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Constitutional Analysis of the Health (Regulation of Termination of Pregnancy) Act 2018

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Constitutional Analysis of the Health (Regulation of Termination of Pregnancy) Act 2018:

Identifying Rights Violations and Suggesting Possible Legislative Reforms.

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BIRMINGHAM

INTRODUCTION

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INTRODUCTION

This paper presents six case studies designed to illuminate some potential constitutional issues raised by the Health Regulation of Termination of Pregnancy Act 2018. In particular, they are designed to show evidence of ongoing breaches of constitutional rights associated with the operation of that Act. The legal analysis in this document focuses on Irish constitutional law; as a result the arguments made in this document may be more conservative in many respects than if the analysis were grounded in international human rights law. This constitutional analysis is based on a research paper, produced by Professor Máiréad Enright (University of Birmingham) and submitted to the public consultation element of the Review of the Health (Regulation of Termination of Pregnancy) Act in April 2022. The research underpinning that analysis was partly funded by the University of Birmingham ESRC Impact Acceleration Account.

Each case study begins with a fact pattern. The fact patterns are based on data collected by the Abortion Rights Campaign (ARC) via an online survey (which ran from 27th September 2020-31 March 2021) among people who had accessed, or attempted to access, abortion in Ireland since January 2019[1], and information provided by the Abortion Support Network (ASN) on clients from Ireland who sought their assistance between January 2019 and December 2021.[2] Data collected by ARC was analysed by Dr. Lorraine Grimes. The ASN data was collected by Mara Clarke and her team, and initial analysis was done by ARC members Anna Carnegie, Dr. Aideen O'Shaughnessy and Dr. Rachel Roth.

Each case study focuses on issues arising under the Health Regulation of Termination of Pregnancy Act 2018. The case studies are complex and raise multiple issues under the Act because people's lives and abortion experiences are multi-faceted.

Section of the Act	**Case Study**
s. 12 "Early Pregnancy" + Failed Abortion	CASE STUDY 3: EMMA
s. 12 "Early Pregnancy"+ Domestic Violence	CASE STUDY 1: LORRAINE
s. 12 "Early Pregnancy" + Socio-Economic	CASE STUDY 3: EMMA
s. 12 "Early Pregnancy" + Migration	CASE STUDY 4: ASH
s. 12 "Early Pregnancy" + Rape	CASE STUDY 4: ASH

[1] Abortion Rights Campaign and Lorraine Grimes. Too Many Barriers: Experiences of Abortion in Ireland after Repeal. Sept. 2021

[2] All potentially identifiable personal details were removed before the data was shared with Professor Enright. None of these case studies by itself represents a single real individual who provided data to either organisation – elements of individual stories are combined to create the case studies presented here. Any correspondence between the names of the people featured in these case studies and those of people who have contacted ARC or ASN is purely coincidental. Although fictional, all case studies present fact patterns and experiences that pregnant people in Ireland disclosed while discussing their attempts to access abortion care under the Act.

s.9 “Risk to life”	CASE STUDY 4: ASH
s.9 “Risk to health”	CASE STUDY 2: GINA CASE STUDY 4: ASH CASE STUDY 6: MOIRA
s.11 “Condition Likely to Lead to the Death of the Foetus”	CASE STUDY 5: NATASHA CASE STUDY 6: MOIRA
s. 22 Conscientious Objection	CASE STUDY 2: GINA

Each case study is analysed according to the same three themes:

1. Why was treatment not provided in Ireland?
2. What constitutional issues are raised in this case?
3. How could the legislation be changed to protect the constitutional rights at issue?

Please direct any questions to Máiréad Enright (m.enright@bham.ac.uk).

CASE STUDY 1: LORRAINE – ABORTION AFTER 12 WEEKS + DOMESTIC VIOLENCE

Lorraine is 24 and living on limited social welfare payments. She and her ex-boyfriend had been broken up for almost 10 weeks when she realised that she was pregnant. He had been emotionally and physically abusive at the end of their relationship, and she did not want to have his baby. She immediately decided on an abortion. She knew from a friend that her local GP did not offer abortion care. The nearest city, where GPs did provide care, was 40 minutes' drive away.

Lorraine discussed her circumstances with her brother. Against her wishes, her brother told her ex-boyfriend what was happening. Her ex-boyfriend showed up at her flat in the middle of the night screaming and banging on her door. He said he was watching her and would kill her if she had an abortion. After this incident, Lorraine was afraid to leave the house. It was a week before she felt able to make an appointment with a GP in the city, and another 2 days before she could travel to meet the GP.

The GP referred her to an early pregnancy clinic for scanning. She had to wait 3 days for the scanning appointment. The scan showed that her pregnancy was at 11 weeks and 3 days LMP. Although her pregnancy was then still technically under the legal limit for abortion access, the GP explained that the law required Lorraine to wait another 3 days before she could access an abortion. By then she would be at 11 weeks and 6 days LMP. Since she was over 9 weeks pregnant, she would need to be treated in the local hospital. This is a matter of policy, not a legislative requirement. The GP sought a referral but the earliest available appointment was in 4 days' time. The GP explained that it was unlikely that Lorraine would be able to complete her abortion in Ireland within the 12 week time limit prescribed by law. The GP was aware that Lorraine was at risk of violence, and was sorry not to be able to offer any other help.

Lorraine found an English clinic by Googling. Their website said the treatment would cost €810 up to 14 weeks' pregnancy. Lorraine didn't have a passport, and so Aer Lingus was her only option; the flight would be €180. Lorraine borrowed another €500 from a friend and spent the next week cobbling together the remainder from acquaintances. She planned to sleep at the airport in England, to take advantage of cheaper early morning flights. A friend offered to accompany her, but there was no way either of them could afford it and so Lorraine planned to travel alone.

Eventually, another friend told Lorraine about the Abortion Support Network (ASN). She left a voicemail with them asking for assistance. ASN gave her a grant to cover most of her costs. They helped her to book flights and buses, and to make an appointment at a clinic in England. They also arranged accommodation, so that she could have some privacy while recovering from the abortion. By the appointment date, Lorraine was 16 weeks LMP and the abortion was more expensive than if she had been able to travel earlier. If ASN had not been there for her, she could not have had the abortion at all. Despite their care and assistance, Lorraine found the experience intensely distressing.

Why was treatment not offered in Ireland?

Treatment was not offered in Ireland because, through no fault of her own, Lorraine could not access care within the 12-week statutory time limit under s.12. The legislation makes no exceptions for women at risk of violence from a current or former partner. Although Lorraine could not be prosecuted if she tried to end the pregnancy herself, any individual assisting her would be vulnerable to prosecution under s. 23 of the Act.

Lorraine's access to treatment was delayed by a combination of avoidable factors within the state's control:

1. The mandatory 3-day wait period under s. 12 is a statutory obstacle.
2. The referral for a scan, which is linked to the policy decision that abortions can only be done in hospital between 9 and 12 weeks, is a further obstacle, and introduces further risk of delay where scans cannot be made available immediately. [3]
3. Criminalisation of abortion is also an issue here. Scanning requirements are intended, at least in part,[4] to ensure that the doctor certifying a pregnant person's entitlement to access an abortion can form 'a reasonable opinion in good faith that the pregnancy concerned has not exceeded 12 weeks of pregnancy', and thus be certain of avoiding the criminal penalities imposed by s. 23 of the Act.
4. The uneven distribution of GP-led abortion services across the country imposes travel burdens on people who need to access abortion care.

When we consider the mandatory 3-day wait period under s. 12 and the delay attributable to scanning, we see that Lorraine was deprived of 6 days within which she could have legally accessed an abortion in Ireland. These 6 days are in addition to other time lost to travelling to meet her GP.

Lorraine was able to access an abortion in England on mental health grounds.[5] In Ireland, the 2018 Act sets a much higher threshold for abortion access than England's Abortion Act 1967 does, even for people in very difficult circumstances. Irish abortion law does not provide for the risk that Lorraine will be harmed by her abusive ex-partner.[6] In theory, the risk to health posed by domestic violence could be considered a risk to health under s.9, but it is unlikely

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[3] See further Mishtal J, Reeves K, Chakravarty D, Grimes L, Stifani B, Chavkin W, Duffy D, Favier M, Horgan P, Murphy M, Lavelanet AF. Abortion policy implementation in Ireland: Lessons from the community model of care. PLoS One. 2022 May 9;17(5):e0264494, at p. 15.

[4] The World Health Organisation maintains that abortion care can be safely provided in a primary care setting up to 12 weeks.

[5] Statistics on people who provide Irish addresses when seeking abortion care in England and Wales indicated that some women who require abortion care are not receiving it in Ireland. Although the numbers accessing NHS abortions pre-12 weeks have declined dramatically since 2018, a significant number (198 out of 375) accessed care between 13-19 weeks. These are likely to be people who have been unable to meet the 12 week threshold; J Mishtal and others, 'Policy Implementation – Access to Safe Abortion Services in Ireland Research Dissemination Report' [2021] UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), Department of Sexual and Reproductive Health and Research, World Health Organization, 20 Avenue Appia 1, 36.

[6] During debates on the 2018 Act Health Minister Simon Harris suggested that the 'emergency' provisions under s.10 would allow doctors to exercise their discretion to treat a pregnant person where, for example, her health or life was at risk from intimate partner violence. There is no evidence that the Act has been interpreted in this way in practice; Seanad 11 December 2018, Vol. 263 No. 3.

that a medical practitioner would consider an abortion an 'appropriate' response to that risk under s. 9(1)(c). IOG Guidelines only refer to complex medical conditions.[7]

Although Lorraine did not seek treatment in hospital, the policy decision to require pregnant people to access abortion in hospital imposes further burdens.[8] The pregnant person must often arrange travel within Ireland and must wait for a hospital appointment to become available. Their privacy may be compromised in ways that would not happen if they were permitted to have the abortion at home.

What constitutional rights are engaged here?

Lorraine's constitutional rights to bodily integrity and privacy are clearly engaged. She was eventually able to access an abortion, but constitutional rights can be breached in cases of delay as well as in cases of outright denial of access to care.[9] Even though Lorraine was eventually able to access an abortion outside of Ireland, the delay in receiving care subjected her to intense emotional distress. Her suffering was not erased simply because she was eventually enabled to travel for an abortion.

Lorraine could argue that the strict 12-week time limit and the 3-day waiting period under s. 12, in combination with the criminal law provisions of s.23, constitute a disproportionate infringement of her rights, particularly the right to privacy. The constitutional right to privacy includes a right to autonomy or self-determination.[10] In particular, it includes a right to make informed decisions about one's own health.[11] The foundational case on the right to privacy is *McGee v. AG*.[12] In that case, the Supreme Court found that a law criminalising the importation of contraceptives[13] was unconstitutional as a breach of the right to privacy.[14] There are strong parallels between the criminalisation of modes of access to contraception in *McGee* and criminalisation of access to early medical abortion under the 2018 Act. By restricting access to abortion through criminalisation, the 2018 Act deprives women like Lorraine of the opportunity to make fundamental decisions about an intimate dimension of their private lives. In addition, if the police investigated a doctor or other person for assisting Lorraine to obtain an abortion outside the terms of the 2018 Act, Lorraine's private

[7] IOG, Interim Clinical Guidance, *Risk to Life or Health of a Pregnant Woman in Relation to Termination of Pregnancy* p. 12 Avalable at: https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2021/11/FINAL-DRAFT-TOP-GUIDANCE-RISK-TO-LIFE-OR-HEALTH-OF-A-PREGNANT-WOMAN-220519.pdf

[8] O'Shaughnessy, A., Grimes, L., Roth, R. & Carnegie, A. 2022. 'Experiences of Late First Trimester Abortion in Irish Hospitals: Suggestions for Change', (Under Review).

[9] See by analogy the minority judgment of Hogan J. in *N.H.V. v. Minister for Justice* [2016] IECA 86 [118] on the relationship between delays in the asylum system and mental health. Although the delay in that case was seven years, a shorter delay may have an equivalent effect in the context of abortion, because the window of time within which abortion is legally available is very short. The delay in *N.H.V.* was 'open-ended and indefinite'. Again, the nature of pregnancy is such that a delay need not be indefinite to destroy the enjoyment of fundamental rights under the constitution.

[10] O'Donnell J. in *Simpson v Mountjoy* [2020] IESC 52 at [10]; *Re A Ward of Court* [1995] IESC 1

[11] *Kearney v McQuillan* [2010] 3 IR 576 per MacMenamin J.

[12] [1973] IR 284

[13] Use of contraceptives was never criminalised, but sale and importation were. Similarly, abortion itself is not criminalised in Ireland, but it is a crime to assist another person to obtain an abortion outside the terms of the act (S. 23(3) of the 2018 Act.)

[14] See also *Kennedy* [1998] 1 ILRM 472

life would be affected by that investigation as well as by any potential court proceedings. Although the *McGee* judgment did not extend to the right to terminate a pregnancy, the right to privacy must be applied against the backdrop of the 2018 referendum, in which an overwhelming majority of voters decided that it was within the Oireachtas' power to legislate to permit the termination of pregnancy.

The strict 12-week time limit and 3-day mandatory waiting period significantly impact Lorraine's privacy rights. The infringement is especially severe because there are no other meaningful routes to vindicating her constitutional rights[15] after 12 weeks, for instance, under the s.9 health ground. The Oireachtas may take the view that this strict approach is justified in the pursuit of legitimate policy interests including (i) protecting fetal life after 12 weeks and (ii) ensuring that women are supported to make informed abortion decisions. However, it is not clear that there is any rational connection between these goals and the wider criminalisation of abortion after 12 weeks. The 3-day mandatory waiting period, in particular, is entirely arbitrary.[16] It is not supported by any medical rationale[17] and there is no evidence that it facilitates women in making better-informed abortion decisions. On the contrary, it leads to delays in abortion access, which may expose pregnant people to unnecessary risk.[18]

How could the Act be amended to resolve this problem?

- The Oireachtas could choose to remove the time limit for abortion on request, or extend it, to reduce its oppressive effects.[19] This would be the simplest solution and would be justified in view of the serious rights violations attributable to a strict 12-week deadline.The 3-day waiting period should also be removed.
- Failing that, there are other options. The Oireachtas could also consider amending s. 12 to give doctors discretion to treat anyone whose pregnancy is very close to the 12-week deadline, or has exceeded it by just a few days. If the 3-day mandatory wait

[15] *cf Murphy v. Independent Radio and Television Commission* [1999] 1 IR 2 [47]

[16] de Londras, F., Cleeve, A., Rodriguez, M.I. *et al.* The impact of mandatory waiting periods on abortion-related outcomes: a synthesis of legal and health evidence. *BMC Public Health* 22, 1232 (2022). https://doi.org/10.1186/s12889-022-13620-z; De Zordo, S, Zanini, G, Mishtal, J, Garnsey, C, Ziegler, A-K, Gerdts, C. Gestational age limits for abortion and cross-border reproductive care in Europe: a mixed-methods study. *BJOG* 2021; 128: 838– 845.

[17] The World Health Organisation recommends against state-imposed waiting periods; World Health Organization. (2022). Abortion care guideline. World Health Organization. https://apps.who.int/iris/handle/10665/349316. License: CC BY-NC-SA 3.0 IGO pp. 41-42

[18] The 3-day provision also compounds delays which do not derive from the Act itself. These arise from (i) the need to travel within Ireland to access abortion if services are not available locally (ii) making an appointment with a local GP only to find that they do not provide (iii) limited MyOptions service on the weekends (iv) the perceived requirement to produce government identification, such as a PPS number (v) slow or ambiguous referral pathways from GPs to hospital providers. All of these factors intensify equality concerns.

[19] A majority of participants in the Citizens' Assembly, which devised the basic structure of what would become the 2018 Act, would have preferred a law that provided for abortion 'with no restriction as to reasons' up to 22 weeks' gestation/LMP (44%) or without regard to time limits (8%). 48% would have permitted abortion on request up to 12 weeks' gestation. 50% would have permitted abortion up to 22 weeks on socio-economic grounds. See Mary Laffoy, 'First Report and Recommendations of the Citizens' Assembly: The Eighth Amendment of the Constitution' [2017] An Thionól Saoránach; Constitution (n 116). These proposals did not attract the support of a majority of the Joint Oireachtas Committee on the 8th Amendment.

period is retained, doctors should be granted discretion to waive it in circumstances where observing it would otherwise result in a harmful denial of abortion access.

- Consideration could also be given to the interpretation of 'serious harm to health' under s. 9, where the pregnant person's life or health are at clear risk from third party violence. For instance, the World Health Organisation's definition of 'health' would encompass safety from domestic violence, and interpreting the legislation in line with that definition would benefit people in Lorraine's position.[20]
- The Oireachtas declined to legislate for abortion on socio-economic grounds, despite the recommendations of the Citizens Assembly. By reversing this decision, the Oireachtas could make specific legislative provision for people like Lorraine, whose access to abortion is compromised by factors including poverty and gender-based violence.
- In order to ensure that legal abortion is accessible in practice after 12 weeks, the Oireachtas should fully decriminalise abortion, so as to address the 'chilling effects'[21] of criminalisation on medical practice. Alternatively, the Minister should revisit the content of existing offences and defences under s.23, and determine why they have been insufficient, to date, in addressing doctors' fears of prosecution.
- The requirement that abortion care after 9 weeks LMP is provided in hospital is not a statutory requirement. Consideration should be given to amending relevant guidelines where these lead to unduly restrictive interpretation of the legislation.

[20] For definition see World Health Organization. (2022). Abortion care guideline. World Health Organization. https://apps.who.int/iris/handle/10665/349316. License: CC BY-NC-SA 3.0 IGO p.10

[21] See A Mullally and others, 'Working in the Shadows, under the Spotlight–Reflections on Lessons Learnt in the Republic of Ireland after the First 18 Months of More Liberal Abortion Care' (2020) 102 Contraception 305.

CASE STUDY 2: GINA – MENTAL HEALTH ISSUES AFTER 12 WEEKS + CONSCIENTIOUS OBJECTION

Gina is 43 and has two children. She works part-time as a cleaner. Her husband's earnings can be erratic. She has been taking medication including antidepressants since her youngest, now aged 2, was a newborn. His birth was very traumatic and Gina did not want to get pregnant again. She began using birth control after her first child's birth.

When Gina first suspected she was pregnant again, she took a test she bought in the pharmacy, but this was negative. She went to the GP some weeks later when she started experiencing stomach problems, and mentioned the pregnancy test. Her GP did another test, which was positive. He advised her that her contraception must have failed somehow and referred her for scanning. To Gina's shock, the scan suggested she was 'around 18 weeks' LMP.

Making travel arrangements was hugely stressful. Although her husband is supportive, he works away from home, and so Gina needed to share her circumstances with some neighbours who agreed to look after her children. It took her a few days to make arrangements for flights and an appointment. She felt deeply ashamed all the time and was very anxious about travelling alone during the COVID-19 pandemic. She began to have intrusive thoughts about hurting herself. She called her GP again, but he told her that he thought that it would be immoral to access an abortion at this stage in the pregnancy unless she was suicidal. Gina was confused, since she knew that abortion should be available in Ireland on mental health grounds. Her GP told her that he could not support her in seeking a 'late-stage abortion'. Gina gave up on an abortion in Ireland.

The appointment in England was scheduled for a week after she made the booking. When she arrived at the clinic they re-scanned her, because the pregnancy was by now quite advanced. Their scan found that she was 24 weeks and 2 days pregnant. It seemed that there had been an error in the Irish scan. The clinic explained that they did not have the facilities to treat patients who were more than 24 weeks pregnant. They cancelled Gina's appointment.[22] She would need to seek a referral to a maternity hospital, in order to be treated in England. Gina travelled home to Ireland that evening. She is still pregnant and doesn't know what to do next.

Why was treatment not offered in Ireland?

An abortion was not offered in Ireland because Gina was over 12 weeks LMP. The legislation expects that women will be able to recognise that they are pregnant, and act on that knowledge, very quickly. In theory, Gina could have requested an abortion under s.9 on mental health grounds. At 24 weeks pregnant, Gina's pregnancy is now likely to be

[22] In theory, Gina may have been entitled to access an abortion under s. 1(c) of the Abortion Act 1967, if the anticipated risk to her health posed by continuing the pregnancy was 'grave and permanent'. However, she was no longer entitled to an abortion under s. 1(a) (so-called Ground C) since her pregnancy had exceeded the 23 weeks + 6 days time limit under English law. See further https://www.gov.uk/government/publications/abortion-clarification-of-time-limit/clarification-of-time-limit-for-termination-of-pregnancy-performed-under-grounds-c-and-d-of-the-abortion-act-1967 .

considered viable, and so she is ineligible for an abortion under s.9. An abortion would only be available under s.10 if her health deteriorates to the point where her life is immediately at risk. Gina's GP could have facilitated a referral under s.9 earlier in her pregnancy. His reference to suicidality no longer reflects Irish law. S.9 covers risk of serious harm to health as well as risk to life. It appears that he conscientiously obstructed Gina's access to care.

S.22 requires a doctor who objects to participation in carrying out an abortion under ss.9, 11, or 12 to transfer the pregnant person's care to an alternative, willing provider. This provision aims to strike a balance between Gina's rights to access legally available care, and her doctor's constitutional right to freedom of conscience. However, the Act makes no provision for enforcement of the doctor's obligation to refer. Neither does it set clear expectations where the objecting doctor is not being asked to provide care under s. 12, but rather to refer the patient to other doctors who will determine her eligibility for an abortion under ss. 9, 10, or 11.

Even where no issue of conscientious obstruction arises, it can be very difficult to access an abortion on mental health grounds where the pregnant person's life is not deemed to be at risk. Even if she had requested an abortion under s.9 earlier in her pregnancy, it is likely that Gina would have been refused. Although abortion is available under s.9 on grounds of risk of 'serious harm to health', including mental health, there is some evidence that this ground is very rarely used in practice,[23] and there is no clear care pathway for access under this ground Uncertainty in the abortion law, and consequent confusion among medical practitioners,[24] could undermine the secure enjoyment of constitutional rights.. The 2018 Act should not be interpreted conservatively. [25] To remedy prevailing uncertainty, the Oireachtas should ensure that s.9 is interpreted[26] so that pregnant people's constitutional rights are 'taken seriously' and have 'life and reality' in practice.[27]

What constitutional rights issues arise here?

Gina's constitutional rights to bodily integrity[28] and privacy are clearly engaged here. She is likely to be required to continue a pregnancy that she took firm steps to end weeks ago. The

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[23] Just 9 terminations took place under s.9 in 2021. S. 9 terminations include terminations on grounds of risk to life, and on physical health grounds. No individual figure is provided for terminations on mental health grounds.

[24] See *AG v. X* [1992] IESC 1 per McCarthy J. *obiter*; *PP v. HSE* [2014] IEHC 622

[25] Remedial statutes should be interpreted purposively, and construed as liberally as possible; *Bank of Ireland v. Purcell* [1989] I.R. 327 and *Gooden v. St. Otteran's Hospital* [2005] 3 I.R. 617; *O'Donnell v South Dublin* [2007] IEHC 204

[26] Where two interpretations are available, and one is constitutional but the other is not, the constitutional interpretation should be adopted *McDonald v. Bord na gCon* [1965] IR 217

[27] *Buckley v. Attorney General* [1950] I.R. 67, 8; X. *A. (An Infant) v. Minister for Justice, Equality and Law Reform* [2011] IEHC 397. This principle has been invoked in relation to marriage (*A v MJELR* [2011] IEHC 397), rights of access to the courts (*O'Connor v. Nurendale* [2010] IEHC 387) involuntary detention (*XX v. Clinical Director of St Patricks* [2012] IEHC 224).

[28] The right to bodily integrity is generally considered to be an unenumerated right under Article 40.1; *Ryan v. AG* [1965] IESC 1. However, courts have also located equivalent protections in a range of cases on 'the right of the person' or the right to the security of the person explicitly protected in Article 40.3.2. See discussion in David Kenny, 'Recent Developments in the Right of the Person in Article 40.3: Fleming v. Ireland and the Spectre of Unenumerated Rights' (2013) 36 Dublin University Law Journal 322.

right to bodily integrity is the right not to have one's health endangered by the state,[29] and to be protected from unjustified bodily interference.[30] The right is engaged when healthcare is criminalised or knowingly withheld, [31] and may encompass a right to help in accessing medical treatment.[32] Since Gina has suffered acute mental distress, her right to bodily integrity is clearly engaged.[33] 'Bodily integrity' refers to more than physical protection. As Hogan J. sets out in *Kinsella v. Mountjoy,*[34] it encompasses "not simply the integrity of the human body, but also the integrity of the human mind and personality." Arguably, because Gina's suffering is extreme, such that she is having intrusive thoughts about harming herself, the violation of her right to bodily integrity may be classified as 'degrading treatment'. [35] Although Gina was eventually able to travel for an abortion, this does not extinguish her constitutional claim.[36] As Gina's case reminds us, travel does not always guarantee access to care.

Gina was certainly entitled to consideration of a request for an abortion under s.9. However people in a position as vulnerable as Gina's understandably struggle to vindicate their constitutional rights for themselves. Even if Gina's request for an abortion under s.9[37] had been considered it is likely that she would have been refused. One key question is whether s.9, as it stands in the context of ongoing criminalisation of abortion under the 2018 Act, strikes an appropriate balance between the Oireachtas' policy goals and the rights of women like Gina. It is difficult to justify these burdens by reference to the Oireachtas' policy goals. The Oireachtas' policy goals will include preservation of fetal life as a dimension of the 'common good'. If s.9 only accommodates those pregnant people whose health is at such serious risk that their lives are actively threatened, then it exposes women like Gina to inhuman and degrading treatment. It is difficult to defend such violations by reference to the policy goal of preserving fetal life. Even if we accept that the goal of preserving fetal life demands restrictions on abortion access, the number of people who are likely to need to

[29] Public bodies such as the HSE have a statutory duty to vindicate those rights under s.42 of the IHREC Act 2014.

[30] The right has been used to protect against a forced C-section. *HSE v B* [2016] IEHC 605, [17]. See also *Governor of A Prison v. GDC* [2020] IEHC 34 (force feeding); *JM v Board of Management of St Vincent's Hospital* [2003] 1 IR 321 (blood transfusion). It would also include the right to refuse consent to abortion: *SPUC v Grogan* [1989] IR 753, 767

[31] In *McGee v. AG* [1973] IR 284, Walsh J. noted *obiter* that, Mrs McGee could have argued that an exception should be made to the criminal law restricting access to contraception on the basis of the risks that future pregnancies posed to her health and life. In the end that case was decided on a different ground.

[32] See *MEO v. Minister for Justice* [2011] IEHC 545 suggesting that the right to the person may be breached where the state places an individual in a situation where they are denied access to life-saving treatment, especially when coupled with severe social and economic deprivation. See also *Barry v Midlands Health* [2019] IEHC 594 [67], on delay in provision of access to medication to a prisoner.

[33] See also *Sullivan v. Boylan* [2012] IEHC 389 *per* Hogan J. noting that the right encompasses protection from 'acute mental distress'.

[34] [2011] IEHC 235; See also O'Donnell J. in *Simpson v Mountjoy* [2020] IESC 52 at [10]

[35] Degrading treatment implies that the violation has reached a certain minimum degree of severity; *Mulligan v. Governor of Portlaoise* [2010] IEHC 269; *Barry v Midlands Health* [2019] IEHC 594. It does not matter that the intention of the Oireachtas was not to subject women to degrading treatment, if the legislation has that effect; *Heaney v. Ireland* [1994] 3 I.R. 59 *cf Frawley*; *Mulligan v. Governor of Portlaoise* [2010] IEHC 269

[36] On a similar point see *NIHRC's Application* [2018] UKSC 27 *per* Kerr J.

[37] It is likely to be important to demonstrate that the pregnant person has actually requested an abortion and disclosed any important personal or health circumstances to a relevant healthcare practitioner; *cf Mulligan v Governor of Portlaoise Prison* [2010] IEHC 269

terminate a pregnancy on mental health grounds after 18 weeks' pregnancy is vanishingly small.

In theory, Gina may be eligible for an abortion outside of Ireland. In practice, it is very difficult to access an abortion at this stage of pregnancy. Even if she can access an abortion abroad, travel would not cure the violation of her constitutional rights caused by the Act. As Gina's case demonstrates, an appointment in England is not a guarantee of abortion access, [38] and the experience of traveling for abortion can be deeply traumatising. The state is essentially continuing to rely on charity and on foreign healthcare systems to vindicate Irish residents' constitutional rights.

It may be that Gina's doctor deliberately impeded her access to care.[39] Doctors bear a duty to protect their pregnant patients' constitutional rights,[40] and the state must regulate the medical profession in a way that secures fulfilment of that duty. The Oireachtas acknowledges the constitutional rights of doctors[41] who conscientiously object to providing abortion care in s.22 of the 2018 Act. The Act provides that while nobody can compel a healthcare practitioner to take part in a non-emergency abortion themselves, they are under a statutory obligation to make alternative arrangements for that patient's care.[42] This limitation on the objector's freedom of conscience[43] is proportionate; necessary to give 'life and reality' to the countervailing rights of the pregnant person.[44] Arguably, the statutory restriction here does not go far enough, because it contains no direct enforcement mechanism.[45] It also allows objectors to obstruct lawful access to abortion in other ways, for instance, through conservative interpretation of the legislation, or delaying treatment, without obliging them to disclose their motivations.[46]

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[38] See also Hogan J. in *A v. MJELR* [2011] IEHC 397 [31]-[33] arguing that a right is not protected where there is no practical opportunity to avail of relevant protective choices abroad.

[39] See discussion of refusal to refer in Abortion Rights Campaign and Grimes (n 23) 55. In P. And S. v. Poland. Application no. 57375/08 ECHR (2012) the European Court of Human Rights found that refusal to refer a girl who had been raped to a willing abortion provider could contribute to a breach of the right to freedom from inhuman and degrading treatment under Article 3 ECHR.

[40] *Kearney v McQuillan* [2010] 3 IR 576. Insofar as the relevant constitutional rights have horizontal effect, it is possible to foresee a constitutional case that is built, at least in part, on a doctor's unlawful refusal to treat or refer.

[41] Although the legislation has been in force for over three years, only 10 or 11 maternity hospitals provide the full range of legal abortion care. It is unlikely that hospitals can assert an institutional right under Article 44.2.5 of the Constitution to refuse to provide abortion care where this conflicts with their ethos, but that question has yet to be considered by an Irish court. Provision of state-funded maternal healthcare within an independent hospital does not fall squarely within the zone of religious denominational autonomy protected by Article 44.2.5.

[42] S. 22(3).

[43] Freedom of conscience is broader than freedom of religion; *AM v. Refugee Appeals Tribunal* [2014] IEHC 388 [32].

[44] *Article 26 and the Employment Equality Bill* [1997] IESC 6

[45] Abortion Rights Campaign (n 22) 21.

[46] It is highly unlikely that hospitals enjoy an institutional right under Article 44.2.5 of the Constitution to refuse to provide abortion care where this conflicts with their ethos, but the question has yet to be considered by an Irish court. See further Fletcher (n 92).

How could the law be changed to resolve these problems?

- Since Gina was at 18 weeks LMP when she first sought treatment, minor adjustments to s. 12 would not assist her. Cases like Gina's demonstrate the value of removing or significantly extending the 12-week time limit, to vindicate the rights of women who are unable to meet the 12-week deadline.
- It is possible that Gina's doctor deliberately deprived her of the opportunity to be considered for an abortion under s. 9. The Act should be amended to impose clear sanctions for misuse of the conscientious objection provisions in s. 22. The Minister should also take steps to clarify that the right to refuse to 'participate' in an abortion under s. 22 does not extend to refusing to refer a patient to a willing provider who will evaluate the pregnant person's right to access care under the Act.
- The Minister should act to establish clear pathways to abortion care under s.9 where a pregnant person's mental health is at risk of serious harm. This includes producing guidance to clarify what constitutes 'serious harm' to mental health.
- If s.9 is interpreted conservatively, such that even people as ill as Gina cannot access abortion care when they need it, that conservative interpretation may be evidence of the 'chilling effects' of criminalisation. To address the risk of chilling effects, the Act should be amended to fully decriminalise abortion. Failing that, the Minister should revisit the content of existing offences and defences under s.23, and determine why they have been insufficient, to date, in addressing doctors' fears of prosecution.

CASE STUDY 3: EMMA – FAILED ABORTION AFTER 12 WEEKS AND SOCIO-ECONOMIC POSITION.

Emma went to her GP for an abortion when she first realised that she might be pregnant. At the time, she and her daughter had been evicted from their flat and had spent months 'couchsurfing' with relatives. Emma was spending a lot of time trying to find housing , and as a result she struggled to prioritise her own health. Suspecting she was pregnant, she went to her GP. Emma was sure of her dates – 8 weeks LMP. The GP confirmed that she was entitled to an abortion. She was treated four days after her first appointment. Everything seemed to go well, and two weeks later she took a pregnancy test. The test was positive. She immediately returned to her GP, who referred her to the local hospital for a second attempt at an early medical abortion. She was treated 3 days later. By then, she was 11 weeks LMP. She took another pregnancy test two weeks later and was relieved to see that it was negative.

However, Emma later became worried when her period didn't come. She went back to her GP and took another pregnancy test at the surgery. This was positive. Her GP explained that she could not help Emma because the pregnancy was now over 14 weeks LMP. Emma considered ordering pills illegally but decided that she couldn't take the risk of another failure.

Emma contacted MyOptions, who put her in touch with ASN. ASN arranged financial aid, allowing her to travel to an English clinic for a surgical abortion. It was two weeks before another appointment was available. The clinic did a scan and found that Emma had suspected placenta accreta, a serious condition the clinic could not handle. Emma's appointment was cancelled, and she had to return to Ireland and wait a further two weeks before she could return to an English hospital for treatment. While she was away, her daughter was passed from one relative to the next. Emma couldn't keep the abortion a secret from those who agreed to care for her daughter, and the stress was almost unbearable. Although Emma first sought treatment at 8 weeks LMP, her pregnancy was not finally ended until she was 18 weeks LMP.

Why was treatment not offered in Ireland?

Abortion is available on request under s. 12 up to 12 weeks. Multiple rounds of treatment are permitted, provided they are completed within that deadline. While S. 12 does not directly address the issue of failed early medical abortion, clinical guidance makes clear that physicians cannot provide further abortion care if a patient is even one day past the 12-week cut-off.[47] It does not matter that a first, legal attempt to end the pregnancy took place within the 12-week period. Emma sought an abortion under s. 12 in good time, but the medication failed. She is now unable to access a legal abortion in Ireland. Anyone who assists her to obtain an abortion is vulnerable to prosecution for offences under s.23. Even if a doctor were willing to disregard the clinical guidance, and take the view that at over 14 weeks LMP,

[47] IOG, *Interim Clinical Guidance: Termination of Pregnancy Under 12 Weeks* p. 12. Available at: https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2018/12/FINAL-INTERIM-CLINICAL-GUIDANCE-TOP-12WEEKS.pdf

the legislation permits them to continue treatment legally begun before 12 weeks, they may be deterred from doing so by the ‘chilling effects’ of criminalisation under s.23.

Emma’s homelessness undoubtedly contributed to her distress. The 2018 Act makes no exceptions for people who are likely to struggle to access abortion abroad, or whose social circumstances may compound the harms associated with inability to access a needed abortion. The Oireachtas did not legislate for abortion on socio-economic grounds, even though the Citizens Assembly expressed clear support for doing so.

If Emma’s mental distress was extreme, a question may arise around her eligibility for an abortion under s. 9. Emma was not referred for assessment under this ground. There is evidence that s.9 is very rarely used, [48] and the definition of ‘health’ applied under s.9 is not a holistic one.

What constitutional issues arise here?

As in the other case studies, Emma’s constitutional rights to privacy and bodily integrity are engaged here. If her inability to access an abortion subjected her to extreme distress, Emma may be able to argue that she has suffered degrading treatment. Emma’s situation is made worse by her effective homelessness and the impact on her family life. Her homelessness also made it more difficult to access care.[49] Although Emma was able to access an abortion outside of Ireland, the violations of her constitutional rights still stand. She was deeply affected by the delay and uncertainty associated with the requirement to travel abroad.

There is a plausible argument for comparing the decision to use early medical abortion in 2022 as broadly equivalent to the decision to use contraception in 1973, as considered in *McGee v. Attorney General*.[50] The intimate decision to determine the number and spacing of one’s children falls squarely within the zone of personal privacy safeguarded by the Constitution.[51] As such, a very strong argument would be needed to justify continued criminalisation of the means of safeguarding that right in the first trimester of pregnancy.

Although her constitutional rights are not absolute, Emma could argue that they have been disproportionately infringed. The state may argue that criminalisation of most abortions after 12 weeks, with no exception for failed early medical abortion, [52] and with no effective exception under s.9 for those whose mental health is at risk, constitutes a proportionate means of achieving the Oireachtas’ policy goals. These goals are likely to include protection

[48] Kennedy (n 23) 29. Abortion Rights Campaign (n 22) 18. ‘Second Annual Report on Notifications in Accordance with the Health (Regulation of Termination of Pregnancy) Act 2018’ <https://www.gov.ie/en/press-release/1135f-second-annual-report-on-notifications-in-accordance-with-the-health-regulation-of-termination-of-pregnancy-act-2018/> accessed 11 March 2022. Note that the statistics published by government do not distinguish between s. 9 abortions performed on grounds of risk to life, and those performed on grounds of risk to health.

[49] The Oireachtas is entitled to make such exceptions *Fleming v. Ireland* [2013] IESC 19 [136]

[50] [1973] IR 284

[51] See Lorraine above.

[52] The Abortion Support Network reported 25 such cases in 2020; Abortion Rights Campaign (n 58) 6.In all cases, treatment was commenced prior to the 12-week cut off under s. 12. The numbers of affected people may be higher – not all those affected contact ASN, and ASN does not require clients to disclose their circumstances.

of fetal life after 12 weeks as a dimension of the common good. The force of the argument for restricting abortion access in order to protect fetal life is weakest in early pregnancy. In any event, the number of people affected by failed early medical abortion is relatively small (2 to 3 women in every 100). Specific provision for this category of women would not open the 'floodgates' to expanded abortion access.

Emma should not be required to go to court to vindicate her constitutional rights. The Oireachtas could act by amending the existing legislation.

How could the law be changed to resolve these problems?

- Some of the issues presented by Emma's case could be addressed without amending the legislation. The Minister should be able to offer guidance on failed early medical abortion; to clarify that treatment may be offered under s. 12 where the abortion was certified before 12 weeks, but cannot be completed until after 12 weeks. The Minister should also facilitate greater patient choice of available methods of abortion, including by widening access to surgical abortion in early pregnancy.

- Emma's case indicates that criminalisation can have chilling effects even in early pregnancy. Decriminalisation, especially if coupled with appropriate guidance, would increase the space available for doctors to safely exercise their clinical or professional discretion in cases of failed early medical abortion.

- Since Emma was at 14 weeks LMP when she sought treatment for the second time, minor adjustments to s. 12 would not assist her. Cases like Emma's demonstrate the value of removing or significantly extending the 12-week time limit, to vindicate the rights of women who are unable to meet the 12-week deadline through no fault of their own. Alternatively, cases like Emma's demonstrate the need to legislate to allow doctors to make exceptions to the 12-week time limit where necessary to vindicate fundamental constitutional rights.

- Emma's case clearly demonstrates the value of a socio-economic circumstances ground for abortion, as supported by the Citizens' Assembly. Although socio-economic rights as such are not protected under the Constitution, and constitutional equality protections are very weak, the Oireachtas enjoys wide discretion to legislate for effective and equitable abortion access. There is no good reason why the Oireachtas could not legislate for access to abortion on socio-economic grounds.

CASE STUDY 4: ASH – PREGNANCY RESULTING FROM RAPE + SEEKING ABORTION AFTER 12 WEEKS + RISK TO HEALTH/LIFE FROM MENTAL HEALTH + MIGRATION STATUS

Ash came to Ireland as an asylum seeker a year ago. She has not been granted refugee status and lives in direct provision.[53] She is in poor mental health and has been under intermittent psychiatric care since arriving in Ireland. She became pregnant as a result of rape by a local man – she has not told anyone about it. Initially, she had trouble accepting the pregnancy, and concealed it from everyone around her. She had lost a child as a younger woman and did not think that she could cope with pregnancy and childbirth again.

One day she used Google to look for help. The first link she found was to a crisis pregnancy centre. Ash did not realise that they were anti-choice until she had been on the phone with a representative for half an hour. The representative made her feel confused about her entitlements, and ashamed to want an abortion. This was enough to put her off seeking help again for several weeks.

By the time she was able to take action, it had been 18 weeks since the rape. She saw an advertisement for MyOptions and phoned them. They signposted her to ASN. ASN explained that she would need to leave Ireland for an abortion and that she would need a travel document to do so. ASN helped Ash to make a clinic appointment for two weeks' time, hoping that the document would be ready by then. The document was delayed by 5 days, arriving just in time. However, in the meantime, the clinic had to cancel, and could not offer another appointment for a week. By now, Ash was growing increasingly distressed and anxious: she was having daily panic attacks and did not think that she could cope with travelling for an abortion at all. She was very worried that if she left Ireland, she would not be allowed to return.

After a very difficult night, during which attempted to end her life, Ash called a friend, who brought her to A&E. She was initially kept in hospital for observation. She disclosed the rape and begged to be considered for an abortion based on her mental health history. The hospital refused to consider this – she does not know why – and she was discharged from hospital. She resumed contact with ASN, who helped rearranged her travel and appointment.

Although Ash was able to access an abortion in the UK on mental health grounds, she could not have afforded to do so without ASN's help. The experience triggered a serious deterioration in her mental health.

Why was treatment not offered in Ireland?

Ash was not entitled to an abortion on request in Ireland because her pregnancy had exceeded the 12-week time limit under s.12. There is no independent rape ground under

[53] Direct Provision is the name of Ireland's system of accommodating asylum seekers, who are typically housed in converted hotels or dormitories outside the major cities.

the 2018 Act. The Oireachtas expects that if a person becomes pregnant due to rape, they will access an abortion on request before 12 weeks, [54] but it does not make any exceptions for people who have been raped, if they miss that deadline.

The activities of an anti-choice organisation obstructed Ash in her search for health care and deterred her from seeking help sooner. This kind of rogue activity is not directly regulated by the Act or by any other legislation.

Ash was able to access an abortion in England on mental health grounds, because the threshold for abortion access on mental health grounds under English law is much less demanding than that imposed by the 2018 Act. While in hospital in Ireland, Ash requested, but was not considered for an abortion on grounds of risk of 'serious harm' to mental health or risk to life under s.9. S. 9 requires two doctors to certify that they are of the reasonable opinion formed in good faith that the pregnancy is a risk of 'serious harm' to the pregnant person's health, that the fetus has not reached viability and that it is 'appropriate to terminate the pregnancy in order to avert the risk'. 'Serious harm' to health is not defined. Neither is 'appropriate'.[55] Although it is not clear that 'serious' means 'permanent' or 'life-threatening', so few abortions are performed under s.9 as to suggest that it is being interpreted in this way.[56] Because Ash's request was not formally considered, she was not entitled to a review of the refusal as provided for under s. 13.

It is not clear why the hospital where Ash presented to A&E refused to consider Ash's eligibility for abortion under s.9, or whether they referred her to a maternity unit providing appropriate care. This may be attributable to unclear referral pathways under s.9, to conscientious obstruction, or to the chilling effects of criminalisation which may deter doctors even from referring women for assessment under the 2018 Act.

Ash's circumstances are very close to those of Ms. Y, who was denied an abortion under the Protection of Life During Pregnancy Act 2013 while the 8th Amendment was still in force. Ash's case demonstrates that the Act has not effectively improved abortion access in key respects. As in Ms. Y's case, rights violations in Ash's case are produced by the intersection of the asylum system and the poor treatment of pregnant people who are not Irish citizens.

What constitutional issues arise here?

Ash's constitutional rights to privacy and bodily integrity are in issue here. A person who cannot access an abortion even though she is pregnant because of rape is undoubtedly exposed to degrading treatment.[57] Ash can invoke these rights even though she is not an

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[54] Abortion Rights Campaign (n 22) 18.

[55] See also IOG Clinical Guidance at https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2019/05/FINAL-DRAFT-TOP-GUIDANCE-RISK-TO-LIFE-OR-HEALTH-OF-A-PREGNANT-WOMAN-220519-FOR-CIRCULATION.pdf

[56] See discussion in Abortion Rights Campaign and Grimes (n 23) 56.

[57] For acknowledgment that rape is a violation of constitutional rights, in part because it exposes the victim to the risk of unwanted pregnancy see *DPP v. Tiernan* [1988] IR 250 *per* Finlay CJ. See also *Mellet v. Ireland*, UN

Irish citizen. [58] As an asylum seeker, she is in a very vulnerable position; subject to the control of the state to an exceptional degree. As such, the state's obligations to vindicate her constitutional rights are especially demanding.[59] The state was also under a positive obligation to assist her to avoid putting her life in jeopardy.[60] Although Ash eventually accessed an abortion, the violations of her constitutional rights still stand; she was required to undergo the stress of travelling to England while recovering from a recent suicide attempt and she is still living with the continuing health effects of her treatment in the Irish healthcare system. Ash's pregnancy was the result of rape and as such she can make a strong argument that the denial of access to abortion care in Ireland amounted to a violation of her constitutional right to freedom from degrading treatment.

Ash's request for an abortion under s.9 was not considered at all. Since it was not considered, she was not given an opportunity to apply for a review of a medical opinion under s. 13 of the Act. It may be that the hospital did not consider her request because it was assumed that Ash was not entitled to an abortion under s. 9. Ash could argue either that (i) that the refusal to offer an abortion under s. 9 was based on an unduly conservative and unconstitutional interpretation of that section (ii) that s.9 as drafted, in combination with the criminalisation provisions in s.23, disproportionately infringed her constitutional rights or (iii) that the strict deadline in s. 12 combined with the criminalisation provisions in s.23 disproportionately infringed her constitutional rights. It is also significant here that there was no alternative means under the legislation for her to exercise her constitutional rights because s.12, which is intended for the use of people who have been raped, was not practically available to her.

Although her constitutional rights are not absolute, Ash could argue that they have been disproportionately infringed. The state may argue that criminalisation of most abortions after 12 weeks, with no exception for people who have been raped, and with no effective exception under s.9 for those whose mental health is at risk, constitutes a proportionate[61] means of achieving the Oireachtas' policy goals. These goals are likely to include (i) protection of fetal life after 12 weeks as a dimension of the common good and (ii) ensuring a degree of legal certainty around abortion eligibility. In practice, however, criminalisation undermines others of the Oireachtas' policy goals, particularly the core policy goal of ensuring that people who have become pregnant through sexual violence are able to access abortions without being exposed to additional severe distress or undue procedural burdens.[62] When the Oireachtas discussed how best to provide for women who had been

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Doc. No. CCPR/C/116/D/2324/2013 (2016). See also UN Human Rights Committee, *Whelan v. Ireland*, UN Doc. No. CCPR/C/119/D/2425/2014 (2017).

[58] Note that these protections generally extend to non-citizens; see *N.H.V. v. Minister for Justice* [2016] IECA 86

[59] *Connolly v Governor of Wheatfield Prison* [2013] IEHC 334

[60] In *McGee,* Walsh J. wrote that one of the personal rights of a woman in Mrs. McGee's state of health would be 'a right to be assisted in her efforts to avoid putting her life in jeopardy', given the extraordinary risks that pregnancy posed to her. The state has 'a positive obligation to ensure by its laws as far as is possible' that the means of preserving her life was made available to her.

[61] The more serious the breach, the stronger the state's justification for preferring punitive measures must be; *Meadows v. Minister for Justice* [2010] 2 IR 701. See *McGee* [1973] IR 284 per Walsh J, stating that in order to justify criminalisation of contraception, the state would have to show that all its other resources 'had proved or were likely to prove incapable' to achieve its legitimate aims.

[62] Joint Oireachtas Committee on the 8th Amendment of the Constitution, 'Report of the Joint Committee on the Eighth Amendment of the Constitution' [2.23].

raped, it specifically decided against a 'rape ground' because it was considered harmful to expect proof of rape or engagement with the criminal justice system. It is almost impossible to access a legal abortion in Ireland after 12 weeks LMP. Therefore, people who have been raped and who need to access an abortion atfer 12 weeks LMP are still subjected to distress, and to a range of bureaucratic hurdles, especially if they need to arrange travel, engage with a foreign healthcare system and navigate the immigration system. The law offers pregnant people no guarantee of prompt access to care, or of help if they are refused a lawful abortion.[63] That Ash's case is so close to Ms. Y's case demonstrates conclusively that the law is undermining the Oireachtas' policy goals.

Ash would find it difficult to bring an independent claim against the anti-choice agency because the Oireachtas has failed to regulate the activities of organisations who obstruct pregnant people's access to legal abortions. The Oireachtas can and should take legislative action to ensure that these agencies cannot effectively obstruct legal abortion access. Members of anti-choice agencies may have a constitutional right to freedom of expression, but this cannot trump the constitutional rights of others, especially when they engage in deceptive practices.

How could the law be amended to resolve these problems?

Ash should not be compelled to go to court to vindicate her constitutional rights. The Oireachtas can intervene to safeguard constitutional rights by amending the legislation.

- Since Ash was at 18 weeks LMP when she first sought treatment, minor adjustments to s. 12 would not assist her or others like her. Cases like Ash's demonstrate the value of removing or significantly extending the 12-week time limit, to vindicate the rights of people who are unable to meet the 12-week deadline.
- The Minister should act to establish clear care pathways under s.9 where a pregnant person's mental health is at risk of serious harm, emphasising referral obligations where the pregnant person is not already a patient in a maternity hospital that provides abortion care. This includes emphasising that where a patient requests an abortion, the request must be taken seriously and promptly considered, even if she is more than 12 weeks pregnant. It also includes producing guidance to clarify what constitutes 'serious harm' to mental health and clarifying that there is no need to demonstrate risk to life to qualify for care under s.9. There is also a strong argument for replacing the word 'avert' in s. 9 with a word like 'mitigate', since this would clarify that abortion is permissible even where the pregnant person's health needs are complex and multi-faceted, such that an abortion would be just one part of a overall medical response.
- In this case, it is not clear why Ash was not assessed under s.9. However, if s.9 is interpreted conservatively, such that even people as ill as Ash cannot access abortion care when they need it, that conservative interpretation may be evidence of the 'chilling effects' of criminalisation. To address the risk of chilling effects, the Act

[63] See similar argument in Center for Reproductive Rights Interveners' Submissions *In the Matter of an Application by Sarah Jane Ewart for Judicial Review* 18 January 2019 p. 9

should be amended to decriminalise abortion. Failing that, the Minister should clarify existing offences and defences under s.23, and determine why they have been insufficient, to date, in addressing doctors' fears of prosecution.
- The Minister should take steps to emphasise that, by not considering a request under s.9, a healthcare provider is also denying the patient the opportunity to apply for a review of a medical opinion under s.13. The Minister should take steps to embed s.13 reviews within s.9 care pathways.
- The Oireachtas should regulate the activities of rogue anti-choice 'counselling services

CASE STUDY 5: NATASHA – A FATAL ANOMALY THAT IS 'NOT FATAL ENOUGH'.

Nastasha received a diagnosis of multiple fetal anomalies when she was 23 weeks pregnant. Her consultant advised that the fetus's prognosis was uncertain and that none of the anomalies by themselves justified an abortion under Irish law. If the baby was born alive, he would require ongoing intensive intervention, including surgery to ensure his survival. He would probably not see his first birthday. The consultant advised her that they should not travel until they 'knew for sure what the issue was'. He advised one more test. The first appointment for testing would not be available for two weeks and results would take one week to arrive. By then she would be 26 weeks pregnant.

Nastasha and her husband John had been looking forward to welcoming their new baby. Natasha was visibly pregnant; her friends and neighbours all knew. Natasha had never considered an abortion before. However, she and John were both deeply distressed at the thought that their baby's life would be short and full of endless pain. They already have two children, including a daughter, Alice, who has cerebral palsy. Natasha gave up her job when Alice was born in order to be more available to support her.

Natasha and John decided to travel to England for an abortion. John is a musician and his income was badly affected by COVID-19 restrictions. The couple could not borrow from family members – Natasha has no close relatives and John's family are very much against abortion in all circumstances. ASN gave them a grant. If ASN had not been able to help them, they do not know how they would have afforded a very expensive hospital abortion. Since the abortion they have felt relieved but distressed.

Why was treatment not offered in Ireland?

Natasha was more than 12 weeks pregnant and so was ineligible to access an abortion under s. 12. She sought a termination under s. 11, which requires two doctors to certify that the fetus is likely to die before birth or within 28 days after birth. The 28 days provision makes it difficult to determine eligibility under s. 11 even in cases like Natasha's where there is at least a strong chance that the fetus will not be born alive. 'Know for sure' is a misleading phrase; doctors are not required to be certain that the fetus will not survive.

In this case, Natasha's request was not actually considered under s. 11. It is not clear whether this is because her doctor was individually unwilling to invoke s.11 until further test results had been obtained, or because it was hospital policy to wait for those test results. Her consultant seems to have been uncomfortable about proceeding to certification without first seeking more information through testing. One source of uncertainty may lie in s. 11's reference to 'a condition'; Natasha's diagnosis indicates the presence of multiple conditions. The consultant's desire to seek further testing may also be attributable to the 'chilling effects' of criminalisation under s.23. Although doctors have a defence where they have acted on the basis of a 'reasonable opinion formed in good faith', that defence may not be sufficient to eliminate the chilling effect.

Natasha should have been entitled to expect a prompt assessment of her case under s. 11. However, the Act does not specifically require that a decision is reached in a timely fashion.

Natasha and John decided to travel rather than wait any longer. [64] Abortion in later pregnancy is extremely time sensitive, and so the delays involved in waiting for further testing may make it impossible to wait for the Irish system to produce a decision. Patients and their loved ones may be conscious of the additional difficulties in obtaining an abortion after 24 weeks, of the expense of private care and of the urgent need to relieve some of the pressure on the pregnant person's mental and physical health. People feel under understandable pressure to act quickly.

What constitutional rights issues arise here?

If Natasha had requested and was then denied an abortion under s. 11,[65] she could argue either (i) that this refusal was based on an unduly conservative and unconstitutional interpretation of these sections or (ii) that s. 11 as drafted, in combination with the criminalisation provisions in s.23, disproportionately infringes her constitutional rights.

Natasha's rights to bodily integrity and privacy - both marital and individual - are clearly in play. Since this is a case concerning one or more potentially fatal anomalies, Natasha also has a strong argument that compelling her to continue the pregnancy engages her right to freedom from degrading treatment. These breaches are not cured because she was able to access an abortion abroad. In some respects, the obligation to travel compounds the original harm.

Although these rights are not absolute, Natasha could argue that the criminalisation of abortions for fatal fetal anomaly except in those circumstances where the fetus is predicted to die within 28 days is much too strict and constitutes a disproportionate infringement of her constitutional rights. This argument is even stronger because the s.9 health ground is not available to pregnant people, even where continuation of the pregnancy will expose the person to extreme distress amounting to degrading treatment. The state may argue that criminalisation combined with a 28-day limit is a proportionate means of achieving its policy goals. These goals are likely to include (i) protection of fetal life in later pregnancy as a dimension of the common good (ii) prohibition of abortion on disability grounds and (iii) ensuring a degree of certainty around eligibility for abortion under s. 11 by specifying a time limit within which a newborn must die. Natasha would argue that the legislation does not strike an appropriate balance between her rights and these goals. The 28-day limit is arbitrary and is not justified by medical criteria. It does not only exclude abortions performed on grounds of disability. It ignores the significant commonalities of experience between many severe and fatal anomalies and excludes many cases of anomaly which are clearly fatal, but where the fetus may survive for several months rather than for several days. In practice, it excludes a great many cases of the kind that people voting in the May 2018 referendum understood would be covered by legislation in the event that the 8th Amendment was removed from the Constitution. The test is very difficult to apply in practice so that, as seen in Natasha's case, the criminalisation of abortion imposes 'chilling effects' on

[64] Abortion Rights Campaign (n 22) 26.

[65] Given how time-sensitive access to abortion care can be in these circumstances, Natasha could argue that it was impractical for her to wait for a decision under s.11; that the legislation afforded her no practical emans of vindicating her rights.

doctors, who feel uncertain about when the legislation empowers them to act. These chilling effects mean that the Oireachtas' policy goals are not facilitated, but are actively undermined.

How could the law be improved to address cases like this one?[66]

- Some improvements could be achieved without amending the legislation. The Minister should clarify that abortion is available under s.11 in cases where the fetus is compromised by a combination of conditions, even if no one condition by itself can meet the legal threshold. Clinical guidance should also be revised to clarify that the 'risk to health' ground is available under s. 9 in fetal anomaly cases, where continuation of the pregnancy places the pregnant person's health at risk of 'serious harm'.
- Access could be improved in cases like Natasha's by removing the 28-day requirement in s.11. This would still ensure that the legislation addresses the Oireachtas' policy of ensuring abortion access in cases of fatal fetal anomaly, because doctors would still be required to confirm that the fetus was likely to be fatally compromised.
- The legislation should be amended to provide for a right to timely assessment on request, and timely decision-making under s.11.
- As elsewhere, full decriminalisation of abortion is the best way to address the risks of 'chilling effects' which undermine the legislation's effectiveness. The existing defences under s. 23 are clearly inadequate to assuage doctors' fear of prosecution.

[66] These recommendations echo and amplify those of Termination for Medical Reasons Ireland. See *Terminations for Medical Reasons: The Women Left Behind By Repeal.* Available at: https://lmcsupport.ie/wp-content/uploads/2022/03/TFMR-Review-Report_FINAL_2022-1.pdf

CASE STUDY 6: MOIRA – FATAL ANOMALY AND RISK TO HEALTH

Moira's pregnancy was considered 'high risk' because of her underlying heart condition and also because her previous pregnancies had ended in miscarriage or stillbirth. At 14 weeks LMP she received a diagnosis of a catastrophic and complex foetal anomaly affecting the fetus' brain and kidneys. Moira's consultant told her and her husband Dermot that he was 'as certain as he could possibly be' that the baby would not live long after birth, if they would even be born alive at all. However, he could not get consensus from the multi-disciplinary team who considered the case, and so Moira was formally denied an abortion under s.11. The team agreed that the baby, if born alive, would not live long after birth, but could not agree on how soon after birth death would occur.

Moira and Dermot asked if they could appeal or get a second opinion, but the consultant insisted that this was impossible. Moira asked whether the consultant could take her heart condition into account in assessing her entitlement to an abortion, and he just shook his head.

The next day, Moira and Dermot rang MyOptions for some advice on their entitlement to an abortion in Ireland. The woman on the other end of the phone was very unsure; she read some sections of the legislation aloud, but couldn't offer concrete advice.

Moira and Dermot decided to travel to England for an abortion. The consultant agreed to send Moira's medical records to any hospital or clinic that agreed to treat her but said that he could not make the appointment on her behalf.

Because of Moira's heart condition, she had to wait some weeks until an English hospital was available to treat her, instead of getting an abortion in a clinic. The abortion was especially expensive because she needed hospital treatment - it cost over £3500, on top of travel and accommodation. Moira was visibly distressed and unwell on the journey home. She and Dermot felt utterly humiliated. They had to bring their baby's remains home on the ferry, which was very distressing.

Why was treatment not offered in Ireland?

Abortion is available on fatal anomaly grounds under s. 11 of the Act. There is some evidence that s.11 is not interpreted consistently from one hospital to the next. [67] S. 11 requires two doctors to certify that they are of the reasonable opinion formed in good faith that there is 'present a condition affecting the fetus that is *likely to lead to the death of the fetus*[68] either before or within 28 days of birth. The legislation does not specify the degree of likelihood, but there is some evidence that in practice many doctors will require something approaching certainty[69] before certifying that a patient is eligible for abortion under s.11. In

[67] Abortion Rights Campaign (n 58) 7.

[68] Emphasis mine.

[69] This is, of course, a skewed approach to 'good faith'. Discussing 'good faith' in the context of abortion in the foundational case of *R v. Bourne* [1938] 3 All ER 615 Lord Macnaghten explained that in some cases 'only the result can prove whether the diagnosis was right or wrong, whether the anticipation was right or wrong', but

addition, decisions are often taken on a consensus basis by multi-disciplinary teams, even though the Act does not require this. Although multi-disciplinary teams are essential in developing an appropriate care plan for the patient, they should not be used in certifying an entitlement to access an abortion – this makes the 'test' for entitlement to access an abortion much more demanding than the Oireachtas intended it to be. [70] Any perceived need to spread decision-making power across a larger group of doctors likely reflects the chilling effects of criminalisation, combined with uncertainty around the interpretation of s.11, [71] particularly its 28 days provision. [72]

It is significant that, at the time Moira sought care, MyOptions were uncertain of her entitlements, indicating broader confusion around the legislation which must be addressed if it has not already been resolved.[73]

Moira does not seem to have been informed of her opportunity to apply for a review of this decision under s. 13. Pregnant people in her circumstances are entitled to such a review; it provides an essential safeguard for their constitutional rights.

Moira's pregnancy was 'high risk' because of her heart condition and history of pregnancy loss. Although s. 9 provides for access to abortion on grounds of risk of 'serious harm' to health, s. 9 is often not considered as an option in cases of fatal anomaly where the pregnancy also exposes the pregnant person to unusual health risks.[74] Although 'serious

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the doctor 'can only base his decision on knowledge and experience', and on consultation with another appropriate doctor. Certainty is not a pre-requisite for a good faith decision.

[70] It is worth noting that the Protection of Life During Pregnancy Act 2013, which legislated for life-saving abortion access under the 8th Amendment, only required shared decision-making by a two or three doctors, depending on the applicable ground for abortion. There is no principled reason why the 2018 Act should be even more demanding.

[71] We should recall that the 2018 Act is criminal law. The vagueness of some provisions of the 2018 Act gives cause for concern. In *McInerney v DPP* [2014] IEHC 181 Hogan J. noted that, where the Oireachtas fails to articulate clear standards for the 'fair, consistent and even-handed' application of criminal law, it falls to others to fill in the gap. The 2018 Act, in some respects, leaves it to doctors to determine when abortion is or is not criminalised. The statutory requirement that two doctors take decisions under s. 9 and s. 11 together is an insufficient safeguard if the Oireachtas has not clearly articulated the standards they are expected to apply. These deficiencies in the 2018 Act could demonstrably lead to 'subjective, arbitrary and inconsistent application of [criminal law]' which represents the very antithesis of' the constitutional commitment to equality before the law. In addition to the impact on abortion access, the 2018 Act poses a special risk to doctors at risk of prosecution, whose constitutional rights to equality before the law and to liberty are clearly in issue. Even if the provisions of ss. 9 and 11 are not so hopelessly vague as to be 'manifestly unconstitutional', doctors and pregnant people have a reasonable expectation of clarity in the application of the 2018 Act.

[72] See discussion in S Power, S Meaney and K O'Donoghue, 'Fetal Medicine Specialist Experiences of Providing a New Service of Termination of Pregnancy for Fatal Fetal Anomaly: A Qualitative Study' (2021) 128 BJOG: An International Journal of Obstetrics & Gynaecology 676.

[73] Grimes L, O'Shaughnessy A, Roth R, et al Analysing MyOptions: experiences of Ireland's abortion information and support serviceBMJ Sexual & Reproductive Health Published Online First: 14 March 2022. doi: 10.1136/bmjsrh-2021-201424

[74] IOG guidelines make clear that healthcare providers must have regard for increased risks to maternal health but do not discuss s. 9 as an alternative care pathway. IOG, *Interim Clinical Guidance: Pathway for Management of Fetal Anomalies and/or Life-Limiting Conditions Diagnosed During Pregnancy* Available at: https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2019/01/IOG-TOPFA-PATHWAY-FINAL-180119.pdf

harm' is not synonymous with 'life-threatening', it appears that s.9 is rarely used in cases of risk to health.

What constitutional and human rights issues arise here?

Moira should have been offered a review of the team's decision under s.13 – this is a clear statutory entitlement and is an essential safeguard for her constitutional rights. Moira could argue that ss.9 and 11 as interpreted in her case, read in combination with the criminal provision in s. 23, represent a disproportionate infringement of her constitutional rights.

Moira's rights to bodily integrity and privacy are clearly in issue. Since she was exposed to unsettling uncertainty,[75] humiliation and extreme distress, she may also argue that her right to freedom from degrading treatment was engaged. Since this is a clear case of fatal anomaly, Moira may also argue that compelling her to continue the pregnancy engages her right to freedom from degrading treatment. [76] These breaches are not cured because she was able to access an abortion abroad. In some respects, the distress involved in attempting to access treatment abroad, [77] away from friends and family compounds the original harm. [78] It is immaterial that pregnant people are not criminalised under the 2018 Act; continuing criminalisation of doctors blocks effective access to abortion following a fatal anomaly diagnosis.

Although her rights are not absolute, Moira could argue that the criminalisation of abortions for fatal fetal anomaly except in those circumstances where the fetus is predicted to die within 28 days is arbitrary and much too strict and constitutes a disproportionate infringement of her constitutional rights. This argument is even stronger if the s.9 health ground is not available to pregnant people, even if, as in Moira's case, continuation of the pregnancy will expose the person to extreme distress and physical harm, amounting to degrading treatment.

The state may argue that criminalisation combined with a 28-day limit is a proportionate means of achieving its policy goals. These goals are likely to include (i) protection of fetal life in later pregnancy as a dimension of the common good and (ii) prohibition of abortion on disability grounds. Moira would argue that the legislation does not strike an appropriate balance between her rights and these goals. The policy goal of protecting fetal life is not strong enough to trump Moira's constitutional rights. Since the 2018 referendum, the state's interest in fetal life is more narrowly drawn than it was under the 8th Amendment.[79] Second,

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[75] In *R.R. v. Poland*, Eur. Ct. H.R. Rep. 648 (2011) the European Court of Human Rights found that the 'painful uncertainty' of not knowing whether it will be possible to terminate a pregnancy following a fatal anomaly diagnosis can be degrading for the pregnant person.

[76] UN Human Rights Committee, *Mellet v. Ireland*, UN Doc. No. CCPR/C/116/D/2324/2013 (2016). See also UN Human Rights Committee, *Whelan v. Ireland*, UN Doc. No. CCPR/C/119/D/2425/2014 (2017).

[77] See by analogy *Aslam v. Minister for Justice* [2011] IEHC 512; mandatory transfer of a heavily pregnant asylum seeker by sea or air, risking the physical distress of early labour or early delivery compromised her bodily integrity.

[78] For an argument to this effect see *NIHRC'S Application* [2018] UKSC 27 [237-238] *per* Kerr LJ.

[79] *M v Minister for Justice and Others* [2018] IESC 14. Even under the 8th Amendment, the courts recognised that the state's duties of intervention were limited where there was little to no chance that a live baby could be born of a pregnancy; *PP v HSE* [2014] IEHC 622.

the 28-day limit is arbitrary. [80] This time limit does not only exclude abortions performed on grounds of disability, and does mark a meaningful distinction between severe and fatal anomaly. It ignores significant commonalities of experience between many severe and fatal anomalies and undermines the Oireachtas' policy goals by excluding many cases of fetal anomaly which are clearly fatal. In practice, it excludes a great many cases of the kind that people voting in the May 2018 referendum understood would be covered by legislation in the event of a majority Yes vote.

In addition, s.11 is very difficult to apply in practice so that, as seen in Moira's case, the criminalisation of abortion imposes 'chilling effects' on doctors, who feel uncertain about when the 2018 legislation empowers them to act. These chilling effects mean that the Oireachtas' policy goal of ensuring legal certainty is actively undermined. The state might argue that imposing a 28 day time limit avoids the need to involve doctors in determining which abortions are 'acceptable' and which are not.[81] However, as seen in Moira's case, the imposition on doctors to make a definitive judgement on how long after birth a fetus will survive imposes its own - potentially more burdensome - challenges on medical professionals.

S. 9 was not applied at all in Moira's case. The failure to do so also suggests unduly conservative interpretation of s. 9, undermining the Oireachtas' policy goal of making abortion accessible to people whose continuing pregnancy places their health at serious risk. If s. 9 requires those whose health is already at clear risk to wait until their health deteriorates, potentially jeopardising their life or exposing them to avoidable permanent or long-term consequences for their health, then it mirrors the old practice under the 8th Amendment, whereby people were denied an abortion in earlier pregnancy, and required to wait until they were almost at death's door.

How could the law be changed to resolve this problem?[82]

- Access could be improved in cases like Moira's by removing the 28-day requirement in s.11. This would still ensure that the legislation addresses the Oireachtas' policy of ensuring abortion access in cases of fatal fetal anomaly, because doctors would still be required to confirm that the fetus was likely to be fatally compromised.

- The Minister should take steps to emphasise that s.13 reviews are available as of right, and not at clinicians' or hospitals' discretion.

- The Minister should take steps to clarify that multi-disciplinary teams have no legal role in certification of an entitlement to abortion under s.11, and that a decision to

[80] See Stacey Power, Sarah Meaney and Keelin O'Donoghue, 'The Incidence of Fatal Fetal Anomalies Associated with Perinatal Mortality in Ireland' (2020) 40 Prenatal Diagnosis 549. Only half of 939 cases between 2011 and 2016 where congenital anomaly was identified as the cause of perinatal death could come within the scope of s. 11.

[81] See similar argument in *Murphy v. Independent Radio and Television Commission* [1999] 1 IR 2 [48]

[82] These recommendations echo and amplify those of Termination for Medical Reasons Ireland. See *Terminations for Medical Reasons: The Women Left Behind By Repeal.* Available at: https://lmcsupport.ie/wp-content/uploads/2022/03/TFMR-Review-Report_FINAL_2022-1.pdf

perform an abortion under s.11 may be considered 'reasonable' and made in 'good faith' if it is based on the decision of two doctors as set out in the legislation.

- Clinical guidance should also be amended to clarify that the 'risk to health' ground is available under s. 9 in fetal anomaly cases, where continuation of the pregnancy places the pregnant person's health at risk of 'serious harm'. The Minister should also ensure the availability of more detailed guidance on the interpretation of 'serious harm', especially by clarifying that 'serious harm' is not synonymous with 'life-threatening'.
- As elsewhere, full decriminalisation of abortion is the best way to address the risks of 'chilling effects' which undermine the Act's effectiveness. The existing defences under s. 23 are clearly inadequate to assuage doctors' fear of prosecution, and the offences are unduly broad.