OFFICIAL REPORT
AITHISG OIFIGEIL

DRAFT

Health, Social Care and Sport Committee

Tuesday 27 February 2024

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 27 February 2024

CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
6th Meeting 2024, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
Ruth Maguire (Cunninghame South) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Rachael Clarke (British Pregnancy Advisory Service)
James Dornan (Glasgow Cathcart) (SNP) (Committee Substitute)
Ross Greer (West Scotland) (Green) (Committee Substitute)
Lucy Grieve (Back Off Scotland)
Dr Rebecca Mason (The Young Women's Movement)
Alice Murray (Back Off Scotland)
Dr Emily Ottley (University of Winchester)
Lily Roberts (Back Off Scotland)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 27 February 2024

[The Convener opened the meeting in private at 09:00]

Decisions on Taking Business in Private

09:50

Meeting continued in public.

The Convener (Clare Haughey): Good morning, and welcome to the sixth meeting in 2024 of the Health, Social Care and Sport Committee. I have received apologies from Ruth Maguire MSP; James Dornan MSP is attending as a substitute.

Today, we begin our scrutiny of the Abortion Services (Safe Access Zones) (Scotland) Bill. As Gillian Mackay MSP is the member in charge of the bill, Gillian will not participate in the committee's scrutiny of the bill by virtue of rule 9.13A.2(b). Ross Greer MSP will attend in her place as a committee substitute by virtue of rule 12.2A.2. Welcome, Ross. By virtue of rule 12.2.3(a), Gillian Mackay is attending the meeting as the member in charge of the bill. Welcome, Gillian.

The first item on our agenda is to decide whether to take item 5 in private and whether to consider in private at future meetings evidence heard at those meetings as part of the committee's stage 1 scrutiny of the Abortion (Safe Access Zones) (Scotland) Bill. Are members agreed?

Members *indicated agreement.*

Abortion Services (Safe Access Zones) (Scotland) Bill: Stage 1

09:51

The Convener: The next item on our agenda is a presentation from Emily Ottley, who undertook commissioned research for the committee on an international comparison of abortion safe access zones legislation. Welcome, Emily. I invite you to give a presentation of no more than 15 minutes, after which I will invite members to ask questions.

Dr Emily Ottley (University of Winchester): Lovely. Thank you. Good morning. My name is Emily Ottley. I am a lecturer in law at the University of Winchester. As you just explained, I was asked to undertake an international comparison of safe access zone legislation to support the committee's scrutiny of the Abortion Services (Safe Access Zones) (Scotland) Bill.

I conducted my research using secondary research methods, specifically doctrinal analysis of the relevant legislation and case law, and a literature review of, principally, parliamentary reports but also relevant academic literature, where that was available.

I have looked at safe access zone legislation from England and Wales, Northern Ireland, New Zealand, the Isle of Man, Australia, Canada, the USA and the Republic of Ireland. Within Australia, Canada and the United States of America, there is a variety of safe access zone legislation. All eight Australian states and territories, six Canadian provinces and five states in the USA have safe access zone legislation. Therefore, in total, I looked at safe access zone legislation in 24 jurisdictions.

The safe access zone bill in the Republic of Ireland is making its way through the Irish Parliament, so it is not yet law. It is widely expected that the Government bill will eventually become law, although there might be some differences from the bill that was passed by the Dáil in November 2023, which is what I used in my research. I should add that, given the scope of my research, I have not examined the Scottish bill as introduced in detail.

Spain also has safe access zone legislation, but I excluded that jurisdiction from my research due to difficulties in accessing the law in English. Also, Spain has a civil rather than common law legal system, which makes it different.

In relation to each safe access zone law, I considered the details of the provisions in the legislation, the context that informed the introduction of the legislation, any challenges that

were encountered during or after the passage of the legislation and the impact of the legislation. I will summarise my four key findings. I will not speak for long so that there is plenty of time to respond to members' questions.

My first key finding concerns the details that the provisions in such legislation contain. Safe access zone legislation is characterised by creating, or providing for the creation of, a protective area around premises where abortion services are provided. However, the details of the provisions in the safe access zone legislation that I looked at vary considerably between jurisdictions, in particular with regard to the method for the creation of the protective areas; the size of those areas; the behaviour that is prohibited within them; and the penalties for violating the law. I will comment briefly on each of those elements; the four comparison tables that are included at the end of my report provide further detail.

First, with regard to the method for the creation of the protective areas, the key point of distinction is whether safe access zones apply automatically to all premises where abortion services are provided, as in England and Wales, or whether some additional step is required to create a safe access zone outside a particular premises. That additional step may involve merely notification by premises operators, as in Northern Ireland, or a more formal application-and-review process, such as the one that has been established in New Zealand. Alternatively, legislation may afford some official a power either to create safe access zones, as in the Australian Capital Territory, or to identify protected premises, as can be seen in Alberta and Nova Scotia.

Secondly, with regard to the size of the protective areas, that typically falls somewhere between 50m and 150m. However, the protective areas in the US legislation are noticeably smaller. The largest, in Colorado, is 100 feet, which—if my maths is right—is approximately 30m. Colorado, along with Montana, also has an additional smaller floating zone around persons who are within the larger fixed zone. That is essentially to prevent protesters from approaching clinic users and staff outside the clinic.

A key distinction with regard to the size of the protective areas concerns whether there is scope for its extension or reduction. In England and Wales, for example, all safe access zones are 150m; that cannot be extended if 150m is insufficient, nor reduced if 150m is excessive. In contrast, a safe access zone in Northern Ireland is 100m as standard, but it can be extended up to 250m for a particular clinic where 100m would not be adequate to afford safe access to the premises.

In Queensland, in Australia, safe access zones are 150m as standard, but a smaller or greater distance can be prescribed in regulation. Queensland is actually a relatively rare example of a law that allows the protective area to be reduced, not just extended, in size. Queensland is also fairly unusual because it does not set an upper limit for the extension of safe access zones.

The size of the protective areas is sometimes connected to the method of creation for those areas. Quite often, where protective areas are not created automatically, the size of the area will be determined case by case, as part of the process for establishing a protective area. There may be an upper limit set out in law for that, as in New Zealand, or a minimum size, as can be seen in the Australian Capital Territory.

Thirdly, with regard to the behaviour that is prohibited in protective areas, England and Wales, along with Northern Ireland, prohibit any act that is done with the intent of, or reckless as to whether it has the effect of, influencing a person in their decision, obstructing or impeding access to the premises, or causing harassment, alarm or distress.

In contrast, most other jurisdictions specify particular behaviours or activities that are prohibited. The prohibited activities and how they are formulated in the law vary, but there are some common examples. Those include recording persons; obstructing or impeding access to premises; threatening or intimidating persons; expressing disapproval of abortion; advising or persuading persons who are accessing or providing abortion; informing persons on matters relating to abortion; and continued or repeated observation of premises. Again, the US stands out, in particular in Colorado and Montana, where all that is prohibited is protesters physically approaching clinic users and staff in close proximity to the premises.

Finally, with regard to penalties, all the jurisdictions that I looked at impose fines, although the amount varies. The key distinction in that regard is whether imprisonment is also a possibility. Anti-abortion protesters who violate the law can be imprisoned in most Australian states and territories, with the exception of the Australian Capital Territory; in most Canadian provinces, with the exception of Québec; in three out of the five US states; and in the Isle of Man. There is currently also provision for imprisonment in the Irish bill. Notably, however, imprisonment is not an option in England and Wales, Northern Ireland or New Zealand.

10:00

I will now move on from the details of the provisions contained in the legislation to my second key finding, which concerns the context

informing the introduction of the legislation. Typically, safe access zone legislation is passed in response to concern about current or future protest in the vicinity of premises where abortion services are provided and a desire to ensure good access to abortion services. In England and Wales, the number of women who are currently affected by protests was emphasised in the parliamentary debates. Elsewhere, the frequency, continuity and severity of protests have been relevant. In some places, a perceived escalation of some kind has been significant.

The Isle of Man is a really interesting example, because there had not really been any protest activity of the kind that we are talking about. However, after anti-abortion protesters had visited the island to protest against the proposed reform of abortion law more generally, members of the House of Keys were concerned that the Isle of Man would experience more protest activity, including outside premises where abortions were provided, once abortion was more widely available there. There was a perceived risk of anti-abortion protest activity in the future. We see that elsewhere, too. There was concern that South Australia would become the only Australian state without safe access zone legislation, and protests could therefore become a big problem there.

The existing lack of legal measures that could adequately deal with protests in the vicinity of premises where abortion services are provided was a common justification for safe access zone legislation across all the jurisdictions that I looked at. Interestingly, those who opposed the passage of safe access zone legislation would often argue that laws already existed that could respond to the perceived problem.

Often, but not always, provision for safe access zones is made alongside or shortly after broader abortion law reform that liberalises access to abortion services. The Isle of Man is a good example of the former, and Northern Ireland and New Zealand are examples of the latter. England and Wales, and indeed Scotland, do not fit that pattern. I note that the climate of severe anti-abortion violence is unique to the United States, although there have been instances of anti-abortion violence in Australia and Canada. That unique context is reflected in US law, which, as I have mentioned, is noticeably different to that in the other jurisdictions that I considered as part of my research.

I now move on to my third key finding, which concerns the challenges encountered during or after the passage of the legislation. It clearly stood out to me that the most significant challenge encountered both during and after the passage of safe access zone legislation has been in achieving a satisfactory balance between the rights of those who wish to protest at clinics and the rights of clinic users and staff. It is of course necessary to strike an appropriate balance in order to comply with human rights and constitutional obligations. That challenge is clear from the parliamentary debates, where those who oppose safe access zone legislation criticise bills for going too far, while others struggle to frame the bills in such a way as to strike that appropriate balance. There is a really close connection between that challenge and the details of the provisions contained within the legislation, particularly with regard to the activities that are prohibited within the protective area.

That challenge is also clear from a number of court cases in Northern Ireland, Canada, Australia and the USA that were brought by protesters, who claimed that safe access zone legislation violated their rights and the rights of other protesters. Most of those legal challenges have been unsuccessful, including the challenge to the Northern Irish law. The United Kingdom Supreme Court acknowledged that making it an offence

> "to do an act in a safe access zone with the intent of, or reckless as to whether it has the effect of ... influencing a protected person"

interferes with protesters' rights to freedom of thought, conscience and religion, freedom of expression and freedom of assembly under articles 9, 10 and 11 of the European convention on human rights. However, the court ultimately concluded that that interference was proportionate, and therefore that the law was compatible with the convention.

A second challenge, which is worth briefly mentioning, is a delay, once legislation has been passed, in safe access zones coming into effect outside premises that provide abortion services. We might expect such a delay in countries in which zones are not automatically created but are instead subject to an application process, as in New Zealand. However, there has also been a delay in England and Wales. The relevant bill received royal assent on 2 May 2023, but the section that establishes safe access zones is still not in force—not when I checked last night, anyway. It is expected to happen soon. Publication of non-statutory guidance is coming, and the commencement of the relevant section will follow in due course. There has been a period of consultation on the draft guidance, but I am not aware of a specified date.

My fourth and final key finding concerns the impact of the legislation. The availability of evidence on the impact of safe access zone legislation is, generally, very limited, although some academic research on the efficacy of safe access zones in Australia has been done, by Ronli Sifris and Tania Penovic. They interviewed

professionals from across Australia and concluded that the safe access zones were achieving their objectives of protecting the rights of patients and staff to privacy, facilitating safe access to services without fear, and reducing misinformation and stigma. Although the researchers noted that some protesters had maintained a presence outside the protected areas, they thought that the distancing away from the premises was significant.

I suspect that the lack of evidence and research to date is due at least in part to the fact that much of the safe access zone legislation has been passed only very recently. Sources that are cited in my report have called for further research to be done in due course. The legislation in Northern Ireland and the bill in the Republic of Ireland require a review of the efficacy of both safe access zones and the operation of the legislation. That might prove to be a useful source for looking into impact, in the future.

Thank you for your attention. I look forward to answering members' questions.

The Convener: Thank you very much, Emily.

Ross Greer (West Scotland) (Green): On that final point about how recently most of those measures have been implemented and the lack of evidence about impact, is there even any anecdotal indication of the reaction of those who were for or against the measures? There is a difference between actual impact and perceived impact. In your research, were you able to even just pick up the reaction of those on either side of the debate once the schemes had been implemented in their areas? Did they feel that there was an impact?

Dr Ottley: Yes, definitely. In particular, anecdotal evidence from service providers and clinic users is generally very positive, even when a presence of protesters has been maintained outside the zones. They feel better because the protesters are kept further away, it seems. I have not come across much about the reaction of those who are opposed, other than through the challenges that have been brought in the courts. However, according to the anecdotal reports that I have read, people on the whole seem to feel better.

Sandesh Gulhane (Glasgow) (Con): Thanks for the presentation. I have a couple of questions. The first revolves around what has been said about a slippery slope argument in other jurisdictions in which measures have been brought in. We are all aware that the reason is very specific and that the scope of the bill is very tight. However, the bill also says something about private dwellings. The slippery slope argument is, "Well, we'll bring this in here, but maybe we'll then be able to say that we will do something else a little later, then we will do that something else," and we start to erode what happens in a private dwelling.

Dr Ottley: I have not seen the phrase "slippery slope" used in any of the reports that I have read, but people are concerned about the fact that legislation often targets abortion in particular. I am not sure that there is concern about it spreading; the concern seems to be more about why it does not apply more generally as opposed to targeting abortion.

Private dwellings are referred to in legislation in Canada and in some of the US—not in the buffer-zone legislation itself, but in other legislation that protects doctors' and clinic staff's homes. In places such as the US and Canada, the same kind of legislation can be used for anti-vax protests, particularly in relation to Covid-19. It is interesting that there seemed to be less opposition to that than there is to safe access zones around abortion clinics. One of the Canadian states that does not have safe access zones for abortion has safe access zones for anti-vax-type protests, which is interesting.

I was going to say something else, but it has slipped out of my mind. Have I answered your question? It does not seem to have been a major concern; the bigger concern was why that very narrow thing was being picked on.

Sandesh Gulhane: The other question, which has come up in other places, revolves around silent prayer. It is sometimes impossible to know whether people are protesting—sometimes it is possible—if they are standing in a circle and are silent and do not have signs or anything. There is one thing that I would like you to touch on if you can in relation to silent prayer. If you are a nun or a priest, you are more than entitled to wear what you want. That is different to me putting something on and standing somewhere, which would be overt. The question revolves around silent prayer for ordinary members of the public, but also for the clergy, nuns and people such as that.

Dr Ottley: That is a good question. Whether silent prayer is included in the prohibited activities varies depending on the jurisdiction. In one jurisdiction, the point was made that silent prayer would not be included because the wording of the prohibited activities included protest, and they did not regard silent prayer as an act of protest.

However, where the legislation is framed more broadly, so that it prohibits any act that has consequence, silent prayer tends to fall within that. It is outside the scope of this research, but other research looks into the impact of silent prayer on people who are accessing clinics. Some of the parliamentary reports cite a lot of research on the impact of silent prayer on people. They talk about

the fact that doing it very close to a clinic can be the problem, as opposed to doing it somewhere else. What comes across from the parliamentary reports is that it is more than just silent prayer.

Silent prayer has been a big issue in the English and Welsh legislation in the sense that an amendment that was tabled at the final stage specifically excluded silent prayer from the legislation. It was not successful, but in the draft guidance that was published recently, which the UK Government has just closed its consultation on, silent prayer seemed to be excluded, so the Government was accused of watering down protection from the legislation.

While I was talking about that, I remembered the other point that I was going to make in regard to your first question. The situation in England and Wales is unique in that safe access zones are dealt with in general protest legislation. In most other jurisdictions, safe access zones for abortion are either a stand-alone piece of legislation or they are dealt with in abortion legislation more generally, but in England and Wales, safe access zones are in quite controversial protest legislation. I wonder whether there might be a connection there—it is not necessarily a slippery slope, but it links to broader protest in that sense. Does that answer your question?

Sandesh Gulhane: Yes. Could you expand on the point about what difference it makes if safe access zones are included in protest legislation rather than in other legislation? I am sorry, I have perhaps not quite understood the relevance of that.

10:15

Dr Ottley: Different people see it in different ways, but there might be a perception, which seems to come across in some of the Hansard reports, that “anti-abortion” protest outside clinics is being lumped together with “normal” protest, whereas advocates of safe access zone legislation tend to see protests outside abortion clinics as being of a very different nature and as something unique. There are comments such as, “It’s not real protest, it’s more like harassment.” That made me think about your point about a slippery slope. Some people in England and Wales might argue that it looks as though that has already happened, because there are other restrictions on protest within that broader legislation.

Emma Harper (South Scotland) (SNP): My question follows on from Sandesh Gulhane’s question about silent prayer. Does the other legislation look at the number of people standing outside a clinic? There is a difference between having one person, who might be a minister or a priest, and having 10 people. Does the legislation cover when it is okay to walk into a place or to stand outside in silence?

Dr Ottley: None of the legislation that I have looked at says that a certain number of people is or is not okay. The legislation is generally quite broad in what is prohibited. It generally tends to prohibit, rather than to spell out what would be okay, so there is a bit of a guessing game about what would be okay.

It is not legislation, but England and Wales have been relying in the meantime on public spaces protection orders, which create something a bit like a safe access zone. The order in Ealing sets up a designated area for protest. Of all the laws that I have looked at, that is the only example of a place that has specifically said what is okay. Does that answer your question? I have not come across anything else.

Carol Mochan (South Scotland) (Lab): This has been really useful. I am interested in what you said about some of the legislation that you have looked at listing prohibited behaviour. The sense we are getting is that we are not likely to go for that option here. Have any of the people who have had to implement the legislation indicated that they found one way to be better than the other?

Dr Ottley: Some of the parliamentary debates show some concern about how to characterise a particular behaviour. Some of the legal challenges regarding human rights compatibility have said that it would be possible to prohibit one behaviour but not another. That was the root of the challenge in Northern Ireland. The Supreme Court asked how police and clinic staff are to characterise whether what someone is doing is intended to influence or harass people, or whether that is okay.

Although legislation that lists prohibited behaviour does so specifically, it lists pretty much everything that you can think of, which is an attempt to make the legislation easier to enforce. That makes sense, because it is difficult to know what is going on in an interaction between two people. We can see that in the Northern Ireland Supreme Court judgment.

Emma Harper: My next question is on a different subject—the rights of protesters versus those of women who are seeking an abortion. Our briefing papers say that the United Nations Committee on the Elimination of Discrimination Against Women found that several aspects of the law on abortion in Northern Ireland violated women’s rights. Its report made a number of recommendations to

“Protect women from harassment by anti-abortion protesters by investigating complaints and prosecuting and punishing perpetrators.”

I am interested in aspects where the rights of women who are seeking medical care supersede the right of people to protest and the right to free speech.

Dr Ottley: To go back to the UK Supreme Court judgment in the Northern Ireland case, the court explicitly said that it was prioritising the rights of women who were accessing abortions. Obviously, it talked about its justification for doing that, but it made the point that it was prioritising those rights.

Throughout the court judgments and parliamentary debates on the issue, we see a constant balancing act, which is about framing the need for safe access zones in a way that achieves a balance. Those who oppose safe access zones say that, by virtue of having such zones, you have achieved the wrong balance. Generally, however, when you look through parliamentary reports, you find that most of the time is spent on that balancing act. People say, "If we phrase it this way or prohibit this behaviour, are we going a bit too far? Are we tipping the balance the other way?"

As I said, that is really the biggest challenge with such legislation. The CEDAW report does not mention protesters' rights, which I guess is because it had quite a narrow focus, but the parliamentary reports and the court judgments clearly do.

Ivan McKee (Glasgow Provan) (SNP): Thank you for your interesting research on the issue. I have a couple of questions about impact. You mentioned a couple of legal cases that have been unsuccessful. Are you aware of any legal challenges that have been successful?

Where legislation is in place, have there been convictions or have charges been brought? You are looking at the issue globally, and some jurisdictions are very different; I am interested in your perspective on jurisdictions such as Ireland that are more similar to Scotland. I also have a follow-up question on the UK legislation.

Dr Ottley: On successful challenges, in the US, an earlier version of the Massachusetts law made it an offence to knowingly enter or remain within 35 feet—about 11m—of the premises. The US Supreme Court held that that was unconstitutional, on the ground that it placed too great a burden on the protesters' first amendment rights to free speech, and it struck down that law. That is the only example that I have found of that happening with safe access zone legislation. For example, the Supreme Court upheld the Colorado law.

There are more cases that I did not look at in detail for the purposes of the research but which looked at what are in effect safe access zones that have been created through means other than legislation. Sometimes, in the US, zones are created by injunction or by local council ordinances. There have been more challenges to them, some of which might have succeeded. I did not look at that for the research, so I will not comment on it, but there is the example of a safe access zone being struck down in the US.

On convictions, in England and Wales, there have been some arrests, investigations and attempts at prosecution with regard to public spaces protection orders. In Northern Ireland, there have been reports—I think that I included a link to a BBC News article on this—of continued protests in an area and the police being involved. Particularly with regard to the PSPOs that we have in England and Wales, charges are sometimes dropped. Someone might be arrested and there might be an investigation process, but that often does not get all the way through to conviction.

Off the top of my head, I think that some legislation talks about giving warnings first, so going down the arrest route is not always the first port of call. Some legislation requires either a warning or removal from the zone in the first instance, and then there might be an arrest or investigation. There are definitely examples of that happening. In reports on the subject, some people say, "Well, that's evidence of it not working," and some say, "No—actually, that's evidence of it working, because those people are being arrested and prosecuted."

Ivan McKee: That is fine. I suppose that it is too early to say how such charges progress, if and when they are brought, with regard to giving some clarity on what behaviours are or are not acceptable or fall within the legislation.

My other questions follow up on the point about the UK legislation. If I understand it correctly, the provisions for abortion zones in that legislation are couched in terms of broader zones in relation to other protest activities. Is that correct? That might include people who are protesting outside workplaces because they are not happy about what is manufactured there, people who are protesting outside other facilities because they are not happy about something that is happening in a specific area, or other forms of political protest. Is that how the UK legislation is framed?

Dr Ottley: Perhaps I did not explain that super well. The Public Order Act 2023, which applies to England and Wales, has been in the news as a controversial piece of legislation for creating new criminal offences for protesting—for example, locking on to things. That legislation does not create safe access zones in any other context; it just creates other restrictions on protests through other means. I am sorry—I probably did not explain that well enough.

Ivan McKee: No—that is fine. If I understand it correctly, that legislation makes a clear distinction

between other protests and abortion zone provisions. Is that correct?

Dr Ottley: Yes. Section 9 of the 2023 act is singled out as relating to abortion safe access zones.

The Convener: Sandesh Gulhane wants to come in.

Sandesh Gulhane: Thank you, convener—it is just to declare an interest as a practising national health service general practitioner.

The Convener: Thank you. Ross Greer wants to come in.

Ross Greer: I will be brief. Dr Ottley, I am interested to know how, in any of the examples that you came across, the legislation, ordinance or whatever it was engaged with the right to private property. One of the hypotheticals that we are looking at concerns what would happen if private residences fell within a zone. Hypothetically, if somebody had a house with a garden and a flagpole in the zone, they could put up a flag. Under the legislation, there would be questions about intent, the messaging on the flag and so on. Are there any examples of legislation that has had a clear interaction with private property rights and of that issue being resolved?

Dr Ottley: Not as far as I am aware. I recall reading about behaviour that could happen in situations in which there were churches in a zone—for example, about whether someone could display a sign outside the church. Some of the legislation that I have seen exempts things that happen in a church. In some places, there is an exemption for things that happen in buildings—often, the medical facility itself is exempted—but I have not come across a situation in which an individual's private property is in the zone and there are questions about what they can do on that property. Perhaps the nature of the zones and where clinics are mean that that has simply not been a problem. It depends—it might be more of an issue in places such as hospitals rather than stand-alone clinics, given where clinics tend to be.

Did that answer your question? I do not know whether you are talking about protecting the private property or how that might impact on behaviour.

Ross Greer: I am talking about the impact on behaviour, such as in the example that you gave. A church can put a sign outside, just as somebody could put a sign in their window—at election time, it is not uncommon for people to put a sign in their window to say which party they are voting for. If someone's house was in a safe access zone, there would be an interesting interaction between the intent of the legislation and rights under article 1 of protocol 1 to the European convention on human rights.

Dr Ottley: Yes—for sure. That is connected to the size of the zones. Some people who do not agree with safe access zone legislation but might prefer a case-by-case PSPO approach, where a zone is created for a particular clinic, mention as advantages things such as the ability to target a zone for a specific area. That would mean that legislation could be framed so that it did not catch a person's property or a church. However, under the England and Wales legislation, which simply provides for a zone of 150m for every single clinic, there is probably a higher risk that what you describe would happen.

10:30

Sandesh Gulhane: I will pick up on that point. Is the bill the only legislation that specifically mentions private dwellings? Do all the pieces of legislation mention them?

Dr Ottley: I am testing my brain power to remember that. I do not think that it is very common for legislation to mention anything such as that. The context in which private dwellings come up more frequently is in the Canadian and US legislation, which deals with protecting the homes and residences of clinic staff and clinic doctors, for example, when they have had incidents of violence. It is interesting that you have brought up that issue; it really has not been on my radar, which makes me think that I have not really seen that in the legislation.

Sandesh Gulhane: Will you write to us to let us know whether private dwellings are mentioned in other legislation?

Dr Ottley: Yes. I will go back and check the legislation, make sure that private dwellings are not mentioned and write to the committee.

Sandesh Gulhane: Thank you.

Gillian Mackay (Central Scotland) (Green): I have a quick question about the nature of the different protected sites in the pieces of legislation. In England and Wales, the approach is very much more on a stand-alone clinic basis than it is in Scotland, where we are looking more at hospital campuses and the nature of those sites. Is that a consistent theme across the other legislation, too? Are the sites in Scotland that we are trying to protect kind of unique compared with many of the sites that are covered in legislation around the world?

Dr Ottley: The sites are not completely unique. I think that, on the Isle of Man, abortions tend to happen in hospitals. There is also somewhere else, but I will have to check that because my brain has now given up. There is definitely

somewhere else that I remember reading about specifically in a note. It said that, unusually, abortions tend to take place in hospitals there rather than in clinic settings.

Scotland is not completely unique—there are some other examples. It is just unusual, because abortions often take place in stand-alone clinics. It is interesting that some of the research talks about how stand-alone clinics attract protests. Hospitals experience protests, too. I will double check the position.

Gillian Mackay: That is lovely. Thank you.

The Convener: I thank Emily Ottley for her research and her attendance at the meeting.

I suspend the meeting to allow for a changeover of witnesses.

10:32

Meeting suspended.

10:45

On resuming—

The Convener: Welcome back. The next item on our agenda is our first evidence session on the Abortion Services (Safe Access Zones) (Scotland) Bill. Before I begin, I will provide a brief introduction to the session.

The evidence that we will hear will relate to the proposed establishment of safe access zones and we will hear from individuals with lived experience as part of that. As such, some of the content of the meeting may be sensitive or potentially distressing and the committee encourages anyone affected by the issues discussed to seek support. If anyone attending needs to take a break during the session, please indicate that to me or the clerks.

I welcome to the meeting Alice Murray, Lily Roberts and Lucy Grieve, the co-founders of Back Off Scotland; Rachael Clarke, chief of staff at the British Pregnancy Advisory Service; and Dr Rebecca Mason, research and policy lead at The Young Women's Movement.

I thank all the witnesses for coming along to give evidence to the meeting. I know that some of you are sharing personal experiences with the committee and we really appreciate you joining us to help inform our scrutiny of the bill. Please note that there is no pressure or expectation to share anything that you are not comfortable with. Again, please let us know if you would like to take a break at any point.

Alice Murray and Lily Roberts will begin by setting out their views on the proposed establishment of safe access zones and how that relates to their experience. I invite Alice to speak first.

Alice Murray (Back Off Scotland): It is great to be here. Thank you for inviting me. We are all glad that the proposal has got to this stage. Everyone has a handout that describes my experience, but I will give a brief summary in my own words.

I found out that I was pregnant in 2019, which was my third year at the University of Edinburgh. Before that time, I was aware that the protesters existed. I had seen their presence outside the Chalmers clinic and always felt very frustrated. However, when I went to get an abortion, it was a different experience. To see them on the street can be quite anger-inducing, but to face them when you seek medical care is not something that you expect in this country.

When I went to the Chalmers clinic, there were around five to seven protesters. I made the choice to go to the clinic alone, so they were the only people that I saw—apart from the healthcare workers inside, who were absolutely brilliant. The protesters were standing on the other side of the street from me. In many ways, it is weird to say that I feel lucky. There is no lucky experience, but some of the testimonies that you will hear over the course of your evidence might seem a little more shocking than mine. Even so, the long-term impacts of facing the protesters have been significant. It has definitely impacted the way that I could think about and process my experience.

I know that everyone will have questions. Everyone's experience of abortion is different. I want to get it across that I had no emotional attachment, regret or issues around my decision to get an abortion. It was an easy decision for me. I did not think too much about it, because I saw it as a healthcare procedure that I needed to get. Even so, the experience was traumatising and that—hand on heart—was only to do with the protesters.

It is easy for people to think that an abortion will never be a pleasant experience, that it will always be traumatising and that that is wrapped up in the experience. That is absolutely untrue. I know for a fact that, if the protesters had not been there, the experience would have been the equivalent of getting a tooth out for me. It was not a big deal, but the protesters made it a politicised and stressful experience.

That is one thing that I would like you to take into account when I talk about my experience. It is also why I support the bill. We need people to be able to access healthcare without the intimidation that I faced.

The Convener: Thank you.

Lily Roberts (Back Off Scotland): I will follow on from what Alice said. I had an abortion in 2018,

when I had just moved to go to the University of Glasgow. I went to Queen Elizabeth university hospital, which is the hospital that has faced the biggest protests on record. At one point, 200 people were there. When I went there, there were 15 to 20 people.

I will explain the geography of Queen Elizabeth university hospital. You have to go round a small ring road, and there is a small section of road that you cannot avoid when you are going in and out of the clinic. I went in with my partner at the time and the protest was completely unavoidable—you simply could not avoid it. It was very intimidating. People were holding up placards. I had always been pro-choice, but I had no concept of the fact that protests happened in the UK. I thought that the protests were a very American occurrence. Coming to Scotland and suddenly being confronted with the reality—which, I am sure, happens to a lot of other people accessing services, too—played on my mind.

Similar to Alice's experience, when processing the abortion, the sole thing that played on my mind afterwards was the protesters being there. I was in hospital for quite a while—about seven hours. When I went in at 7 am, the protesters were all there. Rather than being present in the moment, I spent the entire time thinking about how I would get out. There was an element of feeling trapped and overwhelmed by their presence.

When my partner at the time went outside for some fresh air, he was approached by one of the people. They might say that they just stand there and do not do anything invasive, but that is very far from the truth, as you will know from other accounts. They went up and handed him leaflets containing misinformation about healthcare. It is really important to understand that the protests are not neutral or peaceful. There is something very dangerous and malicious about handing out information in that manner. They would say that they do not act aggressively or that it is not an act of violence to occupy such spaces, but when people gather and distribute such misinformation, it is, frankly, really scary.

If buffer zones had been in place when I had my experience, they would have made me feel really safe. I do not think that it is too much to ask for safety when you are accessing healthcare. It is a shame that we are at this point, but I am really excited to be here to speak with you all and, I hope, to push through a bill that takes a person-centred approach and ensures that healthcare is accessible, safe and approachable for people in this context.

The Convener: Again, I thank Lily and Alice for coming along this morning.

We will move to questions for the whole panel.

Sandesh Gulhane: Thank you so much for telling us your stories and what happened.

I declare my interest as a practising NHS GP.

This is a hypothetical question, so if you cannot answer it, do not feel that you need to answer it. The protests that you faced very much involved things happening—Lily's partner at the time was approached. What impact would silent prayers and vigils potentially have had on you? Obviously, that did not actually happen.

Alice Murray: I am sorry, but I should say that that was my experience. No one directly approached me—I am sorry if I was not clear about that. I went to Chalmers clinic in Edinburgh. You are probably familiar with it. I went in one end, and five to seven people were engaged in silent prayer on the other side of the street. When we talk about silent prayer, we should note that people are sometimes silent, but they sometimes sing hymns and they also have signs. We are getting a bit technical. It might be silent prayer but, if someone is holding a sign that says that abortion is murder, they are sending a message.

That was my experience, so I do not really need to think about it hypothetically. What the protesters say is silent prayer is what I experienced. I can speak only about my experience, but I know that it was all the same. It was all the more traumatising to walk into a clinic when people outside were suggesting that what I was doing was wrong and were questioning my decision. It was horrible and really emotionally draining. I think that it is just the same.

We need to encompass a variety of actions in the bill. One person's idea of engaging in silent prayer can look very different to the person on the other side who is alone and accessing healthcare. My experience involved so-called silent prayer.

Sandesh Gulhane: Thank you—that is very helpful.

I open this up to other members of the panel. The bill before us contains provisions that cover putting up posters or signs within private dwellings. We can fully understand the reasons for that. My question to all the panel is whether you think that it is proportionate to have such provisions, and whether you feel that they have been balanced appropriately with the right for people to do almost what they want in their own property.

Rachael Clarke (British Pregnancy Advisory Service): I am from BPAS and, for those of you who are not aware, we are the largest abortion provider in the UK. We are a charitable abortion provider and we have clinics across England and Wales. We were heavily involved in the passage of the English and Welsh law at Westminster last

year and that question came up quite a lot with the bill team at the time. We were very clear that there needed to be some provision for private dwellings and other buildings within buffer zones. I think that I can speak for everyone in saying that absolutely none of us believes that someone having a private conversation in their own house should be covered. None of us believes that that should be stopped. However, people can use their private dwelling or another building that they own to have exactly the same effect as if those people were stood on a public highway. Our particular concern was around the posting in windows of very large posters with distressing images, or people standing in gardens handing out leaflets over a garden wall, with women essentially having to walk past them.

Where we landed with the law in England is that it does not cover private conversations within a house or between houses, but it does cover anything that is aimed at women in the public space. For us, that balanced the right of people to do what they want in their home with not being allowed to inflict it on people in a buffer zone.

The Convener: We have already heard from Alice Murray and Lily Roberts about their support for the bill. What would the other panel members expect to be the impact of the bill, were it to be passed and enacted?

Lucy Grieve (Back Off Scotland): I am a co-founder of Back Off Scotland. For those of you who do not know, Back Off Scotland is a grass-roots campaign that seeks to secure the implementation of safe access zones around all clinics and medical facilities providing abortion in Scotland. When we started in 2020, with our founding members—Alice Murray, Lily Roberts and me—we heard a lot of stories about similar experiences to those of Lily and Alice. As the campaign started to grow and as we started to get a bit more press attention, we started receiving and collecting testimonies from hundreds of women from across Scotland, and the impact on a whole cross-section of society has been very surprising.

It is easy to think that having the law implemented will help abortion patients, which is great, because one in three women will have an abortion and it is one of the most common procedures that a woman will undergo, but the protests also affect other people. We have collected testimonies from women undergoing miscarriage management, women who have had much longed-for pregnancies, sexual assault victims accessing services, partners of those accessing care and even refugees, who have all been harassed and intimidated through a variety of methods of harassment.

It is very important to us that, when we bring it down to the base level and look at things such as silent prayer, for example, it does not matter whether someone is silent or in your face—it is the presence of somebody targeting you for going for a medical procedure and making a judgment about you that is unacceptable.

The impact that the bill would have on the whole of society would be extremely beneficial. It balances rights well, given that no-one, on either side of the coin—whether they are pro-choice or anti-choice—could protest in a designated zone.

11:00

Dr Rebecca Mason (The Young Women's Movement): For those who do not know, I am from the Young Women's Movement, which is Scotland's national organisation for young women's feminist leadership and collective action against gender inequality. Our work is led by young women and it is for young women.

To ensure that young women's voices are centred in the conversation, we engaged with our advisory collective—which is a group of 31 women who are aged under 30—to discuss its views on the Abortion Services (Safe Access Zones) (Scotland) Bill. The movement supports the bill, because we believe that people who access or provide abortion and associated sexual and reproductive healthcare services should be able to do so free from intimidation and harassment.

As we noted in our report, "The Status of Young Women in Scotland 2022—2023: Experiences of Accessing Healthcare", which was published last year and engaged with nearly 1,000 young women across different parts of Scotland, young women face substantial obstacles when they access sexual and reproductive healthcare in Scotland. That includes accessing contraception, abortion and post-abortion services. The movement believes that all women should have the right to access safe, high-quality and timely healthcare without fear of being dismissed or ignored by healthcare staff or verbally abused by protesters outside healthcare facilities. Since the publication of our report, we have continued to work very closely with young women to better understand how they can have a more positive experience when they access healthcare in their local communities.

The Young Women's Movement believes that compassion, care and concern should be embedded in all healthcare settings and strategies, and that it should start from the initial point of contact, when a person is walking through the entrance of a hospital or a healthcare facility. Young women told us that even quiet protest outside a facility can be very intimidating for them,

and the distribution of leaflets with erroneous information can be detrimental to young women's health and safety.

We believe that the bill will ensure that every person who is entering a clinic or hospital—for whatever reason, that is personal to them and their healthcare provider—is protected from experiencing intimidation and harassment from protesters gathering outside the entrance.

I will finish on a point that it is important to make now. We believe that the bill does not seek to stop or ban anti-choice protests or activity, and the majority of young women that we engaged with were passionate about that and agreed that the safe access zone should apply to both pro-choice and anti-choice protests. One young woman said:

"It is an equal bill, which would prioritise the peaceful experience of a young woman seeking access to healthcare."

Our organisation believes that that is a fair way of policing quite a difficult and contentious issue. We think that the bill is an attempt not to restrict freedom of expression, religion or protest, but to safeguard public health and protect the right of women to access abortion and associated reproductive healthcare without obstruction.

Ross Greer: The opponents of the bill—those who engage in or support the protests—will come and give evidence to the Parliament using arguments that you will be familiar with. One such argument is that, in part, they do not see their action as protest, but as an opportunity to offer advice and an alternative perspective to those who are seeking abortion or reproductive healthcare. It is important that you have the opportunity to answer that claim, so I am interested in your thoughts on the claim that they are offering advice and options that would not otherwise be provided. Lily, you addressed that somewhat in your opening remarks, when you said that they provided misinformation—which is of no surprise whatsoever. I am interested in the panel's thoughts on that, and in hearing your responses to that claim.

Alice Murray: I will speak to my own experience; it is important to say that. Again, I am not 100 per cent familiar with current best practice, and I am sure that Rachael Clarke and Lucy Grieve will have a better idea on that, but my experience when I went to the clinic was that I had a huge opportunity to learn about other options and to discuss my situation. That was one thing that I took away from it. I remember saying to a friend that I was really surprised by how long and extended that conversation was. We went through why I wanted to have an abortion, whether I was in a safe situation, whether I had a partner—a variety of safeguarding questions—and I found myself repeating, "No, I really want this." I was surprised at how big that opportunity was. My response is that the clinic is the appropriate place for that conversation to happen.

In addition, if protesters adamantly think that that conversation does not go on inside a clinic and that healthcare workers are not doing their job and giving patients a fully rounded view of abortion, that is what they need to protest—they should fight to get it into NHS practice. I do not believe that that is needed. In my opinion, that is not a genuine concern of protesters. They know that that happens inside a clinic, but that is not their focus.

On the flip side, a glaring issue is that a lot of the information that protesters give out is either factually or medically incorrect, and we cannot check its validity. For example, we have heard from people who have been given a leaflet that contained medical misinformation. That is really hard for us to track. Once that protester is gone and that leaflet has been given out, we do not know who has seen it—for example, we do not know whether children have seen it.

To summarise, in my experience, that conversation happens inside the clinic. It is entirely inappropriate that it should happen at its door.

Rachael Clarke: As a provider, I can speak to what happens in our clinics. I preface that by saying that we do not provide a service in Scotland, but we and Scottish providers provide in line with international and national best practice. The Royal College of Obstetricians and Gynaecologists is clear that, within healthcare services, counselling should be available to women if they require it. It is also clear that, if women do not require it, they should not be forced to go through it, because, ultimately, a very large number of women come to the service knowing that that is the decision that they want to make. They have had that conversation with their friends and family and they do not need to sit in front of a healthcare professional and justify again and again why they need that care.

This is a message that is, obviously, used against us in England as well. Regulation is hugely important. As providers, we are qualified to provide that care and are highly regulated as healthcare professionals; a random person on the street is not. Ultimately, as a healthcare provider, we cannot know who those people are. As far as we are aware, they are not trained, qualified or regulated to provide the detailed and specialist care that women who present to abortion services in really difficult circumstances may need.

If the action is not about protest, the protesters are doing themselves a disservice when it comes to freedom of speech, because, essentially, they are asking to have free access to women who are

in a vulnerable state, and to offer them healthcare services that they are neither qualified nor regulated to provide.

Lily Roberts: I will add briefly to what Alice Murray said. I cannot speak for everyone but I, too, had very comprehensive options given to me. It is not the case that, if you walk into a clinic, you are instantly just granted an abortion. That is not how it goes down. Given the legal system and how those services are accessed, I had two appointments, both of which involved a conversation of about 30 minutes with healthcare professionals. You have to get the approval of two doctors. It does not instantly happen.

The claim of anti-choice individuals that they offer advice is very much hinged on an idea of saviourship. They frame themselves as providers of care who can help you come back from making a bad decision. In reality, as Rachael Clarke said, what they are doing is incredibly dangerous. If anything, it is very misguided, very naive and rather disrespectful to a healthcare system that is regulated and sets out to protect people's safety and provide accessible healthcare.

Ross Greer: Thank you.

I am interested in Rachael Clarke's perspective from being a service provider down south. In a later session, we will take evidence from providers up here in order to get the perspective of staff. Obviously, one of the elements that we need to consider for the bill is the impact of protests on other people who are accessing healthcare services in the same setting and on staff in those settings. As we have you here now, and given that you are a provider elsewhere, I would be interested in hearing not only BPAS's perspective on but your experience of the impact on your staff of equivalent protests and vigils down south.

Rachael Clarke: The groups that protest up here are also the groups that protest in England. They are the same people using the same guidelines, and they are supported by the same American-backed organisations.

As a provider, we have spent a lot of time gathering evidence first hand from women who attend our clinics and staff who provide care. We have around 3,000 accounts from women and several hundred accounts from staff of their experiences. People's experiences vary, depending on the type of protest, which very much depends on the area.

The most difficult thing for our staff and for our clinics is that, when a new protest pops up, it is very difficult for me to turn to them and say what will be involved. The protests vary so wildly that, ultimately, you will never know what to forewarn women or staff about until the protesters have turned up on your doorstep. In the meantime, the women who come through the door are highly distressed and need additional care. The people who provide care for them are then put under time pressure, because they do not provide just that healthcare. Essentially, they provide a kind of counselling service in response to the experiences of people that we have been talking about.

Women come in who are crying and are worried that some of the disinformation that they have been given outside may be correct. There is also the issue of how staff feel about the situation. That goes back to the question about silent prayer. The issue is not so much about people praying; rather, it is about their prolonged presence that focuses on the entrances to the clinics.

I think that most of our staff would say that they know who I am. They know that I am an abortion provider and that I am there to help women. That has resulted in some pretty nasty altercations between our staff and the people outside. It has also resulted in some of our staff expressing fear when they are walking to their cars at night and have to walk past protesters. I have reports of staff being chased down the street in the dark. Recently, someone was followed to her car, which was keyed the next day. There is no proof of who did that, but I think that it is quite suspicious, if I may put it like that, that that has been happening in that area.

The impact on staff grinds them down. They become quite used and inured to it because they have been there for so long and it happens day in, day out. However, when you begin to dig down into the matter with staff, you find that the impact on them is severe and that it really affects how they feel about their ability to do their job.

Ross Greer: Would anybody else like to come in on the question of the impact on other people in the facilities, such as hospital patients who access them for reasons other than reproductive healthcare?

Lucy Grieve: One thing that we were really interested in was when staff members, as well as people who were accessing services for different reasons, started coming forward to us. For example, we heard from a staff member who worked in the neonatal intensive care unit at the Queen Elizabeth university hospital. She had not had an experience of abortion herself, but she was frustrated and angry about the fact that her patients and parents of the babies in the neonatal unit had to go past a protest and the effect that that had. A lot of times, partners get very angry, too.

I worry about what actually happens when someone is sent over the edge. I think that there is a really big impact on people who do not necessarily think about that.

We also heard from a junior doctor at the same hospital. She had had an abortion while she was at medical school in Edinburgh, and she spoke very courageously about how coming to work every day at the Queen Elizabeth university hospital meant that she would have to pass the protesters in the morning and again at night, and about how that would affect the way in which she provided care to her patients throughout the day. Sometimes she would go home and cry. That was an extremely powerful account of how much everybody is affected.

Alongside that, we have testimonies from refugees who are at extremely vulnerable points in their lives. Members can imagine the impact that there would be on somebody if they were going through some of the worst times of their life and they had to pass through that knowing that people were there to target them, as it is clear what the signs with pictures on them are there to do.

11:15

Emma Harper: The bill deals with protected premises, and there is a definition of protected premises in it. The bill also has commitments for future proofing aspects of it, including the potential to extend its scope in the future to cover general practices, pharmacies and other areas that provide support. I am interested in hearing your thoughts on the definition of protected premises and the ability to modify that in the future.

Rachael Clarke: For those of you who might not be aware of this, there has been quite a revolution in the provision of abortion care in recent years, particularly in relation to the administration and use of early medical abortion and early medical abortion at home. In Scotland, that is now available up to 12 weeks. It involves taking two sets of medication at home. Prior to 2018, both were required to be taken in a clinic.

We have seen quite a rapid change to the way in which women can engage with care. That can be done in a way that perhaps we did not see when that drug was first licensed in the early 1990s, and we certainly did not see it in 1967, when the law was passed. When legislation limits how authorities and ministers can act in relation to updates in best practice and healthcare, those limitations really impact on women.

In some ways, it is possible to see where that might develop in terms of GPs, but I would also like us to think bigger. Just because we provide abortions in hospitals and stand-alone clinics such as Chalmers and Sandyford, that does not mean that, in 20 years, when we almost certainly will still need safe access zones, those will not be needed on new sites. For us, it is essential that there is the power to enable ministers to reflect on current best practice and make sure that women are protected, no matter how that changes.

Emma Harper: Wherever zones might be in the future, a 200m radius is proposed in Scotland. That is different from what is in the UK legislation, which provides for 150m. From reading our briefing papers, 150m seems to be adequate, except at the Queen Elizabeth university hospital in Glasgow, which has a part where people could gather and be heard from the wards that provide healthcare for women. What are your thoughts on the 200m proposal in Scotland and on the potential to give ministers the flexibility to extend or reduce the zones?

Rachael Clarke: I can speak to that, and I am sure that Lucy Grieve will also have something to say.

In England, BPAS focused tightly on 150m for the clear reason that the vast majority of clinics in England are either stand-alone or part of GP surgeries. They are on a much smaller scale than hospitals, and the mix of women who go to them is very different. They tend to be dedicated clinics rather than broad-based hospitals in which there are miscarriage and neonatal units and those kinds of things.

Our concern about distance was never about the distance itself; it has been about its impact on women. We were always concerned about two key things. One was the line of sight and whether women could be watched, observed and potentially filmed as they entered clinics. We were also concerned about whether protesters could identify women when they walked past them. We were concerned that they could see those women go into or come out of the clinic and then catch them when they reached the edge of the buffer zone.

We think that a 150m zone solves those problems in almost every part of the country. That is why we chose that distance, rather than because we thought that 150m would be adequate. Lucy Grieve has some really good reasons for why that distance would be inadequate in Glasgow. Having a 200m distance in Scotland would make more sense, particularly because of the site in Glasgow.

We also support the ability to extend that distance when necessary. It is right that that ability should sit with the minister, because that would mean that any decision would have to be based on evidence on whether that extension is required. We have some concerns that the current wording of the bill seems to give the minister a quite unfettered ability to reduce the size of a safe access zone as much as they want to and without any consultation.

Our position is that, if there is going to be a national 200m distance for safe access zones, that should be the minimum to which zones can be reduced. Therefore, the minister could increase the zone to 300m and then later decide that 200m is fine. However, in our opinion, they should not be able to reduce the distance below 200m, because that would mean that we would lose the value of having national legislation to let women understand what they are walking into and where they are protected. We would also want to ensure that the ability to reduce the area would be subject to the same requirements as increasing an area, which would include looking at evidence and consulting providers and business owners.

Emma Harper: I have in front of me section 8 of the bill, which deals with reduction. Would you require further consultation on that, as opposed to ministers simply making decisions? Are you saying that 200m should be the shortest distance but that ministers should be required to consult on any alteration of a zone to ensure that any changes are informed by evidence?

Rachael Clarke: Yes, that is what we would want. The simple reason for that is that we have been in quite a different position at Westminster compared with where you are at Holyrood. For instance, our current abortion minister is a former vice chair of the pro-life all-party parliamentary group. We have a very different set of ministers.

Our concern has always been to ensure that what we have in statute protects women and that, when ministers make alterations, they have to make them in conjunction with the people who provide the service. We want to ensure that they are not simply able to do whatever they want because of their own personal feelings about abortion. I really wish that that was not the case and that abortion was treated as healthcare, but it is still a relatively political issue. I want to ensure that women are protected in the future against any potential changes to ministerial opinion that might mean that there is a desire to reduce the protection that we want to give them today.

Ivan McKee: Good morning, panel. Thanks very much for coming along to share your thoughts with us.

I want to focus on the aspects of the bill that will create criminal offences, and specifically on the approach of prohibiting behaviours rather than specific activities. I would like to get your perspective on that and your sense of how that would work. Do you have any concerns about that, or do you think that that is the right approach? Those sections of the bill also provide for penalties for people who breach the legislation. What is your perspective on that?

I will open up those questions to anyone who wants to come in.

Rachael Clarke: We had a conversation about that at length at Westminster. The original iteration of our amendment included a list of specific activities. After quite a prolonged discussion in the House of Lords, we concluded that there was probably more value in having a list of the impacts of behaviour rather than including specific behaviours. Part of the reason for that was that the Supreme Court had ruled on the protections in the Northern Ireland legislation. Our choice was to copy those pretty much as they were. That is what has happened in the bill. We support that because there is an element of having that judicial support there already.

One thing that we were ultimately trying to do was pin down every aspect of the harassment, because it is not always possible to keep up. In all honesty, it was very much like playing Whac-A-Mole; you would see something happen somewhere and think, “Oh, that needs to go in the bill,” and then you would see it somewhere else. We did not want to create a situation in which the legislation was always trying to catch up and the anti-abortion groups always had an edge on us because they just needed to act outside the copy of the legislation.

For us, the impact is the right way to go, and I think that we can see that the approach is working in Northern Ireland. When the Home Office decides to introduce the approach in England, I am quite confident that it will work there, too.

Alice Murray: I will add to that. I will not repeat what was said earlier, but it is important that it needs to be that way. My experience would come under this, but if we were to list exact behaviours in that way, it would be much harder to track what protesters are doing. The issue goes back to the protesters, who will ultimately say that they were just engaging in silent prayer and that they were not directly harassing anyone. You can see from my testimony and a few other testimonies that we have collected that the impact is really the same.

Rachael Clarke: I am very sorry—I realise that you asked about punishment at the end of your question.

Ivan McKee: Yes.

Rachael Clarke: Again, that goes back to the Supreme Court’s conclusion on Northern Ireland, which was that the use of fines was adequate in those situations. We started out with optional prison sentences, but we reduced those. In some ways, whether I think that is the appropriate punishment is a little irrelevant, because it would put Scotland out on a limb to include prison sentences in a bill that is not currently in place in Northern Ireland or England and Wales, or—I

believe that I am right in saying—in the proposed legislation in Ireland.

Ivan McKee: That is a helpful clarification. I have one other question to ask. You may or may not want to give any details on this, but one of the things that has been mentioned a number of times this morning in relation to behaviours and impact is inaccurate medical information being given out. Do you want to share any examples of that?

Rachael Clarke: Absolutely. For us, there is a key leaflet that seems to make its way around pretty much the whole country. It includes line drawings of foetuses growing and a poem that starts,

> "Dear Mum, please don't do anything to harm your baby today."

There is a list in that leaflet that includes a large amount of inaccurate medical information, starting with the erroneous fact that abortion causes breast cancer, which is specifically called out in the National Institute for Health and Care Excellence guidance and the RCOG guidance as not being true. The leaflet talks about the mental health impact on women, which is also disproved in the NICE guidance and the RCOG guidance. It claims that abortion leads to child abuse and suicidal ideation, neither of which are evidenced. There is no real sourcing of information, and, where information is sourced, it tends to be from rather fringe journals with a particular kind of bent, usually from America.

That is the kind of thing that we see. Those messages about breast cancer and the impact on women's mental health are very familiar for anyone who is familiar with anti-abortion groups.

Ivan McKee: Thank you for clarifying that.

Emma Harper: You mentioned America, Rachael. I forgot to mention that I was a registered perioperative nurse for 30 years, working in California, England and Scotland. I am thinking about activities in the United States. A lot of violence has been perpetrated over the years, and there has been serious intimidation of people who work in healthcare at the homes of doctors, nurses and staff. My point is that, when we speak about people encountering protest, that includes staff, which you talked about earlier. The overarching aspects of the bill will protect everybody who is going to their work or going to access healthcare. That is what we are aiming for. Is that correct?

11:30

Dr Mason: Yes, that came through in our consultation with young women as well. Many of the young women whom we spoke to did not disclose whether they had had a personal experience, but many of them work as staff in NHS hospitals and healthcare clinics. They said that they felt incredibly attacked every morning as they were going to their job and experiencing those sorts of protests.

It is important that the bill protects not only women who are accessing those services but everyone. That is especially the case in places such as the Queen Elizabeth university hospital in Glasgow, which serves the entire community—it is not solely an abortion clinic. It is important to remember that the bill is not specifically for women who are accessing abortion. It is to allow everyone to work free from intimidation or harassment.

Sandesh Gulhane: I want to say that, as a GP, when a woman comes to me to ask for an abortion, it is not just a case of saying yes and moving on. There is a conversation to be had, because it is about safeguarding. People can conscientiously object, but they have to pass that patient on to somebody who can have that conversation. That is quite important.

I want to talk about human rights. I am going to ask some really difficult questions, which could potentially be quite triggering. There is a group of people, in our country and especially in America, who feel that human rights begin at fertilisation—that the embryo is a human with rights and that, in essence, what is occurring is murder. When someone has a view that is so strong and so set that they use a word like that, they want to be heard. They want their human rights and the human rights of the foetus or embryo—whatever term we or they want to give it—to be heard. What is your opinion about what I have just said, and what would you say in response?

Lucy Grieve: One thing to be very clear about is that, throughout the entire process, the issue has never been about abortion—what people think about it or the morality of it. It has always been about access to care. Whatever somebody thinks about abortion, they are absolutely free to feel that way. We would never want to change somebody's mind on something when they are so set in their ways. We would not want somebody to feel as though we were trying to make everybody pro-choice. However, it does not make sense to me that, if you have that view, you would go directly to the women and target them. I would also say that, if people want to change the law, they can come to Parliament.

The fact that people have a right to freedom of speech, freedom of assembly or whatever does not mean that they have a right to an audience. They do not have a right to have people listen to what they have to say, particularly vulnerable women who are trying to uphold their own rights, such as medical privacy and the right to a personal life.

When we are asked questions about human rights, the questions always revolve very much around the rights of the protesters and the people attending the vigils, but, actually, the rights of the women who are being targeted are very often left as a last thought.

Alice Murray: I agree with Lucy. We are still going to see anti-choice or anti-abortion protests in this country, and that is okay. They usually do one every year on Lothian Road. I live in Glasgow, and there are often protests on Buchanan Street. That will still happen. The bill is not trying to get rid of that. There is also a huge online presence.

As Lucy has said, the issue is not about the morality of abortion. We are not here to have that conversation; we are here to talk specifically about the procedure at the clinic door, which is why it is called a safe access zone. The measures are balanced, in my opinion.

Sandesh Gulhane: I will go slightly off topic, if I may. In Alabama, new legislation has come in on what constitutes a human, and that will make a huge difference to in vitro fertilisation—IVF—treatment over there. What has happened in Alabama marks a huge difference. Opinions change, people change and our thinking changes as time goes on. Do you think that the bill is going to give us future safeguarding in areas such as this when things have happened elsewhere?

Rachael Clarke: First—in case anyone cannot guess—I think that what has happened in Alabama and across much of the US is a travesty for human rights and women's rights, and for women's ability to live their lives as the free human beings they are. What we have seen has been disgusting, frankly, and I cannot ever countenance the idea that any of us in this room or beyond would allow something similar to happen in this country, because it is so far beyond what the British and Scottish public believe in.

The eventual law will be in place for as long as the Scottish Parliament wants it. Ultimately, the Scottish Parliament has the ability to overturn it at any point if, at some point—God forbid—it decided that, ultimately, human beings are human beings from the moment of fertilisation. The Parliament could get rid of the law. My feeling, however, is that that will not happen. Future-proof legislation is required that enables us to maintain the protection for as long as we need it.

Unfortunately, although our experience is that protests of the sort that we are discussing got much bigger and much more organised around 2014, they have been going on since the Abortion Act 1967 was passed. I have no reason to believe that, without the bill being passed, those protests might stop of their own accord or that they are just an issue for this time. They have been used over many decades to induce fear in women seeking to exercise their fundamental legal rights.

Sandesh Gulhane: At the moment, there are no protests occurring outside IVF clinics, but, given what has happened in Alabama, let us suppose that that does happen. Do you think that bills such as the one that is before us would give us the flexibility to future proof against anything that happens in the future, or do you think that we might need to come back and consider the matter again if something happens?

Rachael Clarke: We are not proposing that the bill be used elsewhere. It covers a very particular issue with many years of evidence and thousands of bits of information from women and providers behind it. I am not fundamentally opposed to similar laws elsewhere, but the evidence has to be there.

For us, it is clear that the evidence is there for abortion clinics. If similar things happen elsewhere in the future, I will be more than happy to come and talk to the Scottish Parliament about why we need the relevant protection. You are right, though—that is not where we are at the moment, and I would not want changes to happen without the same level of scrutiny as the committee is giving to the bill before us. We all recognise that such laws have impacts on the human rights of protesters, but those rights have to balanced with the rights of women. Our conclusion, when it comes to abortion, is that those rights are most adequately balanced by the introduction of safe access zones.

David Torrance (Kirkcaldy) (SNP): Good morning to the witnesses. There are individuals and groups who would argue that there are existing criminal offences that deal with behaviour such as harassment and threatening behaviour. In your view, why are those offences insufficient to deal with protests outside abortion clinics?

Lily Roberts: I used to live around the corner from the Sandyford clinic, and I have an example of how people being dealt with by existing legislation does not quite cover it. I went to observe two protesters who regularly frequented the clinic. Those two individuals had megaphones and were chanting hymns and preaching very loudly into the clinic. The police were called and they came. I saw how the police officers dealt with the situation and spoke to them about the existing legislation. Their words were that there was nothing they could do. The legislation is not explicit enough and it is not contextually bound to what is happening.

The police took the megaphones off the protesters, because they were infringing on the peace—or however it would be phrased. But, once the megaphones were taken off them, they started

screaming into the clinic. This clinic, in particular provides, sexual assault and rape counselling, and people were entering the clinic for those reasons while the protesters were screaming verbal abuse into the clinic.

It goes back to the complexity of different actions and how you class them. That is why it is so important to consider the impact. Existing legislation does not really cover or account for it.

Lucy Grieve: I echo what Lily Roberts says. An issue that we also need to bring in is the stigmatisation of abortion. Before we started our campaign, we had not really heard many stories about it. We looked at what BPAS had done in England and what Sister Supporter had done through its local campaigns in Ealing Council, for example. However, people did not talk about this until it became an issue in the media.

When people were reaching out to us through the hundreds of stories that we collected, we found that they never knew what they could do. The last thing that they wanted to do was go into an abortion clinic and call the police, because they were already going through a difficult day. The absolute last thing on their mind was involving the police and having to go through a process that would make the day harder.

Now that people are talking about it more and since more light has been shed on it, people who would not normally see the gates of a medical facility that provides abortion can see what the women are having to go through, and that has rightly changed the conversation around it. I definitely think that the stigmatisation and the conversations that we have been having are changing the chat.

David Torrance: Are there any other issues relating to the bill that the committee has not covered but that you would like to bring up?

Lucy Grieve: One thing is that, since we started our campaign, the protesters and those who attend vigils have been changing tactics. When we started, it was very much about their saying that it is not legal to limit the rights of protesters or their freedom of speech. Once the Supreme Court Northern Ireland ruling came through, they changed tactics and started saying that they were there to help and counsel women.

Fundamentally, the thing that underpins all the protest is nothing to do with the women and it is nothing to do with fighting for their rights. It is all about wanting to ban abortion outright. The messaging on the website of one of the protest groups is blatant and transparent that they want to end the scourge of abortion. Those people are not quiet, kind people who are just trying to go about their day and help people. They are backed by some very dangerous people who are really trying to come for our reproductive rights and, in particular, our right to abortion.

The Convener: I thank the witnesses for their evidence this morning. You have certainly helped with the committee's scrutiny of the bill. At our next meeting, on 5 March, we will continue to take evidence as part of the committee's stage 1 scrutiny of the Abortion Services (Safe Access Zones) (Scotland) Bill.

That concludes the public part of our meeting.

11:44

Meeting continued in private until 12:05.

Official Report
Room T2.20
Scottish Parliament
Edinburgh
EH99 1SP

Email: official.report@parliament.scot
Telephone: 0131 348 5447
Fax: 0131 348 5423

The deadline for corrections to this edition is:

Wednesday 27 March 2024

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba