus and newborn child, and to provide better ways of measuring fetal stress.

25. As there can be uncertainties surrounding estimates of gestational age, the RCOG's report recommended that the requirements for feticide or fetal analgesia and sedation should be consider for abortions at 24 weeks or later. The RCOG then issued a letter to its members in 2001 advising them that for all abortions at 22 weeks or more, the method chosen should ensure the fetus is born dead and to consider the instillation of anaesthetic and / or muscle relaxant agents beforehand.

26. The issue of why women seek late abortions was most recently considered by the Centre for Sexual Health Research at the University of Southampton. This study was published on 17 April 2007 and found that women present late because of:

— Failure to recognise the pregnancy earlier (this can disproportionately affect teenagers or women approaching their menopause)

— Delay in seeking abortion due to personal circumstances, including decision making

— Difficulty in accessing abortion services (not knowing where to go or not being referred promptly)

(b) whether a scientific or medical definition of serious abnormality is required or desirable in respect of abortion allowed beyond 24 weeks;

27. Parliament decided in 1990 that in some circumstances abortion should be available without time limit. Around 100 abortions take place each year at gestations beyond 24 weeks most of which are done on the grounds that "that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped." Parliament did not define serious handicap in the Act. Parliament chose to leave this to the expert judgement of the two doctors based on the merits of each individual case. The doctors must form their own opinion about the seriousness of the handicap the child would suffer if born, taking into account the facts and circumstances of the case.

28. This position was recently challenged. In December 2003, the Rev. Jepson was granted permission to bring a judicial review of West Mercia police's decision not to prosecute two doctors who agreed to an abortion at over 24 weeks gestation because the fetus was diagnosed with bilateral cleft lip and palate. The Crown Prosecution Service announced in March 2005 that the two doctors had acted in good faith and that no prosecutions would be brought against them.

29. The Royal College of Obstetricians and Gynaecologists' guideline "Termination of Pregnancy for fetal abnormality" (1996) states that if an abnormality has been detected and two medical practitioners are of the opinion that there are grounds for an abortion under the Abortion Act, then the woman should be advised that she has this option.

30. Antenatal screening for Down's syndrome is offered within a timeframe of 10 to 20 weeks and the evidence based NICE Clinical Guideline "Antenatal Care, Routine Care for the healthy pregnant woman" recommends offering ultrasound screening for structural anomalies between 18 and 20 weeks. The purpose of antenatal screening is to offer women informed choice and women should be offered information about screening tests as early as possible in their pregnancy. The woman needs to be given enough information and time to help her understand the nature of the fetal abnormality and the probable outcome of the pregnancy in order that she can make an informed decision about the options available to her. If a time limit, or a time limit of lower than 24 weeks, were imposed for abortions for fetal abnormality this has implications for women who have abnormalities identified during the 18—20 week scan.

Medical, scientific and social research relevant to the impact of suggested law reforms to first trimester abortions

(a) the relative risks of early abortion versus pregnancy and delivery;

31. Abortion, both medical and surgical, is a very safe procedure and complications are uncommon. However, the RCOG guideline states that the evidence shows the risk of complications increases the later the gestation.

32. Deaths following abortion are extremely rare. There is about one death a year out of around 180,000 abortions. It is a Government requirement that all maternal deaths should be subject to confidential enquiry and all health professionals have a duty to provide the information required.

33. Maternal deaths in the UK, including deaths from abortions, for all women are at a rate of 53 per million maternities. This compares to a rate of about 5 per million for abortions alone.

34. It is the Government's policy to reduce numbers of unintended pregnancies and reduce the number of abortions. We are working to achieve this through implementation of the Sexual Health and HIV Strategy and the Teenage Pregnancy Strategy. http://www.dfes.gov.uk/teenagepregnancy

(b) the role played by the requirement for two doctors' signatures;

35. The requirement for two doctors' signatures was believed necessary when the 1967 Act was passed to ensure that the provisions in the legislation were being observed and to safeguard women.

(c) the practicalities and safety of allowing nurses or midwives to carry out abortions or of allowing the second stage of early medical abortions to be carried out at the patient's home;

36. One of the requirements of the Abortion Act 1967, as amended, is that a pregnancy may only be terminated by a registered medical practitioner.

37. In 1981, the Royal College of Nursing brought a case to clarify the legal position of nurses and their role in medical abortion. The House of Lords ruled that for medical abortion, the practitioner is not required to perform personally each and every action that is needed for the treatment but must personally decide upon and initiate the process of medical induction and take responsibility throughout (the doctor prescribes the drugs and signs the abortion notification form).

38. The role of nurses has changed considerably since 1967. All over the country nurses are working in new and innovative ways in sexual and reproductive health. Many are working in advanced and specialist clinical roles as independent practitioners and more creative posts are being developed in the NHS to maximise optimum use of nurses skills. There are currently around 15 Nurse Consultant posts in the sexual health field. Nurses have a valuable role to play in supporting women undergoing abortion. In some areas nurses are playing a leading role in providing abortion services. DH is working with the RCN and other professional bodies to ensure that the nurses role continues to be developed appropriately.

IMPROVING ACCESS TO EARLY MEDICAL ABORTIONS

39. The Government agrees that women, who have grounds for an abortion, should be offered the choice of an early medical abortion and that PCTs and abortion service providers should ensure this provision exists. Currently, Mifegyne (mifepristone also known as RU486), the abortifacient drug used in medical abortion, is only licensed up to nine weeks gestation and then 12 weeks gestation beyond, therefore early access is essential. To encourage choice of procedure before nine weeks gestation, PCT's performance in this area is being measured by the Healthcare Commission. There has been an indicator on the percentage of NHS funded abortions performed at under 10 weeks gestation since 2002/3. The latest data for 2006 shows that progress is being made to increase early access: 65% of NHS funded abortion took place at under 10 weeks—compared with 51% in 2002. Use of medical abortion has increased from 5% in 1995 to 30% of abortions in 2006.

Evidence of long-term or acute adverse health outcomes from abortion or from the restriction of access to abortion

40. The safety and psychological effects of abortion were considered by the RCOG in its updated evidence-based guideline, "The Care of Women Requesting Induced Abortion" (2004). In updating the guidance, the RCOG took account of the most recent national and international evidence. The guideline recommends that referral for further counselling should be available for the small minority of women who experience long-term post abortion distress.

GOVERNMENT ACTION ON SEXUAL HEALTH

41. The first ever, National Strategy for Sexual Health and HIV was published in 2001 and its' Implementation Action Plan in 2002 (for England). The Strategy proposes a comprehensive and holistic model for modernising sexual health and reproductive services to provide a comprehensive range of services, shaping services around the needs and preferences of individual patients, responding to the needs of different populations and continuously improving quality services.

GOVERNMENT ACTION ON REPRODUCTIVE HEALTH

42. One of the key aims of this Government, as set out in the Sexual Health and Teenage Pregnancy Strategy, is to reduce the number of unintended pregnancies and consequently abortions, through better access to contraception.

43. The provision of good quality contraceptive services is also essential to achieving the Public Service Agreement target to half the number of under 18 conceptions rates by 50% (from the Teenage Pregnancy Strategy's 1998 baseline of 46.6 conceptions per thousand females aged 15-17) by 2010 as part of a broader strategy to improve sexual health. Eighty percent of under 18 conceptions take place in 16 and 17 year old girls.

44. The cost benefit of contraceptives is well established and has been estimated at £11 for every £1 spent and it is estimated that the prevention of unplanned pregnancy by NHS contraceptive services already saves the NHS over £2.5 billion a year.

45. Through Choosing Health we have invested a significant amount (£40m) to improve access to contraceptive services (2006/07-2007/8) and in July 2006, the Government reduced the VAT rate on contraception from 17.5% to 5%. Primary care trusts (PCTs) completed a national questionnaire of contraceptive services. The results were published in May 2007 and will inform the publication of best practice guidance on reproductive healthcare by the Department of Health and help PCTs determine how best to meet gaps in local services. The guidance will be aimed at commissioners and providers emphasising the need to develop strong links between abortion and contraceptive services. From 2006/07, PCTs' performance in this area is being measured as part of their Healthcare Commission Annual Healthcheck. In

addition, we are also examining the feasibility of undertaking pilots to provide women with tailored contraceptive packages following abortion. The pilots will also examine which groups of women are most vulnerable to repeat abortion.

TEENAGE PREGNANCY STRATEGY

46. The Government's Teenage Pregnancy Strategy is tackling the high number of unplanned pregnancies among young women by: sending clear messages through its media campaigns on avoiding peer pressure and the importance of using condoms when they do become sexually active; improving the quality of sex and relationships education; improving young people's access to contraceptive and sexual health advice; and providing support to parents to help them have open and honest discussions with their children on sex and relationship issues.

47. Teenage pregnancy rates are reducing. Between the 1998 baseline year and 2005 (the latest year for which data are available) the under-18 conception rate has fallen by 11.8% to its lowest level for over 20 years. The under-16 conception rate has fallen by 12.1% over the same period. We are taking steps to ensure that a stronger focus is given to providing contraceptive advice to young women after a birth or abortion, to avoid repeat conceptions.

September 2007

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Department of Health

Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion)

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Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion)

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Introduction

The Secretary of State for Health has a power under section 1(3) of the Abortion Act 1967[1] to approve places where treatment for termination of pregnancy (abortion) may be carried out. All places other than NHS hospitals must be so approved. The Secretary of State also maintains a register of Pregnancy Advice Bureaux. Unless they hold a NHS contract, approved places may only accept patients referred from Bureaux on the register.

The Secretary of State will consider the approval of places for the purposes of section 1(3) of the Abortion Act 1967 if proprietors undertake to comply with:

- The Abortion Act 1967 and Regulations made under the Act – Abortion Regulations 1992[2]
- The requirements set out in regulations under the Health and Social Care Act[3]; and
- The Required Standard Operating Procedures (RSOPs) in Section 3 of this document;

Only after having registered with the CQC and on receipt of written approval from the Secretary of State for Health will independent healthcare providers be able to carry out a termination of pregnancy. Once registered, the CQC will continually monitor compliance with the Health and Social Care Act 2008 and regulations made under it.

Failure to comply with the requirements of the Health and Social Care Act 2008 or the RSOPs may lead to withdrawal of Secretary of State's approval. The CQC may also take independent enforcement action under the Health and Social Care Act

[1] Section 1 was amended by s.37(2) of the Human Fertilisation and Embryology Act 1990 to insert subsection (3A), which extends the power under s.1(3) to enable approval for a class of places.

[2] Abortion Regulations 1991, S.I. 1991/499.

[3] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 S.I. 2010/781 and the Care Quality Commission (Registration) Regulations 2009 S.I. 2009/3112.

2008, which includes the power to suspend or cancel registration and pursue prosecution.

A copy of the application form for the approval of places may be obtained from The Department of Health, Sexual Health Team (details below). The Department will consider all applications. The application process may include visits (and if appropriate unannounced visits by CQC to carry out an inspection for the purpose of its own registration functions) to the premises by CQC staff. CQC has the powers to carry out inspections on an announced or unannounced basis, but once a provider is registered, it normally carries out unannounced inspections, unless there is a good reason to let the service know it is coming.

If you have any enquiries arising from this document, please contact:

Sexual Health Team
Department of Health
Room 124
Richmond House
79 Whitehall
London SW1A 2NS Telephone: 020 7210 6375

Section 1 - Working with Termination of Pregnancy Providers

The Department of Health's overall aims are to ensure that we give effective help and advice to those providing abortion services to help them comply with the requirements of the Abortion Act and the RSOPs

How the Department of Health will help organisations providing services in connection with the Abortion Act

You are entitled to expect the Department of Health

To be objective by

- handling enquiries fairly
- treating all our providers impartially

To help you

- understand how and when the Abortion Act 1967 and regulations, and the RSOPs apply to you and how we may consult you.
- provide you with clear advice in reply to general or specific enquiries about the requirements of the Abortion Act 1967 and the RSOPs

To provide an efficient service by dealing with your enquiries promptly and accurately; by keeping your enquiries strictly confidential, and by requiring compliance with regulations, principles and issued guidance

If you are not satisfied

- You can ask us to look at your complaint and for it to be examined at a senior level elsewhere in the Department

- You can ask your MP to put your case to the Parliamentary Commissioner for Administration (the Ombudsman)

- General or specific enquiries, written or oral, about the requirements of the Abortion Act will be acknowledged within five working days and dealt with as quickly as possible by named officials. We can be contacted at Room 124 Richmond House, 79 Whitehall, London SW1A 2NS or by phone on 0207 210 6375.

- The conditions on which the Secretary of State's approval rest will be clearly set out in writing and made available to those wishing to apply for approval to carry out termination of pregnancy under the Abortion Act. It will be made clear to all applicants that failure to comply with any of those conditions could lead to withdrawal of the Secretary of State's approval.

- The applicant will be notified of the Secretary of State's decision within two working days of the decision being taken and in writing within 14 days. Notification of the Secretary of State's decision following application for re-approval will be sent before the start of the new period of approval.

- A CQC visit may form part of the CQC registration procedure and will be arranged for a time and date mutually convenient to the applicant and the visiting teams. Once registration is granted by CQC, it will continually monitor compliance with the Health and Social Care Act 2008 and regulations made under that Act. Locations (places where the regulated activity of termination of pregnancy is carried out, and in some cases managed from) and satellite clinics managed by that location will be also subject to unannounced inspection by CQC staff unless there is a good reason to let the service know they are coming.

Section 2 - Regulatory Framework

The Abortion Act 1967 (see Annex A for more details on the requirements of the Act) requires that treatment for the termination of pregnancy must be carried out at a NHS hospital or at a place approved by the Secretary of State for Health. In granting any approval the Secretary of State takes into account a set of core principles the aims of which are to:

- Ensure compliance with all legal requirements.
- Provide the best quality of care for patients
- Provide sound management, organisational and clinical governance arrangements.

Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, provides that the termination of pregnancy is a regulated activity. All providers of regulated activities must be registered with the CQC and meet essential standards of quality and safety as set out in Part 4 to the 2010 regulations. DH is in the process of updating the quality and safety requirements that all providers have to meet. The new requirements and guidance will come into force from April 2014 for the NHS. They may commence later for other sectors. The CQC will update their guidance about meeting these requirements.

The CQC registers the service provider of the regulated activity and may place conditions on the registration; for example, where the regulated activity is carried out.

Regulation 20 of the Care Quality Commission (Registration) Regulations 2009 also sets out a number of requirements relating to the termination of pregnancy. This regulation applies to a registered person who carries on or manages the regulated activity of termination of pregnancies and who is not an English NHS body

The Health and Social Care Act 2008 states that all providers must have a registered manager. The exceptions to this are:

- Where the service provider is an individual who is in day-to-day management of the service and who is fit to carry on the service.
- NHS trusts:

Each regulated activity is required to be supervised by a registered manager, and the Act specifies that the registered manager must be assessed for their fitness to do so. Further guidance and details of the application process are available on the CQC website. See link below.

http://www.cqc.org.uk/organisations-we-regulate/registering-first-time

Required Standard Operating Procedures

In addition to compliance with CQC requirements, the Secretary of State will take into account whether proprietors will comply with the Required Standard Operating Procedures (RSOPs), set out below, as part of the approval process.

RSOP1: Compliance with the Abortion Act

The Abortion Act 1967 (as amended) regulates the provision of abortion services in England, Wales and Scotland. If an abortion is performed, which does not comply with the terms of the Act then an offence will have been committed under the Offences Against the Person Act 1861 and / or the Infant Life (Preservation) Act 1929.

The law dictates that, except in emergencies[4], two doctors must certify that in their opinion, which must be formed in good faith, a request for an abortion meets at least one and the same grounds set out in the Act.

If there is evidence that a certifying doctor has not formed an opinion in good faith, then the doctor performing the termination is not protected by the Act and has potentially committed a criminal offence by terminating the pregnancy. We consider it good practice that one of the two certifying doctors has seen the woman, although this is not a legal requirement. The expectation is that both doctors will have taken positive steps to obtain information specific to the woman seeking a termination as part of reaching their decision and to have turned their mind to the particular facts of that case when forming their opinion. Doctors should be able to evidence how this decision was reached if asked to justify it subsequently. The pre-signing of HSA1 forms or "counter-signing" decisions of other doctors is unacceptable in this process and incompatible with the requirement to form an opinion in "good faith". Members of a multi-disciplinary team (MDT) can play a role in seeking information from the woman. However, the Abortion Act places the responsibility for reaching a decision in good faith on the two doctors alone.

[4] See section 1(4) of the Act which enables a termination to be carried out where a registered medical practitioner is of the opinion, formed in good faith, that the terminations is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

The Abortion Regulations 1991 require timely completion of abortion forms. Completion of Abortion Act forms is the responsibility of the registered medical practitioner who certifies that in their opinion a termination falls within one of the lawful grounds (HSA1 or 2) or who carry out a termination (HSA4). It is a legal requirement that abortion notification forms (HSA4) be submitted either electronically or by post to the Chief Medical Officer (CMO) within 14 days of the termination taking place.

HSA1 – Must be completed and signed by two doctors before an abortion is performed under section 1(1) of the Abortion Act 1967. The HSA1 form must be kept with the patients notes for 3 years from the date of termination.

HSA2 – Completed within 24 hours of an emergency abortion and kept by the abortion provider for 3 years.

HSA4 – Must be sent to the CMO within 14 days (by post or electronically). This form is used by the Department to ensure compliance with the Abortion Act.

The HSA1 and HSA2 can be photocopied using a PDF of the form which can be obtained from the website address below.

https://www.orderline.dh.gov.uk/ecom_dh/public/home.jsf

HSA4 forms can be submitted electronically or sent by post. Copies of HSA4 forms can be obtained via the above link.

RSOP2: Medical Terminations including early medical abortion (EMA) - Delegation of Duties and protocols

The Abortion Act requires that only a registered medical practitioner (RMP) may carry out an abortion. However, provided the RMP personally decides upon, initiates and takes responsibility throughout the process, the protection provided by the Act will apply to the RMP and to any other person participating in the termination under his or her authority (e.g. registered midwives and nurses). The RMP is not required to personally perform every action. Certain actions may be undertaken by registered nurses or midwives (who are not RMPs) provided they are fully trained and the provider has agreed protocols in place. For example, in practice a nurse or midwife may administer the drugs used for medical abortions, once these have been prescribed by a doctor.

This does not affect the rights, provided under section 4 of the Act, of those with a conscientious objection not to participate in treatment authorised by the Act unless

that treatment is immediately necessary to save the life or prevent grave permanent physical or mental injury to the pregnant woman.

Under Section 1(3) of the Abortion Act 1967, treatment for EMA can only take place in an NHS hospital or approved independent sector place. Both drugs for the medical abortion must therefore be taken in the hospital or approved place. Women may be given the choice to stay on the premises or to go home soon after taking the second tablet, to be in the privacy of their own home for the expulsion. A protocol should be in place governing the care of women who choose the latter option.

RSOP 3: Follow-ups

All women having an abortion should be able to choose to return for routine follow up and post-abortion counselling, if they so wish. Women should be informed of the most common physical symptoms following an abortion and a 24-hour telephone helpline should be available for use after the procedure.

RSOP 4: Confidentiality

All women seeking abortion have the right to confidentiality from all clinical and ancillary staff. Measures must be in place to safeguard patient confidentiality and all staff must be familiar with them. However, where the health, safety or welfare of a minor, or other persons is at risk, information should be disclosed to a third party. Similarly, if a minor is a ward of court or in care, disclosure may be considered appropriate. The Department of Health published “Confidentiality; NHS Code of Practice” in 2003. This document and subsequent supplementary guidance, sets out required practice for those who work within or under contract to NHS organisations. This code is currently being updated.

https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice

RSOP 5: Notification of Change of Provider

All prospective providers must undertake to inform the Department of any change in the ownership of the controlling business or premises. This is because a new approval is required in every case where the ownership of an approved place changes. Prospective providers must also notify any significant deviation from the design, layout or operation of the premises or business details applicable when the approval was granted (e.g. changes of senior management).

RSOP 6: Compliance with CQC Regulatory Framework

The CQC is responsible for implementing the regulatory framework set out in the regulations made under the Health and Social Care Act 2008 and has issued *Guidance about Compliance*[5], which explains in more detail how registered providers and registered managers can comply with the registration requirements. This guidance in not in itself enforceable, but providers must have regard to it in complying with the registration requirements and it must be taken into account by the CQC when any decision about registration is taken.

RSOP 7: Service Provision for Children, Vulnerable Young People and Adults

The *Guidance about Compliance* includes prompts relevant to termination of pregnancy, which sets out that children, vulnerable children and adults (where appropriate) should be:

Children[6]:

- Asked if they agree for their parents or guardians to be involved in decisions they need to make.
- Able to benefit from an environment that is appropriate to their age and individual needs.
- Treated by staff who are appropriately trained to provide care, treatment and support for children, including Children's Workforce Development Council Induction standards

Adults and Children[7]:

- Confident that they are treated by staff who carry out sufficient levels of activity to maintain their competence, including in relation to specific anaesthetic and surgical procedures , taking account of guidance from relevant expert or professional bodies.
- Receive care, treatment and support by staff registered by the Nursing and Midwifery Council or the advice of such a nurse can be accessed at any time that it is needed. Providers will also need to make robust and practical arrangements for children's nursing advice to be accessed at any time.

[5] See CQC `Essential Standards of Quality and Safety'

[6] Outcome 4 – Care and Welfare of People who use services ` Essential Standards of Quality and Safety'

[7] See Outcome 14 – Supporting Workers CQC Essential Standards of Quality and Safety.

- Fully informed of their care, treatment and support.
- Able to take part fully in decision making.

Girls aged under 13

Under Section 5 of the Sexual Offences Act 2003 sexual intercourse with a girl under the age of 13 is a criminal offence. The total number of abortions performed on this age group is very small (under 10 a year) and the majority are undertaken in NHS Hospitals. It is essential that very vulnerable children's medical, psychological and social needs are met in an appropriate environment. In addition, there are safeguarding issues that need to be considered and protocols should be in place to ensure appropriate referral to the police and social services.

Safeguarding – Under 16s and other vulnerable groups

Managing suspected child abuse, incest; or abuse more generally (e.g. sexual violence) in abortion services can be complex. The need for a decision on an abortion may be urgent because of advanced gestation and both the girl/woman and any accompanying adult may attempt to conceal the truth from assessing staff. The young person may have travelled away from her home area to assist with the concealment. Staff must be alert to the possibility of abuse, particularly if a young woman refuses to involve her parents or general practitioner, or is accompanied by an adult such as a male relative who wishes to remain particularly close to her.

It is recommended good practice that all services should designate a small number of doctors and counsellors, with child protection training, to assess all girls under 16 years of age. Within the scope of their confidentiality duties, it is their responsibility to liaise with the appropriate children's social care team in the Local Authority when it is thought that a girl has been abused or when other children are likely to be at risk. Guidance on this is contained within Working Together to Safeguard Children (published in August 2013), which replaces previous guidance published in 2010.

http://www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children

Disclosure is not always required but it is usual in order that the interests of the child, which are paramount, are protected. A health professional may be called upon to justify before the court or their statutory professional body, such as the General Medical Council and Nursing and Midwifery Council the action that he or she has taken. When such concerns arise in the context of abortion, whether during counselling or subsequently, the duty of the health professional to safeguard the child is clear, and those who practise in this field should ensure that they are familiar with the procedures to be observed. Health professionals should also bear in mind that other children in a family may be in need of protection.

Similar considerations can arise in the case of vulnerable women because of a learning disability or other issue that relates to their capacity to consent. Under the revised Working Together to Safeguard Children guidance, commissioning bodies are required to notify the CQC on the initiation of a serious case review arising from a safeguarding issue so they can feed relevant information into their regulatory activities. In addition, the CQC has developed an operating protocol for its staff to describe their role in safeguarding both children and adults. It covers all the relevant health and social care sectors for which CQC has regulatory responsibility and provides the principles for how CQC will work to help make sure people are protected.

http://www.cqc.org.uk/public/what-are-standards/safeguarding-people

Consent

Adult Women

Adult women aged 18 or over are presumed to be able to consent to their own medical treatment.

Consent must:

- be provided voluntarily and without undue pressure on the woman to accept or refuse treatment.
- be based on sufficient and accurate information (informed consent)

An adult will lack the capacity to consent where they are unable[8] to make the decision because of an impairment of, or disturbance in the functioning of, the mind or brain; and where they are unable to:

- understand the information relevant to the decision;
- retain that information;
- use or weight that information as part of that process; or
- communicate their decision by any means (section 2 Mental Capacity Act 2005)

[8] See section 2 Mental Capacity Act 2005.

Women aged 16 -17 years

Consent to termination provided by a woman aged 16 or 17 years must also be provided on the basis of appropriate information and given voluntarily. Such consent has the same legal effect as consent provided by an adult[9].

As for adults, a woman aged 16 or 17 will lack capacity if she does not meet the test set out under section 2 of the Mental Capacity Act (see above).

Young Women aged under 16 years

Legally a doctor or health professional is able to provide contraception, sexual and reproductive health advice and treatment, including abortion, without parental knowledge or consent, provided that they are satisfied the young woman has sufficient understanding and intelligence to enable her to understand fully what is being proposed; in other words she must be "*Gillick"* competent[10].

As a matter of best practice a medical professional should also have regard to the following factors before providing treatment:

- whether the young person can be persuaded to inform her parents or to allow the medical professional to inform the parents that their child is seeking advice and/or treatment on sexual matters. In the case of abortion, if the young person cannot be persuaded to involve a parent, every effort should be made to help them to find another adult (such as a family member or specialist youth worker) to provide support

- whether the young person does not receive advice and treatment on the relevant sexual matter, her physical or mental health or both is likely to suffer.

- whether the relationship is mutually agreed and whether there may be any coercion or abuse.

Where a young person is not Gillick competent and therefore cannot consent to a termination, consent can be given on their behalf by a proxy (anyone with parental responsibility or the court). A person with parental responsibility must act in the child's best interests when consenting or refusing consent to treatment. The courts

[9] See section 8 Family Law Reform Act 1969.

[10] The case of *Gillick v West Norfolk and Wisbech (1986) AC 112* established that a child under the age of 16 can consent to treatment if they have "sufficient understanding and intelligence to enable him or her to understand fully what is proposed" (189 per. Lord Scarman)

can overrule a refusal by a person with parental responsibility where this is in the child's best interests.

The principles of good practice, which all healthcare professionals are expected to follow when seeking patients' informed consent to examination or treatment, are set out in more detail in the GMC's guidance "Consent: patients and doctors making decisions together" published in 2008.

In addition, the GMC have published two documents: `0-18 Years: Guidance for all doctors' (2007) (Para 70-72, page 29) provides information for doctors dealing with young people and abortion and `Protecting Children and Young People' – The responsibility of all doctors (2012). The BMA's guidance on "Law and Ethics of Abortion" and the Department of Health's comprehensive reference guide to consent for examination or treatment (2009) also set out good practice in this area.

Consent requirements for providers of regulated activities are also set out under regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and in a Supporting Note "Consent to Treatment and Care.

http://www.cqc.org.uk/sites/default/files/media/documents/rp_poc1b_100476_20110331_v1_00_sn_consent_updated_for_publication.pdf

RSOP8: Gestational Limits

All registered providers should indicate which gestations and methods they intend to offer as part of the application process to both the CQC, to carry out a regulated activity, and to DH, to be an approved place. Chapter 7, page 61 of the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines on the Care of Women Requesting an Induced Abortion (2011) summarises the methods considered to be appropriate for women presenting at different gestations.

The purpose of the requirement to specify gestation and methods is to ensure that what is being proposed is in keeping with the physical environment and clinical expertise available. In addition every service provider registered with the CQC is required by law to have a statement of purpose. The statement of purpose should provide information about services and their locations to a level of detail that enables the CQC to understand what actually happens in the location and who the service is provided for. For example this might state: `We undertake both medical and surgical abortion including late abortions for women and young people under the age of 18 years'.

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RSOP9: Professional Guidelines

Good quality clinical practice is guided by authoritative clinical guidelines and professional opinion such as that provided by relevant Royal Colleges. In relation to abortion, the guidelines published by the Royal College of Obstetricians and Gynaecologists; National Institute of Health and Clinical Excellence (NICE) and CQC's Guidance about compliance are of particular relevance. Further guidance on good practice is set out in more detail in Section 3 to this document and in the documents listed in the references attached at Annex 2.

In particular, and in line with guidelines from the RCOG[11], abortion care should be delivered within a robust clinical governance framework to assure accessibility, clinical quality and patient safety. Health professionals working within the service must be appropriately trained and experienced. Clinical appraisal/revalidation procedures ensure that staff keep up to date with the continuing professional development requirements set down by their professional body and registered persons must monitor compliance with these standards.

RSOP10: Access to Timely Abortion Services

Available evidence[12] suggests that the earlier the termination takes place in the pregnancy, the lower the risk of complications; therefore, for reasons of safety, terminations should always be performed as early as possible after having received the woman's informed consent to the procedure being performed.

In order to minimise delays, good practice is that service arrangements should be in place so that:

- Women are offered an appointment within five working days of referral or self-referral
- Women are offered the abortion procedure within five working days of the decision to proceed, and
- The total time from access to procedure should not exceed ten working days

[11] RCOG Guideline ` Care of Women Requesting Induced Abortion (2011)

[12] RCOG Guideline – Care of Women Requesting Induced Abortion (2011)

Women can choose to delay appointments/booked procedures and this should always override issues of timeliness.

Appointments should be expedited for women who present beyond 12 completed weeks or require abortion for urgent medical reasons, to minimise further risk to health.

For all gestations, women should be given a choice of surgical and medical terminations up to the legal limit as part of a care pathway.

Services that provide abortions only up to a certain gestation should ensure rapid transfer of women to appropriate providers via robust care pathways. Gestational limits should be included in the statement of purpose.

Where women are having an abortion under the grounds of risk to physical health e.g. where a pre-existing medical condition may exist, then the provider must ensure that there are clinical pathways in place for access to appropriate medical back up services, if needed.

RSOP11: Information for Women

Women must be given impartial evidence based information (verbal and written) covering the following:

- Alternatives to abortions (for instance adoption and motherhood)
- Abortion methods appropriate to gestation
- The range of emotional responses that may be experienced during and following an abortion
- What to expect, during and after the abortion (to include potential side effects, complications and any clinical implications)
- Full discussion of contraception options and the supply of chosen method
- Testing for sexually transmitted infections including HIV.

Information should be available in a variety of languages and formats (e.g. braille, audio-visual) to maximise accessibility. Women should be given the opportunity to take the information away with them if they so wish, to inform their decision making.

On discharge, women should be given details of a 24 hour helpline to obtain further support and advice if needed and a letter that includes sufficient information about

the procedure to allow another practitioner, elsewhere, to deal with any complications/on-going care etc.

Providers should make women aware that the contents of the statutory HSA4 form used to inform the CMO of abortions will be used for statistical purposes by the Department of Health. The data published is anonymised.

RSOP12: Contraception and Sexually Transmitted Infections (STI) Screening

Providers should be able to supply all methods of contraception, including Long Acting Reversible methods (LARC). Before the woman is discharged, future contraception should have been discussed and the chosen method should be initiated immediately. Particular attention should be given to women who have had repeat conceptions and abortions. Women who choose not to start a contraception method immediately should be given information about local contraception providers in addition to their general practitioner. Providers should have an agreed pathway of care to local community sexual health services.

All women should be offered testing for Chlamydia, offered a risk assessment for other STI's (e.g. HIV, Syphilis etc.), and tested as appropriate. This may trigger the need to be registered with the CQC for the regulated activity of diagnostics and screening. A system for partner notification and follow up or referral to a sexual health service should also be in place.

RSOP13: Counselling

A person trained and experienced in counselling in this field must be available to attend clinics/hospitals if required. All women requesting an abortion should be offered the opportunity to discuss their options and choices with a trained counsellor and this offer should be repeated at every stage of the care pathway. Post abortion counselling should also be available for those women who require it.

The RCOG's 2011[13] clinical guideline highlights that:

> "all women attending an abortion service will require a discussion to determine the degree of certainty of their decision and their understanding of its implications as part of the process of gaining consent. Careful and sensitive enquiry as to the reasons for requesting an abortion should be made, with the opportunity for further discussion, especially where women express any doubts or suggestion of pressure or coercion."

[13] To see recommendation 4-11 (page 31) `Care of Women Requesting Induced Abortion (2011)'

Any woman who remains ambivalent after counselling can be given a provisional appointment for admission but must be told that the procedure can be postponed or cancelled and that she remains free to continue with the pregnancy, if she so wishes.

Clinicians caring for women requesting abortion should be able to identify those who require more support in decision-making than can be provided in the routine clinic setting e.g. young women, those with a pre-existing mental health condition, those who are subject to sexual violence or poor social support, or where there is evidence of coercion. Care pathways for additional support should be available.

RSOP14: Disposal of Fetal Tissue

The Human Tissue Authority (HTA) regulates activities concerning the removal, storage, use and disposal of human tissue. It has issued practical guidance to professionals carrying out activities which fall within its remit to help establishments develop appropriate policies.

The HTA's Code of Practice (Code 5) on *Disposal of Human Tissue* applies to all those involved in the disposal of human tissue and is suitable for developing policies on the disposal of fetal tissue resulting from a number of different pregnancy losses, including ectopic pregnancies, miscarriages, early intrauterine fetal deaths and termination of pregnancy.

RCOG has produced the good practice guidance *Disposal Following Pregnancy Loss Before 24 Weeks Gestation (2005)* (Good Practice No 5) which provides a further source of information if required.

The Stillbirths and Neonatal Society (SANDS (2007)) guidelines for professionals also highlight the need for sensitive disposal.

Women should be made aware that information on disposal options for later medical and surgical abortions are available. Any personal wishes expressed should be met wherever possible.

Women may decide to arrange disposal themselves and they are free to do so. The Royal College of Nursing's (RCN) document, Sensitive Disposal of All Fetal Remains (2007) highlights the options.

RSOP15: Performance Standards and Audit

All providers should have in place clear locally agreed standards against which performance can be audited with specific focus on outcomes and processes. These should be guided by appropriate national standards, for example RCOG Guidelines on Audit[14]. However, it is important that local standards are agreed, applied and

[14] See RCOG Clinical Governance Advice No.5 – October 2003

audited. Subjects which providers and commissioners may wish to audit could include:

- Waiting times
- The consultation process; for example, the outcome of consultations, the number of women who do not proceed to a termination.
- The qualifications and expertise of those responding to requests for advice and support.
- The availability of expert advisors; the nature of the calls received; the number of calls requiring further action.
- The provision of services for women with significant medical conditions; for example, the availability of trained counsellors for those women at risk of particular psychological or emotional difficulties or those with pre-existing mental health conditions.
- The availability of a female doctor for women who wish to consult a woman - especially those from certain cultural backgrounds and ethnic minorities, with arrangements for non-English speaking women.
- The number of staff competent to provide all methods of contraception.
- Patient choice across the range of service provision to include follow-ups, contraception and abortion methods, and for experiences of women who have returned home after taking the 2nd drug for a medical abortion.
- Locally developed strategies for minimising avoidable morbidity, which could include the number of "incidents" and the number of women known to require repeat surgical procedures within four weeks of the procedure; the use of local anaesthesia where this is clinically indicated; medical complications or the use of ultrasound equipment.
- The number of women who have had repeat abortions and whether they left the service with suitable contraception.

RSOP16: Patient Feedback and Complaints

This guidance should be read in conjunction with Regulations 10 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All approved places should have systems in place to undertake post-care patient satisfaction surveys and feedback aimed at identifying women's experiences and

views on the treatment they have received. These should be monitored by the provider who should take appropriate action to address any issues raised.

Registered providers should be prepared to make the results of these surveys available to the Department for Health on a confidential basis. All information would, for reasons of confidentiality, be aggregated and anonymised.

There must be a recognised and clearly defined complaints policy and a procedure that is made known to all clients. A senior manager, director, or proprietor must regularly monitor complaints and take action where appropriate.

RSOP17: Staffing and Emergency Medical Cover

This guidance should be read in conjunction with Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There should be a sufficient number of staff with the right competencies, knowledge, qualification, skills and experience to safeguard the health, safety and welfare of women and young people who use the service and meet their routine and non-routine needs.

Procedures and protocols must be underpinned by regular training in emergency procedures, especially basic resuscitation. Evidence must be available that training has taken place.

The aim should be to stabilise the patient and, when safe, to transfer to a specialised unit where, if needed, there is immediate access to intensive care, laboratory services and other specialist disciplines.

Anaesthetic emergencies are a special problem. These often arise quickly and require immediate attention. Therefore, it must be possible to contact a consultant anaesthetist with appropriate current experience immediately by telephone. All relevant staff must be aware of the emergency call system. An anaesthetist must be present in the recovery room while there is a patient who does not fulfil the criteria to discharge to the ward.

Subject to clinical duties, proprietors of premises should assist CQC inspectors to have access to clinical staff (medical, nursing and midwifery) on duty at the time of a visit (including unannounced visits).

Nursing and Midwifery Staff

One first level registered general nurse or registered midwife should be on duty in the clinic / hospital at all times. The person in charge of each shift throughout the 24-hour period should be a first level registered nurse or registered midwife able to accept professional responsibility for the smooth running of the clinic, of other staff, and of patients.

The first level nurse or registered midwife should be supported by appropriately qualified registered nurses or midwives. Nursing and midwifery staff levels should reflect factors such as:

- the anticipated throughput of patients and abortion methods to be used;
- the incidence of complications (which must be routinely assessed / reassessed);
- the support required for dealing with a patient;
- other emergencies that may arise as well as the continued observation of patients;
- the residence or otherwise of a medical officer.

Particularly where late (i.e. 20 to 24 week gestation) terminations are being undertaken, staffing levels should be calculated with reference to case mix, anaesthesia used, room layouts and skill mix. The particular emotional and psychological support of women undergoing these late terminations should not be overlooked.

There should be an adequate number of appropriately trained and competent nurses/midwives available from the time treatment commenced to the time treatment ended. Midwifery and nursing staff must be competent in the use of all the equipment required to be available in places approved for late terminations.

Each nurse or midwife should have the appropriate knowledge and training on which to base observations and to detect deviations from normal progress and to carry out medical instructions. Each nurse or midwife should have the ability to professionally assess a patient's condition and describe this accurately to a doctor.

Each nurse or midwife should have the appropriate knowledge, training and confidence to initiate immediate action in the event of an emergency and before medical help arrives.

Midwives and nurses should not be asked to undertake duties for which they are not clinically competent.

Nursing or maternity support workers are not nurses or midwives and should not be expected to carry out duties or responsibilities in excess of their capabilities or competence or which are those of a registered nurse or midwife. Arrangements must also be in place to ensure that all auxiliary and support staff are aware of the principles of good quality care and need to respect patient confidentiality.

All nursing and midwifery staff are expected to undertake continuing professional education and training to retain skills and gain familiarity with on-going clinical developments.

RSOP18: Duty Records

Records of duty and shift rotas must be kept for four years after the year to which they relate. A named senior manager should be responsible for ensuring that these are complete and accurate and that staff attend according to the rota.

RSOP19: Confirmation of Professional Status

This guidance should be read in conjunction with Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

A named senior manager, director or proprietor must be responsible for ensuring that qualifications, experience, GMC registration / NMC PIN reference are confirmed for all medical, midwifery and nursing staff. The senior manager, director or proprietor should also be responsible for ensuring that all medical, midwifery and nursing staff have their qualifications, knowledge and skills reviewed on a regular basis to ensure that they are kept up to date with current practice.

RSOP20: Risk Management

This guidance should be read in conjunction with Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

All providers should have in place a formal risk management system and keep a risk register to identify and minimise any risks to patients and staff within their premises. Protocols should exist on action to be taken should incidents occur.

There should be opportunities for medical, midwifery and nursing staff to contribute to risk appraisal. Service provision can be improved by learning from adverse events, incidents, errors and near misses as well as from the outcome of comments and complaints and regulatory findings of the CQC and findings of advice from expert bodies where this information shows the service is not fully compliant.

RSOP21: Maintenance of Equipment

This requirement is also covered by Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Risks and emergencies can be minimised through a programme of regular checking and servicing of equipment. All equipment should be properly maintained and

suitable for its purpose. This is particularly the case with anaesthetic and patient monitoring equipment. Guidelines for checking anaesthetic machines are available from the Association of Anaesthetists (http://www.aagbi.org/publications/guidelines/docs/checklista404.pdf) .

RSOP22: Death of a Patient

See also regulations 16 and 20 Health and Social Care (Registration) Regulations 2009

Arrangements must be in place to immediately inform the CQC and the Department of Health in the event of the death of a patient. A record must be kept of the date, time, cause and place of death. Verbal information should be confirmed in writing to the Department of Health within 24 hours of receiving verbal confirmation. The regulations about notifications changed in June 2012. CQC has issued guidance for non-NHS trust providers on how to notify them of a death of a patient. Further information can be found at:

Notifications for non-NHS trust providers/Care Quality Commission

RSOP23: Payment of Fees

Women must be free of any fear of exploitation when accessing termination of pregnancy services. Fees should not be demanded or accepted for an abortion either directly or indirectly until two certificates of opinion necessary for a legal abortion under the Act have been given on form HSA1. This is also set out in regulation 20(2)(b) of the (Registration) Regulations 2009. The manager of the service must also provide the woman with a written statement specifying the terms and conditions in respect of the services to be provided as far as reasonably practicable prior to the commencement of the service as set out in regulation 19 of the (Registration) Regulations 2009. Where the abortion provider has a contract to provide abortion services on behalf of the NHS, the woman should be informed and should therefore not be charged a fee.

RSOP23: Referrals from Bureaux

Premises approved for the termination of pregnancy should not accept patients from any bureau that is not on the register of approved Pregnancy Advisory Bureaux. NHS-funded patients can access services through routes agreed via local commissioning arrangements.

Section 3 - Maintaining Standards

RSOP24: Maintaining Standards

The approval process provides a framework for maintaining the safety and quality of care in a fully integrated independent sector abortion service. In keeping with the concept of clinical governance, the CQC will be responsible for ensuring that the requirements under the Health and Social Care Act 2009 are maintained through a system of monitoring and where appropriate inspection visits.

The CQC takes account of the RSOPs when interpreting the requirements on providers of terminations and there is also overlap between the requirements meaning that the Department is able to monitor compliance with the RSOPs through a programme of communication with the CQC. Providers are also asked to provide evidence of continued compliance and monitoring of compliance with the RSOPs as part of the re approval process.

Within the NHS, clinical practice will be increasingly influenced through guidance such as that issued by the National institute of Health and Clinical Excellence (NICE) alongside professional bodies.

It is the responsibility of local practitioners, in consultation with providers, to develop good clinical practice within their local setting, reflecting evidence- based guidelines from relevant professional bodies.

RSOP 25: Abortions beyond 9 weeks gestation

Abortions beyond 9 weeks gestation require additional training and particular skills for medical, midwifery and nursing staff. Therefore, they must be conducted by healthcare professionals who can demonstrate that they have sufficient regular and recent experience to ensure that their specialist skills are maintained.

Abortions after 20 weeks gestation raise particular public and professional concern because of the possibility of a live birth. We therefore recommend that premises wishing to carry out terminations at 20 weeks gestation and over should notify the Secretary of State. Under the Health and Social Care Act registration regulations, registered providers not part of the NHS may not carry out terminations beyond 24 weeks gestation.

In addition to meeting all the relevant RSOPs outlined in Section 2, premises must demonstrate that all medical, midwifery and nursing staff involved in the care of patients undergoing late terminations have appropriate recent experience and skills.

RSOP 25: Fetal Awareness and Abnormality

The Royal College of Obstetricians and Gynaecologists (RCOG) released two working party reports in March 2010:

- Fetal Awareness, and
- Termination of Pregnancy for Fetal Abnormality.

The first updates a previous report published in 1997, while the latter replaces a 1996 report. Both documents were commissioned by the Department of Health following recommendations by the House of Commons Science and Technology Committee in 2008. The two reports contain information for clinicians, researchers and healthcare professionals. The report on Fetal Awareness also includes practical information and advice to women and parents. The main findings from each document are listed below.

Fetal Awareness

- The fetus cannot feel pain before 24 weeks because the connections in the fetal brain are not fully formed
- Evidence examined by the Working Party showed that the fetus, while in the chemical environment of the womb, is in a state of induced sleep and is unconscious
- The Working Party concluded that because the 24 week-old fetus has no awareness nor can it feel pain, the use of analgesia is of no benefit
- More research is needed into the short and long-term effects of the use of fetal analgesia post 24 weeks.

Abortion for Fetal Abnormality

- The Working Party concluded that it is unrealistic to produce a definitive list of conditions that constitute ‘serious’ handicap since accurate diagnostic techniques are yet unavailable. Likewise, the consequences of abnormality are difficult to predict.
- The Working Party recommends that the NHS Fetal Anomaly Screening Programme is centrally linked so that specific congenital abnormalities are monitored over time and programmes across the country can be evaluated.

- Appropriate information and support should be offered to all women undergoing antenatal screening.

- In the case of a possible abortion, all staff caring for the mother must adopt a non-directive, non-judgemental and supportive approach.

- The two reports should be read together as the subject matters are inter-related.

Feticide

The RCOG report on Fetal Awareness (March 2010) recommends that feticide be performed before delivery, unless the fetal abnormality is lethal, on medical abortions performed after 21 weeks and six days gestation to avoid the possibility of a live birth.

Feticide can also be used prior to abortion after 21 weeks and six days gestation, or for selective reduction of multiple pregnancies, either where one fetus has an abnormality or where the number of fetuses increases the risk of maternal morbidity or pregnancy complications to an unacceptable level.

RSOP26: Informing the General Practitioner and Pregnancy Advisory Bureaux

It is recommended that, wherever possible, the woman's GP should be informed about any treatment for abortion. Then, in the event of a woman requiring care in the longer term, the GP would be aware of all treatments provided and be in a better position to determine the appropriate therapy. All women should be told of their right to confidentiality and their decision respected if they do not want their GP to be informed.

Pregnancy Advisory Bureaux

Women may obtain advice on pregnancy matters and access to abortion services through general practitioners, sexual and reproductive healthcare clinics, genito-urinary medicine clinics, or a Pregnancy Advisory Bureau (PAB)

PABx are registered by the Secretary of State and are defined as "places that provide advice and help to women who may be pregnant". Services include pregnancy testing, medical advice, assessment, counselling, contraceptive advice and sexually transmitted infection services.

Separate approval is required of places wishing to be registered as a standalone PAB (not one that is co-located within a clinic). Further information on the criteria for

registration as a PAB can be found in the guidance Procedures for the Registration of Pregnancy Advisory Bureaux, obtained from the Department of Health.

Annexes

Annex 1

Abortion Act 1967 (as amended) - Grounds for abortion under the Act

1. Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith –

    a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or existing children of her family; or

    b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or

    c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or

    d) that there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

2. In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (a) or (b) of subsection (1) of this section, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.

The Act permits an abortion to be performed in an emergency on the basis of the opinion formed in good faith of the doctor performing the procedure. The Abortion Regulations permit the doctor in such cases to sign the certificate of opinion before or within 24 hours after the termination if it is not reasonably practicable to complete and sign a certificate before treatment commences. The emergency grounds are:

    e) To save the life of the woman.

    f) To prevent grave and permanent injury to the physical or mental health of the woman.

Annex 2

References

Abortion Act 1967
http://www.legislation.gov.uk/

Abortion Regulations 1991
http://www.legislation.gov.uk/uksi/1991/499/contents/made

Abortion (Amendment)(England) Regulations 2002
http://www.legistlation.gov.uk/uksi/2002/887/contents/made

British HIV Association - UK National Guidelines for HIV Testing 2008
http://www.bhiva.org/HIVTesting2008.aspx

Care Quality Commission
http://www.cqc.org.uk/

Equality and Human Rights Commission
http://www.equalityhumanrights.com/

Faculty of Sexual and Reproductive Healthcare
http://www.ffprhc.org.uk/

Guidance on Abortion Notification Forms
https://www.gov.uk/government/publications/abortion-notification-forms-for-england-and-wales

A Framework for Sexual Health Improvement in England
https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england

Human Tissue Authority (HTA) - Disposal of Fetal Tissue
http://www.hta.gov.uk/legislationpoliciesandcodesofpractice/codesofpractice/code5disposal.cfm

Medical Foundation for AIDS and Sexual Health (MEDFASH) Standards
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4106273

Moving Forward: Progress and Priorities – Working Together for High Quality Sexual Health

National Institute for Health and Clinical Excellence (NICE) – Long Acting Reversible Contraception (LARC) guidance
http://www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=10974

Reference Guide to Consent for examination and treatment (2nd edition)

https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition

Royal College of Nursing's publication "Abortion Care"
www.rcn.org.uk

Royal College of Obstetricians and Gynaecologists (RCOG) - "The Care of Women Requesting Induced Abortions",
http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion

Royal College of Obstetricians and Gynaecologists – guidance on fetal abnormalities
http://www.rcog.org.uk/termination-pregnancy-fetal-abnormality-england-scotland-and-wales

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1. Home (https://www.gov.uk/)
2. Health and social care (https://www.gov.uk/health-and-social-care)
3. Medicines, medical devices (https://www.gov.uk/health-and-social-care/medicines-medical-devices-blood)

News story

Government confirms plans to approve the home-use of early abortion pills

Women in England will be allowed to take the second of 2 early medical abortion pills in their own home.

Published 25 August 2018

From:

Department of Health and Social Care (https://www.gov.uk/government/organisations/department-of-health-and-social-care)

The government will legalise the home-use of early medical abortion pills in England by the end of the year.

Under the plans, women will be allowed to take the second of 2 early abortion pills in the safe and familiar surroundings of their own home.

With clinical and legal advice clear that the use of abortion pills at home is safe and legal, women will have the choice of whether they wish to take the second pill at home or at a clinic.

The current system requires women to take both pills, mifepristone and misoprostol, 24 to 48 hours apart in a clinic to end an early pregnancy before 10 weeks gestation. Women leave the clinic after taking the second pill and pass the pregnancy at home. The 2 visits can be difficult to organise and often uncomfortable or traumatic, and in some cases women can begin to miscarry before they have reached their home.

4 in 5 terminations are early medical abortions, carried out under 10 weeks gestation. This means the majority of women seeking abortions will now have the option for home-use. However, women will still be able to take the second pill in a clinic if they choose to do so.

The plans will not change the way women are assessed and treated for an abortion. Any woman seeking an early medical abortion will be given the usual checks including the criteria under the Abortion Act.

Safeguards will be introduced to protect women undergoing this treatment at home, and the Department of Health and Social Care (DHSC) will work closely with partners in the health system to make the changes quickly and safely.

The next step will be to work with partners, including the Royal College of Obstetricians and Gynaecologists, to develop clinical guidance for all professionals to follow when providing the treatment option to patients.

Professor Lesley Regan, President of the Royal College of Obstetricians and Gynaecologists (RCOG), said:

> Today's announcement that use of misoprostol at home will be allowed in England is hugely welcomed and a major step forward for women's healthcare.
>
> This simple and practical measure will provide women with significantly more choice and is the most compassionate care we can give them.
>
> It will allow women to avoid distress and embarrassment of bleeding and pain during their journey home from an unnecessary second visit to a clinic or hospital. It will also improve access to safe and regulated abortion care and take pressure off NHS services.

Chief Medical Officer, Professor Dame Sally Davies said:

> Abortion can be a difficult experience so it is important that women feel safe and as comfortable as possible. This decision will increase choice for women and help ensure they receive safe and dignified care.

Published 25 August 2018

Explore the topic

- Medicines, medical devices (https://www.gov.uk/health-and-social-care/medicines-medical-devices-blood)
- National Health Service (https://www.gov.uk/health-and-social-care/national-health-service)

The Abortion Act 1967 - Approval of a Class of Places

The Secretary of State makes the following approval in exercise of the powers conferred by section 1(3) and (3A) [i] of the Abortion Act 1967[ii]:

Interpretation

1. In this approval –

"home" means the place in England where a pregnant woman has her permanent address or usually resides;

"second stage of treatment" means the taking of the medicine known as Misoprostol.

Approval of class of place

2. The home of a pregnant woman who is undergoing treatment for the purposes of termination of her pregnancy is approved as a class of place where the second stage of treatment for termination of pregnancy may be carried out where the treatment is carried out in the manner specified in paragraph 3.

3. The treatment must be carried out in the following manner-

(a) the pregnant woman has attended a clinic where she has been prescribed Mifepristone and Misoprostol to be taken for the purposes of termination of her pregnancy; and
(b) the pregnant woman has taken the Mifepristone at the clinic, wants to carry out the second stage of treatment at home and the gestation of the pregnancy has not exceeded nine weeks and six days at the time the Mifepristone is taken.

Tim Baxter
Deputy Director, Healthy Behaviours
27 December 2018

[i] Section 1(3A) was inserted by section 37(3) of the Human Fertilisation and Embryology Act 1990 (c. 37).
[ii] 1967 c. 87.

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Misoprostol:Written question - 12206

Q Asked by **Sir Edward Leigh** (Gainsborough) Asked on: 04 February 2020

Department of Health and Social Care Commons **12206**

Misoprostol

To ask the Secretary of State for Health and Social Care, with reference to his Department's guidance allowing misoprostol to be taken at home, what steps he has (a) taken and (b) plans to take in the next six months to ensure that (i) misoprostol is only given to the woman who wish to use it, and (ii) there is appropriate screening to ensure women are not being compelled to take misoprostol against their will; and if he will make a statement.

A Answered by: **Caroline Dinenage** Answered on: 11 February 2020

Medical abortion is a two-stage process which requires the administration of Mifepristone followed by Misoprostol to successfully complete the procedure. Misoprostol can only prescribed for home use when the woman has requested an early medical abortion and given her informed consent after being assessed by two doctors as meeting the legal grounds for termination of pregnancy as set out in the Abortion Act 1967. The first stage, Mifepristone, must continue to be administered in an National Health Service hospital or an approved independent sector clinic.

Safeguards are in place under the Department's required standard operating procedures (RSOPs) for independent sector abortion providers to identify women and young girls who may feel coerced or endangered and enable them to raise their concerns in confidence. Guidance produced by the Royal College of Obstetricians and Gynaecologists outlines best clinical practice for medical abortion at home and safeguarding vulnerable women and young girls and is available at the following link:

https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf

The Abortion Act 1967 - Approval of a Class of Places

This approval supersedes the approval of 27 December 2018.

The Secretary of State makes the following approval in exercise of the powers conferred by section 1(3) and (3A) [1]of the Abortion Act 1967[2]:

Interpretation

1. In this approval –
"home" means, in the case of a pregnant woman, the place in England where a pregnant woman has her permanent address or usually resides or, in the case of a registered medical practitioner, the place in England where a registered medical practitioner has their permanent address or usually resides;

"approved place" means a hospital in England, as authorised under section 1(3) of the Abortion Act 1967, or a place in England approved under that section.

Approval of class of place

2. The home of a registered medical practitioner is approved as a class of place for treatment for the termination of pregnancy for the purposes only of prescribing the medicines known as Mifepristone and Misoprostol to be used in treatment carried out in the manner specified in paragraph 4.

3. The home of a pregnant woman who is undergoing treatment for the purposes of termination of her pregnancy is approved as a class of place where the treatment for termination of pregnancy may be carried out where that treatment is carried out in the manner specified in paragraph 4.

4. The treatment must be carried out in the following manner-

a) the pregnant woman has-

i) attended an approved place;

ii) had a consultation with an approved place via video link, telephone conference or other electronic means, or

iii) had a consultation with a registered medical practitioner via video link, telephone conference or other electronic means; and

b) the pregnant woman is prescribed Mifepristone and Misoprostol to be taken for the purposes of the termination of her pregnancy.

Mark Davies
Director, Population Health
20 March 2020

[1] Section 1(3A) was inserted by section 37(3) of the Human Fertilisation and Embryology Act 1990 (c. 37).
[2] 1967 c. 87.

News release from the Christian Concern **Click to view in your browser**

Issued by Christian Concern

News release

For immediate release

23 March 2020

Extreme back-door abortion policy pushed through by government goes unnoticed in midst of pandemic crisis

As the coronavirus pandemic escalates, this afternoon the government has announced the biggest change to abortion provision since 1967, without any public consultation, parliamentary scrutiny or debate.

The Department for Health and Social Care announced on **Twitter** on Monday 23 March that it would be introducing telemedicine abortions. This will see 'DIY' abortions performed on women by themselves in their homes without the need for a doctor or medical professional.

Before this proposal, abortions could only take place in hospitals or abortion clinics approved by the Secretary of State.

Under the new temporary policy, doctors will be able to prescribe mifepristone and misoprostol over the phone or video platforms such as Facetime or Skype.

Through these pills, women will then be left to perform their own abortion at home without direct medical supervision.

Chief Executive of Christian Concern, Andrea Williams, said:

"At a time of national and global crisis, to be pushing through a back-door policy that will put thousands of women at risk is dangerous and chilling.

"This policy will not help the women involved and will only lead to further vulnerability and trauma.

"The idea that our medical profession is prepared to prescribe such powerful drugs, in effect on demand, without seeing the patient is disturbing.

"In a time when we are all living in the shadow of death this move is ironic in its flagrant disregard for life. These pills cost somewhere in the region of 15 pence, but end a human life

"It does not smack of a kind and compassionate society, but one that is expedient and does not recognise the value of human life or the vulnerability of a woman who finds herself in a difficult situation.

"Something has gone wrong at the heart of our democratic systems when such a policy is introduced without proper public scrutiny, especially when our NHS is and will be under such strain in the coming weeks and months. We call on the government to urgently repeal these changes."

ENDS

For further information:

Andrea Williams: 07712 591164
Tom Allen: 07974 304620

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1. Home (https://www.gov.uk/)

The page you're looking for is no longer available

The information on this page has been removed because it was published in error.

This was published in error. There will be no changes to abortion regulations.

Covid-19 Update

– in the House of Commons at 2:20 pm on 24th March 2020 *(/debates/?d=2020-03-24)*.

Matthew Hancock

Secretary of State for Health and Social Care

2:20 pm, 24th March 2020

With permission, Mr Speaker *(/glossary/?gl=21)*, I would like to make a statement on covid-19. The spread of coronavirus is rapidly accelerating across the world and in the UK. The actions that we took yesterday are not actions that any UK Government *(https://en.wikipedia.org/wiki/UK_Government)* would ever want to take, but they were absolutely necessary. The goal is clear: to slow the rate of transmission in order to protect the NHS *(https://en.wikipedia.org/wiki/NHS)* and save lives. Our instruction is simple: stay at home.

People should only leave their home for one of four reasons: first, to shop for basic necessities, such as food, as infrequently as possible; secondly, to exercise once a day, for example a run, walk or cycle, alone or with members of the same household; thirdly, for any medical need, or to provide care or help to a vulnerable person; and fourthly, to travel to and from work, but only where it cannot be done from home, and employers should be taking every possible step to ensure that staff can work remotely. Those four reasons are exceptions to the rule. Further guidance is available on the gov.uk website.

I want to be clear that where people absolutely cannot work from home, they can still go to work. Indeed, it is important that they do so in order to keep the country running. Key workers, for example in the NHS and social care, pharmacists and those in the medicines supply chain, should go to work, unless they are self-isolating because they or someone else in their household has symptoms. We will be publishing guidance later today to explain the steps that employers must take to ensure that employees are safe, including making sure that there is a 2-metre gap between workers wherever possible.

In addition, all non-essential shops and community centres are closed as of today, and gatherings of more than two people in public must stop. These measures are not advice; they are rules. They will be enforced, including by the police, with fines for non-compliance starting at £30 but up to unlimited fines.

I want to update the House on the shielding that was introduced yesterday. We are writing to up to 1.5 million of the most vulnerable people in the UK to advise them that they will need to shield themselves from the virus in the coming months. We will provide targeted support for all those who need it so that they have the food supplies and medical care they need to make it through. Guided by the experts, we will look at the evidence and continually review the effects of the measures.

We are engaged in a great national effort to beat the virus. Everybody now has it in their power to save lives and protect the NHS. Home is now the frontline. In this national effort, working together, we can defeat this disease. Everyone has a part to play. I commend this statement to the House.

Link to this speech

In context *(/debates/?id=2020-03-24a.241.0#g241.1)* Individually *(/debates/?id=2020-03-24a.241.1)*

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(Citation: HC Deb, 24 March 2020, c241)

Jon Ashworth

Shadow Secretary of State for Health

2:23 pm, 24th March 2020

I thank the Secretary of State *(/glossary/?gl=23)*, as always, for advance sight of his statement. As he knows, yesterday we called on the Government to move to implement the enforcement of social distancing measures, so the Prime Minister *(/glossary/?gl=264)* was quite right last night to call for people to stay at home.

May I put to the Secretary of State *(https://en.wikipedia.org/wiki/Secretary_of_State)* a few quick questions? The virus thrives on inequalities. It is the most vulnerable, without financial security, who are especially at risk. I therefore urge him to consider abolishing prescription charges for the duration of the outbreak, especially for those with conditions such as asthma. We are very mindful of the mental health implications of asking people to stay at home, and we are also deeply concerned about the potential for domestic violence *(/glossary/?gl=140)* to increase. What support is available on those two fronts?

We also need clear and unambiguous advice around which workers can and cannot go out. The Opposition *(/glossary/?gl=29)* would call for just key workers to be able to go to work. We have seen Sports Direct *(https://en.wikipedia.org/wiki/Sports_Direct)*, for example, insisting that its workers turn up today. We are hearing stories about warehouses insisting that agency workers turn up and about construction sites not putting in place social distancing measures. That is putting workers at risk, and it is putting the lives of us all at risk. We need clear enforcement; if we are telling people that they will be fined for leaving their house, why are we not fining employers for insisting that their employees turn up to work when they should be staying at home? My right hon. Friend the shadow *(/glossary/?gl=137)* Chancellor *(/glossary/?gl=170)* will be putting more points to the Government about income protection in the debate later today.

Let me quickly turn to personal protective equipment. I understand the efforts the Government have made, but there are still NHS *(https://en.wikipedia.org/wiki/NHS)* staff saying that they have no access to adequate PPE *(https://en.wikipedia.org/wiki/PPE)*. We still have hospital chief executives expressing concern that they do not have access to FFP3 *(https://en.wikipedia.org/wiki/FFP3)* masks, that they are not getting the visors and sanitisers they need on time and that, when they do get masks, they are different from the previous masks, so staff have to be retrained. I urge the Government to move heaven and earth to get the PPE our staff need to the frontline. We also need PPE in social care. We are beginning to see outbreaks of covid-19 in social care homes. What support is in place for the residents of care homes, and when will we get the PPE that we need into the social care sector?

Enforced social distancing is welcome—we called for it—but in many ways it is a blunt tool without ramping up testing and contact tracing. That is how countries such as South Korea *(https://en.wikipedia.org/wiki/South_Korea)* have managed to suppress the virus. We are still testing only around 5,000 people a day. We do not have enough community testing. We are still not testing enough NHS staff. As the World Health Organisation *(https://en.wikipedia.org/wiki/World_Health_Organisation)* has instructed the world, test, test, test.

Leaked emails today suggest that, on Sunday, the Government were asking to borrow research institutions' testing kits—we have called for that, and we do not disagree with it—but the emails also said that the Prime Minister *(/glossary/?gl=35)* had said:

> *"there are no machines available to buy".*

Many of our constituents, and indeed NHS staff, will be asking why we did not procure machines and kits sooner.

On intensive care capacity, there are reports today that the ExCeL centre will be turned into a field hospital of 500 beds and that staffing ratios for intensive care are being relaxed. We understand that, given the staffing demands we face, but if we are setting up more field hospitals, will the Secretary of State tell us what oversight there will be? That change also means that more of our specialist staff will be stretched further—we understand why—but what guidance will be in place? Will the Secretary of State update the House on how many intensive care beds are now open, and how many more will be opened; how many ventilators we have, and how many more will be purchased; how many beds with oxygen we have; and what the current extracorporeal membrane oxygenation capacity is?

Will the Secretary of State quickly update the House on an issue that has emerged overnight about access to abortion care, as a result of some of the implications of the Coronavirus Bill *(https://en.wikipedia.org/wiki/Coronavirus_Bill)*? Will he assure the House that women who want access to abortion care will continue to be able to get it?

Our constituents are worried; our constituents are fearful. I hope the Secretary of State understands that when we put these questions to him, we are doing so because we want the national effort to defeat this virus to succeed.

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(Citation: HC Deb, 24 March 2020, c241)

Matthew Hancock

Secretary of State for Health and Social Care

I will go through the answers to the questions the hon. Gentleman reasonably asked. He asked about the most vulnerable. A programme of work is under way to ensure that those who need support because they are staying at home—especially those who are victims of domestic violence *(/glossary/?gl=140)*—get that support. It is incredibly important and difficult work, but we are doing what we can in that space. He also asked about prescription charges. Only around a fifth of people pay prescription charges, so those who are the least able to pay already get free prescriptions.

The hon. Gentleman asked about Sports Direct *(https://en.wikipedia.org/wiki/Sports_Direct)*. Sports shops are not essential retail, and therefore they will be closed. I have seen a bit of the noise that has been going on around today about Sports Direct in particular. I want to be absolutely clear that sports kit is not essential over the next three weeks, so we will be closing Sports Direct, along with other non-essential retail. He also asked about fines for corporates as well as individuals—absolutely, those fines are available if that is necessary.

The hon. Gentleman asked about protective equipment, and he is quite right to do so, because as we discussed yesterday, having protective equipment for staff on the frontline—especially those in the NHS *(https://en.wikipedia.org/wiki/NHS)* and social care, but also in other frontline services—is very important. We are moving heaven and earth, and the military involvement is ramping up the delivery of that equipment. He asked specifically about social care. I am glad to say that the current plan is to get protective equipment to all social care settings by the end of this week, and then we will have to keep going. We have put in place a hotline. If someone needs PPE *(https://en.wikipedia.org/wiki/PPE)* and they are not getting it, they should call the hotline so that we know where the difficulties are in getting PPE to the frontline, and we can respond to those calls and get it to them. I feel that very strongly.

The hon. Gentleman asked about testing. As we have discussed many times, we are ramping up testing as fast as we can, including buying millions of tests. My team are currently buying these tests, which we will make available as quickly as possible. He asked about there being no machines ready to buy. I do not recognise that at all. I have not seen any leak, and I would not want to comment on a leaked email—certainly not one that I have not seen. It is true that we are bringing testing machines together to provide a more efficient testing system, and I am grateful to the universities that have put these testing machines into the system. This is a national effort, and they are playing their part. We are also buying machines where we can.

The hon. Gentleman asked about staff ratios, which have been publicised this morning. It is true that we are having to change the standard staff ratios for delivery of certain types of procedure, including ventilation. The reason is that we cannot easily train somebody to intubate a patient and put them on a ventilator. We are training those who we can train to the standards necessary, but this is an incredibly difficult task, and it is therefore safer to have the doctors who are trained to do it and experienced in doing it doing it to more people, with more support staff than in normal circumstances. That is absolutely necessary to respond to the quantity of need, because this is a very specialist part of the NHS and of medicine that suddenly has much bigger demand than could ever have been envisaged outside a pandemic scenario.

I pay tribute to the staff who will be working much more intensively and who are putting their vital skills at the service of the nation in order to save lives. I am grateful to all those who have worked with the royal colleges to ensure that we get these ratios right and stretch the capabilities we have as far as we safely can in the circumstances. Finally, the hon. Gentleman mentioned abortion. We have no proposals to change any abortion rules as part of the covid-19 response.

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(Citation: HC Deb, 24 March 2020, c243)

Jeremy Hunt

Chair, Health and Social Care Committee

I thank the Health Secretary *(https://en.wikipedia.org/wiki/Health_Secretary)* for the superhuman efforts he has taken to resolve the issues around PPE *(https://en.wikipedia.org/wiki/PPE)* in the last week. The evidence is that we are in a much better situation now than we were a week ago. He will not mind if I follow up what the shadow *(/glossary/?gl=137)* Health Secretary said about testing. The concern is that we appear to be testing on a daily basis virtually no more people than we were over a week ago, when the commitment was to increase the daily number of tests from 5,000 to 25,000. Given that this is a vital part of the success of the suppression strategies in South Korea *(https://en.wikipedia.org/wiki/South_Korea)*, Taiwan, Singapore and Hong Kong *(https://en.wikipedia.org/wiki/Hong_Kong)*, can he give us an estimated date when we will get back to routine covid-19 testing in the community of all suspected cases? Even if that is three or four weeks away, a date means that there is a plan, and without a date, people will not be confident that this really is the plan.

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(Citation: HC Deb, 24 March 2020, c244)

Matthew Hancock

Secretary of State for Health and Social Care

Although I was not in the Chamber, I heard the comments that my right hon. Friend the Chair of the Health and Social Care *(https://en.wikipedia.org/wiki/Health_and_Social_Care)* Committee made about this yesterday, and he is right to push on this issue. I am not going to give him a date today, because we are in the middle of buying the tests that are needed, especially the new tests that have just come on stream. I have been able to give him the update that we have now purchased millions of these tests, which will arrive in the next days and weeks. I will be in a position to give him a more concrete timetable, and I will make sure he gets that as soon as we can make it public.

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(Citation: HC Deb, 24 March 2020, c244)

Owen Thompson

SNP Whip

I extend our continued thanks and gratitude to all who are working around the clock to help keep us all safe, and to look after us and the most vulnerable in our communities. I also extend our thanks to the millions of people who have already acted on the Government's advice to stay at home. The importance of that cannot be stressed nearly enough, because that is what we all need to do to protect our friends and families and the vulnerable people in our communities. It is deeply unfortunate that some employers, such as Sports Direct *(https://en.wikipedia.org/wiki/Sports_Direct)*, seem to be acting in an entirely irresponsible manner, and I welcome the Secretary of State *(/glossary/?gl=23)*'s comments about that.

In looking to see what more we can do, will the Secretary of State *(https://en.wikipedia.org/wiki/Secretary_of_State)* outline when he expects all frontline NHS *(https://en.wikipedia.org/wiki/NHS)* staff to have the PPE *(https://en.wikipedia.org/wiki/PPE)* that they need? We need to do everything we can to support them, given the extent of the risks that they are facing. How many additional ventilators have we managed to procure since the Prime Minister *(/glossary/?gl=264)* put out the call to manufacturers? Are the Government planning to accept the EU *(https://en.wikipedia.org/wiki/EU)*'s offer to share in central procurement of ventilators, testing kits and PPE?

Scotland has a number of qualified doctors and nurses who arrived in the country during the refugee crisis. Will the Secretary of State commit to talking to the Home Secretary *(https://en.wikipedia.org/wiki/Home_Secretary)* about what possible actions could be taken to relax the existing rules, to allow those qualified medical professionals to support the country that they have adopted as their home?

In the light of the outcome of the Keeling study, which was published by the Government on 20 March, is the Secretary of State ensuring that we have rapid and effective contact tracing? The review showed that such action could reduce the number of people infected by each case from 3.11 to 0.21, and that would be a significant step towards greater containment of the current outbreak.

Finally, I stress to the Secretary of State the need to impress on other Cabinet *(/glossary/?gl=108)* members the urgency of finding support for the self-employed, who are still waiting to find out what position they will find themselves in. We know that people with no financial backing come under pressures that may have an impact on their health, which would put further pressure on the system.

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(Citation: HC Deb, 24 March 2020, c245)

Matthew Hancock

Secretary of State for Health and Social Care

On the last point, there was an urgent question about exactly that issue. It really is a matter for the Treasury. The hon. Gentleman is right that contact tracing is incredibly important, and the amount of contact tracing that we have done is one of the reasons why we have managed to be behind other European countries in the curve. At this stage in the epidemic, it is not possible to have contact tracing for everybody, as we can when there is a very small number. We are looking at how we can do that better and enable individuals to contact trace, including by using technology.

The hon. Gentleman asked about refugees. I do not know whether he was in the Chamber yesterday, but that subject was brought up and I said that I would look into it. I will get back on that as soon as I can.

The hon. Gentleman asked about the number of ventilators. We started with around 5,000 and we now have more than 12,000, which we have bought. We have also made the call to arms for manufacturing capability to be turned over to ventilators, and that has been very successful.

I strongly endorse and support the backing of the Scottish Government *(https://en.wikipedia.org/wiki/Scottish_Government)* and the SNP *(https://en.wikipedia.org/wiki/SNP)* in the UK-wide approach to getting the message out to everybody that the most important thing anybody can do is stay at home.

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(Citation: HC Deb, 24 March 2020, c245)

David Davis

Conservative, Haltemprice and Howden

I commend the Secretary of State *(/glossary/?gl=23)* for his heroic efforts in our defence so far. Given that the proscription on travel is now legal and not simply a recommendation, will he give us some clarification on what is meant by the care exemption, and confirm that it does not apply just to professional carers? At the moment, and since special schools have been closed in the last week, a great deal of support has been given from one family to another, for example in providing respite care for special needs children. That is very important and the people doing it are often being very responsible about self-isolation, which they are already applying to their families. Will that continue to be possible, and will my right hon. Friend enable it in future?

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(Citation: HC Deb, 24 March 2020, c246)

Matthew Hancock

Secretary of State for Health and Social Care

I will say three things in response to my right hon. Friend's questions. On special schools, one of the carve-outs in the closure of schools was keeping open schools for those who are vulnerable, including those with special educational needs. The Bill includes a power to enable us to move from that position, but we do not propose to exercise it unless absolutely necessary. The position therefore is that if someone wishes to send their child to a special school, that is fine. It was one of the specific carve-outs. In the same way, if a key worker needs to send their child to school and cannot look after them at home, schools are available.

My right hon. Friend asked about care. I want to make it clear that for people who are volunteering in response to covid-19 and those who are caring, even if their responsibilities are unpaid or informal, they are okay to do that and should do that. They should stay more than 2 metres away from others wherever possible, but that has to be a practical instruction, because of course we need to care for people. As I said in the statement, travel allows for caring, and I want to make it clear that volunteering in the response to covid-19 is a legitimate reason to travel. For example, the increasing numbers of volunteers in the NHS *(https://en.wikipedia.org/wiki/NHS)* are important. Although it is not paid work, it is work in the national effort to respond to covid-19.

My third point is that the Patient Safety, Suicide Prevention and Mental Health *(https://en.wikipedia.org/wiki/Mental_Health)* Minister *(/glossary/?gl=35)* is sitting next to me and close to me, because she has recovered and all the evidence shows that people cannot catch covid-19 twice, at least not in quick succession. I welcome her back to her place.

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(Citation: HC Deb, 24 March 2020, c246)

Liz Twist

Opposition Whip (Commons)

Following on the volunteering theme, I know that the Government have already made arrangements for schools and given advice that volunteers may still go in for certain purposes. Will the Secretary of State *(/glossary/?gl=23)* expand that to cover organisations such as Samaritans, which uses volunteers to travel to call rooms? Will he make it clear that it is acceptable for volunteers to do that?

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(Citation: HC Deb, 24 March 2020, c246)

Matthew Hancock

Secretary of State for Health and Social Care

Yes, it is acceptable. It is right that volunteers in that sort of work, for example Samaritans, should travel to do it.

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(Citation: HC Deb, 24 March 2020, c247)

Mark Harper

Conservative, Forest of Dean

The Secretary of State *(/glossary/?gl=23)* will know that, following the Prime Minister *(/glossary/?gl=264)*'s statement yesterday, all tourism and leisure providers have closed. I commend those in my constituency *(/glossary/?gl=169)* that closed before the advice was given, in order to protect people. However, those who take lots of deposits are obviously being pressed by our constituents to return that money, and that may put them in financial distress, but equally our constituents need the money back given their financial circumstances. I accept that the Secretary of State *(https://en.wikipedia.org/wiki/Secretary_of_State)* may not have an answer for me now, but will he at least commit to take the issue away and see whether an answer is forthcoming, perhaps with the support of the Treasury?

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(Citation: HC Deb, 24 March 2020, c247)

Matthew Hancock

Secretary of State for Health and Social Care

Yes, I will get my right hon. Friend an answer from the Department for Business, Energy and Industrial Strategy *(https://en.wikipedia.org/wiki/Department_for_Business,_Energy_and_Industrial_Strategy)*.

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(Citation: HC Deb, 24 March 2020, c247)

Daniel Zeichner

Labour, Cambridge

The Independent Food Aid Network oversees the work of many food banks, and I listened carefully to the Secretary of State *(/glossary/?gl=23)*'s comments about volunteering. That organisation is worried about the closure of community centres and churches. Will he reassure it that its valuable work and volunteers will be covered by the guidance?

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(Citation: HC Deb, 24 March 2020, c247)

Matthew Hancock

Secretary of State for Health and Social Care

We will set out the breadth of the guidance precisely on gov.uk.

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(Citation: HC Deb, 24 March 2020, c247)

Stephen Hammond

Conservative, Wimbledon

Like my honourable colleagues, I commend the Secretary of State *(/glossary/?gl=23)*'s superhuman efforts. On the subject of procurement, may I say two things? First, he will know that the Public Health England *(https://en.wikipedia.org/wiki/Public_Health_England)* change of guidelines has caused some concern. Will he ensure that they are clear to people? Secondly, a senior A&E consultant reminded me that they need more blood gas machines as well as more ventilators.

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(Citation: HC Deb, 24 March 2020, c247)

Matthew Hancock

Secretary of State for Health and Social Care

Yes, both are important points that we have in hand.

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(Citation: HC Deb, 24 March 2020, c247)

Edward Davey

Liberal Democrat Spokesperson (Treasury), Acting Leader, Liberal Democrats, Liberal Democrat Spokesperson (Social Justice)

It is good to see the Under-Secretary of State *(/glossary/?gl=23)* for Health and Social Care *(https://en.wikipedia.org/wiki/Health_and_Social_Care)*, Ms Dorries *(/mp/?p=11397)*, back in her place *(/glossary/?gl=144)* —I am not sure whether the Secretary of State *(https://en.wikipedia.org/wiki/Secretary_of_State)* still needs to have 2 metres distance.

May I press the Secretary of State on personal protective equipment? I hear what he says, and it is good that the military are being involved in the distribution, but is there enough PPE *(https://en.wikipedia.org/wiki/PPE)* available for all healthcare workers and social care workers? If not, what is happening with manufacturing and the procurement from around the world, because we are told there is some available from around the world?

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(Citation: HC Deb, 24 March 2020, c247)

Matthew Hancock

Secretary of State for Health and Social Care

Yes, we have a huge quantity that we hold ready for an eventuality such as this. That was, in fact, enhanced in our no-deal preparations, but of course we are also using that up, so we are buying to make sure that those stocks are replenished.

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(Citation: HC Deb, 24 March 2020, c247)

Andrew Murrison

Conservative, South West Wiltshire

I am very reassured to hear that by the end of the week, care settings will all get PPE *(https://en.wikipedia.org/wiki/PPE)*, which is not what the leader of my council was being told recently. I accept the Secretary of State *(/glossary/?gl=23)*'s reassurance: it is really good news. Can he further reassure me that the PPE, when it arrives, will be to the right specification, in particular FFP3 *(https://en.wikipedia.org/wiki/FFP3)* respirator masks and not simply paper masks, which are next to useless?

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(Citation: HC Deb, 24 March 2020, c248)

Matthew Hancock

Secretary of State for Health and Social Care

If there are specific concerns about the non-delivery of PPE *(https://en.wikipedia.org/wiki/PPE)* to council settings, I want to know about them through the hotline that we have set up precisely to short-circuit such problems having to be brought to my attention on the Floor of the House. Let us fix them directly. On the second point, it has got to be the right stuff according to the clinical guidelines.

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(Citation: HC Deb, 24 March 2020, c248)

Ruth Cadbury

Labour, Brentford and Isleworth

We have been told that by the time covid-19 peaks, 44,000 women will need access to early medical abortions. Women should not have to leave their homes during lockdown to access basic healthcare, so will the Secretary of State *(/glossary/?gl=23)* commit not to oppose moves in the other place *(/glossary/?gl=129)* to enable individual healthcare practitioners to certify abortions and to reinstate the regulations that were put up for a short while on the Government website last night, so that we can have use of abortion medication and one practitioner being able to prescribe on the phone?

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(Citation: HC Deb, 24 March 2020, c248)

Matthew Hancock

Secretary of State for Health and Social Care

There are no proposals to change the abortion rules due to covid-19.

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(Citation: HC Deb, 24 March 2020, c248)

Graham Brady

Chair, Conservative Party 1922 Committee

Care homes are being asked by local authorities to contract for block bookings of beds, but at the moment they would bear the liability if something were to go wrong—if residents were to come to them with the infection. May I urge my right hon. Friend to look urgently at the question of whether an indemnity can be provided?

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(Citation: HC Deb, 24 March 2020, c248)

Matthew Hancock

Secretary of State for Health and Social Care

I will get back to my hon. Friend on that very, very important point. I am grateful that he raised it with me privately earlier, and I am sorry that I have not been able to get a reply in time.

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(Citation: HC Deb, 24 March 2020, c248)

Kevan Jones

Labour, North Durham

I thank the Secretary of State *(/glossary/?gl=23)* for his statement. Will he join me in commending Pact House, a charity in my constituency *(/glossary/?gl=169)* in Stanley, which is delivering meals and food to the elderly with some 90 volunteers? It contacted me this morning because it is concerned that the building it operates from may need some type of certificate to keep operating, following the announcement yesterday.

Can he clarify the position? Will it just be allowed to open, or will it have to apply for some sort of letter to say that it can operate?

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(Citation: HC Deb, 24 March 2020, c248)

Matthew Hancock

Secretary of State for Health and Social Care

As long as it is operating within the guidelines that the Prime Minister *(/glossary/?gl=264)* outlined in his address to the nation last night, which are set out in detail on the gov.uk website, it is doing the right thing and does not need any further certification.

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(Citation: HC Deb, 24 March 2020, c248)

Tim Loughton

Conservative, East Worthing and Shoreham

One of the glimmers of light in these troubling times are the amazing community volunteer projects that have sprung up in all our constituencies. The Secretary of State *(/glossary/?gl=23)* will be pleased to learn that on Sunday, we set up a “shopital” outside Worthing hospital, and I spent several hours selling rice, spuds and, crucially, loo paper to more than 100 ambulancemen, nurses and doctors. Should not that sort of arrangement be happening anyway with the supermarkets and with the new scheme delivering food packets, to make sure that NHS *(https://en.wikipedia.org/wiki/NHS)* workers for whom going shopping at eight o’clock in the morning during the “golden hour” is not appropriate can get on with their job much more easily?

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(Citation: HC Deb, 24 March 2020, c249)

Matthew Hancock

Secretary of State for Health and Social Care

I did not know that my hon. Friend was engaged in that sort of activity on a Sunday morning, but I am delighted that he was. Making sure that we get hot meals to NHS *(https://en.wikipedia.org/wiki/NHS)* staff who are working often many more shifts than gives them time to make a good meal is incredibly important. It is something that we are working hard on, but I am really glad when it happens spontaneously, as well as when we try to sort it from the Department.

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(Citation: HC Deb, 24 March 2020, c249)

Chris Elmore

Opposition Whip (Commons)

I thank the Secretary of State *(/glossary/?gl=23)* for his statement. I am being inundated, as I am sure many other Members are, in relation to small firms that are still insisting on their staff going in and undertaking roles, including fitting windows and doors, and those that are saying, “Well, the business is coming in; we’re going to stay open and carry on making new work,” despite having to travel house to house to offer what is fundamentally a non-essential service. Will the Secretary of State *(https://en.wikipedia.org/wiki/Secretary_of_State)* raise this issue with the Department for Business, Energy and Industrial Strategy *(https://en.wikipedia.org/wiki/Department_for_Business,_Energy_and_Industrial_Strategy)* and other Ministers to ensure that those small firms, which arguably do not need to be working, are keeping their staff at home?

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(Citation: HC Deb, 24 March 2020, c249)

Matthew Hancock

Secretary of State for Health and Social Care

I will raise that question and make sure that the appropriate guidance is put on gov.uk.

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(Citation: HC Deb, 24 March 2020, c249)

Kevin Hollinrake

Conservative, Thirsk and Malton

The Secretary of State *(/glossary/?gl=23)* is doing an excellent job and is being incredibly responsive, despite what I appreciate must be the huge volume of correspondence coming into his inbox. He is damned if he does and damned if he doesn't. However, there is confusion about whether people should be going to work or not. From both a health and an economic perspective, as a business owner, I would much rather have a short, sharp shock, with everything closed down for 30 days to get this disease under control and allow the Secretary of State *(https://en.wikipedia.org/wiki/Secretary_of_State)* to get his testing and tracking in place and defeat it.

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(Citation: HC Deb, 24 March 2020, c249)

Matthew Hancock

Secretary of State for Health and Social Care

I agree with what my hon. Friend has said—and not just the first bit—but I repeat what I said in my statement. I want to be clear that, where people absolutely cannot work from home, they can still go to work. Indeed, it is important that they do so to keep the country running.

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(Citation: HC Deb, 24 March 2020, c249)

Patrick Grady

SNP Chief Whip

That is the nub of the confusion, because I am hearing reports from constituents and from elsewhere in the city that, for example, workers in call centres for outbound sales calls—which will undoubtedly be disruptive to those self-isolating at home who receive them—are being asked to come in and work in cramped conditions, which we know exist in such places. Should those employers not be taking advantage of the Government's furlough scheme, so that their employees do not have to come into work? Is it not the case that no employee should be punished for doing the right thing and following the Government advice to stay at home?

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(Citation: HC Deb, 24 March 2020, c249)

Matthew Hancock

Secretary of State for Health and Social Care

That sort of activity can technically be done from home and, where work cannot be done from home, employers should be following the guidelines to keep people more than 2 metres apart.

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(Citation: HC Deb, 24 March 2020, c250)

Desmond Swayne

Conservative, New Forest West

There are many essential jobs and repairs that need to be done in people's homes by workmen. So long as those homes are not specifically shielded or self-isolating because of suspected disease, and so long as the proper social separation is maintained, surely those ought to proceed, ought they not?

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(Citation: HC Deb, 24 March 2020, c250)

Matthew Hancock

Secretary of State for Health and Social Care

If they are essential, yes, but the aim here is to try to absolutely push down the speed of transmission of this disease over the next few weeks, to get a grip on its spread. That means that, while we have set out four reasons where it is reasonable to leave one's home, people should stay at home if they do not have a good reason.

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(Citation: HC Deb, 24 March 2020, c250)

Wes Streeting

Labour, Ilford North

I will not read the text message that I have received from my hon. Friend Jess Phillips *(/mp/?p=25364)* because it contains unparliamentary language *(/glossary/?gl=20)*. However, further to the reply given to my hon. Friend Ruth Cadbury *(/mp/?p=25343)*, I think the Secretary of State *(/glossary/?gl=23)* needs to give the House a clear explanation

as to why it was yesterday that clear guidance was provided by the Government on access to abortion early in the day, only for it to be removed from the Government website later in the day. Why is that? Why are the Government not listening to the royal colleges, and why are they making it more difficult for women to get access to an essential procedure during this time of crisis?

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(Citation: HC Deb, 24 March 2020, c250)

Matthew Hancock

Secretary of State for Health and Social Care

All I can do is repeat the clarity that there are no proposals to change abortion law.

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(Citation: HC Deb, 24 March 2020, c250)

Alicia Kearns

Conservative, Rutland and Melton

Will my right hon Friend confirm what the advice is on visiting loved ones in hospital? Will he also confirm that Rutland is not a “hospital desert”—as reported by Sky News, which has concerned my constituents, who have access to Leicester and Peterborough—and urge the media to be cautious about deeply unhelpful and sensationalist reporting?

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(Citation: HC Deb, 24 March 2020, c250)

Matthew Hancock

Secretary of State for Health and Social Care

Yes; my hon. Friend makes a very important point.

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(Citation: HC Deb, 24 March 2020, c250)

Jim Shannon

Shadow DUP Spokesperson (Human Rights), Shadow DUP Spokesperson (Health)

Does the Secretary of State *(/glossary/?gl=23)* not agree that the attempt to alter the abortion regime through the Coronavirus Bill *(https://en.wikipedia.org/wiki/Coronavirus_Bill)* is not the right use of those measures? Any change to abortion legislation, which is almost the last protection for our unborn children, deserves adequate scrutiny and appropriate debate, which is not possible right now. Will he, for the record, assure me that no changes to that legislation, which regulates life and death, will be made in this way through stealth and opportunism?

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(Citation: HC Deb, 24 March 2020, c250)

Matthew Hancock

Secretary of State for Health and Social Care

I repeat an answer that I have given before: there are no proposals to change the law around abortion.

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(Citation: HC Deb, 24 March 2020, c251)

Steve Brine
Conservative, Winchester

Sorry to return to the “going to work” point, but last night the Government were saying, “The only reason you may leave home is to go to work (if you’re a key worker)”, but then the part in brackets changed to “but work from home if possible”. I think that is where there is confusion. People are not sure what they can and cannot do. That is a pattern that we have, sadly, seen repeated, and which has led to “lockdown/not lockdown”. Could the Secretary of State *(/glossary/?gl=23)* say what the advice is again? I am not wishing to cause trouble; I am just looking for clarity.

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(Citation: HC Deb, 24 March 2020, c251)

Matthew Hancock
Secretary of State for Health and Social Care

The Prime Minister *(/glossary/?gl=264)* was clear in his address to the nation; I have been clear in my statement today; and the guidance on gov.uk is absolutely clear on this point.

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(Citation: HC Deb, 24 March 2020, c251)

Kevin Brennan
Shadow Minister (Digital, Culture, Media and Sport) (Arts and Heritage)

Many hon. Members are not here because they are being responsible and allowing some of us to represent them, so that we can observe proper social distancing. My hon. Friend Louise Haigh *(/mp/?p=25357)* has asked me to raise the issue of irresponsible employers. She tells me that the Home Office

(https://en.wikipedia.org/wiki/Home_Office) in Sheffield is requiring workers to come in to do word processing and administrative work that could be done at home. Will the Secretary of State *(/glossary/?gl=23)* undertake to communicate my hon. Friend's concerns to the Home Secretary *(https://en.wikipedia.org/wiki/Home_Secretary)*, and if what my hon. Friend describes is the case, ask the Home Secretary to put a stop to it straightaway and set a good example?

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(Citation: HC Deb, 24 March 2020, c251)

Matthew Hancock

Secretary of State for Health and Social Care

I will ensure that that is looked into.

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(Citation: HC Deb, 24 March 2020, c251)

Tobias Ellwood

Chair, Defence Committee

Will the Secretary of State *(/glossary/?gl=23)* join me in paying tribute to the army *(/glossary/?gl=100)* of volunteers in Bournemouth and across the country—the individuals, businesspeople, charity groups and local organisations—who want to be part of the solution, and to help the elderly and vulnerable, allowing us to adapt to this new way of life? Yesterday, a 30-day lockdown was spoken of; this will require some form of enforcement. Can he say what role the armed forces might play in that?

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(Citation: HC Deb, 24 March 2020, c251)

Matthew Hancock
Secretary of State for Health and Social Care

The armed forces are doing an absolutely fantastic job of supporting civilian efforts, for instance in the NHS *(https://en.wikipedia.org/wiki/NHS)* on the logistics of delivery of protective equipment and much more; but the armed forces will not be involved in the enforcement of the law. That is for the police, who will levy fines, starting at £30 and escalating if people continue to flout the rules.

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(Citation: HC Deb, 24 March 2020, c251)

Bill Esterson
Shadow Minister (Business, Energy and Industrial Strategy), Shadow Minister (International Trade)

One of my constituents is a home carer who has been unable to get PPE *(https://en.wikipedia.org/wiki/PPE)*. She stopped working because her daughter has asthma, and obviously she is concerned about the potential for passing on the virus. I am pleased about what the Health Secretary *(https://en.wikipedia.org/wiki/Health_Secretary)* said about the availability of PPE, but people such as my constituent, and their employers, need to know how to get hold of it. He said that that information would be on the gov.uk website, but not everybody knows about the website. Could he improve awareness of how to find out this information, and make sure that we have access to the website and the phone number?

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(Citation: HC Deb, 24 March 2020, c251)

Matthew Hancock
Secretary of State for Health and Social Care

I will make sure that the hon. Gentleman gets the phone number, so that he can pass it on to his constituent, and so that others in the same circumstances know how to make that happen.

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(Citation: HC Deb, 24 March 2020, c252)

Ruth Edwards

Conservative, Rushcliffe

NHS *(https://en.wikipedia.org/wiki/NHS)* workers are on the frontline of this battle, at huge personal risk. Many have returned to the NHS especially to fight coronavirus. Does my right hon. Friend agree that when this is over, we need to find an appropriate way to recognise and honour their bravery?

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(Citation: HC Deb, 24 March 2020, c252)

Matthew Hancock

Secretary of State for Health and Social Care

Yes. My hon. Friend makes an incredibly important point, which is that we as a nation owe a debt of gratitude to those who work in the NHS *(https://en.wikipedia.org/wiki/NHS)*, and we need to constantly search for ways to show it, so that they all know how much we value the work that they do.

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Matt Western

Opposition Whip (Commons)

I echo the points made by Kevin Hollinrake *(/mp/?p=25415)* about an absolute shutdown, and absolute clarity for the public. Does the Secretary of State *(/glossary/?gl=23)* agree that we urgently need to get more FFP3 *(https://en.wikipedia.org/wiki/FFP3)* masks out there? That is what the frontline health workers are demanding, because they are terrified by the prospect of this crisis. The masks provided to the construction industry would be suitable for healthcare workers, I understand.

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(Citation: HC Deb, 24 March 2020, c252)

Matthew Hancock

Secretary of State for Health and Social Care

I will look into that point. The masks need to be clinically right; it is not for me to make that decision, but I will take this up with the chief medical officer.

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(Citation: HC Deb, 24 March 2020, c252)

Richard Drax

Conservative, South Dorset

May I personally thank my right hon. Friend and the Department for the rapid response he has given to every inquiry that I have made on behalf of my constituents? I also praise the NHS *(https://en.wikipedia.org/wiki/NHS)* in Dorset and, of course, throughout the country for all the fantastic

work that everyone is doing in the face of this appalling virus.

First, we are still having problems getting PPE *(https://en.wikipedia.org/wiki/PPE)*; I heard the Secretary of State *(/glossary/?gl=23)* say that the phone line, to which he kindly referred me, is still the best way to try to follow up on that. Secondly, supermarkets are impossible to get hold of so that food banks can go online to request regular deliveries. Is there some way that we can get a message to all supermarkets to help out in that regard?

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(Citation: HC Deb, 24 March 2020, c252)

Matthew Hancock

Secretary of State for Health and Social Care

I am grateful to my hon. Friend for his first point. He is right that the hotline is the best way to sort out the PPE *(https://en.wikipedia.org/wiki/PPE)* supply issues. I am told that it has already responded to more than 2,000 inquiries, is moving through inquiries fast and has a lot of people on the other end of the line to make sure that people can get hold of somebody. I shall take up the latter point with my right hon. Friend the Secretary of State *(/glossary/?gl=23)* for Environment, Food and Rural Affairs.

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(Citation: HC Deb, 24 March 2020, c252)

Peter Aldous

Conservative, Waveney

I commend my right hon. Friend for the sterling work he is doing. Will he provide some clarification on the definition of essential retail? The general store that purchases a freezer and says that it is a food store quite clearly is not, but the garden centre that incorporates a farm shop that may serve a local community might well be.

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(Citation: HC Deb, 24 March 2020, c253)

Matthew Hancock

Secretary of State for Health and Social Care

These things will inevitably end up being a judgment at the boundary, but if there are two types of shop in one organisation, we will sometimes require some parts of it to close. If there is a café in a shop that sells essential supplies, the café must close but the essential-supplies part can stay open.

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(Citation: HC Deb, 24 March 2020, c253)

Jason McCartney

Conservative, Colne Valley

I, too, praise the Secretary of State *(/glossary/?gl=23)* and his wonderful team for their heroic efforts in fighting this killer virus. Will he confirm that volunteers such as those in the Holme Valley Covid Mutual Aid group, who are providing shopping services, delivering food parcels, picking up prescriptions, posting mail and dog walking, should continue to supply those services for their community, in a safe way?

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(Citation: HC Deb, 24 March 2020, c253)

Matthew Hancock

Secretary of State for Health and Social Care

Yes, they should. They should stay 2 metres away from other people, wherever possible, but we are actively encouraging the voluntary effort in support of covid-19 and we actively support it.

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(Citation: HC Deb, 24 March 2020, c253)

Aaron Bell

Conservative, Newcastle-under-Lyme

I thank the Secretary of State *(/glossary/?gl=23)* for all he is doing and I thank the thousands of retired nurses who have answered his call to come back to the NHS *(https://en.wikipedia.org/wiki/NHS)*, but may I just raise a wrinkle in my constituency *(/glossary/?gl=169)* of Newcastle-under-Lyme? A nurse wrote to me who is 58 and retired at 55. She has returned to work for 16 hours and is happy to work full time, but she is concerned about the possible effect on her pension. Will the Secretary of State *(https://en.wikipedia.org/wiki/Secretary_of_State)* and the Chancellor *(/glossary/?gl=170)* of Exchequer work together to look at the situation and make sure that there are no financial barriers to heroes such as her coming back to work for our NHS?

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(Citation: HC Deb, 24 March 2020, c253)

Matthew Hancock

Secretary of State for Health and Social Care

Yes. We solved several of the problems in the pension system at the Budget, and there are further solutions in the Bill. I have not come across any further problems in respect of pensions, but if my hon. Friend writes to me with the individual case, I will check that that is the case in that instance, too.

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James Wild

Conservative, North West Norfolk

On Saturday, I met the chief executive and the incident management team at the Queen Elizabeth Hospital *(https://en.wikipedia.org/wiki/Queen_Elizabeth_Hospital)* in King's Lynn in my constituency *(/glossary/?gl=169)*, where sadly two patients who tested positive for covid-19 died last week. I pay tribute to the dedication of all the staff who are, as the Secretary of State *(/glossary/?gl=23)* knows, working in buildings that need more investment. Will he make sure that those on the frontline continue to get the PPE *(https://en.wikipedia.org/wiki/PPE)* that they need and have more access to ventilators?

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(Citation: HC Deb, 24 March 2020, c253)

Matthew Hancock

Secretary of State for Health and Social Care

Yes, absolutely—on all counts. I just want to add my thanks to all those working on the frontline, and throughout the NHS *(https://en.wikipedia.org/wiki/NHS)* and social care, to my hon. Friend's thanks to those in King's Lynn. I also put on the record my thanks to my extraordinary civil service political and Public Health England *(https://en.wikipedia.org/wiki/Public_Health_England)* team, who have done amazing work and continue to work incredibly hard in response to this crisis.

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(Citation: HC Deb, 24 March 2020, c254)

Scott Benton

Conservative, Blackpool South

Will my right hon. Friend join me in paying tribute to our fantastic NHS *(https://en.wikipedia.org/wiki/NHS)* staff at Blackpool Victoria Hospital *(https://en.wikipedia.org/wiki/Blackpool_Victoria_Hospital)*? Some private firms in my constituency *(/glossary/?gl=169)* have offered free or discounted parking to NHS staff, to help them out in these difficult times. Will he commend those firms and encourage others to do the same to make sure that it is as easy as possible for staff to get to work?

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(Citation: HC Deb, 24 March 2020, c254)

Matthew Hancock

Secretary of State for Health and Social Care

Yes, I will. I pay tribute to all the staff at Blackpool hospital. I met some of them during the election campaign and I know that they are working incredibly hard in preparation for what is to come. I absolutely commend all those who are giving free parking to NHS *(https://en.wikipedia.org/wiki/NHS)* staff and we are looking at what we can do to make that happy occurrence spread more broadly across the NHS.

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(Citation: HC Deb, 24 March 2020, c254)

Coronavirus Bill

MARSHALLED

LIST OF AMENDMENTS

TO BE MOVED

IN COMMITTEE OF THE WHOLE HOUSE

[*Amendments marked ★ are new or have been altered*]

Amendment No.

After Clause 15

BARONESS THORNTON
LORD LOW OF DALSTON

1★ To insert the following new Clause—

"Monitoring body: effect of Schedule 12

(1) The Secretary of State shall, within seven days of the date on which this Act is passed, appoint by order a body ("the relevant body") to monitor the effect of Schedule 12 to this Act.

(2) The relevant body must—

(a) advise Her Majesty's Government about the effect of Schedule 12;

(b) make recommendations to Her Majesty's Government about the amendment, suspension or repeal of Schedule 12.

(3) The relevant body must publish a report in respect of paragraph 2(1) and (2) of Schedule 12 at least once every eight weeks during any period in which that Schedule is in operation."

Member's explanatory statement
The purpose of this new Clause is to ensure that the impact of Schedule 12 (local authority care and support) is subject to monitoring and review by a body such as the Equality and Human Rights Commission.

After Clause 17

LORD SCRIVEN
BARONESS BARKER

2★ Insert the following new Clause—

"Power to direct for local authorities

(1) This section applies if an appropriate local authority considers that a body within the competence of its powers is required to act in order to respond to the coronavirus.

(2) The appropriate local authority may give a body in subsection (1) directions as to the exercise of its functions in connection with responding to the coronavirus.

(3) A direction under this section must be given in writing.

(4) The power to give directions under this section includes power to vary or revoke the directions.

(5) A body within the competence of the powers of the local authority must comply with a direction under this section."

Member's explanatory statement
This is a probing amendment to raise concerns about whether local authorities have the necessary powers to respond to coronavirus.

Clause 82

BARONESS MCINTOSH OF PICKERING

3★ Page 50, line 35, after "forfeiture" insert "or notice to pay rent"

4★ Page 51, line 45, at end insert—

"(c) a tenancy to which the Agricultural Holdings Act 1986 applies; or

(d) a tenancy to which the Agricultural Tenancies Act 1995 applies."

After Clause 84

LORD CLEMENT-JONES
LORD NEWBY
VISCOUNT COLVILLE OF CULROSS
BARONESS BONHAM-CARTER OF YARNBURY

5★ Insert the following new Clause—

"Statutory self-employment pay

(1) The Secretary of State must, by regulations made by statutory instrument, introduce a scheme of statutory self-employment pay for those whose work has been impacted as a result of the coronavirus.

(2) The scheme must make provision for payments to be made out of public funds to individuals who are—

(a) self-employed, or

(b) freelancers.

After Clause 84 - *continued*

(3) Regulations made under subsection (1) may define the meanings of "self-employed" and "freelancers" in subsection (2).

(4) The payments to be made under subsection (2) are to be set such that the gross monthly earnings of an individual specified in subsection (2) do not fall below—

(a) 80 per cent of their gross monthly earnings, averaged over the previous 3 years (or if records do not date back 3 years, the monthly net earnings averaged for the period records are available), or

(b) £2,500,

whichever is lower.

(5) No payment made under subsection (2) shall exceed £2,500 per month.

(6) Regulations made under subsection (1) may provide that payments made under subsection (2) must be paid back via self-assessment if the payments were made in error.

(7) A statutory instrument containing regulations under this section is subject to annulment in pursuance of a resolution of either House of Parliament."

Member's explanatory statement
This amendment would ensure that the Government introduced a scheme of statutory self-employment pay.

BARONESS BENNETT OF MANOR CASTLE
BARONESS BARKER

6★ Insert the following new Clause—

"Temporary modification of abortion legislation

Schedule (*Abortion provision*) contains temporary modifications of the Abortion Act 1967, and related provision."

Clause 89

LORD NEWBY
BARONESS BARKER

7★ Page 58, line 21, leave out "2 years" and insert "3 months"

Clause 90

LORD NEWBY
BARONESS BARKER

8★ Page 60, line 19, leave out "6" and insert "3"

9★ Page 60, line 21, at end insert—

"( ) A time specified under subsection (2) in relation to a provision of this Act must not be later than the end of the period of 2 years beginning with the day on which it is passed."

Member's explanatory statement
This amendment, along with the amendments to Clause 90 in the name of Lord Newby, would mean the Act expires after three months, with the option to extend the Act in three-month periods for a maximum time of two years.

Clause 97

LORD ANDERSON OF IPSWICH
BARONESS LUDFORD

10★ Page 66, line 41, at the end insert ", and an explanation containing the reasons why the Secretary of State is satisfied."

Member's explanatory statement
This amendment would require an explanation to be given in the two-monthly reports laid before Parliament of the Secretary of State's reasons for continuing to make use (or otherwise) of the provisions in Part 1 of the Act.

Clause 98

LORD FALCONER OF THOROTON

11★ Page 68, line 10, At end insert—

"(2A) A Minister of the Crown may table a motion in the House of Commons to provide that certain temporary provisions under this Act are to expire.

(2B) If—

(a) a motion under subsection (2) is amended to the effect that certain temporary provisions under this Act should expire, or

(b) a Minister of the Crown lays a motion under subsection (2A) providing that certain temporary provisions are to expire which is passed by the House of Commons

a Minister of the Crown must exercise the power conferred by section 90(1) to provide that the temporary provisions specified in the motion expires no later than the end of the period of 21 days beginning with the day on which motion was passed."

Member's explanatory statement
This amendment would allow for certain temporary provisions in the act to expire if a motion to that effect is laid by the government or amended by MPs.

LORD NEWBY
BARONESS BARKER

12★ Page 68, line 13, after "Commons" insert "and the House of Lords"

Member's explanatory statement
This amendment allows the Lords to debate the same motion as the Commons after each 6 month review paper and to have an indicative vote. The Government would not have to take any action in response to the Lords vote.

After Clause 99

BARONESS LUDFORD
LORD SCRIVEN
LORD ANDERSON OF IPSWICH

13★ Insert the following new Clause—

"Powers within the Act: necessity and proportionality

All powers under this Act must be exercised in accordance with the Human Rights Act 1998 and the Equality Act 2010, especially with regard to the principles of necessity, proportionality and non-discrimination."

Member's explanatory statement
This amendment would require the powers in this Act to be exercised in accordance with the principles of necessity, proportionality and non-discrimination and to be compatible with human rights law.

Schedule 29

BARONESS BENNETT OF MANOR CASTLE
BARONESS BARKER

14★ Insert the following new Schedule—

"ABORTION PROVISION

1 (1) References in this Schedule to sections are to sections of the Abortion Act 1967 ("the 1967 Act").

(2) In this Schedule—

"Registered medical practitioner" means a person on the Register of the General Medical Council established by the Medical Act 1983;

"Registered nurse or midwife" means a person on the Register of the Nursing and Midwifery Council, with the meaning given to it by Article 5(5) of The Nursing and Midwifery Order 2001;

"home" means, in the case of a pregnant woman, the place in England or Wales where a pregnant woman is living during the period this Schedule has effect or, in the case of a registered medical practitioner, where that individual is living during the period in which this Schedule has effect.

2 Where any form prescribed for use in connection with a provision of the 1967 Act is inconsistent with a modification made by paragraph 3, the form—

(a) may, in connection with the provision as so modified, be used with appropriate amendments;

(b) is otherwise, for use in that connection, to be read with such amendments as are necessary to reflect the modification.

3 (1) During a period in which this paragraph has effect, the provisions in section 1 apply to a pregnancy terminated by a registered medical practitioner, nurse or midwife.

Schedule 29 - *continued*

(2) During a period in which this paragraph has effect, an opinion under section 1 may be formed by one registered medical practitioner, nurse or midwife, if the professional considers that compliance with requirement under that section for the opinion of two registered medical practitioners is impractical or would involve undesirable delay.

4 (1) This paragraph has effect as an approval of a class of place by the Secretary of State under the powers granted in sections 1(3) and (3A) of the 1967 Act.

(2) The home of a registered medical practitioner, nurse or midwife is approved as a class of place for the treatment of termination of pregnancy for the purposes only of prescribing the medicines known as mifepristone and misoprostol to be used in treatment carried out in the manner specified in sub-paragraph (4).

(3) The home of a pregnant woman who is undergoing treatment for the purposes of termination of her pregnancy is approved as a class of place where the treatment for termination of pregnancy may be carried out where that treatment is carried out in the manner specified in sub-paragraph (4).

(4) The treatment must be carried out in the following manner—

(a) the pregnant woman has—

(i) attended an approved place,

(ii) had a consultation with an approved place via video link, telephone conference or other electronic means, or

(iii) had a consultation with a registered medical practitioner, nurse or midwife via video link, telephone conference or other electronic means; and

(b) the pregnant woman is prescribed mifepristone or misoprostol to be take for the purposes of the termination of her pregnancy.

5 During a period in which this paragraph has effect, the requirement to give notice of the termination in section 2(1)(b) also applies to any registered nurse or midwife

6 During a period in which this paragraph has effect, the provisions in section 5(1) also apply to any registered nurse or midwife."

Coronavirus Bill

MARSHALLED

LIST OF AMENDMENTS

TO BE MOVED

IN COMMITTEE OF THE WHOLE HOUSE

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24 March 2020

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Coronavirus Bill

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25 March 2020

Volume 802

Committee

12.06 pm

Relevant documents: 9th Report from the Delegated Powers Committee, 4th Report from the Constitution Committee

Clauses 1 to 15 agreed.

Amendment 1

Moved by

Baroness Thornton

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1: After Clause 15, to insert the following new Clause—

"Monitoring body: effect of Schedule 12

(1) The Secretary of State shall, within seven days of the date on which this Act is passed, appoint by order a body ("the relevant body") to monitor the effect of Schedule 12 to this Act.(2) The relevant body must—(a) advise Her Majesty's Government about the effect of Schedule 12;(b) make recommendations to Her Majesty's Government about the amendment, suspension or repeal of Schedule 12.(3) The relevant body must publish a report in respect of paragraph 2(1) and (2) of Schedule 12 at least once every eight weeks during any period in which that Schedule is in operation."Member's explanatory statement

The purpose of this new Clause is to ensure that the impact of Schedule 12 (local authority care and support) is subject to monitoring and review by a body such as the Equality and Human Rights Commission.

Baroness Thornton (Lab)

My Lords, the amendment would ensure that the impact of Schedule 12, which concerns local authority care and support, is subject to monitoring and review by an appropriate body. The amendment is about the voice of the people affected by Schedule 12 being heard in the process of the Government reviewing whether the system is working and whether they will keep it in place.

We on these Benches believe that that should be done by an independent body or organisation—that is, an independent voice that is not the Government or one of their organisations. The reason is that we know that this schedule will have an enormous impact on our social care systems. Given that those systems have already suffered a crisis in funding and resources—and will also be taking in volunteers to help—this is an important moment.

It is important for two groups of people in particular. Yesterday, I was struck by the remarks of the noble Baroness, Lady Grey-Thompson; as I said then, she made me realise that the impact of this Bill on the disabled is profound indeed. There are two groups that need to be represented and whose voices need to be heard. One is the elderly and housebound; for them, an organisation such as Age UK, or something similar, may be appropriate. The other is the disabled. Both groups of people will be physically and mentally affected by the schedule, but the disabled are a particular cause for concern because this is also about their rights. I gave the Minister notice of the fact that we want those rights to be suspended for a shorter period.

This amendment is about finding a way for affected people in those groups to have a voice. We all need to be very disciplined in this part of the journey through the Bill so I do not intend to speak for much longer; but I would like to say how impressed I am by the way that Age UK has been approaching this crisis, which, of course, has enormous implications for the people it seeks to champion, represent and campaign for. Age UK's chief executive Steph Harland said:

"Before this crisis began, we were already very concerned about the large numbers of older people who were disadvantaged and isolated. The reality is we're not at the toughest point of this crisis yet, and it's difficult to predict what that will mean for us as individuals, our

charity, and the older people who rely on us and our partners across the country. What we know with certainty is it will get far more difficult than it is today and older people's needs will sky-rocket."

She is quite right. This amendment makes the point that that voice needs to be heard, and the Government need to listen to it as part of their monitoring. I beg to move.

Share

Lord Scriven (LD)

My Lords, my Amendment 2 is also in this group and I want to speak briefly to it. I start by drawing the attention of the House to my interest as a vice-president of the Local Government Association. Amendment 2 is a probing amendment—a very friendly one, as I hope the Minister understands—regarding something that I foresee.

It is clear from discussions with my local government colleagues across the country that there are a number of issues in respect of which local communities are turning to their local authority as the nearest the port of government, as they see it—one they recognise and have a relationship with. Some councils can deal with many of the things that people are turning to them for; others would like to but do not have the powers to do so. As this public health challenge becomes increasingly severe, the demands on local government will be immense. Local authority employees, who are doing a great job up and down the country, will not be immune from getting the coronavirus, which, as I said yesterday, will also affect services not related directly it, such as refuse collection or environmental health; or they may not have equipment such as lorries or vans to deal with issues.

They will need a general power of direction—some way to say to other organisations within their jurisdiction, "We can't negotiate; we can't plead with you. This is a crisis. We need you to act. We need to requisition certain items, personnel or services off you." I ask the Minister this: if the Government cannot accept this amendment, what arrangements will be in place —or what regulations will come forward in a very speedy way—to enable local government to best deal with the issues that will inevitably come to rest on its shoulders?

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Baroness McDonagh (Lab)

My Lords, I want to speak in favour of Amendments 1 and 2, and later Amendment 6, which I think is trying to do the same thing. Like my noble friend Lady Thornton, I was struck by the remarks of the noble Baroness, Lady Grey-Thompson, yesterday when she talked about the suspension of the Care Act, and the NICE regulations. We have to review how these are going to work in practice. I know that the Government are dealing with something that is moving very quickly, but often, having heard an announcement that sounds great, we look at the detail and find that the announcement and what happens in practice are two different things. One issue that my noble friend Lady Thornton's amendment would allow us to review is the protective equipment and clothing of local authority staff in social care environments and, more broadly, the health service.

Share

12.15 pm

I want to make one specific point on this. In the last week, I have been contacted by many medical staff and charities. These fears are very broad. Many of us will have heard or read the recommendations from the Zhejiang University School of Medicine about protective clothing. I do not understand why the Government and NHS England have chosen not to procure those uniforms and protective clothing when there is now substantial evidence on this.

Doctors read data. They can see the data from Italy, where one type of protective clothing was used, and compare the number of fatalities there with the number in China. Will the Minister ask for some independent assessment of the protective clothing that we are using? The Government changed their stance on this only when independent universities produced data to show that modelling on the spread of the virus was wrong. I think the Chief Medical Officer and the Chief Scientific Officer have to put this out for independent study, because it is perfectly possible for us to procure this clothing now. This pandemic is costing the country billions. A cost that equates to $10 per shift is perfectly affordable when lives are at risk.

Lord Adonis (Lab)

My Lords, the objectives of my noble friend's amendment are clearly correct. It proposes that we should keep under review the operation of the powers that are granted in key areas of the Bill because, as she rightly said, they could be extremely damaging and possibly catastrophic in certain sectors of society.

I have two concerns that I would like to probe. First, what my noble friend has done is select one of the many very serious areas that are affected by the Bill. My noble friend Lady McDonagh just raised another to do with protective equipment. We could go into the arrangements for mental health in the Bill, which are extremely serious. We might want to keep under review—I believe we should—the arrangements regarding testing, because it looks increasingly clear that only if we can move towards some form of mass testing will we be able to get this crisis under control. My noble friend has selected just one area but, if there is to be a review of this kind, it needs to look at the operations of the Act at large.

I also have a bigger concern. What my noble friend seeks to do—perfectly understandably, because Parliament will not be sitting for the next month and, as I understand it, will sit only intermittently after that—is set up a body that would do what is surely our job as parliamentarians, namely to keep under review the exercise of the powers that we as Parliament are granting. This goes to the heart of a wider issue. It is proposed that Parliament will not sit in any form for the next month. We will be in complete recess. As I understand it—the Minister will correct me if I am wrong—there will not be provision for any committees to sit formally, not just in person but online or by using what is not even 21st-century technology but rather 20th-century technology to hold meetings.

Surely the right approach, which will be vital as we conduct our affairs in the weeks and possibly months ahead, is that we should keep under review both this crisis and the powers we are granting. When it is not possible to do this by meeting, we should do so electronically. We should do this regularly and in all the principal areas in which we, of necessity, are granting to the Government wholly exceptional powers that could have a very big social impact. I believe it is our duty to keep these under review.

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Baroness Hussein-Ece (LD)

My Lords, I too support the amendments in this group and the spirit in which they have been put forward. Many of us will have received briefings from various charities and organisations that are doing important work face-to-face with very vulnerable people. I declare an interest as my grandson is in lockdown in a residential unit for disabled children and children with

epilepsy. As noble Lords can imagine, we as his family are very worried and concerned about the outcome of that. There are already staff shortages in that facility, as I am sure there are up and down the country.

I received a briefing from Barnardo's and it resonated very much what with what the noble Baroness, Lady Grey- Thompson, was asking about yesterday, so I shall ask about vulnerable children and children with disabilities, many of whom may possibly be falling through the cracks and will not have support networks if local authorities are rolling back some of their duties under the Bill. It makes sense that charities and other bodies could come together under a local authority directive or umbrella to make sure that children who are in care or leaving care or who have disabilities receive care. Those who would normally be attending school and would receive support in school will not be getting that support now, so there is huge concern about thousands of children up and down the country who face incredible disadvantages and possible dangers without these systems in place and without local authorities functioning in the ways they normally would have done. Will the Minister tell us what measures can be put in place for the most vulnerable and at risk? Will the Government work with charities such as Barnardo's and many others up and down the country to ensure that vulnerable children are identified and receive the support that they need?

Share

Baroness Uddin (Non-Afl)

My Lords, I rise to support Amendments 1 and 2. I am pleased to follow the noble Baroness, Lady Hussein-Ece, and I echo her words. I am the mother of a 40 year-old autistic and disabled son, although he does not use any services. I have been inundated by charities telling me that they are very concerned, especially charities which are serving the needs of ethnic minority disabled and elderly people who do not necessarily feel that they have the voice that others have in connecting with local and national organisations. So I welcome the idea suggested by the noble Baroness, Lady Thornton, of an independent body and a voice. I echo that very much.

My second and final point is with regard to the concern expressed by the noble Lord, Lord Scriven, about the role of local authorities. Yesterday, I passionately and enthusiastically overran the guide time, for which I apologise to the House once again, because I had been inundated by groups saying that they were deeply concerned about burial issues. I noted

that the Minister said that it would be up to the local authority. I am already deeply concerned that local authorities are incredibly burdened so, unless they are mandated to do so, they will not seek to talk to a wider range of groups. Yet again yesterday I was contacted in the evening by a number of organisations that say they are willing to work with the Government and local authorities to ensure the provision of extra burial places and storage facilities if the Government are looking for them.

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Lord Hain (Lab)

My Lords, I strongly support Amendment 1, which was moved by my noble friend Lady Thornton, and I hope that the Government will accept it. It is essential to have such a monitoring body covering local authority care and support. If we were in any doubt, surely the searing speech by the noble Baroness, Lady Grey-Thompson, yesterday should have convinced us. Is the Minister aware that organisations caring for the vulnerable and disabled are being hit by the triple whammy of increased operational costs, loss of income from increased vacancies and staff shortages exacerbated by the crisis and a lack of personal protection equipment?

In addition, for those in the third sector, fundraising has collapsed. Will the Minister ensure that all care organisations involved are contacted urgently and directly to offer practical government help? In care homes in lockdown across the country, staff are worried stiff. We certainly do not want to see scenes such as the one in Spain where a care home was discovered abandoned with all the residents dead. I should add that my wife is a trustee of the Leonard Cheshire Disability charity, which has many care homes across the country.

Share

Lord Blunkett (Lab)

My Lords, yesterday I had the privilege of being able to speak, so I will be brief. I support the amendment moved by my noble friend Lady Thornton and the words of the noble Lord, Lord Scriven. Normally, he and I would be knocking bells out of each other but, on this occasion, we happen to be in total agreement.

I want to reinforce the point that in times of trauma, as we are at the moment, civil society is always critical to survival. That is true in war zones and it will be true in the weeks ahead. I have registered interests in a number of voluntary and charitable organisations, including the RNIB and the Alzheimer's Society. I want to stress the importance of monitoring. That is not in the sense of a suspicion that the Government will somehow abuse these powers deliberately but because the prioritisation that underpins this power of suspension of normal rights understandably presumes that it will not be possible to carry out the norms of support available.

We learned today that a staggering 250,000 people have already indicated that they are prepared to volunteer. I recently stood down as a board member of the National Citizen Service, among other voluntary commitments. Picking up on the point made by my noble friend Lord Hain, it would be useful if we were able to reinforce very quickly the fact that those organisations in civil society—this is true at the local level as well—are picking up this cudgel and are able, not necessarily to fill the vacuum but to reach out, particularly to the 1.5 million people who have been asked to isolate themselves completely for 12 weeks. I hope we will be able to revisit that when things are clearer in three or four weeks' time.

I very rarely speak about this, but I want to put on record what it must be like for someone without sight in a high-rise flat. They cannot even look out of the window to see the sun and the birds or make any contact. That is prison. Being able to reach out, even with local government's lack of capacity, through the voluntary sector and volunteers to make contact, provide support and ensure that, where someone has a crisis, their rights are being upheld, will be vital. I believe that the Minister gets all this. From everything I have seen and understood in a metaphorical sense, he and the team around him are tremendously hard-working and appreciate these issues, working as they are in incredibly difficult circumstances. Given that, I hope that there can be a positive response because, frankly, if we cannot mobilise in this way as well as monitor the rights of those who yesterday the noble Baroness, Lady Grey-Thompson, spelled out in a way that I could never manage, we will have let down those who need us most at this critical time.

Share

Baroness Watkins of Tavistock (CB)

My Lords, I hope noble Lords have noticed that my noble friend Lord Low has tried to speak twice, so when I finish, I am sure he will be given an opportunity to do so. When we are so short of people to oversee our proceedings, it is difficult.

I want to make two points. The first is that I am very supportive of the first amendment for two reasons. When I originally read the Bill, I assumed that the issue of local authorities having to decide who needs care in terms of the available resources was about the staff resources available, but it is clear that some among the population with severe disabilities are worried that it is about the allocation of financial resources. That is a very important reason for us to monitor regularly whether it is about money or staff because, as a nurse myself, I know that if we are very short of staff, we will have to prioritise in some form in both the NHS and social care.

The other issue about which many of us have been written to was spoken to yesterday by my noble friend Lady Grey-Thompson. If people with dementia are rapidly discharged from NHS care into care homes, which clearly they should be if that is appropriate, we need to ensure that there is no retrospective charging for them and their families. That is another important reason for Amendment 1.

Share

12.30 pm

Lord Low of Dalston (CB)

I thank my noble friend very much for her support. I do not think I had tried to speak—maybe I gave the wrong signal in some way.

I very much agree with what my co-signatory to the amendment, the noble Baroness, Lady Thornton, said, but I do not wish to add to it. I am perfectly content that she covered what needed to be said.

Share

Baroness Kennedy of The Shaws (Lab)

My Lords, I too am very keen to support these amendments, particularly Amendment 1. Any form of monitoring has to be valued. It is important that we keep on top of those who might be suffering, particularly the most vulnerable. A new word in our dictionary is "intersectionality". The situation is most problematic where people have multiple disadvantages and I want to mention a number of them.

I am particularly concerned about the healthcare that might be available in our prisons. I am concerned for staff and prisoners. Only this morning it was announced that a number of people in our prison system have the virus and are becoming ill. In many prisons they are being kept in isolation because of overcrowding. That means that there will be mental health issues, which many of our prisoners already have. Therefore, I strongly advise making mobile phones available to everyone in their cells, so that they can make contact with their relatives and have the opportunity to speak and get support.

I am also very keen that we think about releasing large numbers of prisoners. Those awaiting trial should be allowed to have bail and, if necessary, have ankle bracelets fitted. We should certainly let out the pregnant women in prison referred to this morning. We should also think about elderly prisoners—those over the age of 65—as well as those with underlying health issues.

This is a population invisible to us. Therefore, I ask that, in monitoring, we take account of that too. We have to find ways of making sure that our prisons do not erupt into a source of serious disease and serious unrest, as that makes for a double punishment.

Share

Lord Russell of Liverpool (CB)

My Lords, first, I strongly support the very sensible amendment moved by the noble Baroness, Lady Thornton. As I think we all know, and as the noble Baroness, Lady Grey-Thompson, said so eloquently yesterday, myriad people are very worried about what is going on and are concerned that things will happen to them but their voice will not be heard. The Government have enough to worry about, so, from their point of view, it seems very sensible to have a review process in which an organisation such as the Association of Chief Executives of Voluntary Organisations acts as a sort of funnel, pulling together all the myriad concerns that many of us seek to represent today through a single forum which can communicate

regularly with the Government —it would be a two-way process. It seems eminently sensible to make sure that the people who are most worried feel that they are being heard and that there is a dialogue.

Secondly, I support the amendment in the name of the noble Lord, Lord Scriven. The variety of powers that local authorities will be required to have—particularly in relation to children in care, children going through adoption or fostering, and child carers—is incredibly important. If they are worried, think what that is doing to the people they are caring for. Therefore, I feel that clarification in that respect would be enormously helpful.

Share

The Parliamentary Under-Secretary of State, Department of Health and Social Care (Lord Bethell) (Con)

My Lords, I start by welcoming this amendment, which in its spirit and intention is utterly sensible, thoughtful and right. I would like to speak on it in a way that reassures the House that the intention of the amendment and the many speeches in the Chamber today are exactly aligned with the way government is thinking and in which we have sought to build the Bill.

I also echo the many noble Lords who have mentioned the speech by the noble Baroness, Lady Grey-Thompson. Who could not have been moved by both the emotional way in which she explained herself and the very real and tangible anxiety of people—particularly in the disabled community, but anyone who depends on local authority services—who must feel incredibly vulnerable and worried that their affairs may not be given the priority they deserve, and may feel exposed and anxious about the future? That testimony was incredibly powerful and moving. It was taken to heart.

I also say a big thank you to all those who have engaged with us as we have drafted the Bill at pace, both at a senior level from major organisations such as the LGA and smaller ones and stakeholders. I assure the House that we absolutely are listening to groups that have concerns about provisions for their stakeholders. We have our ears open. The Government's whole "protect life" strategy is shaped around an absolute priority of trying to save the lives, affairs and futures of the most vulnerable in our society. These provisions are here not because we want to leave anyone behind but because we want to enable local authorities to

make the decisions they need to in order to make a fair, pragmatic and sensible distribution and prioritisation. It is our hope that these provisions will never come into play and that the commitment of resources we have made into the local authority area will see a generous and sensible provision for all those most vulnerable in society.

I will take just a moment to outline a few provisions that are in place, to reassure the House that we are not in any way removing all safeguards. For instance, I assure noble Lords that the Care Quality Commission will continue to provide independent expert regulation of health and care providers. It has already announced arrangements for a proportionate approach to ensuring standards of care over the coming period. We have published an ethical framework to provide support to ongoing response planning and decision-making. This sets out a clear set of principles and behaviours when challenging decisions on how to redirect resources where they are most needed and how to prioritise individual care.

We are working closely with the sector on additional guidance to ensure that procedures and prioritisation of needs operate in the best way possible during this period. The emergency Coronavirus Bill also contains provisions allowing the Secretary of State to direct local authorities to comply with the guidance we issue.

Legislation underpinning our crucial safeguarding arrangements to protect vulnerable people from neglect or abuse remains in place. That was a point that many noble Lords made very well yesterday. We are leaving all statutory duties relating to deprivation of liberty safeguards fully in place.

The noble Baronesses, Lady Hussein-Ece, Lady Thornton and Lady Uddin, all raised the question of carers. I assure the House that we totally agree with the intent of the amendment. We need to ensure that users and carers retain a clear voice in the coming period and are able to make their concerns known. Our guidance on the Care Act changes will cover this. A national steering group is leading the sector's preparations for Covid-19; it includes both user and carer representatives.

The noble Lord, Lord Adonis, quite rightly raised the question of commitment to democracy and oversight. I assure the House that we absolutely embrace the ongoing functioning of Parliament. While I cannot speak for the House authorities and their arrangements for Parliament, I can speak for the health department. We are introducing technology there,

such as video data and home-working, at pace. We are seeing a generational transformation in working practices in the last fortnight. These arrangements have been embraced, and I expect them to be embraced in other parts of the workings of the House.

We will also continue to report on the eight-weekly cycle. The noble Baroness, Lady Watkins, and others emphasised the importance of monitoring. We will put in place structures for providing the correct kind of monitoring.

The noble Lord, Lord Blunkett, rightly emphasised the importance of civil society, which is absolutely key, while the noble Lord, Lord Hain, emphasised the importance of volunteers. I reassure the House that the Bill contains extensive arrangements for a volunteer army to be recruited in a safe, orderly and accountable way and for funding to be put in place for volunteers. The Chancellor has announced generous and important provisions for charities; the noble Lord, Lord Hain, is entirely right that they have seen their donations dry up. They need support and provision if they are to play an important role against this contagion.

I completely understand the intent of the amendment in the name of the noble Lord, Lord Scriven. We have spoken offline about his concerns, which I have taken back. I reassure him that we have worked closely with the LGA and, in its dialogue with us, its emphasis has been on financial commitment rather than changes in the law. We have made a substantial £1.6 billion commitment but we will keep the question of legal changes under review.

The noble Baroness, Lady McDonagh, mentioned PPE, which although it lies to one side of this amendment is of concern to us all. I reassure the Chamber that a massive global procurement programme is in place. Distribution of existing PPE stocks is happening via the Army. A hotline has been issued to all front-line workers in the NHS and social care. We are moving fast and impactfully on that situation.

Lastly, we should not overlook Wales. The Welsh parliament has considered every question of this Bill and has signed off its legislative consent Motion. I am extremely grateful to Vaughan Gething, the Minister for Health and Social Services in the Welsh parliament, for his support.

For those reasons, I ask the noble Baroness to withdraw her amendment.

Share

Baroness Thornton

I thank the Minister for that comprehensive answer. I also thank all the House for its supportive remarks on this amendment.

I say to my noble friend Lord Adonis that the two things we are talking about—the accountability of Parliament and our need to monitor these things, and the voice of the users and people at the receiving end of care, or non-care—are not in conflict. We need to be doing both, of course.

The noble Baroness, Lady Hussein-Ece, was quite right to point to vulnerable children and their care. My noble friends Lord Hain and Lord Blunkett were also absolutely correct about the importance of civil society in getting us through this crisis.

My noble friend Lady Pitkeathley is not here, but she is listening to us. She texted me to say, "Thank you for mentioning carers". Of course in all this, the carers —people who are at home, many of them quite elderly themselves—are caring for people who will be at the sharp end of what comes next. We should not forget that.

I found two things very useful. First, the noble Lord, Lord Russell, mentioned the NCVO's role in this, and he is absolutely right. Secondly, and finally, the Minister mentioned that the Government will produce guidance on the enactment of these clauses. This has to be done quickly but I put in a plea: that the voices we have talked about in this short but pertinent debate should be heard in the construction of that guidance, too. On that basis, I am happy to withdraw my amendment.

Share

Amendment 1 withdrawn.

Clauses 16 and 17 agreed.

Amendment 2 not moved.

Clauses 18 to 81 agreed.

Clause 82: Business tenancies in England and Wales: protection from forfeiture etc

Amendments 3 and 4 not moved.

Clause 82 agreed.

Clauses 83 and 84 agreed.

12.45 pm

Amendment 5

Moved by

Lord Clement-Jones

Share

5: After Clause 84, insert the following new Clause—

"Statutory self-employment pay(1) The Secretary of State must, by regulations made by statutory instrument, introduce a scheme of statutory self-employment pay for those whose work has been impacted as a result of the coronavirus.(2) The scheme must make provision for payments to be made out of public funds to individuals who are—(a) self-employed, or(b) freelancers.(3) Regulations made under subsection (1) may define the meanings of "self-employed" and "freelancers" in subsection (2).(4) The payments to be made under subsection (2) are to be set such that the gross monthly earnings of an individual specified in subsection (2) do not fall below—(a) 80 per cent of their gross monthly earnings, averaged over the previous 3 years (or if records do not date back 3 years, the monthly net earnings averaged for the period records are available), or(b) £2,500,whichever is lower.(5) No payment made under subsection (2) shall exceed £2,500 per month.(6) Regulations made under subsection (1) may provide that payments made under subsection (2) must be paid back via self-assessment if the payments were made in error.(7) A statutory instrument containing regulations under this section is subject to annulment in pursuance of a resolution of either House of Parliament."Member's explanatory statement

This amendment would ensure that the Government introduced a scheme of statutory self-employment pay.

Lord Clement-Jones (LD)

My Lords, my right honourable friend Ed Davey prompted an important statement from the Chief Secretary to the Treasury yesterday. In doing so, he acknowledged the way the Chancellor and the Treasury have given support to businesses and employees so far, but emphasised that this will remain incomplete and inadequate until we see proper measures for the 5 million self-employed across the country who are excluded from current financial support for businesses and employees.

That is the motive behind this amendment, which seeks to replicate the Government's support scheme for those in employment, both in the 80% of gross monthly earnings and in reference to their average earnings over the past three years, with a cap of £2,500. As my old friend Munira Wilson said when introducing a similar amendment in the Commons,

"5 million self-employed and freelancers feel that they have been completely overlooked."—[*Official Report*, Commons, 23/3/20; col. 145.]

They are under real stress as a result of the coronavirus crisis. Freelancers and the self-employed are deeply worried, and the rather confused messages coming out of government about when they should go to work do not help.

In his response to my right honourable friend Ed Davey's Question, the Chief Secretary to the Treasury, Stephen Barclay, used the phrase "further help is coming". But while we all understand that there are complications, the Government must move as fast as possible to meet these people's concerns, because in many cases they are simply running out of money. As my right honourable friend said,

"80% of the 5 million self-employed are sole traders. They are our neighbours, our friends, our family. The vast majority are not wealthy people. They are cleaners, taxi drivers, plumbers, hairdressers; they are musicians, tutors, journalists; and they are builders, electricians and child minders."—[*Official Report*, Commons, 24/3/20; col. 208.]

Most of the self-employed have very modest incomes and are not well off. The majority have taxable incomes of less than £10,000 a year, compared with just 15% of employees on incomes that low. Without help, they will not be able to pay their mortgages, rent and bills, and will face financial ruin.

As the Minister may know, I have a particularly strong connection with the creative sector. Freelance work and self-employment is the predominant pattern in the sector. For instance, 73% of those working in the music industry are freelance. A Creative Industries Federation survey last week revealed that 60% of creative freelancers estimate that their income will more than halve in 2020 due to the coronavirus outbreak and that almost 50% of freelancers who responded to the poll had already had 100% of their work cancelled. They, along with

50 creative bodies, Equity, the MU and the Writers' Guild, have called for an emergency fund that gives a time-limited and carefully targeted cash grant to the self-employed workers and freelancers who need it most.

Other European countries have put in place similar schemes; Norway, for example, has guaranteed temporary income protection for 80% of average self-employed earnings from the past three years, with an annual cap of the equivalent of £45,000. So have France, Belgium and Denmark. An urgent package of help is needed now, which needs to be at least the equivalent of that which has been offered to employees. As I said yesterday in relation to journalists, but it applies across the board for the self-employed and freelancers, they may be forced to ignore government guidance to stay home and plough on with what work is available or face real hardship.

In closing, I was surprised, when I asked the Labour Front Bench to support and sign this amendment yesterday, to be told that it was not a priority in light of the time available for discussion on the Bill. I am glad that they have now changed their tune, especially given the helpful statements of the Mayor of London and John McDonnell yesterday. I urge the Government to be generous and conscious of the necessary urgency in their response. I beg to move.

Share

Viscount Colville of Culross (CB)

My Lords, I put my name to this amendment, because I too am about the need for economic support for the self-employed, freelancers and workers on zero-hour contracts. Yesterday, the noble Earl, Lord Courtown, told the House that compensation for these people must be part of a package that is comprehensive, co-ordinated and coherent. However, he was not prepared to put a timetable to that announcement.

As the noble Lord, Lord Clement-Jones, just said, this amendment will give support straightaway to the 5 million self-employed workers, four-fifths of whom fall below the £2,500 a month threshold suggested in subsection (4)(b) of the proposed new clause, which is about the medium wage. It would be in line with the job retention package for employees announced last Friday.

However, I cannot emphasise enough that the scheme needs to be enacted very quickly. Failure to do so is threatening the lives of workers and those they serve. The great fear is that many self-employed workers have to decide between self-isolating and having no money coming into the house. That is particularly so in the care sector. I talked to a support worker on a zero-hours contract at a private residential home in Somerset run by a charitable trust. At best, she works two 15-hour night shifts a week for minimum wage. Together with her husband's state pension, it is hardly enough to cover her rent and food bills as it is. Her husband is in bad health and vulnerable to the virus. Eventually, after some soul-searching, she decided that in the present crisis she could not threaten his health by continuing to go to work and has gone into self-isolation.

That support worker has done the right thing, even though she will now start running up debts that could take a long time to pay off. But this is a very real dilemma for many lowly paid self-employed people and workers on zero-hours contracts. There are real fears in the care industry that some workers who look after some of the most vulnerable people in this country will ignore any symptoms of the virus and continue going to work because they cannot afford not to. As a country, we cannot take that risk. I urge the Minister to accept the amendment. If he is not prepared to do so, at least will he tell the House when the Chancellor will come forward with a package of help for the self-employed, freelancers and workers on zero-hours contracts? Time is of the essence.

Share

Lord Adonis

My Lords, the proposals that the noble Lord, Lord Clement-Jones, has put forward commend themselves to the House. Essentially, he proposes that the Danish system be introduced here. The Resolution Foundation published a paper this morning that applies considerable expertise and global knowledge to this issue and proposes something similar.

I slightly regretted that the noble Lord made party-political points towards the end, because I do not believe that there is any party-political difference on this at all. We are all looking to the Government—indeed, many Conservatives take the same view. I hope that we can address all these things as a House together and not make party points on them.

However, my concern about this amendment is exactly the same as on the previous one. What we are talking about here is one of the most important decisions that the Government will take in dealing with this crisis. The noble Viscount was completely right about the social impact; 5 million gig workers in the economy, all of whom are self-employed but have been dependent on income from services that have been reasonably predictable in their provision, face their livelihoods being decimated at the moment. Unless provisions of this kind are put in place, they will face serious hardship. Unless a Statement is made today by the Chancellor, Parliament will not have the slightest impact on what is proposed, because we will have no opportunity to question Ministers about it—neither the Chancellor in the other place or Ministers in this place—and we will not get to give any views on this issue again until, I understand, 21 April.

That is not satisfactory. These issues are costing billions of pounds to the taxpayer and will have a huge social impact, but Parliament will be entirely irrelevant to the discussion and the announcement of those proposals. I therefore hope that the noble Earl can give us some indication of how Parliament will be involved in both the announcement and the assessment of the package in respect of the self-employed when it is made. It is not satisfactory that we will play no part in this for another month.

Share

Lord O'Shaughnessy (Con)

My Lords, the noble Lord, Lord Adonis, asked for a cross-party view so I will make a brief intervention. The economic and moral case for doing something for this group of people is unarguable. No one in this House or in the other place disagrees with that. Their needs are just as great as of those who have the good fortune to have employed jobs, and it is on all of us to make sure that we have a solution.

If it was possible to do what is in the amendment, it could have been done already. There are technical and potentially moral hazard issues why this specific amendment might not be right. I do not stand in judgment; I just know that there are technical issues, and I know that there is a great deal of sympathy for this kind of solution. However, I know that the Treasury has been looking at this and other solutions and that it has its concerns. However, the most

important thing is not to agree today on the specific line-by-line items of a package. Exactly as noble Lords have said, this is about getting a sense from my noble friend about when this package of equal weight and power will happen.

There are economic and moral reasons for doing this but health reasons too. If you are young, financially insecure or both of those things, you are highly likely to be at the very wrong end of the economic consequences, but you are also likely to look at it and think, "I might not get this disease and I'm almost certainly not going to die of it, so I'll take my chances. I need to pay the rent"—or whatever it is. We simply cannot all be in this together if we have created a system which creates perverse incentives for certain groups. My noble friend knows that I am saying this with support for him and for the Government, but it is incumbent on us all to solve this so that we can act in unison to make sure that we deal with this health crisis together.

Share

Lord Blunkett

I add my support by saying that those words from the noble Lord, Lord O'Shaughnessy, were very wise. On the people that we have addressed so far and who have been talked about publicly, I reinforce that it is quite right that we should seek, in whatever way we can, to provide the support that has just been described. However, there is a group that falls between those who have already been assisted in support to companies and the purely self-employed: the worker working for themselves in our economy.

There is a group of entrepreneurs, many of them with start-ups and some with continuing businesses, who cannot access what is on offer to those in slightly different circumstances because of this. If they are using serviced premises—I will give an example in this House in a second—and therefore do not pay business rates, they are not entitled to the help that is already been granted on business rates or the grants that have been put in place, all of which are extremely welcome. In addition to what we describe as the self-employed there is therefore a group of people with very small microbusinesses.

The hairdresser's in the Palace of Westminster—I make no declaration other than that I use it—is not unique but is a good example of someone running a small business which employs people but which cannot draw down on the help currently available for the reasons I have

just described. It does not pay business rates in this building, and those with serviced premises that they rent do not pay them either. I hope that the noble Earl will be able to take back to his colleagues that there is this little additional gap that we should not have to come back to and say, “We forgot about those.” I am sure that is not the case but I just want to reinforce it.

Share

Baroness Bennett of Manor Castle (GP)

My Lords, I support the amendment and I stress, as others have, the extreme urgency in this. The noble Viscount, Lord Colville, told us a very moving story about a situation involving an older worker, but I invite the Committee to think about the situation of many young people, who are disproportionately represented in the gig economy in these sorts of roles.

In London and many other cities, young people live in shared households. There may be four, five or six people, each with one bedroom, probably not even with a living room, because what was once a living room is now a bedroom. What happens in that household when most people cannot pay the rent? What strains will there be in that household as people struggle to get by, with the most basic cooking facilities and the smallest amount of space? One can imagine the difficulties such people will be in. They need to be rescued, to know that they have security now, and that will give stability and certainty.

As many other noble Lords have stressed, this would ensure that that person would not have to continue to operate as a courier for food travelling around the country—I am trying not to mention a brand name—or as a care worker or in any other of the roles they might be fulfilling. This is in the interests of everybody’s health, but also in the interests of people who do not have, as some in this situation will, the bank of mum and dad to rely on. It is those young people who do not have the bank of mum and dad that we really have to help.

Share

1.00 pm

Baroness Uddin

My Lords, I add my support to the amendment, particularly on behalf of those who work for small satellite TV channels and ethnic minority newspapers. I have been inundated with hundreds of calls, particularly from journalists who work in this massive, £5 million industry as self-employed freelancers and who feel absolute fear and hopelessness about how they are going to manage in the lockdown. Many satellite channels rely on advertising which is now going to dry up, if it has not already. Newspapers are not being sold, so I want to add their concerns to our consideration of this amendment. I hope the Minister and the Government will look seriously at the Norway model, as the noble Lord, Lord Adonis, has suggested.

The Minister said earlier that we are looking into global procurement: I think we should look also at the global procurement of ideas to ensure that our people are served wherever they are working.

Share

Baroness Thornton

My Lords, this has been another short but important debate and I absolutely agree with my noble friend Lord Adonis; first, about the Resolution Foundation paper that came out this morning, but also on his point about the 5 million gig workers. The noble Lord, Lord O'Shaughnessy, made absolutely the right point: it is absolutely not in our interest for these people not to have enough to live on and to feel that they have to go out to work, even if they are ill and they will infect people, because otherwise they will not be able to pay their rent. We are very pleased to support this amendment—indeed, we always would have supported it.

I shall make just two points. One is about financial support. I really think we need to know when the Chancellor is going to announce what further support can be provided, not only for those who are self-employed, which is very urgent, but measures to improve access to sick pay and deal with the issues of assisting millions of people through the universal credit scheme by increasing it, suspending sanctions and scrapping the five-week wait for a first payment. Those things are absolutely urgent and important.

The other point I take this opportunity to raise is about renters. I looked at the Bill again last night after having said that I thought the three-month pause on evictions was not adequate to protect people who rent because it would defer a crisis only to the end of the period, when landlords will demand total arrears payments for three months' rent. The Minister said that of course this could be renewed and turned into six months, but actually the Bill does not say that, so I seek reassurance. This is linked to income support because the people we are talking about are exactly the people who will not be able to pay their rent.

In the event of that, we need to be sure that individuals and families will not get served with eviction notices. Some people will have been given their eviction notices prior to this legislation, and the Government need to take account of that. Those people should not be evicted because they may have been given a month's notice two weeks ago and they may find themselves evicted right in the middle of the worst point of this crisis.

My final point is about people in shared ownership, which is part of what the noble Baroness behind me said: when you have people with shared ownership, that is an issue. In the housing association world, people with shared ownership apportion their outgoings partly to their mortgage and partly to rent to the housing association. Many housing associations have put up rent from April as a result of the freeze on rent increases being lifted, so how will these tenants and owners be protected in terms of the rent element of those costs? I do not necessarily expect the Minister to be able to answer that question right now, but there are hundreds of thousands of people in the housing association world who will also need our protection.

Share

Earl Howe (Con)

My Lords, I am grateful to the noble Lord, Lord Clement-Jones, and other noble Lords who have spoken to this amendment.

I will get straight to the point. The first thing that I ask the Committee to do is recognise the nature and scale of what the Government have done so far to protect the jobs and incomes of millions of people. The package of measures that we have already announced is unprecedented and is one of the most generous business and welfare packages by any Government so far in response to Covid-19. In the context of those measures, which have

been broadly welcomed, the Government absolutely acknowledge the calls for more to be done in relation to the self-employed. I completely agree with what noble Lords have said about the vital role played by the self-employed in our economy and our national life. We have always said that we would go further where we could, and I can tell the Committee that we are actively considering further steps, which I will come back to.

We have already improved the welfare safety net to ensure that self-employed people and freelancers are better protected. We are temporarily relaxing the minimum income floor for all self-employed universal credit claimants affected by the economic impact of Covid-19 from 6 April for the duration of the outbreak. This means that a drop in earnings due to sickness or self-isolation or as a result of the economic impact of the outbreak will be reflected in claimants' awards. It ensures that the self-employed are supported by the benefits system so that they can follow Public Health England guidance on social distancing and self-isolation.

Freelancers and the self-employed will also benefit from the changes announced to the benefits system such as the £20 increase in the universal credit standard allowance, which will mean that claimants are better off by £1,040 a year and will benefit from the increases to the local housing allowance. I add that we are already making sure that benefits are easily accessible and more supportive for those who need to make a claim. Other changes announced by my right honourable friend the Chancellor, such as deferring income tax self-assessment payments due in July 2020, are designed to help self-employed people and freelancers through this period.

My right honourable friend the Chancellor has stated that he is committed to going further to support individuals and businesses, and will provide a further update on support for the self-employed in the coming days. That is an assurance that I can give today. I have taken full note of the careful way in which the amendment has been drafted and the points articulated by noble Lords in support of it; they have been well and truly registered. An amendment to the Bill is not required for the Chancellor to provide further support for the self-employed, support that I emphasise is already planned and due to be announced shortly.

I emphasise again that everything is being done to ensure that everyone is supported to do the right thing for the good of us all. It would be wonderful for everyone if I were able to go further today, and the noble Lord, Lord Clement-Jones, will understand why I cannot, but I

hope I have provided sufficient reassurance to enable him to feel comfortable in withdrawing the amendment.

Share

Baroness Kennedy of The Shaws

Will agency staff be included in any thoughts that the Government are having about those who might be assisted but who are currently not covered? Many care workers and many people working in offices even here in London are supplied by agencies which do not consider themselves to be their employers but to be facilitators and mediators in creating opportunities to work. They are not able to claim those workers as people for whom they can have the special 80% arrangement. Might such employees be covered by the Government's thoughts?

Share

Earl Howe

The noble Baroness makes a very good point and one that I was familiar with in my previous role as a Health Minister. She is absolutely right: agency workers form a key part of the health and social care network and in other areas of our economy. I can assure her that they will not be overlooked.

Share

Lord Adonis

My Lords, the Minister did not deal with the point about why the statement on this crucial issue will not be made in Parliament and be subject to debate in Parliament.

Share

Earl Howe

My Lords, as the noble Lord rightly said, Parliament will not be able to debate any package of measures for the self-employed which my right honourable friend may announce until it returns on 21 April. That is a statement of the obvious, but it does not preclude parliamentarians from making appropriate representations to the Government once Parliament reconvenes. It will not be too late to do so at that point. One reason why my right

honourable friend the Chancellor has not yet made an announcement is his determination to make sure that any scheme for the self-employed— which would inevitably be more complicated, as my noble friend Lord O'Shaughnessy said—is workable, clear and, above all, fair, without any danger of moral hazard. The measures already announced for those in employment have been widely welcomed. We do not want anything different to happen for any further measures.

Share

Lord Adonis

Is not the reason why Parliament meets precisely so that it can make representations to the Government?

Share

Earl Howe

Absolutely. That is what I indicated that parliamentarians, including your Lordships, would be able to do once we return from the Easter Recess. I suggest that, at that point, it is not too late to influence the Government in any announcement that may or may not have been made.

Share

Baroness Bennett of Manor Castle

Government figures say that there have been 477,000 new universal credit claims in the past nine days, and social media is full of accounts of some 30,000 or 40,000 people being in the queue just to apply. What steps will be taken to ensure that everyone can get access to the provisions to which the Minister has referred?

Share

Earl Howe

I am aware that self-employed claimants will not be required to attend a jobcentre; universal credit can be claimed online or via the telephone. Self-employed people who are unable to work because they are directly affected by Covid-19 or are self-isolating will also be eligible

for contributory employment and support allowance. As announced in the Budget, this is now payable from the first day of sickness rather than the eighth. I recognise that we are likely to see a wave of applications and that the system can cope with only a certain number at a time, but I am aware that the system has been geared up to expect that wave. I can only assure the noble Baroness that the officials and civil servants involved in this process are as keen as anyone else not to let anyone in need go without.

Share

Baroness Lawrence of Clarendon (Lab)

Those applying by making calls rather than going online are at the mercy of whoever answers the phone—if they are able to get through. While they are trying to apply there is a possibility that, because the system is so overwhelmed, they will not be able to get through to put their claims in. What happens to them? They are at home and not able to go to work because they are following the Government's guidelines, but there is a possibility of them not getting through. In the meantime, their family is suffering. With all the will in the world, not everybody will get through. The Government need to bear that in mind when they say that they have things in place.

Share

1.15 pm

Earl Howe

The noble Baroness makes a very important point. She may be aware of instances where the system has broken down, and of course that is very regrettable. I hope that those affected will be able to bring that to the attention of the Department for Work and Pensions. We can only do what we can do. I say again that the willingness to ensure that the system works is most definitely there.

Share

Lord Blunkett

I am in danger of being a pain here, but could the noble Earl acknowledge that he understood the point I was trying to make about micro-businesses? If they employ somebody, they may be able to draw down on the £2,500 per month assistance, which is very welcome. But if the business itself goes bust because it cannot draw down on the generous help that is available to larger businesses with rateable value, then those employees will not have a job to come back to.

Share

Earl Howe

I fully acknowledge the noble Lord's point. I refer him to the various measures that my right honourable friend announced for businesses generally, but in particular for small and medium-sized businesses. They are more vulnerable generally than larger businesses. The job retention scheme was specifically designed to address this situation, as he rightly said, as were mortgage holidays. The business interruption loan scheme is available to small businesses, particularly on finance facilities up to £5 million. That will enable more businesses to access the finance they need to assist cash flow. If it proves necessary for my right honourable friend to look at further measures, I have no doubt that he will do so.

Share

Baroness Kennedy of The Shaws

Like the noble Lord, Lord Blunkett, I regret if I too am being something of a nuisance, but I recognise that this amendment seeks to deal with gaps, where people being short of funds would then create greater risks for others. I want the Government to keep in mind that this is our last chance for several weeks to talk about this because of the Easter break. I am seizing the moment to say in this House that there are people who have no recourse to public funds: asylum seekers. The Government should suspend the relevant policy immediately, so that people who face hardship, who have no recourse to public funds, who are often living in cramped circumstances and who are perhaps most vulnerable to the virus have opportunities to access funds.

Share

Earl Howe

All I can do is assure the noble Baroness that the points she has made will be taken back to the department and considered.

Share

Baroness Uddin

My Lords, I too regret another intervention, but how will people know what is going on if they are number 30,000 in the queue? How will they communicate with the Government or the necessary department? What are the Government doing to ensure that they communicate to these people how they should react and respond? Is everything being done that can be? Maybe some of those working in the gig economy who have nothing to do will be asked to join some of these telephone contact centres as paid employees. That might be of additional assistance to the Government.

Share

Earl Howe

My Lords, as the noble Baroness knows, there are various avenues for individuals to utilise. One might be contacting their local Citizens Advice to enable it to make representations. They can contact their Member of Parliament to enable him or her to make representations on their behalf. They are not without the means to communicate if something does not work as it should.

Share

Lord Clement-Jones

My Lords, this has been an extremely valuable debate. All sides of the House have demonstrated how important support for freelancers and the self-employed is. The Minister will know that he commands quite a lot of confidence in this House, so we take him at his word when he gives us an assurance, as he has, that the Chancellor of the Exchequer is determined to bring in a scheme that is workable and for precisely this cohort of people—5 million freelance and self-employed people. He has given an important assurance because, as the noble Lord, Lord Adonis, pointed out, we will not have the ability to question Ministers and Members in the Commons will not have the ability to question the Chancellor on the

nature of any scheme. In a sense, we have it on trust that something will be done in the coming days. As the noble Viscount, Lord Colville, said, time is of the essence; indeed, "urgent" has been used across the House.

The noble Lord, Lord Adonis, also referred to the Resolution Foundation. Torsten Bell's interview on the "Today" programme this morning set out a clearly workable scheme along the lines that Norway, Denmark and so on have already introduced, so is it any wonder that there is frustration across at the House with the speed at which the Government are acting in this area? I take entirely the Minister's point that the nature and scale of what has been done so far is quite extraordinary —one is not trying to minimise that—but this is the next step that must be taken extremely quickly.

The noble Baroness, Lady Thornton, pointed out the issue of eviction and other noble Lords have pointed out problems with universal credit, not least concerning means testing, capital assets and so on. None of those mechanisms will fit the bill for freelancers and the self-employed so I urge the Government to move on this with all speed, otherwise they will let down a significant proportion of our working population. I beg leave to withdraw the amendment.

Share

Amendment 5 withdrawn.

Amendment 6

Moved by

Baroness Bennett of Manor Castle

Share

6: After Clause 84, insert the following new Clause—

"Temporary modification of abortion legislation

Schedule (Abortion provision) contains temporary modifications of the Abortion Act 1967, and related provision."

Baroness Bennett of Manor Castle

My Lords, first, I want to follow up on a point I made yesterday and compliment the noble Lord, Lord Bethell, and through him the Government. I asked about MOTs; this morning, there was an announcement of a six-month extension, so thank you.

We have already heard some accounts of the terribly difficult situations that people around the country are in. I will begin with another, that of a woman in Lincolnshire with an autoimmune disease. Under the Government's recommendations, for her health and well-being and to protect our NHS resources, she should remain at home and self-isolate for 12 weeks. However, she needs an abortion. She also has at home a two year-old with a heart condition—another reason why she should not leave the house—but she must leave the house and go to a clinic or approved place to take the first of the pills for an early medical abortion under our current law. I am sure that every Member of your Lordships' House will agree that this is a terrible situation. It is also an utterly medically unnecessary situation.

Taking the pill at a clinic is not a medical necessity; the provision is in the 1967 Abortion Act —an Act that was passed 25 years before medical abortions were even introduced. In the next 13 weeks, based on the average figures, 44,000 women will have to travel to a clinic—to an approved place—to take that pill, which is utterly medically unnecessary. In countries such as the United States, Australia and Canada, it is possible for women to take both the pills necessary for an early medical abortion at home.

This amendment provides for—and I stress this—temporary modifications to the Abortion Act 1967. It provides for a woman to take both those pills at home, as happens in the countries I mentioned, and it removes the two-doctor rule whereby two doctors have to sign off on an abortion. Only a small number of doctors and health professionals provide these services. We have discussed time and again in your Lordships' House just how much pressure our medical professionals and NHS services are under and how precious a resource those doctors are, most of whom do other services as well.

The amendment calls for allowing nurses and midwives, who are already professionally qualified and who do much of the work now, to certify these abortions to allow them to go ahead. One nurse, midwife or doctor would then report back to the Chief Medical Officer as usual. There are some points to stress about the general provisions of the Bill that perhaps we have not talked about very much. The Bill, and this amendment, would give the Government the power to switch provisions on and off as they wish. They can also do so

regionally—again, we have not talked about this very much—or the nations can do so according to the needs of place and time. If, for example, there was a real problem with provision in the south-west, the Government could take a small-scale decision for a particular place and time to make sure that abortions are available for the people who need them.

The argument for having this provision—as with many such provisions—is that it is about protecting everybody. If 44,000 women have to make extra journeys, it means more chances for the coronavirus to spread. We would be playing into the virus's hands. We have all heard, seen and have been using the slogan "Stay at home. Save lives"; this provision allows that to happen. We would be protecting our precious medical professionals. The people who are increasingly operating remotely need to be able to operate through telemedicine remotely. We would be protecting NHS resources, which we know there is already enormous pressure on. If people are not able to secure an early medical abortion, they will seek surgical abortions, which will put much more pressure—absolutely unnecessary pressure—on the NHS.

I ask the Minister to accept and incorporate this amendment into the Bill. Doing that will not force the Government to do anything; it simply creates the possibility for the Government to act. As the noble Lord, Lord Adonis, who is not in his place, said, we will not be here for a very long time to make other legal changes. We would expect that to be the time of maximum pressure from the virus, so please can this temporary change be put in place to deal with this crisis?

Share

Baroness Barker (LD)

My Lords, I have attached my name to this amendment, which has support on Benches across the House. In moving this amendment, the noble Baroness described exactly what this is: a power that the Government could and should take unto themselves in order to use it if necessary. Why do we think it might be necessary? "We" includes the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Faculty of Sexual and Reproductive Healthcare—all the providers and people within the health service who know this piece of work better than anybody else. Why do we need it? As of this morning,

25% of BPAS clinics are closed because they do not have the staff to open. That means things are becoming much more difficult for women. Yesterday, women in York needed to travel two miles to secure an earlier medical abortion. As of today, they will have to travel 40 miles.

Share

1.30 pm

Multiple NHS services are not providing. They have reduced staffing—we all know and understand that—and are having to reduce opening times. Some are not taking women unless they have a referral from a GP. Can noble Lords imagine what a GP's day is like in current circumstances? There has been a drastic decline in the capacity to provide surgical abortions, because operating theatres are being used for ICU and urgent cases. Women with serious underlying medical conditions are told to isolate for 12 weeks, yet, if we do not change this, 4,000 will have to make weekly journeys—increasingly long journeys in some parts of the country. This morning France introduced telemedical care for abortion to deal with the pandemic. Telemedical care just for this purpose is supported by all the organisations I mentioned earlier. Remote provision is ruled safe by the World Health Organization.

In this Bill, some of us have conceded points that we think to be fundamentally important to our way of life. For example, we have agreed that people will be incarcerated for mental health reasons on the say-so of just one doctor. I will not rehearse the discussion we had yesterday, but time after time there were speeches in which Members of the House said, "In normal circumstances I cannot do that, but I have to".

This is the situation in week three. Imagine what the situation will be like in week seven when we are back—if Parliament comes back. This is necessary and urgent. It not only affects the lives of the women concerned but has a huge impact on NHS staff and the rest of society. I therefore strongly urge the Government to accept this proposal.

Baroness Thornton

My Lords, I attempted to put my name to this amendment. For some reason, presumably because the Public Bill Office staff are all working from home, it did not quite get through. The Government need to give this very serious consideration indeed.

Share

Lord Bethell

My Lords, I completely recognise the good intentions of this amendment and the desire to protect women in an awkward situation at a difficult time. I also recognise the strong stakeholder views given to me by the royal college, Marie Stopes and others, but it is the Government's priority to ensure that women who require abortion services should have safe, high-quality care and that abortions should be performed under the legal framework already set out by the Abortion Act.

It is vital that everyone, regardless of their views on abortion, be assured that this Bill's provisions work alongside existing priorities of legislation, including abortion legislation. As I have described a number of times from this Dispatch Box, the powers in this Bill are solely and entirely to meet the needs of tackling this current pandemic. It is in that spirit that the Bill has moved so quickly through the House and that we have had such strong multi-party support for it.

The safety of women remains our priority, but it is vital that appropriate checks and balances remain in place regarding abortion services, even while we are managing a very difficult situation such as Covid-19. We have worked hard with abortion providers, including the Royal College of Obstetricians, and listened to their concerns, but there are long-established arrangements in place for doctors to certify and perform abortions, and they are there for good reason. We do not think that it is right that midwives and nurses are suddenly expected to take on expanded roles without prior consultation, proper training or guidance in place.

The coronavirus outbreak is a global issue. We are not the only country having to make difficult and uncomfortable changes. All over the world, clinicians and service users are coming to terms with extremely difficult workloads and workarounds to normal procedures. We are doing an enormous amount to help the NHS cope. We are doing this to protect life and to protect the NHS, but we expect doctors to work flexibly during this time. That means that certification can still take place in a timely way. It should not delay women receiving treatment. There is no statutory requirement for either doctor to have seen or examined the woman, as I described at Second Reading yesterday. Assessment can take place via telemedicine, webcam or telephone. Guidance from my department is crystal clear about that. The doctor can also rely on information gathered from other members of their multidisciplinary team in reaching a good-faith opinion. However, we do not agree that

women should be able to take both treatments for medical abortion at home. We believe that it is an essential safeguard that a woman attends a clinic, to ensure that she has an opportunity to be seen alone and to ensure that there are no issues.

Do we really want to support an amendment that could remove the only opportunity many women have, often at a most vulnerable stage, to speak confidentially and one-to-one with a doctor about their concerns on abortion and about what the alternatives might be? The bottom line is that, if there is an abusive relationship and no legal requirement for a doctor's involvement, it is far more likely that a vulnerable woman could be pressured into have an abortion by an abusive partner.

We have been clear that measures included in this Bill should have the widespread support of the House. While I recognise that this amendment has some profound support, that the testimony of the noble Baroness, Lady Bennett, was moving and heartfelt, and that the story of her witness from Lincolnshire was an extremely moving one, there is no consensus on this amendment and the support is not widespread. Abortion is an issue on which many people have very strong beliefs. I have been petitioned heavily and persuasively on this point. This Bill is not the right vehicle for a fundamental change in the law. It is not right to rush through this type of change in a sensitive area such as abortion without adequate parliamentary scrutiny. For example, there has been widespread support for measures such as permitting cremations to proceed on the basis of only one medical certificate. We simply do not have the same widespread support to make similar recommendations on the certification of abortions. For that reason, I urge the noble Baroness to withdraw the amendment.

Share

Baroness Barker

Can the Minister concede that we are tabling this amendment because of how the NHS and medical services are affected by the Bill. We are not asking for any change in the criteria for abortion. We are asking simply for the process of the administration of decision-making to change.

That is being done right across the whole of the health service. The Minister has explained that telemedicine is being rolled out at a surprising rate. I do not understand why an experienced clinician or a midwife cannot make the judgments that he was talking about via video. They see women all the time and they will be able to make the same judgments. I do not understand that. If the Government do not accept this proposal, I ask him to accept that they should at least be under an obligation to continue to meet very regularly with the Royal Colleges and the organisations involved in this situation day to day, and they should be willing to come back with the power to make this change under a separate piece of legislation—because if, in seven weeks' time, there is a clear pattern of women being failed, we cannot let it continue.

Share

Lord Bethell

I completely recognise that the noble Baroness's intentions are totally and 100% benign. She has the interests of the women concerned at heart. That intention is completely clear to me and I utterly endorse it. Where there is a difference of opinion and where we have taken a huge amount of advice—we have worked with the scientific advice in the department —is in the fact that the changes being offered are a fundamental change to the way abortions are regulated and administered in this country. Those regulations and administration arrangements have been worked on for years and are subject to an enormous amount of consensus. Her point on monitoring the situation is exactly the one that the noble Baroness, Lady Watkins, made earlier. I commit the department to monitoring it. We will remain engaged with the Royal College of Obstetricians and Gynaecologists and other stakeholders. She is absolutely right that we can return to the subject with two-monthly reporting back, and it can be discussed in Parliament in the debates planned on a six-monthly basis.

Share

Baroness Uddin

I say this with the sincerest due respect. The Minister will be aware that there are huge concerns about the power to have just one doctor decide whether a body should be cremated, especially in the light of the crisis becoming more intensive and critical.

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Lord Bethell

The noble Baroness's concerns are noted.

Share

Baroness Bennett of Manor Castle

My Lords, before I get to the procedural part I will refer the Minister to some of his own words. He referred to the Government's desire to ensure that everyone should have safe, high-quality medical care. In this area in particular, given that the option has been given to provide alternatives, that is something that the Government will be judged against, and I hope that he will be able to live up to his promise. However, it is with a heavy heart that I beg leave to withdraw the amendment.

Share

Amendment 6 withdrawn.

Clauses 85 to 88 agreed.

1.45 pm

Clause 89: Expiry

Amendment 7

Moved by

Lord Newby

Share

7: Clause 89, page 58, line 21, leave out "2 years" and insert "3 months"

Lord Newby (LD)

My Lords, the Bill introduces across a whole range of public policy areas significant powers, some of them quite draconian. The noble Lord just said that the proposal in respect of abortion was unacceptable because it would have made a fundamental change. The truth is that we are making fundamental changes across the board. The proposed changes on mental health are, in my view, at least as fundamental as that on abortion proposed by the

noble Baroness. Although the Minister might have reasons for not wanting to make that change, he cannot pray in aid that it was a fundamental change. This is happening across the whole of what we are doing and, frankly, that was not his best moment.

Because the changes being made in the Bill are so powerful, we believe that they need to be in place for as short a period as possible and that they need regular and effective review and renewal. Therefore, the amendments in my name raise two related issues. The first is how often that review should happen. Obviously, we welcome the fact that the Government have moved from a position where there was to be no review for two years to one where there will be a review after six months. However, we believe that the period should be shorter. The Civil Contingencies Act has a renewal date of 30 days. Some of the measures in the Bill could probably have been exercised under that Act and they would have been subject to that 30 days. We are not going as far as that, but the end of September is simply too late for Parliament to have its first chance formally to decide whether this very wide-ranging legislation should continue.

As to the form, we have several concerns. As the Bill stands, there is no role whatever for your Lordships' House in respect of the legislation's continuation and renewal. That is certainly unprecedented and completely unacceptable. The normal way of dealing with legislation that is time-limited and needs renewal is via the statutory instrument route, which obviously applies to both Houses equally. That was the case with the Anti-terrorism, Crime and Security Act 2001, the Prevention of Terrorism Act 2005 and the Terrorism Act 2006. The House of Lords and the House of Commons had exactly the same powers and they worked perfectly well. Your Lordships' House is an extremely responsible body.

An exception to the principle of the two Houses having the same powers in respect of legislation was the EU withdrawal Bill—subsequently the EU withdrawal Act. It was agreed that, although there would be a meaningful vote in the House of Commons, there would be a meaningless vote in the House of Lords. That was on the basis of the circumstances being exceptional, as we were following the democratic mandate of a referendum. I opposed it at the time on the basis that it set a doleful precedent, but that view did not prevail.

Now, a second set of exceptional circumstances is being brought before your Lordships' House in a very short period. I believe that the more often we see exceptional circumstances occurring, the less acceptable it is, if your Lordships' House is to perform the function that it

has done until now in respect of the renewal of legislation. We therefore propose that the former precedent of renewing a Bill by statutory instrument should be followed in this case.

However, in Amendment 12 we also suggest an alternative method of achieving the same involvement of your Lordships' House by proposing that it mirrors what is proposed in the Commons. Personally, I would prefer us to go back to the traditional SI route but, in a spirit of generosity, if the Government would prefer to do it the other way, we are, reluctantly, prepared to accept that.

The other amendments in this group have been tabled by the noble Lord, Lord Anderson, and the noble and learned Lord, Lord Falconer of Thoroton. They have our full support, and no doubt they will be spoken to more eloquently than I could, so I will not attempt that.

I would like to ask the Minister about a practical point, which I hope he will be able to accept. At Second Reading yesterday, my noble friend Lady Barker suggested that the Government should produce a grid to explain which clauses of the Bill have been implemented, and exactly how. That is a very good idea and I hope the Government can accept it, but could they go slightly further by having, as part of that grid, a list of all the other provisions introduced to deal with the coronavirus, but not necessarily under this Bill? I cite, for example, the power to close restaurants and all other places where people congregate, which was introduced under the Public Health (Control of Disease) Act 1984. That would be helpful not only for specialists, as it were, like us, but for those who want to find and then look at the legislative basis for decisions. For others, who just want to see where a particular provision that might affect them comes from, if the Government have a single source saying, "Here's the whole raft of provisions that have been made and this is exactly where you can find them", that would be extremely helpful for public information. Obviously, I hope the Government will agree to our more substantive amendments but, at the very least, I hope they can do this. I beg to move.

Share

Lord Anderson of Ipswich (CB)

.My Lords, I support Amendments 11 and 12, which I think means that I support the idea of six-monthly reviews with debates in both the Commons and in the Lords. However, I rise to speak in particular to Amendment 10, tabled in my name. Regardless of how often the reviews take

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place or precisely who conducts them, surely one needs a degree of information from the Government. Clause 97 provides for that, but in an absolutely minimalist form. As I read it, all that is required is that the Government should explain which provisions have been switched on or switched off in the previous two-month period and that they should certify that they are content with the switching on and the switching off.

I have two points to make. The first concerns effective review in Parliament. As I said yesterday, my experience of reviewing exceptional counterterrorism powers suggests that one really needs at least some basic information from government on how the powers are being applied and how effective they are judged to be. There is also a point for the Government in this. Reports of this kind will provide them with an excellent opportunity to communicate to Parliament and to the wider public what they have done, why they have done what they have done, whether they believe that the measures are having some effect on the disease and, if so, why. I was encouraged to hear the Minister say yesterday in introducing the Bill that the Government would update Parliament regularly on how these powers have been used across the UK, but I suggest that that does not go far enough. In the Bill as written, things are not provided which go even that far.

My Amendment 10 is very modest, and deliberately so. I have sought not to invite the riposte that I am requiring some new power to collate or put forward statistics or that I would overburden an already burdened Civil Service. The Government will of course make their own assessments of whether these powers should be switched on or off and how effective they are. All I ask is that that assessment should be shared with Parliament in an appropriate way. It is a document that the Government will control, so it is very much up to them to decide in what form that communication should be made. If the amendment cannot be accepted, I ask the Minister at the very least to give an undertaking today that these reports will provide information about how the powers have been used across the United Kingdom, what measures may have been necessary to ensure compliance, and whether and why the various powers have been judged effective.

I have saved perhaps my best point until the end. Yesterday, the Minister raised by proxy the comments of my noble and learned friend Lord Judge, who sits beside me in spirit, if not physically. He contacted me this morning and has authorised me to say that if he had

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disregarded his own advice not to attend today, he would have supported my amendment. If I have not persuaded the Minister, I hope that the spirit of my noble and learned friend will have done so.

Share

Lord Hastings of Scarisbrick (CB)

I support the amendment of the noble Lord, Lord Newby, in great detail. In the debate yesterday, we spoke about the seriousness of the situation that the country faces. We are all deeply conscious of it; despite that, we must not be lulled into simply abiding by the pressure of the moment and not consistently thinking our way through the detail of what we are now putting into law. In his statement to the nation the other night, the Prime Minister referred to three weeks. Whether that stands or not is to be debated, but to go from three weeks to six months, as the Bill now provides, is a very long gap. It would be wise to agree to this amendment for three months, which on their return allows this House and the other place to consider the nature of what has been applied, whether it is appropriate and whether it should be retained or removed. That would be a sensible time to allow for national consideration; let us hope we have gone through it by then.

Share

Lord Falconer of Thoroton (Lab)

My Lords, I have tabled an amendment that in effect allows the Commons to sunset some clauses but allow others to go on before the two years are up.

If I may, I will put the timing into context. This is an important debate, because it involves identifying Parliament's role going forward. At the moment, there is a sunset clause in Clause 89 that will bring the whole Bill, and all the regulations made under it, to an end after two years, except that under Clause 90(2) a Minister has the power to extend any of the regulations beyond the two-year period, and he can do that by a statutory instrument that does not have to be approved by Parliament before it has effect. That statutory instrument can last for 40 days before Parliament gets a view on it, and those 40 days do not include

periods of recess, dissolution or prorogation. Under the Bill, therefore, the two-year period is subject to extension, on Ministers' say-so, for a limited period. Even if we get to a point where the 40 days were up, they can produce another order and extend for another period.

We support the Bill, because the country needs the Government to have these powers, but we do so on the basis that it is subject to parliamentary control. That is the position in relation to the two years.

I support the idea of six-monthly reviews. At the moment, after the six-month period, if the House of Commons rejects a Motion that the Bill continue after six months, under Clause 68 the whole Bill and the regulations have to be brought out of force by the Minister. The way the Bill is drafted at the moment, it is an all-or-nothing provision. That cannot be right as a matter of practicality. As we move towards the end of the emergency, which we will, some of these provisions will be required—for example, the continuation of statutory sick pay, and preventing evictions, because people will not have got back on their feet financially. However, other powers should definitely go—for example, Ministers' powers to close down premises, events and gatherings—as the need for those powers goes.

It is wrong that there is no provision for Parliament to say, "We want some of these powers to continue, but not others". My anxiety about the current position of the Bill is that it can be extended over two years without proper parliamentary scrutiny, and can be brought to an end early—on the six-month basis—only on an all-or-nothing provision. Can the Minister assure us, first, that there will be no extension beyond the two years without parliamentary approval? Secondly, will he give an undertaking that if Parliament indicates by a vote that it wants some of the provisions to come to an end—and by Parliament, I mean the Commons—the Government will respect such a vote?

Share

2.00 pm

Baroness Ludford (LD)

As a signatory to the amendment moved by the noble Lord, Lord Anderson of Ipswich, I give it very strong support. I agree with everything that he said. He referred to his experience as the Independent Reviewer of Terrorism Legislation and to how valuable he found the

transparency of reasons being given. That should send a very strong message to the Government about how important his amendment is.

Share

Lord Tyrie (Non-Afl)

I agree with everything I have just heard in support of these amendments. I hope your Lordships will allow me to say some of the things I would have said yesterday had I not been giving evidence to a Select Committee during the opening hour or two of the debate.

The UK is in lockdown. Of course, the pressure on the Government to act has been immense, but we are in very uncharted waters and tight sunset clauses are clearly appropriate. People are understandably fearful for their lives and their well-being, and the Government are right in response to that to try to flatten the peak to enable the NHS to cope and to address the fear that has grown in the wider public. The question now is not whether the lockdown was the right decision but for how long it can sustained. These amendments bear directly on that question.

I have two proposals that I think the Government might want to consider. They have a bearing on whether the sunset clauses might find themselves exercisable. We need to be clear why we have arrived in this position. The epidemiological evidence on which the lockdown decision was taken was very well summarised in the Imperial College paper, which shows that it is needed to prevent an 80% infection rate and between 250,000 and 500,000 impending deaths. What the paper does not contain is an analysis based on wider health outcomes or on wider economic and ethical considerations, as it readily acknowledges. In other words, the full health economics of this huge decision have not been developed or set out at all by the Government.

If, as is widely held, maintaining such a policy indefinitely is unsustainable socially and economically, it must follow, in the absence of an early vaccine or treatment, that an alternative policy will have to be put together very quickly. In order to establish that sustainable policy, we first need a wider analysis of the effects of the lockdown than we currently have in front of us on the basis of health economics, and in particular of the effect on morbidity and mortality that will come as a consequence of the disruption to economic

life. Extensive research on earlier sharp interventions suggests that these effects could be very large, and this may be true for both the full and the partial lockdowns discussed in the Imperial paper.

A second piece of analysis that needs to be undertaken—

Share

Lord Falconer of Thoroton

I very much apologise for interrupting the noble Lord, who is making an incredibly valuable speech, but after my amendment there is one more amendment, which was put down by the noble Baroness, Lady Ludford. We must get to it and debate it by 2.30 pm, which is jolly unfair, in a way. Can we get to that amendment and then perhaps have the Second Reading speech?

Share

Lord Tyrie

I gladly agree to what has been proposed from the Labour Front Bench.

Share

Viscount Hanworth (Lab)

My Lords, my colleague and noble and learned friend Lord Falconer has provided a cue that enables me to talk briefly about Schedule 8 to the Bill, which would allow a patient to be detained in hospital—or sectioned, as the phrase is—under the provisions of the Mental Health Act, on the say-so of a single doctor. The Bill would also provide for a period of extension to be extended, if I understand correctly, by the decision of a single person.

To put these matters in context, we might look back to the late Victorian era, when a problematic member of a family could be incarcerated in an asylum at the insistence of that family. They could be left there for a lifetime, and forgotten by the family, who could thereby avoid the stigma of having mental illness in their midst.

That stigma has been alleviated, but it still exists. The sufferer of mental ill-health may be a fragile young person, whose aberrant behaviour has been in response to some dysfunctional family dynamics. To avoid the hazard of inappropriately sectioning a patient in such

circumstances, it is now understood that a careful assessment is required, which must involve more than one expert and judgment. This is not a fail-safe procedure, and I have been told of its failure in some tragic circumstances. Sectioning a person under the Mental Health Act can injure a person for a lifetime. Therefore, I wish to sound a note of caution, if not alarm, at the provisions in Schedule 8 to the Bill.

This is one of only many hazards present in the Bill, and I wish to make a more general comment about such legislation. Some speakers in yesterday's debate expressed astonishment and admiration at the speed with which the Bill has been assembled to meet an unexpected crisis. However, it must surely have been sitting on the shelf for a considerable length of time. It is the product of the kind of contingency planning that we can expect of any competent system of public administration. There is no lesser need for contingency planning to cope with the public health crisis than there is for detailed military planning. However, whereas military planning is bound to remain largely secret, there is no need for such secrecy in the plans to address a public health crisis. The contingency planning that underlines this Bill ought to be permanently in the public domain, and its clauses ought to have been considered in detail, in the absence of any need to invoke them.

Share

Lord Parkinson of Whitley Bay (Con)

My Lords, I think the House might be keen for the noble Lord to conclude his remarks so that we can proceed at pace with this emergency legislation and hear other noble Lords' contributions.

Share

Baroness Bennett of Manor Castle

My Lords, the Green group supports all the amendments in this group. I have two brief points to make.

Collectively, these amendments make this whole profoundly undemocratic, rushed but essential process that we have undertaken a little more democratic. Statistics show that in epidemics, death rates are lower in democracies than they are in autocracies. Those figures have been worked out over a range of epidemics. Democracy is an effective medicine. Your

Lordships' House has heard me comment often on what I see as the weaknesses of our democracy, both here and in the other place, but this is the best thing we have got. Let us not handicap it further: let us adopt these amendments and acknowledge that they bring the opportunity for more scrutiny and better decision-making through the involvement of more people.

I want to address particularly Amendment 7, about three-month reviews, and the timeframe for this. It was actually about three months ago, it is believed, that the coronavirus crossed the species barrier. This whole thing biologically started three months ago, somewhere in China—probably Wuhan. Two months ago, diplomats were just being flown out of Wuhan. Think about how fast things have moved. Just last night, we had a report from Oxford University—an epidemiological study that basically blew through and potentially redrew our entire understanding of what is happening right now.

Where we will be in three months' time is utterly unknowable and may be massively different from where we are today. We need a proper, full debate in three months' time. With regard to the other amendment and the ability of the other place to amend this legislation, we need a debate there so that it can put in and take out parts of it if they are not working. We cannot leave this for six months. That is more than double the time this entire situation has existed from its first biological moment. Six months is too long.

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Lord Tyrie

I agree with those remarks too. Is it your Lordships' will that I make my second point, or have people heard enough from me? I will do my best to be as brief as I can.

I said that there was one crucial piece of work to be done on wider health economics. A second piece of work that needs to be undertaken derives directly from the Imperial paper; we know that this is a very dangerous disease for the elderly but that it appears to have a very low casualty rate among young people without underlying respiratory conditions. There is no immediate prospect of effective treatment—reinforcing by implication the unsustainability of the lockdown—and no early prospect of a vaccine. It seems to me that it

must be worth considering any means we can to get towards more normal economic life, and therefore not needing these amendments, by permitting young people, who are sharply less vulnerable to severe outcomes, to return to their workplaces.

Those who did this—it would have to be on a voluntary basis—would need to accept that a very high proportion of them might become infected and therefore have herd immunity develop among them. In an indefinite lockdown, massive direct financial support for the elderly would need to be maintained.

Understandably, the Government have not had time to assemble or publish elementary data for such an approach, but I do not think it would be appropriate to maintain this legislation without these sunset clauses or demonstrating an attempt to develop such approaches. The weakness of the data, in any case, is not an argument against developing such policies, any more than it is an argument against the suppression policy. Much of the data on which the current policy is based is very uncertain.

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Lord Parkinson of Whitley Bay

If the noble Lord has made his second point, might he draw his remarks to a conclusion?

Share

Earl Howe

My Lords, I am grateful to the noble Lord, Lord Newby, for introducing this group of amendments. It might be helpful if I start by putting the issues that he and other noble Lords have raised in the context of the Bill as a whole.

The powers in this Bill are extensive. They are there to support the efforts being made across the country to combat the outbreak of this disease. The purpose of the powers is to support public bodies and wider society in responding to a serious emergency. However, we have sought, in parallel, to provide an essential mechanism for controlling the use of those powers. A balance has had to be struck between protecting the public's health and safeguarding individuals' rights, and acting swiftly in response to fast-moving events while ensuring accountability and transparency.

A two-year lifespan for this Act has been chosen to ensure that its powers remain available for a reasonable length of time, with the option to extend the provisions in it by the relevant national authority. I underline to the noble Lord, Lord Newby, in particular that the Bill cannot be renewed after two years without a statutory instrument laid in both Houses, which must be agreed to by both. A reasonable worst-case scenario for this outbreak is that it could last for more than a year. We therefore judged that some of the provisions in the Bill may need to be in place for up to two years. We cannot guarantee that a period of less than 24 months will be enough; nor can we predict which powers will be required or for how long. That is why we may also need to extend some of the provisions beyond two years.

Share

2.15 pm

We must bear in mind that very large parts of this Bill are designed to support people in this time of greatest need. Without being able to predict exactly what those needs might be, or for how long people might require such support, we have to provide at the very least a good degree of certainty that we stand with them. The sunsetting and expiry provisions of the Bill therefore provide that reassurance and at the same time enable us to ensure that these changes are in place only for as long as they need to be.

The measures proposed aim to protect the public and enable life to continue as normally as possible during any significant disease outbreak, but we want the right amount of checks and balances to operate. We brought forward a government amendment to the Bill in the Commons, Clause 98, that will enable the House of Commons to take a view every six months on whether the provisions of the Act need to continue in force. Ministers will report to Parliament every two months on how we have used the powers in confronting this awful epidemic. There will be a meaningful debate in both Houses after 12 months and an affirmative instrument will need to be made for any renewal after 24 months—as I mentioned earlier. Therefore, we are ensuring that the support that people need will be there, but we are also clear that there will be regular reports and debates in Parliament to ensure proportionate accountability—proportionate in the sense that the accountability mechanisms do not make the management of this outbreak harder.

On the specifics of the amendments, I recognise that they are very thoughtful and well considered and provide the opportunity for the Committee to consider why the Bill as currently drafted is the right way forward. I understand the concerns behind Amendments 7, 8, 9 and 12, tabled by the noble Lord, Lord Newby, and the noble Baroness, Lady Barker.

As they will know, these concerns were debated at considerable length in the other place on Monday; they were debated by policymakers and political leaders across the four nations of this kingdom. The conclusion that we and they have come to is that this is no ordinary emergency; it is an unprecedented threat on a global scale, and our response has to meet the scale of the challenge.

However, as the challenge is so great, there are many unknowns. For example, the epidemic might come in one or more waves, which might or might not have a seasonal factor and might or might not be controlled by a vaccine. These things are as yet unknown, and the Government's clear view is that three months is simply not long enough to have measures in force and to be able to evaluate their impact.

Of course, we do not want to see people's lives disrupted for months at a time, so, if we can, we will suspend provisions so that we can alleviate some of the burden on the citizen. Equally, however, people want to know that the payments, reliefs and easements that they have come to rely on will not be switched off too soon. A two-year lifespan with the option to renew for six months gives people such certainty and gives us enough time to make serious progress on halting this epidemic. The requirements to report to Parliament for a one-year anniversary debate and for a six-monthly review all add up to a significant safeguard. Adding in the powers to suspend or revive burdensome but necessary provisions builds in an additional layer of protection.

I can also give the Committee an assurance that the Government will publish an accurate and up-to-date account on our website of which provisions we have in force and what plans we might have to review and/or change that status. The noble Lord, Lord Newby, proposed that the website report should be comprehensive. I believe I can give him that reassurance. There will be a comprehensive report on the workings of the Bill, both legislative and practical, and of all other actions that the Government have seen fit to take. This will be presented to Parliament every two months—I emphasise that we are committed to transparency. The grid he mentioned about the powers in the Bill being switched on and off will be published on the website. The least that the Government can do in these extraordinary circumstances is to make sure that the public and Parliament are fully informed of what is and is not happening.

Similarly, while I have a great deal of sympathy with the intention behind Amendment 11, tabled by the noble and learned Lord, Lord Falconer, I believe equally that the level of accountability, scrutiny and parliamentary control over the Government's use of delegated powers in the Bill is much greater than normal. It needs to be—these are far-reaching powers. It is right that the House of Commons should review this legislation and bring to

bear on that debate the experience of their constituents. Of course, this House has every right to call for such debates too, but as it has noted many times in the past, that role does not need to be legislated for: the House can order its own business as it chooses. I therefore do not believe the noble and learned Lord's amendment is necessary.

The noble and learned Lord asked me to consider the possibility that Parliament should be able to turn off some powers and not others. What I say to that is that we owe it to those to whom we are accountable to use these powers to their full effect if we need to do so. I appreciate that giving Members of Parliament the opportunity to tweak the legislation, rather than make a binary choice, seems attractive and rational. The counterargument is that the package is an agreed, integrated whole that commands cross-party support in all four parts of the UK, and that consideration is one that I believe trumps that of the noble and learned Lord. We must strive to retain that unity of action and of purpose while at the same time acknowledging Parliament's role in making that judgment.

The Government have no intention of using these powers without accounting to Parliament, and nor can we do so. The requirement to seek Parliament's approval is not bound by procedure: we are always going to have to account for our actions. If Parliament is sitting we will use the draft affirmative procedure to seek any extension to these powers beyond two years and we will, of course, always respect any vote or view expressed in the House of Commons.

The noble Viscount, Lord Hanworth, and my noble friend Lord Tyrie made powerful points about the Mental Health Act. As a former Health Minister, I completely understand those points. These are exceptional powers and I re-emphasise that none of them will be introduced unless the advice comes from health experts and the scientists that they are necessary to invoke. If they are invoked, in relation to the Mental Health Act, I can assure both noble Lords that the appeals process will still apply, that we will use this temporary derogation only for as long as we have to and that we will account for its use.

I just want to reassure my noble friend Lord Tyrie that his other points have been well noted.

I therefore believe that, as drafted in the Bill, the scheme meets the balance of objectives that I outlined. Amendment 10, tabled by the noble Lord, Lord Anderson, and the noble Baroness, Lady Ludford, seeks to make a broadly similar point to the previous amendment: that the Government should explain themselves fully in how these powers have been, are

being and will be used. Of course, that is exactly the purpose of the clause as drafted. I hope that the past few weeks have shown how willing Ministers across the UK have been in opening themselves up to scrutiny.

I took full note of the proposals made by the noble Lords, Lord Newby and Lord Anderson. At first blush, they do not seem at all unreasonable but I reserve the right to take advice on how far we can go. I do not think that the amendment will add to the wish, or indeed the obligation, on the part of the Secretary of State to explain why he has drawn the conclusions he has. However, for the record, I reiterate that the Government will provide evidence and explanation in justifying the conclusions set out in these two-monthly reports.

I hope that these remarks are helpful. None of us wants to see the wrong balance struck between the powers conferred on government and Ministers' accountability to Parliament. However, we believe that the balance struck in the Bill is the right one, with the safeguards that we need to bring it about. I therefore urge noble Lords not to press the amendments.

Lord Newby

My Lords, I thank the Minister for his assurances about the website and the comprehensive information that it will contain. That is extremely helpful. On behalf of the noble Lord, Lord Anderson, let me say how grateful both he and I are for that half-assurance, which we think is more than half an assurance, on the justification that the Government are about to give on a two-monthly basis.

On the amendment in the name of the noble and learned Lord, Lord Falconer, I loved the Sir Humphrey argument that it could not be changed because everybody had agreed what was in it. Well, they agreed what was in it; no doubt the Scots and the Welsh did not, with the following breath, say, "But don't you dare suggest that parts of it can be disapplied, or give the Commons such a vote." It was an argument, but I am not sure that I found it completely convincing.

On the amendments that we put forward, the fact that there is an SI provision for the end of the two years only makes the case for having an SI provision after six months. The Minister did not seek at any point to explain why the Lords should be treated differently from the Commons. I see that the concern in the Commons was to get a better position from the

Commons; our position is to make our arguments. I am afraid that I am not convinced by those arguments but, equally, I realise that this is not the point at which we should test the opinion of the House. I therefore beg leave to withdraw the amendment.

Share

Amendment 7 withdrawn.

Clause 89 agreed.

Amendments 8 and 9 not moved.

Clause 90 agreed.

Clauses 91 to 96 agreed.

Amendment 10 not moved.

Clause 97 agreed.

Amendments 11 and 12 not moved.

Clause 98 agreed.

Clause 99 agreed.

2.30 pm

Amendment 13

Moved by

Baroness Ludford

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13: After Clause 99, insert the following new Clause—

"Powers within the Act: necessity and proportionality All powers under this Act must be exercised in accordance with the Human Rights Act 1998 and the Equality Act 2010, especially with regard to the principles of necessity, proportionality and non-discrimination."Member's explanatory statement

This amendment would require the powers in this Act to be exercised in accordance with the principles of necessity, proportionality and non-discrimination and to be compatible with human rights law.

Baroness Ludford

My Lords, my amendment is supported by the noble Lord, Lord Anderson, and I believe that the noble and learned Lord, Lord Falconer, is also in favour. It is pretty self-explanatory and should not cause the Government any problems in accepting it. Indeed, the Minister, in replying just now, talked about getting advice from scientists on what was necessary.

The Minister has made a declaration that the Bill is compatible with the European Convention on Human Rights, but the amendment would provide further reassurance. According to the long title, the Bill is to:

"Make provision in connection with coronavirus; and for connected purposes."

That is quite wide. There are references to a test of necessity—or, variously, necessity and proportionality—in some provisions in the Bill but not in others. There is no consistency, for instance, even between Schedules 21 and 22.

Our Constitution Committee, which I thank for its report, says at paragraph 16 that

"there may be a need to resolve difficult legal questions concerning the proportionality and necessity of restrictions and directions, and of their compliance with the Human Rights Act 1998",

and by "resolve" it means in the courts. It would obviously be preferable to front-load those tests by requiring the Government to observe them in exercising all their powers under the Bill, which is what this umbrella amendment would provide, rather than load up the courts.

In parallel with these tests, the Delegated Powers Committee report, which I thank the committee for, drew attention to the absence in some clauses of a reference to the coronavirus crisis as justification. That mainly concerns postponement of elections, but not exclusively. I am therefore doing precisely what the committee suggests in paragraph 9 of its report—I have given the Minister notice of these requests: I

"seek an explanation from the Minister about why these powers are not, on the face of each individual clause, explicitly linked to coronavirus",

and

“look to the Minister to provide an ironclad assurance that the powers contained in the Bill will be exercisable in relation to the coronavirus outbreak only and in no other circumstances.”

Lastly, will the Minister clarify the situation with regulations? The ones issued last Saturday under the Public Health Act, on premises, are not abolished by the Bill, but the February ones, on persons, are. In a reply during Second Reading yesterday, the Minister said that the powers to enforce the Prime Minister’s instructions regarding essential travel and gatherings

“will be introduced by regulations under the Public Health (Control of Disease) Act 1984.”—[*Official Report*, 24/3/20; col. 1733.]

But I have learned from tweets by journalists that those will be introduced tomorrow, when we are not here. As I asked at Second Reading yesterday, how will these regulations mesh with the Bill and with regulations to be made under it? I beg to move.

Share

Lord Anderson of Ipswich

My Lords, I signed Amendment 13 and I offer two sentences on it. The amendment will have no legal effect because, admirably, nothing in the Bill seeks to oust or modify provisions of the Human Rights Act or the Equality Act. But if the Minister can confirm that there is no intention of departing from those important statutes, that would be a powerful signal to the sceptics and conspiracy theorists, both here and abroad, who might otherwise wrongly suggest that in enacting this unfortunately necessary legislation, we are abandoning some of the fundamental legal and moral principles that bind us together.

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Lord Falconer of Thoroton

My Lords, as the noble Baroness, Lady Ludford, rightly said, we on these Benches support these provisions. I thoroughly endorse what the noble Lord, Lord Anderson, just said and it would be of enormous importance if the Minister gave the assurances that the noble Lord seeks.

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Baroness Kennedy of The Shaws

My Lords, I too support the amendment and hope that the Minister will make appropriate noises about why this matters. Around the world, legislation is being passed in other countries that does not have these kinds of protections attached to it. We are seeing legislation going through in Hungary and, I am afraid, elsewhere, which will greatly erode the rights of the people living in those places. I strongly encourage the Government not only to say that the Human Rights Act and the Equality Act will be conformed to, but to ensure that those are firm instructions given to all those who will be exercising powers under this exceptional piece of legislation.

Earlier today, I sought to insinuate into this debate something about people in prison. I was surprised to find that there was no real reference to prisons in the legislation. But this morning it was mentioned that there is a problem inside the prisons—a number of people have already been diagnosed as having Covid-19—and so people are being confined to their cells. It was indicated that decisions might be made about releasing certain people from custody. Again, I ask that this is done in a way that conforms to the Equality Act and the Human Rights Act, and that real steps are taken with respect to fairness. I ask also that people in prison—who are not getting access to their families in the way that most people who are self-isolating can, through the internet and so on—are given the mechanisms to do that: to have virtual meetings and other mechanisms for contact with their families. At the moment, there is misinformation inside the prison system, and it is likely to cause a great deal of unrest. I urge the Government to be clear about the importance of conforming to human rights and equality standards.

Share

Lord Scriven

My Lords, I am a signatory to this amendment. I shall say two things: first, it is pleasing that the powers within the Bill talk about applying them under human rights legislation; secondly, I am glad those rights are included, because giving two and a half hours of parliamentary scrutiny to a Bill with such wide powers, even though it is emergency legislation, is not the way to make good legislation.

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Baroness Bennett of Manor Castle

My Lords, I am very pleased to speak after the noble Baroness, Lady Kennedy; I second what she said about the prisons and would add immigration detention centres to that. People who have been accused of no crime should not be being held in dangerous conditions that threaten their lives. Particularly with this amendment, we have been focusing a lot on the level of fear. We have heard a great deal of powerful testimony about how fearful many people are—people with disabilities, people who are already ill and sick, and people who are old and frail. Regarding the kinds of reassurances that have been asked for: people may not know the fine details of the rights legislation, but a simple reassurance from the Government that they will comply with something that guarantees people's rights will be terribly important.

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Baroness Kennedy of The Shaws

My Lords, I am sorry to rise again and beg the indulgence of the Committee. One of the categories of people that I am concerned about are non-documented—essentially, illegal—immigrants. The idea that they might have Covid-19 but not seek medical help because they are fearful of what might happen with regard to their immigration status should be a matter of concern to us. I hope that the Government will make a statement to say that nobody will face detriment to their position by seeking help, and that deportation will not meet them at the end of recovery. Something like that has to be said, or we will see the virus spreading through this category of people.

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Baroness Uddin

My Lords, I too beg the indulgence of the Committee. I have raised this point on a number of occasions; I am raising it now with respect to the powers within the Bill relating to necessity and proportionality, particularly as regards matters of dignity in death and what may happen in the unforeseen circumstances that thousands of deaths occur among the faith communities, and cremation may be decided upon due to the lack of burial spaces and storage facilities. I am suggesting that Schedule 28 affects our human rights obligations.

I am requesting, therefore, on behalf of the many hundreds of individuals who have written to me, including faith leaders and organisations, that the Government remove from paragraphs 13(1) and (2) in Part 4 of Schedule 28 the words

“have regard to the desirability of disposing”

and replace them with “dispose”, and then delete from paragraphs 13(1)(b) and 13(2)(b) the words

“in a way that appears”

so that the necessary guarantees are provided in the legislation, which will be required to provide assurance to the relevant faith communities.

Share

Lord Bethell

My Lords, the noble Baroness, Lady Ludford, and all those who have signed up to this amendment have made incredibly important points that the Government utterly confirms. I reassure the Committee that this Bill is very clearly focused on the present danger of SARS-CoV and the Covid-19 disease. If there is any other virus—and even if this virus mutates— we will need a new Act or at least to amend this one.

The Government are 100% committed to protecting and respecting human rights. We have a long-standing tradition of ensuring that rights and liberties are protected domestically and of fulfilling our human rights commitments. That will not change. We have strong human rights protections, with a comprehensive and well-established constitutional and legal system. The Human Rights Act 1998 gives further effect in UK law to the rights and freedoms contained in the European Convention on Human Rights. Nothing in this Bill contradicts that.

I reassure a number of speakers—including but not limited to the noble and learned Lord, Lord Falconer, the noble Lord, Lord Anderson, and the noble Baroness, Lady Kennedy—that there is nothing in this Act that allows the Government to breach or disapply the Human Rights Act or the Equality Act. The Bill itself is fully compliant with the Human Rights Act and the Government have certified this on the face of the Bill— in fact, I signed it myself in accordance with Section 19. Pursuant to Section 6 of the Human Rights Act, every exercise of

power by a public authority under this Bill is already required to be compliant with the Human Rights Act. I further reassure the House that, at all times, this Government will act with proportionality.

I am advised by legal counsel that the amendment is potentially both unnecessary and unhelpful. If we accept it, it might imply that the Human Rights Act and Equality Act do not apply in this way in other Bills or Acts that do not feature this sort of provision. For that reason, I suggest that the amendment should be withdrawn.

Share

Baroness Ludford

My Lords, I thank the Minister for what he said, which gave considerable reassurance—up to the last sentence or two. I was permitted by the Public Bill Office to table this amendment, so I am therefore slightly surprised at his reporting of the advice he has had from legal counsel. Obviously, I have to take note of what he said. No doubt they have greater legal minds than mine, although I note that the noble Lord, Lord Anderson, co-signed my amendment. I am a little taken aback by what the Minister said, but I none the less welcome the rest of his response. I beg leave to withdraw my amendment.

Share

Amendment 13 withdrawn.

Clauses 100 to 102 agreed.

Schedule 1 agreed.

The Deputy Chairman of Committees (Lord McNicol of West Kilbride) (Lab)

My Lords, paragraphs 2 and 3 of Schedule 2 were omitted from the Bill by mistake. The correction was published yesterday. The question is that Schedule 2, as corrected, be the second schedule to the Bill.

Share

Schedule 2 agreed.

Schedules 3 to 29 agreed.

The Deputy Chairman of Committees

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My Lords, there is an error in the Marshalled List. “Schedule 29” before Amendment 14 should instead read “After Schedule 29”.

Share

Amendment 14 not moved.

House resumed.

Bill reported without amendment.

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is, while a 14-year-old boy

their first child in "early summer".

A majority (78%) of staff polled by the Royal College of Midwives last week reported that routine face-to-face antenatal and post-natal appointments had ended.

The closure of birth centres and midwifery units comes as Edward Morris, president of the Royal College of Obstetricians and Gynaecologists, warned abortion services were on the "brink of collapse", with women trying to buy illegal pills online.

The Department of Health last week issued and then withdrew guidance suspending the law that women ending a pregnancy must take a pill at a clinic under the supervision of two doctors.

Morris is one of 50 experts who today called on Matt Hancock, the health secretary, to reverse his decision. "At least 44,000 women would have to leave their home needlessly to access early abortion care," they claimed in a letter to The Sunday Times.

The British Pregnancy Advice Service, the largest provider of NHS abortions, said it had closed 20 clinics and cancelled 1,120 appointments due last week.

After inquiries by The Sunday Times last night, it is understood the government is preparing another U-turn and will permit the use of abortion pills at home. The following stipulations will apply:

- Any abortion, up to a limit of 10 weeks, will require a telephone or

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Government Legal Department
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My Ref: MP:MP2551

Date: 1 April 2020

Dear Sir/Madam

Our client - Christian Concern

This letter is a formal letter before claim, in accordance with the pre-action protocol for judicial review under the Civil Procedure Rules. By doing so we wish to understand your position and will try and settle matters without recourse to proceedings. Our aim is to reach an amicable, just and fair solution whilst reducing the costs of resolving the dispute. We will, however, pursue litigation should you give us no other option.

The parties to the litigation

The claimant is Christian Concern for our Nation Ltd (hereafter 'Christian Concern') of 70 Wimpole Street, London W1G 8AX.

The defendant will be the Secretary of State for Health and Social Care.

Defendant's reference details

The Abortion Act 1967 - Approval of a Class of Places

Mark Davies, Director, Population Health

Details of the matter being challenged

Our client seeks to challenge the 'Approval of a Class of Places' under s. 1(3) and s. 1(3A) of Abortion Act 1967, dated 30 March 2020 and signed by Mark Davies, the Director of Population Health. The decision is published at

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876740/30032020_The_Abortion_Act_1967_-_Approval_of_a_Class_of_Places.pdf

The effect of the decision is to approve "the home of a pregnant woman" as a class of places where an abortion may be carried out under s. 1 of the 1967 Act.

The issues

The present legal position is a result of the proper democratic process, which has resulted in a finely balanced compromise, enacted by Parliament following a great deal of debate and scrutiny. Any alteration of that balance is inevitably highly controversial and sensitive.

S. 1 of the Abortion Act 1967 has decriminalised abortions in England and Wales subject to a number of requirements. One of those requirements is that "*any treatment for the termination of pregnancy must be carried out in a hospital vested in the Secretary of State for the purposes of his functions under the National Health Service Act 2006 or the National Health Service (Scotland) Act 1978 or in a hospital vested in National Health Service trust or an NHS foundation trust or in a place approved for the purposes of this section by the Secretary of State*".

On 25 March 2020, two members of the House of Lords, Baroness Bennett of Manor Castle and Baroness Barker, proposed an amendment to the Government's Coronavirus Bill which would modify the requirements of the Abortion Act 1967 during the Coronavirus epidemic. Part of the amendment was to the same effect as the 'Approval' challenged in the proposed judicial review claim, and worded in virtually identical terms. The substance of the proposed change is that "the home of a pregnant woman" is approved as a class of places for the abortions which take place by self-administration of the drug known as Mifepristone (which kills the foetus) and, subsequently, the drug known as Misoprostol (which ejects the dead foetus from the mother's womb).

On 24 March 2020, one day before the amendment was introduced, the Secretary of State was asked in the House of Commons whether he would "*commit not to oppose*" that anticipated amendment, and "*reinstate the regulations that were put up for a short while on the Government website last night*". The Secretary of State replied: "*There are no proposals to change the abortion rules due to covid-19.*"

In the course of the debate in the House of Lords on 25 March 2020 the Health Minister, Lord Bethell, opposed the amendment on behalf of the government, and relevantly stated:

> *"However, we do not agree that women should be able to take both treatments for medical abortion at home. We believe that it is an essential safeguard that a woman attends a clinic, to ensure that she has an opportunity to be seen alone and to ensure that there are no issues.*
>
> *"Do we really want to support an amendment that could remove the only opportunity many women have, often at a most vulnerable stage, to speak confidentially and one-to-one with a doctor about their concerns on abortion and about what the alternatives might be? The bottom line is that, if there is an abusive relationship and no legal requirement for a doctor's involvement, it is far more likely that a vulnerable woman could be pressured into have an abortion by an abusive partner.*
>
> *"We have been clear that measures included in this Bill should have the widespread support of the House. While I recognise that this amendment has some profound support, that the testimony of the noble Baroness, Lady Bennett, was moving and heartfelt, and that the story of her witness from Lincolnshire was*

an extremely moving one, there is no consensus on this amendment and the support is not widespread. Abortion is an issue on which many people have very strong beliefs. I have been petitioned heavily and persuasively on this point. This Bill is not the right vehicle for a fundamental change in the law. It is not right to rush through this type of change in a sensitive area such as abortion without adequate parliamentary scrutiny."

Following the debate, the amendment was withdrawn. The Coronavirus Act 2020 was passed on the same day. Parliament went into recess on the same day, 25 March 2020. Parliament is not expected to reconvene until late April 2020 at the earliest, which may be further delayed due to the Coronavirus epidemic.

On 30 March 2020, the Secretary of State published the 'Approval' document referenced above.

The Claimant proposes to challenge that decision at least on the following grounds:

(1) Constitutional and/or procedural impropriety and/or improper motive

The 'Approval' was issued immediately after (a) the proposed reform of the abortion regulations was debated and rejected in Parliament, (b) the Ministers assured Parliament that no such reform will take place and (c) Parliament went into recess and is unable to scrutinise the Executive in relation to this decision and its immediate consequences. In these circumstances, it is clear that the form and timing of the decision were calculated to reverse the outcome of the Parliamentary deliberations on this issue and/or to prevent the Parliament from carrying out its constitutional functions; and in any event, had those effects. In those circumstances, the decision is unconstitutional and unlawful: see *R(Miller) v The Prime Minister* [2019] UKSC 41.

(2) Breach of legitimate expectation

The ministerial assurances given in Parliament created a *legitimate expectation* that no such change of the substantive law as envisaged in Baroness Bennett's abortive amendment would be introduced by the Government, or, in any event, introduced without parliamentary scrutiny and approval. The decision of 30 March is an outright breach of that legitimate expectation.

(3) Breach of the* Tameside *duty to make sufficient enquiries, and/or failure to take account of relevant considerations

It is a precondition of lawfulness of any public law decision that the authority has complied with the *Tameside* duty to make sufficient enquiries, to obtain the information necessary to make a decision, and make a decision consistent with that information. The scope of *Tameside* duty varies greatly depending on the nature of the case. As acknowledged in the Ministerial statements in Parliament quoted above, abortion is a sensitive issue which requires a multi-factorial consideration; in these circumstances, the *Tameside* duty is wide.

The only precedent of an approval of class of places by the Secretary of State under s. 1(3) and 1(3A) of the 1967 Act is the Approval dated 27 December 2018. 'The home of a pregnant woman' was approved as a class of place where the patient can self-administer Misoprostol if, and only if, she had attended a clinic where she had been prescribed Mifepristone and Misoprostol, and had already taken Mifepristone at the clinic. That precedent indicates the scope of necessary enquiries for a decision of this nature; in particular, it is clear from the DHSC's press statement of 25 August 2018 that:

- The DHSC announced its decision to introduce that change on 25 August 2018, 5 months before the formal Approval was issued.

- The press statement taken at that time makes it clear that the Department had taken "medical and legal advice" and was satisfied that the proposed scheme was "safe and legal".

- The DHSC undertook to introduce "safeguards" and to "work closely with partners in the health system to make the changes quickly and safely".

- The DHSC further undertook "to work with partners, including the Royal College of Obstetricians and Gynaecologists, to develop clinical guidance for all professionals to follow when providing the treatment option to patients", before the substantive change took effect.

The present decision is much more momentous than the 2018 decision. It removes the need for *any* face-to-face consultation between the pregnant woman and the doctor prescribing the abortion pills. It enables women to self-administer Mifepristone, which actually kills the foetus, rather than simply follow up on that irreversible step after it had been taken in a clinical setting.

It is clear that on this occasion, the enquiries undertaken by the Secretary of State were not comparable in scope with those in 2018, and grossly inadequate. The whole decision-making process clearly took no longer than two working days, between the categorical assurances given by Ministers in Parliament on 24-25 March that no such decision was contemplated and the information provided to the *Sunday Times* for publication on 29 March that the decision has been made. No safeguards have been introduced, and the relevant issues not identified. Unlike the 2018 Approval, this approval is not accompanied by any clinical guidance whatsoever.

In these circumstances, it is evident that the Secretary of State has not made sufficient enquiries and/or has not taken account of all relevant considerations.

(4) Failure to carry out a public consultation

The Secretary of State was under a common law duty to carry out a consultation with various stakeholders and/or the public before making this decision, because (a) failure to consult in this case leads to *conspicuous unfairness*, given the proceedings in Parliament the previous week; (b) there is an *established practice* of public consultations

prior to any significant reform of substantive abortion law or regulations; and/or (c) in the present context, the duty to consult is part of the *Tameside* duty to make sufficient enquiries.

Christian Concern has made submissions in at least five major public consultations relation to abortion over the years, and would have wished to make submissions in any public consultation on the proposed 'Approval' of pregnant women's homes as a class of places for abortion.

(5) The decision is* ultra vires *the Abortion Act 1967

S. 1(1) of the Abortion Act 1967 provides that an abortion may be lawful if, and only if, the "*pregnancy is terminated* ***by*** *a registered medical practitioner*" (emphasis added). That requirement is distinct from the requirement of an *approval* by two registered medical practitioners, having regard to various factors specified in s. 1(1)(a)-(d) and 1(2). The meaning of those words was analysed in great detail in *Royal College of Nursing v DHSS* [1981] AC 800, leaving the House of Lords divided 3-2. The minority thought that s. 1 required the act which actually caused a termination of pregnancy to be done physically by no other person than a registered doctor. The majority held that it was sufficient for the doctor to make material decisions and remain in control throughout the process while physical tasks are carried out under his direction by other medical stuff such as nurses.

The process envisaged by the 'Approval' dated 30 March 2020 does not satisfy that requirement in either of its interpretations in *RCN* case. The involvement of the registered medical practitioner is limited to issuing a prescription after a telephone call with a patient. There is a clear distinction in s.s. 58-59 of the Offences Against the Person Act 1861 between (a) administering drugs to procure abortion, which is an offence under s. 58 punishable by life imprisonment and (b) procuring or supplying drugs to procure abortion, which is a less serious offence under s. 59. The scheme envisaged in your client's Approval is that the drugs will be *supplied* by a registered medical practitioner but *administered* by the pregnant woman herself. That is outside the scope of s.1(1) of the Abortion Act 1967.

For the avoidance of doubt, *SPUC Pro-life Ltd. v The Scottish Ministers* [2019] CSIH 31 does not apply in England and Wales. In any event, *SPUC* case concerned the 2018 Approval, which designated a pregnant woman's home as the place for one particular step during the late stage in the process of abortion, and is readily distinguishable from this case. The 2020 Approval authorises the whole process, including the most crucial decision and the administration of the fatal drug, to take place at home.

(6) The decision is contrary to the legislative purpose of the 1967 Act

The legislative purposes of the Abortion Act 1967 were (1) to broaden the grounds upon which abortions may lawfully be obtained; and (2) to ensure that the abortion is carried out with all proper skill and in hygienic conditions: *Royal College of Nursing v DHSS* [1981] AC 800, per Lord Diplock at 827D-E; *Doogan v Greater Glasgow Health Board* [2015] SC (UKSC) 32, para 9. The decision of 30 March inevitably frustrates (2), and is therefore contrary to the well-known public law principle in *Padfield v Minister of Agriculture* [1968] AC 997.

All places hitherto approved under s. 1(3) were subjected to the regulatory regime of the Care Quality Commission, aimed to ensure that abortions may only be carried out with proper skill, hygiene, and verification of the free choice of the pregnant woman to obtain an abortion. The 2018 Approval does not change the substantive position, because it only permits a follow-up step to be taken at home after the crucial, irreversible part of the abortion has already taken place in a clinical setting. By contrast, the 2020 Approval effectively permits the whole process of abortion to take place wherever in England or Wales the pregnant woman may happen to be living at the time. Self-evidently, there is no guarantee that such a place will always be safe or hygienic, or that the woman takes the pill freely and without pressure.

(7) Breach of s. 6 of the Human Rights Act 1998

The European Court of Human Rights has supervisory jurisdiction over the national regulation of abortion. The principle underpinning the regulation of abortion by the Court is that "once the State, acting within its limits of appreciation, adopts statutory regulations allowing abortion in some situations", "the legal framework devised for this purpose should be shaped in a coherent manner which allows the different legitimate interests involved to be taken into account adequately and in accordance with the obligations deriving from the Convention.": *A. B. & C. v. Ireland* [G.C.], no. 25579/05, 16 December 2010 at para. 214.

This supervisory jurisdiction is not limited to protecting the mother's rights under Article 8, but also extends to protecting the unborn child's right to life under Article 2 (although the state's positive obligation to protect the life of an unborn child is limited). Abortion is recognised as a "derogation" from the absolute protection of life under Article 2: *Vo v. France*, [G.C.], no. 53924/00, 8 July 2004, separate opinion of J-P Costa at para. 17; *Bosa v. Italy*, no. 50490/99, decision of 5 September 2002. In *H v. Norway*, a case involving an abortion which took place against the wishes of the child's father, the Court held that a state not only has a duty not to take the life of a person intentionally, but also to take appropriate steps to safeguard life.[1] As such, when a government decides to permit abortion, it remains subject to the obligation to protect and respect the competing rights and interests of everyone and everything involved.[2]

The Court has on numerous occasions outlined a number of rights and justifications calling for a limitation on abortion:

- the interest of protecting the right to life of the unborn child (*H. v Norway*, *op cit.*);
- the legitimate interest of society in limiting the number of abortions (*Odièvre v. France* [G.C.], no. 42326/98, Judgment of February 2003 at para. 45);
- the interests of society in relation to the protection of morals (*Open Door & Dublin Well Woman v.*

[1] *H. v. Norway*, no. 17004/90, Decision of inadmissibility of the former Commission of 19 May 1992 at para 167.
[2] *Supra n. 4.*

Ireland, Judgment of 29 October 1992 at para. 63);

- the parental rights and the freedom and dignity of the woman (*V.C. v. Slovakia*, application no. 18968/07, judgment of 08/11/2011);

- the interest of the father (*Bosa v. Italy*, no. 50490/99, decision of 5 September 2002);

- the right to freedom of conscience of health professionals and institutions based on ethical or religious beliefs (*Tysiac v. Poland*, No. 5410/03, Judgment of 24 September 2007 at para. 121).

It is apparent, especially from the rushed and inconsistent manner in which the 'Approval' was issued, that the Secretary of State has failed even to consider those competing interests, and in any event, has failed to protect or respect them.

(8) Irrationality

The decision of the Secretary of State represents a very significant change of the substantive abortion law, with massive impact on the delicate balance of competing rights and interests involved in this issue. That momentous decision was taken under the pretext of being necessitated by the Coronavirus epidemic. We will submit that the effect of that decision on the epidemic will be evidently minimal. The substantive liberalisation of the abortion law, and the circumvention of the democratic process, are both out of all proportion to any potential benefit to the anti-Coronavirus measures; to the extent that no reasonable decision-maker could have made that decision, and/or could have done so in this manner.

Action(s) that the defendant is expected to take

We invite your client, as a matter of urgency, to revoke the decision of 30 March 2020 with immediate effect.

Alternatively, we invite your client to suspend the decision of 30 March 2020 pending the resolution of this claim.

ADR proposals

Our client is mindful of parties' mutual responsibility to consider whether some form of ADR might enable settlement of this matter without proceedings being commenced and without the incurrence of significant costs; accordingly, they would welcome an opportunity to meet with you in ADR.

At present, we have no specific ADR proposals. In the event your client makes any ADR proposals, please be assured we will consider them carefully and sympathetically.

Details of any information sought

Please disclose any impact assessments undertaken by the Department as to:

a) the likely effect of the decision on preventing the spread of Coronavirus;

b) the risk that abortions will be carried out under pressure, e.g. from an abusive partner.

c) the risk that abortions will be carried out in unhygienic conditions;

d) the risk that abortions will be carried out without appropriate skills.

Details of any documents that are considered relevant and necessary

Please disclose the following documents:

a) All internal correspondence and documents within the Department in relation to the preparation and promulgation of the 'Approval' dated 30 March 2020;

b) Any relevant correspondence with other parties.

Protective costs order

Please note that Christian Concern is a non-profit NGO pursuing this claim in the public interest, and will seek a *costs capping order* to protect it from any potential adverse costs.

Proposed reply date

You will appreciate that this matter is extremely urgent. Your client's decision, of which the public has had no advance notice, came into force with immediate effect. It is likely that, pursuant to that decision, unlawful abortions will be taking place within days rather than weeks.

Pre-action protocol

Please note, if you ignore this letter or fail to reply within the allotted timescale, fail to provide enough information or fail to consider ADR, then sanctions may apply.

We would ask you to acknowledge safe receipt of this letter with two working days and require a full response to this letter by **8 April 2020**, failing which, proceedings will be issued without further notice.

We look forward to hearing from you.

Yours faithfully

Andrew Storch Solicitors

IN THE HIGH COURT OF JUSTICE

QUEENS BENCH DIVISION

ADMINISTRATIVE COURT

URGENT APPLICATION FOR PERMISSION FOR JUDICIAL REVIEW

BETWEEN:

Her Majesty the Queen

(on the application of CHRISTIAN CONCERN)

Claimant

-v-

Secretary of State for Health and Social Care

Defendant

Witness statement of the Rt Hon. Ann Widdecombe

I, Ann Widdecombe, of [redacted] *SAY as follows:*

1. I was a Member of Parliament for Maidstone between 1987 and 1997 and (following a boundary change) for Maidstone and The Weald between 1997 and 2010. I served in various ministerial positions in the government of John Major during 1990-1997, and then as Shadow Health Secretary during 1998-1999 and Shadow Home Secretary during 1999-2001. In 2019 I was elected, and briefly served, as a Member of the European Parliament for South West England and Gibraltar until the UK's representation in the European Parliament ceased due to this country's exit from the European Union on 31 January this year.

2. I make this statement in support of Christian Concern's application for judicial review of the decision by the Department of Health and Social Care to designate "a pregnant woman's home" as an approved class of places for abortions to be carried out under s. 1(3A) of the Abortion Act 1967.

3. Unless indicated otherwise, all facts and matters in this statement are within my own knowledge and are true. Where I refer to a fact or a matter that is not within my own

knowledge, it is true to the best of my information and belief and I identify the source of my information.

4. S. 1(3A) was added to the Abortion Act 1967 by s. 37 of Human Fertilisation and Embryology Act 1990. I participated in the House of Commons debates on the Human Fertilisation and Embryology Bill 1989 ("the Bill"). I have now been shown the relevant extracts from Hansard (vol. 174, columns 1178-1222, 21 June 1990) to refresh my memory about those events.

5. The Bill (which was mainly concerned with a different issue from abortion) originated in the House of Lords. In the course of its passage through the House of Commons, the Conservative MP for Salisbury, Robert Key introduced the Amendment No 29, which was subsequently passed and became s. 37 of the Act. That amendment was supported by the then Health Secretary, the Rt Hon. Kenneth Clarke. In the course of the debate, the following relevant exchanges took place:

> ***Miss Widdecombe****: [...] Amendment No. 29 gives the Secretary of State powers to enlarge the classes of premises that will be licensed. I believe that that is merely a paving measure—even if it is not intended as such—for self-administered home abortion.*
>
> ***Mr. Key****: It has been brought to my attention that what my hon. Friend has just said appears in the whip issued by the pro-life group. That is not the intention and, quite inadvertently I am sure, my hon. Friend has been very misleading. [...]*[1]
>
> ***Mr Clarke:*** *[...] My hon. Friend the Member for Maidstone mistakenly suggested that the abortion pill will be given out and taken home. First, no such pill is yet licensed here. It will not be licensed unless the Committee on Safety of Medicines is satisfied when the application is made that it should be licensed. Such a pill would be administered only in closely regulated circumstances under the supervision of a registered medical practitioner.*
>
> *A question was asked earlier about what type of premises would be used for administering such a drug. It is possible that the pill could be administered in a GP's surgery under the supervision of a registered medical practitioner. The patient would still have to return two days later to be given the pessary.*

[1] Column 1195

All that my hon. Friend the Member for Salisbury seeks to ensure is that, if such a drug is licensed, the Secretary of State will at least have the power in primary legislation to approve the places and circumstances in which it might be used. If we do not address that matter this evening and if the drug is licensed in a year or two, there will be a private Member's Bill on every Friday for several years about whether the circumstances in which the drug is administered should be changed. It is for the House to decide.[2]

6. I have no reason whatsoever to doubt the assurances given at that time by the Health Secretary. Contrary to my original concerns, I was reassured and believed that the intended legal effect of the amendment was not to pave the way for the Health Secretary to authorise self-administered home abortions. I further believe that the House of Commons, including both pro-abortion and anti-abortion MPs, voted on the amendment on that premise. Whether the pro-abortion MPs may have hoped that some future legislation would ultimately legalise home abortions is a different matter.

7. I took the then Secretary of State's assurances in the spirit of a *Pepper v Hart* statement and therefore assumed that no change could be wrought to the legislation without a vote of Parliament. I perceive the current Department of Health's decision to overturn prevailing regulations without parliamentary endorsement as wholly contrary to the legislative intent.

8. I believe that the facts given in this statement are true.

Ann Widdecombe

The Right Honourable Ann Widdecombe

15 April 2020

[2] Column 1201

STATEMENT OF GREGORY GARDNER

I, Gregory Gardner of [redacted], WILL SAY AS FOLLOWS:

1. I, Gregory Gardner have been instructed by Andrew Storch Solicitors representing the claimant, to prepare an expert independent witness statement.

2. My principal qualifications to act as an expert witness in this case include the following: I am a General Practitioner and a member of the Royal College of General Practitioners. I am an Honorary Clinical Lecturer in Clinical Sciences at the University of Birmingham and a final year medical student tutor. I am a GP Trainer and Educational Supervisor, and supervise candidates for specialist training in General Practice and the examination for Membership of the Royal College of General Practitioners.

3. I have been provided with the following material:
    a. Letter of instruction.
    b. The document 'Temporary approval for home use for both stages of early medical abortion' (The Document)
4. My instructions were to advise on:
    a. What are the dangers to women self-administering Mifepristone and Misoprostol at home?
    b. To comment on any other relevant matter.

Background.

5 Preliminary to any discussion about the risks of taking Mifepristone and Misoprostol at home to procure an abortion should be reflection on the Covid-19 crisis. Self-isolation in itself may – at least for some women – heighten anxieties and change decision making capabilities. The risk of making a life-changing decision

which is subsequently regretted may be higher than normal, so standards of care and counselling must be of an especially high standard.

6 Induced abortion is a medical procedure regulated by law. It is treated differently than other interventions because there is a possibility it may cause injury to the mother – either physical or psychological - and because unborn children need the protection of the law. There may also be risks to a mother's future children (see section below on preterm birth.)

7 There are dangers relating to medical abortion in general, including dangers in the way that communication between doctor and patient may be compromised by changes in the regulations, and dangers to the woman as a result of the relaxation of safeguards.

Assessment of risk

8 Under current abortion regulations, an abortion can be carried out only if the risk to the mother's physical or mental health is greater if she continues with the pregnancy than if she were to have an abortion. The practitioner will therefore have to ask a number of questions in order to complete a risk assessment; this risk evaluation is a critical part of informed consent. Material risks have to be disclosed to the patient in line with the 'Montgomery' principles whereby 'a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.'(1)

9 I include below a shortened list of possible complications of medical abortion, which may be material to a decision to have a home abortion by means of taking both Mifepristone and Misoprostol.

Risks of physical complications

<u>Infection.</u>

10 The Royal College of Obstetricians and Gynaecologists (RCOG) in their guidelines for abortion providers give a figure of 10% for infective complications after abortion.(2) Other studies give lower figures for diagnosed or presumed infection(3, 4) but there is a cohort of women undergoing abortion who may have undiagnosed infection. Abortion without antibiotic prophylaxis risks the later development of Pelvic Inflammatory Disease (PID) and puts a woman at increased risk of subsequent infertility.(5) The RCOG recommend screening for Chlamydia and other sexually transmitted diseases in all women having abortion.(2) This cannot be done other than by a face to face appointment.

11 The lack of provision for this under ‘Temporary approval for home use for both stages of early medical abortion’ regulations therefore increases the risk of personal injury to the woman.

12 A small proportion of women who have abortion may be susceptible to sepsis. Women need written information about sepsis warning signs which could be overlooked if the woman is alone.

Haemorrhage and subsequent Surgical Evacuation

13 A large registry-based study from Finland on medical abortion in 27,030 women noted a 15.4% incidence of haemorrhage in women aged over 18.(4) 10.2% of the adult cohort had an incomplete abortion and 13.0% required surgical evacuation. A second paper derived from the same dataset found the rate of haemorrhage to be eight times greater after medical than surgical abortion.(6)

14 A Swedish study which looked at all abortions from one hospital from 2008 to 2015 reported an overall complication rate of 7.3% in medical abortions under 12 weeks. The commonest complication was incomplete abortion.(7) The complication frequency was significantly higher among women < 7 gestational weeks who had their abortions at home. A significant finding of the study was that the rate of complications associated with medical abortions increased from 4.2% in 2008 to 8.2% in 2015, possibly associated with a shift from hospital to home medical abortions.

15 In Australia a case series of 947 women undergoing first trimester medical abortion resulted in an 11.1% combined total of either emergency department presentation or hospital admission for treatment of complications.(8)

16 These are high figures and contrast with lower figures for complications reported in systematic reviews of clinical trials on Mifepristone/Misoprostol.(9, 10) The higher figures are more reliable than those in clinical trials because this is ‘real world’ reported data.

Risks of psychological trauma

17 The psychological assessment of women by medical professionals prior to abortion is challenging. This is even more difficult when such assessments are done by phone or video link. Reflecting on a study which looked at pre-abortion counselling,(11) Coleman concluded that ‘women arriving at abortion facilities are not necessarily sure of their decision to abort and they benefit greatly from counselling with professionals who address several parameters of the abortion decision.(12)

18 In an exhaustive review of the literature Reardon makes the point that ‘Research has shown that women considering abortion have a high degree of desire for information on ‘all possible complications’, including rare risks.’(13) Included among ‘all possible complications’ must be questioning about suicidal ideation. About half the women who have abortions in England and Wales each year have had at least one abortion previously. The incidence of repeat abortion is therefore high. Sullins found a compounding effect of repeat abortion on suicidal ideation and substance misuse.(14)

19 The American Psychological Association’s report in 2008 identified fifteen risk factors which counsellors needed to ask about in an assessment of women at risk for post abortion psychological injury.(15) Included in this list are, ‘Perceived pressure from others to terminate a pregnancy’ and ‘Perceived opposition to the abortion from partners, family, and/or friends.’ Reardon notes that the list is one of the shortest that has been developed.(13) Other researchers have compiled more extensive lists of risk factors thereby making it highly unlikely that consultations done by phone or video link will be able to fully assess the risk of an abortion to a woman’s psychological health.

Communication risks

20 The difficulty which the practitioner faces is that information obtained by phone/video/other electronic means may be incomplete. It will be virtually impossible to do a full risk assessment and communicate that risk back to the patient. The woman may not accurately report her last menstrual period and without having an ultra sound scan, there is a possibility of wrongly assessing the pregnancy gestation. In practice this risks women taking Mifepristone/Misoprostol at a later gestation thus risking heavier bleeding.(2)

21 A study of post-abortive women from Sweden in 2016 noted that ‘one-third of the women stated that they lacked information in different areas like bleeding, pain, the abortion process, expulsion of the embryo, and the opportunity to see a counsellor. Lack of or insufficient information about bleeding was most frequently mentioned.’(16) This finding is important because home abortion instructions given by phone or video may lead to misunderstanding and therefore potential for harm. This would be especially true if the woman did not have English as a first language.

22 Informed consent implies not just a full risk assessment, but time allowed for reflection and change of mind. How does a doctor ensure that the woman actually takes the medical abortion tablets, at the right time and in the right way, rather than someone else – perhaps a woman at a later stage of pregnancy?

Relaxation of safeguards

23 In the data sheet for Medabon Combipack of Mifepristone with Misoprostol there are clear warnings about the use of these drugs in combination to procure abortion:

24 Because it is important to have access to appropriate medical care if an emergency develops, the treatment procedure should only be performed where the patient has access to medical facilities equipped to provide surgical treatment for incomplete abortion, or emergency blood transfusion or resuscitation during the period from the first visit until discharged by the administering qualified medical professional.

25 The non-negligible risk of failure, which occurs in 4.5 to 7.8% of the cases, makes the follow-up visit mandatory in order to check that abortion is complete. The patient should be informed that surgical treatment may be required to achieve complete abortion.

26 The patient must be informed of the occurrence of prolonged vaginal bleeding (an average of about 13 days after mifepristone intake, up to three weeks in some women.....heavy bleeding may require surgical evacuation of the uterus. Bleeding is not in any way a proof of termination of pregnancy as it occurs also in most cases of failure.

27 The patient should be informed not to travel far away from the prescribing centre as long as complete expulsion has not been confirmed. She should receive precise instructions as to whom she should contact and where to go, in the event of any problems or emergency, particularly in the case of very heavy vaginal bleeding.

28 A follow-up visit must take place within a period of 14-21 days after administration of mifepristone to verify by the appropriate means (clinical examination, ultrasound scan, or beta-hCG measurement) that expulsion [of] the abortion has been completed and that vaginal bleeding has stopped or substantially reduced. In case of persistent bleeding (even light) beyond the follow-up visit, its disappearance should be checked a few weeks later. If an ongoing pregnancy is suspected, a further ultrasound scan may be required to evaluate its viability. Persistence of vaginal bleeding at this point could signify incomplete abortion, or an unnoticed extra-uterine pregnancy, and appropriate investigation/treatment should be considered.

29 During intake and for three hours following the intake, the patient should be monitored in the treatment centre, in order not to miss possible acute effects of misoprostol administration.

30 Since heavy bleeding requiring haemostatic curettage occurs in 0.2 to 1.8% of the cases during the medical method of pregnancy termination, special care should be given to patients with haemostatic disorders with hypocoagulability, or with anaemia. The decision to use the medical or the surgical method should be decided with

specialised consultants according to the type of haemostatic disorder and the level of anaemia.

31 Before Medabon is given to a woman who has undergone genital mutilation (FGM) a physical examination must be performed by a qualified trained medical professional to exclude any anatomical obstacles to medical abortion.(17)

32 No consideration seems to have been given to any of these safeguards in the 'Temporary approval for home use for both stages of early medical abortion' regulations.

Safeguarding and the risk of coercion

33 Control over women's reproductive autonomy by others is common and healthcare professionals need to ask specific questions about it.(18) A study of teenagers found that 10% reported some degree of coercion in making a decision to have an abortion.(19) It will be difficult if not impossible to verify by phone or video whether a woman is undergoing any kind of duress to have an abortion. There does not seem to have been any consideration given to this in the proposed change in policy. There will be women who need delicate counselling to discover coercion or other forms of abuse. Face to face consultation is needed – if necessary on more than one occasion. A phone call or video call to someone at home who may not have the ability to speak in complete confidence may cause important information to be hidden. Even where coercion may not be present, the relatively circumscribed nature of phone or video consultation creates a risk that important bits of information may be missed, thus compromising decision-making.

Longer term risks

Risks of future preterm birth.

34 Women having counselling for first trimester medical abortion should also be informed of the possible increased risk of preterm birth in a future pregnancy. A 50% increased risk of preterm birth after one medical abortion was noted in the most recent meta-analysis on this subject.(20)

Risks of breast cancer

35 Emerging data on the risk of breast cancer after medical abortion are concerning. A paper published in 2019 put the increased risk of premenopausal breast cancer at nearly four times and postmenopausal breast cancer risk at seven times (after adjustment) in women who had undergone one medical abortion.(21) Abortion consent forms need to mention these long term risks (see para. 9 above).

Self-regulation

36 The Care Quality Commission found examples of malpractice at Marie Stopes centres in 2016. Amongst these were pre-signing of consent forms, the flouting of infection control regulations and inadequate safety standards to monitor patients whose condition was deteriorating. In answer to a Parliamentary question in February 2020, it was reported that 121 facilities performing abortions (59% of the total) required improvement for safety.(22) Abortion providers have compromised on safety standards when those standards were higher than under the proposed new regulations. It is likely that lowering safety standards will therefore lead to further compromises on safety.

Systemic Risks

37 The increased risk of complications when abortion is done at home (para. 7) potentially places health services under increased pressure at a time of already stretched capacity. In contrast, because of the nature of the current Covid-19 crisis, some GP practices are double triaging patients by home or video link before referring them for a possible assessment at a 'hot clinic.' That is, the patient is assessed independently by two clinicians before a referral is made. The patient is further assessed by a third clinician before acceptance to the 'hot clinic' is made. The downgrading of assessment by just one clinician for home abortion is likely to increase the risk of medical error.

Other risks

38 In the '*Temporary approval for home use for both stages of early medical abortion'* document there is no proposal for the medication to be supervised. Currently, the Mifepristone is taken under supervision and the Misoprostol may or may not be taken under supervision depending on the patient's circumstances.
A woman whose first language is not English or who does not fully understand the instructions (see para.21 above) or who delays taking the tablets due to ambivalence about her decision, or for whatever other reason does not comply with the instructions, may be putting her health at risk. There is also a risk that she may not take the tablets at all and could end up selling them on the street thus putting other lives at risk. GP's are fully aware of many drugs which have street value and since there is no provision in The Document for proper supervision this is a further risk.

Summary

39 The introduction of home abortions as proposed (notwithstanding the presence of a Covid-19 pandemic) is a policy that is more likely than not to depart from the essential tenets of duty of care through proper clinical assessment, thereby raising the risk of serious injury and harm being done to women self-administering Mifepristone and Misoprostol at home.

EXPERT DECLARATION

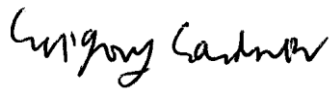
I declare the following:

1. That I understand that my duty in providing written reports and giving evidence is to help the court; and that this duty overrides any obligations to the party by whom I am engaged or, he person who has paid or I liable to pay me. I confirm that I have complied and will continue to comply with my duty.
2. I confirm that I have not entered into any arrangement where the amount or payment of my fees is in any way dependent on the outcome of the case.
3. I know of no conflict of interest of any kind, other than any which I have disclosed in my report.
4. I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issues on which I have given evidence.
5. I will advise the party by whom I am instructed if, between the date of my report and the hearing, there is any change in circumstances which affect my answers to points 3 and 4 above.
6. I have shown the sources of all information I have used.
7. I have exercised reasonable care and skill In order to be accurate and complete in preparing this report.
8. I have endeavored to include in my report those matters, of which I have knowledge or of which I have been made aware, that night adversely affect the validity of my opinion. I have clearly stated any qualifications to my opinion.
9. I have not, without forming an independent view, included or excluded anything which has been suggested to me by others, including my instructing lawyers.
10. I will notify those instructing me immediately and confirm in writing if, for any reason, my existing report requires any correction or qualification.
11. I understand that
    a. My report will form evidence to be given under oath or affirmation.
    b. Questions may be put to me in writing for the purposes of clarifying my report and that my answers shall be treated as part of my report and covered by my statement of truth.
    c. The court may at any stage direct a discussion to take place between experts for the purpose of identifying and discussing the expert issues

in the proceedings, where possible reaching an agreed opinion on those issues an identifying what action, if any, may be taken to resolve any of the outstanding issues between the parties.

d. The court may direct that following a discussion between the experts that a statement should be prepared showing those issues which are agreed, and those issues which are not agreed, together with a summary of the reasons for disagreeing.
e. I may be required to attend court to be cross examined on my report by a cross examiner assisted by an expert;
f. I am likely to be the subject of pubic adverse criticism by the judge if the court concludes that I have not taken reasonable care in trying to meet the standards set out above.

12. I have read Part 35 of the Civil Procedure Rules and Part 3.3 of the Criminal Procedure Rules, the accompanying practice direction and the Guidance for the instruction of expense in civil claims and I have complied with their requirements.
13. I am aware of the practice direction



Gregory Gardner.

15/04/20

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Postgraduate Experience

- Partner Cape Hill Medical Centre, Smethwick. **2007 - present**
- Salaried GP, Cape Hill Medical Centre. **2003- 2007**
- Salaried GP, Swanpool Medical Centre, St. Marks Rd., Tipton. **1996-2003**
- Clinical Assistant in Diabetes, Heartlands Hospital. **1996-2003**
- Sessional GP. **1989-2000**
- GP Locum New Zealand **1988**

I have had experience of General Practice in many different settings including working as a long term locum in several single handed practices. From 1997 to 2000 I helped provide GP services to the Bloomsbury Centre's clinics for homeless men. I am currently contributing to Cape Hill Medical Centre's homeless project at the Health Exchange for approximately 1000 registered homeless patients.

Professional Development

- **Teaching.** **2005-present**
  Teaching year 3 and year 5 medical students. I have also mentored several Students who were studying ethics either as part of a course or as a degree in its own right. I have assisted several sixth form students with work experience aspiring to be medics.
- **Training**. **2009-present**
  I have trained a number of overseas medical graduates as well as UK graduates for the clinical skills examination of the MRCGP with an eventual 100% pass rate.
- **Management**. I have been managing partner twice at Cape Hill Medical Centre. In 2017 and 2020 we were awarded an overall 'outstanding' rating by the Care Quality Commission. I am partner lead for anticoagulation and diabetes.
- **Medical Politics**. Delegate to BMA Annual Representative Meetings 2000-2006 and 2015 to present. Current chairman of Birmingham BMA division. Delegate to BMA consensus conference on Assisted Suicide March 2000. Vice-Chairman of Medical Ethics Alliance 2001-2005. I prepared our submission on the Mental Capacity Bill and gave evidence to the Scrutiny Committee in the House of Lords.

- **Audit**. I have overseen the contributions of Cape Hill Medical Centre to the national audits run by the Association of Clinical Diabetologists for the drugs Exenatide, Liraglutide and Dapagliflozin. I am responsible for the quarterly anticoagulant audits at Cape Hill Medical Centre.
- **Lectures and Presentations**. The risk of preterm birth after induced abortion (Royal Statistical Society annual meeting 2008); Post abortion psychological trauma (Royal Society of Medicine December 2014); Post abortion trauma review (House of Commons November 2017).
- I have exhibited posters on the risk of preterm birth after abortion at conferences of The UK Public Health Association (2010) and The Society of Social Medicine (2011).
- **Current Research**. I am writing up a systematic review and meta-analysis on the subject of abortion and preterm birth. This will be the largest and most comprehensive SRMA of this subject done to date.
- **Publications**. Revalidation Toolkit. Continuing Professional Development for GP Non-Principals. Education for Primary Care 2002;13:135-40; Abortion and Breast Cancer (letter) Br J Gen Prac 2003;53:151; Comfort Care' needs robust moral framework (letter)BMJ 2003;327:52.
- **Public Consultations contributed to**. PSHE 2009; RCGP consultation on Assisted Dying 2013; Gender Recognition Act 2018; SRE 2018.