

**Observations on the  
Protection of Life During  
Pregnancy Bill 2013**

**July 2013**



## **Executive Summary/Summary of Recommendations<sup>1</sup>**

1. The Irish Human Rights Commission (“IHRC”) is Ireland’s National Human Rights Institution, established by the Irish Government pursuant to the Human Rights Commission Acts 2000 and 2001 and functioning in accordance with the United Nations Paris Principles. The IHRC has a statutory remit to promote and protect the human rights of all persons in the State. One of the functions of the IHRC is to examine legislative proposals and assess their compliance with national and international human rights standards and make recommendations for amendments needed to ensure Ireland is in line with its obligations. It is also one of the general functions of a National Human Rights Institution in Europe to support the execution of judgments of the European Court of Human Rights at the national level.

2. The following observations are provided on foot of the statutory remit of the IHRC, and analyse the draft legislation. The IHRC has focussed its analysis on the compatibility of the current legislation with the Constitution and the international human rights instruments to which Ireland is party.

### **Recommendations**

- The right to life of girls and women should be protected through effective and accessible procedures pursuant to the legislation;
- The right to life of the unborn should also be protected, pursuant to the legislation and the safeguards contained therein;
- The legislation lacks a clear pathway for a woman or girl seeking access to the procedure set out in sections 7 and 9 of the Bill through which a medical certification is made or refused and should be clarified accordingly;
- Where a girl or woman receives a ‘negative’ review decision under sections 10 to 14 of the Bill, she should receive written reasons for the decision in the event she wishes to seek judicial review of the decision;

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<sup>1</sup>These legislative observations represent the majority view of 12/14 of the Members of the Irish Human Rights Commission.

- To ensure that any judicial review of a negative decision is accessible and effective, an expedited procedure before the High Court should be provided, with provision for legal aid, and anonymity;
- The number of examinations that a girl or woman is to be subjected to where she seeks treatment under this legislation, particularly girls and women in vulnerable situations, primarily those at risk of suicide, should be framed so as not to unduly increase her risk of mental anguish or suffering. The provision for examination (at initial assessment and on review) by four different psychiatrists raises concerns regarding the intrusiveness of the procedure, on the woman's right to respect for her private and family life under Article 8 of the ECHR;
- In the absence of clear procedures under which persons with intellectual disabilities can be supported in receiving information and advice and in making decisions regarding the procedures set out in sections 7 to 9, and in relation to reviews under sections 10 to 14 of the Bill, the rights of such girls and women may not be adequately vindicated. To address this lacuna, mental capacity legislation, properly formulated to support decision-making of persons with disabilities, should be introduced in tandem with this Bill;
- The Bill should specify that where the action or inaction of a person claiming to have a conscientious objection and refusing to carry out or assist in carrying out a lawful procedure knowingly contributes to the death of or significant harm to the woman, that person and/or the institution shall be guilty of a specified offence;
- The term 'obstetrician' should be replaced in section 7 with suitable terminology which would cover other medical specialists;
- In relation to the power of the Minister to prohibit the performance of treatment under sections 7 to 9 of the Bill, this power must be strictly limited to ensure that the right to access lawful termination of pregnancy is effectively vindicated and its intended use should be specified in the Bill or accompanying regulations;
- All review committees should be required to provide written reasons for their decisions, which are provided as soon as is practicable to the woman concerned;
- Provision should be made in the Bill for detailed regulations in relation to the practice and procedure to be adopted for the reception, storage, prohibition of onward transmission and destruction of records referred to in section 20, and that

the advice of the Data Protection Commissioner would be sought, given the gravity of the impact of a potential disclosure of the medical record of a girl or woman for her Article 8 ECHR rights;

- It should be stipulated in explicit terms in section 20 that any identifying information regarding a pregnant girl or woman would be excluded from the notification to be transmitted to the Minister;
- In order to negate the potential “chilling effects” of sections 22 and 23 in relation to the criminal offence’s up to 14 years imprisonment, which was noted by the ECtHR in *A, B and C*, it is recommended that a statutory duty be placed on the DPP to promulgate guidelines as to the factors that will be taken into account in deciding when a prosecution should be initiated by her Office under those provisions;
- The Bill should address the situation of young women and girls in a crisis pregnancy (including following rape) by setting out the procedures which should apply to take into account their age and vulnerability, potential exposure to criminal sanction, and their consent to treatment, including where the child is in HSE care. The Bill should further provide that young women and girls in a crisis pregnancy have a right to accessible age-appropriate sexual and reproductive health services without discrimination;
- The Bill should address the specific situation of girls and women from ethnic minorities and/or non-English speaking background and specify that they should have a pathway adapted to their needs to facilitate access to the procedures set out in sections 7 to 9 of the Bill, and the reviews pursuant to sections 10 to 14 of the Bill;
- The Bill should be clear as to how medical practitioners will be accountable to women and girls who use their services, including in relation to issues of accessibility and referrals;
- Insofar as the Bill does not provide for access to a lawful abortion under the procedures set out in sections 7 to 9 for women or girls in a crisis pregnancy with a fatal foetal abnormality or following rape, consideration should be given to reassessing of the Constitutional position as it prohibits access to a lawful abortion for women and girls in such situations.
- A long title should be included in the Bill for the purpose of clarity

## I. Introduction

3. The Irish Human Rights Commission (“IHRC”) is Ireland’s National Human Rights Institution, established by the Irish Government pursuant to the Human Rights Commission Acts 2000 and 2001 and functioning in accordance with the United Nations Paris Principles. The IHRC has a statutory remit to promote and protect the human rights of all persons in the State. One of the functions of the IHRC is to examine legislative proposals and to report its views on the implications of such proposals for human rights, having regard to the Constitution and international human rights conventions to which Ireland is a party.<sup>2</sup> The IHRC is also mandated to make recommendations to the Government as it deems appropriate in relation to the measures which the IHRC considers should be taken to strengthen, protect and promote human rights in the State.<sup>3</sup>

4. The Observations herein on the Protection of Life During Pregnancy Bill 2013, are being submitted to Government on foot of this statutory remit. Insofar as that remit, by virtue of section 2 of the Human Rights Commission Act 2000, covers both the rights guaranteed under the Constitution and those international conventions to which the State is a party, these Observations are structured to consider the provisions of the Bill against first the Constitutional standards and then the relevant international human rights standards. After considering the Bill’s provisions, the Observations will then identify those matters not addressed in the Bill which may raise additional human rights concerns.

5. The Protection of Life During Pregnancy Bill 2013, was published as a draft Bill on 6 June 2013. The publication of the Bill is the culmination of a process that began in December 2010, when the European Court of Human Rights (ECtHR) delivered its judgment in *A, B and C v Ireland*<sup>4</sup>, and which found Ireland to be in breach of Article 8 of the Convention in relation to one of the applicants by reason of the practical inaccessibility of any legislative or regulatory system to deal with a lawful termination of pregnancy in Ireland pursuant to the provisions of Bunreacht na hÉireann. The *A, B and C* case directly relates back to the

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<sup>2</sup> See sections 8(a) and 8(b) of the Human Rights Commission Act 2000.

<sup>3</sup> Section 8(d) of the Human Rights Commission Act 2000.

<sup>4</sup> Application No: 25579/05, Grand Chamber 16/12/2010.

judgment of the Supreme Court in *The Attorney General v X* (“the X case”)<sup>5</sup> from 1992, which had found that a termination of a pregnancy is lawful where there is a “real and substantial” risk to the life of the pregnant woman, which can only be avoided by the termination of her pregnancy. In that case the risk identified was one of suicide, whereas *A, B and C* was concerned with physical risk to life of Applicant C.

## II. Binding nature of judgments of the European Court of Human Rights

6. By virtue of Article 46 of the European Convention on Human Rights (ECHR),<sup>6</sup> Ireland is required to “abide by” the final judgment of the ECtHR. The execution of judgments is supervised by the Committee of Ministers, which is assisted the Department for the Execution of Judgments of the Court. In order to comply with its legal obligation to implement the judgment in *A, B and C v Ireland* and further to the procedures for execution of judgments, the State submitted an Action Plan to the Council of Europe’s Committee of Ministers.<sup>7</sup> That Action Plan set out a proposal to set up an Expert Group to consider the Judgment and make recommendations to Government regarding its implementation. The Expert Group identified four options available to Government to address the *A, B and C* Judgment and favoured a legislative option supported by regulations. In publishing the General Scheme of the Protection of Life during Pregnancy Bill 2013 (“the General Scheme”) and the Protection of Life during Pregnancy Bill 2013, the Government has accepted this recommendation.

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<sup>5</sup> *Attorney General v X* [1992] 1 IR 1. The facts of this case are well known. A young girl of 14 years of age became pregnant as a result of being raped. She travelled to the UK, with her parents, to obtain an abortion. Before going to the UK, her parents had enquired with the Garda Síochána if it would be possible to carry out tests on retrieved foetal tissue to confirm the identity of the rapist. The Garda Síochána consulted with the DPP who in turn consulted the Attorney General. The Attorney General brought an application to the High Court seeking an injunction restraining X from leaving the jurisdiction or from arranging or carrying out a termination of the pregnancy, and on 7 February 1992, Mr Justice Costello granted an interim injunction, *ex parte*, in the High Court. X and her parents returned from the UK and successfully appealed the injunction to the Supreme Court.

<sup>6</sup> Article 46 – Binding force and executing judgments “1. The High Contracting Parties undertake to abide by the final judgments of the Court in any case to which they are parties.”

<sup>7</sup> For Ireland’s most recent Action Plan of 9 February 2013, as submitted by the Irish Government to the Council of Europe Committee of Ministers, *see* <https://wcd.coe.int/com.instranet.InstraServlet?command=com.instranet.CmdBlobGet&InstranetImage=2246764&SecMode=1&DocId=1980138&Usage=2> The terms of reference of the appointed Expert Group were threefold; firstly to examine the judgment of the *A, B and C* Case, secondly to “elucidate its implications for the provision of health care services to pregnant women”, and finally “to recommend a series of options on how to implement the judgment”, *ibid* at p. 55.

### III. Overview of legal obligations arising from *A, B and C v Ireland*

7. In August 2005, three women (known as “A”, “B” and “C”) brought applications to the European Court of Human Rights alleging that restrictions on abortion in Ireland were in breach of their human rights.<sup>8</sup> A and B had travelled to the United Kingdom for abortions for reasons of health and/or wellbeing. C, in remission from cancer, also travelled to the United Kingdom for an abortion. Over and above the arguments advanced by A and B, C argued before the ECtHR that, although she believed her pregnancy put her life at risk, there was no procedure by which she could have established whether she qualified for a lawful abortion in Ireland on grounds of the risk to her life.

8. The legal case advanced by all three applicants in *A, B and C v Ireland*<sup>9</sup> was that the restriction on abortion in Ireland violated their rights under Articles 3, 8, 13 and 14 (when read in conjunction with Article 8) of the ECHR. The ECtHR’s consideration of the case was under Article 8 of the ECHR, namely respect for private and family life.<sup>10</sup> The Judgment of the Grand Chamber of the ECtHR was delivered in December 2010, and the court found that there had been no violation of the rights of A and B, but there had been a violation of the rights of C.

9. In *A, B and C v Ireland*, addressing the issue under Article 8 of the ECHR, the ECtHR afforded Ireland a wide “margin of appreciation” in deciding when life commenced in providing constitutional protection for “the unborn” and in seeking to balance the rights of a mother and the rights of “the unborn”. In doing so, the ECtHR again cited its finding in *Vo v France*<sup>11</sup>, that this was so because there was no consensus on when the right to life begins “so that it was impossible to answer the question whether the unborn was a person to be protected for the purposes of Article 2.”<sup>12</sup> The ECtHR found that since the rights claimed on

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<sup>8</sup> Report of the Expert Group on the Judgment in *A, B, and C v Ireland*, November 2012, at pp. 22-24.

<sup>9</sup> Application No. 25579/05, Grand Chamber 16 December 2010.

<sup>10</sup> The Court found that the facts alleged do not disclose a level of severity falling within the scope of Article 3 of the Convention; at para 164. In light of its finding in relation to C (see below), it found that separate issues did not arise under Articles 13 and 14.

<sup>11</sup> Judgment 8 July 2004 (Application No. 53924/00).

<sup>12</sup> *Ibid.*



behalf of the foetus and those of the mother were “inextricably interconnected”, the “margin of appreciation” accorded to a State’s protection of the unborn necessarily translates into a “margin of appreciation” for that State as to how it balances the conflicting rights of the mother.<sup>13</sup>

10. It was only in respect of the third applicant (“C”) that a breach of the ECHR was found, the ECtHR finding no violations in relation to the first and second applicants (“A” and “B”) insofar as the State had struck a “fair balance” between the right of A and B to respect for their private lives and the rights invoked on behalf of the unborn”.<sup>14</sup>

11. In relation to Applicant C, however, the judgment of the ECtHR was unequivocal - it considered that in respect of Article 8 (right to respect for private and family life), the legal framework in place allowing for abortions under certain restricted circumstances was unclear and lacked certainty from the perspectives of both pregnant women and medical practitioners. The ECtHR was heavily influenced by the fact that the X case had identified a constitutional right to a termination of pregnancy under limited circumstances but that this right had remained without any legislative implementation.

12. The concerns and legal issues raised by the ECtHR can be summarised in the following manner; firstly that in light of “*the chilling factor*” of the criminal law provisions, namely section 58 of the Offences Against the Person Act 1861<sup>15</sup> and the general lack of certainty, the “*normal process of medical consultation*” between a pregnant woman in a crisis pregnancy and her doctor could not constitute “*an effective means of determining*

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<sup>13</sup> At para 237.

<sup>14</sup> The ECtHR found that having regard to the right to lawfully travel abroad for an abortion with access to appropriate information and medical care in Ireland, coupled with the protection to be accorded to the right to life of the unborn under domestic law, the ECtHR held that the prohibition in Ireland of abortion for “health and well-being reasons” did not exceed the broad margin of appreciation accorded in that respect to the Irish State but struck a “fair balance” between the right of the A and B to respect for their private lives and the rights invoked on behalf of the unborn so that there was no violation of their rights under Article 8 of the ECHR; at paras 241-242.

<sup>15</sup> Section 58 provides as follows: “Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or not be with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of a felony, and being convicted thereof shall be liable to be kept in penal servitude for life.”

*whether an abortion may be lawfully performed in Ireland on the ground of a risk to life”<sup>16</sup>, and secondly that the constitutional courts are not the “appropriate fora for the primary determination”<sup>17</sup> of this issue. It stated that “neither the medical consultation nor litigation options relied on by the Government constituted effective and accessible procedures which allowed the third applicant to establish her right to a lawful abortion in Ireland.”<sup>18</sup>*

13. The conclusion of the Court was that “... the authorities failed to comply with their positive obligation to secure to the third applicant effective respect for her private life by reason of the absence of any implementing legislative or regulatory regime providing an accessible and effective procedure by which the third applicant could have established whether she qualified for a lawful abortion in Ireland in accordance with Article 40.3.3 of the Constitution.”<sup>19</sup>

#### **IV. Analysis of the provisions of the Protection of Life During Pregnancy Bill 2013**

##### **A. Object and Purpose of the Bill**

14. The Bill creates an offence of intentional destruction of unborn human life while also setting out a legal exception for the ending of an unborn human life that comes about as a result of a medical procedure for the termination of pregnancy required to avert a real and substantial risk to the pregnant woman or girl’s life.

15. The IHRC welcomes the fact that the Bill contains a Preamble (not referred to as a long title) which sets out the object and purpose of the Bill. However, the IHRC **recommends** that a long title should be included in the Bill for the purpose of clarity. In addition the Preamble as drafted does not sufficiently explain the contents of the Bill, which essentially addresses the narrow exceptions to the general prohibition on the termination of a pregnancy for the purposes of protecting human life while also elaborating the constitutional protections under Article 40.3.3 through the creation of an offence of the

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<sup>16</sup> *Ibid* at paras 255 and 258.

<sup>17</sup> *Ibid* at para 258.

<sup>18</sup> *Ibid* at para 263.

<sup>19</sup> *Ibid* at para 267.

intentional destruction of unborn human life. It is also not indicated that the proposed legislation is to address the judgment of the European Court of Human Rights in *A, B and C v Ireland* and more specifically the Supreme Court judgment in the X case. An explicit reference to these judgments would be useful for any future Court that is required to interpret the legislation.

## **B. Section 2 - Interpretation**

16. The Bill sets out a number of definitions, including in relation to the meaning to be ascribed the “unborn” as protected under Article 40.3.3 of the Constitution. Section 2 provides that “unborn, in relation to a human life, is a reference to such a life during the period of time commencing after implantation in the womb of a woman and ending on the complete emergence of the life from the body of the woman”.

### **Analysis against the Constitution**

17. Article 40.3 of the Constitution provides protection for both the pregnant woman and the “unborn”.<sup>20</sup> In the X case, the Supreme Court, in creating an exception to the general prohibition on the termination of a pregnancy where there is a “real and substantial” risk to the life of the woman, declined to define the term “unborn”.

18. However, the Supreme Court in *Roche v Roche*<sup>21</sup> held that “cryogenically preserved” embryos were not “the unborn” within the meaning of Article 40.3.3”.<sup>22</sup> In that case, Denham J (as she then was) held that whereas pre-implanted human embryos did not come within the Constitutional definition of the unborn, “the interpretation of the “unborn”

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<sup>20</sup> Article 40.3. provides:

“1° The State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen.

2° The State shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name and property rights of every citizen.

3° The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.

This subsection shall not limit freedom to travel between the State and another state.

This subsection shall not limit freedom to obtain or make available, in the State, subject to such conditions as may be laid down by law, information relating to services lawfully available in another state.”

<sup>21</sup> [2010] 2 IR 321.

<sup>22</sup> [2010] 2 IR 321 at 382 per Hardiman J.

as arising after implantation constituted a harmonious interpretation of the Constitution.”<sup>23</sup> The Explanatory Note of the General Scheme stated that in specifying implantation in the womb, the definition “aims to exclude the treatment of ectopic pregnancies<sup>24</sup> and emergency contraception from the scope of this Bill”. It is further to be recalled that this legislation is for the purpose of protecting human life through the termination of pregnancy where there is a “real and substantial” risk to the life of the woman and creates an offence of the intentional destruction of human life. It does not remove the constitutional protection granted to the unborn by permitting the intentional killing of a viable foetus who may be delivered at mid to late term as a result of the medical procedures outlined in sections 7 to 9 of the Bill. The ending of an unborn human life by virtue of this Bill must arise as an unavoidable consequence of a medical procedure required to avert a real and substantial risk of loss of life to the pregnant girl or woman if it is not to be a criminal offence. Where the unborn is capable of surviving the medical procedure set out in sections 7 to 9 the constitutional protection of its life remains in place.

19. Otherwise, it would appear that the definition of the “unborn” in the Bill extends from the moment of implantation (as opposed to conception) to the moment of birth. Thus the protections afforded under Article 40.3.3 of the Constitution to the right to life of the unborn<sup>25</sup> extends for this span of time and would appear to be consonant with the Constitutional position as defined in *Roche v Roche*.<sup>26</sup>

### **Analysis against human rights conventions ratified by the State**

20. In relation to the European Convention on Human Rights (“ECHR”), as noted above, the ECtHR in *Vo v France* decided not to define when life commences for the purpose of the Convention.<sup>27</sup> Thus under the ECHR, the only person with justiciable rights is the pregnant

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<sup>23</sup> [2010] 2 IR 321 at 369-371.

<sup>24</sup> Namely, implantation outside the uterus.

<sup>25</sup> Whereby “with due regard to the equal right to life of the mother”, the State “guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right”.

<sup>26</sup> [2010] 2 IR 321.

<sup>27</sup> In *Vo*, the ECtHR noted that unlike Article 4 of the American Convention on Human Rights (which provides that the right to life must be protected “in general, from the moment of conception”), Article 2 of the ECHR was silent as to the temporal limitations of the right to life and, did not define “everyone” (“toute personne”) whose “life” is to be protected by the ECHR. Thus the ECtHR noted that it had yet to determine the issue of the “beginning” of “everyone’s right to life” within the meaning of this provision and whether the unborn child has such a right. It noted that both the European Commission and ECtHR had held that “the unborn child is not

woman and the balancing exercise required under the constitutional protection of the right to life of the unborn is not replicated under the ECHR. Rather, the question of whether, and if so, how, the State balances any conflicting rights of the pregnant woman and the unborn falls within the State's, not unlimited, "margin of appreciation". Thus, the definition contained in the present Bill would not appear to conflict with ECHR rights unless the application of the definition of the "unborn" led to a situation where either the right to life or the right to respect for private and family life of the pregnant woman were violated. This, however, does not follow from the current definition.

21. Under other international conventions to which the State is a Party, the State's discretion in formulating its laws on the issue of abortion as it considers appropriate is recognised, provided that any restrictions relating to how a lawful abortion can be obtained (i.e. as permitted under domestic law) are capable of being justified and provided that such restrictions do not totally impair the woman's human rights such as the right to life, freedom from torture or cruel, inhuman or degrading treatment or punishment or right to health (which includes the removal of barriers that inhibit women's effective access to reproductive and health services including on a non-discriminatory basis).<sup>28</sup>

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regarded as a "person" directly protected by Article 2" and had also held that if "the unborn do have a "right to life", it is implicitly limited by the mother's rights and interests." Thus the issue of when the right to life begins came within States' "margin of appreciation" (see below) meaning that States could decide when life begins and formulate their laws on that basis. Thus although Article 2 did not recognise a right to life "pre-natally", the ECtHR had not however "ruled out the possibility that in certain circumstances safeguards may be extended to the unborn child"; at para 80.

<sup>28</sup> In the context of the ICCPR, see the 2008 Concluding Observations on Ireland's Third Periodic Report, where the Human Rights Committee drew attention to the "highly restrictive circumstances under which women can lawfully have an abortion"; CCPR/C/ILR/CO/3 30 July 2008, Human Rights Committee, Ninety-third session, Geneva, 7-25 July 2008 at para 13 and noted that Ireland should take measures to ensure women do not have to resort to abortions abroad. In the 2011 Concluding Observations on Ireland's Initial Report, the Committee against Torture urged Ireland "to clarify the scope of legal abortion through statutory law and provide for adequate procedures to challenge differing medical opinions as well as adequate services for carrying out abortions in the State party, so that its law and practice is in conformity with the Convention" CAT/C/IRL/CO/1 17 June 2011, para 26. In *L.M.R. v. Argentina* CPCR Communication No. 1608/2007 (2011), Views adopted on 29 March 2011, the Human Rights Committee held that the omission of the State in providing a route for a lawful abortion caused L.M.R. physical and mental suffering constituting a violation of Article 7 (ill-treatment) that was made especially serious by the victim's status as a young girl with a disability. In the context of the ICESCR, General Comment No. 14 of the CESCR Committee on the right to health under Article 12 ICESCR provides that the right to health extends to "control one's health and body, including sexual and reproductive freedom and the right to be free from interference". The General Comment makes clear that any and all barriers to women's right to control of their own health should be removed, including barriers interfering with access to health services, education and information. In the context of CEDAW, the CEDAW Committee in its General Recommendation No. 24 on Women and Health stress that a woman's right to health includes the removal of barriers that inhibit women's effective access to reproductive and health services. In the case law in respect of the interpretation of Article 12 by the CEDAW Committee is also of relevance to Ireland's

22. “Woman” is defined in Section 2 of the Bill as a female person of any age, and so would encompass a minor. In addition, it is noted that there is no gestational point up to which a medical procedure under the proposed legislation will be permitted. The human rights implication of not distinguishing in the Bill between minor girls and women who have reached the age of majority, will be considered further below in relation to section 16 of the Bill. However, the IHRC is concerned that there is no distinction made between women (over 18 years) and teenagers or girls in this Bill (discussed further below).

23. In relation to any medical procedure authorised under the Bill which results in the unavoidable termination of the life of the unborn there is a requirement that a “reasonable opinion” must have been formed by relevant medical personnel (or on review a committee) in relation to the physical and suicidal risks to the woman’s life under sections 7, 8, and 9 of the Bill. Such a “reasonable opinion” is one “formed in good faith which has regard to the need to preserve unborn human life as far as practicable.”

24. While it has been observed that “reasonable opinion” may indicate a subjective element in the decision making by doctors under the Bill, the requirement to have regard to the preservation of unborn life arises from the constitutional protection of the right to life of the unborn under Article 40.3.3. It is therefore presumed that a “reasonable opinion” for the purposes of the legislation is the subjective opinion of a medical professional based upon objective medical evidence. It is noted that in the Explanatory Notes to Head 2 of the General Scheme, it was stated that this requirement governs the medical procedure, such

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obligations under CEDAW. In *L.C. v Peru* Communication No. 22/2009, CEDAW/C/50/D/22/2009 Views 4 November 2011, the CEDAW Committee found that the complainant (a minor) did not have “access to an effective and accessible procedure allowing her to establish her entitlement to the medical services that her physical and mental condition required”; at para 8.15. In *da Silva Pimentel v. Brazil*, Communication 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008 (CEDAW, July 25, 2011), the CEDAW Committee found that in addition to the complaint’s deceased daughter suffering sex discrimination and discrimination on the basis of her socio-economic background (being of African descent) in being refused access to an abortion, the State had failed to exercise its “due diligence” obligation to take measures to control the activities of non-State actors (the health service facilities: “the duty to regulate and monitor private health-care institutions”) to ensure the victim’s rights. Further, it held that there was a lack of “effective judicial action and protection” to secure her rights under Articles 12 and 12(c) of CEDAW. In 2005, the CEDAW Committee expressed concern in relation to Ireland’s abortion laws: “the Committee reiterates its concern about the consequences of the very restrictive abortion laws, under which abortion is prohibited except where it is established as a matter of probability that there is a real and substantial risk to the life of the mother that can be averted only by the termination of her pregnancy.”

that a doctor should do everything possible to save the life of the unborn where possible, but that this should not be a factor to be considered when determining that there is a “real and substantial” risk to the life of the woman. In this regard, the medical procedure involved must not simply be aimed at termination of the pregnancy to save the life of the pregnant woman, there must also be an attempt to preserve the life of the unborn. Insofar as these definitions seek to provide procedural protections to both rights, they would appear to be in conformity with the Constitution. This is in keeping with the express prohibition in the Bill of the intentional killing of an unborn through the creation of a specific offence and the Bill’s purpose in providing for the termination of a pregnancy for the purposes only of saving the life of the pregnant woman.<sup>29</sup>

25. In relation to international conventions to which the State is a party, the question of the legal test to be met and its clarity will be considered in the context of sections 7, 8, 9 and 13 considered further below.

### **C. Section 3**

26. Section 3 provides that the Minister may specify “any institution managed by” the Health Services Executive as an “appropriate institution” for medical procedures leading to termination of pregnancy provided certain conditions such as the provision of intensive and critical care in-patient services are met.

#### **Analysis against the Constitution**

27. Section 3 would appear to be an “enabling provision”. It allows for strict controls of the institutions in which the balancing exercise required on foot of the X case, and which involve prescribing controlled medical procedures as a result of which the life of the unborn is “ended” (see sections 7 to 9 below) may occur. As a consequence, section 3 would appear to conform to constitutional requirements.

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<sup>29</sup> In this regard see *Fleming v Ireland & ors*, [2013] IESC 19 (2013) where the Supreme Court stated that given the importance afforded the right to life under the Constitution “there is no constitutional right which the State, including the courts, must protect and vindicate, either to commit suicide, or to arrange for the termination of one’s life at a time of one’s choosing”; at para 114.

### **Analysis against human rights conventions ratified by the State**

28. Under international human rights standards, one of the elements of the right to health is accessibility. Thus the “appropriate institutions” to be identified for termination of pregnancy procedures under sections 7 to 9 of the Bill would need to be geographically, as well as economically and practically accessible to all girls and women in a crisis pregnancy who may face a real and substantial risk of loss of life (see also commentary on section 7, below). Further, the State would be required to ensure that information on these institutions is easily accessible and readily available to such girls and women.

#### **D. Section 4**

29. Section 4 is the standard provision in this type of legislation allowing the relevant Minister to make regulations in relation to certain matters to be prescribed in the Bill. In this regard the Minister has the power to make regulations on the form, manner and information to be contained in a certification (see below), the records to be kept by appropriate institutions, and locations other than appropriate institutions, with regard to the medical procedures carried out in respect of pregnant women and the form of the application for review of a medical opinion.

30. The IHRC considers that this section does not raise any issue regarding compliance with constitutional or international human rights standards although any regulations prescribed under this provision would be required to be separately considered for their compatibility under those standards.

#### **E. Section 5**

31. This section repeals sections 58 and 59 of the Offences Against the State Act 1861, which are the existing criminal sanctions regarding providing or procuring an abortion. Similar criminal sanctions are proposed to be re-enacted under sections 22 and 23 of the Bill, and the constitutional and international human rights standards implications of those sections will be considered under those specific sections below.



## **F. Section 6**

32. Section 6 is a standard provision regarding the expenses of the Act as incurred by the Minister for Health, and the IHRC does not consider that it raises an issue of human rights.

## **G. Section 7- Risk of Loss of life from Physical illness**

33. Sections 7 to 9 of the Bill are contained in Chapter 1 of the Bill entitled “risk to loss of life of pregnant woman” and represent its substantive aspects insofar as their provisions allow for the ending of unborn human life only where the pregnant woman or girl’s life is at risk and this is the unavoidable consequence.

34. Section 7(1) of the Bill addresses the circumstances under which “it shall be lawful” to carry out a medical procedure which results in “an unborn human life” being “ended”. Those circumstances are set out in subparagraphs (a) and (b) and concern a risk to life caused by physical illness. There are three procedural requirements outlined as follows:

- a) The procedure is carried out by an obstetrician at an appropriate institution;<sup>30</sup>
- b) Two medical practitioners<sup>31</sup> must have examined the woman in question and have jointly certified in good faith that there is a real and substantial risk of loss of the pregnant woman’s life other than by way of self-destruction, and
- c) in their reasonable opinion this risk can only be averted by carrying out that medical procedure.<sup>32</sup>

35. If there is certification that the medical procedure specified under section 7 is necessary, the certifying obstetrician must make the relevant arrangements for carrying out the medical procedure. Any refusal to provide an opinion under this section, or a decision

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<sup>30</sup> “Appropriate institution” is dealt with in section 3 of the Bill, and which allows the Minister for Health to specify by order (statutory instrument) the institutions that will be recognised under the Act. According to the schedule to the Act, 25 such institutions will be immediately recognised under the legislation and presumably others may be added or subtracted at a later date. These would appear to be all public obstetric units, and institutions providing emergency medical care so long as they meet certain criteria regarding medical staff and specialisation.

<sup>31</sup> One of those medical practitioners must be an obstetrician and the other must be a relevant medical specialist.

<sup>32</sup> In addition, it is provided that “if practicable” at least one of the medical practitioners referred to in the section should, with the consent of the woman, consult with the woman’s GP (if any) for the purpose of obtaining information in respect of the woman.

not to certify may be subject to review at the instigation of the girl or woman concerned (see further below).

### **Analysis against the Constitution**

36. The “medical procedure” contemplated in section 7, is one carried out by an obstetrician, and in this regard, appears to exclude other forms of medical procedure that might pose a risk to the life of the unborn during pregnancy, but without any direct intention of terminating that pregnancy, such as by an intervention by an oncologist or other specialist relevant to the physical illness identified in the section. Section 7 is therefore directed to the very limited circumstances relating to physical risk to life in which it may be necessary to terminate a pregnancy for the purpose of saving the life of the mother and in the course of which the life of the unborn is presumably also protected to the degree possible where a pregnancy is terminated at a premature stage. In this regard, the Bill operates on the presumption that other medical treatment, necessary for saving the life of a pregnant woman (such as treatment for cervical cancer), but which has the unintended consequence of terminating a pregnancy, is not as such criminalised or contrary to the Constitution, and this would appear to be the correct interpretation of the law as it stands. The IHRC **recommends** therefore that the term ‘obstetrician’ be replaced with suitable terminology which would cover other medical specialists.

37. The provision thus attempts to provide for an exception to the general prohibition on abortion where there is a “real and substantial risk” of loss of the pregnant woman’s life as set out in the X case. In doing so, it attempts to strike the correct balance between the rights of the pregnant woman and the unborn through prescribing the narrow medical circumstances under which a termination of a pregnancy can occur resulting in the unavoidable ending of an unborn human life. This would appear to conform in general terms to the constitutional right to life and the protection afforded to both the pregnant woman and the unborn under Article 40.3 as interpreted by the Supreme Court in the X case. It may be noted that the legislation does not carve out any exception to the direct taking of life. The legislation thus does not permit the direct taking of life where the unborn survives the termination of pregnancy. It is recalled that the legislation is for the purpose of saving life during pregnancy and only allows for the termination of such pregnancy, not the

ending of an unborn human life, *except* where there is a “real and substantial” risk to the girl or woman’s life that cannot be otherwise averted, resulting in the unavoidable consequential loss of the unborn human life.

38. Section 7 is silent, however, as to how the certification by two medical practitioners will come about or be triggered, and it appears that this will be a matter of medical practice. Section 10 of the Bill (see below) deals with the situation of a doctor who refuses to certify that a termination of pregnancy should occur, however this presupposes that the process has been triggered in the first place. It is unclear under the legislation how a woman could formally seek to trigger the certification process required under section 7, particularly if she is unclear whether there exists a risk to her own life occasioned by the pregnancy and where she is not under the direct care of a medical practitioner. As currently drafted, section 7 assumes that the pregnant woman is within the care of a medical practitioner who has referred the woman to an obstetrician, rather than stating that every woman has the right to seek and receive timely health services in her geographical area (arguably a right of all persons in accordance with the constitutional right to bodily integrity).<sup>33</sup> Although it was stated in the General Scheme that the Department of Health will work with the relevant professional colleges in developing guidelines regarding the operation of the legislation,<sup>34</sup> it is also **recommended** that section 7 be amended to reflect the constitutional right to bodily integrity as identified by the Superior Courts<sup>35</sup>

### **Analysis against human rights conventions ratified by the State**

39. It will be recalled that the concerns raised by the ECtHR in *A, B and C* centred on its assessment that the legal framework in place allowing for abortions under certain restricted circumstances were unclear and lacked certainty from the perspectives of both pregnant women and medical practitioners. While section 7 as drafted addresses the issue of certainty for medical practitioners and for the patients of medical practitioners, a question

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<sup>33</sup> *Ryan v Attorney General* [1965] IR 294.

<sup>34</sup> The relevant colleges are; The Institute of Obstetrics and Gynaecology, the Royal College of Physicians and the Irish College of General Practitioners.

<sup>35</sup> See *The State (C) v Frawley* [1976] 1 IR 365. where, citing the right to bodily integrity identified under *Ryan v Attorney General* [1965] IR 294, Finlay P could see “no reason why the principle should not also operate to prevent an act or omission of the Executive, which, without justification, would expose the health of a person to risk or danger”; at 372.

arises as to women in relation to whom access to a medical practitioner may be in doubt, such as women or girls from lower socio-economic backgrounds with limited access to health care, women or girls of ethnic minority backgrounds<sup>36</sup> or women or girls with intellectual disabilities. In particular, such women and girls have the right to accessible information on how to access their health to right - namely an examination followed by an opinion of the obstetrician specified. As noted above, such groups of women or girls have also been identified by the UN Human Rights Committee, the CESCR Committee and the CEDAW Committee in their General Comments on the right to health and in their jurisprudence. It is thus **recommended** that section 7 be amended to provide for an *accessible right* to the procedure for girls and women seeking access to a lawful termination of pregnancy (as set out in the X case).

#### **H. Section 8 - Risk of loss of life from physical illness in emergency.**

40. Section 8 of the Bill deals with emergency situations arising from a physical cause (not a risk of suicide). Again this provision carves out a specific exception to the prohibition of termination of pregnancy in the same terms as section 7, so long as the following three conditions are met:

- a) The medical procedure is carried out by a medical practitioner;
- b) He or she in good faith believes that there is an “immediate risk of loss of the woman’s life from a physical illness”, and
- c) The medical procedure is, in his or her reasonable opinion, “immediately necessary” to save the life of the woman.

41. Certification is required under section 8(2) either before the procedure is carried out, or if this is not practicable, shall be done within 72 hours of the procedure having been carried out. The emergency procedure set out in section 8 does not extend to a woman who is suicidal. As with section 7, this section sets out the circumstances in which a pregnancy may be ended which may result in the ending of an unborn human life as a result of a medical procedure required to avert the loss of life of the pregnant woman or girl.

#### **Analysis against the Constitution**

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<sup>36</sup>This would include women and girl asylum seekers and refugees.

42. Section 8 addresses emergency situations and the requirement in relation to carrying out a termination of pregnancy in such an emergency situation is far less procedurally onerous than in relation to a non-emergency situation (as set out in section 7). While the risk of loss of life is the same under both provisions, in order to invoke this emergency procedure under section 8, the risk of loss of life must be “immediate” and the medical procedure must be “immediately necessary” and presumably not one that can wait for a second medical opinion, and/or consultation with the woman’s General Practitioner, or removal to an “appropriate institution”. It might be asked whether in fact the test to be met in the circumstances of an emergency, are in fact higher than in the case of a non-emergency, insofar as the procedure must be established to be “immediately necessary” to save life in an emergency, but a “real and substantial risk” is the test for a termination in a non-emergency situation under section 7 of the Bill. It would appear that the non-emergency procedure allows for a greater measure of medical discretion in relation to determining the level risk to the woman concerned, and it does not appear that it must ultimately be decided that the procedure is absolutely “necessary” to save life. It may be that in terms of medical practice, there would be no difference between the two tests, but the language is open to interpretation.

43. The other significant difference between section 7 and 8 is that under section 7 it is an obstetrician who must carry out the medical procedure, whereas in the case of an emergency, a medical practitioner may do so.

44. Overall, the IHRC considers that section 8, in addressing an emergency situation, is in compliance with Article 40.3 of the Constitution, noting that what constitutes an emergency will be a matter of medical opinion in any particular case. Insofar as the requirements of the section are relatively minimal, so that an obstetrician is not required to carry out the procedure, and nor is the location at which the procedure is to be carried out prescribed, it therefore would appear to allow the medical profession to act in accordance with appropriate medical standards to save the life of the woman, and thus vindicate her right to life as required by the X case and the *A, B and C* Judgment. In tandem with this, the “twin lock” requirements of an immediate risk of loss of the woman’s life (from a physical illness) and the medical procedure being “immediately necessary” to save her life would

appear to be framed in a manner to vindicate to the extent possible the right to life of the unborn as required by the Constitution.

### **Analysis against human rights conventions ratified by the State**

45. The IHRC considers that in the context of an emergency procedure, section 8 allows medical practitioners to act in accordance with good medical practice, and to do what is necessary to save the life of the woman. The section appears aimed at ensuring speedy decision-making and does not *prima facie* raise obstacles regarding access to medical treatment for women. However, any regulations under this section will need to be carefully balanced against the right to life of the mother under international human rights standards.

#### **I. Section 9 - Risk of loss of life from suicide**

46. Section 9 of the Bill deals with a further exception to the prohibition on abortion in the context where there is a risk to life to the pregnant woman by reason of suicide. A medical procedure “in the course of which, or as a result of which, an unborn human life is ended” shall be lawful subject to three conditions as follows:

(a) that procedure is carried out by an obstetrician at an appropriate institution;

(b) three medical practitioners, one being an obstetrician and two being psychiatrists<sup>37</sup>, having examined the pregnant woman jointly certify in good faith that:

- (i) there is a real and substantial risk of loss of the woman’s life by way of suicide, and
- (ii) in their reasonable opinion, that risk can only be averted by carrying out that medical procedure.<sup>38</sup>

47. The obvious difference between section 7, which deals with physical risk, and section 9, which deals with suicide risk, is that an additional medical professional, in this case a psychiatrist, is required to certify the risk to life and the requirement for the termination, thus requiring that the woman at risk from suicide undergoes an additional

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<sup>37</sup> See sections 9(2) and (3).

<sup>38</sup> As with section 7, “if practicable “at least one of the medical practitioners referred to” should, with the agreement of the woman, consult with her GP (if any) for the purpose of obtaining information in respect of the woman.

medical examination before a decision may be made regarding a termination of her pregnancy. It is further noted that an emergency procedure is not provided for in the context of a woman who is suicidal. Any refusal to provide an opinion under this section, or a decision not to certify may be subject to review at the instigation of the girl or woman concerned (see further below).

### **Analysis against the Constitution**

48. Section 9 seeks to legislate for the conflicting rights of the pregnant woman and the unborn where there is a “real and substantial risk” to the woman’s life through self-destruction, as arose from the Supreme Court Judgment in X. It does so by introducing additional procedural grounds under which a termination of pregnancy may occur, but as with sections 7 and 8 leaves the determination of whether a termination of pregnancy is necessitated by suicidal risk to the judgment of the three medical practitioners specified.

49. The provision thus provides for an exception to the general prohibition on termination of pregnancy where there is a “real and substantial risk” of loss of the pregnant woman’s life as set out in the X case. As with sections 7 and 8, it attempts to strike the correct balance between the competing constitutional rights of the pregnant woman and the unborn through prescribing the narrow medical circumstances under which a termination of a pregnancy can occur. This would appear to conform in general terms to the constitutional right to life protection afforded to both the pregnant woman and the unborn under Article 40.3 as interpreted by the Supreme Court in the X case. Although there have been criticisms of the X case and the medical evidence presented to it, constitutional law is that as prescribed by the Supreme Court until such time as it revises its Judgment in another case. Accordingly, termination of pregnancy where there is real and substantial risk to life is permitted and even required under Article 40.3 at present.

50. However, as with section 7, section 9 is silent as to how the certification by three medical practitioners will come about or be triggered, and it appears that this will be a matter of medical practice with a person with suicidal ideation presenting to a medical practitioner and being referred to a psychiatrist or in-patient services. As with section 7, it is **recommended** that section 9 be amended to reflect the constitutional right to bodily

integrity/ health This would include an *accessible right* for girls and women seeking access to a lawful termination of pregnancy (as set out in the X case) (see above).

### **Analysis against human rights conventions ratified by the State**

51. Unlike sections 7 and 8 of the Bill which address physical risk, there was arguably no direct requirement on the State arising from the ECtHR's Judgment in *A, B and C* to address suicidal as opposed to physical risk to life as this issue did not arise before the Court. Nonetheless, the ECtHR and other international human rights treaty body mechanisms such as the Human Rights Committee invariably assess a State's justification for restrictions on access to abortion against the question of the domestic entitlement to a lawful abortion. Thus, it is likely that were a suicidal woman who sought effective access to a lawful abortion, and was refused or delayed a determination of her right due to a lack of clarity or uncertainty in the law (as identified by the ECtHR in *A, B and C* as arising from the X case), the State would be in jeopardy of being found in violation of those international conventions. Further, insofar as the Action Plan includes the General Scheme of the Bill which includes legislating for suicidal risk, which was noted by the Committee of Ministers in its periodic reviews of execution, were the State not to proceed to legislate on this ground, there is a danger that it may not be deemed to have fully executed the full import of the ECtHR's Judgment.

52. As with section 7, it is **recommended** that section 9 also be amended to provide for an *accessible* right to the procedure set out in section 9 to all girls and women seeking access to a lawful termination of pregnancy (as set out in the X case). In particular such women and girls have the right to accessible information on how to access their right to health - namely an examination followed by an opinion of the medical practitioners specified.

### **J. Reviews (Sections 10 to 14)**

53. Sections 10 to 14 of the Bill deal with reviews, which are essentially reviews that are requested by a pregnant woman, who has been assessed under sections 7 or 9 but not been certified to undergo a medical procedure as prescribed under those sections.



54. Section 10 entitles a woman who has not been authorised to receive a medical treatment under sections 7(1) or 9(1) to seek a review of that decision. The application for review is made to the Health Services Executive (HSE).

55. The HSE is obliged pursuant to section 11 to maintain a panel of a minimum of 10 medical practitioners, the terms and conditions of that appointment being determined by the HSE. In addition the four relevant medical organisations may each nominate medical practitioners for appointment to the panel who may then be added to the panel at the discretion of the HSE.

56. In terms of the procedure involved, pursuant to section 12 of the Bill, a committee must be established by the HSE and drawn from the membership of the panel, within 3 days of an application being received, to review the decision regarding access to a medical procedure under section 7(1) or 9(1). In line with the requirements of sections 7 and 9, the review committee will have the same composition in terms of specialisation as set out in those sections. In relation to risk to life from a physical illness, this requires one obstetrician and another relevant medical practitioner, and in the case of risk to life from suicide, this requires an obstetrician and two psychiatrists, one of whom shall be a psychiatrist practicing in the area of women and pregnancy.

57. Section 13 provides that the committee shall complete its review within 7 days from the date it was established and convened. In this regard to the maximum time frame between an application by a woman under this section and a final decision of a review committee is ten days. The review committee is required to examine the pregnant woman, which presumably refers to a medical examination. The review committee may, if satisfied that there is a “real and substantial risk of loss of the pregnant woman’s life from a physical illness or by way of suicide” and the risk can only be averted by way of a medical procedure referred to in section 7 or 9, jointly certify that this is so. In any event the committee must inform the woman (or her representative) and the HSE of its determination.

58. Pursuant to section 14, the review committee may determine its own procedures. The pregnant woman is entitled to be heard by the committee, or may nominate another

person to represent her before the committee. No provision is made for legal representation before the committee.

59. The panel from which a review committee is drawn is established and chosen by the HSE, and those that are placed on the panel do so subject to terms and conditions determined by the HSE. Ultimately the review panel is determining whether a particular medical procedure, which involves the termination of a pregnancy is, or is not carried out in one of the appropriate institutions specified under section 3, which may be a hospital under the management of the HSE or funded by the HSE. Therefore the review provided for under the Bill may be characterised as an internal review within the HSE. It is noted that the Bill does not incorporate any statutory appeal mechanism to a Court, and therefore it may be presumed that insofar as the review committee is making a determination regarding the entitlement of a woman under the proposed legislation, such a decision would be judicially reviewable before the High Court.

60. As noted earlier pursuant to section 7 in particular, there is no defined pathway by which a certification is made or refused under the Bill, and this in turn may impact on the accessibility of the review mechanism. In addition, in relation to a situation of alleged risk to life by reason of suicide, if a woman invokes the review mechanism she will then have been subject to a physical examination by two obstetricians and a psychiatric examination by four different psychiatrists, which may raise concerns regarding the intrusiveness of the procedure, particularly if the intrusive nature of the procedure is viewed as unjustifiably infringing the woman's right to respect for her private and family life under Article 8 of the ECHR.

61. In the context of a determination regarding a medical procedure that involves or results in the termination of pregnancy and potentially therefore the ending of an unborn human life, it may also be questioned how the right to life of the unborn is taken into account in the context of the review procedure. However, in relation to the argument as to the possible procedural rights of natural fathers or the unborn itself in the course of these determinations, it should be noted that at present representation in respect of these persons is not required under the Constitution Insofar as there is no discernible

jurisprudence in relation to the rights of the unborn or the natural father to representation. If any such legislative or constitutional provision were to be considered, it would need to be taken into account whether introducing such a process could create a situation where the pregnant girl or woman's right to an accessible, effective and timely determination would be jeopardised.

### **Analysis against the Constitution**

62. There are essentially three questions that arise for consideration in relation to the review mechanism under the Bill;

1. whether it is sufficiently independent;
2. whether it is accessible from the perspective of the pregnant woman;
3. whether it sufficiently vindicates the right to life of the unborn.

63. In relation to the first question, it does not appear that the review mechanism established under the Bill would fall foul of the Constitution for want of independence from the HSE. First neither the X case nor subsequent case law required a review mechanism to be put in place to ensure the vindication of a pregnant woman's constitutional rights. On the other hand, a view has been expressed in the High Court that it is not appropriate that the Courts would be used as a form of "licensing authority" in respect of the termination of pregnancies.<sup>39</sup> It was also stated by McCarthy J. in the X case that the Eight Amendment to the Constitution "remains bare of legislative direction." Therefore it is in keeping with that line of jurisprudence that a legislative framework be established that would allow pregnant women to determine their eligibility for a lawful termination of pregnancy. It is also in keeping with that jurisprudence that the review mechanism in the legislation directs any conflicts away from the High Court, at least at first instance.

64. While it is clear that a review committee as established will not be independent of the HSE, it is also clear that such a committee is not carrying out either a judicial or quasi-judicial function. Section 13(3) of the Bill requires the review committee to come to a conclusion regarding a medical matter, rather than a legal matter. There are no lawyers on the review committee, which is wholly made up of medical practitioners. While there might

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<sup>39</sup> See *A and B v Eastern Health Board*, Judge Mary Fahy [1998] 1 I.R. 464.

be some suggestion of institutional bias, insofar as the committee selected by the HSE reviews a decision already made under the auspices of the HSE, the Supreme Court has distinguished between administrative bodies that have judicial functions and those that are under an obligation to act judicially.<sup>40</sup> While the former category may be open to accusation of bias, insofar as it may be regarded as being a judge in its own cause, the latter category is only required to act fairly and properly. It is arguably the case that a review committee is in the latter rather than the former category, that is, the review committee does not have judicial functions, and so must ensure that the procedures adopted are fair, but need not be wholly independent. However, being based on legislation and having a statutory remit, a determination by the review committee would be open to judicial review insofar as the committee may be considered to be “an organ of the State”.

65. The second issue is accessibility of the procedure from the perspective of the pregnant woman. In this regard, were sections 7 to 9 to be amended as recommended in these Observations to provide a clear pathway to accessible services to a woman or girl seeking an assessment in relation to a termination of pregnancy, this would also benefit the accessibility of the review procedure. Section 10 should be amended to provide for such accessibility in specific terms. In addition, section 12 could be strengthened (perhaps through accompanying regulations) to provide for a right of assistance and supports to women and girls who are particularly vulnerable, including those with an intellectual disability and/ or who have suffered rape or sexual assault.

66. The next issue that arises in a constitutional context is whether the review committee mechanism is a proper vindication of the rights of the unborn under the Bill, for instance the extent to which the interests of the unborn are given due regard by a review committee. Again, this would turn on the nature of the determination being made by the review committee. Under section 13, the review committee is ultimately placed in the shoes of the original doctors who considered the risk to the woman’s life, and must carry out the same assessment as that undertaken by the original doctors at first instance, including the requirement that they come to a “reasonable opinion” reached in “good faith”, which considerations under the Bill requires regard to be had to the right to life of the unborn. It

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<sup>40</sup> *O’Brien v Bord na Mona* [1960] IR 255, O’Higgins CJ.

will also have access to the original documents of the medical practitioner(s) who carried out the first medical assessment. In this regard it would appear that the rights of the unborn are sufficiently vindicated within the overall scheme of the Bill for the purpose of Article 40.3.

### **Analysis against human rights conventions ratified by the State**

67. The ECtHR in *A, B and C* found a breach of Article 8 in the case of the third named applicant. Part of the reasoning of the Court was that there should be an “accessible and effective” procedure pursuant to which the applicant could have established her right to a lawful abortion in Ireland. The Bill sets out the legal test which applies in relation to a lawful termination of pregnancy, and also sets out the procedure that must be followed in that regard, the availability of a review mechanism for the woman or girl is crucial to accessibility and effectiveness, as this is her opportunity to essentially challenge the original determination as to whether she qualifies for a lawful abortion under sections 7 or 9 of the Bill.<sup>41</sup> As stated earlier, however, there needs to be a provision that allows the girl or woman concerned to trigger the process for an assessment under sections 7 and 9.

68. Section 10 of the Bill first places an obligation on the first tier medical practitioner to inform the woman of her right to apply for a review of the initial decision regarding her eligibility for a termination of pregnancy but could be strengthened as suggested above to cover the situation where a vulnerable woman or girl finds it difficult to make such a request. Particular measures will be required for women who may not find it easy to make such an application, such as women whose first language is not English, women who are functionally illiterate, women with intellectual disabilities, or minors. While the precise form of request for an opinion concerned will be set out by Ministerial order, it should not be an overly technical process.

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<sup>41</sup> See also the Concluding Observations on Ireland of the Committee Against Torture in 2011. “The Committee notes the concern expressed by the European Court for Human Rights (ECtHR) about the absence of an effective and accessible domestic procedure in the State party for establishing whether some pregnancies pose a real and substantial medical risk to the life of the mother [Case of *A, B and C v. Ireland*], which leads to uncertainty facing women and their medical doctors, who are also at risk of criminal investigation or punishment if their advice or treatment is deemed illegal. The Committee expresses concern at the lack of clarity cited by the ECtHR and the absence of a legal framework through which differences of opinion could be resolved”; CAT/C/IRL/CO/1 17 June 2011, para 26.

69. The review process itself provides for the woman to be medically examined, and to be heard. In this regard, assistance will also be needed for certain categories of vulnerable women as outlined above. However, the review process would appear to offer the opportunity for any women who has a difference of opinion with the first tier doctors who examined her and gave (or refused to give) an opinion pursuant to section 7 or 9, to have that difference of opinion resolved for the purpose of entitlements to a lawful termination of pregnancy under the Bill, and in accordance with the Constitution. To this degree the procedure set out under the Bill, would appear to meet the requirements of the A, B and C case. However, in *Tysiac v Poland*,<sup>42</sup> which concerned a complaint regarding access to a lawful abortion on health grounds, the Court reviewed the applicable legal framework in place and stated:

In this connection, the Court reiterates that the concepts of lawfulness and the rule of law in a democratic society command that measures affecting fundamental human rights be, in certain cases, subject to some form of procedure before an independent body competent to review the reasons for the measures and the relevant evidence.... In ascertaining whether this condition has been satisfied, a comprehensive view must be taken of the applicable procedures .... In circumstances such as those in issue in the instant case, such a procedure should guarantee to a pregnant woman at least the possibility to be heard in person and to have her views considered. The competent body should also issue written grounds for its decision.

70. In the context of the review mechanism under the Bill, it is notable that the review committee will be in a position to determine its own procedures, and it may be presumed, in line with the practice of Mental Health Tribunals that such committees will ensure that written reasons are provided for their decisions. If review committees were to fail to provide written reasons for their decisions, then the requirement, as set out in *Tysiac*, would probably not be met. The IHRC **recommends** therefore that all review committees be required to provide written reasons for their decisions, which are provided as soon as is practicable to the woman concerned. However, in addition, as noted above, the review mechanism proposed under the Bill is not in itself wholly independent, and thus “a

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<sup>42</sup> *Tysiac v Poland*, Judgment, 20 March 2007.

comprehensive view must be taken of the procedures". In this regard, a decision of a review committee, being one made pursuant to statute, will be open to judicial review. Such a review, while unable to substitute the medical opinion, as found by the review committee, will be able to consider whether the relevant legislation was adhered to; whether the review committee, as "an organ of the State", acted in a manner compatible with the State's obligations under the ECHR,<sup>43</sup> and whether the woman's rights as guaranteed under the Constitution were upheld in the process.

71. In the case of *Bryan v The United Kingdom*,<sup>44</sup> the ECtHR took the view that although a planning inspector could not be regarded as "independent and impartial" for the purpose of Article 6(1), the fact that the inspector acted quasi-judicially and largely complied with the requirements of a fair hearing under Article 6, and in addition the fact that the inspectors' decision was ultimately subject to judicial review, was sufficient to meet the requirements of Article 6(1). The IHRC considers therefore that as long as review committees ensure adherence to fair procedures, and discharge their functions in an independent manner, without undue interference with their independence, then, if there is access to judicial review procedures for the purpose of seeking to challenge the determination of a review committee, this is likely to be in compliance with Articles 8 and 6 of the ECHR. However, in light of the sensitivity of the matters concerned, and the necessity for timeliness in dealing with issues arising under the draft legislation, the IHRC **recommends** that an expedited procedure before the High Court be provided for judicial reviews arising under the legislation, with provision for legal aid, and anonymity, thereby ensuring that judicial review is an "accessible and effective" procedure for vindicating the human rights engaged. It is arguable that such an expedited judicial review procedure would be required by Article 8 ECHR, in light of the ECtHR judgments in *Tysiac* and *P and S v Poland*.<sup>45</sup>

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<sup>43</sup> Section 3, European Convention on Human Rights Act 2003.

<sup>44</sup> *Bryan v United Kingdom*, Judgment, 22 November, 1995.

<sup>45</sup> *P and S v Poland*, (Application No. 57375/08), Judgment, 30 October 2012. In this case, which concerned access to an abortion for reasons of health and well being, the ECtHR held that "measures" to be adopted by the State refer to the provision of a "regulatory framework of adjudicatory and enforcement machinery protecting individuals' rights".

72. In relation to the accessibility of the procedure, taking the first tier decision making under sections 7 and 9 and the second tier decision making by a review committee, this will require a woman to undergo multiple medical examinations. In the case of a physical risk to life, this may not be excessively intrusive, as it will involve four doctors in total carrying out a physical examination, which should not raise any questions regarding the motivation of the woman concerned. However, in the case of a risk to life arising from suicide, this will involve a woman being examined by no less than six doctors, four of whom will be carrying out a psychiatric assessment, which by its nature will be intrusive, no matter how sensitively handled. The purpose of such examinations is not as such, therapeutic, but are in the nature of an assessment for the purpose of the legislation. Concerns may thus arise that a woman who is suicidal and wishes to terminate her pregnancy will be reluctant to submit herself to such an extensive level of psychiatric assessment, and thereby the process under the legislation will be rendered inaccessible. In addition, in light of the potentially vulnerable position of the girl or woman, the number of examinations required may risk increasing her mental anguish and potential suffering with the potential to thereby breach Article 8. The IHRC would **recommend** in this regard that some discretion would be provided for under sections 9 and 13, such that a girl or woman that presents as being suicidal is not subjected to additional psychiatric examinations if that would be detrimental to her mental health and wellbeing, and that one psychiatric opinion would be sufficient, for the purposes of review under section 13.

#### **K. Section 16**

73. Section 16 of the Bill provides that “[n]othing in this Act shall operate to affect any enactment or rule of law relating to consent to medical treatment.” The Bill thus leaves to other enactments or rules of law the issue of consent to medical treatment.

#### **Constitutional analysis**

74. Prior to the Constitution, the common law position was that the issue of a patient’s consent to medical treatment came within the law of tort, either the tort of trespass or medical negligence. Despite the advent of the Constitution, although there is now identified an unenumerated right to bodily integrity under Article 40.3 of the Constitution, the treatment of consent to medical treatment remains within the compass of the law of tort.



Thus in *Re a Ward of Court (withholding medical treatment) No. 2*,<sup>46</sup> Denham J observed that “[i]f medical treatment is given without consent it may be trespass against the person in civil law, a battery in criminal law, and a breach of the individual's constitutional rights”.<sup>47</sup> Where a concurrent constitutional and tort claim is made that consent was not sought or obtained prior to medical treatment, the matter will likely be addressed under the tort of medical negligence and an associated requirement to disclose significant risk. In *Fitzpatrick v White*<sup>48</sup> the Supreme Court stressed a “reasonable patient” approach focusing on the existence of a “significant risk which would affect the judgment of a reasonable patient”.<sup>49</sup>

75. The Constitutional test does not address questions of capacity to consent, however. While there is a general presumption that a person has capacity to make decisions and consent to medical treatment, where a person’s capacity is in doubt, under current law, the Lunacy Regulation (Ireland) Act 1871 and its Wards of Court regime remains the primary mechanism by which incapacity can be determined and then only by the High Court.<sup>50</sup> Thus while section 16 of the Bill does not appear to offend the Constitutional provision (insofar as no existing statute such as the 1871 Act has been struck down as unconstitutional), it does not add any clarity to the circumstances in which the consent of a pregnant girl or woman with a significant intellectual disability to medical treatment can be obtained, much less how such a girl or woman can access the procedure set out in sections 7 to 9 of the Bill. If in creating a new mechanism such a procedure provided insuperable barriers to these girls or women, it could breach the individual's constitutional rights as referred to by Denham J in *Re a Ward of Court*. The IHRC thus **recommends** that the long awaited Capacity Bill be introduced without delay and set out clear procedures under which persons with intellectual disabilities can be supported if necessary in receiving information and advice and in making decisions under the terms of the current Bill.

### **Analysis against human rights conventions ratified by the State**

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<sup>46</sup> [1996] 2 IR 79.

<sup>47</sup> [1996] 2 IR 79 at 156. However, in *Fitzpatrick & Ryan v FK* [2008] IEHC 104, both Abbott J (on the *ex parte* application) and Laffoy J on the hearing held that consent could be overridden and that the non-consensual life-saving blood transfusion by the hospital to a Jehovah’s Witnesses member and recent mother was justified.

<sup>48</sup> [2008] 3 IR 551. This supplanted earlier the paternalistic test in cases such as *Daniels v Heskin* [1954] IR 73.

<sup>49</sup> [2008] 3 IR 551 at 561-564.

<sup>50</sup> See also Mental Health Act 2001.

76. Under international human rights standards, no one can be subjected without his or her free consent to medical or scientific experimentation. Individuals have the right to accessible understandable healthcare services and this includes, in cases involving consent to medical treatment, the right to receive appropriate and understandable information and advice on family planning. Thus in a number of cases involving Slovakia, the ECtHR has held that ensuring informed consent for ethnic minorities brings with it heightened responsibility to ensure “safeguards giving special consideration to the reproductive health of the first and second applicants as Roma women”.<sup>51</sup> Similarly under the Convention on the Rights of Persons with Disabilities,<sup>52</sup> there is a presumption of legal capacity and a requirement for supported decision making. Under Article 25 of that Convention, health professionals are required to “provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private healthcare”.

77. As presently constituted, section 16 of the Bill does little to advance the human rights of persons with disabilities who may have fluctuating or permanent issues of capacity to be supported (or in extremis assisted) in receiving appropriate and understandable information and advice on health care services including cases involving consent to medical treatment, such as the medical treatment proposed in sections 7 to 9 of the Bill. Accordingly it is **recommended** that Capacity legislation be introduced as a matter of urgency in tandem with the current Bill and that that legislation enable accessible pathways to supports and safeguards for persons with intellectual disabilities.

#### **L. Section 17**

78. Conscientious Objection is dealt with under Section 17, which allows for any medical practitioner, nurse or midwife not to carry out, or to assist in carrying out a lawful termination of pregnancy as set out in sections 7 to 9 of the Bill. It is also made clear that

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<sup>51</sup> See *IG v Slovakia*, Application No. 15966/04, Judgment 13 November 2012, where the Court found a violation of Article 8 of the ECHR in addition to Article 3; at 145-146. See also *VC v Slovakia*, Application No. 18968/07, Judgment 8 November 2011, and *NB v Slovakia*, Application No. 29518/10, Judgment 12 June 2012.

<sup>52</sup> While this convention has been signed but not ratified by the State, its provisions are increasingly cited in the jurisprudence of the ECtHR.

the right to conscientious objection is one that applies to the individual rather than an organisation, and so no “approved institution” may refuse to provide a lawful abortion as set out in sections 7 to 9. The terminology and content of section 17 appear to reflect current medical practice whereby a patient is assigned to a particular consultant, which consultant must then remain with that patient unless and until such time as they can be transferred to another consultant, with the focus being on private medical (i.e. consultant to consultant transfer of care) rather than institutional care provision. Section 17(3) of the Bill provides that in the event that a health professional has a conscientious objection to carrying out or assisting in the carrying out of a required medical procedure as authorised under the legislation, he or she shall have a duty to ensure that another colleague takes over the care of the patient, which will include making arrangements for the transfer of her care “as may be necessary to enable the woman to avail of the medical procedure concerned”. It is unclear how situations of emergency will be dealt with and whether an emergency would override a conscientious objection where another medical professional willing to provide the medical treatment cannot be found on short notice.

### **Constitutional analysis**

79. If one accepts that the procedures under sections 7 to 9 are constitutionally mandated in light of the X Judgment, insofar as they seek to balance the competing rights of the pregnant woman and the unborn, the question is whether any modification to those procedures could have further constitutional implications where access to the medical procedure mandated may be hindered.

80. The right to bodily integrity under the Constitution arguably includes the right to have reasonable access to lawful health services particularly where a person’s life may be at risk. Constitutional rights apply to both organs of the State and non-State actors, be they institutions or individuals.<sup>53</sup> In Ireland, there is no entitlement to receive public health services under the Health Acts 1947-2007 unless a person meets certain eligibility criteria. Rather, health services are provided by non-State actors in receipt of State funding while

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<sup>53</sup> *Meskill v CIE* [1973] IR 121 where Walsh J stated that “if a person has suffered damage by virtue of a breach of a constitutional right, that person is entitled to seek redress against the person or persons who have infringed that right”; at 133.

medical responsibility for patients falls to medical practitioners such as those practitioners registered under the Medical Practitioners Act 2007 and the Nurses and Midwives Act 2011 (including under the Specialist Division of the register of practitioners established under section 43 of the 2007 Act).

81. While in-patient institutions, with medical practitioners, have legal responsibility for patients within their institutions, apart from organisational matters in the institution, neither they nor the Health Service Executive have control of the day to day care of individuals seeking and/or receiving medical assistance. That is the responsibility of multidisciplinary teams led by consultants from the various medical specialties. This may explain in part the general medicalised approach taken in the Bill and why the responsibility to ensure the transfer of care of patients under section 17 of the Bill is placed on the person with the conscientious objection rather than with the institution. However, the co-responsibility of the institution under the Constitution cannot be excluded. While section 17 would appear on its face to be compatible with the Constitution, this is premised on the ability of a girl or woman with a risk to life being effectively and swiftly referred to another practitioner to allow the authorised termination of pregnancy (deemed necessary to save her life). To ensure this occurs, it is **recommended** that section 17 be amended to either provide that if the action or inaction of a person claiming to have a conscientious objection and refusing to carry out or assist in carrying out a lawful procedure as prescribed in sections 7 to 9, substantially contributes to the death of or significant harm to the woman, that person and/or the institution shall be guilty of a specified offence.

### **Analysis against human rights conventions ratified by the State**

82. Under international human rights standards, the right to freedom of conscience is recognised such as under Article 9(1) of the ECHR: “[e]veryone has the right to freedom of thought, conscience and religion...” subject to the rights of others.<sup>54</sup> While the majority of case law of the ECtHR in relation to conscientious objection arises from the obligation in many European States to perform compulsory military service, in *Eweida and Others v the*

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<sup>54</sup> Article 9(2) provides: “Freedom to manifest one’s religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.”

*United Kingdom*,<sup>55</sup> addresses the right from the perspective of a person's employment. In that case, which concerned 4 joined cases where the applicants' religious beliefs were in conflict with aspects of their employments, the ECtHR stated that Article 9 could only be invoked if there existed "a sufficiently close and direct nexus between the act and the underlying belief [which] must be determined on the facts of each case."<sup>56</sup> Where an individual's religious observance impinges on the rights of others, some restrictions would apply, and States would be afforded a "margin of appreciation" in this regard. In *Eweida* one of the four Applicant's employers policy was aimed at promoting equal opportunities and to require employees to act in a way which did not discriminate against others and thus had the legitimate aim of securing the rights of others, such as same-sex couples. Thus the ECtHR decided that the correct balance had been struck and therefore held that there had been no violation of Article 9 of the Convention, either alone, or in conjunction with Article 14. Under the current Bill, insofar as the right to life of the pregnant woman (but not the unborn - see above) is at issue under Article 2 of the ECHR, a requirement that employees perform life- saving medical procedures regardless of any conscientious objection would likely be deemed proportionate by the ECtHR. Equally, the current proposal in Section 17 to allow the exclusion of such a requirement on the grounds of conscientious objection (linked as it is to the constitutional protection afforded the unborn by the State) would likely be deemed to fall within the State's "margin of appreciation" provided that any additional risk to the pregnant woman's life can be avoided through the effective transfer of her care to another medical practitioner once the 'effectiveness' of such transfer meets the ECHR requirements as set out in *A, B and C, Tysiac v Poland* and *P. and S. v Poland*.

83. Under other international human rights standards, the right to health encompasses the obligation on the State to remove all barriers to women's right to control of their own health, including barriers interfering with access to health services, education and information. In addition, the State is obliged to exercise its "due diligence" obligation to take measures to control the activities of non-State actors through its "duty to regulate and

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<sup>55</sup> Judgment, 15 January 2013. At time of writing it is noted that this judgment may be referred to the Grand Chamber.

<sup>56</sup> At para 82.

monitor private health-care institutions”.<sup>57</sup> This refers in general terms to the fact that under international human rights law, the range of bodies that may comprise the State extends beyond statutory bodies to include private organisations which operate outsourced Government functions and the concurrent obligation on the State to “control” the behaviour of private actors where they perform such functions.<sup>58</sup> To ensure this occurs, the **recommendation** to amend section 17 set out above, is repeated.

### **M. Section 18**

84. Section 18(1) clarifies that the provisions of the Bill in no way limit the right to travel to another State or to obtain or make available information relation to lawful services available in another State, while Section 18(2) states that nothing in the Bill limits the right to travel to another State for a purpose which would constitute a criminal offence in the State.

### **Constitutional analysis**

85. The provisions of Section 18 of the Bill reflect the constitutional right to travel and information as set out in Article 40.3.3.

### **Analysis against human rights conventions ratified by the State**

86. It should be noted that the Human Rights Committee in its 2008 Concluding Observations on Ireland observed that the State party “should bring its abortion laws into line with the Covenant. It should take measures to help women avoid unwanted pregnancies so that they do not have to resort to illegal or unsafe abortions that could put their lives at risk (article 6) or to abortions abroad (articles 26 and 6).”<sup>59</sup> Under international standards, the emphasis should thus not be on forcing women into illegal or unsafe abortions or abortions abroad. In addition, while most girls and women residing in Ireland have a right to travel as protected under the Constitution, this is not so for all women in the

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<sup>57</sup> See fn 27 above and *In da Silva Pimentel v. Brazil*, Communication 17/2008, U.N. Doc. EDAW/C/49/D/17/2008 (CEDAW, July 25, 2011).

<sup>58</sup> This obligation continues even if there is no specific legislative measure adopted by the State to regulate an activity (such as the level of care to be provided in residential services for persons with disabilities), but where the relationship between the State and the organisation is governed under a contractual arrangement: see IHRC *Follow-Up Report on State Involvement with the Magdalen Laundries*, available at [www.ihrc.ie/download/pdf/20130618164449.pdf](http://www.ihrc.ie/download/pdf/20130618164449.pdf) at p 19.

<sup>59</sup> CCPR/C/IRL/CO/3 30 July 2008, Human Rights Committee, Ninety-third session, Geneva, 7 – 25 July 2008 at para 13.

State, most specifically for women who are undocumented or asylum seekers. In the case of *A, B and C*, the ECtHR took into account the constitutional right of the first two applicants (A and B) to travel abroad for an abortion, when considering the proportionality under Article 8 of the prohibition of abortion in the State for health and well-being reasons. However, it must be questioned whether the same finding would be made if a pregnant woman was not in a position to travel, due to the restrictions on travel attendant on her immigration status within the State.

#### **N. Section 20**

87. Section 20 of the Bill provides for records of procedures to be kept and notifications to be made to the Minister within 28 days of a medical procedure being carried out under sections 7(1), 8(1) or 9(1). The Minister shall then prepare a report on the notifications received which shall then be published by the Minister no later than 30 June of each year. Pursuant to section 20(6), the published report shall exclude “information that identifies, or that could reasonably lead to the identification of, a woman who is the subject of a notification under this section.”

#### **Analysis against the Constitution and international human rights standards**

88. The right to privacy is protected under Article 40.3 of the Constitution as an unenumerated right. It is a qualified right, whereby the right to privacy is subject to restrictions when justified by the “exigencies of the common good”.<sup>60</sup> In the context of qualified rights, the Supreme Court has applied a proportionality test.<sup>61</sup> The right to privacy is also protected under Article 8 of the ECHR, and any interference with the right must pursue a legitimate aim, and be proportionate. Medical records of any kind, *prima facie*, engage the right to privacy pursuant to both the Constitution and the ECHR.

89. The Commission recalls that in its previous observations concerning issues of data storage and retention it has outlined a number of overarching principles that should inform

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<sup>60</sup> *Kennedy v Ireland* [1987] IR 587.

<sup>61</sup> *Heaney v Ireland* [1994] 3 IR 593.

legislation and be reflected in its normative values.<sup>62</sup> These principles are relevant to the consideration under section 20.

- a. Information, although already in the public domain, can fall within the scope of ECHR Article 8 (private life) where it is systematically collected and stored by State authorities.<sup>63</sup>
- b. In order to meet the requirements of Article 8(1) that interferences with one's private life be in accordance with law, the storage of information by State authorities should be established under primary legislation that is sufficiently clear and precise as to its ambit.<sup>64</sup>
- c. The retention of personal data is permitted under Article 8(2) for, *inter alia*, the prevention of crime, the protection of health and for the protection of the rights and freedoms of others.<sup>65</sup>

90. While noting that the Data Protection Acts 1998-2003 would apply in relation to the retention and disclosure of medical records, the IHRC is nonetheless concerned that section 20 may not provide sufficient safeguards as regards the disclosure and use of the information collected to meet the requirements of Article 8. Section 20 does not provide any indication of the duration for which the medical records of women or girls who have undergone a medical procedure under sections 7-9 of the Bill may be kept. Nor does it specify who will receive and handle this sensitive information within the Minister's office.

91. Of particular concern is the fact that the notification in question does not appear to be anonymised when transmitted from the hospital to the Minister. There does not appear to be any justification for the Minister, and officials within the Department of Health to have access to the identity of any woman who has undergone a medical procedure in a hospital. Such information is extraneous to the stated purpose of the notifications, which is to allow

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<sup>62</sup> See for example, IHRC Observations on the National Vetting Bureau (Children and Vulnerable Persons) Bill 2012.

<sup>63</sup> *Rotaru v Romania* (Application No.28341/95), Judgment of 4 May 2000.

<sup>64</sup> *Leander v Sweden* (1987) 9 EHRR 433.

<sup>65</sup> The requirements of a vetting system for employment purposes must be considered to be wholly different from the recording of criminal convictions, prosecutions and so on, for purposes relating to the core functions of An Garda Síochána.



the Minister monitor the operation of the legislation and to make an annual report on its operation available to the public. In this regard it is unlikely that the transmission of such sensitive information would be in compliance with the requirements of the Constitution or Article 8 of the ECHR. There is no reference to the consequences that flow if there is an accidental or intentional disclosure of this information by an official, other than the right to make a complaint to the Data Protection Commissioner. There is furthermore no reference made to any specific requirements regarding the storage or destruction of this information.

92. Given the gravity of the impact of a potential disclosure of the medical record of a girl or woman for her Article 8 rights, the IHRC **recommends** that provision be made in the legislation to empower the Minister to make detailed regulations in relation to the practice and procedure to be adopted for the reception, storage, prohibition of onward transmission and destruction of these records, and that the advice of the Data Protection Commissioner would be sought in this regard. In addition, the IHRC also **recommends** that it be stipulated in explicit terms in section 20 that any identifying information regarding a pregnant girl or woman would be excluded from the notification to be transmitted to the Minister under the Act.

#### **O. Section 21**

93. Section 21 introduces a new power under which the Minister for Health, upon investigation, may serve a notice in writing on the head of an approved institution prohibiting a medical procedure being carried out under sections 7 or 9 of the Bill.

#### **Constitutional analysis**

94. The provisions of section 21 of the Bill affording the Minister the power to prohibit a lawful termination of pregnancy may be an attempt to allow some over-ride provision in the case of public concern about an institution, however its provisions are potentially problematic given the procedural safeguards already in place under sections 7 and 9 of the Bill.

95. While the provision in itself does not appear to contravene constitutional standards (similar provisions appear in other aspects of the Health Acts), its application in practice

could contravene constitutional rights if it resulted in a proposed termination not taking place given the fact that the purpose of the Bill (and its sections 7 to 9) is to balance conflicting constitutional rights. The fact that section 21 does not apply to emergency (section 8) procedures suggests that its use may be questionable where risk to life is at issue. It is thus **recommended** that section 21 or accompanying regulations specify the circumstances under which the power may be invoked. It is further **recommended** that the permitted use of section 21 be strictly limited to ensure that the right to access lawful abortion is effectively vindicated.

#### **Analysis against human rights conventions ratified by the State**

96. As noted above, international human rights standards stress the importance of *effective* access to health care services, which include medical procedures where risk to life is at issue. Such standards also require that States should remove all barriers to women's right to control of their own health, including barriers interfering with access to health services. Such standards thus focus on the woman's right to autonomy and access to healthcare services. Section 21 as currently constituted represents a potential barrier to access to health services insofar as in addition to the woman requiring the certification of two or three doctors under sections 7 and 9 of the Bill respectively, under section 21 there is a further decision-making layer where the Minister may override such safeguards. This provision has the potential to thus remove the already limited right of a woman to access a lawful termination of a pregnancy by way of a medical procedure set out in legislation with stringent safeguards against abuse (including criminal sanctions). As **recommended** above, its intended use should be specified in the Bill or accompanying regulations while its actual use should be minimised.

#### **P. Sections 22 and 23**

97. Section 22 of the Bill replaces the proposed repeal of sections 58 and 59 of the Offences Against the Person Act 1861 in Section 5 and in turn creates a new unified offence as follows "(1) It shall be an offence to intentionally destroy unborn human life" while section 23 extends the provision to bodies corporate and their members or directors.

98. Section 22(2) provides that a person guilty of an offence under this section shall be liable on indictment to a fine or imprisonment for a term not exceeding 14 years, or both while section 22(3) of the Bill provides that a prosecution for an offence under this section may be brought only by or with the consent of the Director of Public Prosecutions (the current requirement for indictable offences). Further, section 22(4) specifically excludes a medical practitioner who carries out a medical procedure in accordance with sections 7 to 9 of the Bill.

99. Under Section 23, where a section 22 offence is committed by a body corporate, a director, manager, secretary, other officer or member of that body may be found guilty of the offence.<sup>66</sup>

100. Thus the proposed offence under section 22 applies to any woman, a doctor or medical professional or indeed non-medical person who intentionally destroys unborn human life. Similarly bodies corporate, their directors, managers, secretaries, other officers or members are subject to the section 22 offence and thus an organisation which were to provide medical services which included any intention to “destroy unborn human life” would commit a criminal offence.

### **Constitutional analysis**

101. The main provisions of the Bill are an exception to the prohibition contained in Article 40.3.3. Section 22 in effect substantially replicates sections 58 and 59 of the Offences Against the Person Act 1861, including the criminal penalties which attach. Insofar as those provisions of the 1861 Act were never struck down as unconstitutional, section 22 would similarly appear to conform to the Constitution. That said, the imposition of an indictable criminal offence against a woman who intentionally destroys unborn human life such as through having an abortion outside the procedure laid down in sections 7, 8 or 9 raises a

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<sup>66</sup> Section 23(1) provides: “Where an offence under this Act is committed by a body corporate and it is proved that the offence was committed with the consent or connivance, or was attributable to any wilful neglect, of a person who was a director, manager, secretary or other officer of the body corporate, or a person purporting to act in that capacity, that person, as well as the body corporate, shall be guilty of an offence and may be proceeded against and punished as if he or she were guilty of the first-mentioned offence.” Section 23(2) provides: “Where the affairs of a body corporate are managed by its members, subsection (1) applies in relation to the acts and defaults of a member in connection with his or her functions of management as if he or she were a director or manager of the body corporate”.

Constitutional question of proportionality particularly for girls or women in a vulnerable situation. Similarly, the extension of the offence to directors, managers, secretaries, other officers or members of bodies under section 23 are onerous, notwithstanding the requirement of specific intent in section 22.

### **Analysis against human rights conventions ratified by the State**

102. In *A, B and C*, one of the factors which the ECtHR took into account in finding a violation of Article 8 of the ECHR was that the criminal provisions of the 1861 Act would “constitute a significant chilling factor” for both women and doctors in the medical consultation process, regardless of whether or not prosecutions are pursued so that any doctor “ran a risk of a serious criminal conviction and imprisonment” if a decision taken in medical consultation, that the woman was entitled to an abortion in Ireland given the risk to her life, was later found not to accord with Article 40.3.3 of the Constitution. Doctors also risked “professional disciplinary proceedings and serious sanctions.”<sup>67</sup> Thus the normal process of medical consultation could not be considered an effective means of determining whether an abortion may be lawfully performed in Ireland on the ground of a risk to life.

103. As noted, other international human rights standards stress the importance of effective access to health care services and require that States remove all barriers to women’s right to control of their own health, including barriers interfering with access to health services.<sup>68</sup> Thus the CEDAW Committee has also stated that such barriers include “laws that criminalise medical procedures only needed by women and that punish women who undergo those procedures”.<sup>69</sup>

104. Insofar as section 22 provides assurances to medical practitioners that they will not be prosecuted provided they perform medical procedures in approved institutions in accordance with sections 7 to 9 of the Bill, the same may not be said for women who may seek an abortion outside such institutions. While such women (and girls) could be arguably encouraged to seek in-patient services in an approved institution rather than in a non-approved institution to avoid prosecution, this does not address situations where women in

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<sup>67</sup> At para 254.

<sup>68</sup> General Recommendation No. 24, Article 12 of the Convention (Women and Health) 1999, A/54/38/Rev 1.

<sup>69</sup> *Ibid* at para 14.

non-life threatening situations may seek an abortion, for example in cases of rape or fatal foetal abnormality (see further below). In those circumstances, the imposition of heavy criminal penalties against such women would likely be observed in a negative light by international human rights convention supervisory bodies such as the Human Rights Committee and the CEDAW Committee, while the concern of the ECtHR in *A, B and C* concerning the “chilling effect” of the law on women may remain unaddressed under the current proposal. In this regard it is **recommended** that a statutory duty be placed on the DPP to promulgate guidelines as to the factors that will be taken into account in deciding when a prosecution should be initiated by her Office under those provisions.

105. While section 23 seeks to “control” the actions of non-State actors as required under international human rights standards, while vindicating the constitutional right to life of the unborn, it may be the case that these measures could constitute a “chilling effect” on medical practitioners and organisations who, for legal risk management purposes, may err on the side of caution when assessing women who may or may not be eligible for a lawful termination of pregnancy under the Bill. Such a risk would increase if the number of “approved institutions” under section 3 were reduced over time in such a manner that there was inadequate geographical or practical accessibility to those in-patient services by means of Ministerial regulations. In this regard, it is **recommended**, that at all times a minimum number of institutions, based on an equitable geographical distribution, would be required to be approved by the Minister under the proposed legislation.

106. Further, the reframed criminal sanctions in section 23 of the Bill raise concerns as to whether institutions will themselves feel compelled to monitor and control their medical staff in respect of the discharge of their functions under the proposed legislation. Corporate governance issues will arise in relation to any hospital designated under section 3 of the Bill as an “appropriate location” where lawful termination of pregnancies may be carried out. Not only will relevant medical staff be concerned to ensure they comply with the legislative framework and any guidelines promulgated by their respective professional organisation, but in addition those individuals listed in section 23 (namely directors, managers, secretaries, other officers or members) will have to consider any internal risk management policy adopted by the hospital in order to distance themselves from any alleged criminal behaviour in borderline cases. Legal risk could potentially also attach to a hospital

attempting to comply with the legislation in an expansive rather than restrictive manner and an analysis of this risk could lead to hospitals adopting internal governance procedures to eliminate any such risk. This in itself could create additional hurdles to accessing the medical procedures set out in sections 7 and 9 of the Bill and ultimately have the chilling effect on doctors previously criticised by the ECtHR. It may also therefore not constitute effective access to healthcare for women in crisis pregnancies as required under international human rights laws to which the state is a party. In this regard it is **recommended** that it be clarified that institutions are also under a legal obligation to ensure effective access to procedures required to save the life of a woman or girl in a crisis pregnancy.

### **Q. Other Human Rights Risks**

107. In this section consideration is given to other human rights risks which arise from what is omitted or not directly addressed in the legislation. These are:

- Fatal foetal abnormality;
- Rape;
- Minors;
- Minority groups;
- Accountability of medical practitioners.

### **Fatal foetal abnormality**

108. *D v Ireland*<sup>70</sup> concerned a fatal foetal abnormality. It was ultimately deemed inadmissible as the ECtHR found that the applicant had not exhausted all domestic remedies on the basis of the State's arguments. The main argument made by the State before the ECtHR was that given the unclear definition of what is meant by "unborn" in Article 40.3.3, the interpretation of Article 40.3.3 in the X case by the Supreme Court, and subsequent legal developments, it is possible that legal abortion could currently be considered to already extend to cases of fatal foetal abnormality as in such circumstances there is no right to life engaged by 'the unborn' because the foetus has "no prospect of life outside the womb".<sup>71</sup> The ECtHR found this argument persuasive and concluded that as there was therefore a possibility that a constitutional action taken by the applicant could have provided an

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<sup>70</sup> *D v Ireland* (Application No. 26499/02) 28 June 2006. See also *Fleming v Ireland & Ors*, [2013] IESC 19 (2013).

<sup>71</sup> *Ibid* at para 69.

effective remedy by allowing for a “lawful abortion” in such circumstances, it was clear that all domestic remedies had not been exhausted.

109. However, since *D*, the Supreme Court has in *Roche v Roche*<sup>72</sup> stated that “the interpretation of the “unborn” as arising after implantation is also a harmonious interpretation of the Constitution”.<sup>73</sup> This definition of the “unborn” is reflected in the current Bill which, in employing the term “unborn human life” reflects the language employed by Denham J in *Roche* and arguably precludes a termination of pregnancy for a fatal foetal abnormality.

110. If a similar case to *D* were considered before the ECtHR it would be by an applicant who could not obtain a termination of pregnancy with a fatal foetal abnormality unless there was “a real and substantial risk” to her life. A year after its judgment in *A, B and C*, the ECtHR found, in the case of *RR v Poland*<sup>74</sup> a breach of Articles 3 and 8, where the Applicant in that case satisfied the conditions under Polish law for a lawful abortion where a possible foetal abnormality was confirmed by an initial diagnosis in her pregnancy, but she was refused an abortion. Notably in Ireland there is no domestic lawful basis to permit a termination of pregnancy in such circumstances.

111. The question would then turn to whether the ECtHR would consider the mental distress of an applicant occasioned by this situation to be in violation of her rights under Articles 3, 8, 13 or 14 of the ECHR. While the State would have a wide “margin of appreciation” and while there would be some legal clarity in relation to the unavailability of a lawful abortion, absence physical or suicidal risk to life, it may be the case that such an application would be successful in light of recent ECtHR judgments against Poland, and much would turn on the evidence in the case and the level of avoidable mental distress occasioned by Ireland’s constitutional and legislative provisions.<sup>75</sup> It is also notable that the arguments made by the Irish State in *D v Ireland*<sup>76</sup> suggested a similar approach to the issue

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<sup>72</sup> [2010] 2 IR 321.

<sup>73</sup> [2010] 2 IR 321 at 369-371 per Denham J.

<sup>74</sup> Application No. 27617/04, 28 November 2011.

<sup>75</sup> See *Tysiack v Poland*, Application No. 5410/03, Judgment 20 March 2007, *R v R* Application No. 27617/04, 28 November 2011 and *P & S v Poland*, Application No. 57375/08, Judgment 30 October 2012.

<sup>76</sup> *D v Ireland*, (Application No. 26499/02) Decision 28 June 2006.

of the application of the balancing of rights under Article 40.3.3 to cases involving fatal foetal abnormalities. In summary, the State argued that given the unclear definition of what is meant by “unborn” in Article 40.3.3, the interpretation of Article 40.3.3 in the X case by the Supreme Court, and subsequent legal developments, it is possible that legal abortion could currently be considered to already extend to cases of fatal foetal abnormality as in such circumstances there is no right to life engaged by ‘the unborn’ because the foetus has “no prospect of life outside the womb”, in which case the reasoning of the ECtHR in the *RR v Poland* case would be relevant.

112. However, the situation would certainly be more complex for the State under other international conventions which stress the woman’s right to accessible sexual and reproductive health services without discrimination and which focus also on the issue of mental distress and access to judicial remedies. Under these conventions, it is likely that the prohibition of lawful termination of pregnancy from such cases would draw criticism on the State, particularly in light of the previous negative commentary on the State by the Human Rights Committee and the CEDAW Committee which preceded the clarification of the “unborn” in the 2010 Supreme Court Judgment in *Roche*. It is **recommended** that were the Bill unable to include provision for termination in cases of fatal foetal abnormality on foot of the current constitutional position that the question of further constitutional refinement be considered. This is recommended in light of both the high likelihood of mental distress being caused to a woman who is refused a termination of a pregnancy where the unborn is suffering from a fatal foetal abnormality and the potential for the State to be found in breach of its international human rights obligations as a result.

## **Rape**

113. Termination of a pregnancy on the ground of rape is not permitted under the Bill unless the woman or girl involved can come within the risk to life requirements of sections 7 to 9 of the Bill.<sup>77</sup> As in the case of fatal foetal abnormality, it is unclear how the ECtHR would consider a claim brought by an Applicant refused an abortion following rape and much would depend on her vulnerability and the mental distress occasioned by the refusal.

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<sup>77</sup> By rape is also meant child abuse and incest.



114. Under other international conventions the refusal of a lawful abortion following rape would likely receive greater negative scrutiny particularly where issues of discrimination arise. The X case involved the rape of a 14 year old girl as did the ECtHR case of *P and S v Poland*<sup>78</sup> where the ECtHR, assessing the case under Article 3 of the ECHR, noted that prohibited “degrading” treatment under Article 3 arose “when it was such as to arouse in its victims feelings of fear, anguish and inferiority capable of humiliating and debasing them” and that acts and omissions on the part of the authorities in the field of health-care policy could engage Article 3. In assessing the case, the ECtHR considered it “of a cardinal importance that the first applicant was at the material time only fourteen years old”, had been clearly raped and was in a situation of great vulnerability. The Court noted how the first applicant was obliged to speak to a priest in hospital, witnessed her mother being forced to sign a statement that an abortion could lead to her death, was the subject of harassment on foot of the hospital releasing her details, was “accosted by anti-abortion activists” leaving the hospital, although discontinued, was initially the subject of a criminal investigation on charges of unlawful intercourse by the authorities. This led the ECtHR to consider that the first applicant “was treated by the authorities in a deplorable manner and that her suffering reached the minimum threshold of severity under Article 3 of the Convention”.<sup>79</sup>

115. In *L.M.R. v. Argentina*<sup>80</sup> the complainant was a young intellectually disabled girl who was raped. Her family sought a lawful abortion for her as provided under the Argentinean criminal code for such cases. This was refused by a lower court. The State Party argued that although the refusal of an abortion may have been a contributing factor to the mental injury that the victim suffered during and after her pregnancy, it did not constitute torture. The Human Rights Committee considered that “the State party’s omission in failing to guarantee L.M.R’s right to a termination of pregnancy, as provided under domestic law when her family so requested, caused L.M.R. physical and mental suffering constituting a violation of Article 7 of the Covenant [prohibition of torture or cruel, inhuman or degrading treatment or punishment] that was made that was made especially serious by the victim’s

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<sup>78</sup> Application No. 57375/08, Judgment 30 October 2012.

<sup>79</sup> At para 168-169.

<sup>80</sup> CPPR Communication No. 1608/2007 (2011), Views adopted on 29 March 2011.

status as a young girl with a disability.”<sup>81</sup> In *L.C. v Peru*<sup>82</sup> the complainant was a 13 year old girl who was subjected to repeated sexual abuse and the CEDAW Committee found, *inter alia*, a violation of the right to health under Article 12 CEDAW.

116. While in these cases domestic law provided access to a “therapeutic abortion” (if certain criteria were met) for rape victims, international human rights supervisory bodies also focus on the vulnerability and mental distress occasioned to consider whether the core non-derogable human right to freedom from torture or cruel, inhuman or degrading treatment or punishment is upheld. It is **recommended** that were the Bill unable to include provision for termination in cases of rape on foot of the current constitutional position that the question of further constitutional refinement be considered. This is recommended in light of both the high likelihood of mental distress being caused to a woman who is refused a termination of a pregnancy where the unborn is suffering from a fatal foetal abnormality and the potential for the State to be found in breach of its international human rights obligations as a result.

### **Minors**

117. The Bill does not specify how girls (minors) may access the medical services specified in sections 7 to 9 of the Bill nor how their consent to medical treatment will be accommodated. While the Convention on the Rights of the Child provides that the definition of children applies to all persons under the age of 18 years and while Article 19 places obligations on the State to take measures to address sexual abuse in the care of an adult,<sup>83</sup> Article 12(1) provides for increased decision making on the basis of the child’s maturity<sup>84</sup> while Article 24 recognises their right to health including access to health services.<sup>85</sup>

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<sup>81</sup> At para 9.2.

<sup>82</sup> Communication No. 22/2009, CEDAW/C/50/D/22/2009 4 November 2011 (CEDAW).

<sup>83</sup> Article 19(1) provides that “States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.”

<sup>84</sup> “States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.” (Article 12).

<sup>85</sup> “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services” (Article 24(1))

118. Accordingly it is **recommended** that the Bill be amended to specify that girls in a crisis pregnancy (including following rape) have a right to accessible age-appropriate sexual and reproductive health services without discrimination and the procedures which should apply concerning consent to treatment, including where the child is in HSE care.

### **Minority groups**

119. Similarly, girls and women from minority groups should have an accessible pathway to the health services set out in the Bill defined in the legislation, including a right to seek and receive the highest attainable standard of health. Women and girls from ethnic minority and/or non-English speaking background should receive particular assistance to access such services and barriers to such women and girls should be identified and addressed.<sup>86</sup>

### **Accountability of medical practitioners**

120. The acts or omissions of medical practitioners pursuant to this legislation triggers the State's international obligations, however the accountability of medical practitioners is not directly addressed in the Bill but will rather fall to the relevant professional bodies. As non-State actors whose acts or omissions will trigger the State's human rights obligations, there should be clearer delineation of how medical practitioners will be accountable to women and girls who use their services including issues of accessibility and referrals and the provisions of the Bill in relation to criminal sanctions should not be such as would restrict a medical practitioner from making a professional medical decision in line with the interests of the right to life of the pregnant woman. This is essential to ensure that the legislation is effective in its operation.

### **Summary of Recommendations**

- The right to life of girls and women should be protected through effective and accessible procedures pursuant to the legislation;
- The right to life of the unborn should also be protected, pursuant to the legislation and the safeguards contained therein;

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<sup>86</sup> In the 2011 Concluding Observations on Ireland's Initial Report, the Committee against Torture expressed its particular concerns that the absence of legislation lead to serious consequences in individual cases, especially for minors, minority women and women living in poverty. CAT/C/IRL/CO/1 17 June 2011, para 26

- The legislation lacks a clear pathway for a woman or girl seeking access to the procedure set out in sections 7 and 9 of the Bill through which a medical certification is made or refused and should be clarified accordingly;
- Where a girl or woman receives a 'negative' review decision under sections 10 to 14 of the Bill, she should receive written reasons for the decision in the event she wishes to seek judicial review of the decision;
- To ensure that any judicial review of a negative decision is accessible and effective, an expedited procedure before the High Court should be provided, with provision for legal aid, and anonymity;
- The number of examinations that a girl or woman is to be subjected to where she seeks treatment under this legislation, particularly girls and women in vulnerable situations primarily those at risk of suicide, should be framed so as not to unduly increase her risk of mental anguish or suffering. The provision for examination (at initial assessment and on review) by four different psychiatrists raises concerns regarding the intrusiveness of the procedure, on the woman's right to respect for her private and family life under Article 8 of the ECHR;
- In the absence of clear procedures under which persons with intellectual disabilities can be supported in receiving information and advice and in making decisions regarding the procedures set out in sections 7 to 9, and in relation to reviews under sections 10 to 14 of the Bill, the rights of such girls and women may not be adequately vindicated. To address this lacuna, mental capacity legislation, properly formulated to support decision-making of persons with disabilities, should be introduced in tandem with this Bill;
- The Bill should specify that where the action or inaction of a person claiming to have a conscientious objection and refusing to carry out or assist in carrying out a lawful procedure knowingly contributes to the death of or significant harm to the woman, that person and/or the institution shall be guilty of a specified offence;
- The term 'obstetrician' should be replaced in section 7 with suitable terminology which would cover other medical specialists;
- In relation to the power of the Minister to prohibit the performance of treatment under sections 7 to 9 of the Bill, this power must be strictly limited to ensure that the

right to access lawful termination of pregnancy is effectively vindicated and its intended use should be specified in the Bill or accompanying regulations;

- All review committees should be required to provide written reasons for their decisions, which are provided as soon as is practicable to the woman concerned;
- Provision should be made in the Bill for detailed regulations in relation to the practice and procedure to be adopted for the reception, storage, prohibition of onward transmission and destruction of records referred to in section 20, and that the advice of the Data Protection Commissioner would be sought, given the gravity of the impact of a potential disclosure of the medical record of a girl or woman for her Article 8 ECHR rights;
- It should be stipulated in explicit terms in section 20 that any identifying information regarding a pregnant girl or woman would be excluded from the notification to be transmitted to the Minister;
- In order to negate the potential “chilling effects” of sections 22 and 23 in relation to the criminal offences up to 14 years imprisonment which was noted by the ECtHR in *A, B and C*, it is recommended that a statutory duty be placed on the DPP to promulgate guidelines as to the factors that will be taken into account in deciding when a prosecution should be initiated by her Office under those provisions;
- The Bill should address the situation of young women and girls in a crisis pregnancy (including following rape) by setting out the procedures which should apply to take into account their age and vulnerability, potential exposure to criminal sanction, and their consent to treatment, including where the child is in HSE care. The Bill should further provide that young women and girls in a crisis pregnancy have a right to accessible age-appropriate sexual and reproductive health services without discrimination;
- The Bill should address the specific situation of girls and women from ethnic minorities and/or non-English speaking background and specify that they should have a pathway adapted to their needs to facilitate access to the procedures set out in sections 7 to 9 of the Bill, and the reviews pursuant to sections 10 to 14 of the Bill. The Bill should be clear as to how medical practitioners will be accountable to women and girls who use their services, including in relation to issues of accessibility and referrals.

- Insofar as the Bill does not provide for access to a lawful abortion under the procedures set out in sections 7 to 9 for women or girls in a crisis pregnancy with a fatal foetal abnormality or following rape, consideration should be given to reassessing of the Constitutional position as it prohibits access to a lawful abortion for women and girls in such situations.
- A long title should be included in the Bill for the purpose of clarity.