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STATUTORY INSTRUMENTS

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**1991 No. 499**

**MEDICAL PROFESSION**

**The Abortion Regulations 1991**

*Made* - - - - *4th March 1991*  
*Laid before Parliament* *7th March 1991*  
*Coming into force* - - *1st April 1991*

The Secretary of State for Health, in exercise of the powers conferred by section 2 of the Abortion Act 1967(1) and now vested in him(2), and of all other powers enabling him in that behalf, hereby makes the following Regulations:—

**Citation and commencement**

1.—(1) These Regulations may be cited as the Abortion Regulations 1991, and shall come into force on 1st April 1991.

(2) These Regulations extend to England and Wales only.

**Interpretation**

2. In these Regulations “the Act” means the Abortion Act 1967 and “practitioner” means a registered medical practitioner.

**Certificate of opinion**

3.—(1) Any opinion to which section 1 of the Act refers shall be certified—

(a) in the case of a pregnancy terminated in accordance with section 1(1) of the Act, in the form set out in Part I of Schedule 1 to these Regulations, and

(b) in the case of a pregnancy terminated in accordance with section 1(4) of the Act, in the form set out in Part II of that Schedule.

(2) Any certificate of an opinion referred to in section 1(1) of the Act shall be given before the commencement of the treatment for the termination of the pregnancy to which it relates.

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(1) 1967 c. 87; section 2(2) was amended by the Transfer of Functions (Wales) Order 1969 (S.I. 1969/388), article 2(2) and Schedule 1, and by the Transfer of Functions (Health and Social Security) Order 1988 (S.I. 1988/1843), Schedule 3.  
(2) See the Secretary of State for Social Services Order 1968 (S.I. 1968/1699), article 5(4).

(3) Any certificate of an opinion referred to in section 1(4) of the Act shall be given before the commencement of the treatment for the termination of the pregnancy to which it relates or, if that is not reasonably practicable, not later than 24 hours after such termination.

(4) Any such certificate as is referred to in paragraphs (2) and (3) of this regulation shall be preserved by the practitioner who terminated the pregnancy to which it relates for a period of not less than three years beginning with the date of the termination.

(5) A certificate which is no longer to be preserved shall be destroyed by the person in whose custody it then is.

#### **Notice of termination of pregnancy and information relating to the termination**

4.—(1) Any practitioner who terminates a pregnancy in England or Wales shall give to the appropriate Chief Medical Officer—

- (a) notice of the termination, and
- (b) such other information relating to the termination as is specified in the form set out in Schedule 2 to these Regulations,

and shall do so by sending them to him in a sealed envelope within 7 days of the termination.

(2) The appropriate Chief Medical Officer is—

- (a) where the pregnancy was terminated in England, the Chief Medical Officer of the Department of Health, Richmond House, Whitehall, London, SW1A 2NS; or
- (b) where the pregnancy was terminated in Wales, the Chief Medical Officer of the Welsh Office, Cathays Park, Cardiff, CF1 3NQ.

#### **Restriction on disclosure of information**

5. A notice given or any information furnished to a Chief Medical Officer in pursuance of these Regulations shall not be disclosed except that disclosure may be made—

- (a) for the purposes of carrying out their duties—
  - (i) to an officer of the Department of Health authorised by the Chief Medical Officer of that Department, or to an officer of the Welsh Office authorised by the Chief Medical Officer of that Office, as the case may be, or
  - (ii) to the Registrar General or a member of his staff authorised by him; or
- (b) for the purposes of carrying out his duties in relation to offences under the Act or the law relating to abortion, to the Director of Public Prosecutions or a member of his staff authorised by him; or
- (c) for the purposes of investigating whether an offence has been committed under the Act or the law relating to abortion, to a police officer not below the rank of superintendent or a person authorised by him; or
- (d) pursuant to a court order, for the purposes of proceedings which have begun; or
- (e) for the purposes of bona fide scientific research; or
- (f) to the practitioner who terminated the pregnancy; or
- (g) to a practitioner, with the consent in writing of the woman whose pregnancy was terminated; or
- (h) when requested by the President of the General Medical Council for the purpose of investigating whether there has been serious professional misconduct by a practitioner, to the President of the General Medical Council or a member of its staff authorised by him.

## **Revocations**

6. The whole of the Regulations specified in Schedule 3 to these Regulations are revoked.

4th March 1991

*William Waldegrave*  
Secretary of State for Health

**Status:** This is the original version (as it was originally made). This item of legislation is currently only available in its original format.

## SCHEDULE 1

Regulation 3(1)

### PART I

Form HSA1 (revised 1991)

Form HSA1 (revised 1991)

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**IN CONFIDENCE**

**CERTIFICATE A**

**ABORTION ACT 1967**

**Not to be destroyed within three years of the date of operation**

**Certificate to be completed before an abortion is performed under Section 1(1) of the Act**

I, .....  
(Name and qualifications of practitioner in block capitals)

of .....

(Full address of practitioner)

**Have/have not\* seen/and examined\* the pregnant woman to whom this certificate relates at**

.....

(full address of place at which patient was seen or examined)

on .....

and I .....  
(Name and qualifications of practitioner in block capitals)

of .....

(Full address of practitioner)

**Have/have not\* seen/and examined\* the pregnant woman to whom this certificate relates at**

.....

(Full address of place at which patient was seen or examined)

on .....

**We hereby certify that we are of the opinion, formed in good faith, that in the case**

of .....  
(Full name of pregnant woman in block capitals)

of .....

(Usual place of residence of pregnant woman in block capitals)

- |                              |   |  |
|------------------------------|---|--|
| (Ring appropriate letter(s)) | A | the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;   |
|                              | B | the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;   |
|                              | C | the pregnancy has NOT exceeded its 24th 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;  |
|                              | D | the pregnancy has NOT exceeded its 24th 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 any existing child(ren) of the family of the pregnant woman; |
|                              | E | 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.   |

**This certificate of opinion is given before the commencement of the treatment for the termination of pregnancy to which it refers and relates to the circumstances of the pregnant woman's individual case.**

**Signed** ..... **Date** .....

**Signed** ..... **Date** .....

\* Delete as appropriate

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PART II

SCHEDULE 1

IN CONFIDENCE

Certificate B

Not to be destroyed within three years of the date of operation

ABORTION ACT 1967

CERTIFICATE TO BE COMPLETED IN RELATION TO ABORTION PERFORMED IN EMERGENCY UNDER SECTION 1(4) OF THE ACT

I, ..... (Name and qualifications of practitioner in block capitals)

of .....

..... (Full address of practitioner)

hereby certify that I \*am/was of the opinion formed in good faith that it \*is/was necessary immediately to terminate the pregnancy of

..... (Full name of pregnant woman in block capitals)

of .....

..... (Usual place of residence of pregnant woman in block capitals)

(Ring appropriate number)

- in order 1. to save the life of the pregnant woman; or 2. to prevent grave permanent injury to the physical or mental health of the pregnant woman.

This certificate of opinion is given—

(Ring appropriate letter)

- A. before the commencement of the treatment for the termination of the pregnancy to which it relates; or, if that is not reasonably practicable, then B. not later than 24 hours after such termination.

Signed .....

Date .....

\*Delete as appropriate

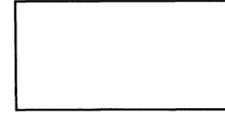
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SCHEDULE 2

Regulation 4

IN CONFIDENCE

ABORTION NOTIFICATION



Please leave blank

ABORTION ACT 1967  
FORM OF NOTIFICATION (England and Wales)

This form is to be COMPLETED BY THE PRACTITIONER TERMINATING THE PREGNANCY and sent in a sealed envelope within SEVEN DAYS of the termination to:-

The Chief Medical Officer  
Department of Health  
Richmond House  
79 Whitehall  
LONDON  
SW1A 2NS

OR

The Chief Medical Officer  
Welsh Office  
Cathays Park  
CARDIFF  
CF1 3NQ

in respect of the termination  
of the pregnancy in Wales

PLEASE USE BLOCK CAPITALS AND NUMERALS FOR DATES THROUGHOUT

1. PRACTITIONER TERMINATING THE PREGNANCY

NAME I, .....  
PERMANENT ADDRESS of .....

hereby give notice that I terminated the pregnancy of the woman named overleaf, and to the best of my knowledge the particulars on this form are correct. I further certify that I joined/did not join<sup>†</sup> in giving Certificate A having seen/not seen<sup>†</sup> and examined/not examined<sup>†</sup> her before doing so.

Signature ..... Date .....

2. CERTIFICATION

In all non-emergency cases state particulars of practitioners who joined in giving Certificate A.

1. To be completed in all cases.

2. Do not complete if the operating practitioner joined in giving Certificate A.

NAME .....  
PERMANENT ADDRESS .....

(tick appropriate box)

Did the practitioner named at 1 certify that he saw/and examined the pregnant woman before giving the certificate?  YES  NO

Did the practitioner named at 2 certify that he saw/and examined the pregnant woman before giving the certificate?  YES  NO

DO NOT COMPLETE IF SECTION 20 BELOW APPLIES

Please leave these boxes blank

3. NAME AND ADDRESS OF PLACE OF TERMINATION .....

Five empty boxes for recording details.

Was the patient a NHS case terminated in an approved place under an agency agreement?

(tick appropriate box)

YES  NO

<sup>†</sup>delete as appropriate

Form HSA4 (Revised 1991)

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4. WOMAN'S FULL NAME AND PERMANENT ADDRESS (INCLUDING COUNTRY IF RESIDENT OUTSIDE ENGLAND AND WALES)	Surname		Please leave these boxes blank
	Forename(s)		
	Address		<input type="checkbox"/>
	Postcode	<input type="text"/>	<input type="checkbox"/>
PRESENT ADDRESS IN ENGLAND AND WALES			<input type="checkbox"/>
	Postcode	<input type="text"/>	<input type="checkbox"/>
5. DATE OF BIRTH	.....DAY .....	.....MONTH .....	.....YEAR <input type="text"/>
6. MARITAL STATUS	(tick appropriate box)		<input type="checkbox"/>
	1 <input type="checkbox"/> Single	3 <input type="checkbox"/> Widowed	
	2 <input type="checkbox"/> Married	4 <input type="checkbox"/> Divorced	
		5 <input type="checkbox"/> Separated	
		NK <input type="checkbox"/> Not Known	
7. PARITY	Number of woman's previous:-		
	(Enter number - If NIL enter 0)	a. (i) Livebirths .....	<input type="checkbox"/>
		(ii) Stillbirths .....	<input type="checkbox"/>
		(iii) Spontaneous miscarriages .....	<input type="checkbox"/>
		b. Legal terminations .....	<input type="checkbox"/>
8*. ADMISSION	Date of admission to place of termination	.....DAY .....	.....MONTH .....
		.....YEAR	<input type="text"/>
9*. TERMINATION	Date of termination	.....DAY .....	.....MONTH .....
		.....YEAR	<input type="text"/>
10*. DISCHARGE	Date of discharge from place of termination	.....DAY .....	.....MONTH .....
		.....YEAR	<input type="text"/>
11*. DAY CASE	(tick appropriate box)		
	Was this a planned day case?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>

\* If the method of treatment used to terminate the pregnancy was Antiprogesterone with Prostaglandin without any supplementary surgical termination do not complete sections 8-11 but INSTEAD complete section 20



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<p><b>12. GESTATION</b> 1. Specify number of weeks by completing a or b as appropriate</p> <p>a. <u>Pregnancy has NOT exceeded its 24th week</u> Gestation estimated at.....weeks</p> <p>b. <u>Pregnancy HAS exceeded its 24th week (ensure that section 14 is also completed)</u> Gestation estimated at .....weeks</p> <p>2. <b>Methods of estimation (tick appropriate box(es))</b></p> <p><input type="checkbox"/> LMP    <input type="checkbox"/> Ultrasound    <input type="checkbox"/> Other - specify:- .....</p>	<p style="text-align: center;"><b>Please leave these boxes blank</b></p> <div style="border: 1px solid black; width: 30px; height: 15px; margin: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 15px; margin: 5px;"></div>																																																																																																																																																																										
<p><b>13. GROUNDS</b> The certified ground(s) for terminating the pregnancy stated on CERTIFICATE A were:- <b>(tick appropriate box(es))</b></p> <p><input type="checkbox"/> <b>A</b> that the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated. <b>A</b> State main medical condition(s):-</p> <p><input type="checkbox"/> <b>B</b> that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman. <b>B</b> State main medical condition(s):-</p> <p><input type="checkbox"/> <b>C</b> that the pregnancy has NOT exceeded its 24th 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. <b>C</b> State main medical condition(s):-</p> <p><input type="checkbox"/> <b>D</b> that the pregnancy has NOT exceeded its 24th 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 any existing child(ren) of the family of the pregnant woman. <b>D</b> State number of children:-</p> <p><input type="checkbox"/> <b>E</b> 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:- STATE</p> <p>EITHER (i) (a) Diagnosis:..... (b) Method(s) of diagnosis (tick appropriate box(es))</p> <p><input type="checkbox"/> Amniocentesis    <input type="checkbox"/> Ultrasound    <input type="checkbox"/> Chorionic Villus Sampling    <input type="checkbox"/> Other - specify .....</p> <p>OR (ii) Condition in pregnant woman causing suspected condition in fetus. Complete 1 and 2</p> <p>1. Condition in woman - specify:-..... .....</p> <p>2. Suspected condition in fetus - specify:-..... .....</p> <p><b>EMERGENCY ONLY</b> Termination was immediately necessary, as stated on CERTIFICATE B:-</p> <p><input type="checkbox"/> <b>F</b> to save the life of the pregnant woman <b>F or G</b> - state main medical condition(s):-</p> <p>OR</p> <p><input type="checkbox"/> <b>G</b> to prevent grave permanent injury to the physical or mental health of the pregnant woman</p>	<table border="1" style="width: 100%; height: 100%;"> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <div style="border: 1px solid black; width: 30px; height: 15px; margin: 5px;"></div>																																																																																																																																																																										
<p><b>14. OVER 24 WEEKS GESTATION</b> If the pregnancy was terminated after it had exceeded its 24th week please give below a full statement of the medical condition of the pregnant woman/fetus.</p>																																																																																																																																																																											

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<p><b>15. SELECTIVE TERMINATION</b> Was this a selective termination? <span style="float: right;">(tick appropriate box)</span></p> <p style="text-align: right;"> <input type="checkbox"/> YES    <input type="checkbox"/> NO         </p> <p>State:- (i) original number of fetuses .....</p> <p style="padding-left: 20px;">(ii) number of fetuses reduced to .....</p> <p style="font-size: small;">All other relevant sections of the form should also be completed</p>	<p>Please leave these boxes blank</p> <input style="width: 20px; height: 20px;" type="checkbox"/> <input style="width: 20px; height: 20px;" type="checkbox"/> <input style="width: 20px; height: 20px;" type="checkbox"/>
<p style="text-align: center;">(tick appropriate boxes)</p> <p><b>16. METHOD</b></p> <p>Cervical preparation? <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <hr/> <p>Surgical termination:-</p> <p><input type="checkbox"/> Vacuum aspiration</p> <p><input type="checkbox"/> Dilatation and Evacuation</p> <p><input type="checkbox"/> Hysterotomy</p> <p><input type="checkbox"/> Hysterectomy</p> <p><input type="checkbox"/> Other surgical - specify:- .....</p> <p style="padding-left: 20px;">*Medical termination:-</p> <p><input type="checkbox"/> Prostaglandin only</p> <p><input type="checkbox"/> Prostaglandins with:- (tick appropriate boxes)</p> <p><input type="checkbox"/> Oxytocin</p> <p><input type="checkbox"/> Antiprogesterone (if used see also section 20 below)</p> <p><input type="checkbox"/> Other medical agents-specify:- .....</p> <p style="font-size: x-small;">* Do not enter an evacuation of retained products of conception as a further method of termination.</p>	<input style="width: 20px; height: 20px;" type="checkbox"/>  <input style="width: 20px; height: 20px;" type="checkbox"/> <input style="width: 20px; height: 20px;" type="checkbox"/>
<p><b>17. COMPLICATIONS*</b></p> <p style="text-align: center;">(tick appropriate box(es))</p> <p> <input type="checkbox"/> None    <input type="checkbox"/> Haemorrhage    <input type="checkbox"/> Uterine Perforation    <input type="checkbox"/> Sepsis         </p> <p><input type="checkbox"/> Other - specify:- .....</p> <p style="font-size: x-small;">*Do not enter an evacuation of retained products of conception as a complication.</p>	<input style="width: 20px; height: 20px;" type="checkbox"/> <input style="width: 20px; height: 20px;" type="checkbox"/> <input style="width: 20px; height: 20px;" type="checkbox"/> <input style="width: 20px; height: 20px;" type="checkbox"/>
<p><b>18. STERILISATION</b></p> <p style="text-align: right;">(tick appropriate box)</p> <p>Was a sterilisation operation performed? <input type="checkbox"/> YES    <input type="checkbox"/> NO</p>	<input style="width: 20px; height: 20px;" type="checkbox"/>
<p><b>19. DEATH OF WOMAN</b></p> <p>In the case of death, specify:-</p> <p>(i) Date .....DAY .....MONTH .....YEAR</p> <p>(ii) Cause .....</p>	<input style="width: 20px; height: 20px;" type="checkbox"/>
<p><b>20. ANTIPROGESTERONE WITH PROSTAGLANDIN</b> Do not complete this section unless the method used was Antiprogesterone with Prostaglandin</p> <p>(i) Date of treatment with Antiprogesterone .....DAY .....MONTH .....YEAR</p> <p>Name .....</p> <p>Address of place of treatment .....</p> <p>(ii) Date of treatment with Prostaglandin .....DAY .....MONTH .....YEAR</p> <p>Name .....</p> <p>Address of place of treatment .....</p> <p>(iii) Date termination confirmed .....DAY .....MONTH .....YEAR</p> <p style="text-align: center;">(tick appropriate box)</p> <p>(iv) Was the patient a NHS case treated under an agency agreement? <input type="checkbox"/> YES    <input type="checkbox"/> NO</p>	<input style="width: 20px; height: 20px;" type="checkbox"/>  <input style="width: 20px; height: 20px;" type="checkbox"/>  <input style="width: 20px; height: 20px;" type="checkbox"/>  <input style="width: 20px; height: 20px;" type="checkbox"/>  <input style="width: 20px; height: 20px;" type="checkbox"/>  <input style="width: 20px; height: 20px;" type="checkbox"/>

## SCHEDULE 3

Regulation 6

## REGULATIONS REVOKED

Column 1 Regulations revoked	Column 2 References
The Abortion Regulations 1968	S.I. <a href="#">1968/390</a>
The Abortion (Amendment) Regulations 1969	S.I. <a href="#">1969/636</a>
The Abortion (Amendment) Regulations 1976	S.I. <a href="#">1976/15</a>
The Abortion (Amendment) Regulations 1980	S.I. <a href="#">1980/1724</a>

**EXPLANATORY NOTE***(This note is not part of the Regulations)*

These Regulations (which extend to England and Wales) are made under section 2 of the Abortion Act 1967, and replace the Abortion Regulations 1968 and the three sets of amending regulations. These Regulations make new provision to take account in particular of the amendments to the Abortion Act 1967 made by section 37 of the Human Fertilisation and Embryology Act [1990 \(c. 37\)](#), including the new grounds for abortion introduced by those amendments. The Regulations—

- (a) prescribe forms for the purpose of certifying opinions under section 1 of the Act and the time for such certification (regulation 3(1), (2) and (3) and Schedule 1);
- (b) provide for the preservation and disposal of such certificates (regulation 3(4) and (5));
- (c) require notice of the abortion, and information relevant to it, to be given to the Chief Medical Officer (regulation 4 and Schedule 2);
- (d) restrict the disclosure of such notices and information (regulation 5); and
- (e) revoke the Abortion Regulations 1968 and the three sets of amending regulations (regulation 6 and Schedule 3).