Neutral Citation Number: [2020] EWCA Civ 1239

Case No: C1/2020/0822

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE DIVISIONAL COURT
LORD JUSTICE SINGH AND MR JUSTICE CHAMBERLAIN
[2020] EWHC 1546 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25/09/2020

Before:

LADY JUSTICE KING DBE
LADY JUSTICE NICOLA DAVIES DBE
and
LORD JUSTICE PHILLIPS

- -

Between:

THE QUEEN (ON THE APPLICATION OF CHRISTIAN CONCERN)	**Appellant**
- and -	
SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE	**Respondent**

- -
- -

Michael Phillips (instructed by **Andrew Storch Solicitors**) for the **Appellant**
Julia Smyth and Yaaser Vanderman (instructed by **Government Legal Department**) for the **Respondent**

Hearing date: 29 July 2020

- -

Approved Judgment

Lady Justice Nicola Davies:

Introduction

1. In proceedings for judicial review the appellant challenges the "Approval of a Class of Places" within the Abortion Act 1967 as amended ("the 1967 Act") made by the Secretary of State on 30 March 2020 ("the Approval" or "the Decision"). This approves the "home of a pregnant woman" as being a place which is authorised for the purpose of section 1 of the 1967 Act where the treatment for early medical abortion ("EMA") may be carried out. The Approval was made under sections 1(3) and (3A) of the 1967 Act. It is time limited until either the date when the temporary provisions of the Coronavirus Act 2020 expire or two years, whichever is the earlier.

2. On 19 May 2020, the Divisional Court, Singh LJ and Chamberlain J, in a judgment of the court, refused permission to bring a claim for judicial review.

3. At the hearing the appellant sought permission to appeal on eight grounds. Lewison LJ granted permission to appeal on grounds 5 and 6, namely:

   Ground 5: The Decision is *ultra vires* section 1 of the 1967 Act in that:

   a) The Divisional Court erred in its analysis of "terminated by a registered practitioner" in section 1(1) of the 1967 Act;

   b) The Divisional Court erred in refusing to admit evidence pursuant to *Pepper v Hart* [1993] AC 593;

   c) The Divisional Court erred in its analysis of the Hansard record.

   Ground 6: The Decision is contrary to the legislative purpose of the 1967 Act (*Padfield v Minister of Agriculture* [1968] AC 997):

   a) The Divisional Court erred in holding that the Decision was consistent with the legislative purpose to ensure that abortions are carried out with proper skill and in hygienic conditions;

   b) Evidence is admissible pursuant to *Pepper v Hart* to ascertain the legislative purpose of section 1(3A), and shows that the power was conferred on the Secretary of State to enable a designation of safe and hygienic places such as GP surgeries, and expressly not of "home". The Divisional Court failed to consider the Hansard record in the context of the *Padfield* argument.

Application to adduce further evidence

4. At the hearing the appellant sought permission pursuant to CPR 54.16 to adduce further evidence in the form of witness statements from Kevin Duffy dated respectively 18 May 2020 and 17 July 2020 together with exhibits and a second witness statement of Dr Greg Gardner. The application was refused, with reasons to be given in this judgment.

The first witness statement of Kevin Duffy and the second witness statement of Dr Gardner

5. These statements were served one day before the Divisional Court hearing. In the application before this court the appellant notes that the statements were referred to in the judgment of the Divisional Court at [65] and [30] respectively. The reference to the statement of Mr Duffy at [65] of the judgment was in respect of ground 3 of the original grounds of appeal, which is not pursued at this hearing. At [30] the court correctly noted that the expert whose evidence was filed on behalf of the respondent fundamentally disagreed with the opinions of Dr Gardner. The court correctly stated that its only function was to adjudicate on the lawfulness of the decision under challenge and the fact that Dr Gardner and others may disagree with the views of the respondent's experts or external bodies was immaterial in the context of judicial review proceedings. Accordingly, there are no grounds upon which to admit these statements of Mr Duffy or Dr Gardner.

Second witness statement of Kevin Duffy and its exhibits

6. The exhibits contain: (a) evidence of a mystery shopper survey of the abortion providers' "Pill by Post" service which was organised by Mr Duffy in June 2020; (b) an internal NHS email dated 21 May 2020 which highlights the Care Quality Commission's concerns about the "escalating risks" associated with "Pills by Post" giving examples of incidents which are said to have led to patients' deaths in May 2020.

7. The application notice is dated 20 July 2020, this hearing took place on 29 July 2020. Mr Duffy describes the survey as mystery shopping which "involves subterfuge and the obtaining of information under false pretences". The service provider and the provider organisations had no knowledge of this survey. Mr Duffy describes this as being in contravention of ethical norms in medical research. Women were asked to make 19 sets of calls to providers in June and July 2020. Each woman provided false information as to being pregnant, the date of her last period, her name, date of birth and contact details. False registration data was given when details of her GP surgery was requested. The only truthful data provided was the address to which the abortion pills should be posted.

8. This was a covert exercise performed under a false premise and using false information. No control group exists. Neither the court nor the respondent is in a position to explore, still less assess, the validity of the information which this survey purports to provide. The late service and inherent unfairness of this "survey" provide no grounds upon which to admit this evidence.

9. The email of 21 May 2020 from a regional chief midwife identifies feedback from a CMO about issues linked to the Pills by Post termination service. Thirteen incidents are noted. The email recognises the seriousness of the incidents. As a result, the decision has been made to keep the process under review and report any incidents to the regional chief midwife. The seriousness of a relatively small number of incidents has been acknowledged and acted upon. The court does not minimise the seriousness of any incident but of itself this email takes the issues in this appeal no further.

The background

10. The 1967 Act sets out the legal framework under which abortions can be performed in England and Wales. Section 58 of the Offences Against the Person Act 1861 makes it a criminal offence to administer drugs or use instruments to procure an abortion. Section 59 of the same Act makes the supply of drugs, knowing that they are intended to be unlawfully used to procure the miscarriage of any woman, a criminal offence.

11. Section 1 of the 1967 Act states:

> "(1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith—
>
> (a)that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or
>
> (b)that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
>
> (c)that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
>
> (d)that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped
>
> …
>
> (3) Except as provided by subsection (4) of this section, any treatment for the termination of pregnancy must be carried out in a hospital vested in the Secretary of State for the purposes of his functions under the National Health Service Act 2006 or the National Health Service (Scotland) Act 1978 or in a hospital vested in ...a National Health Service trust or an NHS foundation trust or in a place approved for the purposes of this section by the Secretary of State.
>
> (3A) The power under subsection (3) of this section to approve a place includes power, in relation to treatment consisting primarily in the use of such medicines as may be specified in the approval and carried out in such manner as may be so specified, to approve a class of places.

> (4) Subsection (3) of this section, and so much of subsection (1) as relates to the opinion of two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman."

Section 1(3A) is an amendment which was made pursuant to section 37(3) of the Human Fertilisation and Embryology Act 1990.

12. In accordance with section 1(3) of the 1967 Act, all independent sector clinics wishing to perform termination of pregnancy must be approved by the Secretary of State for Health and Social Care. The Secretary of State's approval is conditional upon the provider's compliance with the 1967 Act, the Health and Social Care Act 2008 and the Department of Health's "Required Standard Operating Procedures". Failure to comply with the procedures can lead to withdrawal of approval. The termination of pregnancy is a regulated activity within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. All providers of regulated activities must be registered with the Care Quality Commission ("CQC").

13. When the 1967 Act was passed, the termination of pregnancy usually required a surgical procedure. Developments in this field of medicine, in particular in relation to the first ten weeks of pregnancy, have since taken place. Abortion, prior to ten weeks' gestation, is termed "early medical abortion". Presently, this usually requires the taking of two medicines, mifepristone and misoprostol, either at a 24 to 48-hour interval or simultaneously. Mifepristone (the first pill) works by blocking the hormone progesterone which is necessary for the continuation of the pregnancy, misoprostol (the second pill) causes the uterus to contract which results in the loss of pregnancy in a similar way to a miscarriage.

14. In 2014 the Department of Health ("the Department") developed guidance in relation to requirements of the 1967 Act for those responsible for commissioning, providing and managing service provision. This included the multidisciplinary team ("MDT"). The intention of the guidance was to provide support for registered medical practitioners ("RMP") by setting out how the law is interpreted by the Department. The guidance included the following:

> "6. Although there is no legal requirement for at least one of the certifying doctors to have seen the pregnant woman before reaching a decision about a termination, the Department's view is that it is good practice for this to be the case. It is recognised however that, with technological advances, this may well mean that a doctor does not physically see the woman, e.g. there could be a discussion by phone or over a webcam.
>
> …
>
> 12. Whilst there is no statutory requirement for either doctor to have seen and/or examined the woman, it is the Department's interpretation of the law that both doctors should ensure that

> they have considered sufficient information specific to the woman seeking a termination to be able to assess whether the woman satisfies one of the lawful grounds under the Abortion Act.
>
> …
>
> 21. It is acknowledged that the MDT, including nurses and counsellors (it is possible that the MDT would include a midwife where a congenital abnormality has been diagnosed antenatally) plays an important role in supporting women seeking an abortion and in obtaining information from women. RMPs can rely on information obtained by members of the MDT but it is DH's interpretation of the law that the RMPs should themselves review the information before reaching an opinion, for example by considering the paperwork or speaking to members of the team. The RMP must be satisfied that they can justify how they reached their decision in good faith if later challenged. The opinions required under the Act are clearly those of the RMP, not of any other member of an MDT, however experienced or trusted. DH does not think that the Act can be read to enable the opinion required to be that of another person entirely, or the opinion of a team as a whole. An RMP may, of course, take into account the opinions and views of colleagues in forming an opinion."

15. In a witness statement filed in these proceedings, Andrea Duncan, Head of Policy for Alcohol, Sexual and Reproductive Health and Physical Activity at the Department of Health and Social Care, observes, in the context of abortion legislation and evidence, that service provision in England has for some years included remote consultations with women subsequently attending a service for treatment. Certification by the RMPs takes place before the woman attends for treatment.

The 2018 Approval

16. On 27 December 2018 the Secretary of State made the following Approval in the exercise of the powers conferred by section 1(3) and (3A) of the 1967 Act. The Approval stated:

> "1. In this approval –
>
> 'home' means the place in England where a pregnant woman has her permanent address or usually resides;
>
> 'second stage of treatment' means the taking of the medicine known as Misoprostol.
>
> **Approval of class of place**
>
> 2. The home of a pregnant woman who is undergoing treatment for the purposes of termination of her pregnancy is approved as

> a class of place where the second stage of treatment for termination of pregnancy may be carried out where the treatment is carried out in the manner specified in paragraph 3.
>
> 3. The treatment must be carried out in the following manner-
>
> (a) the pregnant woman has attended a clinic where she has been prescribed Mifepristone and Misoprostol to be taken for the purposes of termination of her pregnancy; and
>
> (b) the pregnant woman has taken the Mifepristone at the clinic, wants to carry out the second stage of treatment at home and the gestation of the pregnancy has not exceeded nine weeks and six days at the time the Mifepristone is taken."

17. Following publication of the 2018 Approval, which allowed women and girls to take the second pill for EMA in their own homes, Ms Duncan states that:

> "Typically in these cases, the individual will contact the provider and will be offered a consultation, prior to which she will be emailed written information about the procedure. The woman will then have a video or telephone consultation where the clinician – which might be a nurse or midwife, working as part of a multidisciplinary team – will gather through sensitive questioning information about the woman including her health and personal circumstances. The woman will also have the opportunity to ask questions. Informed consent for the procedure can then take place. Two doctors will then consider whether there are grounds under the Abortion Act 1967 for treatment to proceed. If this is the case, the woman attends the clinic to take the first pill and then returns home to take the second pill 24-48 hours later."

18. In September 2019 the National Institute for Health and Care Excellence ("NICE") published an evidence based review on the accessibility and sustainability of abortion services. It recommended that community services and telemedicine appointments improve access to abortion services. It recorded that patient satisfaction is the same with abortions provided by community or by hospital services and with appointments provided via telemedicine or at the hospital.

The 2020 Decision

19. The Decision was made in the context of a public health emergency arising from the Covid-19 pandemic. The circumstances in which the Decision was taken are set out in the witness statement of Andrea Duncan and are summarised at [16] to [29] of the judgment of the Divisional Court as follows:

> "16. From early March 2020, providers of abortion services began to make clear concerns about how the pandemic would affect their services. Even at this early stage, they were seeking

an approval in the same terms as those eventually made in the Decision.

17. On 19 March, following a Ministerial Submission on 18 March, the Minister of Health for Care agreed that an approval be granted. Officials believed that the Secretary of State also agreed and the Approval was published on the UK Government website on 23 March.

18. On the evening of 23 March, the Prime Minister made a televised statement to the nation, which announced what has become known as the 'lockdown', urging people to stay at home except for certain purposes. The terms of the lockdown were set out in more detail in regulations (SI 2020/350), which were made on 26 March.

19. Within hours of the initial publication of the Approval on 23 March, it was discovered that the Secretary of State objected to it. It was therefore withdrawn. The Secretary of State confirmed in the House of Commons on the following day, 24 March, that there would be no change to abortion procedures at that time.

20. On 25 March, two members of the House of Lords (Baroness Barker and Baroness Bennett) proposed an amendment to the Coronavirus Bill which would have modified the 1967 Act in terms which were, according to the Claimant, similar to the Approval under challenge.

21. On behalf of the Secretary of State, it is submitted that the proposed amendment would have gone much further than the Approval which was later made and is now under challenge. That amendment: (a) would have allowed nurses and midwives to terminate a pregnancy without the input of a registered medical practitioner; and (b) would have allowed a single registered medical practitioner, nurse or midwife to certify their opinion under section 1(1) of the 1967 Act.

22. The Government opposed that amendment. In the course of the debate, Lord Bethell (the Parliamentary Under-Secretary of State) said in the House of Lords:

> 'We do not agree that women should be able to take both treatments for medical abortion at home.'

23. On behalf of the Defendant it is pointed out that the exchanges in the debate did not stop there. Importantly, there was the following exchange between Baroness Barker and Lord Bethell:

> 'Baroness Barker: … If the Government do not accept this proposal, I ask him to accept that they should at least be under an obligation to continue to meet very regularly with the Royal Colleges and the organisations involved in this situation day to day, and they should be willing to come back with the power to make this change under a separate piece of legislation – because if, in seven weeks' time, there is a clear pattern of women being failed, we cannot let it continue.
>
> Lord Bethell … [Baroness Barker's] point on monitoring the situation is exactly the one that the noble Baroness, Lady Watkins, made earlier. I commit the department to monitoring it. We will remain engaged with the Royal College of Obstetricians and Gynaecologists and other stakeholders. She is absolutely right that we can return to the subject with two monthly reporting back, and it can be discussed in Parliament in the debates planned on a six-monthly basis.'

24. Following the debate, the amendment was withdrawn.

25. The Coronavirus Act was enacted on 25 March. Parliament then went into recess until 21 April. This recess would have taken place in any event for Easter, but it was brought forward in view of the pandemic.

26. After the debate on 25 March, events continued to unfold. In particular, the Defendant submits that further evidence came to light about clinic closures and there was mounting concern about safety and the ability of women to access abortion services. For example, an open letter, signed by a large number of specialists in public health, calling for the 'immediate introduction of telemedical abortion services,' was sent to the Secretary of State on 28 March.

27. Having considered the new evidence and advice from his officials, the Secretary of State made the Decision to grant the Approval on a temporary basis. This was published on 30 March 2020.

28. The rationale for the Decision is set out in the witness statement of Dr Imogen Stephens, who is a consultant in Public Health Medicine, a Fellow of the Royal College of Obstetricians and Gynaecologists ('RCOG') and a Clinical Advisor to the Department and the Northern Ireland Office, in particular at paras. 12-15.

29. Dr Stephens states:

‘12. Abortion is an urgent, time-sensitive clinical procedure. This means that any upset in access to abortion services is liable to have substantial negative impacts for women.

13. The COVID-19 pandemic had multiple impacts on abortion treatment and that this would be the case was evident from, at the latest, mid-March 2020. First, fewer women were willing or able to travel to abortion services because of the danger to themselves in contracting COVID-19 and the difficulties faced in leaving home by those with young children or living in coercive and abusive relationships. Second, the incidence of staff illness within some providers had reduced the availability of provision of services and lengthened waiting times. Third, abortion services themselves were being withdrawn because spare capacity was needed for patients suffering from COVID-19.

14. Not making any changes to abortion rules, such as that made by the Decision, would have led to the following potential harms:

a. Women who were intent on having EMAs would have been forced to leave their homes and travel to clinical settings in order to take Mifepristone and obtain Misoprostol. This would have increased the possibility of them being infected with Covid-19 as well as tending to increase the spread of that disease. In 2018, 131,838 EMAs were carried out in England. Prior to the temporary change in approval of class of place, each of these women would have attended a clinic or NHS service at least once, and sometimes on 2 or more occasions. The increased use of teleconsultation and telemedicine will therefore have a significant impact on travel and social interaction and thus play a part in reducing transmission of infection during the pandemic;

b. Alternatively, women seeking abortions would not have been able to take Mifepristone and Misoprostol, either because they did not want to leave their homes, or, even if they had been willing to, would not be able to access treatment because clinics had closed. The result of this would have been:

- Women missing the 10-week deadline meaning that they would be having later terminations leading to greater health complications. The clinical risks of EMA are significantly less than abortions at later stages;

> - There would be a build-up of desired abortion treatments swamping capacity when more women felt able to leave their homes; and,
>
> - Women seeking to undertake illegal, unsafe abortions.
>
> 15. In my view, these risks far outweigh any risks posed by women taking both Mifepristone and Misoprostol at home following a remote consultation …'"

20. The letter of 28 March 2020 ([26] of the judgment), signed by more than 50 leaders in the field of public health, identified their concerns:

> "Dear Secretary of State,
>
> **Request for immediate introduction of telemedical abortion services to reduce coronavirus transmission**
>
> …
>
> We are writing to you as public health specialists to implore you to advise the Prime Minister, and the wider government, on the capacity of telemedical abortion services to help curb the COVID-19 pandemic and protect wider public health.
>
> • Despite instruction to avoid any unnecessary travel by the Prime Minister, in the next 13 weeks as the pandemic is predicted to reach its peak, at least 44,000 women will have to leave their homes needlessly to access early medical abortion care, with an increasing number of clinic closures forcing them to travel long distances across the country exposing themselves and others to COVID-19.
>
> • This equates to over 3,000 journeys per week, with each woman making multiple contacts during her journey and during her time in both independent clinics and high-risk NHS settings. Telemedical early abortion services would eliminate all such contact and therefore protect the health of the wider population, our health system, and our healthcare workers.
>
> …
>
> • Telemedicine for abortion has been recommended by NICE. We believe that the impact of failing to implement this service on both individuals and the wider population will be grave, and services are currently at the brink of collapse.
>
> • Women with severe health issues who have been told to self-isolate for 12 weeks say they are being forced to choose

> between risking their health by leaving their house and being compelled to continue an unwanted pregnancy that also threatens their health.
>
> • Vulnerable women are already turning outside the regulated healthcare system for help from online providers, breaking the law and foregoing the inbuilt safeguarding and support provided by regulated services.
>
> • A quarter (23%) of abortion clinics run by bpas, which cares for 100,000 women per year, were closed on the 24th of March due to staff sickness and isolation, with further closures expected across NHS funded services today.
>
> • Surgical abortion lists are being cancelled across the UK as operating theatres are being used as ICUs. Women who cannot access a safe early medical abortion will have no back up later in their unwanted pregnancy.
>
> • Abortion services are at risk of collapse if the Prime Minister does not act swiftly.
>
> We urge you to act immediately to protect the health of individuals, the wider population, and our healthcare workers. …"

The 2020 Approval

21. The Approval states:

> "This approval supersedes the approval of 27 December 2018.…
>
> **Interpretation**
>
> 1. In this approval –
>
> 'home' means, in the case of a pregnant woman, the place in England where a pregnant woman has her permanent address or usually resides or, in the case of a registered medical practitioner, the place in England where a registered medical practitioner has their permanent address or usually resides;
>
> 'approved place' means a hospital in England, as authorised under section 1(3) of the Abortion Act 1967, or a place in England approved under that section.
>
> **Approval of class of place**
>
> 2. The home of a registered medical practitioner is approved as a class of place for treatment for the termination of pregnancy for the purposes only of prescribing the medicines known as

> Mifepristone and Misoprostol to be used in treatment carried out in the manner specified in paragraph 4.
>
> 3. The home of a pregnant woman who is undergoing treatment for the purposes of termination of her pregnancy is approved as a class of place where the treatment for termination of pregnancy may be carried out where that treatment is carried out in the manner specified in paragraph 4.
>
> 4. The treatment must be carried out in the following manner –
>
> a) the pregnant woman has –
>
> i) attended an approved place;
>
> ii) had a consultation with an approved place via video link, telephone conference or other electronic means, or
>
> iii) had a consultation with a registered medical practitioner via video link, telephone conference or other electronic means; and
>
> b) the pregnant woman is prescribed Mifepristone and Misoprostol to be taken for the purposes of the termination of her pregnancy and the gestation of the pregnancy has not exceeded nine weeks and six days at the time the Mifepristone is taken."

22. On 9 April 2020 the RCOG published additional guidance for abortion care during the Covid-19 pandemic, which included information relating to telemedicine and EMA. The guidance includes the following:

> "… consent can be obtained remotely using telephone, internet or video link providing that it is appropriate to the woman and meets the same standards for content as would be undertaken in a face-to-face encounter.
>
> …
>
> Safeguarding is an essential part of the assessment for abortion care, and providers should follow their processes and assess each case on an individual basis. However there is no automatic need to have to do this in person if adequate assessment is possible via remote consultation, although it is recommended that this should be tailored to the individual. The clinician should be confident that the woman is not being coerced and that she is able to discuss any concerns privately.
>
> …
>
> Routine pre-abortion ultrasound scanning is unnecessary. Most women can determine the gestational age of their pregnancy

> with reasonable accuracy by last menstrual period (LMP) alone. …
>
> There is no requirement for an ultrasound to determine gestational age for a doctor to authorise an abortion as meeting the requirements of the Abortion Act 1967; they only have to demonstrate that they are acting 'in good faith'."

23. Dr Imogen Stephens states that following the 2020 Approval in England (and also in Wales and Scotland following similar decisions made in these areas), providers can now offer a complete EMA service with a consultation taking place via video or teleconferencing and, if appropriate, a treatment package either sent to the woman's home or made available to collect from an abortion service provider. She states, *inter alia*:

> "37. All abortion providers who have experience in the use of teleconsultation and telemedicine already have well developed and effective systems for assessing and managing risks (medical, psychological, safeguarding). Whenever any risks or concerns are identified or considered possible the woman is required to attend for face-to-face consultation.
>
> …
>
> 43. Teleconsultation is a longstanding feature of abortion provision for EMA. All women are given information about aftercare, have access to a 24-hour helpline and are given information about the nearest acute gynaecology emergency centre to attend if necessary."
>
> …
>
> 51. … face-to-face consultation is still required should any clinical or safeguarding concerns be identified, or if it is felt that the woman has language, literacy or mental capacity difficulties that would hinder the assimilation of information in order to provide Montgomery-compliant consent. The temporary changes aim to reduce the need for women to travel at a time when this may not be possible, due to local clinic closures and/or self-isolation."

Case law

The role of the registered medical practitioner

24. The issue as to whether an RMP is required to personally carry out every step of a termination was considered by the House of Lords in *Royal College of Nursing v Department of Health and Social Security* [1981] AC 800 ("*RCN*"). This case concerned the surgical induction method of termination. The first stage, conducted by an RMP, required administration of anaesthesia and the insertion of a catheter. It did not terminate the pregnancy. During the second stage, prostaglandin was

administered which caused contractions leading to the expulsion of the foetus. The medication was given by a nurse or midwife in accordance with the doctor's instructions. The doctor was available to be called if necessary.

25. Lord Diplock addressed the policy of the 1967 Act and stated that there were two aspects: the first being to broaden the grounds upon which abortion may be lawfully obtained; the second "is to ensure that the abortion is carried out with all proper skill and in hygienic conditions" (827D-E). He observed that the terms "termination" and "treatment" are used interchangeably (827H). Lord Diplock determined that "termination" meant the whole process of treatment designed to bring about that process (828A), a conclusion with which Lord Keith and Lord Roskill concurred.

26. At 828B-D Lord Diplock set out his interpretation as to the way in which the treatment was to be carried out pursuant to the provisions of the 1967 Act:

> "The requirement of the Act as to the way in which the treatment is to be carried out, which in my view throws most light upon the second aspect of its policy and the true construction of the phrase in subsection (1) of section 1 which lies at the root of the dispute between the parties to this appeal, is the requirement in subsection (3) that, except in cases of dire emergency, the treatment must be carried out in a National Health Service hospital (or private clinic specially approved for that purpose by the minister). It is in my view evident that in providing that treatment for termination of pregnancies should take place in ordinary hospitals, Parliament contemplated that (conscientious objections apart) like other hospital treatment, it would be undertaken as a team effort in which, acting on the instructions of the doctor in charge of the treatment, junior doctors, nurses, para-medical and other members of the hospital staff would each do those things forming part of the whole treatment, which it would be in accordance with accepted medical practice to entrust to a member of the staff possessed of their respective qualifications and experience."

As to the role of the RMP, Lord Diplock at 828F-829A stated:

> "What limitation on this exoneration is imposed by the qualifying phrase: 'when a pregnancy is terminated by a registered medical practitioner'? In my opinion in the context of the Act, what it requires is that a registered medical practitioner, whom I will refer to as a doctor, should accept responsibility for all stages of the treatment for the termination of the pregnancy. The particular method to be used should be decided by the doctor in charge of the treatment for termination of the pregnancy; he should carry out any physical acts, forming part of the treatment, that in accordance with accepted medical practice are done only by qualified medical practitioners, and should give specific instructions as to the carrying out of such parts of the treatment as in accordance with accepted medical practice are carried out by nurses or

> other members of the hospital staff without medical qualifications. To each of them, the doctor, or his substitute, should be available to be consulted or called on for assistance from beginning to end of the treatment. In other words, the doctor need not do everything with his own hands; the requirements of the subsection are satisfied when the treatment for termination of a pregnancy is one prescribed by a registered medical practitioner carried out in accordance with his directions and of which a registered medical practitioner remains in charge throughout."

27. The essence of Lord Diplock's reasoning is that a doctor will remain in charge of and accept responsibility for all stages of the treatment for the termination but it does not follow that the doctor would have to perform every part of it. It was accepted that nurses and other members of the hospital staff, who did not possess medical qualifications, could play a part in the process but the doctor would remain in charge throughout.

28. In *SPUC Pro-Life Scotland v Scottish Ministers* [2019] CSIH 31 ("*SPUC*") the Inner House of the Court of Session considered a challenge to the 2017 decision of Scottish Ministers, the Scottish equivalent of the 2018 Approval. The challenge was on the ground that a woman's home was not a permissible class of place and that the decision was contrary to the requirement of section 1 of the 1967 Act which required an abortion to be carried out by a medical practitioner.

29. The Opinion of the Court was delivered by the Lord Justice-Clerk (Dorrian). The court considered the authority of *RCN* and at [30] and [31] stated:

> "[30] In our view the concept of 'treatment' requires to be given a wide interpretation, in common with the authorities to which we were referred. Moreover, it is important to bear in mind that what constitutes 'treatment' may vary according to context, and in particular in light of the nature of the procedure being undertaken. … The part played by nurses in the treatment was noted to be of greater importance as well as longer than when a purely surgical method was employed. It was in this context of a 'hospital' having been designated as the place of such treatment that the concept of treatment as part of a 'team' was discussed (Lord Diplock, p 828C–D). It does not follow, however, either that only a hospital may be classed as a place for treatment, or even that it will be an inevitable fact that treatment will involve a team effort. Much will depend on the individual facts of the case.
>
> [31] … In our view, in *RCN* the court was not laying down a fixed definition of treatment to apply in all cases and in all circumstances. In each case the context is vitally important. Accordingly, while we accept that there is a requirement for the RMP to have responsibility for the treatment and to retain a degree of control over it, what will satisfy that requirement will

> be a matter of fact and degree according to the nature of the process involved in the treatment."

30. At [32] the court noted that the woman is now required to be an active participant, which is consistent with the modern approach to patient autonomy. The court described the "real significance of the *RCN* case as the determination that not all acts directed to the termination of pregnancy require to be carried out personally by the RMP", an observation with which I agree. At [33] and [34] the role of the RMP was considered as follows:

> "33. The RMP in charge of the treatment, who has advised the patient and arranged for the administration of the first medication in the clinic, does not cease to be in charge of the treatment merely by virtue of prescribing the second medication to be taken or administered at home, any more than he would cease to be in charge in a clinic by prescribing a medicine to be handed to the patient by a nurse. …
>
> 34. … We do not accept that the doctor's control or supervision over the treatment differs in any material way between the situation of taking the tablet within the clinic and then leaving; and that of delaying the taking of the tablet to allow the woman to travel home. Both result in the termination of the pregnancy taking place outside of the clinic. In each case the RMP can properly be described as taking responsibility for the treatment of the termination of the pregnancy and control in the appropriate sense is maintained."

31. The court concluded at [38] that:

> "The reclaimer has been unable convincingly to explain why an outpatient clinic or GP's premise would necessarily be a 'safer' or more suitable place to take a tablet or pessary than the woman's home."

The reclaiming motion was refused.

32. In *British Pregnancy Advisory Service v Secretary of State for Health* [2011] EWHC 235 (Admin) ("*BPAS*") Supperstone J rejected the submission that a woman could undertake medication for early abortion at home **before** an approval had been given under section 1(3) of the 1967 Act (emphasis added). At [24] Supperstone J stated:

> "The critical phrase in section 1(3) is 'any treatment for the termination of pregnancy'. 'Treatment' is not, in my view, properly restricted to the act of diagnosis and the prescription of drugs or medicine. If the drugs or tablets were prescribed by the registered medical practitioner and not taken by the woman, the opportunity for treatment would have been available but it would not have been taken. The aim of the treatment, whether medical or surgical, must be the termination of a pregnancy.

> Termination is the consequence of the treatment; it is not itself treatment."

At [32] he stated:

> "Section 1(3A) makes clear that 'treatment' which in 1967 was normally surgical treatment covers medical treatment. Moreover, it enables the Secretary of State to react to further changes in medical science. He has the power to approve a wider range of place, including potentially the home, and the conditions on which such approval may be given relating to the particular medicine and the manner of its administration or use."

33. The policy of the 1967 Act was addressed by Lady Hale, with which the other justices agreed, in *Doogan v Greater Glasgow and Clyde Health Board* [2015] AC 640 at [27] as follows:

> "27. … We can agree with Lord Diplock, in the *Royal College of Nursing* case [1981] AC 800, 827, that the policy of the 1967 Act was clear. It was to broaden the grounds on which an abortion might lawfully be obtained and to ensure that abortion was carried out with all proper skill and in hygienic conditions. For my part, I would agree with the interveners that the policy was also to provide such a service within the National Health Service, as well as in approved clinics in the private or voluntary sectors. The mischief, also acknowledged by Lord Diplock, was the unsatisfactory and uncertain state of the previous law, which led to many women seeking the services of 'backstreet' abortionists, which were often unsafe and, whether safe or unsafe, were offered by people who were at constant risk of prosecution and, as Lord Diplock put it, 'figured so commonly in the calendars of assizes in the days when I was trying crime': p 825. …"

Grounds of appeal

34. The appellant's primary grounds of appeal are 5(a) and 6(a).

Ground 5(a): The Divisional Court erred in its analysis of "terminated by a registered medical practitioner" in section 1(1) of the 1967 Act

35. At [41] the Divisional Court held that the appellant's submission would suggest that every step of the termination must be carried out personally by an RMP which would be inconsistent with the decision of the majority in *RCN* (above). At [43], it drew support from the persuasive authority of *SPUC* and stated that:

> "The doctor does not cease to be 'in charge' of treatment merely because the medication is to be taken by the patient herself at home, because it is inevitable that the method of taking the medicine will have formed part of the discussion

> during the required consultation between doctor and patient. We would add that, in terms of the Act, there is no material difference between taking one medicine at home and taking two medicines at home. Whether to permit a method of termination which involves two steps (rather than one) being carried out at home is a matter which Parliament has chosen to leave to the Secretary of State."

At [45] the Divisional Court concluded that "the approval clearly falls within the powers conferred on the Secretary of State by Parliament in the 1967 Act."

36. The appellant contends that section 1 of the 1967 Act contains two distinct requirements which must be satisfied for any abortion to be lawful, namely that: (i) "a pregnancy is terminated **by** a registered medical practitioner" (section 1(1)); and (ii) "any treatment for the termination of pregnancy must be carried out in a hospital … or in a place approved for the purpose of this section by the Secretary of State" (section 1(3)).

37. The appellant submits that any approval under section 1(3) does not alter the meaning of the requirement in section 1(1) that the pregnancy is terminated by an RMP. Where pregnancy is terminated by self-administration of a drug prescribed by a doctor, who may or may not have attended an e-consultation with the patient, and where the pill can be posted to the patient, the pregnancy is not "terminated by a registered medical practitioner". The RMP is unable to make all material decisions and remain in control. A patient cannot be a member of the team, there is no certainty that the patient will act in a particular way. Neither the patient's home nor the taking of the pill can be monitored or controlled by the RMP. The woman's attendance at the clinic ensures her safety as the doctor can assess the pregnancy and any risk, its gestational age (the woman's statement of itself is insufficient), and advise of any adverse consequences of the termination. The effect of the 2020 Approval is to create a conflict between section 1(1) and section 1(3) of the 1967 Act.

38. The appellant accepts that pursuant to the authority of *RCN*, delegation to nurses is permissible in identified circumstances, however, the element of control by the RMP countenanced by the majority in *RCN*, is said to be lost when a woman leaves the clinic or pills are sent in the post to her and she takes the pill(s) at home. The appellant contends that taking of the first pill is more serious as the second pill deals with the consequences of the ingestion of the first pill. The Divisional Court erred in finding at [54] that there was "no material difference between taking one medicine at home and taking two medicines at home".

39. The respondent contends that:

    i) The issue of whether an RMP is required to personally carry out every step of a termination was decided by the House of Lords in *RCN*; the core requirement was for the doctor to remain in charge throughout, it did not follow that he/she had to personally carry out every step of the procedure;

    ii) Medical science has developed since *RCN* was decided. At that time a surgical procedure was used for EMA. The process is now materially different in that no surgery is generally required, the treatment comprises the taking of

medication. That said, the underlying principle set out in *RCN*, namely that the doctor is in charge in the sense identified in *RCN* is met in the altered procedure;

iii) A submission that an RMP must be personally involved in administering the medication rather than simply supplying or prescribing it is fundamentally wrong and flies in the face of real life practice;

iv) The Approval, and the limited change brought about by it, is supported by the authorities of *SPUC* and *BPAS*.

Discussion and conclusion – Ground 5(a)

40. The purpose of the 1967 Act was to broaden the access of a woman to a legal termination of pregnancy, approved on a specified ground(s) by an RMP and provided in a place which was deemed safe for the relevant medical process. In 1981, when the House of Lords was considering the issue of termination of pregnancy in *RCN*, a surgical induction method of termination requiring the administration of anaesthesia represented accepted medical practice. Even then, it was not a requirement that a doctor would have to take part in every aspect of the procedure. It was accepted that parts of the treatment could be carried out in accordance with medical practice by nurses or other members of the hospital staff who did not possess medical qualifications.

41. As was subsequently observed by Lady Dorrian in *SPUC*, the court in *RCN* was not laying down a fixed definition of treatment to apply in all cases and all circumstances. In each case context is vitally important. I agree. Context must take account not only of developments in medical science and medical practice, but also of prevailing conditions in order to ensure that the purpose of the 1967 Act is met, so as to enable women to safely access regulated services and obtain legal terminations in safe surroundings.

42. Since the passing of the 1967 Act, developments in medical science and the practice of medicine have taken place. The requirement of a surgical procedure for an EMA has been overtaken by the prescribing of two medicines: mifepristone and misoprostol. As medical science has developed so too has technology. Recognition of the latter is contained in the 2014 Department of Health Guidance which envisaged a doctor not physically seeing a woman seeking a termination, instead permitting discussion by telephone or over a webcam. Significantly, there is no statutory requirement for either of the two doctors certifying the ground for termination to have seen or examined the woman. The 2014 guidance acknowledged the important role played by the MDT, which includes nurses and councillors, again reflecting developing practice. It is of note that the 2019 review by NICE on the accessibility and sustainability of abortion services recommended the use of telemedicine appointments to improve access to abortion services.

43. The submissions made on behalf of the appellant as to what takes place when a woman is assessed for EMA and the certification which would precede any attendance at clinic fail to reflect what has been the reality of practice for some years. It is clear from the 2014 guidance issued by the Department and from the evidence of Andrea Duncan and Dr Imogen Stephens that even prior to the 2018 Approval,

doctors were not necessarily personally seeing and assessing women for an EMA. It was done by members of the MDT, usually a nurse or a midwife, if there was concern then attendance at the clinic would be required. Further, the RCOG's 2020 guidance is clear: the assessment of the gestational age of the foetus is primarily reliant on the word of the mother, ultrasound scanning is the exception rather than the norm. A further example of medical practice which does not require the presence of a woman at a clinic for the assessment for this treatment.

44. The appellant's submissions also fail to reflect the technological advances which have taken place. To a significant extent, technology has obviated the need for personal attendance at a clinic by a woman seeking an assessment for EMA. What is described as "telemedicine" has become prevalent practice and one, according to the 2019 NICE evidence review, which has been welcomed by those seeking to access the service.

45. Pursuant to section 1(3) and (3A) of the 1967 Act the Secretary of State has power to approve a "class of places" in relation to "treatment for the termination of pregnancy". It was the exercise of this power which resulted in the 2018 Approval, which has not been the subject of legal challenge in England and Wales. A legal challenge to the exercise of a similar power in Scotland failed. It follows that the 2018 Approval, which permitted the identification of a woman's home as a class of place for the purposes of taking the second pill, is accepted as being *intra vires* the provisions of the 1967 Act.

46. If the taking of the second of the two pills at home abrogated the responsibility of the RMP from the termination process then, following *RCN*, the 2018 Approval could have been successfully challenged in the courts. It has not. In *SPUC* the court determined at [33] that the RMP in charge of the treatment does not cease to be so merely by prescribing the second medication to be taken at home, any more than the RMP would cease to be in charge in a clinic by prescribing a medicine to be handed to the patient by a nurse. In my view, logically this must follow.

47. A material difference as between the 2018 Approval and the 2020 Approval in terms of the process envisaged is that the latter allows for the taking of the first pill at home. There is no good evidence before this court upon which to begin to find that the nature and effect of the first pill is such as to render the same unsafe to be taken in a home and thus provide the basis for the appellant's argument that the taking of the first and second pill can properly be distinguished.

48. Section 1(3A) enables the Secretary of State to react to changes in medical science. It gives the Secretary of State the power to approve a wider class of places, including the home, for the administration of a particular medicine or use. One reason for so providing is to reflect a change in circumstances which could at any time arise. That is exactly what happened in 2020, a decision was made in the context of a public health emergency arising from the Covid-19 pandemic. The circumstances are set out above, of particular note is the evidence of Imogen Stephens and the letter of 28 March 2020 ([13] above) which identify the risks to women who were seeking EMAs in terms of their health and wider vulnerability. It records that vulnerable women were having to seek help from online providers, outside the regulated healthcare system, thereby breaking the law and losing the safeguarding and support inherent in the process provided by regulated services. The purpose of the 2020 Approval was to address a specific and acute medical need, in the context of a public health

emergency, so as to ensure the continuance of the protection of the health of women in the context of the 1967 Act.

49. There is no conflict as between sections 1(1) and 1(3) of the 1967 Act. The RMP remains in charge throughout the procedure, which has been altered to reflect the changing and challenging times. The approval is time limited, again a reflection of the particular circumstances which gave rise to the need for the same.

50. For the reasons given, and subject to the views of my Lady and my Lord, in my judgment the 2020 Approval clearly falls within the powers conferred on the Secretary of State by Parliament in the 1967 Act.

Ground 6(a): The Decision is contrary to the legislative purpose of the 1967 Act (*Padfield)*

51. At [46] to [50] the Divisional Court addressed this ground as follows:

> "46. The Claimant relies on the well-known principle in *Padfield v Minister of Agriculture, Fisheries and Food* [1968] AC 997, that no statutory power is unfettered: it must be exercised so as to promote the purpose of the statute conferring it and not to frustrate that purpose.
>
> 47. The Claimant submits that the Approval effectively permits the whole process of abortion to take place in the home of a pregnant woman. It is submitted that there is no guarantee that such a place will always be safe or hygienic, or that the woman takes the pill freely and without pressure.
>
> 48. We can see nothing in the terms of the 1967 Act to support this submission. As we have said, the power conferred by that Act is broadly phrased. Parliament, by using the word 'place', decided not to stipulate that abortions must be carried out in hospitals or clinics; and Parliament conferred on the Secretary of State the function of deciding whether a place, or class of place, was suitable.
>
> 49. Moreover, it cannot be said that the making of the approval to meet a public health emergency contradicts or frustrates the purpose of the 1967 Act. On the contrary, it is consistent with that purpose because Parliament can be taken to have been concerned that otherwise 'backstreet abortions' might take place. They would then take place without a consultation with a doctor and without a prescription by a doctor. It was clearly part of the purpose of the 1967 Act to discourage the practice of backstreet abortions, which had occurred in the years leading up to its enactment: see *RCN v DHSS* [1981] AC 800, at 825 in the speech of Lord Diplock; and *Doogan v Greater Glasgow and Clyde Health Board* [2014] UKSC 68; [2015] AC 640, at para. 27 in the judgment of Lady Hale DPSC.

> 50. This Court has to be alive to the realities of life to which the current emergency has given rise."

52. The appellant submits that the Divisional Court erred in holding that the Decision was consistent with the legislative purpose to ensure that abortions are carried out with proper skill and in hygienic conditions. The appellant relies upon the words of Lord Diplock in *RCN* at 827D-E ([24] above) and Lord Keith at 835E: "part of the policy and purpose of the Act which was directed to securing that socially acceptable abortions should be carried out under the safest conditions available" and Lady Hale at [27] in *Doogan* ([32] above).

53. It is the appellant's contention that the policy of the Act is, *inter alia*, to ensure that abortions are carried out in a regulated environment, as a means of ensuring that all abortions are carried out with proper skill and in hygienic conditions. The 1967 Act envisages a regulatory regime, ultimately operated by the Secretary of State, to ensure that only appropriate places are given approval. The discretion under section 1(3A) must be exercised consistently with the purpose of the Act: *Padfield*. The Secretary of State is free to approve a class of places which are safe and hygienic, for example GP surgeries, but not a class of unregulated places, a significant proportion of which are inevitably unsafe and unhygienic. In an extreme case this could have the effect of legalising abortions which take place in conditions similar to those seen before 1967, the so-called "backstreet" abortions.

54. In summary, the respondent contends that the Decision fell within the scope and purpose of the power in s.1(3), read with section 1(3A), of the 1967 Act. It was entirely consistent with its policy and objects.

Discussion and conclusion – Ground 6(a)

55. The power conferred by the 1967 Act is broadly phrased. It confers a broad discretion on ministers to approve a place or class of places where termination of pregnancy can take place. Parliament in using the word "place" did not stipulate where abortions must be carried out. It conferred on the Secretary of State the function of deciding whether a place or class of places was suitable. Any implied requirement that the class of place be safe and suitable will be for the permitted specified purpose, namely the taking of medication. For the reasons given, a woman's home is suitable as such a "place".

56. As the Divisional Court correctly observed at [49] the making of the 2020 Approval to meet a public health emergency cannot be said to contradict or frustrate the purpose of the 1967 Act. The purpose of the 2020 Approval was to protect women's health and to ensure that women were not driven to EMAs outside prescribed and approved settings. It is wholly consistent with the purpose of the 1967 Act.

Grounds 5(b) and (c)

57. In the event that grounds 5(a) and 6(a) are unsuccessful, the alternative grounds contained in ground 5 are based upon the premise that there is ambiguity in the meaning of section 1 of the 1967 Act, such that the requirements of *Pepper v Hart* are satisfied, namely that where the legislation is ambiguous, obscure or leads to absurdity, reference can be made to Parliamentary material as an aide to statutory

construction. The phrase "terminated by a registered medical practitioner" is said to be ambiguous, evidenced by the litigation arising from the meaning of those words, in *RCN* and *Doogan*. Secondly, the words of section 1(3A) confer such a wide discretion on the Secretary of State that it cannot be reconciled with the policy of the Act.

58. Further, the appellant contends that:

i) the Divisional Court erred in analysing the statement of the then Secretary of State (Kenneth Clarke) in isolation rather than in context;

ii) pursuant to *Pepper v Hart* the appellant seeks to rely on the statements of Mr Key and the Secretary of State as contained in Hansard. The Divisional Court failed to address the statement of Mr Key;

iii) recourse to Hansard resolves any dispute over the meaning of section 1(3A) definitively, being that the provision does not authorise an approval of "home of a pregnant woman".

59. The Divisional Court addressed these issues at [36] to [40]:

> "36. … The words of section 1(3) and (3A) are broad on their face. There is no ambiguity, obscurity or absurdity such as would permit the Court to look at statements made in Parliament, in accordance with *Pepper v Hart* [1993] AC 593. Furthermore, it is important to recall that *Pepper v Hart* was concerned with the interpretation of legislation. Although the Claimant characterises the issue in the present case as one of interpretation, the Parliamentary statements relied upon are not statements about the interpretation of the words used, but rather statements about the ways in which the powers conferred by those words might be exercised in the future.
>
> 37. In *R (Spath Holme Ltd) v Secretary of State for the Environment, Transport and the Regions* [2001] 2 AC 349, at 392, Lord Bingham of Cornhill said:
>
> > 'Here the issue turns not on the meaning of a statutory expression but on the scope of a statutory power. In this context a minister might describe the circumstances in which the government contemplated use of a power, and might be pressed about exercise of the power in other situations which might arise. No doubt the minister would seek to give helpful answers. But it is most unlikely that he would seek to define the legal effect of the draftsman's language, or to predict all the circumstances in which the power might be used, or to bind any successor administration. Only if a minister were, improbably, to give a categorical assurance to Parliament that a power would not be used in a given situation, such that Parliament could be taken to have legislated on that basis, does it seem to me that a

> parliamentary statement on the scope of a power would be properly admissible.'
>
> 38. The statements which Mr Phillips submits constitute a 'categorical assurance' that the power would not be exercised in the way it has are those of Kenneth Clarke MP, the then Secretary of State for Health, on 21 June 1990. He was responding to a concern expressed by Anne Widdecombe MP that the provisions which were to become section 1(3A) of the 1967 Act were 'merely a paving measure … for self-administered home abortion'. We have considered the terms of Mr Clarke's response. He made a number of points. First, he said that the abortion pill would not be licensed unless the Committee on Safety of Medicines was satisfied that it should be; and that it would be administered only in 'closely regulated circumstances'. Next, he said that is was 'possible' that it could be administered in a GP's surgery, with the patient returning two days later to be given a pessary. Finally, he said that all the new provision was seeking to do was to ensure that:
>
> '. . . if such a drug is licensed, the Secretary of State will at least have the power in primary legislation to approve the places and circumstances in which it might be used'.
>
> 39. In our view, it is very clear that none of these statements amounted to a categorical assurance that the power would not be exercised in the way it has been to give the Approval. On the contrary, it seems to us that Mr Clarke was deliberately seeking to leave open for decision on a future occasion the precise way in which the power might be used. Certainly there is nothing in the nature of an assurance as to how the power might be exercised in the extraordinary and then unforeseen circumstances of the current public health emergency.
>
> 40. For even stronger reasons, the witness statement of an individual Member of Parliament, Anne Widdecombe, as to what occurred in the debate in 1990, is inadmissible. Even in cases where the strict criteria in *Pepper v Hart* are satisfied, what is admissible is the official record of Parliamentary proceedings, not the understanding of an individual Member of Parliament. The subjective views of Members of Parliament are never admissible: the task of the court when interpreting a statute is to ascertain the intention of Parliament in enacting it, an intention which is to be determined objectively, not subjectively."

Discussion and conclusion

60. In my view, the Divisional Court was right to conclude that the language of section 1(3) and (3A) is not ambiguous, obscure or absurd. The words were considered in the authorities cited above. The meaning was determined, namely that the RMP is in

charge of the termination but it is not required to take part in every aspect of the process. No recourse to Parliamentary material is required, nor would the same be permissible pursuant to *Pepper v Hart*. In any event, the extracts from Hansard do not amount to a categorical assurance that the power in section 1(3) would not be used to specify a woman's home as a class of place. I agree with the Divisional Court; matters were left open for decision on a future occasion as to the way in which the power might be used.

Ground 6(b)

61. The legislative purpose of section 1(3A) is clear and has been identified above. There are no grounds upon which to admit evidence pursuant to *Pepper v Hart*.

Conclusion

62. For the reasons given, and subject to the views of my Lady and my Lord, I would dismiss grounds 5 and 6 of this appeal.

Lord Justice Phillips:

63. I agree.

Lady Justice King:

64. I also agree.