3. CONSIDERATION OF CLAUSES

3.1. Abortion Reform Bill 2018 – Consideration of clauses commenced

Dr Allinson to move.

The Speaker: We then turn to Item 3, consideration of clauses in the Abortion Reform Bill. Hon. Members, I circulated a memorandum yesterday which will provide the basis of today’s proceedings.

We now turn to clauses and I call on Dr Allinson to move clause 1.

Dr Allinson: Thank you, Mr Speaker.
I beg to move clause 1, the short title of the Bill, which is the Abortion Reform Act 2018.

The Speaker: Miss Bettison.

Miss Bettison: I beg to second and reserve my remarks.

The Speaker: Mr Robertshaw.

Mr Robertshaw: Thank you, Mr Speaker.
I beg to move that the House do resolve itself into the Committee of the Whole House under Standing Order 4.4A.

The Speaker: Dr Allinson.

Dr Allinson: I would like to second that, Mr Speaker.

The Speaker: Hon. Members, the question is that we resolve ourselves into Committee of the Whole House. Is that agreed? (Members: Agreed.)

Thank you.

In Committee of the Whole House

The Speaker: As we are now in Committee of the Whole House, I can advise that there are four witnesses that have been invited to attend today. They are Lord Brennan QC, Ms Jasvinder Sanghera CBE, Mr Bob Fayle and Mr Howard Connell, and all will be available for questions by Members during the course of the sitting.

The themes that have been identified are set out in the memorandum which was circulated yesterday and, in the absence of Lord Brennan as he makes his way to join us this morning, I would propose that we would start with sex selection which is on that list in part C, and with that, I will invite Mr Robertshaw to commence questioning.

Mr Robertshaw: Thank you, Mr Speaker.
I ask the House to recognise Ms Jasvinder Sanghera CBE, who is a spokeswoman for Stop Genocide UK. She was born and brought up in Derby, a survivor of a forced marriage. She is the founder of Karma Nirvana, a national award-winning charity that supports both men and women affected by honour-based abuse and forced marriages. She is a highly acclaimed international speaker and an expert adviser to the courts on the matters of child, civil and criminal proceedings. She also chairs domestic homicide reviews and was instrumental in ensuring that
all UK police forces are required to improve their understanding of honour-based abuse and forced marriage, by inspectors conducted by Her Majesty’s Inspectorate of Constabulary.

Jasvinder’s memoir *Shame* was described in the House of Lords as ‘a political weapon’ and, along with *Daughters of Shame*, is a Sunday Times top bestseller. I have a copy before me and I am not promoting a book on her behalf!

May I then, Mr Speaker, welcome Jasvinder to today’s session and wish to thank her very much indeed for joining us in this incredibly important debate, and I am sure we will listen very carefully to your contribution.

Mr Speaker, I would like to begin by asking a series of questions.

Ms Sanghera, sex-selective abortions may happen in some parts of the world but surely not in the British Isles?

**Ms Sanghera:** First of all, thank you for inviting me to this sitting here today.

With respect to the question, not happening in the British Isles, I have to say I disagree with that. I also believe it is precisely that attitude that makes people believe that; that also allows this to go underground even more where victims are more isolated.

I took the liberty of looking at your population demographics yesterday and it was a profile of 2018, and according to those demographics, 1.9% of the population are Asian, Asian/British and 1.5% are Other. I also looked at the 2016 census and I particularly looked at Asian and Middle Eastern communities, of which it detailed there were 715 in population in 2016 and Middle Eastern, 77.

The reason I raised that is because if we are to surmise that you do not have a significant minority group here, therefore it is not an issue, two things happen. Those people who are at risk will not have that level of understanding when they report and you will not be able to identify them.

If I may, I would like to give the example of Shafilea Ahmed. Shafilea Ahmed was a British citizen born in Bradford, moved to Warrington, which was a town with not significant minority groups. She was Muslim, one of five siblings, and reported honour-based abuse, which is whereby a young teenager reports being abused by family members for fear of shaming the family. That shame can be linked to behaviours such as wishing to integrate, wishing to seek choices, rights and independence.

At every point where she reported to over four statutory organisations and one non-statutory organisation there was this unwitting connivance to fears of cultural sensitivities and fears of offending, whereby professionals looked the other way and they did not believe it was such a problem because there was not a significant minority group in their area. Therefore she was let down. Subsequently, this girl was murdered at the age of 17 years old. Her family actually murdered her.

When we look at that case and we look at some of the attitudes of the professionals that existed, one of the things that contributed to the fact that she was not supported and identified as being at risk was because within Warrington there was the attitude that there were not many of them here, therefore we do not actually have a problem. My point is that I think you have more of a problem if you have fewer minority groups because your victims will be more vulnerable, more isolated and less likely to report.

**Mr Robertshaw:** Isn’t the truth that the gender selective issue is something that has been highlighted in the British Isles somewhat disingenuously by those wanting to champion a wider anti-choice agenda?

**Ms Sanghera:** No, I do not believe that because ultimately the victims that we are talking about who will be pressured or coerced into aborting foetuses do not have a choice actually and we are talking about protecting the most vulnerable of victims. In these cases it is not about undermining those rights and choices; it is about protecting those victims so that we give them a
choice and a right to be able to keep that child, not to be pressured, not to be coerced in having
to abort the child on the basis of gender selection.

So actually I do not think that is the case, that we are removing rights and choices. I believe
we actually have a responsibility and a duty to identify the most vulnerable and also empower
them so that they have a choice to overcome the coercion that they will face.

Incidentally, it is important to note that if we are looking at minority groups – and in my area
of expertise I have worked with South Asian communities, Somalian, Kurdish, Afghan, Iranian
communities etc. – the people who are coercing them and pressuring them are very often within
a family dynamic. They are immediate or extended family members and they will always have
multiple perpetrators who are coercing them and pressuring them. So they are incredibly
vulnerable.

Mr Robertshaw: Thank you.
But hasn’t the British Government said that there is not an issue in England and Wales?

Ms Sanghera: I have to say that in the opinion of many, including victims and survivors ... Our
charity is in its 25th year; we operate the national helpline dealing with over 850 calls a month
nationally, of which we do hear victims calling the helpline in these circumstances, where they
are being forced to abort female foetuses and coerced into it too.

What the Government did not do is they did not go far enough to hear the testimonies of
victims in this case, I have to say. What we also felt was let down with the fact that these tales of
suffering which we hear every day were not heard by Members of Parliament. That was not part
of the debate, I hasten to add, and it is important to hear that.

I proactively campaigned for the criminalisation of forced marriage for 10 years in England
and Wales, and one of the things I know is that there was a huge camp who were against the
criminalisation of forced marriage. They argued that to criminalise forced marriage would make
it go underground even more and victims would not report, they would not want to get their
families into trouble. That is what they argued.

So we lost the battle in 2005 in terms of criminalisation and then we had another
consultation when David Cameron was Prime Minister, and at the heart of that consultation was
the testimonies of survivors who had been forced into marriages, who were very clear that if
they were given the right support and they were identified and education etc. and they were
protected, they would criminalise their family. They would pursue a prosecution if they were
protected. That created a law because that is a powerful testimony.

I feel that part of the reason why there was a reluctance to go far on this debate in terms of
the gender selection conversation in the UK had very much to do with a lack of understanding
and awareness and education also.

Mr Robertshaw: In a way, Jasvinder, you have, to some extent, answered my next question,
but I will ask it just in case there is an additional addendum you want to put to it.

The Isle of Man is less ethnically diverse than many parts of Great Britain, so why should we
be concerned?

Ms Sanghera: It is so difficult to accept uncomfortable truths and have uncomfortable
dialogues and what I know about my own personal experience is I was born in Britain, I am one
of seven sisters and one of the things I know about my mother who was an Indian woman who
arrived in this country in Britain in the 1950s with my father, the abuse that we suffered within
our family dynamic as females, understanding that we were second-class citizens, understanding
that our sexuality was controlled by many family members, had very much to do with the fact
that my family members would justify it on account of culture, tradition and/or religion, which
frankly is not right. Cultural acceptance does not mean accepting the unacceptable.
But the point here is my mother would be frowned upon for giving birth to seven daughters. In fact people would come to the house and almost look at her as if they were in grief and ‘how could this happen to her?’, because to give birth to a daughter is actually not a blessing; it is a curse, for a number of reasons. But I was born here and where we lived there were not many minority groups, and the thing here is my family always had the power.

What I want to ensure is that where you have fewer minority groups, those individuals are going to be heard in the context of being citizens of your country and that they should be given the same safeguarding regard as anybody else. I am not sure and convinced that that is happening in the UK and it is very important that we recognise that rights for people should be rights for everybody. We are made to believe that our family have the power to control us. It is only by seeking professional help we are told something different, but we need people to recognise our rights are very often removed from us and justified on the grounds of religion, tradition and culture, and that is a powerful weapon that they will use.

Mr Robertshaw: Thank you.

The Speaker: I have Mr Hooper and Mr Boot who have indicated that they would also like to ask a question at this point.

Mr Hooper.

Mr Hooper: Thank you very much, Mr Speaker.

You have given us a lot of information about what happens in the UK (Ms Sanghera: Yes.) and you mentioned you get a lot of calls nationally raising concerns. Can you advise if you have had any calls from anyone resident on the Isle of Man?

Ms Sanghera: I have to say I have not checked that information with regard to my helpline but I certainly can go back, because we geographically record where all our calls are coming from as well as numbers. So that is absolutely something that I can follow up.

Mr Hooper: Okay, thanks.

You also mentioned you have got concerns about safeguarding not being taken very seriously in the UK and you do not think the provisions in the UK Act are appropriate. Would you care to comment on the provisions in the draft Bill that we are talking about on the Isle of Man, the provisions specifically in section 9 surrounding informed consent or the requirement for doctors to be acting in good faith, whether you would feel those provisions are providing adequate safeguarding?

Ms Sanghera: In my opinion, I believe you need more than acting in good faith. I think there is a need to have more stringent and stronger procedural measures. For example, in these cases if our potential victims go to see a GP then if she is seeing the GP in the presence of a family member she will not disclose the pressure and coercion. There is a need for very clear guidelines in terms of conducting an assessment and what that assessment looks like in terms of identifying risk, and doing a risk assessment and then identifying somebody of concern. So there are a number of things I think that one has to consider in terms of measures to be able to identify somebody.

Incidentally, just to say, going back to the point you made earlier about the Isle of Man and calls to the helpline, it is very important that victims are aware a helpline exists in order to receive calls. So if I go back and we do not have calls from the Isle of Man, that is not because it is not happening in the Isle of Man; it may be the case that people are not aware of a national helpline.
Mr Hooper: You just mentioned that you think there need to be guidelines about risk assessments and the direct operational side of things – how GPs would determine if they feel someone is being coerced. (Ms Sanghera: Sure.) That is not really something we can do in legislation. That, to my mind, is up to the GMC in the UK to tell their doctors exactly what is expected of them.

Is that a position that you would accept, or do you believe that actually we should be putting within our primary legislation very specific guidelines that really cannot be altered, it is very difficult to change them? Or is it better left up to the medical professionals to actually decide what is appropriate for doctors who are providing these services?

Ms Sanghera: I believe you have to address sex selection and abuses of coercion and pressure within the amendments, absolutely, because that sends out a very direct message and a clear message and will help to ... In the same way we have created criminal legislation, one of the objectives of criminalising forced marriage was to shift attitudes and shift cultures and it was an opportunity to send out a clear message, and you will build on that.

The Speaker: Mr Hooper.

Mr Hooper: Okay, the final question then. The Bill as drafted requires that informed consent is obtained, informed consent being ‘consent by a woman of her own free will’. This Bill makes it illegal to provide abortion services where there is no informed consent, so that has already been done. It is already enshrined in legislation here to say if you do not have informed consent, which is ‘consent by a woman of her own free will’, you are breaking the law. That is a criminal act. There is not much more that we can do in primary law other than saying, ‘If you do this it is illegal and you will be prosecuted to the fullest extent of the law.’ How you determine that is, as you have already identified, a matter for guidelines.

So would you accept that actually the law as drafted is criminalising exactly the things you are talking about that should be criminalised and the next step is to make sure that we have appropriate guidance in place to make sure that when this law is applied in practice, it is done fairly and it is done appropriately?

Ms Sanghera: I do not think it goes far enough to make the point that gender sex selection is illegal. It might be a matter of law for the other witnesses but I do not think that it goes far enough, no.

Mr Hooper: Sorry, I was talking about coercion then, not specifically –

Ms Sanghera: The informed consent?

Mr Hooper: Yes, specifically about ... because it seems to me that gender sex selection, the core issue is about coercion – that is what you have talked about. (Ms Sanghera: Yes.) So, primarily, if we can make sure that coercion is not happening, that coercion itself is illegal, is against the law, that gets rid of, or tries to address at least, the primary cause, the primary concern that you have explained today.

Ms Sanghera: The issue that you have is how does one assess informed consent when somebody is under such pressure.

Mr Hooper: Again, I –
Ms Sanghera: Maybe I am not answering the question.

Mr Hooper: No, again, we have already agreed that that is a place for guidelines. (Ms Sanghera: Okay, right.) You cannot really enshrine an assessment like that in primary law.

Ms Sanghera: No, you cannot.

Mr Hooper: Thank you.

The Speaker: Mr Boot.

Mr Boot: Thank you.

I am still slightly confused as to why you believe that a small community like ours, which is well connected and people are known, would be more vulnerable to this than a larger community in the UK. Perhaps you could comment on that. And I have to express some surprise that you have not done some due diligence in terms of the number of phone calls or enquiries you have had on your helplines from the Isle of Man if you can geographically locate people.

But in general terms, something that I find quite confusing is that we are talking about a problem, but when we have a problem normally we get some numbers with it. What do you consider is the informed opinion of the number of individuals involved in the UK on a yearly basis, for instance?

Ms Sanghera: First and foremost, just because you do not have evidence of a problem it does not mean the problem does not exist. I can tell you that in 1993 when I founded the charity Karma Nirvana I was one survivor of a forced marriage who had one experience and that of my sister, who tragically committed suicide when she was 24 years old. She was taken out of education at 15, forced to marry a stranger and set herself on fire at the age of 24 after a tragic history. The point is I just had one story, which was me, and then my sister, which was the other, and I, in the face of people telling me it is not an issue for the UK because you do not have the numbers, you do not have the evidence ... All I had was one story, which was strong enough, but I fundamentally believed that there were many just like that existed. That led to no reporting to a helpline in 1993 to 1997, to reporting of 50 calls a month, to now, since its inception in 2008 to 2016, dealing with over 65,000 nationally. So I do not buy the argument that because you do not have the evidence and the statistics it is not an issue.

With respect to a community being well connected, again what we recognise about the issues of honour abuse and sex-selection abortion and giving birth to a female where a family is pressuring you to abort that foetus is an issue of dishonour. To have another daughter and not a boy is an issue of dishonour. How the 43 police forces define honour is as serious and organised crime and the perpetrators come from all backgrounds. These are uneducated, educated; these come from very well connected families and appear ... but they will organise themselves. So I do not believe that one should look at the perception of just because they are connected and they get on etc. ... I think you need to hear the testimonies of the females in that community because they are the ones who are representative of whether these issues ... and how they exist, and I think there is some work to do there.

I can only ask you to forgive me for the fact that I did not seek to identify the statistics of the helpline, but I certainly can go back and find that out this afternoon.

Mr Boot: Thank you for that.

Just to widen that out a little bit, you seem to be talking very much about cultural differences and forced marriage in the same breath as an Abortion Act in which, as my hon. friend Mr Hooper pointed out, there are safeguards built in. I am certainly not aware of any forced marriage cultural problems on the Isle of Man but you are mixing the two and they are two
separate entities. I understand how you are connecting them but I think we need to look at the Abortion Bill as it is, not bring in cultural differences. I am just making that point.

Ms Sanghera: I disagree because what I am sharing is a shared experience, the experience of a victim which is underpinned by an honour system which controls the sexuality of females, and that honour system is something that you have to recognise in the context of why our victims are coerced and forced to abort their child on the grounds of sex selection. So I am talking about the experience of an honour system which one cannot remove oneself from.
I also have dealt with concealed pregnancies, and this is where ... It is an issue of shame with these victims to give birth to yet another female. It is an issue of shame within the family in the same way we deal with concealed pregnancies, whereby our victims are forced to conceal that child and then forced to give that baby up for adoption because it is an issue of shame.
So I am talking about an experience which I think you cannot ignore when you are debating and discussing gender selection.

The Speaker: Thank you.

Dr Allinson.

Dr Allinson: Thank you very much, Mr Speaker.
I would like to thank you for coming over to the Isle of Man. My first question is about the need for legislation, because in an inter-agency statement made by the World Health Organisation and UNICEF they stated that Governments in affected countries have undertaken a number of measures in an attempt to halt increasing sex-ratio imbalances. Some have passed laws to restrict the use of technology for sex-selective purposes and in some cases for sex-selective abortion. These laws have largely had little effect in isolation from broader measures to address underlying social and gender inequalities.

And yet you have been very keen to promote more of a legislative way of controlling this subject. I would like to ask you why?

Ms Sanghera: I think the failure to address sex selection and coercive abortion is a problem which I believe has to be addressed through amendments, because that in itself will send out a very direct, clear message and it will enable you to build on that also. We know there is evidence clearly in the UK. In 2011 the National Census in the UK highlighted 4,700 unborn girls aborted. Now, these figures revealed some areas of Britain where the proportion of boys to girls is much higher and those were in areas where you had significant minority groups. This is my area of expertise I am talking to. So what we know is we have a real problem here. We cannot look the other way and therefore it needs to be enshrined in amendments in order to send out that message in my opinion, and in the opinion if you listen to the victims who have experienced this – they will share the same experiences that they have had of not feeling protected.

Dr Allinson: Again, I think there is a slight dichotomy between personal experiences and written evidence. The Department of Health were asked to look into this in response to the Serious Crime Act 2015 and found no hard evidence based on statistics for sex-selective abortion to be carried out in the United Kingdom. Whilst I agree with you that anecdotally that may take place it seems anomalous to base a whole new raft of legislation purely on your testimony. Could I ask also: obviously Stop Gendercide have lobbied about this for some time, particularly following 2015. Are you the only charitable organisation lobbying for legislation about sex-selective abortion?

Ms Sanghera: No, there are other organisations and in fact I do not represent that organisation, I represent Karma Nirvana here. So there are other organisations which exist and
form part of the debate, and I represent the victims who call the helpline also whereby we hear these horrific testimonies. So there are other organisations also.

**Dr Allinson:** Whilst I would confess that as far as I know, Stop Gendercide is the only one lobbying for legislative changes, back in 2015 when the Serious Crime Act was published many organisations found this legislative approach too restricting, and coercion as having some quite serious non-intended consequences, particularly in terms of the possible rise of ethnic profiling of women coming into maternity services. We already know that the Royal College of Nursing have taken on board the issue of coercion quite seriously and normally recommend that counselling for abortion takes place one to one with the woman, not with her partner there.

In 2015 there was an open letter to the *Independent* paper signed by 49 organisations including numerous university professors arguing against legislation on these grounds because they saw it as opening up racial profiling.

How would you view that?

**Ms Sanghera:** I have to say that we know there are some trusts in the UK who are taking on practices not to inform females, certainly from the Asian community, about what the sex of their child is, and I can say this from personal experience, albeit I had an experience. I have three children and in 1985 when I gave birth to my daughter I was told by the midwife when I asked what sex my child was, ‘Oh no, we don’t tell the Asian women’. So there is this practice that exists where people know this is happening on the ground, but actually we also have to look beyond that because we also know that the majority community where we see domestic violence women also can be forced to have induced abortions.

So it is a broader spectrum. My other expertise is in minority groups and what we do know is – if we take countries like India and other countries – there is a population crisis of males to females. There are less females to males because of the attitudes towards females and the high incidences of female infanticide. So I am speaking from this perspective, but I absolutely understand the fact that there are broader issues.

I do not believe you should racially profile, I think you need to look at this in the broader context of other experiences too where people are coerced and pressured to abort on the grounds of gender sex selection.

**Dr Allinson:** Thank you for that explanation.

Obviously we know that in India they have brought in legislation to restrict sex-selection abortion which unfortunately from your testimony does not seem to have worked; and when you compare that with countries like South Korea they have managed to reverse their gender imbalance through actually empowering women, and better education and support for women.

At about five o’clock this morning, the organisation which you are a part of released a press release based on a survey that was carried out on the Isle of Man. The press release went out at about one o’clock in the morning so Members probably have not had a chance to digest it.

Whilst you said you did not want to remove the rights and choices of women, part of that press release argued for no abortion on request up to 14 weeks – minimum I think you said may be up to seven weeks – and also called for abortion not to be available to women who request it for social or health grounds.

How does that marry with your original statement that you do not want to remove rights and choices for all women?

**Ms Sanghera:** First and foremost, I have not read that press release this morning, incidentally. For me, the women I am talking about, that right and that choice has been taken from them by virtue of the fact they have been pressured by multiple perpetrators and coerced into believing that this may be part of their destiny, kismet, faith, religion, culture, whatever.
The point is, I want to see a process whereby there is a robust assessment to identify those at risk, to give them, to absolutely be reassured that this is their choice.

And incidentally with regard to India, yes, we know it is against the law, as we know that there are other offences that are against the law but they still happen, but if I may refer to Dr Sudhir Sethi, who is a paediatrician in Leicester, in his practice in the last 10 years he is very clear, he has seen numerous people going to India to have abortions based on sex selection. He talks about it being a lucrative business in countries around the world, especially India. The point is that these are citizens in this country who are going out of the country to have sex-selective abortions.

Dr Allinson: I completely understand that, but how do you think changing legislation to restrict access to abortion for everyone would therefore stop that sort of practice happening?

Ms Sanghera: I think we have a duty to protect the most vulnerable, and we are talking about protecting the most vulnerable victims. Changing the legislation will send out a very clear message, and also shift attitudes and cultures.

Dr Allinson: Mr Speaker.
Are you aware that we already have a system whereby women who are introduced to maternity services on the Isle of Man can be flagged up as vulnerable women and get a lot more social support and help in doing that, and that vulnerability is not just in terms of coercion due to sex-selection abortion, it is due to coercion on a whole range of issues or due to their own mental health problems?

Ms Sanghera: I am not fully aware of the process in terms of what exists currently, but whether that is robust enough in terms of identification and risk I am not aware, no, I am afraid.

Dr Allinson: A final question, Mr Speaker.
Thank you very much for sharing your views, although I still would ascertain that there is a lack of evidence here, (Ms Sanghera: Yes.) and certainly the press release that was sent through today goes far broader than just looking at coercion. It goes far broader than just supporting women going through a difficult period and making a difficult decision.
I completely agree with you that what we need is support, we need independent informed consent and we need protection from coercion. However, I do not see how your organisation’s recommendations, that restrict quite dramatically the access to abortion services on this Island in the future, would achieve any of those aims. What I would say is that they would restrict access to those vulnerable women that you are actually campaigning to try and support.

Ms Sanghera: And I respect your view, but I have to say that the vulnerable women that I am talking about, who are pressured into sex-selective abortions, have very different circumstances. I am talking about the protection of those individuals and I do not think what currently exists goes far enough.
I am sorry if I am repeating myself and going round in circles.

The Speaker: Mr Robertshaw.

Mr Robertshaw: Thank you, Mr Speaker.
I just want to follow up some comments by the Hon. Member for Ramsey, Dr Allinson. I am asking these questions here to try and establish some degree of clarity. (Ms Sanghera: Yes.) Personally I have difficulties with how one handles the matter of sex-selection abortion coercion and the first trimester period, because the House, I think – and it is not for me to represent the views of the House, but one feels that the view of the House is very much moving towards the
widest possible range of choice for pregnant women in that first period. *(Ms Sanghera: Yes.)* What I am, in my own mind, trying to understand is how one reconciles the need to identify coercion in its broader sense and sex selection with that degree of freedom.

I do not want to put words into your mouth, but do you see it as somehow engaging in a process of supportive engagement with the woman in that early period to help her through possible coercion which can occur in other areas other than sex selection? Could you share your thoughts with us as to how you see that developing so that freedom of choice exists but it clearly identifies those areas where coercion and sex selection may be playing a part?

*Ms Sanghera:* Yes. In these cases, what we have been mindful of is that, where there is the coercion, the victim has not the freedom to make the choice, first and foremost, so it will be important to identify a number of things that mean our victim is being coerced into have an abortion in the grounds of the sex of the foetus. It will be important to recognise who she is at risk from, what is the coercion, how does that manifest itself in terms of the psychological abuse or the physical abuse and also to help this person understand, because one of the things that happens in these cases is our person can be at risk of a number of issues, not just of physical abuse or psychological abuse but maybe even threats by family members and the threat of disownment too. So all those pressures ... the person needs to have an education to understand this and it may be that health professionals need to be trained to be able to identify this – through their CPD, for example; it could be that – and also to ensure that you have supportive structures in place that have an understanding of what that person is going through and what coercion looks like for them within a multiple-perpetrator context. So I think you would have to have those services – which, for example, we do provide and other services can provide them – that have that deep understanding of the cultural issues and risk.

**The Speaker:** I bring in Miss Bettison at this point.

Just for the record, I have Mr Baker, Mr Harmer and Mr Hooper who have indicated that they would like to ask questions at this point.

**Miss Bettison:** Thank you.

I wonder whether you believe that by denying access either to pre-natal sex determination or access to abortions, we would stop sex-selective abortion or simply push women to take desperate unsafe measures.

*Ms Sanghera:* The family may proceed to look to other tactics, which we know happens because they will organise themselves to achieve the outcome of the abortion and there is the argument that it could go underground even more also, which we have seen with other forms of abuse. I think this is where it is incredibly important to raise awareness about the issue and also about how one can receive the right support and care.

**Miss Bettison:** So I wonder therefore whether you think that actually what we should be focusing on is education, empowerment of women and the ability for women to be able to report that through a safeguarding process, rather than actually legislation for sex-selective abortions.

*Ms Sanghera:* I think that is absolutely imperative, that we have that education and awareness, and that is a focus that I would absolutely say would have merits, without a doubt.

**Miss Bettison:** I wonder also whether you think that having clauses specifically around sex-selective abortion could lead to less open and honest conversation between women and their healthcare providers.
Ms Sanghera: I am not sure that there would because this same debate was had with regard
to the criminalisation of forced marriage and what we have seen, whereby to create legislation
to enshrine it in law would mean it would go underground and people would not report. We
have actually seen a complete shift in attitude. We have seen an increase in reporting, but more
importantly we have also seen a sheer willingness of professionals to want to train their staff,
certainly within the police forces, to recognise this and identify this. We have now, as a result of
the criminalisation of forced marriage, trained 26 of the 43 forces in the UK, and that was a
direct result of sending out that very clear message.

Miss Bettison: I wonder also whether, for me, I have concerns that if we were to legislate for
sex-selective abortions very specifically we would actually be sending out a message to our
minority communities that we do not trust them to be able to make their own healthcare
decisions and I wonder where your feelings are around that.

Ms Sanghera: This is where you have to really think about looking at this in the broader
context and looking beyond minority groups and looking at all the other issues around the
evidence that talks about domestic violence and intimate partner relationships where people
are coerced and pressured into having abortions. It is about how you look at the broader
picture, not just making this about racial profiling and how does that impact on minority groups.
I absolutely believe that is the right way, and certainly when you are raising awareness also.

Miss Bettison: So just to round up, you feel it is more about coercion than sex selection per

Ms Sanghera: What do you mean in terms of more about coercion than sex selection?

Miss Bettison: Because if we are not just talking about sex selection, we are talking about
potentially women who have been in domestic violence situations, people who have been
coerced to not use contraception, that would not actually matter on the gender of the baby; we
are talking actually about coercion, not about sex selection. Because there is a much broader
range, is what you are saying?

Ms Sanghera: There is a much broader range, but in the case of the communities that I have
supported, that is very much about gender sex selection or the preference of males to females
and being coerced and forced into aborting female foetuses.

The Speaker: Mr Baker.

Mr Baker: Thank you, Mr Speaker.

I would like to thank you for taking the time and trouble to come to the Island and help us
frame our legislation in the best way we can. We are of course trying to lay the right foundation
and the platform, not just for now, not looking backwards but looking forwards, in a context
where the world is changing significantly and also our own community is changing significantly in
terms of its mix.

My first question was very much a follow on from Miss Bettison’s, in terms of I read that
what you are saying is we have two separate logical issues here: we have one around coercion
and the second around gender selection. Both of those are interlinked in the communities that
you are most familiar with, but actually they are two distinct issues.

Could you expand on that a little bit and make it clear whether your concerns are one or both
of those, and whether they are very specific to communities that come from the Indian
subcontinent or whether they are broader than that?
Ms Sanghera: My concern would be that it is both, not just one, I would say; and in terms of the communities whereby I have seen these cases, they are South Asian communities but also Somalian communities, Kurdish communities, Afghan communities. That is where I have seen it on the helpline also.

I think what we have to be mindful of is that the family dynamic in these cases is what we are talking about, so the victim is incredibly isolated and is being coerced by a number of family members within that dynamic, and that is what you have to recognise.

So if you are going to be forced to have an abortion on the grounds of the gender of the foetus, you are being coerced by a number of family members. You do not have that without the coercion. Does that make sense?

Mr Baker: You touched on some cultural groups there. Looking wider, do you see the issues applying in, for example, communities that hail from China, for instance, or where effectively there has been a very much state-sponsored control over birth patterns and reproduction, which are obviously driven not so much by the honour and the shame aspects that you have touched on but maybe economic considerations in some cultures as well?

Ms Sanghera: I do not have experience of the Chinese community but I am sure in terms of the domestic violence context where you have looked at this broadly, there is evidence that talks about forced abortion, coerced abortion on the grounds of economic reasons, broadly speaking. So that is my experience in that context.

Mr Baker: The final one for me: there was reference from, I think, Dr Allinson or Mr Hooper about a whole new raft of legislation – of course we are contemplating legislation now, that is why we are having this discussion; in terms of the draft Bill, how feasible do you believe it would be – and I appreciate you are not a legal drafter, although the legal drafter is amongst us – to reflect your concerns within the draft legislation that is in front of us?

Ms Sanghera: I think that is a broader debate. I think there has to be something within the amendments to tackle the issue of sex-selection abortion, in my view, because what exists is not working. It is feasible and we have seen this happen in other areas. I do believe it is feasible. I think they need to have a broader conversation and I would be interested to hear the legal position.

The Speaker: Mr Baker, you are open to ask the question of the legislative drafter, if that would help.

Mr Baker: I think that would be a question Mr Connell seems interested in responding to.

The Speaker: If we just move the microphone down please?

Mr Connell: The short answer is that if it is the House’s will to include provision to that effect it is certainly draftable. It would require some careful thought and it might have some of the consequences that have been discussed in the Chamber so far, but it is certainly possible.

The Speaker: Okay, we will move then to Mr Harmer, please.

Mr Harmer: Thank you, and I would like to thank all of the guests today for their time and actually I would go back to the drafter, if I may, because I have tackled ... When you say it is draftable, would you be referring to a clause or a raft of clauses?
Mr Connell: I do not see it as a raft of clauses. I think I see it as a fairly simple rather bald proposition outlawing abortion on grounds of gender selection. I am not at liberty to tell you what I have been asked to draft, because not everybody agreed that I could circulate the amendments, but I would be astonished if something along these lines did not appear! (Laughter)

Mr Harmer: Thank you.

If I may ask, just with the second question, on which I might come back to the drafter, I think rightly it has been pointed out there are two specific issues: one is around the words ‘informed consent’ and whether that is sufficient or whether we have to have an additional clause that says ‘that does not include coercion’ because there are all sorts of social pressures which are much more insidious, with social media and so forth.

The first question is really about informed consent: do you believe that is strong enough or is it an established term that is understood?

Ms Sanghera: I do not know if you need to define it more broadly, in terms of a definition. I do not know – the drafter is looking at me!

If there has been an element of duress, how does one define ‘duress’? Informed consent in these cases is something that you would need to be able to identify, but what we understand about the victim is that there has been an element of duress and what does that duress look like? Duress: is it physical, is it psychological – not to undermine the psychological? The point I am making is it might be helpful define it and define what forms duress can take, possibly.

Mr Harmer: Thank you.

My other question is around the sex selection and looking at it the other way – because I do not think there is anybody here that would support sex-selection abortions in this House, and I think everybody would be absolutely opposed to it.

So my question really is to turn it the other way round to say, if such a clause was there making a statement, in effect would there be any ill effects or is it effectively a statement of intent to say that we do not believe …? And practically, how would you see that working because unless somebody volunteers that information you would not be able to know whether that is the reason for the abortion?

Ms Sanghera: But the statement of intent is a step in the right direction, it is about sending that strong message. But in terms of ... sorry, how that would look? (Mr Harmer: Yes.) That is an opportunity, I believe, to shift a cultural practice, to have the conversation, to have permission to talk about this. Also I have to say it may be an opportunity for a victim to compromise with their family – ‘It is against the law; you don’t want to go to prison for this’, etc. It is an opportunity to almost bargain with the family.

I say that again in the same context of a forced marriage in the UK: what we know about the law is we have seen an increase in reporting, not under-reporting. We have not seen more than one criminal conviction since 2014, absolutely, but what we have seen is a shift where victims are telling us they are able to speak with their family and use it as a compromise and say, ‘Mum, Dad, if you force us into a marriage you could get locked up for seven years, or five years’.

So the point is it gives the victim an opportunity to engage in a conversation and possibly – and I hate to use the word ‘bargain’ with their family but to open a conversation. This is about deeply ingrained practices within families that have existed for centuries and one has to create, I believe, and send out a strong message in order to give that family the law of the land and to have that conversation and the victims will be able to advocate that too.

Mr Harmer: So just to finish on that specific topic, what we are saying here actually underlines what support there is already, I believe, generally in society that sex-selection
Abortions are wrong; but also that it would send a cultural message and really have a more positive effect than any potential negative effect.

Ms Sanghera: I believe there is much merit, but you would also have to consider the support and the impact to the victim and that support would need to be appropriate – a risk assessment.

The Speaker: Mr Hooper.

Mr Hooper: I have got a question for Mr Connell, actually. All the talk so far has been about pressure and coercion and pressure to abort, forced to abort, coerced into abortion, so really we are talking about somebody not acting of their own free will.

Can you please just outline for us what safeguards and provisions there are in this draft Bill that deal with the prevention of coercion or similar?

Mr Connell: There is no specific offence in relation to coercion yet, although you will have noticed that it is one of the topics that Mr Robertshaw raised in his note. It would be possible to put something in specifically. The other aspect is that, of course, whoever is providing the service needs to establish that the woman is giving informed consent and that I think is the safeguard – that was the intention, certainly.

Mr Hooper: That is what I am getting at really. So if a woman under the proposed Bill goes to the GP, goes to a medical professional and says, ‘I would like to have an abortion’, is it up to the GP then to determine if they are providing fully informed consent of their own free will? And, if the doctor identifies concerns or issues, ‘Actually, I don’t think this person is acting of their own free will, I think they are being coerced’, would it be a criminal act then for that doctor to carry on and provide abortion services?

Mr Connell: Yes.

Mr Hooper: Right.

The Speaker: Mr Robertshaw.

Mr Robertshaw: Thank you, Mr Speaker.

What I would like to do now, Mr Speaker, is raise a point about national standards and ask both Dr Allinson and Jasvinder to contribute in the sense that the World Health Authority, having gone through their world guidelines, they specifically emphasise the importance for the development of national standards in support of abortion processes. In particular, I was drawn to a paragraph which reads:

Ensuring health-care provider skills and performance through: training; supportive and facilitative supervision; monitoring, evaluation, and other quality-improvement processes. Training should be competency based and address health-care provider attitudes and ethical issues related to the provision of safe, induced abortion.

What I would like to ask is where does the UK stand on the provision of delivering that sort of standard, and where does Dr Allinson think we are at the moment in the Isle of Man as we, as it were, bring the concept of abortion more on to our own shores?

Could we start perhaps with Jasvinder: could you identify where the national standards sit in the UK?

Ms Sanghera: I am not sure that we have that national standard in the UK in all honesty. I am not aware of medical guidelines on this, personally. In relation to where we have created
legislation with regard to forced marriage and certainly the managing and reporting of female genital mutilation, that has resulted in training and also statutory guidelines for practitioners, and that is a standard, but I am not aware of anything in this field.

The Speaker: Dr Allinson.

Dr Allinson: Thank you, Mr Speaker.
I think the original question was about guidelines, specifically in terms of counselling but also spotting coercion. (Mr Robertshaw: Yes.) There is clear guidance from the General Medical Council for doctors. That is not just in terms of sex-selection abortion but also in terms of female genital mutilation, which is another subject obviously, often to do with coercion and often, unfortunately, similar to the stories you give of people being taken to other countries for coercive and very destructive processes rather than that being provided in their country of birth and their country where they live. So the GMC gives really clear guidance to medical professionals but also the Royal College of Midwives and the Royal College of Nursing give very clear guidance in terms of counselling services for abortion services, which deal with some of the issues of domestic violence, of coercion and of mental health.

Those guidances are actually applied already on the Isle of Man. Although they do not advertise it, the Family Planning Clinic here do give guidance, indeed give counselling before abortion and use this guidance to its best ability. They also, when I have asked them, try to see women on their own to try to deal with issues of possible coercion and do it in a very humanitarian way, even though on our Island obviously access to abortion is very restricted. Again, I think the big difference in the Isle of Man as opposed to southern Ireland is that abortion is legal here and we have moved on a lot. The 1995 Act gave us legal abortion and so these counselling services since 1995 have evolved, although actually access to abortions on the Isle of Man is very restrictive and most women have to go off the Island, but an awful lot of counselling actually goes on on the Island to women, although they cannot provide the services.

Mr Robertshaw: Thank you very much.

Thank you, Mr Speaker. That brings my questioning of Jasvinder to a close, but I would like to thank her enormously for attending today and wonder have you any closing remarks before the Committee moves on?

The Speaker: Next question, Mrs Beecroft.

Mr Robertshaw: I beg your pardon.

The Speaker: Oh, sorry, did you have another question?

Mr Robertshaw: No, please.

The Speaker: Okay, Mrs Beecroft.

Mrs Beecroft: Thank you, Mr Speaker.

It was just really a very quick one to see … It goes back to the coercion and the forced marriage and all the different things that are within other cultures that we really do not see here. We are really not aware, but we should be aware of the coercion angle and one that strikes me, probably because of my age group – a lot will forgive me, they will not remember it – is that when you found out you were pregnant when you were say a teenager or in your early 20s, in my age group, people went, ‘Are you happy about it?’ That is the first thing that they said. And you went, ‘Oh, I’m not sure yet,’ blah, blah, blah. Nobody said, obviously, then, because you could not, ‘Do you want an abortion?’ but there were pressures put on people and
things like, ‘If you don’t have it adopted, what sort of life are you going to give that child?’; ‘If you don’t go away and have an abortion, what sort of life are you going to give that child?’ There was an awful lot of peer pressure put on you, and if your family found out – which they usually did because it is a small community, again which has its benefits and things against it – they were putting pressure on you. It was not that they were trying to force you to have an abortion that you did not want, or force you to keep a child that you did not want; they were trying to do what they thought was best for you, but it was still coercion. How do we actually get round that? How have you found ways of getting round what I would call more ‘friendly’ coercion – coercion with the best intent, but it is still coercion?

You still come across people now who gave up their babies and they do not know where they are now, they are heartbroken now and it is really sad. That should not happen in the future. We are taking choice, again, away from women if we are going to go down that pathway where we are going to allow subtle and gentle coercion for the best of intent. We have to be sure that does not happen.

_Ms Sanghera:_ May I? What one has to recognise about the victims that I represent, and in my own personal experience as well, is we do not even recognise coercion sometimes because this is our family – our nearest and our dearest, that we love and we trust – doing this to us. So, very often we require somebody to step outside and enable us to see that coercion. We will minimise the risk, we will undermine them because this is our family. And an additional layer on top of that is that we have been brought up to believe that this is justified because it is part of our culture and our tradition and somehow our religion. So you have all those things on top of you that make you feel bad, guilty; you feel a sense of shame. So, actually, coercion is something that is subtle, it is conditioned over time, there are the societal pressures. I accept the point you make about they are acting in your interests, I understand that, because to give birth to yet another female when you have got four daughters already, your family will say, ‘We want a boy to carry on the line. How will people see this family? You still haven’t given birth to a son. That makes you a bad daughter-in-law.’ And all the other things.

From personal experience I can tell you that my parents disowned me when I was 16. I have been disowned for 37 years of my life, as have my three children and two grandchildren. I absolutely forgive my family for what they did to me because I understand they were only doing what was right, what was best, what they saw from their generation. That has to shift and that has to change for today’s generation. What you are doing here today is about the future. Your country will look very different 10 years from now, so you are doing this to shift a generation and to help a future generation.

_The Speaker:_ Mr Ashford.

_Mr Ashford:_ Thank you, Mr Speaker.

One thing you just said there which I found quite interesting is that families do not always necessarily recognise it as coercion because of cultural experiences, and also it can be subtle and also controlling and conditioned. Can I ask, then, would you accept that obviously in legislation you can write any provision in, really – I can see Mr Connell pulling a face there, but in theory you can – but what has got to happen is it has got to be workable so that it meets a proof in a courtroom if you are going to be able to prosecute someone.

So would you accept that the main thing around sex-selection abortion to meet that burden of proof is going to be the coercion angle, and the people who are most likely to identify that where it would meet the burden of proof for prosecution in court are going to be the medical professionals themselves, and that is already covered by section 9 of this – that it is highly unlikely that there are going to be family members, again because of culture and everything else, that are going to come forward of their own volition, take it through the process and get a
successful prosecution? And is not the current situation in the UK proof of that, that as far as I am aware, there have been very few successful prosecutions in this regard?

Ms Sanghera: Well, there has been a prosecution, but I have to say also in the consultation of whether to criminalise or not there were testimonies of many survivors who said they would have criminalised and they would today if they were given the right support, protective measures and special measures within the court process. So it was very much about their lack of confidence in the process and not being understood and supported.

So I think yes, I accept the GP perspective, but also you will have a victim perspective here. If that person is supported appropriately and encouraged to access their rights and choices, then maybe you will have a witness who is willing to engage here, and I do not think we should remove ourselves from that either.

Mr Ashford: But isn’t that being provided at the point they go to the medical practitioner, and that is covered by section 9 of the Bill that is already in front of the House?

I do have one final question and it is for Mr Connell. It is hopefully a nice simple one, but then again some of the things I ask are never simple! Can I ask Mr Connell ... He made a comment before that it was draftable. Would he accept, although he did pull a face a few moments ago, that pretty much, in terms of legislation, anything is draftable but the fact that it is draftable does not make it workable?

Mr Connell: That was going to be my point. One can draft just about anything, but producing something that works in the context of law raises other issues because the law is a fairly blunt instrument with black and white. It does not cope very well with grey, except by reference to things like reasonableness, which most Members of this House seem to dislike precisely because it introduces shades of grey in terms of judgement.

It would be possible to produce something that addressed the comments that have been made in terms of what I might, for the want of better terms, describe as honour abortions and to make provision for it. How effective it would be would depend upon the willingness of those who are charged with prosecution to actually institute proceedings, and they might have a reluctance to do so. I cannot really say much more than that, I do not think.

The Speaker: Mr Quayle.

Mr Quayle: Thank you very much.

If I could address my comments first to Jasvinder, please. For Members’ attention, I am making an amendment based on the termination of pregnancy on the grounds of sex of the foetus, which I am more than happy to be shared and I think I have told Mr Connell that.

If anyone wants to look at the debate in the House of Commons in 2015 when this was debated, it was called ‘new clause 1’ but it only stated that you could not have a termination because of the sex. There was no exclusion and I am proposing to put an exclusion in, which I think would have got through the House of Commons.

I am putting a subsection in which precludes the termination of a foetus purely because of its gender, but subsection (2) makes it clear that if, for example, the family history indicates a predisposition to a genetic disorder particularly associated with one gender rather than the other, a termination of a foetus of that gender would not be precluded. That sort of Huntington’s dreadful disease would then be allowed and the medical profession would be able to do that.

I think if that had been moved it would have got through. The vote was 201 to 292, so it was relatively tight.

What concerned me at the time is that on 7th October 2013 the Director of Public Prosecutions, Sir Keir Starmer, said:
The law does not ... expressly prohibit gender-specific abortions ...

That is regarding the Abortion Act 1967 – it was unclear. I know our legislation is fairly similar to that and I just feel that we need to have clear legislation that does state that it is not acceptable on the Isle of Man to have an abortion on the grounds of the sex of the foetus. So I was just wondering if Jasvinder would be able to comment on the clause I am wanting to take, where it says: ‘Nothing in sections 6 or 11 is to be construed as permitting a pregnancy to be terminated on the grounds of the gender of the foetus.’ With the amendment that I have done to allow for medical, genetic ... coming down, would that have been acceptable, do you think, to the organisation you represent?

Ms Sanghera: I would say so, yes, absolutely, because it goes back to the law being used to send out this message also and it gives us an opportunity to raise awareness and educate. If you look at female genital mutilation, we have not had one criminal conviction of female genital mutilation; however, what you have seen is an increase of awareness and more reporting as well. My hope is that this will also achieve the same outcome for the victims.

Mr Quayle: If I could just ask Mr Connell, please, sir, to comment. The clause that I have asked you to work, which as I say is free for all Hon. Members to see, would it clarify that the law is explicitly stating that the termination of pregnancy on the grounds of sex of the unborn child would be illegal? Would it clearly clarify that, whereas before it might not be clear?

There is a phrase, ‘the rule of law is as long as the Chancellor’s foot’, and therefore whoever is interpreting the case will decide one way or the other, but if we come up with a clear clause in this Bill, will that send out a clear message to the interpreter of the legislation that we do not believe the termination of pregnancy on the grounds of sex of the foetus is acceptable?

Mr Connell: Subject, obviously, to the exception that you have indicated, I believe it would be helpful to include such a provision, but of course it is a matter for the House. It is not a matter for me at the end of the day.

Mr Quayle: But it would make it clear, my question is.

Mr Connell: Yes, indeed, sir.

The Speaker: Can I just ask on that point, Mr Connell, where the burden of proof would lie in that matter?

Mr Connell: It would lie on the Crown to establish that the medical practitioner did not believe that genuine consent existed. That is the problem.

The Speaker: Thank you.

Mr Quayle: I am sorry, I had one more question, Mr Speaker.

The Speaker: Sorry, Mr Quayle, my apologies.

Mr Quayle: Jasvinder, sorry, I forgot one. I do not know if you are aware of it, but if you could confirm if you have heard of this. In 2012 The Daily Telegraph carried out an investigation under cover, where they had filmed three doctors offering to arrange terminations as a result of the gender of the foetus. Would she not agree that there is evidence out there that shows that this is happening underground and it needs to be clear, and if you have got Sir Keir Starmer saying that it is unclear, the Abortion Act 1967, then clarity surely must work?
Ms Sanghera: Absolutely, I am very aware of the underground report. This goes back to the point I made earlier that this is serious and organised, and family members, those individuals who are pressuring, will organise themselves to achieve the intended outcome of a forced abortion on the grounds of sex selection. And so the report does not surprise me whatsoever and I think that is just a snapshot of a bigger picture that we have yet to see. I believe that clarification will enable more people to come forward and educate people for us to see the extent of the problem, which is what we have seen with other forms of abuse.

The Speaker: Are you content, Mr Quayle?

Mr Quayle: Thank you.

The Speaker: Mr Hooper.

Mr Hooper: Actually, my question is along very similar lines to the last one from the Chief Minister. In your own experience, do you have any personal experience or any shared experience where there have been GPs or other medical practitioners in the UK that have carried out sex-selection abortions but where they were aware that the individual had been coerced or where they suspected the individual had been coerced and had gone ahead and carried out the procedure anyway?

Ms Sanghera: I do not have any experience of medical professionals carrying out the practice where they knew that it was a coerced or a forced abortion, but Dr Sudhir Sethi, the paediatrician, I would refer to his work where he has held consultations and events in Leicester, where he has real concerns about people coming into his practice who have openly said, ‘I’m having a daughter, I don’t want to have a daughter, my family are pressuring me,’ and in his opinion he believes that some of these women have disappeared and been taken out of the country to have those abortions.

The Speaker: Mr Baker and then Mrs Beecroft.

Mr Baker: Thank you, Mr Speaker. My question is to Mr Connell. He made reference previously to points around the enforcement of law, saying that it can be difficult to enforce and the ability to prosecute depends on the willingness of parties to actually bring a prosecution. Can I ask him does he believe that just because something is difficult to prosecute, whether he believes or not that means you should not put it in the law?

Secondly, is it any different from any other situation that actually requires a willingness to prosecute in order to prosecute?

Mr Connell: The answer, sir, is emphatically not.

I would be very happy to put the provision in if that is the will of the House. Its enforceability is not for me, it is for other members of Chambers and it would obviously be ultimately for the Attorney General to decide whether he thought a prosecution was in the public interest. But in order for a prosecution to be in the public interest you have to remember that we have to get over the threshold of the 51% test, which means we have got to have a reasonable prospect of securing a conviction at the end of the day.

Mr Baker: But for the avoidance of doubt, that does not mean it should not be written in the law?

Mr Connell: Oh, no.
The Speaker: Mrs Beecroft.

Mrs Beecroft: Thank you, Mr Speaker.

Again, I think this is probably one for Mr Connell, but I am not 100% sure.

Everybody would be against an abortion based on the sex of the foetus; I mean that is a given in here. Obviously an amendment, by the Chief Minister or anybody else, will be welcome, to put that in. The concern I have is when Huntington’s is brought in and with it being so specific. I am not medically qualified, I do not know how many other conditions, diseases there are similar to that. Is it a slippery slope that we would be going down? It just made me feel a little bit, shall we say, nervous about it, without knowing more detail and certainly having some more advice on that particular aspect.

Mr Connell: I think I am not the person to ask about which diseases are appropriate in terms of the exception. Dr Allinson might be in a better position to answer that one than me, but certainly it is possible to construct an exception – and I have deliberately framed it in general terms rather than by reference to specific conditions to avoid this sort of complication.

My intention in drafting the Chief Minister’s amendment – and I am afraid I have not brought it with me, it is the one page that did not print off; that is the certain gentleman’s law, isn’t it? – was to ensure that where there was good medical evidence that genetic predisposition was a genuine factor in terms of disease, that the general bar on sex selection should not preclude the termination and obviously what is genetically related is an evolving field. People have discovered that genetics change over time. It is not a static field. So that is one of the reasons why I did not want to put in a list which identified particular conditions and I certainly have not mentioned Huntington’s disease in the draft. (Mrs Beecroft: Okay.) If that reassures you, madam.

Mrs Beecroft: Thank you, Mr Speaker.

Yes, that certainly goes some way to helping.

Part of the problem is I think it is not just medical, because the insurers are watching all these things with great interest to see who they can say, ‘Oh, we are not going to insure them,’ from day one. But from a medical point of view – I do not know if Mr Fayle has any words of wisdom that he could add to that or help. If he has I would be grateful and if not –

Mr Fayle: About sex-linked diseases, you want to know?

Mrs Beecroft: Yes, about the possible genetic ones that can be determined before birth, as we have been talking about.

Mr Fayle: I am sure it can be drafted in appropriate terms so that you can terminate the pregnancy for any sex-linked diseases. These are diseases specific to certain sexes and if you can do that then, as long as you are not preventing the terminations for those groups of diseases, it should be fine.

On the issue of gender selection, I started training in 1983 and I retired in 2016; I was approached once with regard to a termination for sex selection. I told the person to forget it – no chance. We have heard on the issue of coercion and I suspect if sex selection is going on in the UK they are not coming directly to the doctor and saying, ‘I want it on the basis of the sex of the baby’; it will be for another reason. So it is about training for the staff to recognise coercion and how to deal with it and support the woman who is under that pressure – and that pressure can be tremendous. I think it does occur, but the people who are being coerced are coming and asking for it on different grounds.

The Speaker: Mrs Beecroft, are you content?
Mrs Beecroft: Sorry, yes, thank you.

The Speaker: I have Mr Hooper and then Dr Allinson.

Mr Hooper: Firstly, a question for Mr Connell. He talked about the burden of proof in these circumstances. Essentially, we would be criminalising the medical professional who carries out the procedure; the woman requesting it obviously would not be criminalised – section 13 of the Bill specifically says that it will never be a criminal offence to incite and induce someone else to provide you with the services. Sorry, section – yes, you know what I mean. (Laughter)

So we are criminalising the GP, so we are actually putting the burden on the medical professional to say, ‘No, I won’t do this’. If the medical professional does it they will most likely be struck off as a medical professional, if they do perform a sex-selective abortion. Do you see then any advantage in adding this extra legislative layer, seeing as we already have that effective regulation of the medical profession by the various supervisory bodies?

Mr Connell: I am going to duck that one. That is a policy question.

The Speaker: I was just about to save you having to say that, but well done. (Laughter)

Mr Hooper: Thank you very much. In which case, I would like to ask exactly the same question to Mr Fayle actually. Do you see that actually the regulation by the professional bodies within the medical space, the GMC, the Midwifery Council –?

Mr Fayle: I would expect that any doctor who did it specifically for gender selection would appear before the GMC and I would expect them to be struck off.

Mr Hooper: Thank you. So do you see then any real advantage in adding an extra layer of criminality to that by specifically saying sex-selective abortions are illegal, when as you have already admitted, if I am going to approach a medical practitioner for a sex-selective abortion I am not going to tell you that is the reason I am asking for it?

Mr Fayle: I can give you my point of view from somebody who has worked on the shop floor.

Mr Hooper: Yes, that is all I am after.

Mr Fayle: I think the GMC certainly would police that and you would not get away with it from the GMC. From my point of view, the issue is about coercion to have terminations and you see this a lot over the issue of termination. You will recognise it in most cases, but I think the issue for the Isle of Man is we are not very diverse here and it is recognising coercion in the different circumstances and recognising some of the subtle coercion that occurs.

I think it is not for me to say whether it should be in the Act or not; that will be for Keys to decide, but I do not see an advantage, from my point of view as a doctor, in having it criminalised. But I can accept Jasvinder’s argument that to have it clearly stated that we do not support specific gender selection would be an advantage.

The Speaker: Dr Allinson.

Dr Allinson: Thank you, Mr Speaker.

I would like to come back with one statement that was made by the Chief Minister in support of his proposal amendments, that Keir Starmer had made a statement in 2013. In 2015 actually, the GMC and the BMA both judged that abortion solely on the basis of parental preference for...
foetal sex where there is no health implications would be against the 1967 Act. So I think they
did lay some quite strong guidance for that.

I would also just like to come back to Mr Fayle, just for clarification. You said that during your
long and quite distinguished career you had been approached once for sex selection; was that
on the Island or across?

Mr Fayle: That was in the mid-1980s in England. (Dr Allinson: Thank you.)
I have never been approached on the Isle of Man, never.

The Speaker: Hon. Members, we are going to proceed thematically and I just want to make
sure, at this point are there any more questions specifically relating to coercion and sex
selection? I think we have given that –

Mr Cregeen.

Mr Cregeen: Thank you, Mr Speaker.
If I could just ask Mr Fayle a question of what training is currently in place to recognise
coercion and would you consider that training should be put in place prior to any change in the
law so that we are not in a situation that the law is behind the protection of what we are trying
to put in place?

Mr Fayle: There is training with regard to domestic violence and recognition of domestic
violence within the clinics. I am not aware of any specific depending upon racial origin and any
specific training in that area.

I think it certainly would be of benefit, but again I would have thought that is not something
for legislation.

Mr Cregeen: A follow-up. Dr Allinson has said the Medical Council, it is in their guidance and
all this, but if it was in the legislation to make it criminal ... Can the GMC put in an imprisonable
offence for a doctor to act outside the guidance, or will that be something we need to put in the
legislation? Because no doubt you could be struck off, but it may not include an imprisonable
offence for what they have done? Is that the case?

Mr Fayle: I do not think the GMC could imprison you! (Laughter)

Mr Cregeen: Mr Speaker, that was my point.

Mr Fayle: The ultimate is that you would be struck off –

Mr Cregeen: That is my point.

Mr Fayle: There are various things that can be done less than that, but the ultimate is struck
off, but it is not a criminal offence.

Mr Cregeen: I think that was my point, Mr Speaker, that by putting it in the legislation, if they
do commit this then it becomes a criminal offence, rather than just a professional
misdemeanour.

The Speaker: Mr Quayle, you had another point to bring in before we move on.

Mr Quayle: Yes, sorry, it was just to Mr Connell, just a clarification. Is there a disadvantage of
moving an amendment that makes it clear that the Isle of Man does not stand for the abortion
of a foetus based on gender selection? There seems to be an inference that if we do this, then it
is going to make things really bad on the Isle of Man. I just wanted to see is there anything that
would cause a problem on the Isle of Man if my amendment was to be successful?

Mr Connell: I do not believe so.

The Speaker: We will move on then to our next topic and I think we will move on next to
disability rights and selection in that area. I will ask Mr Robertshaw to start the ball rolling in this
particular area.

Mr Robertshaw: Thank you, Mr Speaker, and may I welcome and ask that we acknowledge
Lord Brennan QC’s presence this morning. Thank you very much, sir, for coming. Clearly, the
bomb in the Thames has been dealt with, I assume, as you are here with us.

Mr Speaker, Lord Brennan is a most eminent and highly experienced barrister and described
as Barrister of the Year at one stage in The Lawyer magazine. I have invited him today because
he has a real special and long-standing interest in a number of the themes that we are
concerned with in our discussion this morning. So, with your permission, sir, I will commence.

Lord Brennan, I would ask you about clause 6(5). During the Second Reading debate on
30th January one of the MHKs thanked the Bill author for meeting him to confirm that a cleft
palate or clubfoot would not be defined as having significant physical or mental impairment. I
am pleased that it is not the intention that this legal drafting should open the door for abortion
on the basis of cleft palate or clubfoot between 14 and 24 weeks.

So, given the formulation of clause 6(5), however, will that actually be the effect, sir?

Lord Brennan: Mr Speaker, Members of the Committee, greetings and good wishes from the
House of Lords to the House of Keys.

Answering the question: the clause that deals with this in the draft Bill is 6(5) in terms of pre-
24th-week abortions. The phrase used is:

a significant physical or mental impairment which – will have a seriously debilitating effect on the child;

That is not all that different from the British Act, but the fact is that by 2016 figures for that
year, nine abortions were recorded because of cleft palate up to 24 weeks in England and Wales;
and as to congenital malformations, 100 up to 24 weeks, and nine after 24 weeks. So whatever
the legislature thought it was intending, the fact is, without real clarity, the law in practice may
result in that which you did not wish to legislate for.

So, some suggestions – it is for you to legislate and draft. The first is the clause itself: if you
look at clause 6(5) and after the words ‘applies if’ inserted ‘, on objective and reasonable
consideration,’ the foetus will be affected. I cannot think, on that phraseology, it could be
plausibly argued objectively and reasonably that an abortion would be justified for a cleft
palate – or a clubfoot if it can be properly managed and having regard to the signs on the scans.

Next, you could – and I do not want to draft too much for a lawyer, it is a terrible
temptation – but the next couple of points are: it is very important, isn’t it, that in your 1995
legislation it operates on the basis of two doctors, the surgeon who does the abortion plus
another practitioner, and that goes right through the Bill; whereas in this Bill, in this section, the
decision up to 24 weeks on a medical basis is one doctor? Why the difference?

The next point is, the argument could be advanced that to apply that kind of terminology to a
cleft palate or clubfoot, which could be remedied by prosthesis and so on, the view of the House
of Keys was at debate on such an amendment or such an issue, everybody or two-thirds or
three-quarters were against abortions for cleft palate or manageable congenital conditions. I do
not know what applies in the Isle of Man legally but in England and Wales the Supreme Court
can apply a principle called Pepper v Hart and if there is an ambiguity between the legislation
and the facts as to how the legislation should be applied, you can look at the proceedings of the House of Keys and clearly establish nobody intended it to be read that way. So, ideas there.

Definitions you can try: ‘significant impairment’, ‘seriously debilitating’ are all vague phrases – even medically they require some definition. That is a task I think you need expert advice on. But those are ways of trying to deal with avoiding that occurring which you do not want to occur, which I think would occur.

The Speaker: Perhaps this would be an appropriate point to bring in Mr Connell on the Manx equivalent of Pepper v Hart.

Mr Connell: Well, for good or ill, the doctrine in Pepper v Hart with which I am familiar from my previous practice in HMRC Solicitor’s Office because it was a tax case on the construction of benefits in kind, funnily enough, and it was decided by the House of Lords – an enhanced House of Lords’ judgment because it was a panel, I think, of seven – that where the legislation was ambiguous the House or the Court deciding the point could refer to the proceedings of the House of Commons and to speeches made by the mover of the relevant proposition in order to work out what the provisions meant.

For good or ill there is a decision by Deemster Kerruish, and I have not got the citation, where he said that the similar approach should not be adopted here. I do not quite know what the rationale for that was, but he decided that Pepper v Hart should not be applied here. I am quite sure that were a decision to go all the way to the Privy Council, they would actually look at the proceedings of this House on the same basis as they look – wearing their other hat, as the Supreme Court – at the proceedings of the House of Commons in appropriate circumstances.

But of course you have to remember that the first test in Pepper v Hart is, is the legislation ambiguous on its face? If it is not, you do not get past first base and you therefore cannot refer to the proceedings of the House in any event.

The Speaker: Mr Robertshaw, continue, thank you.

Mr Robertshaw: Thank you.

Lord Brennan, I would now like to ask you about clause 6(8)(d)(ii) of the Bill which deals with terminations on the basis of disability between 24 weeks and full term.

Clause 6(8) allows abortion up to birth for certain circumstances. The decision on whether these circumstances are met is made by a registered medical practitioner in good faith and ‘after taking specialist medical advice as appears to the practitioner to be appropriate’.

At Second Reading, Dr Allinson said:

All late terminations after 20 weeks are routinely seen across at an English specialist foetal medicine unit

In your view, does the working in clause 6(8) require a second opinion?

Lord Brennan: If Members looked at clause 6(8) you will see that in the beginning of the first few lines it talks about the ‘registered medical practitioner’ and then says about him or her, that that person ‘after taking such specialist medical advice as appears to the practitioner to be appropriate’. So it is giving the doctor the choice to take advice as he or she thinks appropriate. It does not, on its face, require it to be taken regardless.

Mr Robertshaw: So do you find that a weak position?

Lord Brennan: Sorry?
Mr Robertshaw: Do you find that a weak clause in the Bill? Do you feel that it should be strengthened?

Lord Brennan: I must say I was surprised by looking at this Bill compared to our Abortion Act and the 1995 Act as to why there was an apparent shift away from two practitioners to one. Why?

Mr Robertshaw: Thank you.

Lord Brennan: It is a difficult question to answer but it is one which is put in the Act in both our jurisdictions, I think to satisfy our electorates that what was going on was a highly serious, profound decision process in which several minds are better than one.

The Speaker: Mr Hooper, you wanted to come in on that point?

Mr Hooper: Yes, I was just wondering, do you accept that clause 6(3) – which is the subsection on which the rest of these subsections rely in their entirety – actually has a requirement for the medical practitioner to be acting in good faith – which means the burden of proof would be on the medical practitioner to prove that what they did was in good faith; and that somewhat negates the need for the amendment that you mentioned earlier about things being objective and reasonable, because actually the doctors will have to be able to demonstrate that they acted in good faith if there was ever a challenge to what they have done, which would require there to be an objective third party to make that call?

The same really goes for subsection (8) where you are talking about ‘after taking such specialist medical advice’, whilst it gives the doctor the choice they are still required to have acted in good faith, which means they cannot intentionally go out to harm someone.

Lord Brennan: Well, I am not sure that the phraseology in section 6(3) actually deals with the question, because it says ‘if the registered medical practitioner attending her is of the opinion’ – that is his medical opinion – any of the following factors apply. ‘Formed in good faith’ is a matter of bona fide as it does not necessarily import medical competence in the making of the decision.

So I think that the points I made before continue to apply and the rhetorical question is: why not two doctors? If it has been good for the last 50 or 60 years in England and Wales and here for the last 20-odd years, why the change?

Dr Allinson: Thank you, Mr Speaker.

Thank you, Lord Brennan, for coming to answer some of these very difficult questions.

The reason the 1995 Isle of Man Act brought in the two signatures was that very much at the beginning it was copying some of the 1967 Act. Would you say that one of the perhaps flaws of the 1967 Act was that it did not repeal the Criminal Code and therefore the need for two signatures by two doctors was perhaps to protect the doctors themselves from prosecution, rather than necessarily protecting the woman from the wrong decision?

Lord Brennan: That may have played some part in the process but I think I ought to remind the Members of the Committee that under the Abortion Act the doctors involved in these decisions – not in your proposed draft but in England and Wales – are required to note the circumstances at the time, adequately note, so they can refer back to it, and there is actually a criminal penalty in the 1967 Act for failure to do that by a medical practitioner.

So the point, I think, is to invest the decision-making of two doctors with historical significance – ‘We advised or concluded this because …’ – which gives them the opportunity
briefly, not at length, to explain objectively and reasonably their view and why they took the
view they did.

**The Speaker:** Mr Connell, if you want to come in on that, and then I have Mr Baker and
Mr Hooper also seeking a bit of clarification on this particular issue, I understand, sir.

Mr Connell.

**Mr Connell:** By way of slight clarification, can I draw your attention to clause 15 of the Bill,
which provides:

(1) The Department must make regulations —
(a) requiring any registered medical practitioner or other healthcare professional who terminates a pregnancy —
(i) to record the reasons for the termination and its circumstances (including which of subsections (4) to (8) of
section 6 apply); and
(ii) to give notice of the termination and such other information relating to the termination as may be prescribed;

That is to secure the recording of the reasoning, albeit of one doctor but it is required to be
recorded in the same way that it is required in England, and that is for the exactly the reasons
that Lord Brennan has given.

**The Speaker:** Mr Baker.

**Mr Baker:** Thank you, Mr Speaker.

My point is regarding clause 6(8)(d)(ii):

(d) there is a substantial risk that, were the child born alive—
... (ii) the child would suffer a significant impairment which is likely to limit either the length or quality of the
child’s life.

That, to me, seems an extraordinarily broad definition, which pretty much would allow any
condition to be interpreted in a way that complied with the clause and effectively gives carte
blanche to the termination of any unborn child or foetus which is not perfectly formed.

**Lord Brennan:** If I may, Mr Speaker, just clarify the last point ... I am happy for Mr Connell to
amend me. I have got a pile of stuff here which I have been trying to get on top of. I think my
essential point was directed at Dr Allinson’s point about some of the motivations in the original
Abortion Act, about two doctors and notes. My point essentially was notes and penalties in
respect of two professionals, not just one, so I am happy to accept the correction in that regard.

The question which has been posed now about clause 6(8) is a similar line of analysis to that
that arose under 6(5). What does ‘significant impairment’ mean? What does ‘likely’ mean in the
context of limiting length? What do we mean by ‘length’ here – years or decades? What do we
mean by ‘quality’?

The disability community – I do not know about the Isle of Man but certainly in England and
Wales – are very concerned about this because they are wanting the disabled to be dealt with
on a very positive basis and the UN Convention on this, which I know does not apply to this
territory, makes it very important to consider phraseology like this when you are considering an
abortion in respect of disability.

So I think that the same considerations arise, and because it is after 24 weeks it makes it
exceptionally important, in my view, that you have two doctors and they are independent. I
noticed with interest – I do not know whether some of the Members have picked it up – in the
1995 Act, the House of Keys, in saying that there had to be a reference to a second independent
medical practitioner, in section 6 set out a pile of provisions: ‘but not a doctor who is closely
connected with the first doctor’ in half a dozen different ways, or institution; in other words,
properly independent. Why can’t the same continue under this Act, if was thought appropriate then – especially for this post-24-weeks stuff?

**The Speaker:** Are you content, Mr Baker?

**Mr Baker:** I am trying to think.

**The Speaker:** Perhaps if I bring in Mr Hooper with a point on this as well and then I will give you the chance to come back before I continue with Mr Robertshaw.

**Mr Hooper:** Again, it is just picking up on that same clause 6(8)(d)(ii). Obviously, our Act – the proposed Act, rather – talks about ‘a substantial risk, were the child born alive’ that they ‘would suffer a significant impairment’, whereas the UK equivalent simply reads:

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.

I am just wondering if you could possibly expand on where you see the differences are between the UK wording and the proposed wording in our Bill. To my mind, our Bill has much more specific requirements because the disability has to have an impact on the quality or length of the individual’s life, whereas the UK Act does not have that requirement; it simply says if you are seriously handicapped.

**Lord Brennan:** Well, the comparison that you have just drawn is between section 6(8)(d)(i) of this draft and what is in the Abortion Act, but I understood the questioning on this theme to be directed at 6(8)(d)(ii). The first one refers to the child being likely to die because of foetal complications. The 1995 Act:

(i) unlikely to survive birth;
(ii) unlikely to be capable of maintaining vital functions after birth; or –

**Mr Hooper:** Sorry, I think there has been some confusion. I am specifically talking about (8)(d)(ii), which is in reference to the length and quality of an individual’s life should they be born with a significant impairment, compared to the UK Abortion Act 1967, clause 1(1)(d), which specifically references ‘a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped’.

The UK Act does not then go on to specify ‘and this handicap must also impact on the quality or length of the individual’s life’, whereas our proposed Bill actually does add those extra criteria. It is not simply enough for an individual to be at risk of being seriously disabled; there must also be the requirement that that disability has a knock-on effect on their length or quality of life.

I am just wondering if you could comment on the comparison or the difference between the two Acts.

**Lord Brennan:** I apologise, I misunderstood what you were directing the question at.

If I go to the 1967 Act, ‘substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped’, this one within your draft is referring to ‘limit … length or quality of the child’s life’. I do not understand ‘likely to limit the quality of the child’s life’ to be synonymous with ‘seriously handicapped’.

**Mr Hooper:** Sorry, the synonym would be ‘significant impairment’ versus ‘seriously handicapped’. They are the two … phraseology. Our proposed Bill talks about a ‘significant impairment’; the UK Act simply mentions ‘seriously handicapped’. They are the two
comparators. But then our Act also goes on to add the extra criteria about the likelihood of limiting the length or quality of life.

I am just wondering if you feel the UK ... What I am basically getting at is do you feel that describing it as a significant impairment is in any way weaker than the UK’s use of the phrase ‘seriously handicapped’? Is there a difference?

Lord Brennan: If you are a lawyer, I will ask your forgiveness; if you are not, you ought to be one! (Laughter) (Two Members: Hear, hear.) You are elegantly luring me down a line which I do not really accept. (Laughter) (Mr Hooper: Unintentionally.)

It is not a question here of just changing the phrase or word; it is the conceptual approach of the legislation. If you note in our Abortion Act, ‘substantial risk ... it would suffer from such physical or mental abnormalities as to be seriously handicapped’, seriously handicapped means seriously handicapped, if you will forgive me for making that unnecessary emphasis of the words. In this instance I do not read into that phraseology a concept of significant impairment, that is not the same as seriously handicapped, and I do make a distinction between ‘seriously handicapped’ and a phrase like ‘quality of the child’s life’. What does ‘quality’ mean when it is in a disabled context here?

This is why the disabled in our community get so excited about this kind of terminology. I think the idea that they put forward and which appears to be reasonable is if you are talking about this degree of handicap, make it plain what you are talking about; don’t use words that might work their way into the disabled world and be used in subsequent and different legislation to change the concept of ‘seriously handicapped’ into something like ‘significant impairment’.

Mr Hooper: Okay, if I could ask the actual lawyer in the room, Mr Connell –

Mr Connell: One of the actual lawyers.

Several Members: One of them!

Mr Hooper: – if you would actually comment on the same thing, really: whether you do see there being a substantial difference, or a meaningful difference, between the phrases ‘significant impairment’ or ‘seriously handicapped’.

Mr Connell: I deliberately avoided the word ‘handicapped’ for the obvious reason that it is, dare I say it, old speak, completely inappropriate in disability legislation in the modern context. I had to avoid it when we were drafting the Equality Bill for the same reason, and in using ‘impairment’ I was trying to convey the same idea. That said, I accept that perhaps ‘significant’ is a lower threshold than ‘serious’, but that is the point where I would agree with Lord Brennan that perhaps we might need to change the wording.

As to ‘limit the length or quality of the child’s life’, that was a policy question and Dr Allinson is the person who can answer it.

Mr Hooper: Thanks.

The Speaker: Next up I have got Mr Harmer.

Mr Harmer: Thank you.

I just want to drill down into this because I have to say on the whole legislation, clause 6(8)(d)(ii) is the one that I really am worried about and how at the moment this ‘significant impairment’ could be used, and also about the ‘quality of the child’s life’ because quality does not necessarily refer to physical handicap – it can refer to social circumstances in
the family. So I am trying to understand the purpose of that clause and actually, in your opinion, how wide could it be used considering the fact that actually at 24 weeks a foetus is viable?

**Lord Brennan:** A very important question, and assuming my stance as an England and Wales lawyer and not an Isle of Man lawyer, the word ‘handicapped’ is still in the Abortion Act, which has been amended many times, as recently as 2012, obviously I think for the deliberate purpose of indicating the degree of severity of the condition which is being looked at in the Act.

But I wonder what the House, when it is determining this in Committee ... What are you going to say to yourselves? What does it mean, ‘significant impairment’? And what does ‘quality of the child’s life’ mean? Is it social circumstances; or as one would have thought here, if it is post 24 weeks it must be some medical circumstance to justify the abortion?

This is where two doctors become very important and it is where I think in due course the Committee should be astute about terminology post 24 weeks. I think Dr Allinson himself said at the Second Reading debate how seriously that time for abortion is treated by everybody, and if it is that serious then the terminology should reflect post-24-week abortion, if that is what the House wishes to pass.

**The Speaker:** Just seeking guidance from Mr Robertshaw, are you supplemental to this or are you moving us on to another topic? I have Miss Bettison and Dr Allinson both on this particular area.

**Mr Robertshaw:** Well, can we continue that way then, Mr Speaker. I have got one more question in this heading before we move on, so if you want to stay in this heading, please.

**The Speaker:** Thank you.

Miss Bettison next, please.

**Miss Bettison:** Thank you.

You mentioned before your concern about the reduction throughout the Bill for a requirement of two healthcare professionals down to one. I wondered if you are aware that the Royal College of Obstetricians and Gynaecologists found no compelling reason for abortion being the only situation where a competent woman requires permission from two third parties to make a personal healthcare decision.

**Lord Brennan:** I was not aware of that. All I can say by way of reply, as a lawyer and a parliamentarian, is that up to 2012, the last amendments of the Abortion Act, seven or eight Acts amending it, nobody in Parliament thought it appropriate to change from two to one.

**Miss Bettison:** And I wonder if you recognise that obtaining two doctors’ signatures actually causes unnecessary delays to women accessing abortion services.

**Lord Brennan:** Well, I would be surprised if that were the case in the Isle of Man with a smaller population as against big cities in the UK, but if it is a cause for delay then the Department of Health in the Isle of Man should take appropriate steps.

**The Speaker:** Dr Allinson.

**Dr Allinson:** Thank you, Mr Speaker.

Just for clarity, would Lord Brennan agree that there is a difference between impairment and disability? One of the reasons I changed the wording of this clause was due to feedback from the consultation period, particularly from disabled groups who frowned particularly on the phrase,
‘It would suffer from severe handicap’, being extremely objectionable. That is why we tried to bring the legislation and the wording of it up to date.

Impairment is an individual’s physical condition but the resulting disability depends on the social consequences of impairment and the social construct. For instance, a child who is born deaf may be significantly disabled unless they have the right apparatus and the right conditions to get over that impairment. I would hope that if we are looking at disabled rights and the ability of disabled people to do better in society and being accepted by society, surely it is our responsibility to create the right social construct to support those people throughout their life, rather than instead try to inhibit access to terminations.

I would like to ask Lord Brennan, in terms of that, whether he thinks that having a significant difference from the 1967 Act could cause problems when we are referring women across to the United Kingdom for these late terminations, which are incredibly rare and might only affect one woman from the Isle of Man every one or two years?

Lord Brennan: Dr Allinson, I fully accept the good will in which you are seeking to clarify these matters if you can.

What I was seeking to do in the last couple of replies is to put the phraseology that is apparently intended to figure in this section into its context, and the context immediately follows the prospect as an alternative that the child will die shortly after birth. So in the next subsection finding significant impairment tends to lead us a little away from the gravity of the apparent (i), where as in (ii) is ‘disability’ a word that is not appropriately useable instead of ‘impairment’?

And as to quality of the child’s life, is that a medical judgement, a social judgement, an educational judgement? What is the woman involved going to be counselled about? What are the doctors going to be basing their decisions on? This may turn out to be, because of this first 24 weeks, one of your toughest subsections to clarify, but if I were in your position, as a lawyer, I would start with two extremes, soft end and hard end, and try to work out something in the middle that accommodates most people’s views.

Dr Allinson: Thank you very much.

If I could then come on to Mr Fayle, through your own experience with some of these late terminations, if you could, for the House, just go through why women might need a late termination after 24 weeks and what are the practical procedures in terms of trying to achieve that for women on the Isle of Man as opposed to who might be living in the UK?

Mr Fayle: Yes, the terminations after 24 weeks are very rare. In 2015 they accounted for less than 0.4% of terminations in England and Wales. This was brought about in one of the amendments of the UK Abortion Act, because there are a small number of very severe abnormalities that could not be diagnosed until late in the pregnancy, and in that situation all you could say to the parents of that child was, ‘Your child will die shortly after birth,’ which left those parents with three months or more of pregnancy knowing that their child would die when it was born. So this amendment was introduced to allow termination of pregnancy at that stage.

The advice of the Royal College of Obstetricians and Gynaecologists is to remember that this is a termination act and the purpose of this is to terminate the pregnancy and the life of the baby. Therefore any pregnancy beyond 21 weeks and six days should be referred to a specialist unit where foeticide is performed by specialist by means of an injection of usually strong potassium chloride into the baby’s heart to ensure that the child is dead before the abortion is commenced. This is a very specialised technique and is not available on the Isle of Man and certainly in the foreseeable future will not be available on the Isle of Man. In my career, I had one woman I referred late in pregnancy, so it is very rare on the Isle of Man. In practical terms we refer to the foetal centre in Liverpool for this to be performed.
Now, you could say there is your second opinion, because again the foetal centre have to act within the UK Act, so it is very important that when we consider our legislation the two dovetail because there is no point in having the legislation that permits late termination of pregnancy on the Isle of Man but not in the UK, because we will not be able to do it here. As things stand, I cannot foresee it ever being available on the Isle of Man.

I think it is important also for the Members to recognise the difference between termination of pregnancy – and we are talking about terminating the life of that baby for a very serious condition, and this is very traumatic for everybody concerned – and not to confuse it with early delivery of babies which are a different issue; because once we get up to this area beyond 24 weeks we are getting into the area where babies can be born alive and there is a definite distinction between the two.

**The Speaker:** Mr Robertshaw.

**Mr Robertshaw:** Thank you, Mr Speaker. I did have one more question but I am mindful of the time. We only have Lord Brennan until three o’clock, so I will review the questions to him and if there is anything that I think we have missed off, because he has actually dealt with some of my further questions in some of his answers, then perhaps Lord Brennan will allow me to write to him and perhaps he could reply and I will circulate a reply to the Members if that is permissible.

**The Speaker:** Yes, thank you.

**Mr Robertshaw:** Okay. Mr Speaker, I will move on to social grounds. Lord Brennan –

**The Speaker:** Mr Baker, can you be really brief because I am conscious, as Mr Robertshaw has outlined, about the time that we have?

**Mr Baker:** Thank you, Mr Speaker. I will be really brief. I would just like to ask Mr Connell as the drafter if he feels that the drafting of 8(d)(2) really reflects the tone that has just been described by Mr Fayle in terms of the seriousness and the rarity of it, because I heard words like ‘very serious’ as opposed to ‘significant impairment which is likely to limit either the length or quality of the child’s life’? If the drafting does not reflect the serious tone I would propose that needs to be looked at again.

**Mr Connell:** At the end of the day, sir, the drafting of this particular provision is a matter for the House. I just produced something that reflected my instructions as they stood at the end of the consultation period. Listening to what has been said today, if it is the will of the House to move to something which is closer to the wording of the 1967 Act provisions in similar circumstances and, given Mr Fayle’s evidence, you may think that desirable, then of course it is possible. But at the end of the day, to quote one of my predecessors in the Office of Parliamentary Counsel in London, I am but the humble scribe, I will do what the House requires me to do.

**The Speaker:** Members will also be relieved to know that we have Mr Connell during the clauses stage as well of this Bill should he be required at that particular point.

**Mr Robertshaw:** Thank you, Mr Speaker. Lord Brennan, I would now like to turn your attention to clause 6(7) of the Bill, which provides a ground for abortion between 14 and 24 weeks on the basis of what is described as
serious social grounds. When drafting legislation there is of course scope for a difference between what the drafter intends and what this provision in the Bill actually means as a matter of legal fact. So my question, Lord Brennan, is can I ask you as an eminent QC what does ‘serious social grounds’ mean in clause 6(7)?

Lord Brennan: I am not sure what it means. Let me answer it rhetorically.

The first topic you were considering today: supposing a young woman from a particular section of society which had the tradition of preferring children born to be boys and not girls was pregnant with a girl, turned up at a doctors saying, ‘I want you to give me an abortion because in my society and my family this is what is expected of me and I believe it. I want it to happen,’ is that a serious social ground?

This is a very complex area because when you switch from medicine to social, from mental and physical illness to social considerations, matters become, I think, necessarily somewhat vague.

I was looking at the English Act and it talks about physical or mental injury to the mother, which could include a mental injury, a concept which you might generalise as serious social grounds. But your very question posits a problem for a doctor – what is a serious social ground? – if he is going to be involved in the decision making.

So I regret I think it is intended at what I would call mental or physical injury to the mother, which is going to affect her life and perhaps her family around her, but it is not a phrase you would normally come across in legislation, whatever its intent might understandably be.

If I could just go back to – because I am concerned about this legally – in the UK at the moment you cannot have an abortion after 24 weeks save in life-threatening circumstances; it is not clear to me how under clause 6(8) somebody could be found in the Isle of Man to be ... [Inaudible] justifiably needs an abortion and goes to England where it would not be a justifiable ground. It is not clear to me, having looked at this, how that lady would be dealt with, because it is a different law.

But to your first question – Mr Connell is an excellent chap! (Laughter and interjection by Mr Connell)

The Speaker: Mr Quayle.

Mr Quayle: Thank you.

I am moving an amendment on this clause to omit lines 20 and 21, which is effectively subsection (7) of the clause and then renumber the succeeding subsections, because as a layman – I am not an eminent QC, I am not even a fantastic legal drafter with a multitude of experience – I am just a member of the public with maybe an O-level in law – with my tutor here, funnily enough.

But to me as a layman, I just see this as a clause where it is well intentioned and I can fully follow the logic of the mover wanting to do it for a specific issue, but to me it allows a person to drive a coach and horses through that, and you could use any excuse then to have an abortion. I am just wanting to say am I, as a lay person, correct in that interpretation or the way it is written, is there anything that could allay my concern that it could be dramatically abused, I suppose is what I am looking for?

The Speaker: Mr Quayle, who was that question directed to?

Mr Quayle: Sorry, it was to Lord Brennan and then Mr Connell.

The Speaker: Thank you.
Lord Brennan: I think the proponent or proponents of this particular part of the Bill at debate have, with clarity, to explain what it means, what its limits are, what it is intended to cover; because you cannot, I do not think, responsibly legislate a phrase like that, putting it out into the community to be used as a factor for decision in what for many people is one of the most important things ever going to happen in their lives.

Mr Connell: Once again, I do not really wish to be drawn on the policy of this proposition. As originally drafted in the Bill that was exposed for consultation, there were a list of examples, but following consultation and following responses from various people, including Members of this House, the examples were removed, and that, I think, does have the effect of widening the effect of the subsection, perhaps not helpfully.

The Speaker: Mr Hooper.

Mr Hooper: I think Mr Connell has touched on what I am going to say actually, but it is a question for Lord Brennan. He talks about this being possibly one of the most important decisions somebody would have to make. Do you accept then that this clause really is more a matter of policy than legislation?

It is about how much choice you want to give people when they are going through this process, of deciding themselves whether they feel they want to have an abortion or not, and really this clause is, like you say, quite broadly drafted but that is primarily because it is a matter of policy and the intention of the Bill is to give people that choice rather than being very prescriptive as to what the social grounds may be. I accept what you are saying, that it could be interpreted very broadly, but that surely is a matter of policy more than anything else.

Lord Brennan: I am sorry, I did not interpret the words to refer to choice simpliciter. But it seems to me, as a lawyer and a legislator, the more profound the object of a piece of legislation on ordinary people’s lives, the greater the responsibility of the legislature involved to make things as clear as they conceivably can.

Mr Hooper: I suppose what I am getting at really is, if it was the intention of the drafter to give people as much choice as possible, doesn’t this clause achieve exactly that?

Lord Brennan: Well, I am sorry, ‘serious social grounds’ I have interpreted to refer to physical, mental conditions which seriously interfere with a person’s life and family life. I had not understood this Bill to be legislative abortion by choice in the Isle of Man. If it is then I am sorry, that was not my reading of it.

Mr Hooper: Mr Connell, do you want to weigh in?

Mr Connell: You will be delighted to know that it is not the drafter’s policy. (Laughter) You referred to ‘if the purpose of the drafter was to achieve this’ – the purpose of the drafter was to achieve what his instructions told him to do. And at the risk of sounding like a broken record, that is a matter for the mover of the Bill, it is not a matter for me.

Mr Hooper: Sorry, my phrasing – I was intending to refer to the Hon. Member for Ramsey, my colleague, Dr Allinson rather than you who actually physically drafted the legislation.

The Speaker: Which brings us neatly to Dr Allinson.

Dr Allinson: Thank you very much, Mr Speaker.
Yes, the function of this was purely about choice: to give women the choice to request the termination when they were in an impossible situation and when, with counselling and with support, they still felt that termination was the right choice for them.

We do not have references in this Bill as in the 1967 Act in terms of ‘and their family and their other children’ but that was the intention – choice.

In terms of just for clarification, Lord Brennan, when you talked about ‘late terminations’ and I know we are going backwards slightly, there is a clause in the 1992 Human Fertilisation and Embryology Act where abortion is permitted only beyond 24 weeks if there is evidence of severely handicapping mental or physical abnormalities, and that is where late terminations are taking place in the UK. However, again, we have got some very outdated language of ‘severely handicapping abnormalities’, and one of the functions of this Bill was to change that language in response to criticisms from groups with people with disabilities to actually make it far more suitable for this century.

The Speaker: That was a statement rather than a question, I think, if I have read that right, Dr Allinson – yes?

Mr Harmer.

Mr Harmer: Yes, thank you.

I just wanted to draw in on both of these angles, because where I see the differences between the UK law and the proposed law is essentially around that clause section (7), and also (d)(ii).

How far apart are the two – the legislation? And what could be done to bring us back together? Again I think a very valid point has been made that if it is legal here and illegal in the UK, that could present an issue.

Lord Brennan: I am not talking as a lawyer but as a legislator: it would be unfortunate if in different parts of our Islands different processes applied to such a matter of common occurrence throughout the nation and the Islands.

The fact is that whether the language is from the past or not, if it is clear then so be it. Changing language to accommodate concerns about using words like ‘disability’ or ‘handicapped’ … handicapped I can understand, but I have not in our legislature come across much concern about using the word ‘disability’ with an appropriate adjective – ‘seriously handicapped’ in the Abortion Act.

But as to ‘serious social grounds’ that is a similar kind of … and is it serious social grounds pertaining to the mother, to the family which she is connected with either as a child, or a partner, or wife? How is it to be interpreted by her and all the doctors who are supposed to be playing some part in this judgment?

Mr Harmer: Can we just ask Mr Connell the same sort of question, but practically speaking, particularly after 24 but also prior to that?

Mr Connell: There is obviously a problem if something is authorised by the law of the Isle of Man that can only take place in the adjacent island, because obviously medical practitioners there are bound by the 1967 Act.

When drafting this I had in mind, I confess, that these abortions might in time take place here, so the mismatch did not actually matter; but having listened to Mr Fayle’s evidence this morning I am conscious that the mismatch might create some quite serious problems. I cannot put words into his mouth, but I think I might need to have a conversation with Dr Allinson afterwards on this topic, because it is obviously the will of this House that the Bill should reflect something that is manageable and workable in a Manx context, and if that means that women
have to go off the Island to have terminations in these circumstances then clearly we have got to make it align with the UK, otherwise it will not work.

The Speaker: Mrs Beecroft.

Mrs Beecroft: Thank you, Mr Speaker.

Just a very quick one: going up on to the ‘serious social grounds’ again. It has been said it covers mental and physical, but is it possible that it can be construed to cover ‘financial’ as well?

That to me is a social issue if you have not got enough money – you say ‘I haven’t got enough money to have this baby’.

Can that paragraph be construed that way?

Lord Brennan: To take it up a little further than that: ‘haven’t got a lot of money’; ‘can’t look after the basic needs of the child’; ‘don’t have the opportunity of getting it through state benefits’; ‘husband’s not able to work and I can’t work for whatever reasons’.

I think if it is financial the ‘proof’ element, so to speak, becomes pretty stark because it is easier to suggest a financial reason for an abortion. But it would be a sorry state of affairs in whichever jurisdiction we live where you sought an abortion because you could not afford to bring up a child – either yourself or through the state.

The Speaker: I would like if we may, then, to move on to our next theme, ‘Conscientious Objection’ if that is alright?

Again, I will ask Mr Robertshaw to take the first question.

Mr Robertshaw: Thank you, Mr Speaker.

Lord Brennan, the current Bill provides a conscientious objection protection for doctors. Section 8 of our current 1995 Act has a provision to protect medical professionals who use their conscientious objection right from employment discrimination.

To my mind this looks like a very useful provision. It is, however, not in the Abortion Reform Bill before us and would not apply if it became law. So the question is: do you concur that to this end the employment discrimination provisions are much weaker in the Bill before us than previously?

Lord Brennan: It may become important for the House of Keys to bear in mind that at the moment there is going through Parliament in London a Private Member’s Bill about conscientious objection, to restate our view of what the law should be according to the proponent. It has passed the Lords and has now gone to the Commons – I think it is at that stage. So this is a moving matter for us.

There was a decision of the Supreme Court from a Scottish case clarifying that conscientious objection does not extend to medical staff having to deal with the mother as a patient and the aftermath of an abortion, basic medical treatment, because they would not be participating in the abortion, it is providing treatment afterwards.

But the concern I have about the fact that there is no conscientious objection clause here is quite serious and, rhetorically, why not?

Several Members: There is.

Lord Brennan: Sorry, I misunderstood, I am suffering from jet lag and flu! (Laughter)

My concern was not about that, it was about the fact that the conscientious objection clause has a criminal penalty in it. I am not aware of any time in the Westminster Parliament we have ever coupled a conscientious objection clause with a criminal penalty in a medical context – ‘if

you don’t agree to do it’. The point being that you would thereby deter people from having the right to pursue a profession – nursing or doctoring.

So I think that the Bill ought to have full provision for conscientious objection but not with this criminal penalty. I do not see the utility that it serves. Fifty years after the Abortion Act nobody has ever suggested that in England and Wales in Parliament.

The Speaker: Mr Ashford.

Mr Ashford: Thank you.

Just in relation to and following very much on from that, Lord Brennan, with the criminal penalty though, isn’t it a case that if you look at the section we have before us in terms of conscientious objection, the criminal penalty is very clear in subsection (5) that it relates to somebody not acting in relation to subsections 3 or 4? So it is not a general criminal penalty, it is a very defined one as to where the criminal penalty would apply – whereas in the UK Act those provisions are not in place.

The UK Act is silent on that. So would that not be a reason as to why it would be very difficult to put a criminal penalty into the UK Act, because it would be so wide-ranging; but with this particular Bill where someone is committing a criminal act it is really drilled down and defined quite well?

Lord Brennan: I am not entirely clear that there is an evidential basis for the need for this, because certainly in England and Wales most hospitals are now structured in a way in which the treating doctor or nurse will refer the patient to another doctor or nurse in the same hospital – it is almost common practice. So is it really necessary?

Mr Ashford: Just following on from that, can I ask in reaction to subsection (2) where it states:

In any legal proceedings the burden of proof of a person’s conscientious objection rests upon the person who claims to rely on it.

I am personally minded to move an amendment to remove the clause 8(2) by virtue of the fact that we have subsections (4) and (5) which lay out when someone would not be acting legally anyway.

So can I ask, Lord Brennan, what your views are on 8(2); and also the fact of how would, in your opinion, someone actually meet the burden of proof if this went to court?

Lord Brennan: Have I understood this means that subsection (2) is a consequence of (5)? What legal proceedings are we talking about?

Mr Ashford: My view is it is clear from subsection (2) that in any legal proceedings the burden of proof of a person’s conscientious objection rests upon the person who claims to rely on it. I am just wondering what your opinion would be of how anyone would ever in a court of law adequately prove their conscientious objection.

Lord Brennan: The burden of proof would normally arise in the context of something having happened which involved some potential liability on the person who is claiming the conscientious objection, which is why I thought it must relate to (5). If it does not relate to (5), I do not see how it arises.

The concern I have got here is that, as far as I am aware, in the UK context in England and Wales this is not a problem that has arisen, certainly in modern times.
My memory is being assisted. When I say the Bill does not deal with something, it does not in my view reflect the following. It deletes the employment discrimination protection provision in the current legislation for those who have used the right of conscientious objection. In other words, if you do exercise this right it is not used against you in your career structure thereafter, which I understand is a deletion from the previous Act. My apologies for confusing you.

Mr Ashford: Can I ask Mr Connell, in relation to clause 8(2) – and obviously we have had conversations around a potential amendment that I might be looking to move – obviously 8(4) and 8(5) lay out the reasons as to why someone would face potential criminal penalty, so surely 8(2) is redundant, whereas in the UK Act their version of 8(2), which is their clause 4(1), does not have those subsequent provisions in.

While I am on my feet, I know there have been discussions around what would happen in an employment tribunal, but surely an employment tribunal, if considering someone’s case, would have to refer to 8(4) and 8(5) because if that was not complied with, it would be unfair dismissal anyway.

Mr Connell: Subsections 8(4) and 8(5) are dealing with a different proposition from that which is covered in 8(1) and (2). Subsections 8(1) and (2) are, as it suggests, based on section 4(1) of the 1967 Act. The provision occurs there because it is necessary.

Leaving aside the question of employment rights having been diluted, which may or may not be the case, the point about 8(1) is that it confers a general exemption in relation to legal liabilities, which include employment liabilities arising as a result of the person having a conscientious objection. All that subsection (2) does is it says if you want to assert in any proceedings that you have an objection the burden is on you to show it. It is probably very easily discharged by somebody saying, ‘I have a conscientious objection.’ I do not think the average court would go beyond that, but I do not accept that because we have 8(4) and 8(5), which are about a specific circumstance in which conscientious objection is invoked, we do not need subsection (2). Subsections 8(3), (4) and (5) are ensuring that a person who does have a conscientious objection takes appropriate and timely action to ensure that a woman is not disadvantaged by reason of the conscientious objection. So they are dealing with slightly different things under the theme of conscientious objection. They could have actually been in two separate clauses.

Mr Ashford: But just on that point, how would anyone actually end up involved in legal proceedings and in court if they could show that they had not breached 8(3), 8(4) or 8(5) anyway?

Mr Connell: Well, they might have a term of their contract which required them to provide counselling services, and as it stands at the moment the exception does not apply in that particular circumstance, as it is not within the meaning of ‘treatment’, thanks to the decision in Doogan v the Greater Glasgow Health Board, to which my learned friend referred.

I have lost my thread ... The intention behind the provision was to ensure that the conscientious objection provisions could be invoked in the event that somebody was subjected to detriment in relation to their employment as well as in the context of the proceedings under 8(4) and 8(5), which are clearly criminal.

The Speaker: Mr Robertshaw.

Mr Robertshaw: Thank you, Mr Speaker.

This is to Mr Connell. Would (2) not be dealt with simply by the Department holding a simple register of declarations that were permanently in position, and therefore you would not get into a retrospective knot afterwards?
Mr Connell: That would be one of the ways in which the matter could be dealt with, and bearing in mind that there is a requirement for authorisation for any medical professional to actually undertake any of the activities in the Act, it could be part of the authorisation to record that the exception arose.

Mr Robertshaw: Thank you.

The Speaker: Mr Hooper.

Lord Brennan: Mr Speaker, if I could just clarify –

The Speaker: Oh, sorry, one moment.

Lord Brennan: – the employment protection clause I was having in mind springs from section 8(2) of the 1995 Act, which gives such protection and it is not in the present Act.

The Speaker: Okay. Mr Hooper.

Mr Hooper: My question is specifically about the employment protections, actually, to Mr Connell. The Equality Act that this House has very recently finished has a provision in it that specifies that you are not allowed to discriminate against somebody based on philosophical beliefs, essentially. So if someone’s conscientious objection is a religious belief or a philosophical one – which is, I would suggest, a very broad term – you could not discriminate against someone in employment terms anyway, so those employment protections are essentially unnecessary in this Bill because we already have them elsewhere. Is my understanding broadly correct?

Mr Connell: No, sir, it is not. This is dealing with a specific set of circumstances and the tension between the specific and the general is that where there is a specific provision it will prevail rather than the general provisions in the Equality Act.

Mr Hooper: So does that mean that the provisions in the Equality Act would not apply? So if someone had a conscientious objection, refused to provide a service and was then fired as a result of that, the provisions against discriminating against that individual because of their beliefs would not apply for some reason?

Mr Connell: Well, at the end of the day I am not a court, but that certainly would be a possibility.

The Speaker: The next topic to move on to will be about private clinics and again I call on Mr Robertshaw.

Mr Robertshaw: Thank you, Mr Speaker.

Lord Brennan, I would like to ask you a series of questions about how abortion services might be provided under this Bill.

Currently abortion services have to be provided via NHS hospitals. Clause 5(1)(b) allows the Department of Health and Social Care to approve other premises to provide abortion services. During Second Reading Dr Allinson said, ‘It looks to the future where nurse- or midwife-led clinics might develop’ and ‘We are not about bringing in private abortion clinics in the Isle of Man.’ Please can you tell me whether private clinics would be allowed under this clause?

Lord Brennan: Yes.
Mr Robertshaw: Thank you, that deals with that.

Mr Hooper: Actually, here is a follow-up question then, but this is directed at our Minister for Health. Seeing as it would be the Department approving any such places, can I ask if it is his intention now or in the future to ever even consider the possibility of approving private abortion clinics on the Isle of Man?

The Speaker: Minister.

Mr Ashford: I am not aware of any discussion having taken place.

The Speaker: Dr Allinson.

Dr Allinson: Thank you very much for that brief answer to a very long question, Lord Brennan.

One of the problems in the United Kingdom is that abortion services have been freelanced out to private providers and over 80% of abortions are provided by private clinics, and that has caused concerns in the United Kingdom from various organisations. Would you accept that the stronger provisions under this legislation which give the Department of Health and Social Care the express ability to control this are actually better than in the United Kingdom?

Lord Brennan: Well, of course it is for the Department of Health to exercise general control of health services for the benefit of the Manx public. I think people’s concerns about this kind of provision would be it is almost an open invitation to, at some earlier rather than later stage, consider privatising this element, as happened in the UK.

Dr Allinson: But in the United Kingdom those terminations by and large are funded by your NHS.

Lord Brennan: You are right, the taxpayer pays both ways.

The Speaker: Mr Baker.

Mr Baker: Thank you, Mr Speaker.

In the event that we did end up with a private clinic opening, which is clearly possible under the provisions, where is the legislation around regulation, around quality control, around ensuring that the service they deliver would be of a suitable standard?

Mr Connell: Who is that aimed at?

Mr Baker: Well, anybody who wants to answer it. (Laughter)

Mr Connell: I hold no brief for the Minister, but because of the approval process I would assume – and it is an assumption and you might get him to confirm it – that appropriate quality standards and other provisions would be included in whatever contract supported the approval process in relation to a private clinic.

Mr Hooper: If I may, Mr Speaker, I draw Mr Baker’s attention to clause 5(2), which states:

An approval ... may contain such conditions and exceptions as the Department thinks fit.
So that is the clause under which the regulations would be brought in, assuming there was a desire for a private clinic on the Island. So the law covers that, essentially.

**The Speaker:** Mr Ashford.

**Mr Ashford:** Thank you, Mr Speaker. Maybe I should just clarify that, as far as I am aware, it would fall under the current inspections regime anyway.

**The Speaker:** Okay. I think we will make a start on the next topic, which is counselling, all being well. I am not expecting that we will actually be able to complete that before lunch, but again I will turn to Mr Robertshaw to start the ball rolling.

**Mr Robertshaw:** Thank you very much, Mr Speaker.

Lord Brennan, there has been a lot of support that counselling will be available under this Bill. It was also set out in the 1995 Act. Lord Brennan, I would like your views on the counselling provisions in clause 6, sir.

**Lord Brennan:** Clause 6(9) is a general obligation that the pregnant woman will be offered counselling, and then at (13) there are guidelines about counselling and so on. The provisions that are set out here are extremely important in this Bill, and I do not know how things work in the House of Keys and the Government here but at some stage of the Bill the Minister on most occasions with us would be required to explain when such counselling is going to be made available, how it is going to be provided and how it is going to be funded, especially as the Bill drafts itself as mandatory: ‘she must be offered counselling’ before the abortion services are provided.

**Mr Robertshaw:** Thank you.

**The Speaker:** Mr Quayle.

**Mr Quayle:** Thank you.

If I could address this question to all of our distinguished panel, because whilst I am grateful for Dr Allinson bringing this legislation forward, we all have the right to try and come up with something different to try and make it better for the people of the Isle of Man. We do not necessarily have to follow the UK, we can look wider afield and I know my learned colleague for Ramsey, Dr Allinson, has looked at numerous other countries to see where the best legislation works to help people.

I have come up with an amendment on page 9, lines 38 and 40, and it was looking at the German model of pre-counselling, where they have a rule that you go for counselling to determine whether you wish to have an abortion or not, and then within three days there is a cooling-off period. And then, if you wish to have the abortion you go ahead but you have a letter saying, ‘Yes, I have been for counselling’. They currently have nearly half the abortion rates of the UK and they also have – and I have not got the evidence with me – I am told, a lower suicide rate in ladies who have had abortions, as they have been able to square the circle in that they have taken advice, they have thought about it, there has been a cooling-off period and they have done what was right.

I was preparing to bring this in, but I did do exemptions for people to ensure that if you had been raped, incest, you were unable to give ... if you were in a coma, for example. I have got a number of exemptions but I was just wondering, starting from the left and working along, if the hon. members of the panel – they are expert witnesses – could give me an opinion as to whether they would see that working, because I am genuinely trying to come up with something
to give better counselling. If we can reduce the suicide rate in women that has got to be, for me anyway, a good thing, but I would just like your feedback to say whether you see it working or not.

**The Speaker:** Ms Sanghera.

**Ms Sanghera:** I absolutely would fully support pre-counselling. This is an NHS statistic, not mine, but in England and Wales the suicide and self-harm rate for South Asian British-born females is three to four times higher than the national average. I am not saying it is linked to these issues; however, it does have everything to do with the issues of shame and honour, of which this is an issue of dishonour if you were to have another female and be coerced into having an abortion on those grounds.

So my only caveat would be for any sort of counselling, any sort of practice, to recognise the cultural complexities in these cases; so, if you were going to have counselling, that counselling would have to have an understanding of these issues and the pressures that individual would be faced with, because very often it is not a personal decision they are making; they are making it in the context of the family and family pressure.

**The Speaker:** Thank you.

**Mr Fayle:** Thank you.

I am not sure of the direct relationship between the counselling you offer and the figures on suicide; I think you are making a little bit of a jump in your assumptions there.

I would say yes, offer good counselling to women; however, I would say you cannot force anybody to be counselled if they do not wish to be counselled. The whole delivery of medicine is about informed choice and decision. You can offer these issues, you discuss the issues, but at the end of the day it is the woman’s choice. So I would say by all means offer counselling but we cannot force the women to have it.

**The Speaker:** Mr Connell.

**Mr Connell:** You will be delighted to know I have absolutely no view on this because it is a policy question. *(Laughter)*

**The Speaker:** Lord Brennan.

**Lord Brennan:** Well, common sense tells us that some women in this situation will not accept counselling and do not want it. If that is what this proviso in (9) is referring to about practicability and undue delay, I can understand it, but if ‘if it is practicable ... and without causing undue delay’ is some kind of financial caveat, I would be very concerned about it because the declaratory beginning ‘she must be offered counselling’ appears to involve a legislative input for the executive which you are therefore required to pay for.

**The Speaker:** Thank you.
Standing Orders suspended to continue for further 30 minutes

2055  The Speaker: Hon. Members, I am conscious that we all have a pre-standing engagement at one o’clock and I therefore adjourn the House at this point and we will resume our deliberations at two –

2060  Mr Cregeen: Mr Speaker –

2065  Mr Cregeen: I am just wondering if, bearing in mind some of our distinguished guests here have a flight to get, would it be possible to sit for possibly another 30 minutes so that Hon. Members have the opportunity to finish any other questions? They may not have any but I just thought if we could take advantage of this opportunity.

2070  The Speaker: I need a seconder for that motion. (Mr Quayle: I second.) Mr Quayle.

2075  Mr Ashford: We may look to rearrange, Mr Speaker, if Members wish to continue.

2080  The Speaker: Thank you.

Abortion Reform Bill 2018 –
Consideration of clauses continued

2085  The Speaker: In which case, we will continue and the next person I had to speak on this was Mr Hooper.

2090  Mr Hooper: Thank you, Mr Speaker.

2095  Mr Fayle: It is certainly not just another procedure; it is a very significant procedure and requires a lot of time and discussion with the people involved. It has profound effects on the woman, her partner and family, so it is by no means just another procedure. However, abortion
does not sit on its own, it sits in society and in the background you have got to have teaching people, starting at school; it is about relationships, self-respect, respect for others, as well as tying in with the provision of adequate family planning services throughout the Isle of Man, and it sits in a whole nest of things together.

So it is not another procedure; it is a very significant procedure but must be considered in the context of the whole of life on the Isle of Man.

The Speaker: Mr Robertshaw.

Mr Robertshaw: I have no further questions on this.

The Speaker: In which case, a brief one from Mr Hooper and then we will move on.

Mr Hooper: It is a brief one actually. Maybe I should have phrased the question: are there any other serious procedures where you are aware of mandatory counselling?

I myself have undergone very serious surgery recently which has had, and will have, long-term profound implications for myself and my family. I was offered counselling; it was not mandatory that I was forced by law to undertake counselling beforehand. That is the question I was getting at.

So I think to try to dismiss these concerns as simply 'just another procedure' is extremely inappropriate.

The Speaker: Okay. It is more of a statement there.

A Member: It was.

Mr Baker: Mr Speaker, can I respond to that?

The Speaker: You can but we are entering into a debate that we will have in the future, rather than seeking evidence from our witnesses which I think is the purpose that we are here for today.

Mr Harmer.

Mr Harmer: Thank you.

The first thing, just about this counselling, it is 'must offer'; they do not have to take it. I just want to check from the drafter that is correct.

Mr Connell: Let us clear up the confusion, the Bill as drafted requires that counselling must be offered. The Chief Minister’s proposed amendment, on the other hand, would require the woman to have received counselling and to have received it at least 48 hours before undergoing any procedure. That is the difference. As drafted, the Bill provides that counselling has to be available, because that is obviously good medical practice. The Chief Minister, in his amendment, seeks to go further.

Mr Harmer: Can I just drill on to that point about the cooling-off period, or so to speak, or just explore it from a medical point of view in terms of splitting the counselling, but is there any merit in the woman having two days to either come back to the doctor or just the thought the prescription is post-dated by two days or something like that to give a cooling-off period?

Mr Fayle: Certainly it would be good practice to give the woman the opportunity to have a cooling-off period, and certainly I can speak in my practice that I would never perform a termination on the day I saw that woman. We would always discuss all the options, what
procedures were involved and the woman or the woman her partner would then be allowed to go and think things over and make sure that they have arrived at the right decision.

**Mr Harmer:** Thank you, and if I may just briefly, obviously the difference now with technology is that we have medical abortions, so therefore, would that be the same sort of application?

**Mr Fayle:** I would say it would be good practice to give people time to think because when you are in a consultation you have got a lot of information to take in. I can only speak for myself here, but I would discuss it with the people concerned and give them time to go away and think about their decision and make sure it is the right decision.

**The Speaker:** Mrs Beecroft.

**Mrs Beecroft:** Yes, thank you, Mr Speaker.

It is about counselling and the terminology, I think, used in that, but that actually goes into a lot of other areas because everybody ... I cannot say everybody – an awful lot of people seem to use very different terminology depending on which angle they are coming from and how they see things from their particular personal perspective. So some people refer to them as foetuses, some people refer to them as babies, others as just a clump of cells. What terminology, and at what point, is recommended in counselling?

If I could ask Mr Fayle – sorry, I forgot to say that at the beginning – because I think you are probably the best qualified on that.

**Mr Fayle:** I am not aware of any guidelines with regard to counselling of what you call the foetus, baby, clump of cells. As you speak, I think the important thing is that you deal with things sensitively. That is the important thing about the counselling – that you are sensitive in the way you are talking to your patients, you are aware of their problems, you are aware of any outside influences which may bring an undue influence on them; and these all feed in to make your decision about the appropriateness of the termination.

**Mrs Beecroft:** If I may then, could I just ask would you then normally mirror that person’s ...? If they said to you, ‘I do not know if I want to keep this baby,’ would you use that terminology back to them or if they said, ‘I do not know if I want to keep this foetus,’ again, would you reflect that back to them in the terminology that they use to you, given that there does not seem to be any clear definition?

**Mr Fayle:** My honest answer is I have no idea. I just hope that when I spoke to patients I was sensitive, but I could not say to you exactly what I said.

**The Speaker:** Dr Allinson.

**Dr Allinson:** Thank you, Mr Speaker.

Again, a question to Mr Fayle, just in terms of clarification. We have talked about the unnecessary aspect of forced counselling, but you have also brought up the issue of a gap between counselling and the actual procedure of termination. Do you think that we necessarily need to have this in legislation, or guidance from the Department to the practical facilities at Noble’s Hospital make this essential anyway?

**Mr Fayle:** My personal view is you do not need it in legislation, there is good guidance from the Royal College of Obstetricians and Gynaecologists on the setting up of abortion services and how they should be appropriately run.
Dr Allinson: Thank you.

The Speaker: Mr Robertshaw.

Mr Robertshaw: Thank you, Mr Speaker.

I move on to the final section, final theme, for Lord Brennan – it is a question of comparisons with other jurisdictions.

Lord Brennan, a suggestion that has been made is that in embracing the Abortion Reform Bill, the Isle of Man is basically catching up with Great Britain in this; is this correct? I use the word ‘Great Britain’ here because at the time the UK Bill came in it was Great Britain, rather than England and Wales. Do you think, Lord Brennan, that we are catching up with Great Britain?

Lord Brennan: Not just catching up but leaving us behind. This is considerably more permissive legislation than we personally have in England and Wales. It will become known around our Islands and become a topic for public comment and debate, I have no doubt about that.

The present position in the UK is that there is talk of debating a reform of the first 24-week regime for abortions, but we have not got to a new legislative stage about that yet. In present circumstances it is highly unlikely the government would choose to try to legislate that kind of thing, certainly within the next year or two.

So it might be useful, when you come to your committee stage – if I may say so, respectfully – for each of you to read the England and Wales statute so you can make appropriate comparisons and note you can get it on the internet in a way which has all of the current amendments already into the Bill, so you are reading it as it now is, not as it was. That is very useful. One of the amendment Acts which was involved here, I will tell you it was as recently as 2012.

This definitely opens new ground. I have illustrated the points to doctors, etc. and it will become a source of debate across the Islands, no doubt about it.

Mr Robertshaw: Thank you, Mr Speaker.

Could you enlighten our Committee about the discussion debates going on in Westminster around the 24 weeks? What is the thinking that is developing in Westminster around the 24-week issue?

Lord Brennan: Well, it is not generalised thinking but there is a body of opinion in the Commons, I am not sure about the Lords, who want to reconsider entitlement to abortion in the period after 24 weeks. But it has not yet been brought to the floor of the House – 21 weeks I meant, not 24.

But this is not surprising, if I may say, so to you. Bills such as this – fertilisation, embryology and all this stuff – comes back in general debate every two or three years, usually depending on medical knowledge advance, or lack of advance, as the case may be.

Mr Robertshaw: So the thinking then, sir, is that the conversation in Westminster is moving from 24 weeks in its discussions down to perhaps –

Lord Brennan: It is moving toward debating it again, not introducing it

Mr Robertshaw: Right, thank you.

The Speaker: Mr Malarkey.

Mr Malarkey: Just a simple question, Lord Brennan: you say our legislation will be ahead of other jurisdictions. Obviously we are a Crown Dependency: in your opinion, if we are that far
ahead will we have problems getting Royal Assent if the Bill is seen by Westminster to be a step too far?

**Lord Brennan:** I regret to say my homework has not included the constitutional position between the Isle of Man and Westminster! But I am certain sure from the legislative antennae that this is a very sensitive topic across the whole of our Islands and it will come up again in Northern Ireland, Scotland, England, Wales, for general debate.

So I think that your Committee Stage is one that is going to require considerable prudence from all of you and the way you deal with it, particularly as to terminology – ‘serious social grounds’ and that kind of thing. The press will seize on that kind of phrase and it will be debated – unproductively, I suspect. The more clarity you have, the less scope there is for belligerent debate.

**Mr Malarkey:** Can I ask the same question to Mr Connell, because he did actually nod his head a little bit there when I asked the question?

**Mr Connell:** I am obviously giving too much away! (Laughter)

**The Speaker:** Don’t play poker, Mr Connell!

**Mr Connell:** Sir, the answer is that in terms of recent constitutional practice, the Secretary of State has never advised the Governor to refuse Assent under the relevant prerogative order. I would be surprised, given the length and maturity of the debate which is going on here, if the Secretary of State would think it proper in relation to this particular Bill to second guess this House and the other place. In fact I would be astonished if it did.

I do not think the fact that we are doing something different – and bear in mind we have done something different in relation to marriage and civil partnership too – I do not think that the Lord Chancellor would think it proper to refuse Assent simply because we were doing something different, providing it is consistent with our international obligations; and I believe, as currently drafted, it is.

**Mr Malarkey:** Thank you.

**The Speaker:** Mr Hooper.

**Mr Hooper:** Talking about comparisons with other jurisdictions, in the UK Abortion Act there is no provision for buffer or access or exclusion zones, but a number of UK councils are starting to use public space protection orders to try and create these around some places where abortions are provided. I know Mr Peake is bringing an amendment to our Bill in respect of buffer zones.

I would just like to get Lord Brennan’s and Jasvinder’s opinions, really, and your views on whether buffer zones around places where abortions are provided are a sensible approach?

**Lord Brennan:** I think I have already made it clear that the two critical issues in general parliamentary action around the Islands are going to be one doctor and not two, and the phraseology that surrounds the right to intervention – those are the two areas which are going to be most carefully looked at and which we have been looking at during today.

**Mr Robertshaw:** Ask the question again.
Mr Hooper: My question was more specifically about access zones, so areas where you are not allowed to interfere with somebody’s right to access medical services, to stop people protesting directly outside of abortion clinic, for example.
I am just wondering whether or not you have got any thoughts on that?

Lord Brennan: I am sorry, for a moment I have been acoustically challenged!

The general questions about demos outside abortion clinics and so on has been around for debate in Parliament for the last couple of years, not in terms of legislation but concerns on both sides about it – freedom of speech, protection of the individual and so on.
I may have misread this Bill but there is nothing in here about that.

Mr Connell: Not yet!

Mr Hooper: No, there is an amendment coming forward to the Bill which is not included currently. That is why I was asking, really, whether you think it needs to be included in this Bill.

Lord Brennan: With the legislative drafter’s helpful intervention, not yet. This is an Abortion Bill, not a civic rights Bill. I think it is something which most of us in the rest of the islands would be concerned about if a Bill like this involved more generalised statements.
Whatever you say its limitations are, if you try to get it into this Bill it will be read as a human rights question affecting free speech – Brexit, Britain First, whatever you want to call it, they will be arguing about it.

Mr Hooper: Okay, and in terms of we talked earlier a lot about coercion and pressure, I am just wondering if you have got any thoughts on that, really. That is to Jasvinder, sorry.

Mr Connell: Whether I have got any thoughts on coercion?

Mr Hooper: No, sorry, Ms Sanghera.

The Speaker: Ms Sanghera.

Ms Sanghera: Coercion and pressure in the context of what? Sorry.

Mr Hooper: Of actually physically accessing services – harassment outside abortion clinics and whether or not there needs to be legislative provision in respect of that.

Ms Sanghera: Well, there are a lot of societal pressures and issues within the community and stigma and shame attached to going to clinics anyway, and we have to think about that in the context of the complexities I have talked about today. So even seeing a male GP and wanting to see a female GP, there are issues there too.
I think the communities I am talking about would be challenged with respect to people seeing them and that being reported back to families and communities, and one would need to consider that. I am not sure whether you need legislation for that. However, I think you do need to recognise that, absolutely.

The Speaker: Hon. Members, I am conscious we have another five minutes. If anyone has any general questions on any wider topic, then I think this would be an opportunity.
Mr Malarkey.

Mr Malarkey: No, not at all.
The Speaker: Sorry, Mr Harmer.

Mr Harmer: Just a general question. There has been some talk of between 12 and 14 and 22 and 24: is there any legal or medical difference between the two numbers – why some places go for 12 or 22 instead of 24?

Lord Brennan: The legal argument has always been directed at viability of the foetus in terms of determining these periods. I will defer to the doctor.

Mr Fayle: Yes, I agree, it largely refers to the viability of the foetus. That is why it was brought down to 24 weeks and why there is now debate about further reduction. But you would hope in that debate that ability for the very late post-24 terminations for the very serious abnormalities would remain.

Mr Harmer: And just finally, between 12 and 14, I think some jurisdictions are looking at 12 instead of 14 – is there any reasoning behind that, would you say?

Mr Fayle: The foetus gets larger, so there is more ... certainly bleeding and problems as the pregnancy progresses.

The Speaker: Mr Baker.

Mr Baker: Thank you, Mr Speaker.

Thank you for clarifying the time, that it has been around the viability. Is it correct to say that the viability dates are likely to change over time with advances in medical technology? And if so – and I will address this both to Mr Fayle and Mr Connell – would it make sense to actually have those time limits in secondary legislation so that we can adapt as we move through time rather than having it in primary legislation, which is more cumbersome to amend?

Mr Fayle: Yes, medical technology is advancing all the time. The original 1967 Act set 28 weeks; now you would expect a 28-week baby to survive and as technology advances those limits are getting lower and lower. So it is right that these matters are debated; however, I do not think you can set a set time limit to discuss it, because some medical advances happen very quickly, some happen very slowly. So I think the appropriate time to debate it is when those advances are occurring and it becomes obvious that your legislation is now out of date.

The Speaker: I think I am only going to have time for the last three questions, and they are Mr Robertshaw, Mr Cregeen and Dr Allinson. So, Mr Robertshaw.

Mr Connell: Ah –

Mr Robertshaw: Mr Connell needs to answer yet.

The Speaker: My apologies.

Mr Connell: Thank you, Mr Speaker.

The answer is that whilst it would be possible to prescribe the upper time limits entirely in secondary legislation, that would not, from a drafting point of view, be my preferred option. What I would think would be a better way forward would be to put the current time limits which are suggested in the Bill on the face of legislation but include a power to amend in the light of changes in medical science so that the limits could be reduced by means of an order of Tynwald on an approval motion. That would at least keep the legislation clear to the outside reader.
dislike burying fundamental principles in secondary legislation, and this is a really important issue.

The Speaker: Mr Robertshaw.

Mr Robertshaw: Thank you, Mr Speaker.
While we have the doctor with us perhaps he could help me with something that troubles me, and that is something related to freedom in the first trimester. Particularly I am concerned about ectopic pregnancies, identifying them and responding to them insofar as I understand from the World Health authority that neither mifepristone or misoprostol impacts or touches an ectopic pregnancy in any way. So, if the House chooses to have a very free arrangement in the first trimester, are we in danger of causing concern or damage in the area of missed ectopic pregnancies?

Mr Fayle: Not that I am aware of, but you have to bear in mind I retired 18 months ago so if there is anything that has come to light about mifepristone and misoprostol since then ... but certainly in the time I was working I am not aware that it masked or hid the symptoms of ectopic pregnancy.

Mr Robertshaw: So, Mr Speaker, are we saying that the World Health authority is incorrect in its statement here?

The Speaker: For debate and further clarification potentially, then.

Mr Cregeen.

Mr Cregeen: Thank you, Mr Speaker.
If I can ask Mr Fayle: what is the safest pathway for a woman looking for an early termination on request? This is on the lines of the 12 and 14 weeks, so if you could just give some guidance on what is the safest pathway you would advise women on.

Mr Fayle: Well, the earlier the termination is done the better and preferably in the first trimester. In fact, if you look at the statistics, the vast majority are done in the first 12 to 13 weeks of pregnancy.

Dr Allinson: Thank you very much, Mr Speaker.
Just a brief point of clarification for Mr Robertshaw. I think what he was possibly getting at was the use of ultrasounds to confirm a pregnancy is intrauterine rather than ectopic, and I know the Royal College of Obstetricians and Gynaecologists have said that with early abortions you do not necessarily need ultrasound, but certainly talking to your colleagues who are still working at Noble’s they still want ultrasounds to confirm a gestation.

Dr Allinson: Could I also just bring up a point that was done before, which was about foetal viability, and certainly over the last 10 years, although medical advances have improved, the Epicure Study showed that at 22 weeks only 0.4% of children born from the onset of labour leave without disability and that increases to 8% at 23 weeks, but only 22% at 24 weeks. Is that...
your own experience, that although babies are being delivered earlier and living longer that is at the risk of quite severe disability?

Mr Fayle: Oh, yes, certainly at the limits of gestation the risk of disability is massive, but as the science advances things are improving. But yes, once you are down around 23, 24, 25 weeks, the likelihood of the baby being intact are minimal.

The Speaker: Hon. Members, I have been advised by the Ministers responsible for the presentations that if Members could go straight to the Barrool Suite there will be an abridged briefing session.

With that, the House stands adjourned and we will resume our deliberations at 2.30.

The House adjourned at 1.32 p.m.
and resumed its sitting at 2.30 p.m.

Abortion Reform Bill 2018 –
Consideration of clauses continued and adjourned

Continuing in Committee of the Whole House

The Speaker: Fastyr mie, good afternoon, Hon. Members.

We continue our deliberations in Committee of the Whole House on the Abortion Reform Bill. We were talking about time limits in particular. I therefore seek from Members if they have any further questions, on this or any other particular topic. We are all content then?

Mr Baker.

Mr Malarkey: Should we move to come out of ... ?

The Speaker: In which case then, if there are no further questions –

Sorry, Mr Baker.

Mr Baker: Sorry, I was going to give way to Mr Malarkey ...

Mr Malarkey: I was going to move that we move out of Committee.

Mr Baker: Ah, right.

Just one point I would like to raise and it is to do with girls under the age of 16, which I think is clause 9. My interpretation of it – and is Mr Connell not with us any more?

The Speaker: It would appear not.

Mr Baker: It implies or my reading of it infers that essentially doctors can provide abortions to girls under 16 and provided they believe that she has maturity and intelligence, then they can do it and there is no need for any parental awareness of the situation. Now, to me as a parent of two young ladies, whilst it would be a difficult topic to deal with, I think if a young lady had had that sort of experience, for a parent not to know about it, how can you carry out your duties as a parent effectively to support them if this sort of thing has gone on and you have not been made aware of it?
Clearly there is provision in here if she does not have sufficient maturity and intelligence, but there is no clarity around how the GP assesses that, the healthcare professional, and for me I think this is something that needs debate.

The Speaker: Do you have a specific question, in view of … ?

Mr Baker: Well, if I could ask Mr Fayle for his view as a medical practitioner as to that situation, please.

Mr Fayle: You are on to a subject called ‘Gillick competence’. Basically what that says is that you assess the maturity of the person, you try to persuade them to talk to their parents and discuss it with their parents, but if you feel that the child’s health is at risk and you cannot persuade them to talk to their parents about it, then if you feel that they are able to consent, you can proceed.

But in the circumstances, you do your utmost to try and persuade the young woman to talk to her parents about it.

Mr Baker: Thank you for that clarification.

The medical practitioner may do their utmost, but there is nothing in this legislation which requires them to do that.

Mr Fayle: You would be expected as a doctor to be aware of Gillick competence and would be expected to act under those guidelines. It is a very clear teaching in your training as a doctor about Gillick competence.

The Speaker: Mr Cannan.

Oh sorry, Mr Connell, you wanted to come in on that?

Mr Connell: I apologise, Mr Speaker, for being late.

On the question of Gillick competence, as Mr Fayle has already said, it is well drilled into doctors and they know the tests they are required to apply in order to decide whether or not a person under age is capable of making their own decision.

Obviously they will try to educate and persuade the young lady to talk to her parents, but at the end of the day if she does not want to and she is able to make the decision for herself, as the House of Lords in Gillick made clear, she can make the decision.

The Speaker: Mr Cannan, sorry.

Mr Cannan: Thank you, Mr Speaker, and I may come to the hon. experts at the Bar in a second but I direct this question to the mover of the Bill. Just moving on slightly from some of the clauses we have been looking at, I wanted just to question on clause 11(3) and (4), clause 3 states that a person commits an offence if they prescribe a relevant product for, or supply a relevant product to, a pregnant woman intending thereby to procure her miscarriage otherwise than in a National Health Service hospital or otherwise in compliance with that section.

Then clause 11(4) goes on to say that:

For the sake of clarity, a pregnant woman does not commit an offence (under this […] Act)—

(a) by soliciting or inciting [such a] person to prescribe a relevant product for her, or to supply a relevant product to her …

Can I ask the hon. mover of the Bill at this stage why he felt that a pregnant woman should be absolved of any blame when soliciting or inciting such a person to prescribe a relevant product, but the person who is prescribing it or administering it should be guilty of an offence?
The Speaker: Dr Allinson.

Dr Allinson: Thank you, Mr Speaker.

Certainly I am quite happy to answer your question. Can I just make the previous point though, that the phrase ‘Gillick competence’ is not just about abortion rights; it was brought in originally in terms of prescribing contraceptives to women under the age of 16 and they apply throughout healthcare in terms of any procedure, any prescription that is given. So this is not just centred on abortion services, and it would be quite strange to have legislation — our legislation here to do with abortion — that went against how we apply healthcare across the board for everything else. That would be the first thing.

The Hon. Member for Ayre and Michael, subclauses (3) and (4), you are quite right: (3) makes it a criminal offence to prescribe or supply products to bring on a termination outside the law, as an offence, and this was designed to try to stop the essence of backstreet abortions and to provide things within the NHS in a secure way; but subsection (4) decriminalises women for this and what we were trying to do here is to stop women being criminalised for procuring abortion services.

We have seen that in Northern Ireland with women being prosecuted. Our own Criminal Code allows that at the moment on the Isle of Man, should the Attorney General want to, but it seemed to be against the health of a woman if she needs a termination to actually make her guilty of a criminal offence, when she is trying to provide that.

One of the interesting things that came out of today, talking to Lord Brennan during the break was his ideas for refining section 3 in terms of ‘supplying by any means’, so bringing into that people supplying things over the internet, and again, trying to future proof the legislation but I think it is very important that we do not criminalise women on the Isle of Man for wanting to procure a termination; and what we do is support them and try to provide that service within the NHS.

Mr Cannan: Thank you.

The Speaker: Mr Baker.

Mr Baker: Thank you.

A final point from me, Mr Speaker, is that Mr Fayle touched earlier on the wider context of abortion decisions which are essentially results of a failure at some point in the process, and talked about the need for sex and relationship education and also the adequate provision of contraception, which I know is something that the mover of the Bill has raised in this House recently. There is nothing about those within this Bill, and maybe that is quite correct, that there should not be, but I think it would be remiss of us not to think about how we move forward on those themes as well. We have an Education Bill coming up, for instance.

I would just welcome thoughts of Mr Fayle and Mr Connell on how we might ensure that we are not just dealing with the consequences but actually the prevention as well.

Mr Fayle: It is a big question!

In principle, it is not sexual relationships; it is relationships in general. It starts at a very young age. It is teaching respect, it is about self-respect and about respecting others. Teaching about the importance of relationships and as the child matures, then you will bring in teaching about sexual relationships.

The provision of good sexual health services, education about things like sexually transmitted diseases and sexual health, and provision of a good service on the Island: you have got to remember on the Island, everybody knows everybody else, so you go to your GP to get the pill; your auntie will see you in the GP’s — ‘Oh, I saw your … at the GP’s – what’s wrong with her?’
So you have got to provide a service that will allow young people to get family planning without the world and his wife knowing, because not every teenage girl has that relationship with her parents that they can discuss these things with them.

Then the provision of good sexually transmitted disease health services on the Island as well, because these are all interlinked. But you start off at the beginning with that teaching of respect and self-respect, and then there is a link in of course with child protection, because some of these issues involve inappropriate relationships, and they are always at the back of your mind – or at the forefront of your mind if you are dealing with a very young person who is pregnant. What are the circumstances of this relationship? Is there anything here that is ringing alarm bells?

The Speaker: Mr Robertshaw.

Mr Robertshaw: Thank you, Mr Speaker.

I just want to ask the mover to help me understand in clause 11(2) where we are talking about a pharmacist, are we talking about a prescribing pharmacist or a pharmacist?

Secondly, if there is some limitation because it has to be a prescribing pharmacist, I am somewhat concerned about accessing the appropriate products online. Is there some way that he would like to talk about how that might happen safely?

Thank you.

The Speaker: Dr Allinson.

Dr Allinson: Thank you, Mr Speaker.

A very good question from the Hon. Member.

Parts of this legislation were, as other Hon. Members have said, to try to future proof how we could provide better services in the future. We know that the Health Department are under strain in terms of staffing. We know that people may have conscientious objection to providing a service and we want to make sure that they can exercise that objection, but we still need to provide that service.

This was in no way meant to say that people could walk into a pharmacy and be given abortion tablets and go away. That is not the idea. But what it does give the scope for is a woman might go and have some counselling, let’s say at a family planning clinic and then one or two days later, go and collect the medication from perhaps the hospital pharmacy where she can then take it at home. That was the idea to bring some leeway into how you could provide a service and how you could provide it in the future.

The practicalities are that certainly at the moment, we would want to keep this in-house, in Noble’s Hospital or perhaps in the family planning clinic, and have it run by the medical profession, i.e. perhaps nurses, but also doctors.

As things change, and as nursing training and midwifery training changes, there are calls by the Royal Colleges for them to have more nurse-led services. Quite a few nurses are not prescribers. Some are but some are not. It is quite a long process to get that qualification and so freeing up pharmacists to help them provide that service seemed to be a good idea in the future.

But there are parts of this Bill which will not be enacted straight away but give that flexibility to provide a slightly different service perhaps in the future, if the need arises, to the Department of Health and Social Care.

Mr Robertshaw: Mr Speaker, could you also give regard to purchase online and is there any way of protecting young girls?

Dr Allinson: Thank you, Mr Speaker.
Again, that is a very good question. One of the problems with the internet is regulation. I would say it is almost impossible to regulate people buying things on the internet. It is very difficult to regulate technologies and as a House we will be dealing in the future with things like genome and genetic testing and how far we go – and it is not just us. Society as a whole is struggling over these things.

So it is very difficult to prosecute somebody the other side of the world for sending a package. What we can do though, through this legislation, is in clause 11(3). I have already talked to the drafter about this – perhaps bringing in a slight change of wording in terms of ‘or supplies by any means a relevant product’, so that those people who were supplying online who we could find out, who are doing it against the law here, that they perhaps could be prosecuted on the Isle of Man. That is a possibility, that we can use this legislation, and I will be talking to the drafter afterwards about that, but it is a very difficult thing to police.

One of the reasons to bring this in, particularly as the Hon. Member for Ayre and Michael talked about, in subsection (4), is that we know that people are buying these tablets online at the moment and taking them in their homes. The Post Office do a job in terms of intercepting these packages, but they are still going through. Some are from very reputable sources, sent with the best will; others we do not know. They could be almost anything that you buy online in the same way as we know that people are being sold fake drugs, fake Viagra, lots of things are available online.

If a woman takes these products and gets ill, they have to be able to seek medical help without feeling that they are going to be criminalised, and that is what section 4 brings in, that if they do take other products and suddenly have problems in terms of haemorrhage or pain or bleeding, they can seek medical help and be honest about what they have taken without the fear of prosecution.

I have heard anecdotally – and again we are going back to anecdotes, but we have had quite a few of those this morning – that women on the Isle of Man have taken abortion tablets that they have bought online, had a big bleed, gone to Noble’s and have had to say that they have had a miscarriage. They have had a scan then and been told, ‘Oh no, the baby’s fine, the baby’s fine!’ That is not what they need to hear but they have not been able to tell people what they have actually taken.

So it is very important that we have that flexibility that women can be honest with their healthcare provider to tell them what they have taken, how they have got into this position, without fearing prosecution for their own health.

**The Speaker:** Mr Robertshaw.

**Mr Robertshaw:** Thank you, Mr Speaker.

I just want to revisit ultrasound services and perhaps address the Minister here as well. We have heard the role that ultrasound plays and also, when I was reading up on the World Health authority guidelines on abortion, it was talking about how it – the World Health Organization – considers it important wherever possible to separate ultrasounds for a woman pursuing an abortion from those pursuing a routine ultrasound scan. Do we have a long waiting list at the moment for our ultrasound scan services and would that impact or inhibit the provision of these services within the context of this Bill?

If he is not able to give me the answer now, could he perhaps circulate it before we get to the final clauses stage?

**The Speaker:** You have an answer to the question?

**Mr Ashford:** I am happy to reply, Mr Speaker, in that I will certainly get the information for the Hon. Member.
I do have an indication in my head of what the waiting list is, but I do not want to say it on the floor of the House now and then be proved wrong later. So I will get the information and make sure it is circulated.

Mr Robertshaw: Could he also perhaps think about the World Health authority’s thinking about separation of the service?

Mr Ashford: It definitely can be considered, Mr Speaker.

The Speaker: Dr Allinson.

Dr Allinson: Thank you, Mr Speaker. As with lots of different issues, there are differences of opinion in terms of this. The Royal College of Obstetricians and Gynaecologists – the UK-based organisation that controls all consultants – does actually in their recommendations from their 2011 paper say that the use of routine pre-abortion ultrasound scanning is unnecessary, but it should be available as it may be required as part of the assessment, and should be provided in a setting and manner sensitive to the woman’s situation.

I think those three are important. When I talked to the existing staff at Noble’s Hospital, they are keen to still have the ability to scan women, partly to know how far pregnant they are, because some women do not know, but partly because of the worry about either molar pregnancies or ectopic pregnancies which can happen. They are very rare, but can happen.

When I have talked to the ultrasound staff at Noble’s, there is an increased requirement for ultrasound. A simple dating ultrasound scan is relatively straightforward. I used to do them myself in terms of an early pregnancy unit, and I think with the right resources could be provided on the Island.

I think it is important to remember the number of people we are dealing with here. If we say two to three women a week might be requiring these services, I do not think that that is too much for the health services to actually provide within existing resources, but they may need a few extra slots to provide that.

The Speaker: I think, Mr Malarkey, this is your cue. (Laughter)

Mr Malarkey: Oh right! I move, Mr Speaker, that we come out of Committee.

The Speaker: That business be resumed.

Mr Ashford.

Mr Ashford: I beg to second, Mr Speaker.

The Speaker: The question is that business be resumed. Those in favour, please say aye; against, no. The ayes have it. The ayes have it.

On behalf of the House, I am sure you would wish me to convey our thanks to our witnesses today: to Ms Jasvinder Sanghera CBE, Lord Brennan QC, Mr Fayle and Mr Connell for their attendance and their evidence.

Members: Hear, hear.

The House moved out of Committee and business was resumed.

The Speaker: Dr Allinson to move the debate on clause 1.
Dr Allinson: Thank you, Mr Speaker.

I would like to reiterate your thanks to the speakers and can I also thank this House. I think the dignity and the respect we have shown to this subject today is very moving, and I think it will go a long way to actually fostering a greater respect perhaps amongst the public for what we do in Tynwald.

I would like to move that consideration of clause 1 be adjourned sine die.

The Speaker: We need a seconder for that proposal?
Miss Bettison.

Miss Bettison: Yes, I beg to second.

The Speaker: Does anyone wish to speak?

The proposal therefore is that debate on clause 1 be adjourned sine die, which means we will return to it at another time. All those in favour, please say aye; against, no. The ayes have it. The ayes have it.

Dr Allinson, I understand it is your intention to resume consideration of clauses on 6th March. Is that correct?

Dr Allinson: Yes, please.

The Speaker: In which case, I need to remind Hon. Members that any amendments need to be with the Secretary of the House by 5 p.m. on Monday, 26th February.