

# **Consent, decision-making and safeguarding: a briefing on the frameworks to protect and support women and girls seeking pregnancy advice and abortion care in the UK today**

## **Introduction**

There has been significant discussion about removing abortion from the criminal law and a bill to decriminalise abortion up to 24 weeks through the removal of sections 58 and 59 of the 1861 Offences Against the Person Act (OAPA) passed a first parliamentary hurdle in March 2017. The 1967 Abortion Act did not eliminate the sections of the OAPA which made procuring an abortion a crime, rather it created exemptions from prosecution when 2 doctors confirmed a woman met certain criteria, primarily that the continuation of the pregnancy posed a greater risk to her health than its continuation, and gave their legal authorisation for the procedure to be performed. If these sections of the 1861 Act were removed, the Abortion Act would no longer be applied to terminations of pregnancy up to 24 weeks, although it would still apply to those after that gestation.

If abortion were removed from the criminal law, abortion as a medical procedure would remain a healthcare matter and only those qualified to perform a medical procedure would lawfully be able to do so – although this could now also include suitably qualified nurses and midwives who are today involved in an ever-expanding range of clinical procedures. However it has been suggested, primarily by those opposed to women’s access to abortion care, that protections for some groups of particularly vulnerable women would be removed if the Abortion Act ceased to apply, and women would be stripped of the opportunity to discuss their decision, and potentially disclose coercion or abuse. This suggestion reflects a fundamental misunderstanding of the nature of healthcare law and regulation today, as any service providing abortion care in this way would be operating outside existing legislation.

There is nothing in the 1967 Abortion Act that makes provision for the safeguarding of young or vulnerable women, access to counselling services, or specifies that informed consent must be obtained before an abortion can be lawfully performed. The Act is entirely silent on these issues. These provisions and safeguards are all contained in entirely separate bodies of regulation and legislation, which would remain firmly in place were abortion decriminalised.

This briefing document explains how abortion services are regulated today, and what provisions ensure that women have access to high quality support and care throughout their treatment. It explains what frameworks to protect and support women are currently in place – and would remain so – were abortion decriminalised and the 1967 Act no longer the primary piece of legislation to govern the provision of abortion services.



## The regulation of abortion services today

Abortion, alongside other clinical procedures, diagnostic and screening procedures, maternity and midwifery services as well as nursing care, became a regulated activity under the Health and Social Care Act 2008, a piece of legislation designed to improve professional regulation and which created a new regulator, the Care Quality Commission (CQC), for that purpose. The regulator was established with a focus on providing assurance about the safety and quality of care for patients and service users.

Today the CQC provides a series of standards against which it inspects the quality and safety of an abortion service, whether provided within the NHS or by an independent provider. The CQC has the power to enforce improvements, suspend services and ultimately pursue criminal prosecutions against providers for failing to provide treatment or care in a safe way. “Safety” in this context refers not just to the clinical standards of the care being offered, but also covers whether the service user is appropriately safeguarded and supported during the process, and their informed consent to any intervention appropriately obtained.

The CQC draws on a large body of existing common laws, legislation, and statutory guidance when publishing the standards on which it will inspect and judge services. With respect to abortion services, this will include (although not be limited to):

<i>Common law principles regarding consent to treatment, including Gillick v Wisbeck Area Health Authority (which lays down the ‘Fraser Guidelines’) and Montgomery v Lanarkshire Health Board</i>	<b>1986, 2015</b>
<i>The Sexual Offences Act</i>	<b>2003</b>
<i>Section 11 of The Children’s Act</i>	<b>2004</b>
<i>Mental Capacity Act</i>	<b>2005</b>
<i>0 -18 Years: Guidance for all Doctors, General Medical Council</i>	<b>2007</b>
<i>Health and Social Care Act</i>	<b>2008</b>
<i>Consent: patients and doctors making decisions together, General Medical Council</i>	<b>2008</b>
<i>Reference guide to consent for examination or treatment (second edition), Department of Health</i>	<b>2009</b>
<i>The Care of Women Requesting Induced Abortion (Evidence-based Clinical Guideline No. 7, Royal College of Obstetricians and Gynaecologists)</i>	<b>2011</b>
<i>The Required Standards Operating Procedures (RSOPs): Procedures for the approval of independent sector places for the termination of pregnancy</i>	<b>2013</b>
<i>Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients, Academy of Royal Colleges,</i>	<b>2014</b>



<i>Safeguarding Children and Young People: Roles and competencies for Health Care Staff</i>	<b>2014</b>
<i>The Serious Crime Act</i>	<b>2015</b>
<i>Working Together to Safeguard Children, Department for Education</i>	<b>2015</b>
<i>Guidance for physicians on the detection of child sexual exploitation, Royal College of Physicians</i>	<b>2015</b>
<i>The Multi-agency statutory guidance on female genital mutilation, Department for Education, Department of Health, and Home Office</i>	<b>2016</b>
<i>Domestic abuse: a resource for health professionals, Department of Health</i>	<b>2017</b>

Taken as a whole, the documents underpin the support and care provided in the UK's abortion service today, and will continue to do so were abortion decriminalised.

## Obtaining consent

All women currently attending an abortion service will have a discussion about their pregnancy options, their decision about whether to continue or to end the pregnancy, and in the latter case, their understanding of the available procedures and associated risks as part of the process of gaining informed consent. **Informed consent is entirely separate from - although often confused with - the requirements in the Abortion Act for 2 doctors to certify that a woman meets the grounds for abortion.**

The need for consent in healthcare is founded in common law and the principle of bodily autonomy. For consent to be valid and legal, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. These principles apply to *all* medical procedures, including abortion.

As explained by NHS Choices, these terms mean the following:

- **voluntary** – the decision to either consent or not to consent to treatment must be made by the person themselves, and must not be influenced by pressure from medical staff, friends or family
- **informed** – the person must be given all of the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment doesn't go ahead
- **capacity** – the person must be capable of giving consent, which means they understand the information given to them and they can use it to make an informed decision



These principles are well-tested in the courts, and are encapsulated within the same universal healthcare requirement for informed consent for any clinical procedure.

Any suggestion during the consent discussion that a woman is under pressure to make a particular decision regarding the future of the pregnancy will require further exploration, not least because the woman's consent may not be valid if it is given under pressure or duress from another person – this applies equally whether in the case of abortion or any other clinical procedure. As part of standards set by the CQC, abortion services must be able to prove they have processes in place to ensure that all women and girls are seeking services voluntarily. These are entirely unrelated to the provisions of the Abortion Act.

It is a requirement of an abortion service, laid out in the *Required Standard Operating Procedures*, that staff should be able to identify those who require more support than can be provided in the routine abortion service setting, for example young women, those with a pre-existing mental health condition, those who are subject to sexual violence or poor social support, or where there is evidence of coercion.

### **Decision-making support**

Although the majority of women who request an abortion have already carefully considered their situation and are sure of their decision when they first present to a provider, some women are undecided about whether to continue with or end the pregnancy and need additional support. Women seeking abortion have access to trained staff who can discuss their pregnancy options with them, including continuing the pregnancy and becoming a parent, having the child fostered or adopted, or ending the pregnancy by abortion. Women who remain undecided will be given all the time they need to arrive at a decision, and offered additional time to discuss their options further with a trained member of staff if they wish. This can be offered in person, or on the phone, if women prefer.

Women must be made aware that they can change their minds or delay the procedure at any time.

All women attending a service must also have access to post-abortion support or counselling if they need it. Again, this does not have to be face to face with a counsellor or provided directly by the abortion provider. Pathways to further post-abortion counselling should be available for any woman who may require additional emotional support or whose mental health is perceived to be at risk

### **Safeguarding young women and girls**

The legal framework to protect children is contained in *Working together to safeguard children* (2015). This guidance references the intercollegiate document, *Safeguarding Children and Young People: Roles and competencies for Health Care Staff*, published in 2014.



Healthcare services have a duty under section 11 of the Children Act 2004 to ensure that they consider the need to safeguard and promote the welfare of children when carrying out their functions.

Safeguarding and promoting the welfare of children is defined as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes.

All clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to level 3 (the penultimate level) in safeguarding.

If the service treats women under 18 years of age, staff need to be able to recognise potential cases of child sexual exploitation (CSE), explore them sensitively with the young person, and make prompt referrals.

Under the Sexual Offences Act 2003, those under the age of 13 are considered of insufficient age to give consent to sexual activity. Most child protection agencies regard pregnancy in a client under 13 as evidence that she is 'at risk' and so expect to be notified by any healthcare provider should she present to that service.

### **Female Genital Mutilation (FGM)**

In the UK, FGM has been a specific criminal offence since the Prohibition of Female Circumcision Act 1985. The Female Genital Mutilation Act 2003 replaced the 1985 Act in England, Wales and Northern Ireland. Section 1 of the 2003 Act provides that a person is guilty of an offence if he 'excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris'. The definition of FGM includes other harmful procedures to the female genitals, which include pricking, piercing, cutting, scraping and burning the area.

The 2003 Act made it an offence for the first time for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where FGM is legal.

The Serious Crime Act 2015 further strengthened the law on FGM. It is now also an offence to fail to protect a girl from FGM. Lifelong anonymity for victims of FGM has been guaranteed. FGM protection orders were introduced on 17 July 2015, and the extra-territorial reach of the 2004 Act has been extended to habitual UK residents. From October 2015, there is a statutory professional duty to report all girls *under 18* who directly disclose FGM, or are identified to have undergone FGM, to the police. All abortion providers must adhere to this legislation.



## **Domestic violence, including forced marriage and honour-based violence**

Responsibilities for safeguarding adults are set in legislation by the Care Act 2014 and through regulations. The cross-government definition of domestic violence and abuse is: 'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

Pregnancy is a time when domestic abuse is more likely to start or to escalate, with 15% of women reporting violence during a pregnancy. Physical abuse is common in women seeking abortion and may be one factor in their decision to end the pregnancy.

Abortion services are very aware of the risk of domestic abuse and will see all women alone at some point to allow safe disclosure. Services may also employ 'routine enquiry', similar to maternity services, where all women are routinely asked whether they feel safe at home. This is carried out in a sensitive way that does not imply or suggest the woman is subject to abuse but includes the following:

- provision of an environment where a woman feels able to discuss her experiences
- a focus on the woman's safety and that of any children
- assess the risk she is at, give information ('signposting'), and refer to specialist agencies
- not judging the woman (for example respecting a decision not to leave the abusive relationship at that point) but provide support and reassurance that help will always be available

If there is reason to suspect children are at risk, safeguarding and child protection must always take precedence over confidentiality.

## **Conclusion**

This short briefing clearly illustrates that it is not the Abortion Act which affords young and vulnerable women and girls protection against harm, or protects women's ability to make their own informed decisions about their pregnancy free from coercion. Were abortion to be removed from the criminal law, the safety and support of women would absolutely not be compromised but their care experience would likely be enhanced significantly.

