DÁIL ÉIREANN

AN COMHCHOISTE UM AN OCHTÚ LEASÚ AR AN MBUNREACHT

JOINT COMMITTEE ON THE EIGHTH AMENDMENT OF THE CONSTITUTION

Dé Céadaoin, 25 Deireadh Fómhair 2017

Wednesday, 25 October 2017

The Joint Committee met at 1.30 p.m.

MEMBERS PRESENT:

Deputy James Browne,	Senator Paul Gavan,
Deputy Lisa Chambers,	Senator Rónán Mullen,
Deputy Ruth Coppinger,	Senator Lynn Ruane.
Deputy Clare Daly,	
Deputy Bernard J. Durkan,	
Deputy Peter Fitzpatrick,	
Deputy Billy Kelleher,	
Deputy Mattie McGrath,	
Deputy Catherine Murphy,	
Deputy Hildegarde Naughton,	
Deputy Jonathan O'Brien,	
Deputy Kate O'Connell,	
Deputy Louise O'Reilly,	
Deputy Jan O'Sullivan,	
Deputy Anne Rabbitte,	

SENATOR CATHERINE NOONE IN THE CHAIR.

The joint committee met in private session until 2.15 p.m.

Business of Joint Committee

Chairman: We are now in public session. I welcome members. I welcome viewers who may be watching our proceedings on Oireachtas television to this meeting in public session of the Oireachtas Joint Committee on the Eighth Amendment of the Constitution. We will be holding three separate sessions this afternoon. The first session will address risk to mental health; the second will address termination arising from rape and the third will look at personal experience of cases of fatal foetal abnormality. We had invited the support group One More Day to that third session, however, they could not make today's session and the secretariat will accommodate them on a date in November.

I welcome Professor Veronica O'Keane to the meeting, but before I introduce her I must attend to some housekeeping matters.

There are two items of correspondence that I need to read into the record. The first is a letter from Ms Cora Sherlock dated 18 October 2017 and addressed to me.

Dear Senator Noone,

I would appreciate the opportunity to set the record straight about comments made by me that were misrepresented by Deputy Ruth Coppinger at last week's meeting of the Joint Oireachtas Committee on the 8th Amendment.

Deputy Coppinger called into question statements I have previously made surrounding the rate of abortion of babies diagnosed with Down Syndrome in the womb in England and Wales, namely that 90% of babies diagnosed with the condition are aborted.

As on previous occasions, Deputy Coppinger disputed this figure, claiming instead that the correct rate is 44% and seeking confirmation from Dr. Fergal Malone who indicated that the abortion rate from the Rotunda when babies are diagnosed with Down Syndrome is already around 50% even with the 8th Amendment in place.

By means of clarification, I would point to the fact that under Ground E of the Abortion Act 1967, abortion is allowed to birth if the baby in the womb is diagnosed with any disability or foetal anomaly and this includes Down Syndrome.

I would refer to the Parliamentary Inquiry into Abortion on the Grounds of Disability (July 2013). Item 21 on page 14/15 of this Report states that "approximately 90% of babies with a definite diagnosis of Down Syndrome are aborted".

This figure has been generally accepted within the wider abortion debate and is regularly referred to by disability rights activists such as the "Don't Screen Us Out" campaign in the UK which is trying to preserve the right to life of babies diagnosed with Down Syndrome in the womb. I would add that this worrying phenomena was highlighted at the January session of the Citizens' Assembly when reference was made to a worldwide "trend" of aborting babies on the basis of a diagnosis of Down Syndrome.

I ask that you bring this letter to the attention of your fellow colleagues on the Committee and that it be read into the record.

With every good wish.

Yours Sincerely,

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Cora Sherlock

Pro Life Campaign

The next is an email from Dr. Peter Boylan dated 25 October 2017.

Dear Senator Noone,

Thank you again for the invitation to last Wednesday's meeting of the Oireachtas Committee on the Eighth Amendment. I was very impressed with the work of the Committee and thought the session was notable for the most part for its thoughtful and open-minded questioning and collegial atmosphere.

However, although Senator Ronan Mullen was absent for much of the committee on other business, while he was present he made several assertions at odds with the facts regarding what was said at the hearing in respect of my evidence. The next day, he appeared on at least two radio shows, during which he repeated those inaccurate assertions.

In particular, he repeatedly claimed that Savita Halappanavar's treating consultant in Galway did not "hide behind the Eighth Amendment", i.e. that Dr Astbury was in no way constrained by the Eighth Amendment. This claim was made in direct contradiction of the evidence of both myself and Professor Arulkumaran last week. I am therefore attaching for your attention, and that of the committee, transcripts of the third day of the inquest into Ms Halappanavar's death, in which it is absolutely apparent that Dr. Astbury, her treating consultant, could not have been clearer about how the eighth amendment prevented her from intervening. The relevant section is on pages 46 and 47, questions 176 to 179, inclusive.

I have also attached Professor Arulkumaran's evidence to the committee last week in response to Senator Lynn Ruane in which he categorically stated that the eighth amendment contributed to Savita Halappanavar's death (page 30 of transcript).

Both of us reviewed Ms Halappanavar's full medical case records, and Professor Arulkumaran also had the advantage of interviewing those involved in her care in University Hospital Galway.

This point is so fundamental to your hearings that I believe the record should be corrected in respect of Senator Mullen's inaccurate assertions last Wednesday that the eighth amendment did not constrain Ms Halappanavar's treating doctor.

Yours sincerely,

Peter Boylan.

For the purposes of clarification, the attachments referred in the email will be available on the website and form part of the record of the committee.

Risks to Mental Health of Pregnant Women: Professor Veronica O'Keane

Chairman: Before we begin our first session, members and those in the Visitors Gallery are reminded, at the request of the broadcasting and recording services, to ensure their mobile phones are turned off completely for the duration of the meeting.

By virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by it to cease giving evidence on a particular matter and continue to so do, they are entitled thereafter only to qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or an entity by name or in such a way as to make him, her or it identifiable.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official, either by name or in such a way as to make him or her identifiable.

I welcome Professor Veronica O'Keane, professor of psychiatry at Trinity College Dublin and consultant psychiatrist at Tallaght hospital, and invite her to make her presentation.

Professor Veronica O'Keane: I thank the Chairman and members of the committee for inviting me. I hope I can be of help to them in their task of interpreting the findings of the Citizens' Assembly. I have been asked specifically to give my opinion as an expert in the field of mental health. My current role is a joint academic and clinical one, as consultant psychiatrist in the service of the HSE at Tallaght hospital and professor of clinical psychiatry at Trinity College Dublin where I lead a research programme in perinatal psychiatry. My previous experience includes leading a national perinatal psychiatry service in London for five years at the Maudsley Hospital which covered all of the United Kingdom. Concurrently with that position, I was head of the perinatal psychiatry section at King's College GKT School of Medical Education where I led a research programme in perinatal depression. I have had papers published in the scientific literature on the subject of perinatal depression and written a book on the topic. I co-authored the standard clinical assessment tool for perinatal psychiatry disorder in the United Kingdom and served as an expert for the National Institute for Clinical Excellence in devising guidelines for clinicians on the management of perinatal depression. I set up two hospital psychiatry services, including the suicide prevention service in Beaumont Hospital. I was an expert witness at the two Oireachtas hearings which led to the introduction of the Protection of Life During Pregnancy Act and was also privileged to serve as an expert witness at the Citizens' Assembly. Last March I co-hosted, with the National Women's Council of Ireland, the World Congress on Women's Mental Health at the RDS in Dublin.

I begin by thanking the members of the Citizens' Assembly for their work. The process and governance of the assembly in its consideration of the eighth amendment were an example of the best of democratic principles in action. Its conclusions were solution-focused and not ideologically driven. Most of the recommendations made are relevant to mental health, but they have been spelled out in a very helpful way that leaves no room for ambiguity. That clarity is one of the strengths of the document. A majority of the citizens recommended 12 reasons for which termination of a pregnancy should be lawful in Ireland. For each general health reason listed, a parallel mental health reason was given. For example, where 99% voted that abortion should be lawful when there was a real and substantial risk to the life of a woman, 95% voted the same where there was a real and substantial risk to the life of the woman by suicide. Similarly, 93% and 90%, respectively, of the citizens supported abortion where there was a serious

risk to the physical health of a woman and a serious risk to her mental health. The same applied to a risk, as opposed to a serious risk, to physical health and mental health, with 79% and 78%, respectively, voting that abortion should be available to women in these circumstances.

There are two particular points I wish to highlight in respect of the assembly's recommendations. The first is that, as I have outlined, support levels for the provision of abortion care for medical and mental health reasons were very similar. In fact, 72% of members recommended that a distinction should not be drawn between the physical and mental health of women. That recommendation was an enormous relief to me and my colleagues. The mind-body dualism division has plagued our society and created much unnecessary suffering, leading to stigmatisation of and discrimination towards those who suffer with psychiatric disorders. Separation of mental health from physical health has been at the heart of the debate about abortion for the past three decades, following on from the 1992 ruling in the X case that suicide risk constituted grounds for an abortion. We have had two referendums, in 1992 and 2002, where suicide was upheld by a majority of voters as a legitimate reason for an abortion. We had a very difficult debate on the suicide provision leading up to the enactment of the Protection of Life During Pregnancy Bill in 2012 and 2013. It is now recognised in law that suicide constitutes a risk to the life of the woman in the circumstances of an unwanted pregnancy. The Citizens' Assembly understood there was no distinction between physical and mental health and made its understanding explicit. The importance of that recommendation cannot be underestimated and changes everything.

I will comment briefly on dualism which has been a very destructive force in society's understanding of health. It might seem evident, but it is important to point out that the brain controls the body. While one may feel sad in one's heart or anxious in one's gut, these feelings are directed from the brain. The dialogue between the body and the brain is never stronger than during pregnancy because the pregnant uterus produces hormones which cross into the pregnant woman's brain and modify the emotional brain. Emotional changes also occur because pregnancy is very challenging and parenthood is probably the most serious challenge any of us will face in our lifetimes.

My research group has looked at rates of depression during pregnancy, the first such study to be conducted in Irish maternity hospitals. We found rates of 16%, which is slightly higher than EU norms. Being depressed when pregnant is a very serious problem. Not only is the woman intensely distressed, but the stress hormones alter the baby's physiology such that the foetus is growing in a high-stress milieu and at increased risk of being born earlier and with obstetric problems. Depressed pregnant women are often unable to attend to their own needs and do not present as regularly for outpatient appointments as non-depressed women. Infants born to women who are depressed during pregnancy are more likely to suffer from childhood learning and behavioural problems and depression in early adulthood. All of this demonstrates that the emotional brain is important not just to the general well-being of the pregnant woman but also to the subsequent health of her baby and that baby's trajectory throughout life. The treatment of psychiatric disorders in pregnancy is seen as a priority for this reason.

An unplanned or unwanted pregnancy increases the risk of depression during pregnancy. A US study of more than 100,000 women was published earlier this year. The study examined the relationship between unwanted pregnancy and perinatal depression. The study showed that an unwanted pregnancy increased the rates of perinatal depression by 50%. It must be said that in this study, as in all other published studies from OECD countries, the option of legal abortion was available for these women.

Chairman: Excuse me for interrupting, Professor O'Keane, but there is a phone interfering with her microphone. Does she have a phone on her person, in her handbag or near her?

Professor Veronica O'Keane: I have but it is switched off.

Chairman: Is it completely switched off? Airplane mode should be fine. I ask her to please check.

Professor Veronica O'Keane: Shall I put it somewhere else?

Chairman: Yes. Broadcasting can let us know if that does not work. Interference makes it difficult for people to report the debate and interferes with television coverage.

Professor Veronica O'Keane: Is that any better?

Chairman: Does Professor O'Keane have a tablet, an iPad, computer or anything else?

Professor Veronica O'Keane: No.

Chairman: Is Deputy Mattie McMcGrath's phone switched off as well? Yes. Let us continue.

Professor Veronica O'Keane: Who cannot hear me?

Chairman: The people who report the debate and the broadcast unit which provides television coverage.

Professor Veronica O'Keane: I was talking about unplanned pregnancies in a US study on more than 100,000 women. The study showed that perinatal depressions increased by 50%.

My last point was that-----

Chairman: I am sorry for interrupting.

Professor Veronica O'Keane: -----the option of legal abortion was available. This point was made again in a very impressive meta-analysis published by the Academy of Medical Royal Colleges in London. It showed that the academic literature only reflects findings where abortion services are available. There are no scientific studies from OECD countries on mental health outcomes where women could be forced to go through with an unwanted pregnancy. We are talking about high risks of depression in countries where women have the option of legal abortion.

The difference between Ireland and other OECD countries is a woman's only option to obtain an abortion here is to travel. Access to this service is facilitated by State funded information services. A service based in another jurisdiction clearly has inherent problems that will affect the mental health of the woman. There will always be women who will be unable to travel for an abortion. The situation with the migrant women who are unable to travel has been very painfully laid out by the case of Miss Y. I have seen women in my own practice who were unable to travel because of hostility from abusive partners or threats from their community where abortion is unacceptable, culturally.

The category of women who are too sick to travel also includes women who have debilitating mental illness. I have patients who are too sick to travel to an outpatient clinic without being accompanied by a community psychiatric nurse. Many of these women have never trav-

elled outside of Dublin. It would be way beyond their capacity or personal resources to travel to the UK. Neither would they have the capacity to source the abortion pills nor would any of the mental health workers be able to facilitate them in doing so because it is obviously a crime. Women with a handicap such as this need to be compassionately cared for in settings appropriate to their high needs.

The second problem about having a de facto UK-based service is one that every Irish woman or girl who travels bears. The UK path to abortion is a sad and shameful one that Irish women have endured for five decades and it is damaging to women's mental health. It is filled with shame and humiliation. The girl or woman is easily identified and sees herself as being easily identified. What should be a private and sensitively conducted procedure becomes a public journey.

At the heart of the problem of abortion in Ireland is one issue - unwanted pregnancies. It is self-evident that there will always be unwanted pregnancies. There always have been and there will always be a requirement for abortion. The mental health arguments for decent abortion services apply not just to the women who need abortion care. I would go further and say that the mental health of everybody in Ireland is being damaged by the eighth amendment because we are all shamed by the current situation.

To conclude, the recommendations of the Citizens' Assembly are a welcome departure from the dualism of physical versus mental health in its recognition that mental well-being is inseparable from physical well-being. This is particularly relevant in pregnancy where high levels of emotional vulnerability are inseparable from the physiology of the pregnancy. The recommendation that all facets of mental well-being, from suicide risk to damage to mental health, be considered as grounds for abortion takes into account the complexity of each individual woman's psychological experience of an unwanted pregnancy and the unpredictability of risk. The rigidity of constitutional absolutes is the polar opposite of what we need to deal with the needs or pregnant women who have unwanted pregnancies. I think a solution-based compassionate response to this problem will require the removal of the prohibition on abortion from the Constitution. I agree with the recommendation made by the Citizens' Assembly that a legal framework that allows for the unpredictability of obstetric and psychiatric risk should be put in place. A mental health service needs to be embedded within future abortion care because of the complexity of the emotional issues that are frequently experienced in unwanted pregnancies.

The constitutional ban and the consequent rigid legal restrictions in Ireland can escalate psychiatric risk. The constitutional vice-grip and the legal complexities that have followed makes the mental health care of women within unwanted pregnancies unpredictable and is an obstacle to care.

Chairman: I thank the professor and apologise for the interruptions. We appreciate her contribution.

There are four lead speakers on my list today and they are Deputies Kelleher, O'Reilly, O'Connell and Coppinger. I ask them to indicate how much time they require.

Deputy Browne has indicated that he will commence. Does he wish to spend most of his time posing questions to this witness? Shall I tell him when five minutes have elapsed?

Deputy James Browne: I will ask a couple of questions first.

Chairman: I will let him know how much time he has left over.

Deputy James Browne: Yes. I thank the professor for being here. She is very welcome. I very much echo her welcome for the belated recognition that there should be no distinction between physical and mental health. I think it is very important, whatever decisions are made, that no distinction is made between the two of those.

In terms of Professor O'Keane's role as a consultant psychiatrist and the impact of the Protection of Life During Pregnancy Act 2013, has its application been effective or non-effective in practice?

Professor Veronica O'Keane: In terms of practice, my view is that the majority of women who are suicidal because of an unwanted pregnancy are still travelling. I do not think we are treating the women who are suicidal, because of unwanted pregnancies, in Ireland. I think we are treating the women who are suicidal with unwanted pregnancies, who are unable to travel, in Ireland.

So far, seven women, theoretically, have had their lives save by the legislation. Obviously that is a very good thing in itself. It is a very good thing that we have legislation that will save women's lives if their lives are at risk because of being pregnant. In that sense the legislation has worked. It is very clumsy legislation and the majority of my colleagues feel very uncomfortable with trying to work within this legislation. It is very difficult for women. As most people here probably know, three specialist assessments are required. The legislation also requires that the woman would go to a GP or an accident and emergency doctor who would initially refer her. In order to have a legal abortion because of a risk of suicide a woman must see a minimum of five doctors. If one of those doctors is unwilling to see her the process is clearly lengthened and that has happened quite a lot with this legislation.

Colleagues feel uncomfortable with the legislation and do not want to deal with the matter. A woman who has been referred by a GP or an accident and emergency department presents to the doctors. The first person may say, "I am not comfortable with this, call me a conscientious objector". He or she rings up his or her clinical director who also says: "Call me a conscientious objector, I am not comfortable with this legislation." The clinical director then rings another colleague. It may escalate to a national level and a psychiatrist from a national panel might have to be called. There is usually a period of delay in which the woman does not know what is happening because no one knows what is happening. She may then see someone who does not believe that she fulfils the criteria, so the process must restart. It is distressing for a woman who is feeling suicidal, is pregnant and is highly vulnerable to have to repeat her story to everyone. Every time she tells the story, it is an emotional journey that takes an emotional toll on her, and she is someone who is suicidal. In my practice, I try to minimise the number of people to whom my sick patients have to talk. If a patient has already been clerked in an accident and emergency department, I will see him or her next and say that the patient does not need to be clerked again in a ward. The repetitive intrusion into a patient's extremely private crisis is counter to good sensitive practice.

Deputy James Browne: Is there an indication of how long the delay is? In an acute situation, what is the typical period?

Professor Veronica O'Keane: I am not privy to that information, so I will discuss my experience in a general way. The delays have been unacceptable. There have been delays of up to two weeks where each day is a nightmare for the woman. Sometimes, she has been hiding this fact from everyone, including her partner or ex-partner and her children. Most of the women I have seen in this regard have been mothers and have been trying to pretend that this is not

happening to them. They are not given any reassurance about whether it will happen. They are usually financially destitute, but are unable to look for money because they must hide the fact that they are seeking an abortion. I cannot say what the time lapse is generally, but it has been unacceptable in the cases that I have seen.

Another issue that is worrying about the Protection of Life During Pregnancy Act is that while we have a register of women who have had the procedure, we have no idea of the number of women who have applied for abortions. There may be women who applied for abortions and were not certified as being appropriate for same and - I say this with trepidation and a great deal of sadness - who have not survived from a psychiatric point of view or have gone on to kill themselves. I do not know - nobody knows - because there is no register of women who apply for the procedure. There is only a register of women who have received it.

Deputy James Browne: I thank Professor O'Keane. Her last comment answered what was going to be my next question.

Professor O'Keane stated that we needed a solution to the real life problem of unwanted pregnancies and not a moral, ethical, metaphysical or philosophical discussion about abortion. Will she expand on that?

Professor Veronica O'Keane: People want a solution to this problem. They do not want to discuss any more the metaphysical issues that have dominated the debates or the hypothetical situations of if this or that happens. People understand that there is a real problem that has been festering for a long time. They understand that we need a solution to it. At this point, the ethical issues need to be driven by the need of women with unwanted pregnancies rather than by metaphysical philosophical discussions.

Chairman: I call Deputy O'Reilly next.

Deputy Louise O'Reilly: The Chair might tip me off at the five minute mark so that I can do half and half.

Chairman: Yes.

Deputy Louise O'Reilly: I thank Professor O'Keane for attending and for her presentation, which cleared up many issues, particularly regarding the Protection of Life During Pregnancy Act and its practical or impractical operation, whichever the case may be. There is an imposition on women. The fact that there is no register of those who applied and, dare I use the word, were unsuccessful in their applications is remiss of us because we cannot get a clear picture of how the legislation operates other than through the evidence that Professor O'Keane has given us, which is that the Act often leaves a woman in acute distress for up to two weeks while colleagues await a decision. That is most unfortunate, but it is welcome that this information is now in the public domain.

Professor O'Keane might address two points. First, it is clear from her opening statement but, in her opinion, are her pregnant patients who require psychiatric care more at risk of suffering physical ill health as a result of their mental ill health? The two are inextricably linked. Maybe Professor O'Keane might expand on that point.

Second is a point that we should probably be addressing in every session. There is an argument that, in the event of us making a change, be it large or small, to the level of access that Irish women have to abortion care, we will somehow be opening floodgates and there will be

a dramatic increase. From Professor O'Keane's experience, will she give us an indication of what the likely implications will be in that regard?

Professor Veronica O'Keane: I will start with the Deputy's second question on floodgates. I do not understand the floodgate phenomenon. A good presentation made to the committee earlier showed that the rate of abortion had been steady over the years, although I hope that it will decline slightly with better contraceptive care. The availability of abortion pills on the web has increased and the rate of travel for surgical abortions has reduced. The floodgates are open and always have been. They have only been pointed towards the UK. We have a de facto abortion service. It is just not in our own country. I cannot see making abortion legal in Ireland changing the number of women having abortions. Rather, I hope that, by having a better health service that is more women focused, inclusive, sensitive and compassionate, we will reduce the number of unwanted pregnancies and improve our care for women with unwanted pregnancies. At the heart of this matter is giving care to women who have unwanted pregnancies.

The Deputy's other question was on whether a woman who was depressed would be at an increased risk of developing obstetric problems or other physical ill health. That is definitely true. If one is depressed in any circumstance in life, one is at greater risk of becoming medically unwell. That is because our stress system is controlled in our brain. It is the control station for the secretion of our stress hormones. If I am stressed, my brain tells my adrenal glands to secrete cortisol. Being in a stressed condition for a long period of time is damaging physiologically. It has been shown to lead to cancers, heart disease, lung disease and osteoporosis. Every physiological system is sensitive to stress hormones, particularly long-term exposure. During pregnancy, there is a rapidly developing foetal system. It will of course be sensitive to stress hormones. If we are thinking about abortion care, we should be thinking about it in the care of the general mental health of pregnant women, and as I stated previously, specifically in the area of unwanted pregnancies. "Yes", is the answer. Are specific disorders that are specific to pregnancy, such as pre eclampsia, Caesarian section and obstetric complications, more likely during pregnancy if a woman is depressed? "Yes" is the answer. Being depressed disadvantages the woman and the foetus, and the delivery of the foetus into the world.

Deputy Kate O'Connell: I thank Professor O'Keane for coming in today.

There are just a couple of things I want to touch on. Professor O'Keane's presentation was very helpful.

On this division of mind and body health which Professor O'Keane referred to as dualism, and which she stated today is found by the Citizens' Assembly to be the entirely wrong approach, she quotes a study showing that, according to her statement: "Pregnancy is associated with increases in anxiety and depressive symptoms and is the highest risk period in a woman's life for depression." The following are three questions around that whole concept. Is an unplanned or forced pregnancy a threat to the short and long-term mental health of the woman carrying it and can it cause mental harm to others around her? When a couple - two people together - are challenged by an unplanned or unexpected pregnancy, what effects does this pregnancy have upon the mental health of the man? When a couple seek a termination together, is there any evidence that the male partner can suffer from mental health challenges, such as stress, depression, guilt, shame and emotional pain also? Has Professor O'Keane any experience with the effects on the men in the situation?

I am conscious that some people are trying to shut down a debate regarding mental health grounds by proclaiming that abortion is not a solution for suicidal ideation. Would Professor

O'Keane agree that, while the act of administering an abortion may not *per se* be a solution, circumstances can differ from woman to woman and the option to access an early termination is far more likely to result in better outcomes for the mental health of the woman and her partner?

In Professor O'Keane's professional opinion, should mentally-ill pregnant women who do not want to be pregnant be subject to internment until they have delivered a child and would this be harmful to their mental health? Are Ireland's laws acceptable to retain without alteration? Do they adequately assist women who are too poor to travel for a termination who may be immigrants without papers - Professor O'Keane spoke about women with diminished mental and physical capacity - or women who are psychiatrically unwell to the point of psychosis, delusion or catatonia? What did we do in the past and what do we do currently with poor people, mentally unwell people or those with diminished capacity? What I am trying to get at here is what Professor O'Keane spoke about in her statement. Who is left behind? Really, that is what I am getting at here. I would ask Professor O'Keane to elaborate on some of that in her professional capacity.

Professor Veronica O'Keane: I thank Deputy O'Connell. There are quite a few questions in that. I will start again at the end because of my short attention span.

The Deputy talked about the vulnerable women who were unable to travel. If I had to pick the worst situations that arise from our current situation in relation to an absence of a proper abortion service it would be those of the women who are left behind. It is the women who sometimes do not have the education to understand how to access resources. They do not have the confidence to go to professionals. They do not have the knowledge to access the professionals and they do not have the confidence to talk to those professionals about what they might want. They may be ashamed of what they want. They may be in a terrible state of conflict about it. They may want an abortion and not be able to put words on it. There are as many extremely sad situations as there are women pregnant who are left behind in that very vulnerable category.

I can only talk about my experience of dealing with very vulnerable women who have very significant mental health disorders. I might be talking about women who may not even understand that they are pregnant for a few months. Perhaps the medication they are on is suppressing their menstruation and they do not have regular cycles, and they may not even be aware. By the time they become aware of the pregnancy, they could be 14 to 16 weeks pregnant. They are unable to process the idea that they have to go for maternity care and their GP will try and sort out their obstetric care, when they go to their GPs. This group of women do not have sensitive, appropriate services that can meet their high needs. These sensitive services are available in other branches of medicine for these women. I have had women who have had breast cancer and they have had really wonderfully appropriately sensitive services, in terms of guiding them through the palliative stage of their care and, indeed, from the palliative stage of their care to their passing. We can only guess about those women. In a sense, I know that group of women are left behind. We should feel ashamed by the fact that these women are ignored and neglected.

In relation to early abortions, obviously, the earlier an abortion, the better it is for the woman. The situation that we have in Ireland delays abortion. I have just told the committee how the Protection of Life During Pregnancy Act 2013 is cumbersome and certainly delays abortions, but travelling also delays abortions because some women do not have passports, some women do not have the finances and some women have not made up their excuses that they are going away with a friend for a weekend for fun in Liverpool or whatever. Obviously, travel takes away a woman's privacy. That is probably one of the worst aspects of it but it also leads to later abortions. It is an established fact that the average age of gestation of Irish women is

higher than that of women in the UK.

On unplanned pregnancies, I think the Deputy referred to "unplanned and forced pregnancies". I guess I would see them as being in very different categories.

Deputy Kate O'Connell: "Or forced" not "and forced".

Professor Veronica O'Keane: Unplanned pregnancies obviously can become wanted pregnancies and everybody is happy. Of course, unplanned pregnancies can become unwanted pregnancies and as I said, sometimes that is an ambivalent place for a woman to be. Some women will remain ambivalent and they will obviously proceed with the pregnancy, and those women need a lot of support because they are at a very increased risk of developing depression and having complications with parenting.

However, the women who have the unwanted pregnancies who want an abortion can be in a very difficult position because, obviously, they may not be able to travel. We are letting those women down with the current situation here and forcing them to travel; we are putting women who are unable to travel in positions of having pregnancies that are not wanted which leads to children that are not wanted. It is an issue that does not raise its ugly head often, but it does happen. My practice is full of adults who were not wanted as children and that has to be borne in mind.

In terms of forced pregnancies, obviously, it is very important that women who have forced pregnancies have immediate access to abortion care that is sensitive to their situation.

On the mental health of men, in my view men are very traumatised by the situations that their pregnant wives can find themselves in in relation to unwanted pregnancies. The committee will hear evidence later today from a man, Gerry Edwards, who will be able to tell the committee a lot about it from his point of view.

On abortion and non-foetal anomaly abortion, there is not much literature. I have never seen a man who was traumatised, unwell or presented to me with depression because a partner had an abortion. That is not to say that it is not a problem but it is an area that has not been explored in great detail. Post-partum depression in men has been explored but not post-abortion psychological status.

Deputy Kate O'Connell: I have one final question.

Chairman: That is over ten minutes. If members ask lots of questions, there will be lots of answers.

Deputy Kate O'Connell: When the National Association of General Practitioners was before the committee last week or the previous week, the issue of referral was raised. We were told the law effectively precludes a doctor from giving the file of a patient to medics in the UK. The professor has experience as a psychiatrist who often deals with people with very complex psychiatric needs. As a professional at the height of her game, how does Professor O'Keane feel about sending a women away with a file under her arm which might relate to a long and complex psychiatric history? Does she sit in her office feeling stressed over what will happen on the other side? As a medical person and a professional, how does she feel about sending that patient that she has cared for away on her own?

Professor Veronica O'Keane: I do not know if the joint committee is ready to hear that

evidence. I will understate it in as appropriate way as I can. I find it extremely distressing. I think it is wrong. It is against all our instincts and training. We do not have a right to express our distress because we are witnessing so much more distress, but it is extremely distressing, very frustrating and very stressful.

Chairman: I thank the Deputy and Professor O'Keane. Deputy Coppinger has ten minutes.

Deputy Ruth Coppinger: I thank Professor O'Keane for her presentation. Earlier, she said that people want a solution and that they know we need one. I agree with her, and we need a real solution that deals with the whole issue of abortion in this country. There are ten people who travel daily and the five who we know now are taking abortion pills in their own bedrooms, so that is 15 people a day. Today we are discussing mental health which is critical for all those people, and later we will discuss rape and fatal foetal abnormality, which probably accounts for about 6%, and is a small minority among the reasons people have abortions. The evidence this committee has heard over recent weeks has been resounding regarding the need for abortion legislation which deals with the reality of all those people, the 92% who fall under the abortion under 12 weeks, on request, which is just one recommendation of the Citizens' Assembly which could deal with this entire issue. It relates to a previous decision in private session not to delay or put back a decision to repeal the eight amendment.

I want to make a point on that because it is a cause for concern that if people who believe in repeal are not willing to make a decision on the matter now, it suggests that later in the process, they may only give their vote for repeal if it is based on conditions being attached. According to a report in *The Irish Times* at the weekend, we learned that despite being told that every member of this committee has freedom of conscience to vote as they wish, party head offices will not allow abortion legislation which will deal with anything beyond rape and fatal foetal abnormality and possibly serious risk to health-----

Chairman: It is difficult for the witness to comment on those.

Deputy Ruth Coppinger: I am making those points because we agreed-----

Chairman: I have allowed the Deputy significant latitude

Deputy Ruth Coppinger: We agreed that matters taken in private session can be brought out in public in order that the public knows what is going on.

Chairman: They could have gone into public session.

Deputy Ruth Coppinger: I will finish on that. Some of my questions relate to abortion pills, which have changed attitudes towards abortion in this country. It is inevitable that eventually, no matter what happens on this committee, that will continue to be normalised here.

The mental health of all women who want abortions matters, and of course this is the case for women who are suicidal. Is it the case that suicide is the leading cause of direct maternal death in Ireland? In Professor O'Keane's statement, she noted that pregnancy should be a time of great joy, which is how it is often portrayed, but it is also the time when women are most likely to suffer from depression. In her presentation, Professor O'Keane noted the link where the lower a person's socio-economic status and lack of support, the higher the rate of depression. Will she expand on this? Does she think that these are some of the reasons women choose abortion?

Professor Veronica O'Keane: On the Deputy's remarks about exceptions-based legislation, there is something that is probably relevant. If the committee decides to go down a route of recommending an exceptions-based legislation, that will continue and propagate the same problems with which we have been continually dealing. With constitutional restrictions determining the law that will determine clinical practice, there is a lack of flexibility. Medical and psychiatric work is absolutely unpredictable. There could be a woman who says that she wants to have an abortion, that she wants to end the pregnancy, and then she meets a doctor who tells her that she cannot do that in this country, that they are sorry and that they will deal with it as compassionately as they can. That woman could become suicidal. Risk fluctuates very quickly. To enact legislation within a constitutional vice grip of a ban on abortion is extremely difficult.

I want to read something to the committee relating to that because it is very important, if that is okay.

Chairman: Yes.

Professor Veronica O'Keane: I do not know if this has been brought to the committee's attention. These are the official guidelines from the Department of Health for the implementation of the Protection of Life During Pregnancy Act 2013. If we go to page 1, the second paragraph begins as follows:

> The Protection of Life During Pregnancy Act 2013 was enacted in July 2013 and commenced in January 2014. The purpose of this Act is to restate the general prohibition on abortion in Ireland while regulating access to lawful termination of pregnancy in accordance with the X case and the judgment in the European Court of Human Right in the *A, B and C v Ireland* case.
>
> The Act achieves this objective in the following ways:
>
> - by providing a clear criminal prohibition on abortion.

These are the guidelines for doctors, on the first page. Any sort of legislation within an unyielding constitutional framework will not be appropriate to the sort of medical care that is practised. It does not allow for unforeseeable circumstances. Good care cannot be dictated by exceptions.

It just cannot be done. If we decided to restrict to rape, for example, would we then have to prove that every woman had been raped? What is rape? The whole thing would be very difficult. I do not know if that is any help in answering what problems could arise from replacing as opposed to repealing the eighth amendment. Medics need the eighth amendment to be repealed in order to have a free field in which we can create a legislative framework to provide the flexibility of care that is necessary in medicine to manage women in these very difficult situations.

Deputy Ruth Coppinger: In another study that Professor O'Keane did about the prevalence of rates of antenatal depression in the Irish obstetric service - it has a very long title but she knows the one I mean - she found that one in six pregnant women was depressed, which seems to be a higher rate than in other countries in the OECD. The depression got worse as the pregnancy advanced by trimester and depression was higher among poorer women with less support, issues of domestic violence and also among younger women. Does that suggest to Professor O'Keane that the stress of being pregnant is exacerbated by the illegality of abortion in Ireland?

Professor Veronica O'Keane: That is the only study that has ever been done among preg-

nant Irish women. I cannot say that because I did not ask that question, but it is a sad fact that our rates of antenatal depression are higher than in other European countries, or at least that is what our research has indicated. In response to what I think Deputy Coppinger is asking, which relates to her previous point about lower socioeconomic status and socioeconomic disadvantage, rates of depression are higher and rates of unwanted pregnancy are higher in women who are socio-economically disadvantaged. When we are looking at depression and abortion needs, we are talking about the most vulnerable people. When we are looking at people who cannot travel, we are talking about the same group of marginalised very vulnerable people. They are the people we are turning our backs on. I do think we are also treating women who have the means in a very shoddy and humiliating way, but the women who bear the brunt of the constitutional ban on abortion here are the very vulnerable women.

In relation to the study, it could be interpreted that the lack of abortion in this country or the fact that our services are de facto in another jurisdiction does lead to higher rates of unwanted pregnancies and therefore higher rates of depression, but it could also be that our perinatal psychiatry services are very underdeveloped. I know that Dr. Anthony McCarthy is coming here in the near future to give evidence in relation to that because he works directly within that service, so I will leave that to him. We are woefully under-resourced here. Colleagues from around the world are gobsmacked at the situation. When they came to the conference in March they were absolutely amazed at the lack of health care services in perinatal psychiatry in Ireland. I do think the issues are connected. I think perhaps the entire mental health area is a no-go area because we are ignoring a very big problem. Once we allow ourselves to see that there is a need, embrace it and look for pragmatic solutions I think a lot of other services will follow.

Senator Lynn Ruane: I thank Professor O'Keane for her presentation. It is a very important topic that we do not talk much about. She made a comment about the women who are left behind and that got me thinking about the women who cannot travel or who cannot access abortion, who may be in the mental health system for whatever reason in terms of the severity of their condition. Without identifying women, in my career in addiction services I have watched women with dual diagnosis. I remember one woman who wanted to access abortion very early not being able to. She was seen as presenting with addiction not having a dual diagnosis. I remember her just giving up on that. When she did continue with the pregnancy, which she did not want, I watched her fight for a long time through the courts to try to hold on to that child so she was traumatised over and over again for her mental illness. She could not win in any way. Some people have the impression that when pregnancies continue the women are glad that they did and they go off and have normal, happy lives and everything is okay. Could Professor O'Keane comment on the effects on some of those women because of how we have treated people with mental health difficulties in this country? If one has a physical illness such as cancer nobody accuses one of not being able to look after one's children but if one has a mental illness people will assume one is not capable of caring for one's children. What kind of support is there for women in that situation? Without identifying individuals could she refer to some of those women who have found themselves in that situation?

When we looked at the risk to physical health the witnesses who came in were very clear that there is no one moment in time where one can identify, regulate or create legislation for the point at which one becomes a serious risk. Because we are making no distinction between mental and physical illness, does that same principle underpin mental health in the sense that there is no moment in time when one can say a person has gone from being a minor risk to a serious risk?

Professor Veronica O'Keane: Senator Ruane has brought up a number of points. The point about the woman with dual diagnosis should not arise. If somebody is suicidal somebody is suicidal, and if they are suicidal because they are pregnant then the analysis does not have to go below that unless there is a treatable mental disorder which is making them suicidal and is not related to the pregnancy.

Situations are very complicated so I guess third hand information is very difficult to comment on, so I will talk perhaps about my own experience instead of addressing that directly. Some people have very complicated lives. They have complicated lives because they were born into situations of deprivation that are unimaginable to a lot of us. Children are neglected. They are left in dirty nappies. They are not spoken to. Nobody gets them up in the morning or puts them to bed. I have a lot of contact with Tusla because a lot of my patients were brought up like that. Of course they need psychiatric services in adulthood and of course they have difficulties parenting. It begets a cycle. If one does not have control over one's reproductive fertility or whether or not one has children, if one cannot practise responsible parenthood this situation of deprivation is going to continue. I think it is a very important societal point. If one has somebody with dual diagnosis I would say that increases rather than diminishes the risk. On the other hand, if a woman changes her mind during a pregnancy, if she initially has an unwanted pregnancy and then decides it is wanted then that wish should be respected. The same choice that pertains to choosing whether or not to continue with a pregnancy also pertains to whether or not one wants to be a parent, if one continues with a pregnancy, even if one is being forced to continue with the pregnancy. Choice is terribly important. If a woman does want to continue with a pregnancy and she is in dire circumstances, what we need to do as a society and as a medical service is to intervene with all the supports we can muster to help her. We really try to break the transgenerational transmission of deprivation by targeting young mothers who have children and who want help. It is very satisfying work, because the children benefit from it and the mothers develop great confidence in their own lives and in their abilities to mother. When we are talking about abortion, we are talking about parental care as well, and all those other services. This debate allows us to talk about issues that we could not talk about previously, such as very difficult parenting, children who were perhaps not wanted and became wanted, or children who are simply not wanted whom the State may have to provide for or for whom alternative parents may have to be found. It is a very complex area, but in my experience it is tremendously satisfying, and intervening when families are young to try to help women parents, regardless of whether those children where even considered or ever wanted, can be done. We need that as much as we need abortion services.

Senator O'Connell asked a question about how we treat younger women and girls and whether it would be appropriate to detain them in psychiatric hospitals if they are suicidal because of unwanted pregnancies. I believe that is absolutely and utterly unacceptable. The case of the 15 year old who was detained is unacceptable. I am not talking as a psychiatrist who knows anything about the case. I am talking as a citizen who is observing what has happened. Pregnant women who are suicidal because of their pregnancy should never be locked up and detained, ever. If we are stooping to that level of abandonment and putting girls in captivity who are in desperately complicated and distressing situations emotionally, we really need to look deep into our hearts. We need to move this legislation forward because it is absolutely the wrong way of doing it.

Chairman: I am trying to manage time for each individual member so I apologise if I intervene to speed things up.

Deputy Peter Fitzpatrick: I welcome Professor O'Keane to the committee. I have listened to what she has said. It is important to say at the outset that when it comes to any change to the eighth amendment, the burden of proof is squarely on those who want to see it changed and to show that change would be a good thing.

Professor Veronica O'Keane: I agree with the Deputy.

Deputy Peter Fitzpatrick: In order for the pro-choice people to make their case, they need to prove that having an abortion would be a dramatic improvement for the woman. We already know that it would be a bad thing for the baby, because the baby's life would end. There is clearly a huge amount of evidence around the world which shows that there is no real benefit to a woman's mental health from abortion, but there is evidence to show that it can have a detrimental effect on her mental health. People on the pro-choice side of the debate get very defensive in their questioning. They feel as though we cannot ask them to give us evidence on the mental health of a woman. Listening to the pro-choice campaigners, one would get the impression that the evidence shows that abortion is a good thing for the woman. It is not. Why are pro-choice people so defensive when it comes to the lack of evidence, and why do they not want to acknowledge that there is evidence to show that abortion does not benefit a woman's mental health?

Professor Veronica O'Keane: The Deputy said that there is evidence that the mental health of a woman suffers from abortion.

Deputy Peter Fitzpatrick: Yes.

Professor Veronica O'Keane: I would be interested in seeing that evidence.

Deputy Peter Fitzpatrick: Dr. David Fergusson has written a book on the topic. Has the witness read his book?

Professor Veronica O'Keane: I am aware of Dr. Fergusson's academic work, and that of Dr. Coleman. They are the two people the Deputy is going to quote.

Deputy Peter Fitzpatrick: I have only quoted Dr. Fergusson.

Professor Veronica O'Keane: They are the two studies that people who are opposed to abortion always quote, so it is very easy to predict. There are only two studies. In index No. 3 of my submission there is a document which has been written by the Academy of Medical Royal Colleges, supervised by the National Collaborating Centre for Mental Health. This document looks at literature research which identified almost 9,000 references. The body was composed of individuals hailing from many different disciplines, including obstetricians, psychiatrists and physicians. The conclusions are laid out here. Very interestingly, the Coleman-Fergusson work is specifically cited as being unscientific and not meeting the standards of other work in the area. I am not trying to become the expert here, but I am simply letting the Deputy know that the Fergusson and Coleman work is not up to par. It is not evidence. The evidence is to the contrary, being that abortion does not damage a woman's mental health. I am very happy to send the Deputy more details about that because he seems to be misinformed.

Deputy Peter Fitzpatrick: I would appreciate if the witness could read Dr. David Fergusson's book and give us her opinion on it. There are 100,000 people alive in Ireland today because of the eighth amendment.

Professor Veronica O'Keane: Sorry, I do not understand that comment.

Deputy Peter Fitzpatrick: Can I finish please?

Chairman: We will allow the Deputy to finish what he has to say, and the witness can reply.

Professor Veronica O'Keane: I apologise.

Deputy Peter Fitzpatrick: There are more than 100,000 people alive in Ireland today because of the eighth amendment. In the UK there are 190,000 abortions every year. Some 98% of those abortions take place on mental health grounds. Has the witness come across Ms Ann Furedi, who is the director of the British Pregnancy Advisory Service?

Professor Veronica O'Keane: In what way? I am aware of her work.

Deputy Peter Fitzpatrick: She is the CEO of one of the leading providers of abortion in the UK. She said, "It is not the case that the majority of women seeking abortions are necessarily at risk of damaging their mental health by continuing the pregnancy". This is significant in terms of the law. Women and men in the UK have indicated that this is the law. Will the witness discuss those comments and the current operation of the laws in the UK?

Chairman: The witness can make the point that she wanted to make a few moments ago and respond to the Deputy's question.

Professor Veronica O'Keane: I am baffled. I do not understand that statistic. I have not met anybody who is able to explain it to me in a way that makes sense to me either. I am going to move on from it. I do not understand where the Deputy found this evidence.

Deputy Peter Fitzpatrick: The statistics are there. That is the amount of people who have been saved since 1983.

Professor Veronica O'Keane: I do not understand that. Is the Deputy saying that every abortion that a woman has is potentially a life?

Deputy Peter Fitzpatrick: The restrictions in place under the eighth amendment mean that there are roughly 100,000 people alive today. In the UK there are 190,000 abortions every year. That is one in every five children. The director of the British Pregnancy Advisory Service in the UK said that 98% of abortions in the UK are down to mental issues. This lady then said that is not the case. We have good, strict laws in Ireland which have done us no harm over recent years. The last thing I would do is follow the example set by the UK. Can the witness imagine one in every five pregnancies in Ireland being aborted?

Chairman: The British advisory service to which the Deputy refers will be giving evidence to the committee in the coming weeks. I will allow Professor O'Keane to respond but time is nearly up so Professor O'Keane and Deputy Fitzpatrick should constrain themselves to a couple of comments each.

Professor Veronica O'Keane: Each?

Chairman: The witness may comment and if the Deputy wishes to respond, he may.

Professor Veronica O'Keane: That does not seem like a particularly fair division of time. I intend no disrespect but that was more of a speech than a question. I fail to------

Deputy Peter Fitzpatrick: The witness has been making speeches all evening.

Chairman: It often happens in the Oireachtas that people make statements when they should be asking questions. Unfortunately, it is not an unusual phenomenon in these parts. Please continue.

Professor Veronica O'Keane: What the Deputy has referenced is the opposite to evidence. I do not see how a vague and abstract extrapolation such as that amounts to evidence in respect of 100,000 people being alive because of the eighth amendment. As regards whether we want to go down the road the UK has, we have already done so. That is where our abortion service is. Women go to England and that is where our service is provided. I do not know if doctors in Ireland aspire to having a service similar to that available in the UK. We want a solution appropriate to our needs. We want a compassionate, woman-centred service that will address the needs of Irish women. That will inevitably involve a more liberal regime. It is not possible to make flexible legislation within the vice grip of the constitutional prohibition. The amendment did not save lives; it diverted the problem to our neighbours in the UK.

Deputy Peter Fitzpatrick: The protection of the eighth amendment has saved the lives of many people in Ireland. The last thing I want to happen is for Ireland to become the UK. I do not want every fifth child to be aborted. We have very safe rules and regulations in this country and I would love to see them protected. There is an onus on the Government to invest far more money in mental health. It has given many commitments in that area. The last thing I want to happen is for abortion to be as freely available in Ireland as it is in the UK.

Chairman: That is more a comment than a question but the witness may want to briefly respond.

Professor Veronica O'Keane: To our shame, we do not provide abortion care for women here. We are turning our back on women. We have health services but they are in a different jurisdiction and we are turning our back on those women.

Chairman: There are more witnesses coming before the committee at 4 p.m. and that is why I must be strict on time. I apologise if it seems I am cutting speakers off but there is a difficult process that needs to be managed.

Deputy Catherine Murphy: I thank the witness for her paper and her attendance. It has been very interesting. Not a day goes by without committee members learning something. On page 4 of Professor O'Keane's paper it is stated that pregnancy is associated with increases in anxiety and depressive symptoms and is the highest risk period in a woman's life for depression. That claim is referenced and it is a published work but is it the commonly held view? Is there any deviation from that view?

Professor Veronica O'Keane: It is the commonly held view.

Deputy Catherine Murphy: I wanted to ensure that is understood. I was interested by the point the witness made in respect of the US study conducted where abortion was available. She said no comparative study has been done in an area where abortion is not available. Along with several other Deputies and Senators, I attended a symposium called by the Ceann Comhairle at the beginning of the Dáil session and one of the issues raised was the deficiency in perinatal care. It was said that suicide, including post-partum suicide, is the number one cause of maternal death. Is there a comparable study on maternal suicide in countries where abortion is not available?

Professor Veronica O'Keane: No.

Deputy Catherine Murphy: There is not.

Professor Veronica O'Keane: There are no such comparable studies. Apart from very small states in Europe, Ireland is the only substantive state that does not have legal abortion services available. It is impossible to discern what the outcome of an unwanted pregnancy would be in Ireland because there is no access to abortion here. The study is a little strange. It is difficult to apply such studies to Ireland because unwanted pregnancies were examined but there was quite a bit of ambivalence in terms of the unwanted pregnancies as some of the women who had unwanted pregnancies had abortions while others had unwanted pregnancies but did not have abortions. Those were the two groups analysed in the study. In a place where there is no access to abortion, the quality of unwanted pregnancies will be different because one could not say who from a group of women with unwanted pregnancies would have gone on to have an abortion had it been available. It is not possible to do the study in an area that does not have abortion. That is my point. I am sorry if it was a bit obtuse.

Deputy Catherine Murphy: That is fine.

Professor Veronica O'Keane: We cannot replicate those findings. There are some studies in countries such as some African states that do not have abortion services or de facto abortion services in a nearby state. The studies are not highly academic because they cannot be. They have to be based on observational or empirical work rather than testing a hypothesis. However, such studies in those countries indicate that suicide occurs because of an absence of the option of abortion. However, we are in the unique situation that we cannot test any such study in Ireland. That is why colleges in the UK such as the Royal College of Psychiatrists, with which we have a very close relationship, tried to answer the question that kept being brought up in Ireland of whether there are adverse mental health outcomes from abortion. Although Ireland was not specifically mentioned, the colleges repeatedly made the point that the question cannot be answered for any country that does not have abortion services. They were very clear about that and it was very helpful of them to do that study because it has informed the debate here. That is why I was somewhat surprised when Deputy Fitzpatrick said abortion has adverse effects on women's mental health. Did Deputy Murphy ask another question?

Deputy Catherine Murphy: No, that is fine. It was regarding suicide rates.

Professor Veronica O'Keane: Another member also asked about that and I forgot to answer. Margaret Oates was the tsar of perinatal psychiatry services in the UK in 2002. At that time, suicide was the leading cause of maternal mortality there. As Deputy Murphy rightly said, that was due to post-partum psychosis, which is a very malignant disorder. It occurs in the few days following the birth of a baby. It occurs in one in 200 live births. The woman becomes very psychotic very quickly. It is considered to be a psychiatric emergency. Unfortunately, some women do not present and they kill themselves. Sometimes they kill their babies as well, very unfortunately. There was a year when maternal mortality from psychosis was the leading cause of maternal death but, to the best of my knowledge, in more recent years it has been cardiac disease that has been the leading cause of maternal death. Psychiatry and suicide is up there among the top three. It is second or third, but not the leading cause, to the best of my knowledge.

Chairman: I call Deputy Durkan, who has six minutes altogether.

Deputy Bernard J. Durkan: I thank Professor O'Keane for her very interesting submission. I want to ask about studies. In the case of the determination of an unwanted pregnancy or a crisis pregnancy, is there a difference between the two? I ask Professor O'Keane to comment on this. In relation to women who have had to avail of abortion outside the State, what studies have been done on the particular psychological effects of the abortion afterwards? What extent of counselling is available? Is counselling available? I know I have asked this question of other people who have come before the committee. What does the abortion service in the UK normally provide to its own citizens? Does it provide counselling? Does it provide support or advice? To what extent is that advice and support available to Irish women who have to go to the UK for an intervention in pregnancy?

Chairman: Does Deputy Durkan want to let Professor O'Keane answer answer that much, as there is quite a bit in it.

Professor Veronica O'Keane: A crisis pregnancy is an unplanned pregnancy, as such. A crisis pregnancy can evolve into a wanted pregnancy, where a pregnancy was not timed correctly but it is ultimately wanted, but it can develop into an unwanted pregnancy, where the woman does not want to be pregnant - it was not planned, it was a crisis and it progressed to being unwanted. That would differ from a crisis pregnancy, which is a more ambivalent state. As I said, crisis pregnancies can go on to become wanted pregnancies, and that is not an issue as obviously we do not have a problem. Is that okay?

Deputy Bernard J. Durkan: Yes.

Professor Veronica O'Keane: The Deputy's second question was about what counselling services were available. Irish women, when they go for abortions, are given what is called counselling beforehand, and really, that is a process of informed consent that is common to all medical procedures that are undertaken. If I start people on medication I would obviously tell them what it is, how it works, what the side-effects would be and what the consequences would be if, for example, they were to get pregnant. An abortion is like any other medical procedure. We have to talk about the consequences of having it and the possible risks involved. Counselling at a more in-depth emotional level is not always, in practice, something that is done. It will be done, obviously, if there is a need for it. Irish women who go across to the UK leave within 24 hours of having had the procedure, and they are usually quite unwell, or at least in a very delicate position and situation, and they are in pain. I guess they do not get counselling before they leave the UK and they do not go back there for counselling.

On the GP care that is provided here, GPs provide counselling care but, unfortunately, there is no proper training for abortion care in Ireland. There is training for the procedures that are used because essentially some forms of surgical abortion are the same as procedures that would be done, for example, for difficult menstruation problems or for retained products of conception, so while there is procedural training, there is not necessarily explicit training in relation to having had an abortion, which is a different emotional issue, obviously, to having the contents of a uterus evacuated. If we are looking to have abortion services in Ireland, and the Deputy made reference to this, counselling would have to be a part of it, but I do not think it is always necessary. I do not think women always need counselling. Some women are quite clear about what they want to do, and it is not necessarily a very complex or a very heartrending difficult problem for them. Obviously, for a lot of women it is very complicated and where counselling is required it should be, obviously, embedded into services and it needs to be. There is no specific counselling for such women when they come home, but GPs are very creative and they are used to dealing with this problem.

Deputy Bernard J. Durkan: The second part of the question is related to residents of the UK and a comparison with the support services. What is the difference there? I will add onto this, if I might, a couple of other questions, which I might be able to get through if I can, and if not the Chairman might let me back in some time in the not too distant future.

Chairman: I am already allowing the Deputy a little extra time.

Deputy Bernard J. Durkan: I knew the Chairman would and I thank her. Not all European countries have similar unrestricted access to abortion facilities. The UK is one of the least restrictive, in comparison to Germany, where there is fairly extensive counselling before and after. I would like Professor O'Keane's comments on this. My final point, among many, is if a woman has a miscarriage, very often she requires counselling. It is a normal and natural thing and we have all read about it and the lack of counselling on some occasions. How would Professor O'Keane compare the need for counselling following a miscarriage with the need for counselling following an abortion?

Professor Veronica O'Keane: The need for counselling will be determined by the woman who has had the experience. Obviously, as the Deputy said very rightly, miscarriage can be a terrible tragedy for some women, and particularly a late miscarriage is devastating. If a woman is devastated she will need counselling. In a similar vein, we may have a woman who had a very early abortion who is not devastated. All of our medical services and psychiatric services are there to respond to need, so we need to have counselling and psychiatry embedded within our obstetric services, and that is something that is going to happen in the future, but if we are planning to legislate for abortion the Deputy is absolutely correct that we need a model whereby counselling services are available prior to and following procedures. We should not discriminate between whether that is an abortion or a miscarriage. There are counselling procedures in place for women who have late miscarriages or stillbirths. They are established in the three maternity hospitals. We need to expand the range of counselling services for abortion and earlier miscarriages. Again, I would say medical services should be responsive to need, and we need to build it in.

Deputy Clare Daly: I thank Professor O'Keane for coming in. I know we are pushed for time but I have a couple of quick questions. Professor O'Keane was correct to pinpoint the Citizens' Assembly clearly stating there should not be a distinction between physical and mental health. The irony is, of course, the Protection of Life During Pregnancy Act very much makes that distinction, in that it puts up incredibly onerous provisions in relation to mental health access *vis-à-vis* physical. I wonder, as a medical professional, in terms of the regulatory or legal environment to allow her to do her job properly, in terms of our job of work, if there is any advice Professor O'Keane could give us as to how she sees us treating this, or the best way forward for her to deal with it.

Professor Veronica O'Keane: That is a really pragmatic question. I cannot represent my profession before the committee today; I am simply an individual. However, there are general principles that apply to this as they apply to all of medicine, and it is worth repeating them.

Risk is unpredictable, especially risk where someone is in a situation of extreme emotional vulnerability. Such a woman is vulnerable because she is pregnant and because she has an unwanted pregnancy. If she is looking for abortion care, she is vulnerable because she is going down a pathway in which she will absolutely need support, although it is an autonomous decision. Such a woman ought to have care provided to her on that journey, including counselling and care for whatever other psychological requirements she may have. We need a framework

that is not restrictive - that is the main principle. We need something that will allow clinicians to practise flexible best practices. A clinician cannot practice good medicine with a document like the one in my hand standing over her. A clinician cannot practice good medicine by saying to a woman in every second sentence that she can do something but she should bear in mind that there is a constitutional prohibition. A clinician working in a very circumscribed and highly legalised area where she has to get three, four or five opinions is the polar opposite to what we require. For doctors to practise, we need the prohibition to be removed from the Constitution. We need repeal of the eighth amendment. Then, we need flexible legislation that will reflect the unpredictability and unforeseeable situations that arise in clinical practice.

Pathways cannot be exact. The idea that a woman can walk into any psychiatrist or doctor and then be referred to three specialists within 24 hours and have a legal termination within a few days does not work. It simply does not work like that. We must have a legal framework that will free us and liberate us to practise medicine and psychiatry. At the moment we are working against obstacles. It is an obstacle race that we are trying to negotiate.

Deputy Clare Daly: I think that is helpful. The need for flexibility has been a theme we have heard from other medical practitioners. This is something that comes up at all of our meetings. It is related to the whole area of criminalisation, which impacts on psychiatrists as professionals. Can Professor O'Keane advise on the mental health impact on women and, potentially, doctors based on her expertise? We know criminalisation does not stop abortion. Is there a quantifiable impact in terms of stigma, isolation, shame and the negative impact these can have? Can Professor O'Keane expand on some of those points? Can we quantify them in any way?

Professor Veronica O'Keane: It is evident in the way that my psychiatrist colleagues have responded to the legislation. Doctors are not immune from discrimination or from feeling the stigma that abortion care brings with it in a country like this, where there is a constitutional ban.

Deputy Clare Daly: What about the effect on women themselves?

Professor Veronica O'Keane: I understand that, but I have to make the point that the constitutional ban in place creates stigma for people who are practising medicine as well. I believe my colleagues are terrified. They are terrified of the narrow rigid legal framework that they are being told they have to practise within or else what they do will be a criminal offence. We all know the maximum sentence is 14 years. That is the position for doctors. That restricts medical practice. There is the chilling effect that everyone refers to.

The discrimination and stigma facing the women is deeply regrettable and hurtful and it creates unnecessary suffering. Suffering is inherent in life. I work in a profession where people develop psychotic illness in their late teenage years and their lives are changed. The whole trajectory of the family life is changed as well, and that is a tragedy. What we want to do is, as Hippocrates said, prevent unnecessary suffering. Yet, we are creating unnecessary suffering in trying to work within the system that we are working within at the moment. It is creating unnecessary suffering in women.

Women are sitting in airports feeling the shame. I believe we all feel the shame, as I said in my opening statement. I think it is shameful too. One thing will always remain with me. I recall when I walked through an outpatient clinic. RTE Radio was reporting there on the tribunal into the care that Savita Halappanavar had received in University Hospital Galway. I was absolutely shocked and terribly distressed to hear the RTE presenter talking about intimate gynaecological details in a room full of patients. There were so many levels to it. On one level

I was the doctor and the patients knew I was the doctor. At that level there was violation of the sacred trust between doctor and patient. It was violation of the most intimate of intimate things that many women would not share with a best friend, mother or sister. Yet it was there being broadcast. We were listening to all of that – I think that is shameful.

We need to move it from a legal constitutional framework into a medical clinic, which is where it belongs. Stigma is a really important mental health issue and is central in the whole problem that this committee is trying to resolve. I wish the committee members all the very best in their work.

Chairman: We still have next week – we are not finished yet.

Deputy Jan O'Sullivan: Deputy Daly covered some of what I wanted to ask, so I will be quick. Professor O'Keane has said to us clearly that Article 40.3.3o should be taken out of the Constitution. If I understand her correctly, she believes it should be dealt with on the basis of a health issue and health provision rather than the criminal law. I gather that is a correct interpretation. It is helpful for us to hear that from Professor O'Keane.

I would like to go back to a related issue. I am unsure whether the number is correct, but let us suppose there are ten people per day going to Britain and five people taking pills each day. Earlier, Professor O'Keane described the other women-----

Professor Veronica O'Keane: They are left behind.

Deputy Jan O'Sullivan: She described them, understandably, as the women left behind. I was particularly taken by the women who did not have the knowledge or access to information as well as those who did not have the money. There is a money element to the pills as well as for travelling to Britain. Let us consider these women. To what extent would it help if we changed the atmosphere? Professor O'Keane said that we can talk about it now. We certainly could not talk about it clearly in 1983. I was one of those who were around at the time. What can we do to allow those women to come earlier or to be able to access pills earlier rather than have to contemplate a later abortion? How can we deal with that?

As a practising perinatal psychologist, can Professor O'Keane advise on abortion pills? Can she tell women about how to access them? Is she precluded? Does the eighth amendment stop her in that regard? Can Professor O'Keane give us some clarity on that?

Professor Veronica O'Keane: The two questions are linked. They are related to the women who are left behind. For many of my more seriously ill patients with whom we develop long-term relationships, we are like their family. If they need to fill out a form for social welfare, our social worker helps them to fill out the form. If they are trying to get back to work or do courses, our occupational therapist will help them. The allied mental health professionals work with individuals with serious mental health problems and advise them in different areas of their lives. We cannot advise them in this area. The Deputy is absolutely correct because we are prohibited from helping anyone to procure an abortion. I absolutely cannot tell anybody about how to procure pills. None of us can because it is against the law. We are not allowed to help anyone to procure an abortion and nobody here is allowed to procure an abortion. Yes, it is breaking the law and that has been laid down very clearly in the Protection of Life During Pregnancy Act.

I guess that answers the question as to why in situations where very vulnerable women want abortions, they need the same help they would require if they wanted to look for a dis-

ability allowance or to do anything else in their lives; they are very dependent on us. They live independent lives that are as autonomous as they can possibly be within the limitations of their handicaps. Our ideal is to maximise their autonomy, but they need a lot of support. We cannot support them in this area because we are prohibited from doing so. We are prohibited from doing so because there is a constitutional ban on abortion. We are legally prohibited from doing it because it is against the law, with a sentence of up to 14 years applying. That is very regrettable because in situations like this we are not able to practise medicine as we ought to be practising it, namely, by helping and facilitating our patients to live their lives. It is very difficult for them.

Senator Paul Gavan: The good news is that most of the questions I wanted to ask have been posed and I only have one left. I thank Professor O'Keane for her excellent presentation, which was full of facts and evidence. That is what all of us want to hear. The line that resonates with me most is the one she repeated a moment ago to the effect that the mental health of everybody in Ireland is being damaged by the eighth amendment. I remember campaigning against the amendment in 1983. We need to remember that, at that time, the State was still locking women up when they were pregnant. They were being locked up in the Good Shepherd Convent in Limerick, next door to where I lived when I was a student. Those were the times in which we lived. This amendment is a vestige of that dark culture of hiding everything away, particularly in the context of women. That is the end of the speech.

We heard about rogue agencies, counselling agencies that were not actually offering non-directive counselling but counselling to persuade women one way, namely, to not have terminations. Has Professor O'Keane come across people who have had access to those rogue agencies and, if so, what was the impact on the mental health of those individuals?

Professor Veronica O'Keane: I actually have not had direct contact with somebody. The Senator raises a very important point, namely, that counselling in this area should be completely non-directive. We should support whatever a woman wants to do. The trickiest situations are those in which women do not know what they want to do. They continue through with the pregnancy feeling ambivalent and wondering if they will want the child when it is born. The more ambivalence that is there, the more support women need. We need to direct a considerable amount of our mental health resources to the area of unwanted pregnancies. If women choose to have abortions, that resolves the issue, if the Senator sees what I mean. The situation we are in now, whereby women who choose that they do not want to have a baby and they cannot have a baby, creates a whole set of problems. Non-directive counselling within a framework where we have abortion services available is definitely at the heart of good practice.

Deputy Billy Kelleher: I thank Professor O'Keane for her presentation. We meet again; we soldiered through during the debate in advance of the Protection of Life During Pregnancy Bill in 2013.

One could argue that life is never black and white; it is grey and messy. Human relationships are complex and all of that. The Protection of Life During Pregnancy Act exists because of a very blunt instrument in the middle of the Constitution, that is, the eighth amendment. During the debates that resulted in the passage of the Protection of Life During Pregnancy Bill, some outlandish claims were made to the effect that there would be queues of women claiming to be suicidal in order to try to procure abortions. Some of the insinuations in that debate were quite hurtful.

The Protection of Life During Pregnancy Act introduced monitoring systems. In 2015, a total of 14 terminations were carried out under the Act because of a real and substantial risk to

the life of the woman due to physical illness. There were nine emergency terminations carried out due to an immediate risk to the life of the woman because of physical illness and there were three because of suicidal intent. Would the professor agree that because only three terminations were carried out in 2015 on foot of suicidal intent, it is clear that many distressed women are still going abroad in very agitated states? From a clinical point of view, where does that leave psychiatrists, psychologists, GPs and clinicians in general in terms of allowing a patient with her files under her arm and in a very distressed state to go an airport and travel abroad to have a termination carried out in another jurisdiction? Where does that leave Professor O'Keane and her colleagues in terms of their ability to care for a patient, either in advance or on her return? Does it put them in a very difficult position in that they cannot counsel or advise patients that a termination may resolve their suicidal intent?

Professor Veronica O'Keane: I thank the Deputy for his questions. He is absolutely right. There have been three annual reports following the introduction of the Protection of Life During Pregnancy Act showing that three women with suicidal intent had the procedure in 2014, three in 2015 and one in 2016. I might have mentioned earlier that my view is that the women who are suicidal and who can travel are going to England. Why would they not? Why would anybody with the means stay here to be subjected to an inquisition before three specialists. Senior specialists are intimidating people. They usually do not live in the same place. They are interrupting their normal routine and such appointments will not usually be during working hours. It is a very difficult process. Why would people subject themselves to that when they can go to the UK? Going to the UK is shameful but a woman subjecting herself to that sort of repeated questioning is soul-destroying and humiliating.

The Deputy is absolutely right; many women are saying, "I'm distressed and potentially suicidal if I don't get this abortion. I'm leaving; I'm out of here." It is the women who cannot travel who become suicidal because they cannot do so. We are actually creating suicidal women and we are creating desperate women by means of this constitutional clamp. I wonder if we would have so many difficulties and so many tragedies regarding abortion if we did not have this clamp. Would situations escalate so quickly? I do not think they would.

That is one point. What was the Deputy's other question?

Deputy Billy Kelleher: I will just continue on from that and we will leave it there because time is of the essence.

It is clear from what Professor O'Keane said that the process under the Protection of Life During Pregnancy Act is very cumbersome and is certainly a deterrent to people, particularly as it involves two psychiatrists and an obstetrician, I think-----

Professor Veronica O'Keane: Yes.

Deputy Billy Kelleher: -----after referral by another clinician. I refer also to the fact that a woman has to go abroad for a termination. There is obviously a cohort of women in this country who have not the capability or financial means to organise travel. Among both the indigenous population and the migrant community, in particular, there is a strong emphasis on religious culture, and they have views on abortion. Is there a cohort of women who are completely unable to gain access to any form of help or support because the Protection of Life During Pregnancy Act is too cumbersome, because they do not know about it or because England is just too far away?

Professor Veronica O'Keane: Migrant women have all the vulnerabilities. A migrant woman with an unwanted pregnancy represents a case full of all the vulnerabilities. She is not Irish and probably does not have an Irish passport, although she may be at a point where she does. If she is in direct provision, she certainly does not have any financial means whatsoever. I treated women in the United Kingdom who had been raped in wars and who gave birth secretly because their families would have rejected them had they known they were pregnant, even though the pregnancies were forced and, unfortunately, the result of war crimes.

Women live desperate lives sometimes. There are sub-communities, and there are sub-communities in our own culture in which abortion is utterly unacceptable. If the women in question were living in a more compassionate state, their difficulties might not be as extreme. It arises sometimes in psychiatry that families do not believe in psychosis, for example. We are there to help the patient, however, so we can bring in those families and talk to them. We can explain the circumstances to them and give them the education they might never have received. One wins people around and educates them, and things move on. In this situation, however, there is no possibility of helping the woman who is stranded by her culture and by the absence of services. There is no way of pulling her to safety. Therefore, the absence of services within Ireland particularly affects the women in question.

Deputy Mattie McGrath: Professor O'Keane made an extraordinary statement in her opening remarks, to my mind in any event, when she said, "I would go further and say that the mental health of everybody in Ireland is being damaged by the eighth amendment". Is this a medical opinion or has the professor carried out research, backing up this conjecture, that has assessed the mental health of every person in Ireland? Does she at least have an inclusive representative group? If not, I presume the professor's opinion is a political rather than a medical one. What about the 80,000 people who marched in this city not so long ago, not far from this building, to retain the eighth amendment?

Chairman: Does Professor O'Keane wish to respond to that?

Deputy Mattie McGrath: I do not mind.

Professor Veronica O'Keane: I was asked to come to the Oireachtas as a specialist in mental health. This is a national issue. This is the place where the laws are made and where our legislation is discussed. I am giving an opinion as a mental health specialist and I believed that was the reason I was invited here. On the question as to whether my remark was based on a methodologically driven study, the answer is, "Absolutely not." Much of what I have said here today is based on my own experience and contacts I have had with people who have been in desperate situations. I have made that very clear.

Deputy Mattie McGrath: I thank Professor O'Keane for that. Her statement was very sweeping and I was alarmed by it. I thank the professor for clarifying that it is her own opinion. Would she outlaw gendercide where a woman may seek to abort her baby simply because the baby she is carrying is a girl?

Professor Veronica O'Keane: Sorry, that is way outside my remit.

Chairman: That is probably not a question for a psychiatrist.

Deputy Mattie McGrath: Is it not?

Chairman: It is, perhaps, one for another individual. The professor is a psychiatrist-----

Deputy Mattie McGrath: I accept that. I am asking the questions. I am entitled to ask.

Chairman: Of course. I believe Professor O'Keane has indicated that-----

(Interruptions).

Chairman: Could we allow Deputy Mattie McGrath to proceed, without interruption?

Deputy Mattie McGrath: This is the usual banter we get. This is why the people outside are so annoyed. We cannot ask our questions. I did not interrupt anybody.

Chairman: As Chair, I am trying to protect the Deputy.

Deputy Mattie McGrath: Could we have a small bit of decorum, please?

To follow on from my question, according to an article in *The Economist* in 2010 this practice has led to a massively skewed sex ratio in China, India, Taiwan, Singapore and elsewhere. The head of the British Pregnancy Advisory Service, BPAS, has said it should be legalised in Britain because women should be free to make the choice. I refer to a baby being aborted simply because she is a girl. Does Professor O'Keane agree with BPAS or would she outlaw sex-selection abortion?

Professor Veronica O'Keane: I have already made it clear to Deputy Mattie McGrath that this is way outside my area of expertise. I feel uncomfortable that this question is even being put to me. I am not going to comment on it.

Chairman: That is perfectly fine.

Deputy Mattie McGrath: The professor may feel uncomfortable but I am entitled to ask the questions. We had a sweeping statement that everybody's mental health is affected by the eighth amendment. I was very uncomfortable with that. Thousands of people in the country are very uncomfortable about it.

Professor O'Keane stated that she is not representing her profession here today and that her views on all the questions are personal.

Professor Veronica O'Keane: Could I ask the Deputy a question?

Deputy Mattie McGrath: No, I am here to ask questions. Could I get an answer to my question please? Professor O'Keane can ask me a question any time.

Chairman: She can answer with-----

Deputy Mattie McGrath: But if she does not want to answer the questions-----

Chairman: She might wish to clarify something.

Deputy Mattie McGrath: We were to have Professor Casey here today. She is also a very eminent psychiatrist. Her letter was not read into the record by the Chairman.

Chairman: Sorry, Deputy-----

Deputy Mattie McGrath: I am making this point because I asked during private session to have the letter read into the public record. That should have happened because Professor Casey had elaborated on many views that are the opposite of those of Professor O'Keane.

Chairman: This actually proves the point that it is a pity that she did not attend.

Deputy Mattie McGrath: When?

Chairman: I am disappointed she did not attend.

Deputy Mattie McGrath: I am sorry.

Chairman: If she were here, she would be able to make the points the Deputy would like her to make. There is no facility for me, under the rules of the Houses, to read a letter into the record for a witness who did not appear.

Deputy Mattie McGrath: But the Chairman has done-----

Chairman: Clarification is a different matter.

Deputy Mattie McGrath: The Chairman has read other statements into the public record.

Chairman: Only clarifications.

Deputy Mattie McGrath: I had to read my own correction last week; the Chairman refused to read it. We know how biased the committee is. We know the way it is treating the people and we know what is happening.

Chairman: That is completely unfair.

Deputy Mattie McGrath: It is not; it is very true.

Chairman: I have only read points of clarification into the record up to this point.

Deputy Mattie McGrath: I wrote to the Chairman to ask her to read a clarification from my good self and she did not allow it. She said I would have to read it myself.

Chairman: The Deputy wrote to the CPP, about which I only heard a rumour,-----

Deputy Mattie McGrath: I did not-----

Chairman: -----and I will address that matter.

Deputy Mattie McGrath: That is another issue. That is about something else. I read the clarification last week because the Chairman did not do so when I wrote to her requesting that she read it.

Chairman: It is probably inappropriate to challenge me on this point while there is a witness present and when we are asking questions. The Deputy should, by all means, take this point up with me at another time.

Deputy Mattie McGrath: On that point, I offered last week to listen to our three witnesses before I read the clarification. I am not being unfair to anybody. Let us be fair. I am just making the point that we have heard from Professor Patricia Casey, a very eminent psychiatrist, and she asked that her letter be read into the public record here.

Chairman: On a further point of clarification, the Deputy wrote to me in his capacity as a member of the committee. That is a different from a witness writing to me to make a point of clarification.

Deputy Mattie McGrath: Whatever. All I want is fair play and a hearing.

Chairman: The Deputy is here to make clarifications like the one he has just made now.

Deputy Mattie McGrath: I also asked the Chairman to look at a short video-----

Chairman: And I did.

Deputy Mattie McGrath: -----of an animated abortion. That did not happen either.

Senator Paul Gavan: How are the Deputy's six minutes going?

Chairman: We are not quite at six minutes.

Deputy Mattie McGrath: There are constant, ignorant interruptions from people-----

Chairman: Excuse me. Could we have order please?

Deputy Mattie McGrath: -----who will not tell us where Jean McConville was murdered or her body hidden. Her family-----

Chairman: Deputy-----

Deputy Mattie McGrath: The Senator talks so much about Limerick. There are double standards at this committee. That is the double standard we are dealing with from Sinn Féin,-----

Chairman: Listen-----

Deputy Mattie McGrath: -----which will not tell us where a woman with 12 or 13 children who was abducted-----

Chairman: The Deputy should respect the Chair.

Deputy Mattie McGrath: -----and then the Senator talks about a home in Limerick.

Chairman: I do not mean me necessarily, but the office I hold.

Deputy Mattie McGrath: These facts are unpalatable.

Chairman: Deputy-----

Deputy Mattie McGrath: I am respecting the Chair.

Chairman: I thank the Deputy. I will move on to the next questioner, Deputy Rabbitte.

Deputy Anne Rabbitte: Sorry, I was-----

Deputy Jonathan O'Brien: Mesmerised.

Deputy Anne Rabbitte: I am speechless.

Deputy Mattie McGrath: Excuse me, I want the remark to the effect that I mesmerised somebody to be withdrawn. I am stating what I believe.

Deputy Jonathan O'Brien: The Deputy mesmerised me.

Deputy Mattie McGrath: I want that retracted please.

Deputy Jonathan O'Brien: I cannot withdraw from the fact that the Deputy mesmerised me with his contribution.

Deputy Mattie McGrath: I want that retracted please.

Chairman: Sorry, the Deputy-----

Deputy Mattie McGrath: I am entitled to come in here to speak. Or am I? Do other members want us to leave this committee completely, like we threatened to? We will have to, if they continue. I want that retracted. I do not believe I mesmerised anybody. I am stating the facts.

Chairman: Various comments have been thrown across the Chamber.

Deputy Mattie McGrath: I did not throw anything at anybody across it.

Chairman: I am not saying that Deputy Mattie McGrath did. I am only saying that various comments have been thrown around the place and there is no benefit. No good can come from this sort of thing.

Deputy Mattie McGrath: Senator Noone has been here a long time now chairing the committee. She should have learned at this stage we cannot have this sideshow and these kind of snide attempts to undermine us.

Chairman: What sideshow?

Deputy Mattie McGrath: I asked the Chairman about Deputy O'Connell's remarks before and she ignored it. I had to go to the Committee on Procedures and Privileges and now this is going on again. Are we having a committee or is it just a charade?

Chairman: Deputy-----

Deputy Mattie McGrath: It is a charade. I want it withdrawn that I mesmerised anybody.

Chairman: Deputy, I understand your frustration-----

Deputy Mattie McGrath: I want that withdrawn. Senator Noone is in the Chair.

Chairman: -----that the professor did not attend today.

Deputy Mattie McGrath: I am not talking about that.

Chairman: I understand Deputy Mattie McGrath's frustration about that but these are all wider issues.

Deputy Mattie McGrath: I am talking about a statement that has been made by Deputy O'Brien that I mesmerised members of the committee.

Deputy Jonathan O'Brien: I said Deputy Mattie McGrath mesmerised me.

Chairman: I cannot control how members-----

Deputy Mattie McGrath: The Chairman does not want to control-----

Chairman: No, no.

Deputy Mattie McGrath: -----because she is totally biased. I am leaving this charade right now, for today anyway. I am exposing what it is. It has been a total absolute charade, from the start. The Chairman sat at a meeting in England last week again, trying to get people over here to talk about bringing abortion into Ireland in the middle of this committee.

Senator Lynn Ruane: The Chairman needs to do something about Deputy Mattie McGrath standing up and pointing his finger at the Chair. Deputy Mattie McGrath is so disrespectful. The Deputy is standing and shouting across at the Chairman.

Deputy Mattie McGrath: I am making my point that it is a charade and Senator Ruane is part of the charade.

Senator Lynn Ruane: It is not on.

Deputy Mattie McGrath: We can see the charade.

Senator Lynn Ruane: It is not on. Everybody is here trying to do their work and trying to engage with the witness, and it is absolutely unbelievable.

Chairman: If it is Deputy Mattie McGrath's choice to leave, I would be grateful if he did.

Deputy Mattie McGrath: I will leave but I want that record corrected.

Deputy Billy Kelleher: "Mesmerised" is not an offensive word. The definition is, "capture the complete attention of someone, transfix".

Chairman: Sorry, can we have some order in the room?

Deputy Catherine Murphy: If Deputy Mattie McGrath chooses to accuse the Chair of being biased, I do not believe in silence as consensus. I do not subscribe to the Chair being biased. I do not see any bias.

Chairman: I call Deputy Rabbitte.

Deputy Anne Rabbitte: I thank Professor O'Keane. I am sorry I missed some of the professor's presentation but I have read it. I will not apologise for anybody who has spoken in the last few moments but it was not proper or appropriate that one of our guests would be spoken to in such a manner or had to witness it, but I will continue.

The questions I had prepared for Professor O'Keane are as follows. We have heard in previous sessions about the difficulty of quantifying risk and serious risk in respect of physical health. Is it possible to quantify risk or serious risk in relation to mental health? That is one of my questions. Will I ask the two questions together?

Chairman: Yes.

Deputy Anne Rabbitte: Professor O'Keane outlined the negative impact that maternal mental health issues can have on a child's development in the womb and after birth. Are these issues of maternal mental health being properly addressed in Ireland at present and if not, how can we do better?

Professor Veronica O'Keane: The first issue of risk - Deputy Rabbitte has put her finger on the button there - is very difficult to evaluate. It is unpredictable because risk can change very quickly. I have outlined - I do not want to repeat too much - that women who are pregnant

are vulnerable emotionally, because of what is happening to them but also because physiologically the gestational hormones alter the emotional centres in one's brain. Anxiety symptoms and depressive symptoms are much more common, even from women who do not suffer from depression, when women are pregnant. There is this vulnerable background. In such situations, what might not be something tremendously challenging can become something tremendously challenging. Amplification can occur in terms of emotional responses. Psychiatric presentations can be unpredictable and unforeseeable and that is because of the nature of the pregnant female brain. We need to allow for that. That is why I really liked the recommendations of the Citizens' Assembly. Although almost 100% - it was 95% - recommended that abortion be available for women who are at risk of suicide, almost 80% stated that abortion should be available for women whose health was at risk so that the range between the highest risk and the lowest risk was only 20%. That is a narrow range. That reflects the unforeseeable fluctuations that can occur. Risk cannot be gauged rigidly. It cannot be fixed. That is important for the legislators to understand in terms of mental health problems that might arise.

The second issue Deputy Rabbitte asked about was maternal mental health. I guess it is broader than maternal mental health services. It is women's mental health because if women choose to have abortions then it is not really maternal mental health. We need to see women's mental health. The National Women's Council of Ireland has been lobbying for this for quite a long time. Its phrase is gender-sensitive mental health services or health services. That is a very good way of looking at it because there are some issues that are very sensitive to one's gender. Of course, reproductive health care is one of those areas. The services are bad at present but clinicians and the leaders within the health care systems are all working hard to improve services and to improve the delivery of services. I suppose the national maternity strategy has had a sluggish start with a little bit of remonstrating, but the mental health services are very much an intrinsic part of the services that will be developed now.

In psychiatry as well, there is the area of perinatal psychiatry. I do not want to go into Dr. Anthony McCarthy's territory. He will be talking about that and I do not want to duplicate any information that the committee might be given. Dr. McCarthy will address that for the committee in a fuller sense. Is that okay?

Deputy Anne Rabbitte: I thank Professor O'Keane.

Chairman: I thank Professor O'Keane for attending here today. We really appreciate her time and the care that she gave in answering all of the questions that the members have asked. We might just take a five-minute break.

Professor Veronica O'Keane: I would just like to say that I have been very impressed by the Chair's skills.

Chairman: I thank Professor O'Keane.

Sitting suspended at 4.27 p.m. and resumed at 4.36 p.m.

Termination Arising From Rape: Mr. Tom O'Malley, NUI Galway; Dublin Rape Crisis Centre; and Dr. Maeve Eogan, Rotunda Hospital

Chairman: We are now in public session. I welcome members and those who may be viewing at home back to this meeting. On the behalf of the committee I extend a warm welcome

to our witnesses for the second session of this afternoon's meeting in which we will address termination arising from rape. I welcome Mr. Tom O'Malley, SC, senior lecturer in law, NUI Galway; Ms Noeline Blackwell, chief executive officer, and Ms Angela McCarthy, head of clinical services, Dublin Rape Crisis Centre; and Dr. Maeve Eogan, consultant obstetrician and gynaecologist, Rotunda Hospital. I have already read the statement on the Defamation Act 2009 and on privilege. Are the witnesses all aware of the implications of this? I can read it again if they need me to.

I now call on Dr. Eogan to make her presentation.

Dr. Maeve Eogan: I thank the Chairman and the committee for inviting me to speak today. I am a consultant obstetrician and gynaecologist at the Rotunda Hospital but have been invited before this committee in my capacity as medical director of the hospital's sexual assault treatment unit, SATU, as well as the national sexual assault treatment unit. As we know, sexual violence occurs in all cultures and countries, with a range of epidemiological studies recording a far higher prevalence than previously thought. There is no "typical victim"; there is no "typical scenario". In the Irish context, as summarised in the Sexual Abuse and Violence in Ireland, SAVI, report, of which there has been much discussion in recent weeks, more than four in ten or 42% of women have reported some form of sexual abuse or assault in their lifetime. The most serious form of abuse, penetrative abuse, was experienced by 10% of women.

We know that disclosure of sexual violence enables the patient to get access to the medical and psychological care that they need, as well as facilitating commencement of a judicial investigation if the person chooses to engage with the criminal justice system. Both national and international data, however, highlight that for a broad range of reasons including self-blame, shame, fear of judgment and lack of information, many people who experience sexual violence never tell anyone about it. Almost half of those who disclosed a history of sexual abuse or assault in the SAVI survey, for example, had never previously disclosed it to anyone. Notwithstanding that, if someone is going to disclose sexual violence, it is very important to facilitate them to do so as soon as possible after the incident. Doing so enables appropriate provision of care, as well as the collection of relevant forensic evidence, including DNA evidence. It is hoped that provision of early responsive care may reduce the short-term and long-term physical and psychological effects of sexual violence. To respond to this need, this country has six sexual assault treatment units, SATUs, to provide care to men and women over the age of 14 years who disclose sexual violence. These are located in Dublin, Cork, Waterford, Mullingar, Galway and Letterkenny and they aim to provide responsive care 24 hours a day, seven days a week. In addition there is a service in Limerick which provides out-of-hours care only. Each SATU is staffed by clinical nurse and midwife specialists and doctors trained in sexual assault forensic examination. Since 2009, we have collated national data for key service activities within the SATU. In 2016 more than 700 men and women attended SATU services.

SATU staff work collaboratively with allied agencies, including An Garda Síochána, Forensic Science Ireland, Rape Crisis Centres and Rape Crisis Network Ireland, paediatric forensic medical services and the Office of the Director of Public Prosecutions who together form the sexual assault response services. This group has developed national guidelines and aims to provide responsive patient care as espoused by our mission, vision and working philosophy.

As with my presentation to the Citizens' Assembly earlier in 2017, I am not presenting anonymised cases to assist deliberation and discussion. While any cases we discuss would be anonymous to us, a survivor of sexual violence may recognise themselves in the scenario and in that context they may feel re-victimised. For this reason I offer a fact-based overview and I

will address questions.

When a patient discloses a recent incident of sexual violence and wishes to receive care in this regard, they have three options, which are explained to the patient in detail, and informed consent is obtained. Option number one allows access to prompt and thorough investigation of the incident and is most frequently chosen. This involves the patient reporting the incident to An Garda Síochána, who brings them to a SATU. The patient receives comprehensive medical care, including preventative treatment for infectious diseases and emergency contraception, psychological and forensic care from the allied rape crisis centre. Injuries are documented and treated and appropriate intimate and non-intimate samples are taken.

If the person chooses not to engage with An Garda Síochána and not to report the incident, he or she can attend the SATU to avail of a health check. In that context the person can still receive medical care, including emergency contraception and infectious disease prophylaxis. He or she can also receive psychological care, but without reporting the incident to An Garda Síochána. If the person chooses this option and subsequently changes their mind, the opportunity to take time-sensitive forensic samples may have passed, which could compromise potential prosecution. Because of Children First guidelines this option is only available to those persons over the age of 18. Because the opportunity to take forensic samples may be lost when a person chooses to not report, in 2016 we introduced the option of storage of evidence. Again, this is for patients over 18 years of age who are undecided whether or not to report to An Garda Síochána. They receive a health check and medical in the SATU, forensic samples are taken and stored within the SATU for a period of up to one year. With this option patients will also receive emergency contraception.

It is clear from this summary of care options that regardless of which option the patient chooses in terms of reporting the incident, she will be offered emergency contraception, which is successful in preventing pregnancy in the majority of patients if provided within the appropriate timeframe. I have included a table in my written statement that highlights the efficacy of the available contraceptives with up to 99% of pregnancies being prevented when emergency contraception is given in a timely fashion.

All patients who attend SATUs are then offered a series of follow-up appointments, to provide ongoing support and to undertake sexually transmitted diseases, STI, screening, pregnancy testing and to meet any other needs as required. All of the women will have been offered emergency contraception and it is thus rare that we confirm a pregnancy at a follow-up visit, however up to one third of our patients do not attend for these reviews. The follow-up data, including on pregnancy, on some who attend SATU services is incomplete.

While pregnancy after rape is infrequently encountered in those who attend SATU services, the extrapolated rape-related pregnancy rate is 5%. This estimate results from a three-year survey of over 4,000 women regarding the prevalence and incidence of rape and related physical and mental health outcomes. This study was published more than 20 years ago, but in broad terms the figure is consistent with recent data from Rape Crisis Network Ireland, which was presented at the Citizens' Assembly, and also consistent with data that Ms Noeline Blackwell will present today.

An individual's pregnancy risk will, of course, be influenced by the time in the menstrual cycle at which the incident occurred as well as other variables. While it is reassuring that few pregnancies occur in the population who attend SATU services for care, women do become pregnant after sexual violence either because they did not disclose the incident and thus did

not receive emergency contraception or because they received emergency contraception and it failed. Studies have identified that women who become pregnant after sexual violence may only present after the first trimester of pregnancy, during the second trimester. This limits options in terms of decision making with regard to continuing the pregnancy.

In 2015, 5% of women attending an Irish rape crisis centre reported that they became pregnant as a result of rape. The majority went on to give birth and parent but other outcomes included miscarriage, stillbirth, adoption and fostering and termination of pregnancy. As the committee is aware, termination of pregnancy for a woman who is pregnant as a result of rape is currently only available in this country if there is a substantial risk to her life, including risk of suicide, which can only be averted by termination of pregnancy. Under-disclosure of sexual violence, however, is common so it is very likely that women who have become pregnant as a result of sexual violence in the State are represented in the population who travel for termination of pregnancy in another jurisdiction or in the population who access Mifepristone or Misoprostal online.

It must also be emphasised that it would not be appropriate to mandate that these women would be obliged to report the details and circumstances of this incident to An Garda Síochána or other regulatory third party if termination became available in this jurisdiction, prior to being approved for termination of pregnancy.

Finally, it is vital to remember that even in the context of intimate examination by trained personnel, there is no physical finding that conclusively demonstrates that unwanted sexual contact has occurred. Published and peer-reviewed literature - of which there is much - shows that the presence and pattern of injuries sustained during a sexual assault can show considerable variation ranging from a complete absence of injuries, which is most frequently seen, to fatal injuries, which thankfully is very rare. There is a considerable evidence base confirming that genital injury is not an inevitable consequence of sexual assault and that lack of genital injury does not imply consent by the victim and does not imply lack of penetration by the assailant. Furthermore, the belief that absence of the hymen confirms that there has been penetration of the vagina is incorrect. Equally false is the suggestion that a normal or intact hymen means that penetration has not occurred. In support of this, for example, one paper reviewed examination findings in a group of pregnant adolescents and identified that despite definitive evidence of sexual contact having occurred - all these adolescents were pregnant - only 2 of 36 adolescents had genital changes that were diagnostic of penetrating trauma. From the physical perspective, therefore, there is no conclusive test that women who are pregnant after rape could or should be subjected to.

In summary, holistic, patient-focused services for women who have experienced sexual crime mean that pregnancy as a result of rape is infrequently encountered by those of us who work in SATU services. Therefore, in addition to the other health, forensic and societal benefits of reporting sexual crime, in terms of pregnancy prevention it is imperative that people are encouraged and enabled to disclose acutely in order that they can receive appropriate care including emergency contraception, which works very well.

With regard to access to termination of pregnancy on the grounds that the pregnancy was conceived through sexual violence, it is important to acknowledge that very many women do not wish to report that rape has occurred, and should not be mandated to do so. Furthermore, even if disclosure does occur I must reiterate the absence and inappropriateness of any single conclusive test which could be used to either confirm or refute the disclosure.

Chairman: I thank Dr. Eogan. I now call on Ms Blackwell to make her presentation.

Ms Noeline Blackwell: I thank the Chairman for the invitation to present to the committee. I am the chief executive of the Dublin Rape Crisis Centre and I am joined today by my colleague Ms Angela McCarthy who is our head of clinical services.

A slightly longer paper of our presentation was submitted to the committee and I will now give an edited version of that - a readers' digest version. Our purpose is to give members evidence as based on the experience of our personnel and the analysis of our own data on the impact of pregnancy where it happens as a result of rape of women.

Our data comes from the 24-hour helpline that we run from the Dublin Rape Crisis Centre and from clients that we see face to face. We support those attending Dr. Eogan's sexual assault treatment unit. We also accompany people to police stations and court.

Over the last number of years, approximately 80% of callers to the national 24-hour helpline were women. Callers to the helpline may not disclose their age at all but of the approximately 12,400 calls we got in 2016 whose age was known, 40% were women under 50 and 44% were women under 60. In terms of people coming directly to our doors, about 90% of those who attended for face-to-face therapy were women, and 80% of the 500 we saw were women under 50 while 89% were under 60.

While rape is about abuse of power, and violence, it does not always require force. Many rapes do involve force but many also happen when a person feels compelled to have non-consensual sex through external or societal pressures. Where sexual intercourse happens without consent, it is rape. Our therapists and helpline counsellors bear witness to the trauma, hurt and harm of rape every day. The psychological impact of rape can include self-blame, depression, post-traumatic stress disorder, flashbacks, sleep or eating disorders, distrust of others and feelings of personal powerlessness. Women may experience none, some or all of those at different times. Those impacts are not signs of illness, deficiency or weakness in a woman, nor are they characteristics of a particular woman, they are responses to traumatic events and trauma is real. In the experience of our personnel, the trauma of rape is exacerbated for those who become pregnant as a result of the rape.

I will say a little about how women present to us generally. Dr. Eogan has said from her perspective, and we can say from our experience, there is no such thing as a "normal" response to rape. Rape impacts on everyone differently depending not just on the circumstances of the rape but on the person themselves. The immediate aftermath of a rape can vary. It can be a time of overwhelming turmoil and confusion where a victim or survivor feels extreme and conflicting emotions. Some people present as numb, quiet and reserved. Others will respond quite differently being distraught, anxious, or hostile. The effects of the trauma can be short term or they can last long after the rape.

I will not speak about the experience of our volunteers in the sexual assault treatment unit because Dr. Eogan has covered that ground but there is some discussion of how our volunteer counsellors work with women who attend there. On the national 24-hour helpline, we aim to hold a confidential non-judgmental space for callers where they are empowered to explore their feelings, consider how the rape has impacted on them and make their own decisions about what to do and how to proceed. We seek to engage the caller and establish whether they are safe, have support or are in need of medical care.

Raising that issue of medical attention can prompt mixed responses. The possibility of having contracted a sexually transmitted disease or getting pregnant is now something else the woman must consider. A caller may ask questions related to a possible pregnancy. These may include questions about termination of a pregnancy. In those cases, callers to our service are referred on to a service that would be better placed to answer questions and provide information such as a free text number or the Positive Options website. Calls that relate to pregnancy are not the only ones we refer on. We also make referrals to other rape crisis centres, domestic violence support agencies, social workers, the Garda, other helplines and the like. It is important that not only do callers have the correct information but that they understand we are there to support them irrespective of the outcome of their decision about pregnancy. Such calls tend to finish quite quickly because a pregnancy and the decisions around it are uppermost in the woman's mind.

In terms of face-to-face therapy, clients present with a blend of issues. Memories of the rape can evoke feelings of shame or betrayal. There can be terror of the physical hurt, the fear of a violent threat and the possibility of a pregnancy. The intensity of their feelings can often overwhelm people as they embark on their therapeutic journey. Some clients will even have difficulty acknowledging the reality of their rape. Some may only reveal that the rape resulted in pregnancy weeks, months or years later. A therapist may never hear about the pregnancy at all. While we note information on those who reveal to us that they have become pregnant we will often only hear about it as a historical event. The scenarios that we hear about include the following: a client has had a baby as a result of a recent rape. That can bring conflicting emotions about an innocent child that is born out of aggression and there can be a loving and-or loathing of the child; a client has had a miscarriage and may have a sense of relief that there is not the added dilemma of being pregnant but there may be a sense of loss of a baby; a client may present as being pregnant and unsure what she is going to do. The pregnancy presents a double crisis - on top of the rape and trauma they also face the additional crisis of pregnancy and a decision in relation to that. They have to work through the practical, financial and emotional difficulties in proceeding with an unplanned pregnancy or having an abortion. The client will have to assess that in terms of all existing relationships within her family and her community; and, a client may present as having had an abortion. She may feel relief that there is not the added dilemma of being pregnant. Some feel a sense of guilt and sadness at having terminated the pregnancy. Others feel stigma, shame and isolation. The secrecy surrounding the abortion presents a burden for some. Some will feel anger that they could not have the abortion procedure in Ireland, travel having made the whole process expensive, complicated and traumatic; a client may have had a baby as a result of a historic rape.

In 2016, 11 women disclosed pregnancies as a result of rape to the Dublin Rape Crisis Centre. We noted the outcomes for those 11 women. Four had become pregnant and were parenting; three had terminations; one had miscarried; one had a child adopted; one had a child fostered and in one case the outcome was unknown. Those figures do not indicate a victim or survivor's choice, but merely the ultimate outcome. The figures may relate to recent or historic pregnancies.

There is no reliable Irish information available about the prevalence of pregnancy as a result of rape because there is such massive under-reporting of rape. Dr. Eogan referred to the 2002 SAVI report, which found that 42% of women reporting abuse had never told anyone at all. Only 8% of women reported their experience of sexual violence to the Garda; 6% disclosed to medical professionals and 14% of women in that survey reported to counsellors. Other studies give comparable results.

In 2014 an EU survey undertaken by the European Union Agency for Fundamental Rights, FRA, found that about 2% of women aged between 18 and 74 experienced sexual violence in the previous 12 months. From our own evidence, most rape and serious sexual violence is perpetrated by someone known to the victim. Our statistics for 2016 identified that just under 17% of adult rape and sexual assault was perpetrated by the client's spouse or partner, 2% by other family members and almost 46% by other known persons. That includes friends, recent dates, work mates and the like. About 50% of childhood sexual abuse revealed to us by adults was perpetrated by a family member.

We have no reliable national data on the prevalence of pregnancy as a result of rape. However, from our own statistics over 11 years, and also using the statistics from the Rape Crisis Network of Ireland, RCNI, which collects data from a number of other smaller rape crisis centres, it seems that approximately 4% of the total number of female victims or survivors who presented to rape crisis centres report pregnancies as a result of rape. That is very near the 5% Dr. Eogan spoke about in other surveys. Of that 4%, a little over one third of our clients went on to parent while a little less than one third terminated their pregnancy. The RCNI figures show almost half went on to parent, while just under 20% terminated their pregnancy.

The final point relates to concerns about women's health if rape must be reported to access abortion, the so-called rape exception. If the committee is considering special provisions for those who have suffered rape to access termination, then it seems inevitable that the pregnant rape victim or survivor will have to say that a rape occurred. Many of those who contact us are not ready to report to police for a long time, if ever. It is noteworthy that the Garda now provides storage of forensic evidence at the sexual assault treatment unit for up to a year, recognising the realities of the investigation of this type of crime. Clients are sometimes fearful of the reality that once they report to the Garda, gardaí must commence the investigation of a crime, thus notifying the alleged perpetrator of the complaint even if the victim is not ready. They may also initially have concerns about their own blame for the events which makes them reluctant to speak. Clients may not be ready to report to a doctor, social worker or the like. They may not want to talk to someone they fear will judge them and who must judge them to some extent. In the context of the long journey our clients and callers must take to re-build their self-esteem and manage their self-doubt after the violence of rape, many would be set back if questions were raised about their credibility.

Requiring a woman to share such a traumatising experience about her rape and subsequent pregnancy has the potential to not only re-traumatise, re-trigger and re-victimise her, it also leaves her in a situation where she has to convince someone that her story justifies access to support. It disempowers the person who has suffered the rape while empowering the person giving permission to access a procedure or service. Once more, the consent of the victim or survivor is seen as irrelevant. I am happy to answer any questions that the committee may have.

Chairman: We will now have a presentation from Mr. Tom O'Malley, BL.

Mr. Tom O'Malley: The purpose of this presentation is to identify or explore some legal issues that may arise in the event that it is seriously being considered to have rape as a ground on which abortion or a termination of pregnancy might be granted. I am not really concerned with or in a position to address the more normative or policy question as to whether rape should in fact be a ground for abortion. My purpose is simply to explore some of the legal issues that would arise if that were seriously being considered. As such, there are two broad questions to be addressed. First, one must address what exactly is meant by "rape" in this context. In other words, what range of offences might justify granting a termination? The second and perhaps

more difficult question is what kind or level of proof might be required where someone seeks an abortion on the grounds that she had become pregnant as the result of a criminal offence.

As to the range of offences, there are obviously now a very large number of sexual offences known to Irish law, most of which are defined in a gender-neutral way. For practical purposes here, we are only concerned with those offences involving heterosexual intercourse, as they are clearly the only ones that might result in pregnancy. We are not just talking about rape, which I will explain in a moment, we are also talking about sexual intercourse with an under age female, namely someone under the age of 17; sexual intercourse between a person in authority and a female aged between 17 and 18 years; sexual intercourse with a female who has a mental disability or learning difficulty; and, finally, incest. All of those offences may be quite familiar in legal terms to members of the committee as most of them were redefined or in some cases created by the Criminal Law (Sexual Offences) Act passed by the Oireachtas earlier this year.

I start with rape itself, which is probably the most relevant offence for present purposes. It is important to mention the definition of rape, which has three components. First, sexual intercourse must take place. The defendant must have intentionally had sexual intercourse with the complainant and it must also be proved that the complainant did not at the time consent. It must also be proved that the defendant knew that she was not consenting or was reckless in that regard. As such, two of the key elements of rape are the absence of consent on the part of the complainant and knowledge on the part of the defendant that she was not, in fact, consenting.

As I have set out in a bit more detail in the paper I submitted to the committee, the law on consent changed as a result of the 2017 Act which included, for the first time, a statutory definition of consent in Irish law as far as sexual offences are concerned. It is now the law that a person consents to a sexual act only if he or she freely and voluntarily agrees to that act. The relevant section then sets out a range of circumstances in which, as a matter of law, a person will be held not to have consented. It is very important also that the mental element, as we call it, or culpability be considered because a man will not be guilty of rape unless the prosecution proves beyond a reasonable doubt that he either knew the woman was not consenting or was reckless in that regard. It is very often said that a man has a defence if he can show that he thought the woman was consenting but that is not, in fact, the law. The defendant does not have to prove anything. It is always up to the prosecution to prove all of the elements of the offence, including the absence of belief on his part. They are the essential elements of rape as it is currently defined. It is also important to note that since 1990 there has been no ambiguity but that rape can occur within marriage. A husband may be convicted of raping his wife. The definition is the same and the maximum sentence, which is life imprisonment, is also the same.

The law relating to sexual acts with a person under the age of 17 years was changed somewhat earlier this year. In the old days, we used to call those offences "unlawful carnal knowledge", but as a result of a Supreme Court decision in 2006, which struck down the old law, we have had to amend the law on a number of occasions since. In essence, it works as follows. There are two separate offences involved which are differentiated according to the age of the young person. It is an offence punishable with up to life imprisonment to have sexual intercourse, among other acts, with a person under the age of 15 years. That is the more serious of the offences. Consent on the part of the young person provides no defence whatsoever to the male or perpetrator in question, but a defendant has a defence if he can prove that he was reasonably mistaken as to the age of the young person. If he reasonably thought she was over 15, he is not guilty of that particular offence.

Section 17 of the 2017 Act creates a separate offence of sexual intercourse with a person,

or female in the context of the committee's deliberations, under the age of 17 years. That is regarded as a less serious offence in the sense that the maximum sentence varies depending on a number of circumstances. It is not life imprisonment as it is in the case of the other offence. Again, the accused person has a defence if he can show that he thought on reasonable grounds the young woman was over 17 years. However, the question of consent then arises and the situation becomes a little more complicated as a result of changes made to the legislation earlier this year. That might be relevant to the present discussion. At one time, consent was simply not a defence in those circumstances. If the young person was under 17, consent was no defence. However, we introduced a significant change to that earlier this year. Consent on the part of the young person can now be a defence to the male provided he was either younger than the female in question or he is less than two years older than her. To give a practical example, if the girl is 16 years of age and consents to the intercourse and the male in question was 15, 16 or 17, no offence has been committed. On the other hand, if he was 19 years of age, an offence has been committed irrespective of whether she consented or not because he is more than two years older than her. It is important to be aware of that.

The next sexual offence to take into account is a completely new offence created by the 2017 Act, namely a sexual act with a person who is between 17 and 18 years of age committed by a person in authority. We never had such an offence in Ireland before. In effect, it raises the age of consent to 18 years but only in circumstances where the person who has intercourse with the young person is, in some sense, in authority over him or her as the case may be. A "person in authority" is defined in the Act and includes, for example, a teacher, a guardian, an employer, a parent, obviously, or a close relative.

The next offence the committee needs to consider is another one which was completely revamped and redefined in the 2017 Act. This is a sexual act with a protected person, namely a person of any age who has a mental illness or mental disability. It has long been the law, only that it was amended somewhat this year, that it should be a criminal offence for a man to have sexual intercourse with a woman who has a mental disability of a certain kind. Now this is defined in a gender-neutral way. We now define a protected person as someone who by reason of mental or intellectual disability or mental illness is incapable of understanding the nature and the reasonably foreseeable consequences of the act or incapable of evaluating the relevant information. Again, this offence carries a maximum sentence of life imprisonment.

Incest, of course, is still an offence in this country. Irish law is special in this regard. Ireland was not historically unique in this regard, but incest in this country is committed not just when one of the parties is a minor, but also when people who are, let us say, brother and sister, mother and son, or father and daughter, have heterosexual intercourse, irrespective of age. This provides a role in preventing child abuse if one of the parties is under age, but incest can equally be committed, for example, by two siblings who are well into adulthood and who consent to the act in question and even in circumstances where there would not be any danger of pregnancy to begin with. Again, this is the kind of thing the committee would have to take into account. This is the range of sexual offences in this country, so one of the questions the committee should ask for present purposes is, which of these offences, if any, might provide on policy grounds a justification for allowing termination of pregnancy if one of them were committed.

Now I wish to consider the issues of proof that might arise. There are two questions in this regard. The first is the one I have just asked, namely, what range of offences should be taken into account, to what extent and so forth. Next is the question of proof. If a woman comes forward seeking a termination on the grounds that one of these offences has been committed,

what kind of proof should be required? This question is linked into the broader policy on abortion that might be adopted by this committee or eventually by the Oireachtas generally. In other words, if it were ultimately decided that abortion should be available on a wide variety of grounds or freely available for the first three months or whatever it might be, what I am talking about would probably be irrelevant in the sense that the reason for seeking the abortion simply would not arise. However, what I am talking about would become relevant if the ultimate decision taken by the Oireachtas was to the effect that unborn life should still be protected but that abortion should be available on a range of grounds, including rape and sexual offences. If the latter approach were taken, issues of proof would arise. It is only on the assumption that this is a possibility that I raise this issue at all.

One could see the various possibilities regarding proof as being arranged along a spectrum. At one end of the spectrum is, let us say, a position whereby nothing short of a criminal conviction by a court would suffice to prove that the rape has been committed. At the other end of the spectrum, a simple assertion or claim by the woman in question that she has been raped or subject to another offence could suffice. The former is out, to be quite honest, simply because, given the length of time it takes to process a case through the system, apart altogether from what my two colleagues have said, with which I absolutely agree, that is, that many people do not report cases for quite a long time anyway, it would not even arise. However, even if the woman were to report the case at the very first opportunity, there is no way the criminal case would be concluded within nine months, which is the very maximum period we are talking about.

At the other end of the spectrum, there is the possibility of simply asking why we do not simply believe what the person says. This is a perfectly legitimate approach as well. I can see many circumstances in which it might not be problematic. In a so-called stranger rape case where the woman has been not just raped but also seriously assaulted in other ways and she goes to the Garda immediately, perhaps to the sexual assault unit, and to a rape crisis centre, no one would seriously question whether she is the victim of a rape. Therefore, I do not see any difficulty in accepting such an assertion backed up by such evidence.

However, if this were to become an issue at all, the kind of scenario on which the committee would have to concentrate would be one in which, let us say, a woman comes forward, perhaps two or three months, perhaps more, into a pregnancy and claims at that point that she has been raped or is the victim of another offence. Would proof be required at that point and, if so, what kind of proof? Of course, the fact that she might come forward at that point does not mean that she is to be disbelieved. On the contrary, as we know from experience, many people who are the subject of rape or child abuse choose not to report for all the kinds of reasons Ms Blackwell has mentioned. However, if they discover subsequently that they are pregnant, at that point they may come forward and say they have been raped. At that point there may not be any forensic evidence that would be of any use for the purpose of proving the rape has been committed. Therefore, the question would arise of what kind of proof would be required, given that a criminal trial is out.

Some kind of inquiry or body could be set up, on either an *ad hoc* or a permanent basis, to assess such claims. Again, questions would arise. Would it be necessary to identify the perpetrator? Would the perpetrator have a right to be heard? Suppose, for example, a woman says she has been raped by her husband or partner. Would he have the right to come forward and say it was not rape and that he objects to the abortion taking place? Would that end up in court? Of course, it would in those circumstances. These are the kinds of issues the committee might need to consider.

I have gone over time. I think I have already dealt with the sexual offences other than rape that might become an issue. One of the questions the committee must ask is if abortion were allowed to take place in respect of these offences, would it only be allowed where a criminal offence has taken place? A criminal offence might not always have taken place in the case of sexual intercourse with a person under the age of 17 because, as I said, sometimes that is criminal and sometimes it is not, depending on the age of the male involved. For example, would the right to a termination be granted to everyone under the age of 17 who becomes pregnant or would it be confined to cases in which a criminal offence has been committed?

I do not wish to give the impression from what I have said so far that there would be insuperable difficulties in proving rape where some time had elapsed. I have been examining what happens in other countries in this regard, including many European countries. Various countries, parts of the United States and so on provide for access to abortion on the grounds of rape. It is not an issue in many of these jurisdictions because many of them also provide for a general right to termination within the first few months of pregnancy in any event. Elsewhere there seems to be general acceptance that requiring a criminal conviction would be largely impossible because of time constraints, so some jurisdictions have provisions to the effect that abortion is permitted where there are strong grounds for believing the pregnancy is the result of a criminal act. In other words, they do not require absolute proof but they normally require evidence that the person has, for example, reported the matter to the police or a doctor or whatever else.

They are the main issues I wished to raise. When I addressed the Citizens' Assembly, as my colleagues did, I had been asked to say something about the sentencing of serious sex offences, the reason being that some people had quite legitimately asked, if we had a different sentencing system, whether that might reduce the incidence of sexual offences. The answer, to be honest, is no. I have included at the end of my written submission an appendix setting out the observations I made at the Citizens' Assembly.

Chairman: I thank Mr. O'Malley and the other witnesses for their presentations. Deputy Browne has time remaining from the first session if he wishes to use it.

Deputy James Browne: Would it be fair to say that if legislation were provided to allow for terminations in the event of unlawful intercourse resulting in a pregnancy, each of the five instances Mr. O'Malley has listed would have to be addressed? Outside legal technicalities, many people might consider that the first three come under the generic term "rape". Is it the case that we would have to address all five?

Mr. Tom O'Malley: Yes, I think one would. The United Nations website, with which members may be familiar, sets out the various grounds for which abortion is available for every member state. The heading it has for this is rape or incest. It is not as simple as that by any means because each of those offences is defined in a different way. As the Deputy rightly says, those drafting the legislation would have to look at each of those offences and set out what circumstances or factors might be taken into account if a termination was to be granted in respect of any of them.

Deputy James Browne: Is it fair to say that at the moment, in each of those circumstances, as they are criminal offences, the standard of proof is beyond reasonable doubt?

Mr. Tom O'Malley: Yes.

Deputy James Browne: If a woman had to prove a criminal offence through the courts

beyond reasonable doubt, it would have no effectiveness, due to the delay it would take in getting to that point.

Mr. Tom O'Malley: Yes. It would be the Director of Public Prosecutions who is taking the case who would have to satisfy the court beyond reasonable doubt. In all those cases, unless the complainant, the victim, is there to give evidence - because she will be the principal prosecution witness and her role is crucial in the trial process - I do not think it is possible to secure a conviction.

Deputy James Browne: To legislate for these instances, in order to be of any practical use, one would have to address the standard of proof. It would have to be something substantially lower.

Mr. Tom O'Malley: Yes, I think so. That is if one is talking about some system other than a criminal trial.

Deputy James Browne: That is fine for the moment. I thank Mr. O'Malley.

Chairman: Deputy Fitzpatrick has six minutes altogether.

Deputy Peter Fitzpatrick: I welcome the witnesses. I will address my questions to Ms Noeline Blackwell. I do not think there is any doubt in this room about the seriousness of rape, the trauma that it has on women, and it is vital that services are improved and that they see proper justice.

How does Ms Blackwell feel about people who are conceived in rape? I am thinking of Pam Stenzel and Ryan Bomberger. Ryan's story is well known because he is a human rights campaigner who has publicly thanked his biological mother for giving him a chance in life. I was struck by something he said, which is that we are all wanted by somebody. Similarly, Pam Stenzel recognised that her birth mother gave her life instead of aborting her. People like Ryan and Pam say they feel like second-class citizens when the question of abortion on grounds of rape arises, when they are made to feel as though there is no value on their lives before birth because of a crime committed by somebody else. How are they supposed to feel that they matter the same as others after birth? What would Ms Blackwell say to Ryan and Pam if they were in this room today? How would she reassure them that their lives were as valuable as anyone else's if the eighth amendment was removed, and abortion was allowed on grounds of rape?

Ms Noeline Blackwell: To be clear, I am speaking here on behalf of the Dublin Rape Crisis Centre. What we provide is a totally confidential non-judgmental service. We make no judgment. We aim to help people to run their own lives and worth through whatever trauma they have. In the case of everybody who presents to us, we give them the dignity of the human being that they are when they come in to us. We do not make any judgment. Even if somebody comes to us and chooses a certain course of action, whatever that is, because they have become pregnant as a result of rape, we assure them that we are there to help them deal with the trauma of rape, which is what we are expert in.

Deputy Peter Fitzpatrick: My question is, from Ms Blackwell's experience, how does she feel about a person who is conceived in rape? I am only asking a question.

Ms Noeline Blackwell: I may not be explaining what we do properly. Our job is to support everybody who walks in our door who has suffered trauma as a result of rape or whose family member or whatever has suffered trauma. We are there to support all of those people to work

out their own lives. We are not there to make any judgments on them. We will not and do not make judgments.

Deputy Peter Fitzpatrick: I am asking Ms Blackwell a question because she is a senior person in the Rape Crisis Centre. There are people listening to these proceedings who would like to hear this from a professional such as herself. If the two people I mentioned were in the room, how would Ms Blackwell think they would feel? Their biological mothers accepted them and they were born and had good lives. Can Ms Blackwell give me any kind of a comment?

Chairman: I think that the witness has indicated that she is not able to answer about her own opinion.

Ms Noeline Blackwell: For everybody who might be listening or who might read the transcript, the point we really want to get across is that this is what we do in the Rape Crisis Centre: we are there to support every single person who comes in, who has been traumatised, affected or impacted by rape or sexual violence. That is our function. I cannot put it any further for the Deputy.

Deputy Peter Fitzpatrick: My problem is that I am limited in the kinds of questions I can ask. I have a question and I cannot get an answer. The Rape Crisis Centre sees many people come in, but women come into the centre who have been raped. They are probably asking for advice. It is very important. As a person involved in the Rape Crisis Centre, they will listen to Ms Blackwell and they will ask her questions. This is important. I need to know what Ms Blackwell's beliefs are so that I can see what kind of reception they might get from her.

Ms Noeline Blackwell: To be clear, we are absolutely non-judgmental. We are there for every single person whatever their beliefs; they come in to us and we are there to provide a professional service and support to them, regardless of their beliefs. Our belief is only that people can be helped, they can be supported and they can cope with the impact of rape and sexual violence.

Deputy Peter Fitzpatrick: What I am trying to get through to here is that there are many others like Ryan and Pam. I want to see if Ms Blackwell comes across anyone in that field. I spoke earlier about an abortion. The child, to me, has no say whatever if it is aborted. That means the mother is fine. What kind of reception do people get when they present themselves who have been conceived as a result of rape? I am just asking a question. I cannot seem to get any answers from anyone on this.

Chairman: Do any of the witnesses have any comment to make with regard to the Deputy's question?

Ms Angela McCarthy: I will answer because I am the head of clinical services. The Deputy might imagine that every day of the week we meet people who might be the children of rapists. That would rarely happen. I do not know if it has ever happened. If they did come through the door, they would be as welcome as anyone else. The Deputy might imagine that we give advice to people every day of the week in relation to abortion. As the statistics in our longer submission show, we made two referrals in 2016 to the Crisis Pregnancy Agency. I do not know what the Deputy's picture is of the Rape Crisis Centre. Basically, we provide counselling to victims of sexual violence. That is the bottom line of what we do. If someone rings our helpline and says they think that they might be pregnant or they wish to get advice around pregnancy issues, we do not deal with that ourselves - we, properly, refer them to the Crisis Pregnancy Agency. That is our role.

Deputy Peter Fitzpatrick: It seems to me the child is not the victim here at the moment. It is great to hear stories such as those of Ryan and Pam. Did any children ever come into the Rape Crisis Centre whose mother had decided not to abort them, to give their side of the story?

Chairman: I think to be fair to Ms McCarthy, she has answered that question. If I understand her correctly, from what she is saying, it is a rare occurrence that someone would present to their services in such circumstances.

Ms Angela McCarthy: It has never happened. If somebody presented, and we had some reason to speak with that person, we would welcome that person and listen as we would listen to anybody else's story. We do not have any bias against people of any kind.

Deputy Jan O'Sullivan: I thank the witnesses for their presentations. I think statistics from surveys and such have shown that most people in Ireland feel that a woman who has been raped should have the option of ending her pregnancy. I think that statement would be true but from the evidence from the witnesses today, it is much more complex than simply stating it. Mr. Tom O'Malley's evidence in particular indicates the legal complexities and the other witnesses addressed the difficulties of actually proving criminality. I ask Dr. Eogan to expand on what she said about there being no conclusive test. Maybe I will ask all the questions because I only have a couple-----

Dr. Maeve Eogan: Does the Deputy want to ask all the questions?

Deputy Jan O'Sullivan: I will ask all the questions if that is okay. I want to ask any witnesses who want to answer about whether they believe we need to decriminalise abortion so that the person who is a victim of crime, who has been raped or sexually assaulted, does not also have to become a criminal if travelling for abortion or taking an abortion pill. Do the witnesses have a view on that? Somebody has asked about the issue of decriminalisation at nearly all of our meetings. How does the experience for women who have to go to England and are effectively described as criminals affect people?

Some statistics were given by the Rape Crisis Network to the Citizens' Assembly. To respond to Deputy Fitzpatrick, I think the percentage who went on and completed their pregnancies was as high as those who had a termination. I am not sure if it is the same in the Dublin Rape Crisis Centre. In effect, what we are discussing here is options rather than forced terminations. I know a judgmental question was asked of the witnesses there but it is important to state that we are not saying the witnesses would force anyone to have a termination.

Will Mr. O'Malley elaborate on other countries? He was saying that in countries where there is not a general right to access early termination, in some cases, one has to prove it which does not work because of the time the court case takes. Sometimes, there is an acceptance of the woman's word. Does Mr. O'Malley have anything further to say on that?

Dr. Maeve Eogan: On there being no conclusive test that confirms or refutes that unwanted sexual contact has occurred, when somebody comes to a sexual assault treatment unit, SATU, we gather a number of pieces of evidence. Firstly would be the patient's disclosure and history of what happened. There may be corroborative evidence such as from CCTV. There may be forensic evidence from the samples that we take and the tests that we do that confirms that sexual intercourse has occurred. However, there is not a specific test that can be done that absolutely confirms that the sexual intercourse was unwanted. Anecdotally, if one asks people, they will say that it is surely very clear from examination whether somebody has been raped.

As Ms Blackwell says, the rape does not always involve physical force. Even if it does involve physical force, because the body is designed to have sexual intercourse, that physical force may not actually cause an injury.

That study that looked at pregnant adolescents is really important. These people were absolutely and definitively pregnant. There were 36 of them. Of those 36 women, when they went back and looked at the tests that were done - they had colposcopy because they were adolescents and so there were photographs - they could see if injuries were identified at the time and there were not. There is huge heterogeneity in whether or not there will be an injury at the time of sexual intercourse when rape happens, and therefore there is not a definitive or conclusive test that can either confirm or refute that the sexual intercourse has been unwanted. The Garda investigation takes all the different evidence and the court process will have all the witnesses and the standard of proof there is to prove a matter beyond reasonable doubt. There is no single test we could do if somebody says that she is ten weeks pregnant as a result of rape.

The Deputy is right about the impact of criminalisation. There is much discussion about this. The Royal College of Obstetricians and Gynaecologists has absolutely recommended that termination of pregnancy should not be criminal. The Deputy is right that there is a potentially huge amount of additional stress that is placed on people not just because they travel but because there may be a fear that there may be some kind of criminal accusation visited upon them. That is a whole source of additional stress. Ms Blackwell will probably mention, speaking to people after this meeting, that concerns can be raised about that.

Ms Noeline Blackwell: I will pick up on that particular point. The way we collected the evidence that we are presenting here today was by going around to all of our therapists, some of whom have much experience working with us. They work with the approximately 500 clients we see in the year and on the phone lines. I set out five scenarios on page 4 of my longer paper to try to identify what they hear from the people who come into us about how they feel about being pregnant as a result of rape. There is the issue of the crisis of the rape and the crisis of the pregnancy for the person who is pregnant and is unsure of what to do and she is working through a whole set of scenarios, including practical, financial and emotional difficulties, as we put it here. I think the legal difficulties or criminality of the abortion are not the issues noted by therapists to a great extent for those people. We definitely come across people who present as having had an abortion and are angry that they could not have had the procedure in Ireland, had to travel and because it was complicated and traumatic for them to have to do that.

Deputy O'Sullivan is right about the statistics. We collect statistics from the national helpline, which gives the national figure, and from our own clients. Those show that over one third are parenting, a little under one third had a termination and the other third have miscarriages or are cases of historic pregnancies where children have been adopted or fostered. They are likely to be the older ones, people from years ago who come back to us later. That number is likely to go down. The Rape Crisis Network of Ireland has collected statistics from between 11 and 15 of the centres over the years including the rural centres to a great extent. A greater number of those, approximately 49%, are parenting and a little under 20% had terminations so there was a bit of a disparity. The numbers are still small. We can only report, as can the other rape crisis centres, on the people who tell us. Most people may never tell us at all.

Mr. Tom O'Malley: I will answer the question about how other countries approach the matter. By way of sources of information, the Green Paper on abortion published in 1999 has an appendix which sets out the regime in other European countries, including this question of where it is available on the grounds of rape and the kinds of proof that are required. That is

almost 20 years ago but there was a recent report by the Library of Congress in Washington, D.C., a usually objective source of information, which looked at abortion laws in European countries which provides some information on that. The committee must remember that this is the kind of area that changes a lot since countries change their laws over time. In my research, two things come forward. Most European countries that allow abortion in these circumstances will have something to the effect of this, from Portuguese law, "there is serious evidence of a significant indication that pregnancy resulted from rape". Likewise, in Germany, if there are serious grounds for the assumption that the pregnancy resulted from rape. What they are doing there is they are not insisting on anything like legal proof to the extent that would be required by way of criminal or a civil trial but rather some kind of serious grounds. Again, the question is how those grounds would be established. Some countries require a report from a prosecutor. A Polish case recently came before the ECHR. In Poland, the local prosecutor is entitled to issue a certificate saying that he is satisfied that a rape took place. In that case, it was what we would call a sexual act with a person under the age of 15. That would not be the role of a prosecutor within our system. The equivalent in our system would be for a member of the Garda or a senior Garda officer to have to issue such a certificate. However, all that goes back to the question of whether, and at what time, the matter had been reported to the Garda to begin with. It is almost a vicious circle in terms of whether the report has been made and at what point it has been made. The most difficult scenario would be where a report was not made in the immediate aftermath of the rape or another offence but where it is made several months down the road. That is all I can glean from the comparative survey I have done of laws in other countries.

Chairman: Will members be mindful when they ask questions that there are three witnesses before us and I do not want to interrupt witnesses? Each member has six minutes but we have more witnesses coming in at 6 p.m. and it is absolutely inconceivable that we will be able to bring them in then because we want to make the most of our time with the current witnesses.

Deputy Billy Kelleher: Mr. O'Malley referred to one issue. Traditionally when a rape case is brought, there has to be a perpetrator. Allegations cannot just be made and then a case taken. There has to be a perpetrator for the conviction purposes.

Mr. Tom O'Malley: Of course, yes.

Deputy Billy Kelleher: Across the continuum to which he referred from a criminal conviction to a statement from a girl or a woman that she was raped, I assume Mr. O'Malley is not implying that a perpetrator would have to be named even with the lesser burden of proof or is he saying the perpetrator is named in other countries?

Mr. Tom O'Malley: The Deputy is right. I am not making a suggestion one way or the other but if one went down that route, that would not be necessary. There could be all kinds of dangers involved, for example, if the person who was named decided to take a civil action for defamation against the woman who made the allegation, which would be entirely possible. If such a system were introduced, serious consideration would have to be given to giving a qualified privilege to a woman if she was going to name the alleged perpetrator. That would be one of the issues that would have to be taken into account and, therefore, it may well be that there would have to be a system whereby the focus of the inquiry in those circumstances, is whether the information that the women has given to the police or a doctor or whomever, as they put it in other jurisdictions, provides serious indications that she has been raped but without necessarily mentioning the person in question. That is a possibility at least.

Deputy Billy Kelleher: In most countries that have rape as a ground for abortion, is there

a lesser burden of proof than a criminal requirement and is there not always a requirement to name a perpetrator?

Mr. Tom O'Malley: To be honest, I could not answer the last part of the question with confidence because I do not know. It varies a great deal from one jurisdiction to another and, indeed, from one situation to another. The Deputy may be right in the way he phrased this. It may not be inevitably necessary to name the perpetrator but, in some cases, it may be because the woman has gone to the police. One of the best ways the police can be assured of the truth of her statement is to ask who did it. There is a possibility, therefore, that a person will be named but that does not mean to say that the name ever has to be revealed.

Ms Noeline Blackwell: I refer to the number of people who are raped within intimate relationships and as part of domestic violence. In those cases, one does not necessarily have to name the perpetrator for the perpetrator to be fingered and that could be a real concern for people because they are now identifying that they were raped in an intimate relationship and aspersions are being cast on the spouse or partner in those circumstances. Last year 19% of our clients reported pregnancy as a result of rape by an intimate partner.

Deputy Billy Kelleher: Where a clinician meets the patient in the context of a rape, are there obligations on medical practitioners to interact with the criminal justice system if the patient has been raped? Is there absolute privilege in this context?

Mr. Tom O'Malley: Is this related to the mandatory reporting obligation?

Deputy Billy Kelleher: Yes.

Mr. Tom O'Malley: We have rather complicated legislation dating from 2012-----

Deputy Billy Kelleher: I refer, in particular, to minors. If a minor wants a termination because she has been raped and goes to her GP, is there an obligation to mandatorily report the case of a minor?

Mr. Tom O'Malley: That would certainly be an issue. Under the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012, where a doctor, teacher or whoever becomes aware of a possible sexual offence against a child, there is a mandatory reporting requirement. That is something else that would have to be addressed in these circumstances; in other words, as part of the overall package of reform that would be considered in the event that rape or sexual abuse is accepted as a ground for abortion. It would be a complicated issue to go into now. I do not have the legislation in front of me and, therefore, I could not give a much more-----

Deputy Billy Kelleher: But there is a mandatory requirement to report if a minor is involved if someone becomes aware.

Mr. Tom O'Malley: Yes, in certain circumstances.

Dr. Maeve Eogan: And under Children First.

Chairman: I thank the Deputy for his brevity, which is appreciated.

Senator Lynn Ruane: I thank the witnesses for their presentations. I have three questions. My first question is to Ms Blackwell and Dr. Eogan. Mr. O'Malley outlined a number of potential options for how verification of pregnancies arising from rape could work such as

self-declaration, formal criminal proceedings, a special form of expedited adjudication process, police reports, medical reports, or a prosecutor's certification. As service providers, could they comment on the feasibility of these options and how they would interact with their processes for providing care for women?

My second question is to Dr. Eogan. She outlined three options in her presentation that she offers to women who wish to access care. Options two and three allow women to receive care without reporting the incident to An Garda Síochána if aged over 18. If we were to legislate for the involvement of the criminal justice system in assessing access to abortion on ground of rape, would this impact on her ability to dispense care without involving the Garda?

My final question is to Mr. O'Malley. He stated in his presentation that in later term pregnancies arising from rape, a balancing of competing interests between the woman and the unborn child is at stake and a legal adjudication may, therefore, be required to judge these interests. However, if the eighth amendment was repealed and the explicit right to life of the unborn removed from the Constitution, would that balance of competing interests continue to exist in the same manner as he has articulated?

Ms Noeline Blackwell: In terms of the care for women, we raise this because of our concern in this regard. Of the 12,000 calls we took last year, more than 400 were silent calls. They were people who picked up the phone and were unable to talk to us on day one. Even saying, "I will call that number" or coming in through our door is a big deal for many people. We are concerned that it can take time. Some people will report their rape immediately to the Garda and that is fine while others will take a long time to do it. That is the concern we have. If someone has to self-declare, and even if it is a simple form of self-declaration, someone else has to sign a certificate at the far end of it. Yet again, the woman has to put herself before someone who has a choice in whether to believe her or not and sign the certificate or not. This is in the context of people who are traumatised by the rape and whose consent has been taken from them. This is the essence of what has happened and that is our concern about any form of certification. If there is an adjudication process many of them will not do it. They will not be able to do it within the context of a crisis pregnancy. We are quite clear that it is not in women's interest to have to go through a reporting process in order to access abortion or any other medical service. Women should not have to do that. That is why we raised the issue.

Dr. Maeve Eogan: I cannot see how an adjudication process based on some sort of examination that simply does not exist would be feasible. The Garda can detect the crime using the various pieces of evidence it has, including physical evidence and DNA evidence. However, none of those are singularly conclusive. There is no examination that a person could be subjected to, even if it were appropriate to subject them to an examination, that could confidently determine whether rape had occurred. An examination or some sort of adjudication in that way is not appropriate. Again, a disclosure makes it difficult for all the reasons that Ms Blackwell has mentioned.

In terms of whether options two and three would be precluded from being offered if we had some sort of mandatory reporting, it is because of Children First and the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012 that those options are available only to those over the age of 18. I cannot see how it would be appropriate for us to have mandatory reporting to An Garda Síochána or some other third party before somebody could be approved for termination of pregnancy. Even if there was some bizarre scenario where that existed, I believe that would be separate from us being able to offer these options. We would always aim to offer care, not just for those who wish to engage with

the criminal justice system but also for those who are adults and who wish not to.

Mr. Tom O'Malley: I accept that the question of the kind of testing or verification process that might be deemed necessary in the event of abortion being sought on the grounds of rape would depend very much on the fundamental law that was put in place on the availability of abortion generally. If, for example, abortion was freely available for a certain period of time, this issue probably would not arise. If one eventually decided that there was going to be some sort of balancing test to be struck, as there is at present - perhaps it would not be the same test - where the right to life of the unborn was still an issue, on constitutional and other grounds it would be necessary, or at least desirable in many cases, to have some method of evaluating or validating a claim that rape had taken place as a basis for abortion.

Deputy Hildegarde Naughton: I thank all the witnesses for their excellent presentations here this evening. From Mr. O'Malley's presentation, it is clear that there is no feasible way that the successful conviction of a rapist could ever be used as a level of proof for a woman to access abortion. Does the witness know what the conviction rate for rape prosecutions is? It would be useful for the work of this committee to have those data. Of those indicted how many are convicted?

The question of the complications of requiring proof around rape has been well answered by all the witnesses.

During the Protection of Life During Pregnancy Bill debate, there was an assertion that thousands of women would be presenting themselves to their general practitioners, GPs, and falsely asserting that they were suicidal. I do not believe there is any evidence to justify that at present. Is it fair to say that if abortion was allowed in the case of rape, we could safely say that would not be abused?

Mr. Tom O'Malley: There is often misinformation circulating about the rape conviction rate. Sometimes one hears figures of 2% or 5%. That is not necessarily misleading in the sense that what it is often referring to is the attrition process, whereby the number of people who are eventually convicted formally by a court of rape will only represent a very small fraction of the total number of rapes that were actually committed. Of course, the vast majority of rapes are not reported, which explains the considerable difference between the two. The figure we should look at is what the conviction rate is for those who are indicted for the offence, that is, those who are tried and prosecuted. It is quite high. I am reluctant to mention a figure. I have Courts Service statistics in front of me but I am not sure if it readily gives that figure. I believe it is over 60%, and possibly considerably more than 60%. One of the things that complicates it is that when one is looking at the figures, one has to differentiate between people who are convicted of the offence with which they are charged - rape, for example - and other people who may be acquitted of that offence but convicted of a lesser offence such as sexual assault or another offence of that nature. I believe the conviction rate is quite high overall.

Ms Noeline Blackwell: It is high once it gets to court.

Mr. Tom O'Malley: Yes, on the assumption that it gets to court. The bigger problem is that many cases never get to court at all.

Deputy Hildegarde Naughton: That further complicates the whole scenario. Do any other witnesses wish to comment?

Ms Noeline Blackwell: When one is looking at the Courts Service statistics, which are by

no means perfect - as admitted by the Courts Service itself - one is looking at cases which start in one year and finish in another, and one cannot see the trail from the first report to the final conviction. It is very hard to tell. I believe the conviction rate is significantly higher once the accused persons are indicted, but it is really hard to tell. There are only around 100 convictions for rape in any year, which is a tiny number. Some 2,500 sexual offences were reported to the Garda in 2016. That is the highest number ever. From that it dribbles away to perhaps 100 at the end of the process. The process can take four or five years.

Mr. Tom O'Malley: I probably understated the level of convictions there. It would be quite high, perhaps 70% to 80% once the cases go to trial.

Ms Noeline Blackwell: There are many pleas where people agree to plead guilty to a serious sexual assault charge if a rape charge is withdrawn, which has a lesser sentence. That happens all the time. There is not enough study carried out in that area.

Ms Angela McCarthy: One of the most difficult things for victims is how long it takes for the case to get to court. A conviction might not happen for up to three years.

Deputy Hildegarde Naughton: If the witnesses feel that they cannot answer my other question, that is fine.

Dr. Maeve Eogan: It is on the record here that during the discussions on the heads of Bill for the Protection of Life During Pregnancy Act, the issue of whether there would be people banging down the doors of their GPs claiming that they were suicidal arose. That has not occurred. As an obstetrician, I work in a maternity hospital and I can say that it does not occur. One would hope that the same would happen if termination of pregnancy were legal on the grounds of rape. One can see that within the data Dr. Aiken provided to this group on women who access medications to terminate their pregnancies and where they just have to tick a box, even at that, rape is not ticked very frequently. In general it is more common for psychological stress and distress to be ticked.

Deputy Catherine Murphy: I thank the witnesses for their time and their papers.

In terms of people who present to the Rape Crisis Centre, report rape and are being counselled, the issue of power in the assault will influence what steps are taken afterwards. I mean in terms of self-preservation. People may not want to go through a criminal prosecution because they fear they will not be believed. I ask the witnesses to deal with the two issues and I then will ask Mr. O'Malley a question.

Ms Noeline Blackwell: I will speak briefly and then I will hand over to Ms McCarthy, who is involved in such work.

The question of power and control is really important. Every single rape involves non-consensual sex and, therefore, involves an abuse of power. That is key to the people who come to the centre. That sense of a loss of control and loss of their own power is one of the things, in the therapeutic work of the Rape Crisis Centre, that we seek to build - a person's better understanding of their own power. My colleague will say a little bit about the matter.

Ms Angela McCarthy: In terms of belief, it is important when somebody comes to the centre that the person feels we take the matter seriously. The person may have spoken already to family members. If it was another family member who committed the outrage or somebody known to the family, which is frequently the case, or somebody known to the group of friends -

it may be a friend or an acquaintance and maybe it happened at a party - the person may be met with disbelief and sometimes treated with less than respect. The function of the Rape Crisis Centre is to be there for the victim, in terms of belief.

Deputy Catherine Murphy: As Mr. O'Malley has outlined, there is a variety of grounds. He talked about stranger rape where there is a lot of evidence such as injuries and things like that. Who would gather all of that information? How quickly can it practically be used? It does not seem practical to collect all of that to start with, as it is a very traumatised environment.

Let us say a case is difficult to prove, the person has not gone to the Garda and then the person is not believed. Is that not the most difficult scenario to legislate for? How does one legislate for such an instance? It may well be technically possible to do so but it will be very difficult, though not if one considers the case from an holistic point of view. All of that goes against the point that has been made about being believed.

Mr. Tom O'Malley: In terms of the first scenario mentioned by the Deputy, where there is evidence of a stranger rape-type situation, even then somebody has to make a decision. In other words, the woman must go and apply for or request an abortion but the question then is who does she go to.

Deputy Catherine Murphy: Yes.

Mr. Tom O'Malley: If that matter arises, then another important policy decision would have to be taken. Who should be the first port of call? I presume a GP or a hospital. Ultimately, the decision will be who should actually decide whether to permit the termination to take place, assuming that it is not freely available in any event. If abortion was a specific ground then in all circumstances, somebody would have to decide whether the grounds had been satisfied or not. That is a comparatively simple enough scenario in a sense that there would be some evidence or supporting material to back up the person's claim that she had been raped. I absolutely agree with the Deputy. I was sorry that, in my own presentation, I could not be more helpful about it because it is a really difficult matter.

The second scenario refers to where the person comes in. Again, in all probability perfectly truthfully, the person says that she has been the victim of a criminal offence but has never reported it until now, two or three months or whatever down the road. If we insist on some kind of validation and verification of that claim then that is when one would need to have some kind of special panel to deal with the matter. Either an individual or a group would have to be designated to evaluate that claim. Obviously the matter could be stressful for everyone concerned, including the person who seeks the abortion.

Deputy Catherine Murphy: I want to ask a question about a criminal trial for someone who is accused of rape and where a termination was permitted by the panel. How is that scenario presented in evidence?

Mr. Tom O'Malley: That is another one. I mentioned it very briefly in my paper. It is something again which the legislation would have to address as to in what circumstances or, indeed, in any circumstances, it might be permitted to mention in the course of the criminal trial that an abortion had taken place. In a criminal trial, under the Constitution, the first and foremost consideration is fairness to the accused. Article 38 of the Constitution says that nobody charged with a criminal offence shall be tried other than "in due course of law". The primary concern of a criminal trial, under our Constitution, is to provide fairness to the accused. Other

people have rights too but the accused is front and centre. Therefore, the legislation would have to be drawn up in such a way that it did not jeopardise the person's right to a fair trial by, for example, introducing information that could be unduly prejudicial to the accused. It is another factor that would have to be taken into account if this kind of legislation were being introduced.

Chairman: I appreciate the Deputy finishing bang on time. I call on Deputy Clare Daly and she has six minutes.

Deputy Clare Daly: I thank the witnesses for coming in. Deputy Jan O'Sullivan was right that we need to contextualise why we are here. I think we are here discussing this topic because repeatedly it has been shown that Irish people believe that in circumstances where somebody has become pregnant as a result of rape, the person should not be forced to continue with the pregnancy against her will. That does not, in any way, undermine or devalue the opposite decision made by people who decide to continue with their pregnancy. It is a case of recognising the other circumstances of people who may be married and have other children and who may have to grapple with issues and the impact on their own mental health of dealing with a pregnancy as a result of rape and who cannot continue with the pregnancy. It is their rights that we are considering here and time after time, the Irish people have accepted that. We, as a committee, are considering how to best provide for that situation. The witnesses have answered that question already. There is not a chance in hell of doing that by any circumstances requiring any issue of proof. Even in the most basket case of countries, nobody requires judicial authorisation. No countries do so, not even ones with restrictive regimes. Only a handful of countries in Europe require a police report.

As the witnesses have clearly said, to provide any sort of declaration to anybody constitutes a re-traumatisation of the victim. Are we not over-complicating things here? As Mr. O'Malley has said, the issue of proof only comes up if we deal with exceptions-based legislation. The way most countries in Europe deal with this matter is by making abortion available in the first trimester without any restriction as to the reason and thereafter based on medical grounds. Would we not do ourselves a favour by providing that scenario thus avoiding re-traumatising women?

I am unclear about the point made by Dr. Eogan about a study. Does the study show that some people who become pregnant only present after the first trimester?

Dr. Maeve Eogan: No.

Deputy Clare Daly: Do people present at that time in the units?

Dr. Maeve Eogan: No.

Deputy Clare Daly: Is it when women declare their pregnancy?

Dr. Maeve Eogan: It was when women declare their pregnancy. Please bear in mind that the study is 20 years old.

Deputy Clare Daly: Yes.

Dr. Maeve Eogan: At the time emergency contraception was not as available or effective, so things may be different now. In general, people have a greater awareness. Even in normal obstetric practice, people generally present with their pregnancies earlier than previously.

Deputy Clare Daly: Does the European solution of no restrictions as to reason take ac-

count of practically all or the vast majority of the cases where somebody would be impregnated as a result of rape and may seek a termination? My last question is for all of the witnesses.

Chairman: I wish to acknowledge the first comment made by Dr. Eogan.

Dr. Maeve Eogan: I thank the Chairman.

Deputy Clare Daly: Are we not over-complicating matters? Would the European solution deal with the situation?

Mr. Tom O'Malley: I am trying to be as open as possible about it, in that I was asked to address the legal issues. I am trying to consider the legal issues that would arise, which would be very few, if abortion was available freely up to the first three months or whatever it might be. All I am saying is that if one took the opposite approach of restricting abortion under certain grounds, then one would have to deal with those real questions that we have been addressing. I am not recommending which one should be achieved but it is quite clear that one would avoid those problems in the event that abortion was freely available for the first three months or whatever the period may be. I am not sufficiently familiar with the abortion policy issue.

Deputy Clare Daly: How many would that capture in medical terms if it were a case of abortion being allowed in the first trimester? Is that more of a medical issue?

Dr. Maeve Eogan: We do not have that information. We know that far more people are raped than become pregnant after rape. That may be because of the trauma of becoming pregnant after rape that one does not disclose it until later on. However, the Deputy is correct that there are very many countries that get over this by having easy access to termination of pregnancy and which already have access to termination of pregnancy without having to give a reason. Ultimately, we are the technical advisers and the committee members are the legislators so they can take our information and use it in their deliberations.

Deputy Kate O'Connell: I thank the witnesses for coming before us. I also thank them for their patience and their presentations. I will start with Ms Blackwell. In her role at the Dublin Rape Crisis Centre, has she heard of attendees or staff being abused in the street verbally or in any way? I have seen reports of images displayed outside clinics and centres. What do the witnesses think is the purpose of those images?

My next question is for Dr. Eogan. She said that one third of first-time patients do not come back to the unit. Could she elaborate on why she thinks that is the case? We touched on it already but, in her experience, has she ever come across reasons why she would not believe a woman who says she was raped?

Mr. O'Malley touched on pretty much everything I was going to ask him. Is he saying that it would not be workable if we put in some sort of hierarchy of people as *de facto* judges who would deem women either eligible or miserable enough to deserve terminations?

Mr. Tom O'Malley: It would be very difficult. It would cause a lot of practical difficulties in all probability.

Deputy Kate O'Connell: Before the witnesses came in, we heard from a psychiatrist who said it is a case of the earlier the better in terms of a resolution. I do not want to misquote her but my understanding is that prolonging the situation for women seems to be very difficult. In their experience, do the witnesses see lengthy processes involving verification and validation

of a claim as having a negative effect on women's lives? The longer women are pregnant, the greater the complications that arise in the context of terminations. It could be argued that if it went on long enough, for example, past 26 weeks, that essentially a woman could be forced to be an incubator for an unwanted pregnancy.

I draw the committee's attention to a legal case where custody was granted to a rapist in Michigan. It was reported by the BBC at the start of this month. A man who raped a 12-year old girl, on his release from prison as a convicted paedophile, gained access and parental rights to the offspring of the crime, the child produced as a result of the rape. He was committed to prison for his action but his name was added to the birth certificate of the child against the mother's wishes. Does Mr. O'Malley think there is scope and capacity in Irish law to allow parental access or rights to a convicted rapist father upon his release from prison? Should he be supported by the State in that capacity, in that he would he have access to children's allowance payments and so forth? I understand that paternity leave probably would not be a factor unless he got a very short sentence because the timing would not be right. Theoretically, however, if it was a short sentence, he could potentially apply for two weeks' paternity leave within 26 weeks of the child being born. I would welcome Mr. O'Malley's views on that.

Dr. Maeve Eogan: In response to Deputy O'Connell's question on why one third of people do not come back, we do not know because they do not come back. From a positive perspective, however, because we give people infectious disease preventative treatment and emergency contraception, hopefully they feel that they have no physical sequelae so they do not need to come back for an STI screen or a pregnancy test. In reality, their reasons are probably far more complex and include the fear, concern, stress and emotional trauma. They are able to contact the helpline and access crisis counselling, and, hopefully, are doing that, but it is a hugely stressful event for somebody and it is unfortunate but not surprising that not everybody returns for their follow-up.

Second, on whether one would not believe somebody who comes to a sexual assault unit after an incident of sexual violence, that is not our role. Our role is to support patients when they are there. It is up to the Garda and, ultimately, the criminal justice system to determine whether a crime has occurred and to process that through the courts. It is up to us to take the evidence, the intimate samples, that An Garda Síochána cannot take as part of its detection. The forensic samples we take and the examination findings that we record all form part of the investigation and then there is also the medical piece that we do at the same time. It is not for us in the sexual assault treatment unit to be judge and jury for a patient who presents there.

The Deputy is correct that if a verification aspect were to be introduced, it could only prolong the process. Already, women who, for example, travel from Ireland for termination of pregnancy are more likely to have surgical termination of pregnancy than medical termination because they present later due to the process of having to travel. One would imagine that if there was a similar verification process, it could delay the termination of pregnancy and, potentially, convert a more physically low-risk instance into a more high-risk instance.

Ms Noeline Blackwell: I will deal with Deputy O'Connell's question to me about people on the street. I have been with the Dublin Rape Crisis Centre nearly two years at this stage. Time flies. I did hear there was an instance of somebody setting up an anti-abortion lorry across the road from us. That was before my time. We are not clear on the reason for that because we take no position on a person having an abortion. Everybody who comes to us is treated the same. Everybody is treated in a non-judgmental way. There was only one incident of protest. What we do get is a certain amount of ignorant abuse from people who are on the street and who

point or make it a little bit more difficult occasionally for people to come in to us. I cannot say enough about how difficult it can be for people to take that step through our door, not just the first time but the fifth or the tenth time as well. People come in despite the fact that they could not possibly be to blame for the rape or sexual violence that has happened to them. They do blame themselves. They feel ashamed on occasion and it is hard for them to come in. It is much harder if there is somebody harassing them or making their lives difficult. In terms of the verification process, all we can compare it to is the process of being in court. If a client is involved in the criminal justice system it impedes her progress personally in dealing with her trauma.

Mr. Tom O'Malley: I agree with what my colleagues have said because they know better than I about the psychological side any kind of verification process would have and that there would be a traumatic effect. There is a verification process under the Protection of Life During Pregnancy Act. I do not know whether it has ever been invoked in a case where a right to an abortion was refused.

All I can say is that Deputy O'Connell raised a very interesting question about paternity rights but we would probably need another seminar to deal with that particular one.

Deputy Lisa Chambers: I thank the witnesses for their presentations and for their engagement on this matter. What has been clear from the witnesses' comments is that requiring proof of a victim would further compound the trauma. Most of us are in agreement that not many citizens would be supportive of the suggestion that a woman should be required to continue with a pregnancy against her will if she were raped. There is support in the country generally, albeit not among everyone, for a change on this niche issue. Obviously, we are considering many other issues.

Mr. O'Malley might correct me if I am wrong, but he made the interesting point that, if there remained some constitutional protection for the unborn, we could not get around the necessity to require some proof because we would need to try to balance the rights of the unborn and the mother. I do not know whether it was the German way to which Mr. O'Malley referred. Does it require a police report? I am not sure which jurisdiction it was.

Mr. Tom O'Malley: I believe it is a police report.

Deputy Lisa Chambers: Were we to go down that route and choose the easiest option of requiring a Garda report rather than a formal complaint, would that be sufficient to balance those rights? Could there be a constitutional challenge on the grounds that a termination would be too easily accessed if just a simple report or something of that nature were required? I would be interested in hearing Mr. O'Malley's thoughts on this matter. Any suggestion that a victim should be required to present before anyone or any organisation, for example, a member of An Garda Síochána, who would be professional in his or her report, and make a case in order to be believed about being raped and traumatised raises grave concerns.

Mr. Tom O'Malley: I am repeating myself. If this section of the Constitution was redrafted and a balancing exercise was undertaken, which is the situation under the eighth amendment and was reflected in the X case, the right to life of the unborn child would have to be taken into consideration. In a sense, I am trying to predict what might happen in the event of the matter going before a court on constitutional grounds. I imagine the outcome to be that some kind of verification should be required in order to vindicate the rights to life of the unborn. This would not necessarily mean a criminal trial or formal adjudication, but some kind of verification process would probably be called for. Perhaps it would be something like what obtains in some

European countries, where the test is of whether there is significant evidence or a significant indication that a rape or some other offence has taken place. That might be deemed sufficient, especially if it is written into legislation, which would attract the presumption of constitutionality in any event.

Deputy Lisa Chambers: I thank Mr. O'Malley. With the Protection of Life During Pregnancy Act and the eighth amendment in place, a woman who has been raped and who takes the abortion pill at home could theoretically be prosecuted and jailed for up to 14 years. That is an horrendous situation. Many citizens would agree that no one whose rights have been stripped from her should find herself in a courtroom setting being criminalised and possibly sentenced to a prison term. It is remarkable that this is our current situation. That is no more than a statement, though. I do not expect a response.

Chairman: I love statements when it means that a member finishes quickly.

Deputy Ruth Coppinger: I thank the witnesses for their presentations. I wish to make a few brief points. I believe it was the Dublin Rape Crisis Centre which stated that, based on its research, approximately 5% of women could become pregnant as a result of rape.

Ms Noeline Blackwell: It is 4%.

Deputy Ruth Coppinger: Okay. I saw 5% somewhere else.

Ms Noeline Blackwell: The 5% figure was in Dr. Eogan's presentation, but it is near enough.

Deputy Ruth Coppinger: It is 4% or 5%. While I was growing up, there was a myth, which I am sure the witnesses have heard, that no one could become pregnant as a result of rape. It is not that long ago since these myths still existed.

How many rape victims would be likely to be able to access their right to an abortion if a rape ground was introduced with some burden of proof? According to the Dublin Rape Crisis Centre's stats, only 42% ever speak to anyone at all, never mind reporting to the Garda or another official agency. Immediately, a large number would not have access. What are the barriers to people reporting generally? Is it not the case that many rape victims, particularly young people, can be abused over years before telling anyone?

Mr. O'Malley referred to international research. From my examination, it is impossible to access an abortion anywhere that just has a rape ground and little else. In one eight-year period, a state in Mexico did not grant any applications for abortion. In Poland, where the legislation is similar to the eighth amendment but with a rape ground, it is difficult for anyone to access abortion. As such, we know the answer to this question already. We have the proof from other countries. Perhaps the Dublin Rape Crisis Centre has more information on this through its networks, but the only way that people seem to be able to access abortion is upon request from the person herself up to the first trimester or, if there are additional health grounds, later.

We already have the concept of deserving and undeserving abortions, but would we be getting into having deserving and undeserving rapes if we use a rape ground? There has been much commentary in society of late about how the victim should not have been there and asking why she was in that hotel room, walked home on her own, was drunk, etc. One could see how some might say that one woman deserves an abortion while another does not. Is this something that the witnesses would fear?

Chairman: Perhaps the Deputy will allow them to answer those questions.

Deputy Ruth Coppinger: Yes. I just wanted to ask them together.

Chairman: That is great.

Ms Noeline Blackwell: I will start off because Deputy Coppinger mentioned the Dublin Rape Crisis Centre. There is a 4% or 5% pregnancy rate. The 2002 SAVI report is too old, but it is all that we have. Only 42% of people ever speak about the rape. When one woman in the report was asked why she had not told anyone that she had been raped, she said that no one had ever asked her before.

One of our concerns, which is shared by our colleague centres, is that only approximately 10% of those who need our services actually access them. This is without any complication of pregnancy. Therefore, it is likely that those who are better resourced or have better supports are the people most likely to access us. We have a concern about people not knowing how to access us.

The barriers that the Deputy asked about are long-term abuse and disruption. Since 75% to 80% of victims and perpetrators know each other, it is disruptive to report. For example, someone might be reporting her father, husband, long-term partner, boss, etc. Self-denial of the rape is also a barrier. It takes a long time. People phone and tell us that, for example, something happened and they do not know what it was but it was not rape. It turns out to have been rape, though, only the person was not ready to say it. Denial can last a long time.

Dealing with various authorities can be another barrier. We have an excellent police service that has been working hard to put in place specialist investigative units, but not all of those are in place yet. There are patchy reporting skills in the police. It can be difficult for everyone to understand perfectly how to receive a report of rape.

A question was asked about someone being deserving. Once a woman is asked to sign a certificate, her power to say that she was raped is taken away from her. Someone else has to make a decision about that rape. We were slow to raise this issue at all. Traditionally, rape crisis centres are non-judgmental, confidential places that do not speak on these issues. In the interests of the women who were approaching us, we felt that we had to ask legislators to think carefully before putting barriers to healing in their way. This is why we are speaking about the dangers of requiring a woman to get a certificate saying that she was raped signed by someone else.

Chairman: Does either of the other witnesses wish to comment?

Mr. Tom O'Malley: I agree with what Deputy Coppinger said about Poland. It has been before the European Court of Human Rights on several occasions for failing to properly apply its own law. If Ireland were to introduce some kind of verification procedure, people who became pregnant as a result of rape would probably go to England, as they do now. That would be far simpler from their point of view than going through the trauma a verification process might cause. That is what would most likely happen.

Chairman: Does Deputy Coppinger have a point of clarification?

Deputy Ruth Coppinger: A survey conducted at the Rotunda in 2000 found that one in eight pregnant women experience violence during pregnancy. It is a heightened time for vio-

lence against women. Does Dr. Eogan agree that many such women were probably raped at some point during their abusive experience but did not attend a sexual assault treatment unit?

Dr. Maeve Eogan: Through preparing for this meeting and reviewing details and documentation over the past several years, it is has become clear that there are more pregnant women in the sexual assault unit than women who become pregnant as a result of the rape, which is a damning indictment of the statistics in terms of domestic violence and pregnancy. The Deputy is correct.

Deputy Jonathan O'Brien: Like Deputy Coppinger, I considered the situation in other countries. I found only eight countries that require a judicial authorisation for abortion and they are Zimbabwe, Eritrea, Namibia, Rwanda, Bolivia, Panama, Georgia and Macedonia. Several other countries, such as Mauritius, Hong Kong, Uruguay and Colombia, require police certification. Members can extrapolate their own conclusions from the requirements in those countries.

Mr. O'Malley touched on the issue of whether the problem would really be dealt with if there were to be a certification process, regardless of who would conduct it and even if it were only required to report the rape to a GP. Would people just travel to the UK instead? I do not know if it is feasible or practical for people to be forced to make some sort of certification or admission. It could result in a return to the situation whereby only those who can afford to travel do so. Victims of rape who could not afford to do so would have to report the rape, continue with the pregnancy or obtain an illegal termination. I ask the witnesses to comment on that issue.

My final question is for Mr. O'Malley. However, because of her background, Ms Blackwell may also be able to provide an answer. How would legislation requiring a reporting system fit in with the directive on victims' rights? Would Ireland be in contravention of European laws or directives if it forced victims of rape to report the crime in order to access a termination?

Mr. Tom O'Malley: The Deputy's first question raises a very valid point. As I said, many may opt to travel to England, as they do now, rather than go through the trauma of reporting. As the Deputy rightly said, that assumes one can afford to travel to England. It could lead to wealth-based discrimination. The verification that might be introduced would not necessarily be too traumatic and so on to be workable but in many cases it probably would be quite traumatic, which is why people might choose another option such as travelling to the UK.

I am familiar with the victims' rights directive. It concerns assisting victims of crime and so on. I am unsure if there would be a conflict in that regard but that needs to be examined and we could revert to the Deputy on the issue.

Ms Noeline Blackwell: If Mr. O'Malley does not know the answer, I will not say that I do. The directive concerns the area of criminal justice. If a report had to be made to the Garda, the Garda would then have to try to identify whether there were implications in terms of the victims' rights directive. I will not say if that is so if the learned expert on the topic is not commenting on it. The Garda may have some obligations in respect of victims of crime. No matter how simple a report one makes to the Garda, one is reporting a crime and the Garda has obligations on foot of that. That may have an impact in terms of victims' rights.

Deputy Jonathan O'Brien: It could be a reason for people not to report it.

Ms Noeline Blackwell: Absolutely.

Deputy Jonathan O'Brien: I am somewhat hesitant to ask the next question but I need to know the answer to it. If legislation is brought in that allows terminations solely on the grounds of rape or incest and does not allow for freely available abortion in the first trimester but the issue of decriminalisation of abortion is not dealt with, could a woman who obtains a termination on rape grounds be liable to be judged to have committed a criminal offence if, at a subsequent criminal trial, the alleged rapist is found not guilty on the basis of insufficient evidence?

Mr. Tom O'Malley: Even under current law, I do not think that would be the case. It is a criminal offence to make a false report of a crime to the Garda, whether in respect of rape or any other crime. That an accused is put on trial and acquitted does not mean a false report has been made------

Deputy Jonathan O'Brien: I asked in respect of a woman who had obtained a termination------

Mr. Tom O'Malley: I am drawing an analogy. The answer is probably not. However, the Deputy's very pertinent questions show that legislating for this matter would be quite a complicated process and all those factors, including the victims' rights directive, would have to be taken into account. In my paper I referenced some issues that would arise if there were to be a verification process. There would be questions as to how that would link in to a subsequent trial. The Deputy's point about what would happen in the case of an acquittal would also need to be addressed. A law would have to be introduced to grant immunity from prosecution to women in such circumstances. Considerable attention would have to be given to drafting the appropriate law to take into account the various factors that have been mentioned here.

Deputy Jonathan O'Brien: Would it be possible to draft such legislation in view of the complexities that have been discussed today?

Mr. Tom O'Malley: It would be possible but it could be quite complex legislation. The more complex it is, the more difficult it is to implement and the more likely to give rise to court challenges as to its exact meaning, particularly during the early years of its implementation.

Deputy Jonathan O'Brien: And the more likely it is to fail the women we are trying to help.

Mr. Tom O'Malley: Yes. A court challenge could be totally counterproductive. The courts would have to decide the matter very quickly but, even so, it is a very unsatisfactory way of dealing with the law in this area.

Deputy Bernard J. Durkan: I acknowledge the work done by the Dublin Rape Crisis Centre over many decades in providing help, support, advice and counselling to women in very distressed situations who have often been brutalised and may have been thrown out of their homes, raped or both and may be pregnant. That should be acknowledged at the outset.

The question I want to raise relates to the under-reporting of rape and how we can get to deal with it in a way that is going to change the attitude. For example, let us consider a minor being the victim of rape. To my mind, there should not be any failure to report in that kind of situation. Whether it means better education in schools or for parents or whatever, we need to do that as a matter of urgency. This is because of the tendency to minimise the act if we allow it to continue the way it is.

My next question relates to a rape victim being pregnant. If there is no reporting, we cannot

do much about it. The witnesses have referred to advice and so on, but it should be possible not to force the victim to continue with a pregnancy and not to force her not to continue. There should be some degree of negotiation or discussion with her.

My last question is for Mr. Tom O'Malley. Is there reluctance by the authorities to take up cases of rape? I imagine this applies to other committee members as well, but I have put down Dáil questions on numerous occasions asking whether a given line of action was going to be taken in particular circumstances. Usually, this arises from the mothers of the victims, who have raised the question and are inquiring as to whether there was likely to be a prosecution or whatever.

My next point relating to prosecution is important. When a case goes to court, is the questioning of the victim not too strenuous? In some cases the victim may be young or inexperienced. She may have moderate special needs or may feel completely at sea under the degree of cross-examination applied. That may leave the victim virtually admitting in some cases that she was the cause of it.

Ms Noeline Blackwell: Under-reporting of rape is Europe-wide. It is everywhere we look. It is one of those areas where people do not report. This happens for some of the reasons I mentioned before: it is disruptive, and it may involve someone whom the victim knows well. The victims are not ready to say it because the trauma of the rape often takes time to come through. There is much discussion in the media at the moment on this. Our telephone lines are going crazy with people who are, sometimes for the first time, saying that they were victims of rape. It is something that is hard to do. We could not agree more with Deputy Durkan on the need for education, better awareness, and recognition that no persons are responsible for a crime that is committed against them. We certainly agree with Deputy Durkan on the need for decent school programmes.

To be clear, in the case of all people who come to our centre, it is entirely their decision as to what they do next. Actually, more people who have come in to us over the years saying they are pregnant as a result of rape have gone on to parent rather than take terminations. It is the woman's decision in all cases. She is the main agent.

We could not agree more with Deputy Durkan about cross-examination in court cases. This can be re-traumatising. We are hoping the victims' rights directive will help. I will put in a plug at this point: the Criminal Law (Sexual Offences) Act 2017 has not been commenced in respect of some really important criminal evidence provisions that would give better protection to vulnerable witnesses. We will mention them here as well.

Mr. Tom O'Malley: Deputy Durkan asked whether there was reluctance to prosecute rape. Once it gets to the stage of coming into the Office of the Director of Public Prosecutions, the criterion is clear. At that point, a prosecution will be taken if there is a realistic prospect of conviction. Sometimes, there can be so-called public interest factors at stake, where, for example, the victim is very young or old or there may be exceptional reasons why a prosecution should not be taken. Anyway, this is one area where the victims' rights directive mentioned by Deputy O'Brien becomes important, because people are entitled to reasons for decisions why prosecutions were not taken. There are some circumstances where the giving of reasons can be refused, for obvious reasons. However, the Director of Public Prosecutions has set up a special section within the office to deal with the giving of reasons to persons who are concerned that certain prosecutions were not taken. There are good developments taking place in that area.

Deputy Durkan asked about cross-examination. Certainly, many improvements have been made over the past 25 years or so. At one time, complainants could be cross-examined quite mercilessly about their sexual experiences with people other than the accused or with the accused. Now, there are severe restrictions, in that judicial permission is needed to engage in such cross-examination. In any event, juries nowadays are far less sympathetic to such cross-examination. They would not necessarily welcome the idea of a complainant being cross-examined in that fashion. Still, as Deputy Durkan rightly said, there is much thinking to be done about the optimal way of treating complainants, especially people who are vulnerable on the grounds of age, mental incapacity, learning difficulty or whatever. We have done a lot in that area. As Ms Blackwell has said, some further valuable innovations were made in the Criminal Law (Sexual Offences) Act 2017. They have not come into force yet.

We all have our own pet topics. One of my pet topics, which I earnestly urge upon Members of the Oireachtas, is the problem of how the law on sex offences, the entire law on evidence and the way it operates in the trial of sex offences, is now dispersed among at least a dozen statues dating from 1885 up to 2017. It is something of a maze in which one section from one statute amends another. There is a crying need for something that many other countries have done, that is to say, produce a single comprehensive sexual offence statute that sets out all the offences. There are all kinds of little inconsistencies in the statutes at the moment. For example, rape is governed by a subjective test of liability. A man is not guilty unless he believed the woman was consenting, whereas in the case of sex with an underage person, the man only has a defence if he was reasonably mistaken. There are many such inconsistencies. It would be wonderful if we had a single sex offence statute. The process of developing that could well provide us with the opportunity to look at the optimal conditions that should govern the trial process. In other words, it is a chance to examine what should really be in place to facilitate complainants who have problems in respect of age, mental disability or whatever to see the extent to which the existing law copes adequately with those problems. Then, in the process of reform, we could make any further changes that are needed.

Deputy Anne Rabbitte: I think most of the questions have been asked already, so I am not going to go back over them. I wanted to ask two questions in particular of Dr. Eogan and Ms Noeline Blackwell. They relate to funding of both units. Are they adequately funded because both units do an amazing amount of work? The second question is on consent and respectful relationships. I would like to see where we can take the area of education, because it comes in under three different points referenced earlier. It is a major block of work that needs to be addressed and I am keen to hear input from the witnesses.

Dr. Maeve Eogan: The funding of the sexual assault units comes through the HSE. However, it must be said that each unit is very much supported by the hospital in which it is situated as well. For example, my unit in the Rotunda Hospital is financially bankrolled by the Rotunda. The funding the hospital receives from the HSE would be inadequate to fund the unit as it currently operates. The same applies to all the units throughout the country.

Ultimately, although my unit sees 700 patients per year, I work in a hospital that delivers almost 9,000 babies. Committee members can imagine that it can be difficult to make the case for something that only provides care for 700 people in the year, albeit important care, when that service is in conflict with a health service that is subject to extraordinary demand. There is not enough funding.

Ms Noeline Blackwell: There is not enough funding for us either. All 16 rape crisis centres, operating within their own geographic areas nationally and collaborating where necessary and

possible, lost huge amounts of money, approximately 20% of funding and more in some cases, during the course of the recession. Funding has not yet been restored to pre-recession levels and we cannot meet the need we know exists with the funding we get from the Department of Children and Youth Affairs via Tusla and the Department of Justice and Equality via Cosc. While we recognise that both Departments are doing their best within their budgets to fund us, we have huge concerns, given the challenge to meet our current need, that we are certainly not meeting the full need that is out there. There is a requirement to better assess and understand the need, which is why we keep going back to the call for more adequate and improved data on sexual, domestic and gender-based violence in Ireland. That is a constant struggle. While we appreciate what we get, fundraising must supplement it. We receive contributions from clients where they can pay, but the majority of clients, if they pay anything, pay less than €20. It is really a token contribution.

Consent in respectful relationships is part of the key to the solution. So much damage is done where children and young people, in particular, do not understand consent, fail to talk about it, fail to learn when to say "No" or "Yes" and fail to learn how to hear "No" or "Yes" either. It would make a huge difference to the development of respectful relationships and improved self-regard if there was a sufficient focus on that at a time when children are at a vulnerable age. We have programmes whereby we work with teachers and Youthreach facilitators but it is voluntary. Teachers and Youthreach workers have to find the money to come to us, although we get some funding for that from Cosc. In addition, a programme is being rolled out by us and other rape crisis centres and the Manuela Riedo Foundation in Galway is also trying to develop something but these programmes are tiny and they are not going to get us where we need to go. We also work with universities but while good work is being done there also, it is a patchwork. While all of that is necessary, there is also a big job for the public. We have people contacting us, including women of mature age, who say "I thought I had to put up with it". They are only starting to learn now about what consent means in their own relationships. They were putting up with abusive and violent relationships. As such, there is a great deal of work for us to do in that area. It would be a game changer if there was a sufficient focus on that as a topic. I apologise for running on a bit.

Chairman: It is probably a topic on which to expand on another day, perhaps in a different committee.

Ms Noeline Blackwell: Indeed, it is one of the ancillary recommendations of the Citizens' Assembly. As such, we would be very happy to come back and give a fuller presentation on that if it is of use.

Chairman: The committee agreed that, if necessary, we could have people back under another module but we will try to avoid having to do that. If Ms Blackwell has any input on that, we would appreciate it. I thank the witnesses for their attendance here today, for which the committee is very grateful. We will take a ten-minute break, even though there are witnesses waiting outside, as it would be nice to grab an apple or something to keep us going.

Sitting suspended at 6.55 p.m. and resumed at 7.20 p.m.

Termination in Cases of Foetal Abnormality: Termination for Medical Reasons Ireland

Chairman: I welcome members back to the third session of today's meeting of the Joint

Committee on the Eighth Amendment to the Constitution where we will receive a presentation from Termination For Medical Reasons Ireland.

Senator Mullen has written an email to me today in response to Dr. Peter Boylan. I have not had the opportunity to read the email properly because I am focused on what this committee is doing here today. If the Senator would like to read it to the committee I will allow that.

Senator Rónán Mullen: I thank the Chairman. I am very grateful to her for affording me this opportunity and I will be brief.

> I note that Dr. Peter Boylan sent in an email today just before the Committee met, relating to last week's proceedings. I also note that you read his email into the record at today's first session of the Committee. [I have no problem with that] I believe that Dr. Boylan has misrepresented me and that nothing that I said was at variance with the facts ... Dr. Boylan claims that I "made several assertions at odds with the facts" at the Committee hearing at which he appeared last Wednesday. He only attempts to provide one such assertion and even there he doesn't manage to bring his claim home.
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> I said at the Committee that the doctors involved in the Savita Halappanavar case "did not claim that it was down to the law in Ireland but that it was down to the mismanagement of a situation". My point has been, and remains, that the doctors involved in that tragic case did not try to blame the law in Ireland for what happened to Savita, but rather that they acknowledged the medical mismanagement of her sepsis. I have been critical, and remain so, of campaigners who try to exploit Savita's death to bring about the legalisation of abortion, when it has always been the case that any life-saving treatment a mother needs, including treatment that brings her pregnancy to an end, is legal and is routine practice.
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> In support of his claim, Dr. Boylan draws attention to a transcript of the inquest and in particular to a section in which the consultant in the case was asked if she felt "constrained or inhibited by Irish law" and her answer of "Yes. Because termination of a pregnancy which is what she was requesting, is not legal in the context in which she requested it". The doctor had just stated that she understood the late Savita was "not physically unwell" and because "the law states that in the absence of risk to the life of the mother there is no reason to intervene". At a later point in the transcript, the doctor says that, had she been aware of certain physical symptoms which had been noted earlier, she would have intervened. So it is clear that the doctors never sought to blame Savita's death on their being unable to give necessary treatment because of the law in Ireland. My presentation of the facts at the Committee was therefore completely accurate. Dr. Boylan shouldn't misrepresent my words.
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> It is noteworthy in passing that several obstetricians and a consultant in emergency medicine have taken issue in public with Dr. Boylan's opinion that Irish law prevented necessary treatment to save Savita Halappanavar's life - see Irish Times Letters, 1st May 2013. They suggest that Dr Boylan's view on this matter is "a personal view, not an expert one".

That concludes that portion of the statement I issued today relating to Dr. Boylan's comments. I am very grateful to the Chairman for giving me the opportunity to put this on the record promptly. Because the committee will not meet next week two weeks would have elapsed before I had the opportunity to take issue with what Dr. Boylan had said in his complaint.

Chairman: I thank Senator Mullen. Both pieces of correspondence are on the public record now. It is up to the public to make judgments on Dr. Boylan's and Senator Mullen's comments. There is a potential for Dr. Boylan to seek to reply once again, thereby creating a cycle of cor-

respondence, which I would like to avoid, as I said to Senator Mullen before the meeting. For the moment we will leave it there.

Deputy Ruth Coppinger: I did not know that this was going to come up in public session. The matter came up in an earlier session, and if the person wanted to reply he should have raised it there. Things have just been said that are completely and utterly refuted by Professor Sabaratnam Arulkumaran, who actually conducted an investigation and did not just read the notes. It is quite upsetting that this is constantly being brought up in the week when this woman's family must relive the nightmare of what happened. It is her family that wanted social change arising from her death. It is very awkward; who will answer all this, and who will address these untruths and misinformation?

Chairman: That is my point. When I explained the scenario to Senator Mullen he appreciated that it is likely to be a tit-for-tat situation on the issue, and I am not being frivolous in my language. Deputy Coppinger has quite rightly pointed this out as an issue.

Deputy Billy Kelleher: We do not want to end up in a situation where the committee's public session every week has clarifications sought and given, which then require further clarifications. Some of the commentary about the late Savita Halappanavar is very distasteful, to say the very least. I do not believe that the committee should be consistently referring to this woman who tragically died as if she was just a statistic and in such a harsh, cold and clinical way all the time. We should now listen to the witnesses who are before us this evening.

Chairman: I could not agree more.

Senator Rónán Mullen: Since I have been criticised by two members of the committee-----

Deputy Billy Kelleher: I did not make reference to the Senator. I was speaking about the committee.

Senator Rónán Mullen: I assumed that Deputy Kelleher was not referring to me, so I thank him for clarifying that. Dr. Boylan's email reached me very shortly before the committee today. It is the Chairman's call to read it into the record so soon. As I have said, I have no issue with that. A longer period of time has elapsed before I got my response in and this is why I am very grateful to the committee for allowing me - in the spirit of fair play - to not have to wait two weeks before rebutting what I regard to be a completely ungrounded criticism. That was my only reason. I am sorry that Deputy Coppinger wishes that I had emailed the whole committee at the time I emailed the Chairperson today, but I thought that this decision seemed to be in the remit of the Chairman. I too want to apologise to our guests today because I have no wish to hold up their presentation.

Chairman: There is a lot that I would like to say but I shall restrain myself and ask that our witnesses speak to us. I welcome Mr. Gerry Edwards, chairman of Termination for Medical Reasons Ireland, and Ms Claire Cullen-Delsol, also from Termination for Medical Reasons Ireland.

Mr. Gerry Edwards: We thank Senator Noone and the committee for extending an invitation to us to present to it today. Termination for Medical Reasons Ireland, TFMR, is a group of parents, mums and dads, who have all been affected by pregnancies where there was a diagnosis of a severe or fatal foetal anomaly. We were all denied access to the care that we needed as a direct result of the eighth amendment. Many of us had to travel to another country to access the care we needed, while others among us were forced, against our will, to continue our preg-

nancies in Ireland. All of us were forced to endure suffering above and beyond the loss of our babies because of the constraints this amendment placed upon us and our care givers.

TFMR has also provided emotional support to other women and families who have faced into similar tragedies and journeys for many years and we are privileged that some of them entrust their stories to us so we can share them today with the members today. It is, however, not just us who are behind the stories we will describe and the circumstances we will outline to the committee. Behind everything we discuss there are bereaved families and we trust that all the members will afford them the respect and dignity that they deserve.

We hope that our submission document and the contribution we make here will help each committee member to arrive at a fully informed position when they make their own recommendations at the end of this process.

We think it would be appropriate for us to start off by looking at the events which lead up to us having to make what is, without doubt, the most difficult decision of our lives. This decision is a deeply personal one. We shall present a fairly high-level view of the matters but have provided more detail in our written submission.

Most of us received our first indication that there was any problem with our baby's development at the anomaly scan. This typically takes place between 19 and 22 weeks of gestation. Others, who may have a history of foetal anomaly or are at increased risk, may receive earlier scans and some people pay for additional testing themselves. It is important to note that a lot of women do not have access to these tests at all. Only about half of pregnant women in Ireland are offered anomaly scans. We heard this week that access to scans in Galway is due to be scaled back later this year or early next year. I am sure the committee does not need us to tell it how much of a shock it is to be really excited about a pregnancy in one moment only to have a doctor say there may be a serious problem in the next. In some cases, further tests may need to be performed to get a confirmed diagnosis. There may also be a need to refer to other specialties like cardiologists, paediatricians and neurologists. It can take several weeks to schedule all of these tests and to get results, and in some cases we may need to have them repeated over a period to see whether the prognosis for the baby is improving or deteriorating. Eventually, our doctors will sit down with us and explain in good faith and based on their personal experience what they believe is the most likely outcome for our pregnancy, that our babies are going to die or they will have a very seriously compromised quality of life. This prognosis will be based upon the results of our tests, what they have learned through their professional experience and the specific manner in which these anomalies have affected our babies.

It is devastating news to hear. Our hearts are broken and our worlds stop but it is so important that our doctors are frank and honest when they deliver the prognosis to us. It is important they do not sugar-coat the news with euphemisms because we must have a clear understanding of what our baby faces, and what we face, so we can accept and understand the reality and make an informed decision on how best to proceed.

The decision to either continue or terminate a pregnancy in these circumstances is very difficult for most people. To make it we need the best information available to us and we need to be able to discuss all options with our medical teams; most importantly, we need personal time and space to arrive at the decision we believe to be best for our baby, for us and our families.

It is important to point out at this stage that it is simply not possible for families to get that level of information, process it and arrive at a decision best for them within a 22-week gestation

limit. We should bear in mind that those who get news at all may only receive an indication that something is wrong around that time. We propose the 22-week limit recommended by the Citizens' Assembly be set aside in the committee's consideration and there should be no time limit with regard to foetal or maternal health. We all want to hold on to hope for as long as we can and nobody should be rushed or judged for coming to the point where hope ends.

For those of us who chose to terminate our pregnancies and were forced to travel to lose our babies, we were basically left to our own devices. As our doctors could not do this for us, we had to find and contact overseas hospitals. We had to make our own appointments, get copies of our medical records and find fax machines, which is becoming increasingly difficult. We had to make our own travel arrangements and decide if we would go by aeroplane or by car or boat. How do we get from the airport or ferry port to the hospital? Who will travel with us? If we already have children at home, who will look after them? How do we get time off work? Do we have a passport and can we even afford it? It is also worth pointing out that when we go for an induced labour and delivery we have no way of knowing how long it will take and we cannot book a return journey. We have to wait until the process is over and then make separate arrangements. This adds to the stress and cost for the families involved.

It is worth reflecting in this context on the words of Mr. Justice Horner when he said that forcing women to travel in these circumstances "can have the consequence of imposing an intolerable financial and mental burden on those least able to bear it". He went on to say "the protection of morals should not contemplate a restriction that bites on the impoverished but not the wealthy. That smacks of one law for the rich and one law for the poor". Nobody in Ireland would support such inequality today. At a time when we are experiencing the most intense grief of our lives, we find ourselves in another country, often having left Ireland in secret, feeling like medical refugees. We are abandoned by Ireland - the State and its people - isolated from our families and friends and separated from the medical team that looked after us up to this point.

After the procedure, when we return, we need to figure out if we can bring our babies with us and, if so, how? If we have our car we can bring our baby home on the boat. This journey involves us having to go to a supermarket to buy freezer packs. These are like the types that one uses on sport injuries. We have to stop at regular intervals on the homeward journey, at petrol stations or supermarket car parks, to open the coffin and change the freezer packs so our baby's remains can be kept cold. This is so we can present our babies to siblings, grandparents, aunts and uncles when we return home at a funeral. When we cross the Irish Sea, we must leave our baby in the coffin in the car, either on the back seat covered with a blanket or in the boot. If we are coming home by ferry and do not have a car, we must use public transport; we would have to carry coffins on buses or trains from Liverpool, Manchester, Birmingham and London to Holyhead before boarding the Stena ferry. That is just inhuman.

If we are flying home, we may be able to bring our baby's remains home but we must check in advance with the airlines and deal with the special assistance staff. We may need to place the coffin in a holdall or suitcase and check it in as luggage. This leaves us in a position where we must trust baggage handlers to treat our dead babies with the respect they deserve. Many people are afraid that simply will not happen. We could have to collect our baby's remains from a luggage carousel in Dublin, Cork, Shannon, Galway or Knock. Alternatively, we could take the small coffin on the plane as hand luggage. These are the circumstances that women and families have to go through literally within hours of giving birth. Women from this country have had to go through the normal trauma of delivery and the utter grief of losing a much-wanted baby before taking on this type of journey. How do members think it makes people in

this country feel? Would they be comfortable with their family members or neighbours having to make a journey like that?

Sometimes we cannot bring our baby home as there may need to be an autopsy or results of genetic testing that will provide information about considering future pregnancies. As we are not in Ireland and we are not National Health Service patients, we have to pay up to £900 for an autopsy. We then have to arrange cremation, which we may not be able to attend because it involves another trip to the UK or further afield. We still have to bring our baby's ashes home to the family. Specialist courier services are now costing between £800 and £900 for delivery of cremated remains so most people travel back to the UK to collect them. This creates much additional trauma, as apart from cost, one must get back through airport security with a box containing the baby's cremated remains. Very often, that involves dads having to send mums through ahead as these people know a box with powder will show up on the security scanner and they must explain the origin of the box and why they are travelling home.

Even if we get our babies home, there are more logistics. How do we arrange a funeral when one is not coming from a hospital in Ireland? Can we get a priest to officiate? Some people are afraid to tell priests the truth as they are afraid of being judged and condemned. Others simply do not want to lie so they forgo the religious ceremony. Not being able to bring our baby home and not being able to have a normal funeral service, with the support of our family, friends and community, further compounds the sense of isolation and abandonment we feel. This is a process that is important not just for the parents to get closure, but for the grandparents, siblings and other family members too. It makes it almost impossible for us to grieve normally and leads to more traumatic, complicated and disenfranchised grief than would be expected if we were properly supported throughout this entire process.

Ms Claire Cullen-Delsol: It is often assumed the decision to terminate is black and white; a person will do it or not, depending on what she wants. There are those of us who wish to avail of a termination of pregnancy but do not travel. Many families and women in Ireland continue a pregnancy, not because it is the right thing for them to do but because the ordeal involved in ending a pregnancy under the current regime is too arduous. We may not be able to afford to do so. As Mr. Edwards stated, there are the costs of flights, which may involve up to three round trips, accommodation, the procedure, a post-mortem, cremation and transport home of the baby's remains. These may amount to as much as €4,000 for each couple, which is a substantial sum of money for most families. It is certainly a massive sum for my family. In most cases, these costs are prohibitive.

We may not be able to travel. We may simply not be able to face the stress of travelling and returning home without a bump or a baby. The emotional toll of travelling cannot be underestimated. Grief has many more facets than sadness. Anxiety, exhaustion, panic attacks and deep mistrust are all symptoms of complicated grief, which can make travelling through airports to foreign cities and in taxis and buses to a strange hospital impossible and much more traumatic than it may appear to an outsider. This was the greatest barrier for me, alongside the unbearable thought of leaving my two children in Ireland and then leaving their dead sister in England.

The stigma associated with travel is enormous. Many fear there will be gossip and judgment and their family, friends or community will exclude or talk about them. This, along with the grief, is more than we can cope with. These are just some of the limitless number of reasons that travelling to end a pregnancy is not an option for everyone, even when we know a termination is the right thing for us, our baby and our family.

What happens to us in circumstance where we will not have a baby is that we are unable to travel and become trapped. We are in a nightmare scenario where we appear to be expecting a baby but are preparing for a massive loss. We are asked questions about our growing bump and people expect us to be happy about it. This is more than a woman can cope with. To avoid this, we isolate ourselves and hide. We go inside, lock the door and do not go out again. We suffer anxiety and nightmares and experience the ever-present knowledge that we are losing a baby alone. While we wait, we cannot lead normal lives and go to work, we struggle to take care of other children and all our relationships suffer massively. According to the eighth amendment, none of this matters because being alive is enough. It is not enough and it was not enough for me.

Pregnancy can affect our physical and mental health, even in previously healthy pregnancies where there are no foetal complications. However, when something goes wrong, whether it is a miscarriage, the woman's waters break or a foetal anomaly is detected, the risks to one's physical and mental health increase. Why is it that only our lives matter while we are pregnant? Why is it okay to completely ignore our physical and mental well-being? Does our well-being not matter when we are pregnant? Is it simply set aside and is it okay to be just alive? Whatever else we do with our laws, we need to ensure the normal duty of care to us, as living, breathing, functional members of society and as women and individuals, is never set aside.

When considering proposed changes to our laws, it is important that the committee also consider how women in Ireland will be protected and assured of access to information and services and have their safety and privacy protected. If abortion is legalised, it should be incorporated into current maternity care. Do not leave us out or continue to stigmatise and isolate us. It is important that lawful services are available to all pregnant women in Ireland, irrespective of where they live, how much they earn or how much money they have. This means that every maternity hospital, irrespective of its ethos, must be in a position to provide these services at all times. Health care should never be a black market product and no woman should ever be afraid to seek medical assistance for fear of arrest.

We respect and fully understand that some medical practitioners may object to carrying out abortions of any type on the basis of their own sincere beliefs. That is grand but we do not accept that this should ever be allowed to prevent a person from accessing the medical care he or she needs. The responsibility must be on every medical facility, regardless of ownership or ethos, to ensure the facility can and will provide procedures that are legal in this country. Conscientious objection should not be used in a manipulative manner to avoid taking care of some patients.

We also need to ensure protests, harassment of patients and the barring of access to medical facilities are not tolerated. We have seen what has been done in other countries and it cannot be tolerated here under any circumstances. Legally enforceable safe zones around medical facilities should be part of any legislation. These will be crucial to provide privacy and safety for patients, staff and visitors.

We hope we have been able to open a window into the unnecessary suffering the eighth amendment has inflicted on us and continues to inflict on other women at a time when they are at their most vulnerable and the diagnosis they receive should be the worst thing that has ever happened to them. We have provided much more detail in our main submission and we recommend that members take time to read the personal stories made available to the committee. None of us should have to reveal these intimate details to achieve change and we are grateful to those who have trusted us to submit their stories to the committee.

We hope we have been able to shine a light on how unworkable a gestational limit would be when addressing issues of foetal or maternal health. We are sure that by listening to our lived experiences and reading about how Ireland and its current laws added to our trauma, members will be in a much better informed position to consider the mature and compassionate recommendations made to them by citizens. We can only speak to the committee of our personal experiences. We know, however, that all women make decisions in these matters based on their private, personal and valid needs. We support all choices for everyone.

The committee has an opportunity to make a recommendation to the Government which recognises that we all make decisions around pregnancy and parenting in a mature and responsible manner. We trust that, having heard the expert evidence and lived experiences presented to it, the committee's recommendations will support us all in our decisions and look after us all when we need it.

Chairman: I thank Mr. Edwards and Ms Cullen-Delsol for sharing their very sad, personal and intimate stories with us. We appreciate that this is a difficult thing to do.

Deputy Louise O'Reilly: I thank Mr. Edwards and Ms Cullen-Delsol and echo the sentiment expressed by the Chair. I understand it is not easy for the witnesses to share their stories and it is extremely regrettable that it is necessary for them to do so. We sincerely thank them for sharing their stories with the committee. I understand the point Mr. Edwards made about people being afraid to talk to a priest about this issue. I can see exactly why it is regrettable and I imagine it is very real.

With regard to the support the group provided to the two women who took cases to the United Nations Human Rights Committee, will the witnesses talk us through that journey and the support the group provided to the women in question? Will they elaborate on the full range of prenatal tests that are required? We know, for example, that the maternity strategy was launched in January 2016 and that access to anomaly scanning is very much hit and miss. The witnesses are correct that access sometimes depends on a person's bank balance. However, it can also depend on where a person lives. We heard statements that scans are offered where clinically indicated but a screening scan will clearly not be clinically indicated.

When discussing the time involved, will the witnesses explain the screening that is available and the extent to which it needs to be enhanced in order to provide a full service? As Ms Cullen-Delsol stated, the first screening may show cause for further investigation. Given that time is often very important in these types of cases, will the witnesses talk the committee through how the process would work for people living in County Kerry or another area where people may not have access to these scans? What are the implications of this?

Chairman: I understand the witnesses are eager to answer any questions members may have. It is absolutely fine, however, if there are any questions that they find too difficult or that they are not comfortable answering. I ask them to just proceed as they wish.

Mr. Gerry Edwards: In respect of the two women who took their complaints to the United Nations Human Rights Committee, Ms Amanda Mellet is one of the founding members of Termination for Medical Reasons, TFMR. Ms Siobhán Whelan was one of the women who received support from Ms Mellet, Ms Ruth Bowie and Ms Arlette Lyons quite early on in the group's history. Ms Mellet provided support to many women while she was still recovering from her own traumatic loss. Ms Mellet and Ms Whelan made the decision to take the complaints against Ireland because Ireland did not seem to be stepping up to its own responsibilities.

It was really to show everybody the extent to which women are being brutalised and abused by the eighth amendment and by the lack of response from successive Governments to this issue. I am glad that we have moved on from that point and that we are here today to discuss a solution.

Questions were asked about tests. It is mainly the large Dublin hospitals that offer anomaly scans, the so-called "big scan" between 19 and 22 weeks. Some people get a dating scan earlier on just so as to make sure that sizes and dates are all right and we know, roughly, the rate at which babies are expected to continue to grow. These early scans sometimes pick up anomalies, particularly structural anomalies that are easier to spot, but sometimes what doctors refer to as "soft markers" do not show up until the 22-week scan. Soft markers do not give a clear diagnosis but indicate that there may be developmental issues. Further tests are then involved. Some tests require the taking of samples - chorionic villus sampling, CVS, tests frequently go to Scotland, for example - which means that the parents could be waiting for a further week or so to get a schedule for the test and then to get the results back. They could also be left waiting to get genetic information from an amniocentesis. There might also be a need for an MRI scan. Advanced scans might be required for heart issues, for example, which means that further specialists have to get involved to look at the extent to which the heart is developing incorrectly and whether this might be corrected by surgery *in utero* or shortly after birth. With some conditions, particularly where there is potential for severe impact on the baby that may not necessarily be fatal, parents need a lot more certainty before they can make a decision. It can take up to two weeks to get an MRI scan. A mother could quite easily be heading into 26, 28 or 30 weeks by this point and this is assuming that she is receiving proper care. In other parts of the country outside of Dublin, however, services can be particularly poor. This is no reflection on the doctors or medical staff involved but rather on the lack of resources. A mother might, for example, go to her GP at 30 or 32 weeks and comment that she has been feeling a reduction in the level of movement. It might be a mother's instinct that something is wrong late on in the pregnancy that eventually gets her referred for further tests.

In the context of the 22-week limit then, there was almost no discussion of severe foetal anomalies at the Citizens' Assembly. The sets of gestational limits put forward to the assembly did not apply to one particular option over another; they were put forward for all of the votes taken by the citizens. There was a lack of information there and they were not terribly well informed with regard to the process of diagnosis and getting a prognosis. Even at that, anyone who is told one's baby has a fatal or very severe condition needs time to think about it. It would be very damaging to put an arbitrary gestational limit in front of parents to the effect that unless they make their minds up before a certain point, they will be unable to avail of services in Ireland. There would be a risk that parents might make decisions more hastily than they otherwise would, possibly resulting in people opting for a termination where they might have realised that this was not perhaps the right decision for them if they had only had more time. Once that decision is made, however, it is made. I consider a 22-week limit, then, to be completely inappropriate and I hope that fatal and severe foetal anomalies would be considered together in this context and recognised as the tragedies that they are. These are wanted pregnancies. Parents who get to the 20-week or 22-week scan intend to bring that baby into their family and anything that intervenes in that is unforeseen. We need to make allowance for that in our legal and health systems in Ireland, rather than trying to find ways of catching people out or of leaving people outside of the safety nets.

I should also point out that some people have negative views about scans and testing almost as though they were a means to screen out and to eliminate. I have 11-year old twin daughters at home who are alive only because of the anomaly scan. They had severe twin-to-twin transfu-

sion syndrome diagnosed at 20 weeks and it was expected that they would both be dead within a matter of days. We were able to travel in order to have life-saving surgery for them which is now available here - we had to travel at the time because of resources rather than because of the law. My daughters are here because we were able to have scans.

While I acknowledge it is the intention of the national maternity strategy to provide these services to women throughout the country, it is not happening quickly enough People may be losing babies as a result of not being able to find out about conditions that could require intervention or necessitate mothers to give birth with the suitably skilled doctors in attendance.

I hope I have answered the questions fully.

Deputy Catherine Murphy: I thank the witnesses for sharing their experiences. Unfortunately people often need to hear real people talking about real experiences to get a full understanding of what exactly is involved. I have a question for Ms Cullen-Delsol. I know she did not travel. What would it have meant to her to have had different care pathways available to her here? What difference would that have made?

Ms Claire Cullen-Delsol: I get asked that a lot because my daughter Alex died in the womb at 26 weeks, only five weeks after her diagnosis. Those were the longest five weeks of my life. She was born in the maternity wing of University Hospital Waterford and then I got to bring her home for a night and to have a funeral service. Her family, that is, my parents and my brother got to meet her and my kids got to meet their sister. It probably sounds like it would not have made a difference had I travelled but I refer to those five weeks We were standing in the kitchen the day we got the phone call with the diagnosis. We had decided that we were going to paint the kitchen for the new baby so myself and my husband were standing in the kitchen painting when the phone rang. We answered and the fabulous midwife from Holles Street hospital told us the she was very sorry but that she had bad news and that our baby was going to die. I cannot describe that moment. The world just fell apart and it has never come back together properly since then, though I am getting there.

I realised at that point that I was going to have to continue the pregnancy. I could not face the thought of leaving my kids and I did not have the money to travel; I would have had to borrow it. I just could not do it. My little fellow was only 18 months old at the time and he had never spent a night away from me. As the pregnancy progressed, however, I could feel her getting weaker. I could feel the movements changing from kicks to movements to flutters that grew further and further apart. I was timing them and how long it had been since I felt a movement - six hours, ten hours, 14 hours. For two nights I sat up in bed convinced that she had died and I went through all the emotions. My child had died. In my head, she was gone. I had the grief, the mourning and all those feelings, and then I felt a tiny flutter ten hours later and again 14 hours later. In essence, I mourned her death twice before I actually experienced it.

In that time, I could not go out. I could not face the school run, for example, with the other mams at the gates saying, "When are you due? You will have a busy Christmas this year. Are you mad? They are so close together", and all the other excited questions. If somebody said that to me, I would just stand and bawl in front of them. The children would get distressed and I just did not know what to do. I was trying to get out and go to the supermarket. A woman would walk past with her baby and I would literally abandon the trolley and just leave, walk out the door. I could not face it. I could not participate in any part of my normal life. I called in sick to work and I never went back to that job again. I could not even drive up the road there because the other two women on my team who were pregnant were due around the same time

as me. I still have never seen them in person again.

This was looming ahead of me - I knew I was going to have a stillbirth. I knew she was dying. I was 24 weeks pregnant and she still was not kicking. I knew there was no way she was going to survive very long. I knew she was going to die. I was going to have to give birth to a dead baby. It was ahead of me; I did not know when, but it was going to happen. The worst thing in my life was in my future but there was no way for me to prepare for it or plan for it and I had no idea when it was going to happen. The nightmares I had were horrendous. Every single night I dreamed about what that birth was going to be like. The fear, the pain, what was going to get me through labour knowing that I would not have a baby at the end of it? What gets us through labour? The thought that it will all be worth it in the end. That is it. That is what the midwives say to us. Nobody was going to be able to say that to me. There was going to be no cry. I was not going to have a baby to bring home. I was not going to be able to feed her. She was never going to have baths. I was never going to change her nappy. That was all ahead of me and I could not bear the thought that it was going to happen and I was not able to do anything about it. I was not going to be able to be her mam.

During that time it just felt like I did not matter. It felt like I did not count. All the things that I hold dear, all the things that are important to me in my life, like minding my kids and being a good mam, having a good relationship with my husband, being a good friend, a good daughter, being an all right sister - those things are important to me. My job was important to me. When I could not perform any of those functions, it did not matter. There was a thing that could have been done to help me. There was something. I was not asking for a procedure to be invented. I was asking for something that takes place all around the world, that people recognise as real medical care. I was denied it. I was told I did not deserve it, that I was not good enough for it. The fact that I had to drop out of society, that I could not function, that I was not able to be me any more did not matter just as long as I was alive. From that experience, I ended up with post-traumatic stress disorder. I have been on medication ever since. I take a tablet every day to stop myself going off the deep end. Had I been given control and had somebody said, "actually, it does matter that you feel like this. It matters enough for us to do something about it", it would have made all the difference.

Deputy Catherine Murphy: I thank Ms Cullen-Delsol for sharing that with us. The written submission from Termination for Medical Reasons Ireland included two testimonies, by Aoife and Sarah. Sometimes other medical issues arise, such as sepsis, which was a very big risk to Aoife, or, for Sarah, issues relating to continuing care that had to happen in a psychiatric hospital which, she says, was not to do with the termination but how she was treated. Might Mr. Edwards expand on those a little bit?

Mr. Gerry Edwards: Aoife, not terribly dissimilarly to Savita actually, got ill during the pregnancy. It was quite apparent to all the doctors that her pregnancy was not going to carry to term, that her baby was not going to survive. Aoife got sick and developed infection. She needed to be in hospital. She was given three choices. She was told that the baby's heart could stop and they could induce labour, much like Claire was told; that she could get sick enough for them to intervene in the pregnancy; or that she could go to England. It is terrifying for a woman to be told to hang on in there until she gets sick enough for them to intervene. We know now that she might get sick enough for intervention but might become too sick to be saved. The only reason we have not had another Savita in five years is that, because of Savita, people know about the risks and they travel. The thirteenth amendment is what saves women's lives, not the eighth.

Chairman: I thank Mr. Edwards. I do not wish to curtail what he is saying but a lot of members want to ask questions.

Deputy Kate O'Connell: I thank both witnesses for coming in to speak to us today. For me, the focus of this committee is on the dignity of women. We are also focusing on unborn life or the unborn children. Do both witnesses think that the eighth amendment afforded them and their unborn children, now their children who have passed, any dignity?

There is a thing when someone is expecting a child - maybe I am wrong on this - that once it gets to 12 weeks, there is a feeling that it is all grand. Obviously we all know now that is not the case. However, we think that what happened to the witnesses will not happen to ourselves, that those things happen to other people. I do not think there is any greater pain, although I know it is hard to quantify pain. We heard earlier from a psychiatrist about the hormones in the brain affecting the body and all that, which explained a lot to me, but it is a complicated grief, as has been said. There really is a sense of abandonment and almost a guilt - as though somehow the woman is nearly to blame for the situation because she is the carrier of the child.

As the man in the situation, I would like to ask how Mr. Edwards felt. My own story is documented. My husband was probably more affected than I was at the time. How did Mr. Edwards feel in that moment when decisions had to be made? How did he feel about a vulnerable pregnant woman who, I suppose, he would have liked to take care of and mind?

Mr. Gerry Edwards: I will take the last question first and then come back to the issue of dignity. I felt useless when we got the diagnosis. We went in for the scan together and we were looking at crèches near work. I was thinking that if we went for this particular crèche, I would be able to pop up during my lunch breaks. I would be "Super Dad" and it would all be wonderful. For both of us, everything stopped. My wife, Gaye, was the one who was pregnant. She was the one who could feel Joshua moving inside her. She was the one going through all that physical thing. As dads, we are sort of bystanders. I think I felt I did not have a function. There was not a job that I could do to fix anything. I could not make anything better. I got to make all the phone calls. I got to do things like pick out the Golden Pages and try to find phone numbers in London and explain to strangers what was happening.

Since we were at 20 weeks, we could go to a hospital - we did not know any hospitals in England. I was trying to support Gaye as best I could. I could not, and did not, deal with any grief at the time because I had things to do. I had to be the person who did practical things - make appointments, drive, all of that stuff. At the end, I had to take Gaye away from her baby, our baby. He was delivered in Belfast and we did not know that one could bring a baby home. I thought I would have to smuggle my dead son back to try to have a funeral. I had visions of climbing over a cemetery wall with a shovel. I knew that I could not do that so we had to leave him behind for cremation and I had to take Gaye away from him. I did not feel like a good husband or father at that time. That stuck with me for a long time afterwards.

On dignity, me, my wife and our son were treated with the utmost dignity abroad; we felt we were treated like outcasts here. We did not get to attend our son's cremation. We did not know when it was; we just got a courier package at our door within a couple of weeks of his death. We signed for him like one would any Amazon delivery. The thought that our son was cremated alone troubled us for a long time. It really haunted us that we were not there. Years later, I learned that the pathologist from the hospital travels to the crematorium with the babies that are left in her care. She takes them in her car and she sits with them while they are cremated so they are not alone. I learned that about ten years after he died and we cried again then because

we saw that there were people who did not know us from a bar of soap and cared about us and our baby enough to do that in a completely unsung way. It just made us more angry at how we had felt abandoned by Ireland at the time.

Deputy Kate O'Connell: Every couple's experience is unique. It is clear from the many stories we hear that the outcomes are different and there are many different permutations. I hope that next year the law is changed in order to provide dignified access to medical care in Ireland.

The witnesses spoke of people who receive a diagnosis of complications, of fatal foetal abnormalities, a complex blend of things, and of term limits and testing. What they said about things taking time was correct. No one will make the decision easy. There will always be a second or third opinion and that brings us back to matters of education and access to information; the wealthier one is and the more educated one is, the more access one has to all this.

What would the witnesses like to see happen? Would they like to see people in their situation supported to whatever stage in the pregnancy they continue? Can the witnesses spell out what, ideally, they would hope to see which would alleviate the grief to some extent? I believe the witnesses do worthwhile work but what would be the achievement that they would like to see that would be of massive significance in Ireland?

Ms Claire Cullen-Delsol: The Deputy's observation that no couple is the same is really important. Nor is any pregnancy the same. We work with many women who receive the same diagnosis twice, for example. In their first, they might do what I did and carry the baby to term and on the second they might say that they absolutely cannot do it again. There are many permutations of that. It depends on the children one might have at home, for example, and one's other responsibilities. One might be looking after elderly parents, or one might have no money. We cannot go through all the variables. No one law will cover every permutation of people's lives because life is messy. Life is hard at times and there is no quota on tragedy or the amount that life can throw at one and what one has to deal with.

What I would like is to never again have to answer the phone to a woman who has questions such as how long her baby will stay warm for or if can get finger prints. Can she take pictures? Can she show them to people? How will they react? I would love for someone who is qualified, someone who has more than just the experience of having gone through this, to answer those questions for every woman who has them. I want to see everyone's needs met. That might be utopian but pregnancies are tough. Even healthy pregnancies are incredibly hard. I did not see the earlier session, but the committee will have heard how prenatal mental health care does not exist here. There are no services. One does not get looked after, particularly for pregnancies after one has had a loss. It could be a healthy pregnancy but it could be the hardest, and there is nothing there to support women through those journeys. I want to see a respectful, dignified procedure where women are listened to, their needs - whatever they may be - are met, where the external family, including the partner, is looked after, the children can talk about what is happening and where a woman can come to a decision that actually meets her needs. People ask me if I would have a termination if I received the same diagnosis again. I do not know; I cannot answer that question now. What I would like is the choice, which is all we can ask for. Give people the choice.

Deputy Hildegarde Naughton: I thank both of the witnesses for their brave and powerful words this evening. In their submission, they said that they were forced to endure unnecessary suffering. Ms Cullen-Delsol may have answered part of my question already, which relates to

State supports during the pregnancy, whether leading up to the termination or in the case that the woman proceeds with the pregnancy, and then afterwards. Other than termination being offered in Ireland, from their own experiences and those of others, can the witnesses identify specific State supports that should be in place prior to termination or birth and afterwards?

Ms Claire Cullen-Delsol: Currently there is nothing. Most of our counselling came from charities or support groups such as our own, Termination for Medical Reasons Ireland. My daughter has never had counselling although we have requested it several times. My husband only had counselling this year through work. Much of it is just maternal mental health care, because there is nothing that can be done physically, especially while one is still pregnant, but one could be supported, listened to and have the opportunity to talk about the situation. At the moment there is nothing there. Even in terms of practical support, there is nobody to explain how to fill up a stillbirth certificate or at what stage. One has to Google it. If it was not for my GP, I would have had no one to talk to outside my family. She used to call me and tell me to come up for an appointment and made sure that I came up every week to talk to her. I would sit there and rant and cry and she would listen. That was it and because maternal antenatal care with the GP is free, I could do that for free.

My midwife in the hospital only saw me once. She took me through what a still birth would be like, how I would know when Alex had died, what the signs were and what to do afterwards. That was in a maternity setting, in a maternity hospital. When I went in after my doctor could not find a heartbeat, I went to the clinic to have a scan and sat in a room with 30 other pregnant women who were all expecting babies, and I knew my baby was dead. My son was asleep beside me in his push chair and my husband was beside me, with people coming in and out, asking all the normal questions. That was just unbearable. There was no need for that. We need to be able to afford people privacy and dignity and respect and be understanding of their circumstances. Imagine sitting there, knowing one's child has died and facing a still birth, having to sit in a waiting room with 30 pregnant women and their excited families. They were swapping scan photographs in front of me.

Maternal mental health care is very important. It is essential for the well-being of all of society because the mams are making the people for the country. We need to keep them well and mind them, and that means minding their mental health because, God knows, being pregnant and having kids can be trying on mental health. That is probably step one and then after that choices and availability.

The little touches that make it bearable, such as the little things that one gets in the hospital like the clothes for the baby, the photographer who comes and takes pictures, the memory box, candles and blankets, are all provided by a charity, Féileacáin. They are not provided by the hospital. To my knowledge, the only thing the State actually provides is the coffin and that might be quite telling regarding the State's position on providing support and services.

Deputy Ruth Coppinger: I thank both witnesses for contributing. It would be difficult for anybody to listen to what they had to say. Nobody, including myself, would have even considered some of the details and how harrowing it must have been, particularly for somebody who wants to go through with the abortion but cannot for practical reasons. That is not widely known in Ireland. Awareness about fatal foetal abnormality and foetal abnormality, which is as serious, has increased over the past number of years with people such as them speaking out in the national media.

How did they feel when two Bills were voted down that might have allowed for fatal foe-

tal abnormality to be dealt with even within the confines of the eighth amendment? We have been told that it is necessary to repeal or at least amend the amendment to provide for this vital health issue. The presentation refers to the time limit proposed by the Citizens' Assembly. We are here to deal with the assembly's report. It was hugely sympathetic to the view that there must be change on this issue and it overwhelmingly voted in favour. Would it be fair to say the assembly did not have sufficient time to hear evidence about the difficulties of imposing a 22-week limit? Termination for Medical Reasons Ireland did not get an opportunity to testify, which is one of the reasons we were anxious to bring the group before the committee. Should there not be any time limit? Should it be indefinite? Will the witnesses elaborate on that?

Last week, I asked Peter Boylan a question about late term or post-23 week abortions that we hear a great deal about from people who are opposed to abortion in general. It tends to be the image that is presented, which must be upsetting for those who have had to go through that. He made the point that they probably accounted for 1% of abortions. The issue of a time limit, therefore, would arise rarely.

I would like them to comment on another issue but it is entirely up to them. Reference has been made during previous meetings to Canada and this notion of botched abortions and babies being left to die, which must have been upsetting for people to hear. The organisation feels strongly about this and I wonder whether the witnesses would care to comment. I gather from people who have experienced this that sometimes they have been abused on social media by people who oppose abortion. Would they like to comment on that?

Mr. Gerry Edwards: With regard to the fatal foetal anomaly Bills that were presented and defeated, we were heartbroken. We believed that there was a legal avenue available. The advice the Government received was based on the predication that life meant born alive rather than capable of sustaining life and I still believe that had that question been put to the Supreme Court, it would have viewed it sympathetically. However, that did not get anywhere and we are where we are today. Hopefully, we can move this on. It is unfortunate that many people will have suffered in the intervening period without that having been explored to its fullest when the opportunity presented.

Gestational limits just cannot be applied when it comes to both foetal and maternal health. They are completely unworkable and totally arbitrary. The Citizens' Assembly did not get to discuss severe foetal anomalies. They recognised that there could not be a time limit for fatal foetal anomaly, but there was no discussion about severe anomalies. When they were presented with the various options - not at all, up to 12 weeks, 22 weeks or without gestational limit - in respect of each of the votes they cast, questions were asked about where they came from. They came from the advisory group working with Ms Justice Laffoy; they did not come from the citizens themselves. They were, therefore, tied into voting along those lines. Our view is that there cannot be gestational limits. That will perpetuate the situation of driving people who can travel, from a health point of view, a financial point of view and a legal status point of view, out of the country. That would create a situation whereby we would be by design making women in Ireland dependent on another country for health care. If that is done, then we are not an independent country. If we are going to describe ourselves as an independent country, then we need to look after all the people in Ireland here. That is what independence is about; it is not just about the bits one likes.

The comments on late term abortions have been made for some time and not just during the current committee debates. Comments about botched abortions, whether they are in Canada, Australia and England, and babies being born alive and left to die alone by parents and doctors

in corners of hospital rooms, as though they have to move equipment out of the corner to put the baby in to die, are absolutely outrageous. I cannot understand the humanity behind coming up with that type of a grotesque scenario. We were aware that late term abortions generally happen because of foetal or maternal health. If the mother's health is in danger, the doctors will do everything they can to save the baby without compromising the mother, otherwise we are talking about situations where it is because of foetal health. There is always the possibility that a baby may be born alive and there is a medical procedure the mother can take, which will stop the baby's heart. That is to prevent distress to the baby if he or she is alive when delivered. Some women choose that and people in the anti-abortion campaign criticise those women for making that difficult decision while other women choose not to do this. That can result in a live birth but that is not a botched abortion. An expected outcome from a premature induced labour is that the baby may die and women choose that because they may wish to have the opportunity to meet their baby. It gives them great comfort to do so and those babies, like any other baby, are given all the comfort and care they require to help them to pass away peacefully. They may do that in their mother's arms. It is quite repugnant for anybody to try to portray bereaved parents and the doctors who care for them in that particular manner. We fully understand that people will have different views about abortion services. That is perfectly natural, but it is important, both here and in the national debate, that we stick to facts and honesty and keep the grotesquery away from this kind of debate. It is too serious. I will leave it at that, if that is okay.

Deputy Lisa Chambers: I thank Mr. Edwards and Ms Cullen-Delsol for their presentation. Quite honestly, I found it difficult to listen to what they have just told the committee. I cannot imagine how difficult it is to have gone through that and then to have to recount the trauma that they and their families went through for the purposes of effecting change, but I thank them for doing so.

I do not have many questions because I do not disagree. The purpose of the committee is to hear evidence and to test that evidence at times or provide an alternative view, but I do not disagree with anything that they have said. What they said makes perfect sense. What does not make sense is that we do not have services for those situations today. It is remarkable. Only for the services provided in another jurisdiction close by we probably would have dealt with this issue a long time ago.

I would be interested to know what the next steps were immediately after they got the diagnosis. Ms Cullen-Delsol mentioned she got a phone call and I am not sure whether the Edwards family were told in person or over the phone. What did their doctors do because, obviously, they are quite constrained in what they can say and what help they can offer? What happened, maybe that day or the day after, subsequent to them getting the diagnosis?

Ms Claire Cullen-Delsol: I live in Waterford and I had to travel to Dublin to have an amniocentesis and a scan done. The amniocentesis was done in Holles Street after a scan. They send the sample to the UK and then the results are faxed back. My results were delayed. I was supposed to get them on a Friday and I had wait the weekend and get them on Monday because the fax machine in the laboratory in Scotland broke. Rather than, I think the term was "dragging us up and down to Dublin", they said they would give us a call. The fabulous midwife in Holles Street rang and gave us the news. Then she said she would leave it for a few minutes and give us a call back and see what we would do. When she called back, she asked whether we would like to come in to speak to them again, and I said I wanted to go back and to know what was going on.

We drove back up to Holles Street the next morning - we found childcare for the children

and headed back up - and we had approximately 20 minutes or half an hour with the foetal medicine specialist there. He was very kind. Mostly, he was just very honest. "Your baby is going to die," he repeated. He did not give us any false hope. When I asked what do I do, however, he started saying that some people find work is a nice distraction and I might go back to work. I was saying I could not go back to work. I was massive. I had a huge bump. Later I found out that was because Alex did not have a mouth or stomach and she was not swallowing the amniotic fluid. So my bump grew and grew and grew. I could not face that.

Then they said that they were not going to keep dragging me up and down, there was nothing they could do for me there and they would relay me back to my team in Waterford. I had been with the Domino midwives, who look after the woman, but with a light touch with very little intervention. When I got back, I rang them and asked what I should do, and they said they could not look after me because it was no longer a simple, low-risk pregnancy. They said they would refer me on to somebody else.

At that point, the doctors in Dublin were supposed to be referring me back to a doctor in Waterford and the Domino team was also supposed to be referring me on, and it seemed I just kind of got lost. I did not get an appointment, a phone call or anything. I was just left. So I went to my GP and asked what I should do. At this point, there were three people I had asked what I should do. Eventually, I got an appointment with the consultant in Waterford and he saw me. I had a funny turn when I went into that waiting room again, with lots of pregnant women, but, luckily, another amazing midwife came tearing out and dragged me into the corridor stating that she did not want me to have to sit out there and she had been waiting for me all day. Then I had another scan and was asked to come back in five weeks. That is what happens. A person goes in, she is scanned, they check her blood pressure and they send her home.

Mr. Gerry Edwards: We were told pretty much nothing. Our son had anencephaly so that most of his skull and brain were absent. There was no need for further tests. The scan was as conclusive as it needed to be. We were told that they could continue to bring us in and check for a heartbeat, but that was all that they could do in this jurisdiction and that was it. We ourselves had to pick up that the term "in this jurisdiction" was like a breadcrumb and we had to follow it ourselves. Otherwise, my wife would just have to go back into Holles Street every couple of weeks and confirm that our son was still alive inside her which, with that particular condition, would have been likely. He would continue to grow because he was being supported by the umbilical cord but, because he did not have a brain, once that separation occurred, he would die. This was at 20 weeks and the pregnancy could very easily have gone on for another 20, but it is just a case of, "Keep coming back and if your baby's dead, we will deliver you." That is what happens, I am afraid.

Ms Claire Cullen-Delsol: That is pretty much it.

Deputy Lisa Chambers: I do not have any more questions. I thank Ms Cullen-Delsol and Mr. Edwards.

Senator Lynn Ruane: With every word the witnesses said and every detail they disclosed here, I have to be honest, my heart was racing in my chest. I have not experienced what they have experienced. I can only thank them for taking what is nothing but trauma and transforming it into a fight for change. I cannot express my gratitude enough to them both and to those they represent.

I have one question only. They have both mentioned severe anomaly and the lack of dis-

cussion on it. If there has been a lack of discussion in this regard, perhaps this would be the best time to discuss that at some level in terms of what they feel should have been discussed. Perhaps they support women who have had a pregnancy which involved a severe anomaly. Maybe it is not the first time because we have spoken about multiple pregnancies resulting in the same thing and everything that brings, and how relative and individual the impact of a diagnosis is on every woman and also every family. We look at everything that has to be taken into account with severe anomalies, in terms of finances, whether there will be someone to care for the child when the parents become elderly and die, what happens to the child then if he or she has a severe disability, the impact and burden on the child's siblings, and if there is another child in the household with high needs. I do not know whether that is the type of discussion that Mr. Edwards was saying was lacking at the assembly but he may want to comment on that in general or add anything that he feels would be appropriate.

Mr. Gerry Edwards: Parents and families who have been affected by a diagnosis of a severe anomaly have been generally quite under-represented so far. Many of them are quite understandably anxious about speaking out as publicly as we are. They have seen how some of us have been treated publicly and they are naturally concerned that they will be vilified. Some have said they would be stoned if they spoke because they feel that is how much society would judge them for the decisions that they make.

It is really important when we look at this that we put the pregnant woman in the centre. There is a woman, a real person, there who was trying to have a baby and was trying to bring another member into her family, whether it was a first or a subsequent, and she got this news. A lot needs to work right for us all to be born, and sometimes nature is cruel and things just do not work out or develop that way.

The consultants have spoken about the high proportion of miscarriages that are attributable to foetal anomaly. Obviously, there are other contributing factors there. Sometimes we do not miscarry. Sometimes it carries on but the baby is severely compromised.

Women have spoken to me about the rest of their family. They have spoken to me about their other children. Sometimes they have other children who have severe conditions, which are taking up all of their time and energy and for which they are reliant on charity. They are carers 24 hours a day, 365 days a year. They are trying to have a normal family existence with their other children. They know how difficult life is for themselves, their families and for other children. They find that in trying to have more children, they sometimes have to face this again. There is not a one-size-fits-all solution. We all have our own family units and challenges in life. It is no easy task to try to cope in these circumstances. A woman is going to make a decision based on her immediate family and other environmental factors, such as whether she has family support, enough money, how she is coping with her life, if she has underlying physical or mental health conditions, her age, and whether the baby she is expecting is going to have serious quality of life issues that will not, however, necessarily shorten his or her life. The woman has the question of what happens when she can no longer care for this dependent child as an adult. Will she have to ask her other children to do that? Will she have to depend on the State to do that? That woman will have to look at and ask those questions. The Constitution is not a factor there. Women are not saying that the law says that they have to continue with pregnancies and therefore must. The law, as it stands, just interferes with women accessing the care that they may choose to take, which is in the best interests of them, their family and the baby. It is their parenting decision to make.

If the committee wants to create a situation in which more women will choose to continue

with their pregnancies, then it needs to provide a better environment for them to do that. There need to be better social supports, carers need to be better treated and there need to be better facilities for people with additional needs. If money and skilled people are no object and there is a utopia, there will still be people who choose to terminate a pregnancy and the Oireachtas will still have a responsibility to support them in that decision. We certainly should not need to try to bring other families out into the open to explain their personal circumstances for the committee to imagine that scenario. Anyone who has been pregnant or who has contemplated having a family knows that, going through pregnancy, anything can go wrong. We are all afraid of getting bad results and I think most of us can understand that people sometimes have to make very difficult decisions and need to be supported in that. I think it is a wider societal issue, and just saying what the law is and that there is a medical service that we are not prepared to provide benevolently is not a solution for the issue nor is it against it. The issue is wider than that.

Deputy Billy Kelleher: I thank Mr. Edwards and Ms Cullen-Delsol for their very emotional testimony. Most of the questions I would have asked have already been asked and answered in detail. I ask this question to get inside the minds of people who have alternative views. What type of abuse have the witnesses or other members of their organisation received? Is it coming from very extreme cranks or is it seeping into the middle consciousness of Ireland? Mr. Edwards mentioned that there should be no gestational limit on fatal foetal abnormality, to meet people's needs, and there are clearly people who would have huge difficulties with that. At the same time, the gestational limit is often debated. We had that in the Protection of Life During Pregnancy Act debate four years ago. Is there resistance to this issue? What have the witnesses gone through and have other members of their organisation been put through that? Is there resistance even within the medical profession, or do they find the medical professions in general very supportive and open to what the witnesses claim is required in making sure that they can access what is fair and reasonable for what they will have to endure or others will have to endure when they get that tragic diagnosis?

Ms Claire Cullen-Delsol: I will take the question of abuse first. I think Deputy Coppinger mentioned it too. Before I spoke to anybody about what I had gone through, I was absolutely terrified and convinced that there was something wrong with me since I wanted to end a pregnancy. There must have been something wrong since, if I could not do it, how could it be considered right? I was convinced that there must be a reason we did not provide it. By the time that I came to the understanding that there was nothing wrong with me and it was a reasonable thing, I was still terrified because I thought everybody else would think there was something wrong with me. I started to speak to people about it, including family, friends and wider circles. I then spoke to an amazing journalist who interviewed me and took the story. It snowballed from there. The vast majority of the thousands of messages that I have received publicly and privately or from people coming to me on the street have been nothing but supportive, kind and understanding. I cannot overstate that and the resonance that people have when they hear the story. They all have their own stories about sisters, friends and mothers. It has touched every family from what I can see.

There have been some voices, mostly on the fringe, who would disagree vehemently with what I believe. I am pro-choice and they are not, and they have no problem expressing that, sometimes in really vile ways. They are keyboard warriors for the most part and it is all online. I attended a pro-choice march and put a video online of what I believed were grotesque images that counter-protesters decided to bring. This happened in Ballybricken in Waterford. It is not a bustling metropolis-----

Deputy Billy Kelleher: Ballybricken or Waterford?

Ms Claire Cullen-Delsol: I will not have anything said about Waterford. It was just a video that I put up because I thought that people needed to see what we are faced with. I lost a baby and none of these images will ever be worse than looking at one's own dead child. At the same time, it is not on. It is awful. There are kids present. I have my own kids. It is normally one of those things where people get together, there are many mothers, all chatting, we go for a little walk, we chant a bit, and then we all go for coffee and cake. I took a video of this horrible counter-protest, having been set up with all these rotten images, and put it online. Thousands of people saw it and commented. Maybe five of the 30,000 or so people who watched that video had something very nasty to say. It is all along the same lines. Much of it has a religious basis, and when that does not sink in, they target people personally. They will say that I am a terrible mother and did not love my baby enough, that if I had enough faith in God, I would not have lost my baby, that if I had loved the baby enough, she would still be here, and that I am using my own dead baby to allow for the deaths of other babies. They call me a murderer and a witch etc. It is a very small number of people. The impact of it at the time varies depending on my own emotional well-being. Sometimes it floors me and sometimes it does not.

In general, the response is amazing. People are fabulous and inherently good. I know we tend to legislate assuming the worst of people but I do not believe that. I think people are genuinely good and that if we give people the opportunity to show their true colours, people are generally fantastic. The support, kindness, care, love and compassion we are capable of is outstanding. It comes from all sides and sectors of society and from all ages. It is fantastic and has got me through some of my worst times. A perfect stranger, someone who used to work with my husband, came up to me when I was queueing for a coffee and said that I was amazing, to keep doing what I was doing and that they were sorry for my loss.

I did not encounter resistance in the medical community. I found it to be incredibly supportive. When I said that I was considering travelling, many people in it said not to consider it yet but to wait and see what happened. They said to wait and see what services I would get and how I got on. I think much of that was more to protect me. As time went on and my condition was deteriorating mentally and emotionally, many said to me that if they could do something for me, they would and that they were sorry I had go through that and that it was not fair. That was the general response that I got. It goes back to people being generally compassionate. They understand it and they get it. They see it every day and they know. I cannot speak highly enough about the people who took care of me when I was pregnant.

The woman who did my first scan insisted on doing the last one also. She was there. That was one of the reasons I was waiting so long in a room with a pregnant woman. The same woman wanted to be the one to do the scan. She wanted to look after me, and she did. She took loads of pictures for me. She let me be the one to say there is no heartbeat because she knew I needed to take back some of the control at that point. While I was in labour, which took two days, she came in to see me to make sure that I was getting enough pain medication and make sure I was being looked after. The antenatal midwife did the same thing. Both of them popped in and out, with their coats on or with their lunch boxes, when they could. If they could get the time they would come in to see me. When my consultant realised that after 36 hours I still had not given birth, and that after three doses of Misoprostol or whatever it was called, I still was not in active labour but that I was just in pain and waiting, he left the conference he was at in Dublin and drove back down to Waterford. He walked into the room and he said it was Friday afternoon and that if I did not give birth by that evening, I would have to go home for

the weekend and come back on Monday. He asked me what I wanted to do. I said I could take the pain and to double the dose and he did. A couple of hours later, Alex was here. It meant I did not have to go home and wait another weekend carrying a dead baby. I cannot speak highly enough of them. Once we give our medical teams the tools and the freedom to take care of people properly, we can trust them to do so.

Deputy Jan O'Sullivan: I suppose all I can say is that this is extraordinarily difficult for both of the witnesses and for others who are in the same situation. It is also extremely powerful in terms of explaining to people what is involved. Like others, I thank the witnesses for this. Most of the questions have been around the experience of the baby dying. I was particularly moved by the cruelty of what happens after the baby dies, and having to bring the baby home in the case of people who went to England or Northern Ireland, and having to put the baby in the boot of the car crossing the ocean, or on the carousel in the airport, or having the ashes of the baby with a courier. For any of us who lose somebody we love, having a funeral, whether it is cremation or burial or religious or otherwise, is an important right, and it must be particularly important in coming to terms with, and dealing with, the whole traumatic experience. Will the witnesses expand a little on this experience and, in particular, on the fear of people actually saying they have had a termination but need a funeral?

Mr. Gerry Edwards: I will take this question. We delivered our son in Belfast, which was just a car journey up the road, and we were afraid to bring him home. We did not know how to bring a dead baby across the Border and what do we do when we get home. Nobody could tell us what to do. Nobody could counsel us on that. Neither my wife nor I ever got counselling of any description. As I explained earlier, he was cremated without us being there and we got his ashes from a courier. We still have them at home. I did not realise it at the time, but I certainly came to realise over the passing years, that the lack of a funeral had affected me greatly. It caused me an awful lot of hurt. I was on antidepressants for ten years and I did not really know why until I went and got better help myself. One day, we were expecting and we had the dreams and then we had nothing. We had no place to go. We had no grave. All of our friends knew we were expecting a baby and then there was nothing. There was no closure. My parents never met their grandson. My sisters and Gaye's father never met him. Gaye's mother travelled with us. She is the only other person who saw him and met him. If we had been able to deliver him here, all of our families could have got to see him. It would have made him more real for all of us, and not just this spot of bother we had or something. He is still our son. The whole ability to have a funeral, and have that social right, is really important. This is why more and more people are going to the extremes they are going to try to ensure that they can bring their baby home, because they need that closure.

I mentioned earlier about people being anxious about approaching their priests. Unfortunately, having a severe or fatal foetal abnormality is quite indiscriminate and does not recognise whether someone is religious or not or has money or not, or anything like that. A number of people we have supported have told us about going to their priests and the nuns in their parishes, and every one of them has said they were treated wonderfully. It is important to point this out because sometimes this is played out as being something that it is not, in terms of being religious or non-religious. For those who have religion and for whom having a religious right is important, our experience anecdotally has been the priests and nuns in the parish and community, the ones who will sit at someone's kitchen table having a cup of tea while someone is crying, understand it and they get it. They approach it from a ministry of love, compassion and healing. Some of the hierarchy have a bit more of a judgment and condemnation thing going on, and this is unfortunate because it scares people away from approaching their local clergy be-

cause they have that fear. I do not think this helps anybody. Life is tragic enough. Sometimes people need psychological help and sometimes they need spiritual help. Those doors should be open to them. Having proper closure and not being treated as an outcast is crucial for their well-being.

Deputy Bernard J. Durkan: We need to acknowledge the importance of the witnesses' words to the committee in highlighting these issues, which, to passers-by and those not directly affected, are not issues at all but which have an impact on those who are directly affected in a way the witnesses have described very adequately. We have all in our various lifetimes had similar brushes with the same experiences. It serves to remind us these things do not go away and there is a need for the kind of things the witnesses have spoken about. There is a need for concern, compassion, caring, recognition of the situation in which a parent or parents may find themselves and recognition of the extent to which isolation can affect people being left alone to fend for themselves. We have dealt with it before and it has not diminished with the passage of time. We thank the witnesses for being here.

Senator Paul Gavan: I thank the witnesses for their presentations. There is very little left to say, apart from that I am sure I am not the only one who is struck wondering how we ended up with a system of laws so devoid of humanity. I am absolutely stunned in terms of the suffering that the witnesses, their colleagues and their partners have gone through. It is just horrific. Forgive me for asking this because it is obvious, but it is important that we put it on the record. We have a big decision to make in a few weeks' time in terms of the type of changes we will seek. I take it the witnesses are calling on us to make a straight repeal and take this thing out of the Constitution.

Ms Claire Cullen-Delsol: Absolutely.

Senator Paul Gavan: That is great. I will take it beyond that. The clear message the witnesses are communicating is that we need to give our medical practitioners the flexibility to give people like the witnesses, those who have this huge challenge that can come to anyone, the support and service that they need.

Mr. Gerry Edwards: I think we need to go beyond that. It is not just a matter of supporting people like ourselves. Any woman experiencing a crisis in pregnancy, either because she is pregnant or because of how that pregnancy has developed, needs the support of her own country.

Senator Paul Gavan: I really hope that we, collectively, do not let the witnesses and others in their situation down.

Chairman: I thank Mr. Edwards and Ms Cullen-Delsol for attending. We are indebted to them for their bravery in coming here to give us their personal stories, which must be a very difficult thing to do. It has even been difficult for us to hear it. We are very grateful for their assisting us in the job that we have to do.

As there is no other business, we will now adjourn until 1.30 p.m. on 8 November. Is that agreed? Agreed.

The joint committee adjourned at 9 p.m. until 1.30 p.m. on Wednesday, 8 November 2017.