

# **Response to the HMG Gibraltar Command Paper for a Draft Bill to Amend the Crimes Act 2011 to permit Abortion in Certain Limited Cases as Required by the Jurisprudence of the Supreme Court of the United Kingdom**

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## **1. Introduction**

We welcome the publication of the Command Paper and the decision by HMG Gibraltar to proceed with reform of its abortion law.

The reflections and proposals in this paper are informed by best international legal and medical practice, international human rights law, and the expressed desires and objectives of advocates for abortion law reform in Gibraltar.

## **2. General Note on Best Practice**

The Command Paper frequently refers to the Abortion Act 1967 as instructive and indicative of best practice in abortion law. We would note that the Abortion Act 1967 is now widely recognised as outdated and, in some ways, stigmatising. We suggest that in seeking best international practice in abortion law reform HMG Gibraltar might also look towards newer abortion laws, such as those recently proposed in Isle of Man and Ireland, as well as those introduced in Spain for indications of ways in which medical and legal advances since 1967 might be used to inform the formation of new laws. The insights to be found in the WHO Safe Abortion Guidelines should also be reflected in the content of the new law.

## **3. Availability of Abortion in Early Pregnancy**

We welcome the proposal that abortion would be available in early pregnancy.

The proposal as currently contained in proposed new S163A(1)(a) is that abortion would be available where (i) two doctors, (ii) certify, (iii) in good faith, that (iv) the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of (v) injury to the physical or mental health of the pregnant woman, and (vi) the pregnancy has not exceeded a gestational limit to be determined but to be either 10, 12 or 14 weeks.

We note that in many ways this reflects s. 1 of the Abortion Act 1967. We also note that this is how HMG Gibraltar intends to make lawful abortion available in situation of rape or incest. We welcome the decision not to include a stigmatising and potentially traumatising express 'rape' or 'incest' ground.

However, we **propose** that the better way to make abortion available in early pregnancy (up to 14 weeks) is by introducing a protected period during which abortion is available without indication as to reason and where the role of the medical practitioner is simply to certify that the pregnancy has not exceeded the statutory time limit.

Only one certifying practitioner would be required.

In this formulation, pregnant people would not have to establish risk to their health, even to the low 'greater than' standard proposed in the draft law, and thus would not feel

compelled to (although of course they would be supported should they wish to) disclose their experiences of sexual violence. It would also ensure that doctors could focus on the provision of support and healthcare and would not be required to act as ‘gatekeepers’.

Such a change would, then, be better for both pregnant people and medical practitioners and would not materially change the situations in which abortion is lawfully available in early pregnancy as the ‘greater than’ standard, currently proposed and modeled on the Abortion Act 1967, is likely always to be met given that pregnancy involves inherent health risks.

#### **4. Abortion in Cases of Risk to Health**

We welcome the decision to allow for lawful abortion without time limit where there is a serious risk to health, as certified by two medical practitioners.

However, the standard proposed is problematic in three ways: (a) it allows for abortion only where there is a risk of “grave permanent injury to the physical or mental health of the pregnant woman”, (b) the termination must be “necessary” in order to (c) “prevent” the injury.

First, the requirement of “grave permanent injury” does not allow for abortion to be provided where a pregnant person is at risk of serious injury to health, which might not be grave and permanent. This requires women to continue with pregnancies even where such continuation might pose extremely serious risks to their health but where two doctors cannot agree such risks pertain to *permanent* risk. In this respect the provision is overly restrictive and does not allow for termination to enable a woman to maintain health during pregnancy where that is her preference.

Second, even where there will be a “grave and permanent” injury to the woman’s health if she continues with pregnancy abortion will be permitted only where it is “necessary to prevent” this, not where it would be *likely* to prevent it, or to *reduce* or *mitigate* the risk.

The effect of proposed s. 163A(1)(b) is that lawful abortion after 10/12/14 weeks (depending on what is decided in s 163(1)(a)) will be available only in very exceptional cases, that women will not be empowered to make decisions about the level of health risk they are prepared to take on during pregnancy, and that medical practitioners will be prohibited—bolstered by a criminal sanction—from providing abortion care to reduce very serious health risks in pregnancy.

Thus, we **propose** that s. 163A(1)(b) would allow for lawful termination where two medical practitioners certify that the pregnant person is at risk of injury to her physical or mental health where there termination of the pregnancy would, in the opinion of the practitioners formed in good faith, reduce or mitigate that risk.

#### **5. Abortion in Cases of Risk to Life**

We welcome the decision to allow for lawful abortion without time limit where there is a risk to the life of the pregnant woman greater than if the pregnancy were terminated.

#### **6. Abortion in Situations of Fatal Foetal Anomaly**

We welcome the decision to allow for lawful abortion without time limit where the foetus has been diagnosed with a fatal condition, as certified by two medical practitioners.

In order to ensure that medical practitioners can proceed with treatment without being overly apprehensive of either criminalisation or negligence suits **we propose** that this should clearly allow for lawful abortion to be provided where two medical practitioners certify that, in their opinion formed in good faith, the foetus is suffering from a condition that means it is likely to die before or shortly after birth.

## **7. Abortion in Situations of Non Fatal Foetal Anomaly**

The proposed legislation proposes to allow for lawful abortion without time limit where “if the child were born it would suffer from such physical or mental abnormalities as to be seriously disabled”. We note that this mirrors language from the Abortion Act 1967. However, we note also the opinion of the UN Committee on the Rights of Persons with Disability that express ‘disability grounds’ in abortion legislation are deeply stigmatising and ought to be avoided.

We therefore **propose** that this be removed, although we note that where a person suffers mental or physical ill-health in situations of diagnosis of foetal disability abortion may be available under the proposed grounds for lawful abortion in cases of ill-health and the protected period up to 14 weeks of pregnancy. Abortion in such cases is *not* based on the predicted disability of the foetus if born, but rather on the impact of the diagnosis on the pregnant person’s health, bearing in mind that some foetal disabilities can cause serious physical ill-health during pregnancy.

## **8. Locations for the Provision of Abortion Care**

We note that the proposed law foresees abortion care being provided in hospital settings alone except in situations of emergency (proposed s 163A(3) and (5)).

We **propose** that the primary legislation would allow for abortion to be provided in primary care settings in early pregnancy, i.e. where that is safe according to standard medical procedure. Requiring women always to access hospital care for abortion is stigmatising and places unjustifiable burdens on hospital care settings and staff. Local, primary care provision is more appropriate. This proposal does not undermine or conflict with HMG Gibraltar’s policy preference not to have independent abortion clinics established in Gibraltar.

## **9. Conscientious Objection**

We welcome the protection of conscientious objection in the Bill. However, in order properly to balance the right to conscientious objection with the right of a pregnant women to access abortion healthcare **we propose** the insertion of a duty on medical practitioners to refer women to a colleague without conscientious objections. In the alternative, the practitioner should be required to refer her to a government-run 24 hour telephone information line through which she can receive the information required to access abortion care elsewhere. Given the very short gestational time limit proposed under proposed s163A(1)(a) time will be of the essence, so that it is of fundamental importance that women not be left to navigate the system alone and instead be referred to a willing practitioner.

## **10. Criminal Offences**

We note the proposal to continue to criminalise abortion for pregnant people who seek abortion outside the terms of the law, and for medical practitioners and those who may provide assistance to pregnant women.

We **propose** the complete decriminalisation of abortion.

A pregnant person who seeks to terminate her pregnancy should not be the subject of criminal offences; this is the case even in tightly restrained legal regimes including Poland and the proposed new law in Ireland. This is the case as a matter of principle, but also because criminalisation may result in women not seeking, or delaying in seeking, abortion after care even in cases of severe bleeding. Criminalisation is, thus, damaging from a women's health perspective.

Persons who assist women in access abortion should not be the subject of criminal offences as they will often act out of friendship and support, for example by procuring abortion medication for daughters or friends. The criminal law of assault is sufficient to protect women against coerced abortion. Criminalisation of assistance may also may result in women not seeking, or delaying in seeking, abortion after care even in cases of severe bleeding, in order to protect friends and family members who assisted them. Criminalisation is, thus, damaging from a women's health perspective.

Finally, medical practitioners should not be criminalised when providing abortion care. Medical professional regulation is already sufficient to ensure professional and regulatory sanctions where abortion is provided outside the terms of the Act. Furthermore, non consensual abortion is an assault, so that criminal law already deals with this. Residual criminalisation can set the conditions in which practitioners operate with a 'chilling effect' and interpret the law overly cautiously or restrictively, thus undermining provision of healthcare to women and the policy objectives of the law. Should criminalisation be retained, a broad defence of 'good faith' should be put in place to protect medical practitioners operating in good faith and in line with best medical practice.

## 11. About the Authors

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de Londras and Enright have written extensively on abortion law and abortion law reform, including the requirements of international human rights law, including the book *Repealing the 8<sup>th</sup>: Reforming Irish Abortion Law* (Policy Press; 2018). They both remain involved in the process of abortion law reform in Ireland.