VOICE FOR JUSTICE UK

VfJUK REPORT

DIY Abortions up to 10 Weeks:
What are the Legal and Medical Issues?

"Home use of both pills for early medical abortion up to 10 weeks gestation"

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1. Executive Summary

Introduction

In the wake of the pandemic, temporary legislation was passed (2020 Approval), allowing women for the first time to self-administer two abortion drugs (mifepristone and misoprostol) at home. Covering early medical abortions (EMAs) up to 10 weeks gestation, there's no requirement of a physical examination. The pills are sent by post, following a remote consultation. The Government is now consulting on whether to make these measures permanent, to repeal them immediately, or for them to remain lawful for the minimum two-year duration of provisions contained in the Coronavirus Act 2020.

The Law

The Abortion Act 1967 sets out the lawful conditions for abortion. This includes a requirement that two registered medical practitioners (RMPs) authorize the abortion in good faith. Abortions can only be done at registered and approved locations like hospitals and clinics; private residences are not included. Further changes to abortion law were made in 1990, giving the Health Secretary a power to issue regulations,

widening the types of locations at which abortions could be done. The change was driven by the prospect that drugs like mifepristone, would one day be licensed. The then Health Secretary rejected fears that the new powers were a "paving measure" for home abortions, assuring parliament that this pill "would be administered only in closely regulated circumstances" under supervision of an RMP.

While the 1967 Act requires the RMP to perform the abortion, the courts have interpreted this to allow RMPs involvement to be supervisory. RMPs must remain in authority and take responsibility throughout the process, even while nurses and midwives administer the abortion drugs. An RMP need not see or examine the woman themselves but they must ensure they have considered sufficient information, ensuring the abortion meets the relevant statutory ground.

The Offenses Against the Person Act 1861 makes it a criminal offense for a woman to procure her own abortion, and for any person intentionally to assist a woman in the administering of a substance that procures an abortion. The 2020 Approval breaches these two requirements, falling foul of the criminal law.

Abortion providers must receive written approval from the Health Secretary to have their premises recognised as a lawful class of place for abortions. Abortion is a regulated activity. People carrying out a regulated activity without appropriate registration commit an offense. Given the rigorous approach to the regulated activity of abortion, allowing women to administer both abortifacient drugs at home, disregards essential legal and medical safeguards.

Changes to 'Class of Place'

In 2018, the rules for EMAs recognised a woman's home for those who chose this option. This was only for the purpose of her self-administering the second pill. Women would continue to attend a clinic where the first pill was administered, and relevant tests were conducted.

In March 2020, the rules changed again, doing away with the need for physical examinations, blood tests and an ultrasound scan to determine the gestational age of the foetus. Under the 2018 rules, while some of the assessment may have begun by phone, it was followed by a visit to the abortion provider, where the woman's medical history was taken, verified and then assessed for eligibility.

One of the purposes of the 1967 Act was to "ensure that the abortion is carried out with all proper skill and in hygienic conditions." Residential settings cannot be expected to comply with the hygiene standards of clinics or hospitals.

Days before the government caved into lobbyist pressures, the Health Minister strongly rejected the need for change, citing safety concerns, including the protection of women in abusive relationships who may be coerced into an abortion. He also paid regard to the existing checks and balances and established arrangements in place for RMPs to certify and perform abortions. Any change, he explained, lacked widespread parliamentary support, and it was not right to rush through such a sensitive measure without adequate scrutiny.

Risk of Coercion

Research shows that intimate partner violence is a strong risk factor in abortion around the world. Remote consultations make it difficult to know if a woman is acting freely or under coercion. If seen in person and alone, she is more likely to feel able to disclose issues of domestic violence, intimidation or manipulation. The Health Minister said at the time that the Government believed it was an "essential safeguard" for women to attend a clinic, thus ensuring the opportunity to be seen alone.

Evidence of Multiple Legal Abuses & Medical Risks

Evidence from an undercover investigation exposed a raft of serious safety concerns and blatant legal abuses of the telemedicine regime. In a report produced by a former Director of Marie Stopes International, it found that "Abortion providers are operating as if abortion on-demand for any reason is legal." Women had abortion pills sent to them, having provided false identities and conflicting information about their last menstrual period. Reliance on a woman's self-assessment, the report continued, meant a woman has been "co-opted as an essential member of the multidisciplinary team" working for the RMP, and "providing important clinical information necessary for the correct [legal] certification" of an abortion.

The report found that women could keep their abortion confidential even from their GP; there were no follow-up care calls after the abortion pills were sent out; the RMP cannot know if the woman, for whom the pills are prescribed, is actually pregnant and, if she is, whether it falls within the required gestational limit; the RMP cannot ensure she takes the drugs at the prescribed times, thus safely completing the abortion. The 'good faith' requirement of an RMP authorising an abortion no longer depended, the report concludes, upon a direct, supervisory relationship between the RMP and the multidisciplinary team, but on "unsubstantiated information" provided by a woman, so the right boxes are ticked.

The report considers guidance published by NICE, often cited as recommending the use of telemedicine for abortion assessment. The report explains the guidance is actually about making it easier and quicker for women to access the service, so that

the phone call is only part of the consultation process. While the NICE recommendation for a medical abortion is that it can be done without a certifying ultrasound scan to determine gestational age, this is in the context of doing an hCG blood test. Therefore, a clinic appointment is needed.

The report warns against the use of codeine phosphate, pain management tablets sent out with the abortion drugs. This drug is addictive, liable to abuse, is rarely prescribed alone and is unsafe for pain relief. Women seeking medication for menstrual bleeding at a pharmacy won't routinely be offered this class B drug as a first resort, but advised to take pain relief like ibuprofen or paracetamol. The report cites NICE guidance that advises ibuprofen to be taken for heavy bleeding, or if found to be harmful, paracetamol is offered as an alternative. Women who featured in the report's findings were not given sufficient guidance on dosage and timing of self-administered doses of the pain relief tablets, and the report warns about vulnerable women overdosing, resulting in conditions including chest pain.

There are concerns about ectopic pregnancies, which don't always have symptoms. Ectopic pregnancies are serious and may be fatal, if left untreated. Remote consultation can easily miss the signs but tests can provide confirmation of diagnosis. There are well-founded concerns about the risks of post-abortion mental health outcomes.

Medical risks

With telemedicine abortions, there are medical risks: antibiotics are not provided that would reduce infection risks and the later development of Pelvic Inflammatory Disease, putting women at greater risk of subsequent infertility. The RCOG recommends screening for STIs for women having abortions but, again, telemedicine prevents this from happening. There are also risks of sepsis and haemorrhage.

Questions asked include: "How does a doctor ensure that the woman actually takes the medical abortion tablets at the right time and in the right way, rather than someone else – perhaps a woman at a later stage of pregnancy?"

The Royal College of Obstetricians and Gynaecologists states that the interval between both abortion drugs must be 24-48 hours. If this timing is missed, the abortion may be incomplete, and there's an increased likelihood of bleeding if the interval is delayed. Likely symptoms to be experienced both during and after the abortion are menstrual-like cramps, pain and bleeding.

The authoritative electronic medicines compendium (EMC) advises that in emergencies, a "patient has access to medical facilities equipped to provide surgical

treatment for incomplete abortion, or emergency blood transfusion or resuscitation" – telemedicine doesn't allow for these safeguards. Neither does it cater to cases of failed abortions, where the EMC advises mandatory follow-up visits within 14-21 days to verify via tests and scans that the abortion is complete, and that vaginal bleeding has ceased or reduced. Patients must be informed about the possibility of surgery in cases of a failed abortion. The EMC states: "Bleeding is not in any way a proof of termination of pregnancy as it occurs also in most cases of failure." A strong warning is issued on the administration of both abortion drugs: "This product SHOULD NEVER be prescribed" in a range of situations that include a "pregnancy not confirmed by gynaecological examination, ultrasound scan or biological tests."

These medical dangers faced by women haven't been accounted for in the 2020 rules. Previously, when women had much or all of their medical abortion at a registered location, this provided essential safeguards against adverse medical outcomes. Women now face increased medical risks on a variety of fronts. Attempts to make permanent these temporary provisions must be resisted.

Further to the report, questions are raised about the as yet unknown full mental health impact on women, who do their own abortion at home in their bathroom. Popular public health messages appear to claim there's no adverse mental health outcomes for women undergoing abortion, but it's not risk-free. The scientific literature doesn't entirely deny these post-abortion risks, but they're treated as minimal, or more likely for certain at-risk groups. While a global consensus is yet to be reached, a growing and credible body of scientific evidence means it's misleading for women to be told that abortion poses no risk to their future mental health.

The new rules allowing women to self-administer two abortion pills at home brings numerous medical risks and harms to their health. VfJUK is calling on the government to immediately end this set-up. Women must no longer be denied the right to be seen and examined in person to certify relevant aspects of the pregnancy, thus having more regard for their medical safety.

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2. Background to the Government Consultation[1]

In the wake of the Covid-19 pandemic, emergency and temporary legislation was passed in March 2020, allowing women and girls for the first time to self-administer two abortion-inducing drugs at home. This covers abortions up to 10 weeks gestation (9 weeks and 6 days), otherwise known as early medical abortion, without the requirement of a physical examination. The pills are sent in the post, following a conversation with the woman or girl by phone or video link.

Early medical abortion involves the administering of two separate pills: mifepristone (RU-486), a drug that terminates the life of the unborn child, and misoprostol, the follow-up drug taken 24 to 48 hours later, to expel the dead child from the mother's womb. Although there is no disease or illness to prevent or treat, the DIY administration of either drug is commonly described in governmental or medical documents as a form of medicine or medication. Since the passing of the Abortion Act 1967, all abortions, including early medical abortions, have been carried out at registered locations, typically approved hospitals or other healthcare facilities recognised by the Secretary of State for Health.

Radical changes were made to the law in 2018,[2] according to which the first drug was required to be administered at a hospital or other approved location, while the second pill could, for the first time, be taken at the home of the woman. Concerns for patient safety determined that the first step of the process had to be done under medical supervision, rather than at the girl or woman's home. In March 2020, the further changes that were implemented (2020 Approval), allowed women to take *both* drugs at home, without the need for any physical examination or medical monitoring at any stage of the process. Previously, it was routine procedure to do an ultrasound scan to assess the gestational age of the unborn child. Now that this essential step is entirely bypassed, it allows the law to be easily violated. See further below: **Evidence of Multiple Legal Abuses and Medical Risks**.

The Government is now consulting on whether to make the temporary Covid-19 measures permanent, whether they should be repealed immediately, or if they should only remain lawful for the minimum two-year duration of emergency provisions contained in the Coronavirus Act 2020.[3] We now know that even before Covid-19 struck, abortionists were already planning to lobby for a permanent shift to home-administered abortions. In private correspondence between the British Pregnancy Advisory Service (BPAS), who undertakes about half of all abortions, and the Secretary of State for Health and Social Care, Matt Hancock, BPAS stated in early March 2020

that it "has been preparing to ask for the home-use of both drugs to be considered in any case, in the light of the development of remote counselling provision"[4]

The UK Government consultation, which closes on **26 February 2021**, only applies to England. The Scottish Government has launched its own consultation.[5]

3. What Does the Law Prohibit and Allow?

The law governing abortion and the location at which the procedure is deemed safe to be done (sometimes known as 'class of place') is found in a mix of Statute, Regulations, common law and guidelines from professional and statutory bodies.

3.1 Abortion Act 1967

The Abortion Act 1967[6] sets out the conditions that must be satisfied for abortions not to incur criminal liability for the registered medical practitioner (RMP) involved.

Lawful abortions can only be done by an RMP, after two RMPs (exceptions apply) have, in good faith, formed the opinion that the reason for the abortion falls within the statutory criteria.[7]

As to the location at which an abortion can lawfully take place, the 1967 Act stipulates:

> … any treatment for the termination of pregnancy must be carried out in a hospital vested in the Secretary of State for the purposes of his functions under the National Health Service Act 2006 or the National Health Service (Scotland) Act 1978 or in a hospital vested in ...a National Health Service trust or an NHS foundation trust or in a place approved for the purposes of this section by the Secretary of State.[8]

Private residences are evidently not included in the approved list of locations.

3.2 Human Fertilisation and Embryology Act 1990

Changes to the 1967 Act were made by the Human Fertilisation and Embryology Act 1990, which included empowering the Secretary of State for Health to issue regulations to widen the class of places at which abortions may take place.[9] The legal change was driven by the future prospect of abortion drugs like mifepristone (RU486) being licensed. During the passage of the Bill, the Secretary of State for Health rejected the suggestion that was put to him, that the measure was a preparatory step enabling home abortions. Where doubts exist about the meaning of a statutory clause, and to understand the intentions of the sponsoring MP or Minister who proposed the

measure, appeal to the parliamentary debate during the Bill's passage is a helpful and commonly recognised method of interpretation in courts of law.

Ann Widdecombe, then a government minister, expressed her concerns to Robert Key, the MP who introduced the amendment to the 1990 Act that this was "merely a paving measure—even if it is not intended as such—for self-administered home abortion." Key stated clearly this was "not the intention."[10] The then Secretary of State for Health, Kenneth Clark, who supported and defended the measure, dismissed her fears, explaining that the legal change "anticipates the possibility" that drugs like RU486 will receive a license and be approved, but as the law stood then, he said that patients will need to attend a hospital or other approved place. In the event that such a pill was ever licensed, he said:

> Such a pill would be administered only in closely regulated circumstances under the supervision of a registered medical practitioner.
>
> A question was asked earlier about what type of premises would be used for administering such a drug. It is possible that the pill could be administered in a GP's surgery under the supervision of a registered medical practitioner. The patient would still have to return two days later to be given the pessary.

The Health Secretary went on to explain that all that was intended by the measure was:

> … to ensure is that, if such a drug is licensed, the Secretary of State will at least have the power in primary legislation to approve the places and circumstances in which it might be used.[11]

The Health Secretary was clear that in the event RU486 was licensed, the new powers would not to be used for authorising home abortions, because "Such a pill would be administered only in closely regulated circumstances under the supervision of a registered medical practitioner." In other words, as required by the 1967 Act, an RMP must be involved.

The Act refers to the termination needing to be done by the RMP but the courts have interpreted this to allow the RMPs involvement to be supervisory.[12] While the RMP must take responsibility throughout the process from the point of deciding upon the abortion, he or she need not, therefore, directly participate for the statutory protection from prosecution to apply. It is vital, however, for the medical practitioner to remain in authority throughout, when, for example, trained and registered nurses or midwives perform the actual procedures.[13] Nurses or midwives can, therefore,

administer abortion drugs to a woman, if these have been authorised by two registered medical practitioners.

In Department of Health Guidance (2014),[14] it is said that the RMPs certifying an abortion need not see or personally examine a woman:

> Whilst there is no statutory requirement for either doctor to have seen and/or examined the woman, it is the Department's interpretation of the law that both doctors should ensure that they have considered sufficient information specific to the woman seeking a termination to be able to assess whether the woman satisfies one of the lawful grounds under the Abortion Act.[15]

On the role of the RMP, the Guidance states that:

> … the Courts have determined that provided the RMP personally decides upon and initiates the process of medical induction and takes responsibility for it throughout the termination, the protection under the Act applies to both the RMP and any other person participating in the termination under his or her authority. The nurse or midwife would not be responsible for leading or directing the procedure or care, or taking the overall decisions, this is firmly the responsibility of the doctor.[16]

3.3 The Offenses Against the Person Act 1861

The Offenses Against the Person Act 1861[17] makes it a criminal offense for a woman to procure her own abortion. It is also a criminal offense for any person intentionally to assist a woman in the administering of any substance that procures an abortion.

Section 58 makes it an offense for a woman intentionally to administer any substance to herself to procure an abortion. Section 59 makes it an offense to supply or procure any substance to procure an abortion.

Under the current legal regime in force since March 2020, an RMP is only involved in the issuing of a prescription, following a telephone call or video link with the patient. Whereas section 58 prohibits the administering of drugs by a woman to procure her own abortion, section 59 prohibits the supply or procurement of drugs by another person to bring about an abortion. While the current law (2020 Approval) provides that an RMP supplies the drugs, the fact that they are administered by the woman breaches the Abortion Act 1967.[18]

3.4 Statutory Rules and Other Guidance

In March 2020, the Department of Health and Social Care updated its detailed and rigorous set of procedures governing the approval process of the places at which

abortions may take place in accordance with the law.[19] These procedures include what is known as the "Required Standard Operating Procedures" which account for the legal requirements and standards of best practice.

In order to operate legally, abortion providers must receive written approval from the Secretary of State for Health and Social Care to have their premises recognized as a lawful class of place for the purpose of carrying out abortions. As abortion is a regulated activity,[20] it is an offense for a person to carry out a regulated activity without first being registered with the Care Quality Commission[21] (CQC). As the independent regulator of health and social care in England, the role of the CQC is to monitor the provider's compliance with the Health and Social Care Act 2008[22] and Regulations issued under the powers granted by that Act.

The Secretary of State may withdraw approval, if the provider is found to be in breach of the 2008 Act, the Abortion Act 1967, including Regulations issued under the respective powers of these Acts, as well as the Required Standard Operating Procedures.[23]

The CQC may use its enforcement powers granted under the 2008 Act. This includes a power to either suspend or cancel registration of the provider operating a regulated activity[24] and launch prosecution.

Given this rigorous approach to the regulated activity of abortion, to allow women to administer both abortifacient drugs at home disregards the safeguards in place, should things go wrong, and places a woman at risk of avoidable medical harm. See below: **Assessment of Medical Risks.**

Guidance from the National Institute for Health and Care Excellence (NICE) is considered below on pp. 22-23.

3.5 RCOG Clinical Guidelines

RMPs are expected to follow the best practice guidance (2019) for early medical abortions in England up to 10 weeks, produced by the Royal College of Obstetricians and Gynaecologists (RCOG).[25] Abortion is said to be "safe" at all gestational ages, and major complications are rare. It is also stated that the "symptoms likely to be experienced both during and after the abortion [are] … menstrual-like cramps, pain and bleeding."

RMPs are reminded by the RCOG that 1 to 2 in every 100 early medical abortions are unsuccessful. Surgical intervention is necessary in what is said to be less that 5% of cases. It should be noted that these figures are out of date, and therefore don't

account for the post-pandemic regime, where the two drugs are prescribed at home, without any medical supervision.

Women administering both drugs at home should, the guidelines state, take them within a timely interval of between 24-48 hours. If this timing is not observed and the interval is shorter, the abortion may not happen. Where the drugs are taken simultaneously, there is a 94.5% "success" rate, instead of 97.5%. If the interval is longer, there is an increased likelihood of bleeding.

In further RCOG guidance aimed at healthcare professionals published in the wake of Covid-19,[26] it is recommended that consultations for abortion are done by either video link or phone, "but experience from providers who regularly use telemedicine shows that both women and staff value video-links…"[27] In a mystery client investigation, detailed further below, three main abortion providers were contacted for consultations, with a combined total of 85 phone calls made, yet in none of them was it suggested that video should be used. This, despite the fact that all calls were made from a mobile phone.[28] In fact, the Department for Health and Social Care suggests video call should be considered for "women who prefer this,"[29] while the 2019 guidance from NICE recommends video-based assessments for women who want it.[30]

As with any medication taken outside of a hospital or other medical setting, instructions for timely administration may be ignored or misunderstood, exposing the woman to harm. In a *BPAS v Secretary of State for Health* [2011],[31] it was ruled that if abortifacient drugs are prescribed by an RMP, yet administered at home by the woman, this breaches what is permitted by the Abortion Act 1967, s. 1 (1). The judge explained the legal meaning of "treatment", which is conditional upon actually *taking* the abortifacient drugs, not merely having them prescribed. Treatment, he said, is not "restricted to the act of diagnosis and the prescription of drugs or medicine." He explained if the abortion tablets were prescribed but not taken by the woman, the treatment would have been available but not taken. "The aim of the treatment," he said, "whether medical or surgical, must be the termination of a pregnancy. Termination is the consequence of the treatment; it is not itself treatment.[32]

This ruling makes it clear that the administering of both abortifacient drugs at the woman's home easily opens the law to abuse. Such powerful drugs also raises urgent questions about patient safety. See below: **Assessment of Medical Risks.**

3.6 Changes to 'Class of Place' (2018)

In 2018, the approved "class of place" was revised for early medical abortions up to 10 weeks, to now include a woman's home, but only for the second stage of abortion treatment when misoprostol is taken.[33] According to this new regime, a woman was

required to attend a clinic where she was prescribed both mifepristone and misoprostol. The woman was obliged to take mifepristone at the clinic, but given the option of taking the follow-up drug, misoprostol, at home.

A physical examination at the clinic would establish if the pregnancy was within the legal scope of 9 weeks and 6 days, an essential practice that is bypassed by the current 2020 Approval.

3.7 Changes to 'Class of Place' (2020)

The 2020 changes to the early medical abortion rules (up to 10 week gestation) allow a woman[34] to be sent the abortion pills in the post, following a consultation by phone or video link.[35] This is known as telemedicine. No physical examination of the pregnant woman is required. Previously, a woman visited a clinic and was given an ultrasound scan in order to assess the gestational age of the unborn child. This routine guaranteed legal compliance with the time-limits for lawful abortions. Under the 2018 Approval rules, while some of the assessment may have begun by phone, it was followed by a visit to the abortion provider, where the woman's medical history was taken, verified and then assessed for eligibility, which included physical tests.[36]

Before the government announced its temporary changes to the law, attempts within parliament to modify the abortion rules were rejected. In a short parliamentary debate during the passage of the Coronavirus Bill, on 25 March 2020, Baroness Barker and Baroness Bennett proposed an amendment that would change the law. The Health Minister Lord Bethell, acting on behalf of the government, explained:

> … it is the Government's priority to ensure that women who require abortion services should have safe, high-quality care and that abortions should be performed under the legal framework already set out by the Abortion Act.[37]

On safety, Lord Bethell further explained:

> The safety of women remains our priority, but it is vital that appropriate checks and balances remain in place regarding abortion services, even while we are managing a very difficult situation such as Covid-19 … there are long-established arrangements in place for doctors to certify and perform abortions, and they are there for good reason.[38]

The safety concerns alluded to by the Minister clearly point to a range of real risks. These may be summed up as: the possible medical harms involved in self-administering both abortion pills at home (see below, **Assessment of Medical Risks**); inaccurate or misleading assignment of gestational age, enabling abortion beyond the limits allowed by law; a woman's honest reporting of the first day of her last period,

may, of course, be inaccurate. Unhelpfully, she is also burdened with self-assessing aspects of her own medical history.[39] Furthermore, a residential setting cannot be expected to comply with the hygiene standards of clinics or hospitals (see below, *Royal College of Nursing vs Department of Health and Social Security* [1981]).

Lord Bethell while recognising the different opinions that exist, and explaining that his department had taken a "huge amount of advice", including scientific advice, believed the proposal was a "fundamental change to the way abortions are regulated and administered". The existing regime was based on an "enormous consensus", he said.

The Minister voiced concerns that there had been no consultation with midwives and nurses taking on broader responsibilities.[40]

Lord Bethell also emphasised the Bill's measures should have widespread parliamentary support which it lacked. In a further justification of the Government's rejection of the amendment, he said: "This Bill is not the right vehicle for a fundamental change in the law. It is not right to rush through this type of change in a sensitive area such as abortion without adequate parliamentary scrutiny."

Historically, abortion in parliament has been treated as a matter of conscience and with thorough debate. Therefore, it is a matter based on free votes, as opposed to the party whip system. For the Government to therefore issue significant abortion regulations, such as the 2020 Approval, is a violation of this parliamentary safeguard. It also seriously undermines the democratic process.

As expected, the new home abortion regime has opened the door to outright legal abuses. This evidence is based on a mystery client survey, an undercover investigation that exposed a raft of serious safety concerns**,** blatant legal abuses of the telemedicine regime, and repeated failures to obtain basic information such as NHS patient numbers.

Additionally, recent reports reveal examples of women illegally self-administering abortion drugs beyond the legal 10 week limit. In one of these cases, the unborn child of 28 weeks was aborted by the home-administered drugs.[41] Not only had this exceeded the legal gestational limit for home abortifacient drugs permitted under the new rules, it also violated the lawful 24-week limit for which most abortions are permitted under the Abortion Act 1967. It was further reported that a coroner was investigating the death of this 28 week-old baby, and police were also informed.[42]

In *Royal College of Nursing vs Department of Health and Social Security* [1981], Lord Diplock said of the Abortion Act 1967, that one of its purposes was to "ensure that the abortion is carried out with all proper skill and in hygienic conditions."[43]

The 2020 Regulations fails to ensure that a medical abortion will be done under hygienic conditions.

3.8 Risk of coercion

Research shows that intimate partner violence is a strong risk factor in abortion around the world.[44] [45] [46]

If a woman requesting an abortion is not seen in person, it is much more difficult to discover whether or not she is acting under coercion. If she is seen in person and alone, she is more likely to feel able to disclose issues of domestic violence, intimidation or manipulation.

In its 2019 guidance, the RCOG calls for vulnerable groups of women to be identified – for example, victims of domestic abuse or gender-based violence – and for them to be "signposted" to appropriate support services.[47]

In its 2020 guidance,[48] providers are told to ensure women have "adequate privacy at the start of the consultation"[49] and are free from partner coercion:

> The clinician should be confident that the woman is not being coerced and that she is able to discuss any concerns privately. Remote consultation may enable vulnerable women, for example those with a coercive partner, to access care more discreetly, especially during COVID-19 and lockdown.[50]

It is difficult to see how a woman living with a coercive partner can access care "more discreetly". If she is within earshot of her abusing partner while talking on the phone to the abortion provider, she is may feel fearful enough not to want to disclose her ordeal.

Lord Bethell said the Government believes it was an "essential safeguard" for women to attend a clinic, thus ensuring the opportunity to be seen alone. He explained that such women are often vulnerable and would want face to face, one-on-one confidential contact to discuss concerns and alternatives.[51] He added that in an abusive relationship, and without the requirement of an RMPs involvement, a vulnerable woman is more likely to be pressured by an abusive partner into an abortion.[52] A woman speaking remotely provides little to no assurance she is not being pressured into an abortion. A private, face to face meeting is more likely to provide a setting in which coercive influences can be detected.

Government policy in support of protecting women was strangely overturned five days later when the new home abortion regime was instituted. No new research or facts

had emerged in this short time-window but there was lobbying pressure on Government from abortion providers and abortion-supporting groups.[53]

VfJUK understands that under the temporary 2020 Approval, women are not protected from the risks of partner coercion. Making the telemedicine abortion regime permanent will therefore leave woman less safe.

If and when the decision to abort is driven by a woman's partner, this only serves to further reinforce an already deleterious situation. Following the Government consultation, if the temporary law becomes permanent, women with abusive partners will be more at risk of being exposed to coercive control than before. It also runs directly counter to government policy, as for example seen in the Domestic Abuse Bill, currently under debate and providing statutory protection for victims of domestic abuse.[54]

4. Evidence of Multiple Legal Abuses & Medical Risks

4.1 Background to an Investigation

A mystery client investigation,[55] designed to investigate the practice of telemedicine and abortion provision in the wake of the 2020 Approval, has exposed multiple legal violations of abortion law and safety concerns. The report has also brought to light a range of serious health risks to which women are now exposed. Christian Concern commissioned Kevin Duffy, a former Director of Marie Stopes International (since renamed MSI Reproductive Choices) to carry out a mystery client exercise.

Non-pregnant volunteers were recruited to assume a persona, while having recourse to a checklist of information for use during the phone call to the service provider. Three service providers were surveyed for this undercover investigation: British Pregnancy Advisory Service (BPAS), Marie Stopes UK (MSUK, since renamed MSI Reproductive Choices), and National Unplanned Pregnancy Advisory Service (NUPAS). There were 26 'clients', with 85 phone calls in total, all of which were recorded by video, and have since been transcribed. For BPAS and NUPAS, there were usually two phone calls, while for MSUK, there were three. In some cases, extra calls were made.

4.2 The Report's Findings

Drawing on evidence it gathered, the report says: "Abortion providers are operating as if abortion on-demand for any reason is legal."[56] This is an abuse of law, exposing vulnerable women to risk of severe physical and mental harm. See: **Risk of coercion** above, and **Overview of Medical Risks**, below.

Key findings of the report include:

False identities All 26 women provided false information about their identity, their purported pregnancy and other information, and were sent abortion pills in the post. While the woman's address, to which the pills were sent, was genuine, it did not correspond to actual patients on the NHS register.

This raises questions involving both law and basic husbandry. The extreme demands under which the NHS finds itself during the pandemic, makes its scarce resources all the more in need of wise management. Accessing NHS services for free is not an automatic right for everyone, unless, in general, the individual is a UK citizen, or they are from the EU and arrived before 31 December 2020.[57]

The women claimed factiously that they were registered with specific GP surgeries.

No NHS registration None of the abortion providers obtained valid NHS numbers from the mystery clients. In some cases, the woman was asked for her NHS number, which she said she did not have to hand. Asked to supply this on the follow-up call with the nurse, the nurse did not ask for this information. Neither was this information sought during subsequent calls.

The law does not require the RMP performing the abortion to include the woman's NHS number on the HSA4 form (a form which legally must be completed by the RMP and submitted to the Chief Medical Officer within 14 days of the abortion). Among the Report's recommendations, the NHS is urged "To correctly identify the client and to ensure correct use of NHS funding, the telemedicine process should be amended to collect and validate each client's NHS number before proceeding with the consultation. It should be mandatory for inclusion of the NHS number on the HSA4 form and payments should be withheld if this is not completed correctly."[58]

Unsafe and illegal Telemedicine abortion provision depends on client self-reporting about gestational age. The report states: "In some cases, the clients altered the date of her last period between calls and this was accepted without question."[59] The report points to the lax attitude underpinning the gathering of medical data: it is "…very easy for women to deliberately or mistakenly misdirect the abortion provider into prescribing the abortion treatment in cases when it is neither legal nor safe."[60]

The report states: "The prior use of an ultrasound scan was to overcome any lack of a service provider's confidence in the woman's recall."[61] This safeguard has now been removed.

How accurate then are women's self-reporting of their last period? According to evidence cited by the RCOG,[62] 1.2% of women from a sample of 4,484, who were

seeking early medical abortion, wrongly dated their last period to below 10 weeks, when an ultrasound confirmed it beyond 10 weeks.

It should be noted that a woman must self-administer the both abortion pills *within* 9 weeks and 6 days for the abortion to comply with the 2020 rules. The report warns of what happens if the gestation is wrongly assessed: "…it is accepted that the efficacy of the medical abortion treatment reduces as GA [gestational age] increases, with a resulting increase in the potential side-effects experienced or adverse events arising."

Bizarrely, relying on a woman's self-assessment means she has effectively been "been co-opted as an essential member of the multidisciplinary team… working for the registered medical practitioner…providing important clinical information necessary for the correct certification" of an abortion to comply with the Abortion Act 1967.

This astonishing conclusion casts a shadow on the NHS and its decline in both standards of law and safety.

Exclusion of GP A woman can choose to keep all information concerning her abortion confidential from her GP. Shockingly, she can instruct the abortion provider to not make contact with her GP surgery. In the name of confidentiality, the abortion provider will comply with her request, unless there is a "serious risk to the woman's health or her safety."[63] Excluding the GP, who has access to the woman's medical records, cannot be right and severs the important bond between patient and doctor.

Self-assessment The women who used the telemedicine process provided by the three abortion providers, BPAS, MSUK, and NUPAS, were responsible for assessing if the termination was proceeding as expected, and whether it had been achieved correctly. Women are provided with both verbal and written guidance on what warning signs to be aware of during this process, such as bleeding too much. They are also given a checklist and pregnancy test kit to use up to three weeks after taking both pills. This test is designed to self-assess completeness of the termination process.

No follow-up care calls Surprisingly, there were no follow-up care calls made in any of the 26 client cases. Abortion is an unsettling or traumatic event for many women, not to mention the risk of physical side-effects and complications, so it is all the more extraordinary that there is an absence of follow-up contact.

Summing up some of the extraordinary conclusions of the survey, the report states:
"As our mystery client survey has shown, it is simply not possible for the registered medical practitioner to be certain that the woman for whom the abortion treatment is being prescribed is actually pregnant, is within the regulated gestational limit, is medically eligible for such treatment, satisfies the legal grounds permitting a ToP

[termination of pregnancy], will correctly administer the treatment, will do so in a timely manner, or will successfully and safely complete the termination procedure; most of which the RMP certifies when completing and submitting the HSA4 form to the Chief Medical Officer in the Department of Health."[64]

Timing of pills It should be stressed that if the two abortion pills are not taken at the prescribed intervals, this can lead to medical problems. The report notes that "delay beyond the regulated gestation limit is the critical factor determining the safe and successful completion of the termination process using these medications."[65]

The report explains how some of these risks are mitigated, if an in-clinic assessment was mandated *before* a woman self-administers her treatment at home, "though this will still not address the risks associated with a delay in the administration of the mifepristone or the mistiming of the misoprostol administration."[66]

Given the emotionally vulnerable state some women find themselves in when seeking abortion, the report warns how abortion providers cannot be certain if their clients have understood how to correctly self-administer the pills, and the importance of timing between the mifepristone and the misoprostol.[67]

Abortion Act contravened In all the phone calls, the women were asked to provide a reason for their abortion. Irrespective of the reasons provided in the survey, the abortion provider either commented that this was an "emotional reason" or nothing was said. In all but one of the 26 cases, the "reason was a form of 'you seem to be unable to cope emotionally'."

These abortions were provided under, and justified by, appeal to what is sometimes called Ground C abortions, or the statutory mental health ground, where there is a hypothetical future risk to a woman's mental health, if she gives birth.[68] The vast majority of abortions in England and Wales are justified under this ground (98% of 202,975 in 2019, of which 99.9% were for reasons of risk to mental health**,** where Ground C provided the sole Ground).[69] Where the woman protested that she had no mental health or emotional issues, she was told the reason making her eligible for the abortion would be under the 'emotional category'.

Lack of supervision The report states it is "very unlikely"[70] an RMP will be involved with the woman undergoing a home-administered abortion. Neither will he or she even be aware of the details spoken between the woman and the abortion provider. The RMP will therefore rely solely on the information provided to them, in order to complete the abortion certification form, and authorise it.

The Abortion Act 1967 requires that an abortion must be carried out by the RMP. As noted earlier, the courts have interpreted this to allow the RMP's involvement to be supervisory.

The Abortion Act 1967 also requires that an abortion is authorised by *two* RMPs, who form an opinion in "good faith"[71] that the relevant statutory reason is satisfied, for the abortion not to incur criminal liability. The report points out that the "good faith" requirement is weakened by remote assessment.[72] Not only is there reliance on members of the multidisciplinary team who gather data on the client, but this depends on the "accuracy and honesty of the woman's own self-assessment."[73] It is further stated by the report that good faith no longer depends, upon a "direct, supervisory relationship" between the RMP and the multidisciplinary team, but on "unsubstantiated information" provided by the woman, so that the right boxes can be ticked.[74]

On the basis of the report's findings, the role of the RMP in the telemedicine process appears to have become all the more remote from the abortion itself, rendering the requirement for involvement, at best, to be disregarded, at worst, made effectively redundant.

NICE guidance The report cites the 2019 guidance from the National Institute for Health and Care Excellence (NICE), entitled *Abortion Care*,[75] noting that it is often pointed to as commending telemedicine for abortion assessment. The report states: "[B]ut this is far from definitive. Indeed, the recommendation to consider providing abortion assessments by phone is in the context of making it easier and quicker for women to access this service. The implied context in this guideline is that phone calls should be considered as part of the process, rather than becoming the whole of the process."[76]

It should be noted that NICE admits there is only "limited evidence" for their recommendation that abortion can be done before what it calls "definitive ultrasound evidence".[77] Furthermore, the NICE guidance provides caveats: "Services offering surgical or medical abortion before ultrasound evidence of pregnancy will also need to be able to assess serum human chorionic gonadotrophin (hCG), and have staff trained in interpreting test results."[78] The hCG blood test is used, among other reasons, to confirm pregnancy or to assess gestational age. Under the 2020 rules, it is impossible for this extra testing to be done.

Ethical Considerations

An OUP 2019 study based on a systematic review[79] and cited by the mystery client report, considered the ethics of mystery shopping, concluding that "'deception' of

clinicians can be ethically justified" if: other options are unable to address research questions; the risks to the service providers and acting client are minimal; and the "knowledge generated is of value to society…"

For pro-lifers, especially, this investigation provides crucial evidence exposing grave medical risks to which women are put, while also uncovering how existing abortion law is being trampled upon. It is clear there was no other viable, systematic means to obtain the required evidence.

5. Overview of Medical Risks

5.1 Physical health risks

Dr Gregory Gardner, a GP and Honorary Clinical Lecturer in Clinical Sciences at the University of Birmingham was asked, as part of a Judicial Review[80] challenging the government on the legality of the 2020 Approval of home-administered abortions, to advise on two questions. First, "What are the dangers to women self-administering Mifepristone and Misoprostol at home?" and secondly, "To comment on any other relevant matter." [81]

Dr Gardner issues a reminder that "Material risks have to be disclosed to the patient in line with the 'Montgomery' principles.[82] This is a test as to "whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."[83]

Drawing on a range of professional guidance and peer-reviewed journals, Dr Gardner highlights the risks of possible physical complications involved in medical abortion that could be "material" to a decision to have a home-administered abortion. A selection of the cited risks include:

5.2 Infection issues

There are 10% of complications resulting from infection after abortions, though other studies provide lower figures; there is a cohort of women having an abortion with undiagnosed infection; abortions without antibiotic prophylaxis (antibiotics used before surgery or a dental procedure) to prevent bacterial infection risks the later development of Pelvic Inflammatory Disease, putting women at greater risk of subsequent infertility. The RCOG recommends screening for chlamydia and other STIs for women having abortions, but Dr Gardner points out this cannot be done other than by a face to face appointment. As the 2020 rules do not cater for these testing scenarios, he concludes they therefore increase the risk of "personal injury" to

women. Susceptibility to sepsis is a risk in a small proportion of women who have an abortion. Therefore: "Women need written information about sepsis warning signs which could be overlooked if the woman is alone."

5.3 Haemorrhage and subsequent surgical evacuation

In a Finnish study involving 27,000 women who had a medical abortion, there was a 15.4% incidence of haemorrhage in women aged 18 and above; there was an incomplete abortion in 10.2% of the adult cohort, while 13% required surgical evacuation. A further paper drawing on the same data found haemorrhage rates to be eight times higher for medical abortions, over surgical ones.

In a Swedish study concerning all abortions at a hospital between 2008-2015, there was a complication rate of 7.3% in medical abortions below 12 weeks. Incomplete abortion was the commonest complication. The frequency of complications was much higher among women whose gestation was under seven weeks, and had self-administered their abortion at home. Complication rates for medical abortions increased hugely from 4.2% in 2008 to 8.2% in 2015, and Dr Gardner says this is "possibly associated with a shift from hospital to home medical abortions."

5.4 Communication issues

The information obtained by a practitioner in contact with a woman over the phone or via link may not only be incomplete but: "It will be virtually impossible to do a full risk assessment and communicate that risk back to the patient." As a woman may not accurately report her last period, and in the absence of an ultrasound scan, it is possible the gestation will be wrongly assessed. Dr Gardner concludes: "In practice this risks women taking Mifepristone/Misoprostol at a later gestation thus risking heavier bleeding."

On the receipt of medical treatment and the need for patient consent, he states: "Informed consent implies not just a full risk assessment, but time allowed for reflection and change of mind." In a warning of what could go wrong, he then asks: "How does a doctor ensure that the woman actually takes the medical abortion tablets at the right time and in the right way, rather than someone else – perhaps a woman at a later stage of pregnancy?" As noted earlier in *BPAS v Secretary of State for Health* [2011], "treatment" as authorised by the Abortion Act 1967, is conditional upon actually *taking* the abortifacient drugs, not merely having them prescribed.

5.5 Weakening safeguards

Dr Gardner cites the authority of the electronic medicines compendium (EMC). This is a medically authoritative and trusted information source, whose documents are

validated by either UK or European government agencies which license medicines.[84] In the data sheet for Mifepristone with Misoprostol, warnings are issued about combining these pills to induce an abortion:

> Because it is important to have access to appropriate medical care if an emergency develops, the treatment procedure should only be performed where the patient has access to medical facilities equipped to provide surgical treatment for incomplete abortion, or emergency blood transfusion or resuscitation during the period from the first visit until discharged by the administering qualified medical professional. [85]

For risks of failure, the EMC states:

> The non-negligible risk of failure, which occurs in 4.5 to 7.8% of the cases, makes the follow-up visit mandatory in order to check that abortion is complete.[86]

It is further said that patients need to be informed that surgery may be required to achieve a complete abortion. Patients must be informed about:

> … the occurrence of prolonged vaginal bleeding (an average of about 13 days after mifepristone intake, up to three weeks in some women). In a few cases, heavy bleeding may require surgical evacuation of the uterus. Bleeding is not in any way a proof of termination of pregnancy as it occurs also in most cases of failure.[87]

To safeguard the woman's health, and to ensure the abortion has been completed, follow-up examinations are mandatory:

> A follow-up visit must take place within a period of 14-21 days after administration of mifepristone to verify by the appropriate means (clinical examination, ultrasound scan, or beta-hCG measurement) that expulsion … has been completed and that vaginal bleeding has stopped or substantially reduced. In case of persistent bleeding (even light) beyond the follow-up visit, its disappearance should be checked a few weeks later. If an ongoing pregnancy is suspected, a further ultrasound scan may be required to evaluate its viability.[88]

EMC issues a strong warning on these drugs: "This product SHOULD NEVER be prescribed" in a range of situations that include a "pregnancy not confirmed by gynaecological examination, ultrasound scan or biological tests."[89] [emphasis original]

The medical risks cited above from the EMC, associated with mifepristone and misoprostol, are just some of the wider range of problems listed that could manifest. These issues do not seem to have been accounted for in the 2020 Approval. Formerly,

when women had much or all of their medical abortion at a registered medical location, this provided essential protective safeguards against adverse medical outcomes. Women now face increased medical risks on a variety of fronts. Attempts to make permanent these temporary provisions must be resisted.

5.6 Codeine Phosphate

In the mystery client survey, concerns are raised by Kevin Duffy, former director of Marie Stopes International about codeine phosphate. In his report, he writes that these tablets are included in the treatment packs sent to women administering their own at-home abortions. Abortion providers, BPAS, MSUK, and NUPAS, provide these tablets in their packs for pain management. The mystery clients were told they could take codeine phosphate "as and when needed, in addition to or instead of either ibuprofen or paracetamol; the survey recordings reveal a lack of sufficient or detailed guidance on the dosage and time period between self-administered doses of the pain medication."[90]

During the mystery survey phone calls, the women were often told that the pain associated with abortion was similar to, or a little worse than, that experienced during a heavy period (dysmenorrhea). According to guidance from NICE for the management of dysmenorrhea, a nonsteroidal anti-inflammatory drug (NSAID) such as ibuprofen is advised. If this is harmful for the patient, then paracetamol should be offered as an alternative.[91]

As a class B drug, codeine phosphate is, states Duffy, "liable to abuse and is rarely prescribed alone and prescribing it for pain relief is inappropriate and unsafe, and inconsistent with NICE guidance." Duffy adds that a woman seeking medication without prescription, for dysmenorrhea at a pharmacy, will not be offered codeine phosphate routinely as a first resort, due to its addictive nature. Typically, she will be advised to use ibuprofen, naproxen, mefenamic acid, or paracetamol.

Duffy raises serious concerns for vulnerable women who are sent these tablets: taking all 28 tablets sent for example, in a pack supplied by BPAS, would be a toxic dose, resulting in bluish lips, drowsiness, chest pain and slow heart rate. When taken with alcohol it would be "extremely dangerous". There is a significant risk that one of these vulnerable women might intentionally use these codeine tablets for an overdose."[92]

5.7 Detecting ectopic pregnancies

Ectopic pregnancies is when the pregnancy is outside the uterus. They are very serious and may be fatal, if left untreated. About 2 in every 100 women are affected.[93] Ectopic pregnancies do not always have symptoms, so should be diagnosed. Remote

consultation could miss diagnosis.[94] Various tests can provide confirmation using urine or blood; ultrasound scan; a laparoscopy.[95]

The evidence provided above indicates severe risk of medical harm. If women are to be kept safe, objective medical facts must be prioritised over lobbying pressure from abortionists.

In addition to the physical health complications, there are also questions of post-abortion mental health outcomes.

5.8 Mental health risks

The full mental health impact on women who perform their own abortion at home in their bathroom has yet to be known. In a *Decision Aid* document produced by NICE,[96] designed to help women in their options between medical or surgical abortions, one question raised regarding medical abortions is: "Will I see the products of the pregnancy pass?" Women are told: "You will be awake and aware of the process. You may see the products of the pregnancy as they pass, and these might be more visible after 9 weeks."

Pro-abortionists claim abortion is a minimum-fuss procedure, some even likening it to having a tooth removed.[97] This may be so for some women, yet it is difficult to deny how other women will be greatly traumatised, especially when they see their partly formed baby flushed down their own toilet.

We should note that, at six weeks, the baby's cartilage skeleton is fully formed and the heart begins to beat. Small buds appear at this stage which will become arms. At seven weeks, the baby's face and brain are growing. At eight weeks, all organs are developed and functioning, except for the lungs, while the nose and upper lip have now formed. At nine weeks, the baby sucks his/her thumb, and the elbows and toes are visible. These are snapshots, showing how the unborn baby is developing. Therefore, the embryo or unborn baby is not, as abortionists like to stress, merely "products of conception" or "products of pregnancy", suggesting a mass of meaningless cells.

While popular public health messages claim there are no adverse mental health outcomes for women undergoing abortion, it is not risk-free. The mainstream scientific literature does not entirely deny post-abortion mental health risks, but they are treated either as minimal, or more likely for certain at-risk groups.[98] There is a growing and credible body of scientific evidence showing that women who have abortions are putting their mental health at future risk.[99] While a global consensus is yet to be reached, it is misleading for women to be told that abortion will not pose any possible risks to their mental health.

6. Conclusions

Following legislation passed in March 2020, allowing women for the first time to self-administer two abortion drugs at home for EMAs, there's now no requirement of physical tests or examinations to certify the gestational age of the foetus. Blood tests, ultrasound scans or other essential medical checks are no longer carried out, therefore putting women at risk of harm. The pills are sent by post, following a remote consultation. The Government is now consulting on whether to make these measures permanent, to repeal them immediately, or for them to remain lawful for the minimum two-year duration of provisions contained in the Coronavirus Act 2020.

The criminal law forbids a woman to procure her own abortion, and for any person intentionally to assist a woman in administering a substance that procures an abortion. The new telemedicine regime is therefore a legal breach. As a regulated activity, performing abortions are subject to a rigorous set of rules, covering the class of place or locations at which they can be done. The 2020 rules bypass the new regime overseeing registered locations, failing to ensure that the basic hygiene standards expected of a hospital or clinic are met.

There are risks to health if the administration of the two abortion pills are mis-timed. This includes menstrual-like cramps, pain and bleeding. Under the previous rules brought in 2018, while some of the assessment may have started by phone, it was followed by a visit to the abortion provider, where the woman's medical history was taken, verified and then assessed for eligibility.

When the Secretary of State for Health gave the go-ahead for the telemedicine regime, this was a response to abortion lobbyists, rather than new scientific research or medical facts. Only days before the changes, the Health Minister strongly rejected the call to change a fundamental part of the law, stating that it was an "essential safeguard" for women to attend a clinic and be seen alone. Research shows how abortion decisions can be driven by the pressures from abusive partners. Women who are not seen in person may want to hide abuse issues. Only a face to face consultation is more likely to uncover partner coercion that may be pushing a woman into an abortion.

The Health Minister had also expressed concerns that the proposed changes to abortion law would lack the much needed parliamentary scrutiny and support, and should not be rushed through.

Evidence from an undercover investigation exposed a raft of serious safety concerns and blatant legal abuses of the telemedicine regime. The report found that "Abortion

providers are operating as if abortion on-demand for any reason is legal." Reliance on a woman's self-assessment meant a woman has been "co-opted as an essential member of the multidisciplinary team" working for the RMP, and "providing important clinical information necessary for the correct [legal] certification" of an abortion. The 'good faith' requirement of an RMP authorising an abortion no longer depended, the report concludes, upon a direct, supervisory relationship between the RMP and the multidisciplinary team, but on "unsubstantiated information" provided by a woman, so the right boxes are ticked.

Remote consultation can miss the signs of an ectopic pregnancy, which is serious and may be fatal, if left untreated. Tests can provide confirmation of diagnosis. With telemedicine abortions, there are a number of medical risks to which a woman is exposed, including: infection and subsequent infertility; sepsis and haemorrhage; not having access to emergency facilities equipped to provide services including, surgical treatment for incomplete abortion.

Telemedicine also fails to cater to the need for mandatory follow-up visits within 14-21 days to verify, via tests and scans, that the abortion is complete, and that vaginal bleeding has ceased or reduced. Patients must be informed about all the potential risks, including the possibility of surgery in cases of a failed abortion. Medical advice warns against the two abortion drugs being prescribed, if the pregnancy was not confirmed by gynaecological examination, ultrasound scan or biological tests. All these medical dangers faced by women have not been accounted for in the 2020 rules and place women in the path of harm.

The full mental health impact on women who do their own abortion at home in their bathroom is as yet unknown. Despite popular health messages claiming little or no post-abortion mental health risks, the procedure is not risk-free, and women ought to be told about the possible risks to their future mental health.

The new rules allowing women to self-administer two abortion pills at home brings numerous medical risks and harms to their health. VfJUK is calling on the government to immediately bring this to an end. Women must no longer be denied the right to be seen and examined in person, to certify relevant aspects of the pregnancy, and having greater regard for their overall medical safety.

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[8] S 1 (3).
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[10] https://publications.parliament.uk/pa/cm198990/cmhansrd/1990-06-21/Debate-16.html
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[13] Ibid.
[14] *Guidance in Relation to Requirements of the Abortion Act 1967: For all those responsible for commissioning, providing and managing service provision*, Department of Health, May 2014, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/313459/20140509_-_Abortion_Guidance_Document.pdf (accessed 15 January 2021)
[15] Para 15.
[16] Para. 29.
[17] https://www.legislation.gov.uk/ukpga/Vict/24-25/100/contents
[18] In section 1 (1), it is stated that the conditions under which an abortion may be lawfully done must comply with the "law relating to abortion". In section 6 (Interpretation section), it is explained: "the law relating to abortion" means sections 58 and 59 of the Offences against the Person Act 1861…"
[19] *Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion),* Department of Health and Social Care, March 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/874241/Procedures_for_approval_of_independent_sector_places_for_abortion.pdf
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[24] Sections 17 and 18 (https://www.legislation.gov.uk/ukpga/2008/14/part/1/chapter/2/crossheading/further-provision-about-registration-as-a-service-provider-or-manager).
25 *Clinical Guidelines for Early Medical Abortion at Home – England,* produced by the Royal College of Obstetricians and Gynaecologists, The Faculty of Sexual and Reproductive Healthcare and The British Society of Abortion care Providers, January 2019 (https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf, accessed 12 January 2021). These guidelines were produced

in collaboration with other professional bodies, a range of NHS representatives, as well as input from the Department for Health and Social Care.

[26] *Coronavirus (Covid-19) infection and abortion care: Information for healthcare professionals,* produced by the Royal College of Obstetricians and Gynaecologists, The Faculty of Sexual and Reproductive Healthcare and The British Society of Abortion Care Providers, The Royal College of Midwives, 31 July 2020, (https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-31-coronavirus-covid-19-infection-and-abortion-care.pdf, accessed 15 January 2021).

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[28] *Abortion at Home: a Mystery Client Investigation,* Christian Concern, October 2020, p. 16. (https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Abortion-At-Home-A-Mystery-Client-Investigation-201210.pdf) (Accessed 12 January 2021).

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[31] https://www.bpas.org/media/1185/bpas-v-secretary-of-state-for-health-approved-14-02-11.pdf

[32] Para. 24.

[33] *The Abortion Act 1967 - Approval of a Class of Places*, Department of Health and Social Care, 27 December 2018.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/768059/Approval_of_home_use_for_the_second_stage_of_early_medical_abortion.pdf

[34] Unlike the 2020 *Approval*, in which the government makes reference to "girls" and "women" who are pregnant, the 2018 *Approval* only refers to women without a single reference to "girls". The 2018 Approval was still relevant to girls having abortions, but the fact that there is now a direct reference to girls, underlines the health vulnerabilities of associated with teenage girls.
2018 *Approval* decision:
(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/768059/Approval_of_home_use_for_the_second_stage_of_early_medical_abortion.pdf)
Government's 2018 announcement:
(https://www.gov.uk/government/publications/approval-of-home-use-for-the-second-stage-of-early-medical-abortion).
Note that in the 2020 Approval, the government's reference to women and girls is found on the introductory page to its Open Consultation. (https://www.gov.uk/government/consultations/home-use-of-both-pills-for-early-medical-abortion). However in the 2020 *Approval* decision document, the reference is only to women:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876740/30032020_The_Abortion_Act_1967_-_Approval_of_a_Class_of_Places.pdf

[35] The *Approval* statement from the Department of Health and Social Care, declares that a woman must have a "had a consultation with a registered medical practitioner via video link, telephone conference or other electronic means".

[36] p. 10.

[37] 25 March 2020, Vol 802, Col: 1762-1763 [HL] https://hansard.parliament.uk/lords/2020-03-25/debates/3C266E78-4BB7-4330-9199-D361CDBAE2AD/CoronavirusBill

[38] Ibid.

[39] This point is made in *Abortion at Home: a Mystery Client Investigation,* Christian Concern, October 2020, p. 5 (https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Abortion-At-Home-A-Mystery-Client-Investigation-201210.pdf, accessed 12 January 2021).

[40] 25 March 2020, Vol 802, Col: 1762-1763 [HL] https://hansard.parliament.uk/lords/2020-03-25/debates/3C266E78-4BB7-4330-9199-D361CDBAE2AD/CoronavirusBill

[41] Pills by Post: Police probe death of unborn baby after woman has illegal 'abortion by post' at 28 weeks – four weeks past limit, *The Sun*, 22 May 2020 (https://www.thesun.co.uk/news/11690506/police-probe-death-of-unborn-baby-after-woman-has-illegal-abortion-by-post-at-28-weeks-four-weeks-past-limit/).

[42] Ibid.
43 *Royal College of Nursing of the United Kingdom v Department of Health and Social Security* (1981) [HL], (https://www.bailii.org/uk/cases/UKHL/1980/10.html). See section 13.
[44] *Intimate partner violence, abortion, and unintended pregnancy: Results from the WHO Multi-country Study on Women's Health and Domestic Violence*, C Pallitto et al (2013), International Journal of Gynecology & Obstetrics, Vol 120, Issue 1, 3-9.
[45] *Male Perpetration of Intimate Partner Violence and Involvement in Abortions and Abortion-Related Conflict*, Silverman J, et al, (2010), American Journal of Public Health 100(8):1415-7.
46 *Predictors and Correlates of Abortion in the Fragile Families and Well-Being Study: Paternal Behavior, Substance Use, and Partner Violence*, Coleman P et al (2008), International Journal of Mental Health and Addiction, 7(3):405-422.
47 *Clinical Guidelines for Early Medical Abortion at Home – England*, produced by the Royal College of Obstetricians and Gynaecologists, The Faculty of Sexual and Reproductive Healthcare and The British Society of Abortion care Providers, January 2019 (https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf), p. 4.
[48] *Coronavirus (Covid-19) infection and abortion care: Information for healthcare professionals,* produced by the Royal College of Obstetricians and Gynaecologists, The Faculty of Sexual and Reproductive Healthcare and The British Society of Abortion Care Providers, The Royal College of Midwives, 31 July 2020, (https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-31-coronavirus-covid-19-infection-and-abortion-care.pdf, accessed 15 January 2021).
[49] p. 12.
[50] p. 24.
[51] 25 March 2020, Vol 802, Col: 1762-1763 [HL] https://hansard.parliament.uk/lords/2020-03-25/debates/3C266E78-4BB7-4330-9199-D361CDBAE2AD/CoronavirusBill
[52] Ibid.
[53] See the letter from Marie Stopes UK to Secretary of State for Health and Social Care, Matt Hancock, dated 27 March 2020: https://christianconcern.com/wp-content/uploads/2018/10/CC-Misc-Resource-Judicial-Review-Abortion-Marie-Stopes-Letter-200327.pdf. No medical evidence is provided to justify home-administered abortions in this letter, though forecasts are produced to show how service users are expected to fall under pressure during the Covid-19 pandemic. See also an e-mail dated 27 March 2020 from BPAS to the Department of Health and Social Care: https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Misc-Judicial-Review-Abortion-BPAS-Email-2-200327.pdf. Both accessed 18 January 2021.
[54] For the stages that the Domestic Abuse Bill have gone through, see: https://services.parliament.uk/bills/2019-21/domesticabuse.html
[55] *Abortion at Home: a Mystery Client Investigation*, Christian Concern, October 2020, (https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Abortion-At-Home-A-Mystery-Client-Investigation-201210.pdf) (Accessed 12 January 2021).
[56] See pp. 4 and 14.
[57] https://www.citizensadvice.org.uk/health/help-with-health-costs/nhs-charges-for-people-from-abroad/ (Accessed 12 January 2021).
[58] p. 6.
[59] p. 4.
[60] Ibid.
[61] p. 5.
[62] *Coronavirus (Covid-19) infection and abortion care: Information for healthcare professionals,* produced by the Royal College of Obstetricians and Gynaecologists, The Faculty of Sexual and Reproductive Healthcare and The British Society of Abortion Care Providers, The Royal College of Midwives, 31 July 2020, p. 12. (https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-31-coronavirus-covid-19-infection-and-abortion-care.pdf, accessed 15 January 2021)
[63] p. 9.
[64] p. 12.
[65] Ibid.
[66] Ibid.
[67] Ibid.

[68] Section 1 (1) (a) permits abortion if "the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family."
[69] *Abortion Statistics, England and Wales: 2019*, Department of Health and Social Care, 11 June 2020, pp. 9-10, (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf).
[70] p. 14.
[71] s. 1 (1).
[72] p. 14.
[73] Ibid.
74 Ibid.
75 https://www.nice.org.uk/guidance/ng140/resources/abortion-care-pdf-66141773098693 (accessed 15 January 2021).
[76] p. 16.
[77] p. 44.
[78] p. 45.
[79] *How to do (or not to do) ... using the standardized patient method to measure clinical quality of care in LMIC health facilities*, King JJC et al, Health Policy and Planning, 34, 2019, 625–634. See: https://academic.oup.com/heapol/article/34/8/625/5551391
[80] For access to all the legal documents of the Judicial Review, see: https://christianconcern.com/cccases/diy-abortions/ (accessed 18 January 2021).
81 https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Misc-Gregory-Gardner-Witness-Statement-Abortion-200420.pdf (accessed 18 January 2021).
[82] For basic information about the Montgomery principles, see: https://www.themdu.com/guidance-and-advice/guides/montgomery-and-informed-consent, (accessed 18 January 2021)
[83] See the Supreme Court ruling, *Montgomery v Lanarkshire Health Board [2015]* UKSC 11, para. 87, https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf.
[84] https://www.medicines.org.uk/emc/about-the-emc
[85] See: section 4.4, Special warnings and precautions for use: https://www.medicines.org.uk/emc/product/3380/smpc, accessed 18 January 2021.
[86] Ibid.
[87] Ibid.
[88] Ibid.
[89] Section 4.3. Contraindications.
[90] *Abortion at Home: a Mystery Client Investigation,* Christian Concern, October 2020, p. 17. (https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Abortion-At-Home-A-Mystery-Client-Investigation-201210.pdf) (Accessed 12 January 2021).
[91] Ibid.
[92] Ibid.
[93] https://www.plannedparenthood.org/learn/pregnancy/ectopic-pregnancy#:~:text=Ectopic%20pregnancies%20are%20dangerous%20when,as%20soon%20as%20you%20can
[94] This concern is expressed by Kevin Duffy in his report, *Abortion at Home: a Mystery Client Investigation,* Christian Concern, October 2020, p. 11. (https://christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Abortion-At-Home-A-Mystery-Client-Investigation-201210.pdf) (Accessed 12 January 2021).
[95] A form of keyhole surgery providing access to the inside of the abdomen.
[96] *Abortion before 14 weeks: choosing between medical or surgical abortion, Decision Aid*, NICE, last updated September 2019, (https://www.nice.org.uk/guidance/ng140/resources/abortion-before-14-weeks-choosing-between-medical-or-surgcical-abortion-patient-decision-aid-pdf-6906582255) Accessed 15 January 2021.
[97] https://www.thesun.co.uk/fabulous/8877475/my-abortion-was-as-routine-as-getting-a-tooth-pulled-comparing-it-to-rape-is-brutally-untrue/
[98] See, for example, a Report produced by the American Psychological Association, which evaluated all empirical studies published in English from 1989, comparing the mental health of women who had an abortion to the mental health of comparison groups. *Report of the APA Task Force on Mental Health and Abortion*, 2008. https://www.apa.org/pi/women/programs/abortion/mental-health.pdf (accessed 15 January 2021)

[99] See *Abortion and Women's Health* by Dr Gregg Pike, a medical researcher, published by SPUC, updated 2017. (https://www.spuc.org.uk › 750-abortion-and-womens-health-april-2017-pdf)
See also "Abortion and Mental Health: What do the Studies Say?" by Robert S. Harris, in *Relationships and Sex Education: The Way Forward,* a Report from the Lords and Commons Family and Child Protection Group, September 2018, published by Voice for Justice UK. (https://vfjuk.org.uk/vfjuk-supports-rse-report-challenging-government/).