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RESEARCH ARTICLE

Maternal infliction of harm via prenatal alcohol exposure – a public wrong?

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Abstract
In recent years concern about Foetal Alcohol Spectrum Disorder (FASD) has intensified, prompting calls for societal action. Pregnant women's consumption of alcohol is increasingly surveilled, public health campaigns now promote abstinence, and in some jurisdictions, prenatal alcohol exposure (PAE) resulting in FASD has received criminal sanction. This paper anticipates potential calls to criminalise PAE resulting in FASD by envisioning what such a case might look like. Applying Duff et al's framework for determining whether an act should be criminalised, we draw upon public health and jurisprudential discourses to trace the outline of an argument for framing maternal alcohol consumption causing injury to the child born alive as a public wrong and a crime.[1] We show how an 'in principle' case may be constructed, but argue that countervailing principles, including women's rights, and practical considerations, tell decisively against criminalisation.

Keywords: public wrong; criminal harm; prenatal alcohol exposure; FASD; maternal liability

Introduction

In this paper we sound an alarm about how readily current public health responses may tip over into calls to criminalise prenatal alcohol exposure (PAE) where the child subsequently born alive is found to have Foetal Alcohol Syndrome Disorder (FASD). While criminalisation of maternal behaviour is a matter that has received some attention in the past,[2] the need for a reconsideration arises due to the intensifying public health focus on the harm of FASD and the recent and worrying shift towards public health surveillance of women's alcohol consumption both before and during pregnancy. We present findings from the burgeoning FASD literature and track recent public health developments to demonstrate how an empirical basis for criminalisation might be established. The positioning of FASD as a preventable and serious injury worthy of public concern, coupled with widespread public scrutiny of maternal conduct, suggests that some of the factors that lead other injurious actions to be categorised as public wrongs requiring criminal sanction might be identified in cases of PAE. We show how a case for criminalising PAE resulting in FASD might be mounted via mainstream jurisprudential approaches, brought together within Duff et al's framework for criminalising conduct. We find that the individualistic lens applied in much child health research lends weight to potential calls to

[1]RA Duff et al 'Introduction: the boundaries of the criminal law' in RA Duff et al (eds) *The Boundaries of the Criminal Law* (Oxford: Oxford University Press, 2010) p 1.

[2]Particularly in the US with regard to so-called 'crack babies': see D Paone and J Alperen 'Pregnancy policing: policy of harm' (1998) 9(2) International Journal of Drug Policy 101 and L Paltrow and J Flavin 'Arrests of and forced interventions on pregnant women in the United States, 1973–2005: implications for women's legal status and public health' (2013) 38 Journal of Health and Politics, Policy and Law 299.

criminalise PAE resulting in FASD, a prospect that we warn would threaten the rights and wellbeing of women and children. Our analysis advances efforts to protect women's rights by giving form to anticipated threats and pointing to resources to counter them.

1. Context

In recent years, child health researchers and practitioners have increasingly called for action about alcohol use amongst women of child-bearing age. Such calls are animated in large part by concerns about the individual and societal impacts of FASD, a condition seen as avoidable if only women of child-bearing age would abstain from drinking alcohol.[3] Research conducted by Popova et al found that globally about 10% of women consume alcohol while pregnant, although rates are much higher in certain countries. For example, it was found that in Ireland over 60% of women in the general population consume alcohol during pregnancy, with 41% in the UK, 35% in Australia and 26% in New Zealand.[4] It has been estimated that 1 in 13 infants exposed prenatally to alcohol (PAE) will develop FASD and that worldwide there are over 1700 new FASD cases per day.[5]

Public health messaging in the UK now recommends complete abstinence from alcohol for pregnant women and any woman who thinks that she could become pregnant.[6] The shift to abstinence has occurred despite a lack of evidence that low level alcohol consumption during pregnancy causes harm to the foetus and for many is reflective of an overly paternalistic approach which questions women's ability to properly evaluate the risk of PAE.[7] There has also been a move towards greater medical surveillance of alcohol consumption by pregnant women. Recording of maternal alcohol consumption during pregnancy is now mandatory in Scotland, England and Wales.[8] These policies apply to all pregnant women and not just those who are believed to be drinking heavily during pregnancy and require recording of all levels of alcohol exposure, not just high levels of PAE.[9] While other factors (such as maternal age, nutrition and socio-economics) have been found to affect whether a child exposed to alcohol prenatally will develop FASD,[10] the public health approach focuses intently on alcohol consumption by women. In light of concerns that pregnant women tend to under-report their alcohol consumption, some have also questioned whether newborn meconium screening for PAE is necessary.[11]

[3]World Health Organisation *Global Status Report on Alcohol and Health* (2018); D Dozet et al 'Screening for alcohol use in pregnancy: a review of current practices and perspectives' (2023) 21 International Journal of Mental Health and Addiction 1220.

[4]S Popova et al 'Estimation of national, regional and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis' (2017) 5 The Lancet Global Health e290.

[5]L Burd and S Popova 'Fetal alcohol spectrum disorders: fixing our aim to aim for the fix' (2019) 16 International Journal of Environmental Research and Public Health 3978.

[6]*UK Chief Medical Officers Low Risk Drinking Guidelines* (August 2016), available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf. It represents a shift from the previous advice that, while advocating avoidance of alcohol, recognised that low level consumption was unlikely to cause harm. See for instance the UK Department of Health's advice that pregnant women or women trying to conceive should avoid alcohol, but 'If they choose to drink, to minimize the risk to baby, they should not drink more than one or two units of alcohol once or twice a week and should not get drunk': Department of Health *The Pregnancy Book* (2007, 14th edn), available at https://webarchive.nationalarchives.gov.uk/ukgwa/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_074898.pdf.

[7]C Gavaghan '"You can't handle the truth"; medical paternalism and prenatal alcohol use' (2009) 35 Journal of Medical Ethics 300–303, C Auckland 'Knowing who to trust: women and public health' (2022) 48 Journal of Medical Ethics 501.

[8]Scottish Intercollegiate Guidelines Network *Guideline 156 on Children and Young People exposed Prenatally to Alcohol* (2019); National Institute for Health and Care Excellence *Fetal Alcohol Spectrum Disorder Quality Standard* [QS204] (2022).

[9]R Bennett and C Bowden 'Can routine screening for alcohol consumption in pregnancy be ethically and legally justified?' (2022) 48 Journal of Medical Ethics 512.

[10]P May and J Gossage 'Maternal risk factors for fetal alcohol spectrum disorders: not as simple as it might seem' (2011) 34 Alcohol Research and Health 15.

[11]S Lange 'A comparison of the prevalence of prenatal alcohol exposure obtained via maternal self-reports versus meconium resting: a systematic literature review and meta-analysis' (2014) 14 BMC Pregnancy and Childbirth 127; R Arkell and E

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Prior to this more invasive approach, the main method of regulating maternal behaviour during pregnancy had been through a form of 'liberal governance' which relied upon the discourse of risk and the 'responsible' pregnant woman.[12] Perceived failures by women to adhere to advice about PAE have been seen as 'private wrongs' rather than as public wrongs necessitating criminal sanction.[13] But the shift from private regulation by the woman of her alcohol consumption during (and even before) pregnancy to a precautionary public health response that monitors and surveils women raises for us serious concerns about how far the 'public' response to this problem could be taken, and the possible impacts upon women and children of treating PAE leading to FASD as a public wrong.[14] When harms are seen as transcending the private sphere to become public, calls for criminalisation can follow.

To treat such maternal conduct as a public wrong and indeed a criminal act is not without precedent. In the US, criminal prosecutions have been brought against women who harmed their children by means of drug/alcohol consumption during pregnancy, with charges ranging from child abuse or neglect to murder.[15] Bell, McNaughton and Salmon suggest these cases indicate a shift from viewing 'foetal alcohol exposure as a problem of public health to a problem of public order'.[16] In the UK, the issue arose somewhat tangentially when a local authority made an application on behalf of a two-year old child (CP) in its care for compensation to the Criminal Injuries Compensation Authority (CICA).[17] It was claimed that the child, who suffered from FASD caused by the mother's reckless consumption of alcohol during pregnancy, had been the victim of a crime of violence (a necessary condition for compensation to be awarded).[18] The compensation application was ultimately unsuccessful but raised questions as to whether maternal conduct during pregnancy which inflicted harm on the child subsequently born alive could be viewed as criminal behaviour.

In considering how the criminalisation of PAE might be argued for, we apply the three stages outlined by Duff et al in *The Boundaries of the Criminal Law*.[19] To our knowledge a Duffian analysis of this issue has not been undertaken. The first 'in principle' stage considers whether conduct is in theory deserving of criminal sanction. We draw upon public health and jurisprudential discourses to trace the outline of an argument for framing PAE as a public wrong and a crime and find substantial resources within them to mount an 'in principle' case for criminalisation. The second stage considers

Lee 'Using meconium to establish prenatal alcohol exposure in the UK: ethical, legal and social considerations' (2023) 49 Journal of Medical Ethics 531.

[12]L Ruhl 'Liberal governance and prenatal care: risk and regulation in pregnancy' (1999) 28 Economy and Society 95, at 95. See also R Mykitiuk and D Scott 'Risky pregnancy: liability, blames and insurance in the governance of prenatal harm' (2011) 43 UBC Law Review 311, at 319. Silja Samerski goes so far as to suggest that the medical discourse of risk has been most powerful in the context of prenatal care: see S Samerski 'The decision-trap: how genetic counselling transforms pregnant women into managers of foetal risk profiles' in K Hannah-Moffat and P O'Malley (eds) *Gendered Risks* (London: Glasshouse, 2007) p 59. Increasingly, the responsibility to reduce pregnancy risk is attributed to all women of childbearing age. See, for instance, the CDC Foundation's Show Your Love Campaign (and associated App), available at https://www.cdcfoundation.org/ShowYourLove. For a critique, see M Waggoner 'Cultivating the maternal future: public health and the pre-pregnant self' (2015) 40 Signs: Journal of Women in Culture and Society 939. For an example of surveillance of women's compliance with health advice before pregnancy see H Inskip et al 'Women's compliance with nutrition and lifestyle recommendations before pregnancy: general population cohort study' (2009) 338 BMJ 586.

[13]L Miller 'Two patients or one? Problems of consent in obstetrics' (1993) 1 Medical Law International 97.

[14]E Lee et al 'Beyond "the choice to drink" in a UK guideline on FASD: the precautionary principle, pregnancy surveillance, and the managed woman' (2021) 24 Health Risk and Society 17.

[15]E Foley 'Drug screening and criminal prosecution of pregnant women' (2002) 31 Journal of Obstetric, Gynaecologic and Neonatal Nursing 133; K Hui et al 'Criminalizing substance use in pregnancy: misplaced priorities' (2017) 112 Addiction 1123; M Goodwin *Policing the Womb: Invisible Women and the Criminalization of Motherhood* (Cambridge: Cambridge University Press, 2020) ch 3; Paltrow and Flavin, above n 2.

[16]K Bell et al 'Medicine, morality and mothering: public health discourses on fetal alcohol exposure, smoking around children and childhood overnutrition' (2009) 19 Critical Public Health 155, at 160.

[17]*CP v First Tier Tribunal (Criminal Injuries Compensation)* [2014] EWCA Civ 1554, hereafter referred to as *CP*.

[18]Specifically that the mother had administered poison to another person so as to endanger life or inflict grievous bodily harm contrary to the Offences Against the Person Act 1861, s 23.

[19]Duff et al, above n 1.

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countervailing principles that militate against criminalisation such as the rights and interests of the pregnant woman, the legal position of the foetus, societal interest and public policy. The third stage examines practicability and costs. Here we consider the likely deterrent effect of criminal sanction, the impact criminalisation would have upon the health and welfare of women and foetuses and highlight possible difficulties with criminalisation of PAE more generally. It is in these later stages that we find the readiest and most decisive arguments against criminalisation of PAE. Before proceeding to a Duffian analysis of the case for criminalising PAE, we provide more background about FASD and set out the various factors and considerations that are generally said to justify treating an act as a public wrong and consequently a crime.

We focus not on PAE in and of itself but on a specific harmful consequence of some instances of PAE, FASD, as this is where the case for criminalisation is arguably most compelling and the urge to criminalise is greatest. However, for brevity, we use the term PAE to refer to PAE that results in FASD (noting that maternal alcohol consumption is not the only factor implicated in FASD).

2. Foetal alcohol spectrum disorder

It has been widely evidenced that alcohol use during pregnancy can lead to adverse pregnancy and neonatal outcomes including miscarriage, stillbirth, premature birth, low birthweight, intrauterine growth retardation and FASD.[20] The consequences of PAE for both the child born and wider society are significant. Adverse impacts of FASD have been identified across multiple domains of function, development and wellbeing. These include restricted growth,[21] neurobehavioural deficits including those related to general IQ, attention, memory, executive function and language processing,[22] affect regulation and conduct disorder,[23] impaired metabolic function[24] and higher rates of mental health conditions such as anxiety, depression, low self-esteem and suicidal ideation.[25] These impacts reveal themselves in increased prevalence of adverse events and circumstances during adolescence and adulthood, including unemployment,[26] involvement with the justice system (as offenders and victims of crime), confinement in prisons or psychiatric institutions, drug and alcohol issues and disrupted education.[27] People with FASD report difficulties reading social situations and cues, enjoying close relationships with peers, completing tasks, maintaining employment, handling money and living independently. The economic and social costs of FASD for wider society are numerous and substantial. There are direct costs to welfare, education, health and criminal justice services such as special education, long-term care, supportive housing, prescription drug use, psychiatric care, addiction treatment, acute inpatient care and law enforcement.[28] Greenmeyer et al projected that globally the annual

[20]K DeJong et al 'Alcohol use in pregnancy' (2019) 62 Clinical Obstetrics and Gynecology 142.

[21]C O'Leary et al 'The effect of maternal alcohol consumption on fetal growth and preterm birth' (2009) 116 BJOG 390.

[22]S Mattson et al 'Fetal alcohol spectrum disorders: a review of the neurobehavioral deficits associated with prenatal alcohol exposure' (2019) 43 Alcoholism: Clinical and Experimental Research 1046.

[23]V Temple et al 'Mental health and affect regulation impairment in fetal alcohol spectrum disorder (FASD): results from the Canadian national FASD database' (2019) 54 Alcohol and Alcoholism 545.

[24]L Akison et al 'Adverse health outcomes in offspring associated with fetal alcohol exposure: a systematic review of clinical and preclinical studies with a focus on metabolic and body composition outcomes' (2019) 43 Alcoholism, Clinical and Experimental Research 1324.

[25]K Easey et al 'Prenatal alcohol exposure and offspring mental health: a systematic review' (2019) 197 Alcohol and Drug Dependency 344; British Medical Association *Alcohol and Pregnancy: Preventing and Managing Fetal Alcohol Spectrum Disorders* (2016) pp 8, 16, 31, 46.

[26]V Temple et al 'Long-term outcomes following fetal alcohol spectrum disorder (FASD) in adulthood' (2021) 46 Journal of Intellectual & Developmental Disability 272.

[27]M Mela et al 'Neurocognitive function and fetal alcohol spectrum disorder in offenders with mental disorders' (2020) 48 Journal of the American Academy of Psychiatry and the Law 195; A Streissguth et al 'Risk factors for adverse life outcomes in fetal alcohol syndrome and fetal alcohol effects' (2004) 25 Developmental and Behavioral Pediatrics 228.

[28]S Popova et al 'Social and economic cost of fetal alcohol spectrum disorder' (nd) *Canada FASD Research Network*, available at https://canfasd.ca/wp-content/uploads/2016/05/IssuePaper_CostFASD-Final.pdf; S Popova et al 'Burden and social cost of fetal alcohol spectrum disorders' in *Oxford Handbook Topics in Psychology* (Oxford: Oxford Academic, 2016) p 1.

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costs of care per child and per adult with FASD are US$22,810 and $24,308 respectively.[29] Indirect societal costs associated with productivity losses due to morbidity and premature mortality of people with FASD have been found to be considerable.[30]

3. Crime as a public wrong

The notion of a private wrong is often constructed in opposition to a public wrong – a wrong or crime which is subject to criminal sanction. A private wrong may belong to the world of civil liability such as tortious liability for negligent behaviour or, alternatively, a private wrong can be understood as a wrong that is not subject to the law at all.[31] As recognised by the Wolfenden Committee when discussing the parameters of criminal law, there is an area of 'private morality and immorality which in brief and crude terms is not the law's business'.[32] As for what constitutes a public wrong, Blackstone defined it quite narrowly, as one that harms the public as a whole.[33] However, a public wrong can also be understood as the sort of wrong which is of concern to the wider community (and not just the individual harmed or wronged) as it transgresses a set of values/interests that society is properly concerned with.[34] Wall describes a criminal wrong as conduct that is an affront to a set of interests and values that the community considers important.[35]

Yet typically more than mere inconsistency with societal values is required to criminalise: we can disapprove of many sorts of behaviour without wishing to criminalise them. Wall distinguishes a private (civil) wrong which confers rights and imposes obligations from a public (criminal) wrong which prohibits wrongful conduct.[36] Criminalised acts are what Marshall and Duff refer to as 'socially proscribed wrongdoing':[37] wrongs that we do not leave to private condemnation, but claim normative authority over and publicly condemn.[38] Criminalisation enables a collective response to wrongdoing in the form of state-controlled prosecution on behalf of both victim and society.[39] This focus on both the nature of the wrong and on calling wrongdoers to public account distinguishes criminal from civil or private wrong where the primary emphasis is on ensuring the harm caused is repaired or paid for.[40]

Harmfulness is a typical feature of conduct that is criminalised; perhaps reflecting Mill's contention that the state can only justifiably interfere with individual liberty when someone's actions harm or risk harming others.[41] Harm is, however, not a straightforward concept. While most would agree that broken limbs or lacerations constitute harms, things become less clear when dealing with minor scrapes, hurt feelings, offence, future harms and risks.[42] Feinberg, in his exploration of what conduct the state could rightly criminalise, sought to rein harm in conceptually by defining it as a wrongful set-back of

[29]J Greenmeyer et al 'A multi-country updated assessment of the economic impact of fetal alcohol spectrum disorder: costs for children and adults' (2018) 12 Journal of Addiction Medicine 466.

[30]Popova et al, above n 28.

[31]RA Duff *Answering for Crime* (Oxford: Hart Publishing, 2007) ch 4.

[32]*Report of the Committee on Homosexual Offences and Prostitution* (London: HMSO, 1957) at [61].

[33]Sir W Blackstone *Commentaries on the Laws of England (1765–1769)* Book IV (London: Strahan and Woodfall, 1971) ch 1, p 5.

[34]RA Duff and S Marshall 'Public and private wrongs' in J Chalmers et al (eds) *Essays in Honour of Sir Gerald Gordon* (Edinburgh: Edinburgh University Press, 2010) pp 71–72. See further J Wall 'Public wrongs and private wrongs' (2018) 31 Canadian Journal of Law & Jurisprudence 177, at 180.

[35]Wall, ibid, at 185.

[36]Wall, above n 34.

[37]SE Marshall and RA Duff 'Criminalization and sharing wrongs' (1998) 11 Canadian Journal of Law and Jurisprudence 7, at 13.

[38]L Farmer *Making the Modern Criminal Law: Criminalization and Civil Order* (Oxford: Oxford University Press, 2016) ch 1; Wall, above n 34, Duff and Marshall, above n 34.

[39]G Lamond 'What is a crime?' (2007) 27 Oxford Journal of Legal Studies 609, at 611. See also Duff, above n 31.

[40]RA Duff 'Perversions and subversions of criminal law' in RA Duff et al (eds) *The Boundaries of the Criminal Law* (Oxford: Oxford University Press, 2010) p 88.

[41]JS Mill *On Liberty* (Cambridge; Cambridge University Press, 2012).

[42]Some question the utility of harm and the harm principle: see B Harcourt 'The collapse of the harm principle' (1999) 90 Journal of Criminal Law and Criminology 109; J Stanton-Ife 'What is the harm principle for?' (2016) 10 Law and Philosophy 329.

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interest.[43] Feinberg excluded harms that are not wrongs (ie set-backs of interest that can be justified or excused) and wrongs that are not harms (violations of rights that do not set interests back).[44] Feinberg also held that only avoidable, substantial harms should be subject to criminal sanction.[45] Again the concept of wrongfulness enters here as we do not generally punish activity simply because it causes harm, but because it caused or risked harm in a *wrongful*, and thus blameworthy, manner.[46] Feinberg refers to this element of wrongfulness as 'morally indefensible conduct' – conduct that has 'no adequate justification or excuse'.[47] Blameworthiness invokes notions of individual responsibility and capacity.[48] Foreseeability of harm by the wrongdoer is for some commentators an essential element of criminal fault (at least for more serious crimes).[49] For others, wrongfulness is at least partly a matter of the morality or immorality of the person's actions (or inactions).[50]

In truth, there is no definitive explanation as to why something is considered a public wrong and also a crime – there is no 'objective benchmark of criminality'.[51] Nor is there a 'single master principle'[52] that determines whether conduct ought to be criminalised.[53] It is clear that concepts such as blameworthiness and harm (to the victim and wider society), societal values and interests and a desire to condemn, prevent and deter wrongful conduct (as opposed to offering civil redress) all come into the mix when determining whether something ought to be criminalised. There is much in this mix that could be used to justify criminalising maternal infliction of harm through alcohol consumption during pregnancy.

4. Stage one: the 'in principle' argument for criminalisation of PAE

An argument for viewing PAE as a public wrong and a crime would likely be comprised of several claims: first, that FASD is a harmed state caused by alcohol consumption during pregnancy; secondly that it is a *wrongful* harm; and thirdly that it is a public wrong warranting criminal and not civil or private redress. Identifying the effects of FASD as harms would be an important step towards identifying them as wrongs that concern the state. As indicated by the survey above, the damage of alcohol exposure to developing cells in utero can detrimentally impact a person with FASD's physical health

[43]J Feinberg *The Moral Limits of the Criminal Law. Vol 1, Harm to Others* (Oxford: Oxford University Press, 1984) p 215.
[44]Ibid.
[45]Above n 43, p 12.
[46]Strict liability is an exception.
[47]Feinberg, above n 43, p 108.
[48]See for instance Honoré's focus upon responsibility for the harm caused: T Honoré *Responsibility and Fault* (Oxford: Hart Publishing, 1999) and Hart's discussion of whether the accused was capable of acting differently in HLA Hart *Punishment and Responsibility: Essays in the Philosophy of Law* (New York: Oxford University Press, 1968). Lacey and Zedner review concepts relied on by the law to identify blameworthiness, such as capacity and responsibility; see N Lacey and L Zedner 'Criminalisation: historical, legal and criminological perspectives' in A Liebings et al (eds) *The Oxford Handbook of Criminology* (Oxford: Oxford University Press, 4th edn, 2007) pp 65–67.
[49]See G Williams *Textbook of Criminal Law* (London: Stevens, 2nd edn, 1973) and JC Smith and B Hogan *Criminal Law* (Oxford: Oxford University Press, 11th edn, 2005) and Lord Bingham in *R v G & Another* [2003] UKHL 50. For challenges to the subjectivist view see RA Duff *Intention, Agency and Criminal Liability: Philosophy of Action and the Criminal Law* (Oxford: Wiley Blackwell, 1990); A Norrie *Crime, Reason and History: A Critical Introduction to Criminal Law* (Cambridge: Cambridge University Press, 3rd edn, 2014) or A Norrie 'Between orthodox subjectivism and moral contextualism' (2006) Criminal Law Review 486.
[50]See Duff, above n 31, ch 4 and ch 6; P Devlin *The Enforcement of Morals* (London, New York: Oxford University Press, 1965); HLA Hart *The Morality of the Criminal Law: Two Lectures* (Jerusalem: Magnes Press, Hebrew University, 1964). Although it has been noted that morality is an unhelpful concept when seeking to identify a universal characteristic of a crime (see Law Commission *Criminal Liability in Regulatory Contexts* (LCCP 195) (London: HMSO, 2010) at [4.39]), more recent scholarship tends to combine morality with concepts such as harm to render it more workable. See H Gross *A Theory of Criminal Justice* (New York: Oxford University Press, 1979) p 119; A Simester and A von Hirsch (eds) *Crimes, Harms and Wrongs: On the Principles of Criminalisation* (Oxford: Oxford University Press, 2011).
[51]A Ashworth and J Horder *Principles of Criminal Law* (Oxford: Oxford University Press, 7th edn, 2013) p 22.
[52]A Duff *Answering for Crime: Responsibility and Liability in the Criminal Law* (Oxford: Hart Publishing, 2007) p 142.
[53]D Brown 'Criminalisation and normative theory' (2013) 25 Current Issues in Criminal Justice 605.

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and impair capacities to exercise agency, achieve goals and sustain fulfilling relationships.[54] These impacts are often framed as harms in public health literature and international instruments. For instance, the World Health Organisation (WHO)'s Global Alcohol Action Plan holds that 'one of the most dramatic manifestations of harm to persons other than drinkers … are the consequences of prenatal alcohol exposure, which may result in the development of fetal alcohol spectrum disorders (FASD)'.[55] Feinberg himself recognised the possibility of prenatal harms, writing that: 'Harm can be caused to a person before his birth, or before the commencement of personhood in pregnancy, in virtue of the later interests of the child that can already be anticipated'.[56]

The attribution of harmfulness to PAE sets a foundation but more would be needed to construct maternal alcohol consumption as a public wrong. On Feinberg's interpretation of the harm principle, and in keeping with the standard reading of a crime as a public wrong, only harms that are also wrongs legitimate (subject to other conditions, such as necessity) state intervention. Feinberg cashes out wrongs in terms of rights violations. Here, one might foresee an impediment to the establishment of maternal alcohol consumption as a possible public wrong. The question of whether foetuses are properly seen as moral rights holders is shrouded in metaphysical darkness. Some say yes of course, some deny it absolutely, others hover in intermediate positions.[57] Under the criminal law of England and Wales the 'born alive rule' provides that, apart from certain statutory offences, the foetus is not protected until it becomes a 'human being in being' (that is, until birth).[58] The issue with PAE is that it is inflicted upon the foetus, who lacks legal personhood; and no criminal liability attaches to injuries caused in utero that lead to a harmed state for the child subsequently born alive.[59]

The foetus' lack of legal personhood is an obstacle to criminalisation of PAE, but a surmountable one if the desire to criminalise exists.[60] In the US it has been managed in a variety of ways – by interpreting 'child' to include 'unborn child'[61] or by enacting specific measures such as foeticide statutes.[62] An alternative approach focuses on the future child's rights and interests. Dominic Wilkinson et al argue that even if the foetus does not have the legal or moral status of a child, or any legal or moral status at all, there is still 'an ethical and legal case for intervening to prevent serious harm to a future child'.[63] Savulescu contends that women may have a duty to refrain from certain behaviours out of respect for the interests of sentient beings and prevention of harm to future individuals and that

[54]Feinberg, above n 43, ch 1.

[55]World Health Organisation *Global Alcohol Action Plan 2022–2030* (2023).

[56]Feinberg, above n 43, p 96.

[57]Much scholarship on foetal rights originates in the debate about abortion and focuses on the right to life. Sometimes the argument is conducted in terms of personhood or the humanness of foetuses. For an argument against foetal rights, see MA Warren 'On the moral and legal status of abortion' (1973) 57 The Monist 43. For an argument in favour of foetal rights, see JT Noonan Jr 'An almost absolute value in history' in JT Noonan Jnr (ed) *The Morality of Abortion: Legal and Historical Perspectives* (Cambridge, Mass: Harvard University Press, 1970) p 51. For an intermediate view see MT Brown 'The moral status of the fetus: implications for the somatic integration definition of human life' (2021) 35 Bioethics 672.

[58]Statutory provisions which protect the foetus are unlawfully causing or procuring a miscarriage as per ss 58 and 59 of the Offences Against the Person Act 1861 and child destruction under the Infant Life Preservation Act 1929. To be a human being in being the child must be born alive and have an existence independent of the mother: *Enoch* (1830) 5 C & P 539; *Poulton* (1832) 5 C & P 329.

[59]See *CP (A Child) v First-Tier Tribunal (Criminal Injuries Compensation)* [2014] EWCA Civ 1554; *A-G's Reference (No 3 of 1994)* [1997] 3 All ER 936. Injuries caused in utero which lead to death after birth may be the subject of a murder or manslaughter charge. Fortin discusses the 'anomalies and inconsistencies in the existing legal principles relating to the unborn child' in J Fortin 'Legal protection for the unborn child' (1988) 51 Modern Law Review 54, at 54.

[60]K Norrie 'Protecting the unborn child from its drug or alcohol abusing mother' in M Freeman and A Lewis (eds) *Law and Medicine Current Legal Issues* Vol 3 (New York: Oxford University Press, 2000) p 226.

[61]See *Whitner v State* 328 SC 1 (SC 1997); *State v McKnight* 352 SC 635 (SC 2003) and *Ankrom v State* 152 So 3d 397.

[62]See National Conference of State Legislatures *Fetal Homicide State Laws* (2015), available at http://www.ncsl.org/issues-research/ health/fetal-homicide-state-laws.aspx.

[63]D Wilkinson et al 'Protecting future children from in-utero harm' (2016) 30 Bioethics 425. In the New Jersey case of *Smith v Brennan* 13 NJ 353 (1960), at 364 it was said that 'justice requires that the principle be recognised that a child has a legal right to begin life with a sound mind and body'.

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'in those few instances when pregnant women make autonomous choices which result in great harm to their offspring, the state is justified in protecting the interests and rights of future generations'.[64] Feinberg expresses no reservation about the idea that the child-born-alive has rights associated with the condition into which they are born:

> The advance dooming of these interests deprives the child of what can be called his birth-rights … Thus, if the conditions for the eventual fulfilment of the child's future interests are destroyed before he is born, the child can claim, after he has been born, that his *rights* (his present rights) have been violated.[65]

The evidence of PAE's adverse impact upon the life prospects of persons with FASD, combined with a Feinbergian reading of rights that can be violated prenatally, offer support to an 'in principle' case for regarding maternal alcohol consumption as a wrongful harm.

It is likely that advocates of criminalising PAE would attempt to strengthen an 'in principle' case by arguing that maternal alcohol consumption is blameworthy, taking into account factors such as responsibility, knowledge and capacity. The idea that a pregnant woman owes *some* responsibility to her unborn child is generally accepted.[66] McNolty and Garrett refer to the narrative of motherhood as one of sacrifice.[67] In a similar vein Milne discusses the 'foetus-first mentality', in which a pregnant woman is expected to put the needs and wellbeing of her foetus before her own interests.[68] Traces of such thinking appear in case law, as when, in *St George's Healthcare NHS Trust v S*, Judge LJ states that 'pregnancy increases the personal responsibilities of a woman'.[69] Brazier suggests that having decided to become a mother, the woman is required by 'morally responsible motherhood', to consider the interests of the child she has chosen to mother.[70] The question is whether this is a legal responsibility (breach of which may lead to criminal sanction) or, as Brazier argues, purely moral. To date, a maternal legal duty of this nature has not been found in law. While recognising some sort of maternal responsibility in *St George's Healthcare Trust v S*, Judge LJ did not render it in legal terms.[71] In *CP* the Court of Appeal stated that in English law women do not owe a duty of care in tort to their unborn child and warned of incoherence if the criminal law were to take a different view.[72] However, this is an area of law where arguments about moral responsibility giving rise to legal responsibility may be persuasive. Indeed, Mathieu queries whether the conflation of moral and legal responsibility in this

[64]J Savulescu 'Involuntary medical treatment in pregnancy and the duty of easy rescue' (2007) 19 Utilitas 1. See also S Bewley 'Restricting the freedom of pregnant women' in D Dickensen (ed) *Ethical Issues in Maternal Fetal Medicine* (Cambridge: Cambridge University Press, 2002) p 136, who argues that 'if pregnant women fail to fulfil their obligations and serious harms occur, society must respond on behalf of the unborn, as it too has an obligation to its future members to take reasonable steps to ensure that they are born in good health'.

[65]Feinberg, above n 43, pp 98–99. Feinberg, considering wrongful life suits, holds that if it is known that the basic interests of the future child that a foetus would otherwise become are doomed before their birth, and that their resulting life would be not worth living, they may be regarded as wronged through birth. Feinberg concludes that if the adverse impacts occur through conception, then the infant cannot rightly be seen as harmed, as they are not made worse off. However, in the case of PAE, conception pre-dates alcohol exposure. Thus, the prospects for establishing harm could be considerably better.

[66]A Wetterberg 'My body, my choice … my responsibility: the pregnant woman as caretaker of the fetal person' (2004) 48 Berkeley Journal of Sociology 26; C Benoit et al 'Providers' constructions of pregnant and early parenting women who use substances' (2014) 36 Sociology of Health and Illness 252; R Hammer '"I can tell when you're staring at my glass …": self or co-surveillance? Couples' management of risks related to alcohol use during pregnancy' (2019) 21 Health, Risk & Society 335.

[67]L McNolty and J Garrett 'For whom the burden tolls: gender and the unequal management of fetal risks and parental expectations' (2016) 16 American Journal of Bioethics 17, at 18.

[68]E Milne 'Putting the fetus first – legal regulation, motherhood and pregnancy' (2020) 27 Michigan Journal of Gender and Law 149, at 153.

[69][1998] 3 All ER 673, at 692.

[70]M Brazier 'Liberty, responsibility, maternity' (1999) 52 Current Legal Problems 359.

[71]J Herring 'Caesarean sections and the right of autonomy' (1998) 57 Cambridge Law Journal 438, at 441 finds there is a lack of clarity on this in the judgment.

[72]*CP v First Tier Tribunal (Criminal Injuries Compensation)* [2014] EWCA Civ 1554, at [47].

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context can be justified under the concept of 'role-responsibility' stating 'it could be argued that part of the "role-responsibility" of a pregnant woman is to provide for the welfare of the child she will bear'.[73] Robertson has suggested that when a woman chooses to carry a foetus to term she may 'reasonably be held to have a duty to avoid harm to her expected offspring'.[74] If recognised as a legal responsibility, the criminal law could be used to delineate and enforce a maternal duty not to harm one's unborn child.[75] As noted by Henry Hart, the role of the criminal law is to set out 'the minimum conditions of man's responsibility to his fellows and [to hold] him to that responsibility'.[76]

If such a legal duty is found to exist, then knowledge regarding the risk of PAE would become key to a finding of culpability, with blame more easily attaching to the person who is aware of the risk of harm to the child but nevertheless continues to drink alcohol. Given widespread public surveillance of pregnancy and maternal behaviour, most women could likely be held to possess some knowledge that alcohol consumption during pregnancy should be avoided.[77] In *CP* the First Tribunal found that the dangers of alcohol consumption in pregnancy were commonly known and this general knowledge was used to infer knowledge on the part of CP's mother regarding the risk of harm.[78] The woman's engagement with healthcare services was also relied upon as evidencing her knowledge of the risk.[79] The introduction of the NICE Quality Standard (requiring that pregnant women are advised not to drink alcohol and that maternity care providers ask pregnant women about their alcohol use and record this information)[80] and Sign 156 guideline (which imposes mandatory screening and recording of all women's alcohol consumption during pregnancy in her and the child's health record)[81] means that now a woman's medical records could be drawn upon to show that she had been informed about the dangers of PAE and may also provide evidence of alcohol consumption. While this raises issues of privacy and confidentiality – a matter that we return to when considering the rights of the woman as a counterpoint to the in principle argument – it does mean that it will be even easier in the future to make the case that women are aware of the risk of PAE.

It could be argued that in order for blame to be warranted, a person must not only know about the risks of PAE but must also know they are pregnant when consuming alcohol. Alcohol is most harmful to the foetus in the first trimester and a woman may consume alcohol during this time without knowing she is pregnant.[82] If this is the case (and the woman does not drink throughout the rest of the pregnancy), it may be considered wrong to blame her for causing harm if the child subsequently born suffers from FASD. Yet, the public health advice which promotes abstinence to women of childbearing age and not just those who are pregnant or trying to become pregnant, means that such practical considerations may be depicted as irrelevant. A woman of childbearing age who has unprotected sex and consumes alcohol could arguably be deemed reckless (she has knowledge of the risk but takes it anyway) and this could be sufficient for criminal liability. Current medical advice, which is based on

[73]D Mathieu *Preventing Prenatal Harm: Should the State Intervene?* (Washington DC: Georgetown University Press, 2nd edn, 1996) p 48.

[74]JA Robertson *Children of Choice: Freedom and the New Reproductive Technologies* (Princeton: Princeton University Press, 1994) p 179.

[75]JA Robertson 'Procreative liberty and the control of conception, pregnancy and childbirth' (1983) 69 Virginia Law Review 405, at 438.

[76]HLA Hart 'The aims of the criminal law' (1958) 23 Law & Contemporary Problems 401, at 410.

[77]D Lupton 'Precious cargo: foetal subjects, risk and reproductive citizenship' (2012) 22 Critical Public Health 329.

[78]Decision of the First Tier Tribunal (Social Entitlement Chamber) 7 February 2001, at [50]–[52], reported in *CICA v First-tier Tribunal and CP* [2013] UKUT 0638 (AAC), at [3].

[79]Ibid.

[80]NICE, above n 8. See also Public Health England 'Maternity high impact areas: reducing the incidence of harms caused by alcohol in pregnancy' (2020), available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942477/Maternity_high_impact_area_4_Reducing_the_incidence_of_harms_caused_by_alcohol_in_pregnancy.pdf.

[81]Sign, above n 8.

[82]A Duso and J Stogner 'Re-evaluating the criminalization of in utero alcohol exposure: a harm-reduction approach' (2015–2016) 24 William and Mary Bill of Rights Journal 621.

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the (currently unevidenced) view that there is no safe level of alcohol consumption, effectively precludes autonomous decision-making on the part of the woman about acceptable levels of risk with regard to low or moderate alcohol consumption.[83] In this way, support for treating PAE as a known and therefore wrongful – and criminalisable – harm could be drawn from public health and clinical measures to prevent FASD.

A further factor for consideration when determining culpability is the question of capacity.[84] As noted by Honoré, when capacity to make a rational decision about one's behaviour is present, then blame for bad behaviour is appropriate.[85] When that capacity is lacking, it could be thought that blame is inappropriate or that such behaviour should be excused. In cases where a woman has the capacity to make an informed choice regarding alcohol consumption the decision to drink when pregnant (or possibly pregnant) could be viewed as wrong/blameworthy. Matters become more complex when dealing with addiction and resulting mental impairment. Emma Cave argues that punishing pregnant addicts for prenatal harm caused by their addiction is inappropriate as they have little choice or control over that behaviour.[86] It is suggested that in cases of addiction, women are not intent on harming their unborn child but consume alcohol to feed their addiction.[87] However, the approach taken in the criminal law to intoxication and addiction is fairly unforgiving even while accepting that responsibility may be impaired.[88] It is only in the most extreme circumstances that alcoholism is considered to deprive an individual of capacity and, as noted by Tolmie, this is based on an understanding of alcoholism that 'even the most hardened alcoholic would find difficult to meet'.[89] For the most part sufficient culpability is found to lie in the initial decision to start drinking. A similar approach could be expected in the context of alcoholic women and PAE. In the case of *CP*, it was recognised that the mother had an alcohol addiction, but the First Tribunal found she had capacity, noting that she had 'no learning disabilities or mental health or other issues to affect her ability to understand the dangers to her baby of drinking during pregnancy'.[90]

Advocates of criminalisation would also need to establish that any wrong entailed by PAE is public in character and cannot be sufficiently addressed by means of civil redress. Such an argument would likely invoke its detrimental impacts for both the child and the wider community. Given that not only the child, but also the public, pay the cost of PAE, it may be held that the putative wrong it entails is done to the public, and cannot be viewed solely as a private matter.[91] Public health discourse further supports the claim that PAE is a public concern.[92] Framing something as a matter of public health brings with it a normative dimension – a sense that as a community we have an obligation to do something about it.[93] It provides a mandate for the state to seek to enforce certain norms or encourage

[83]Lee et al, above n 14; Gavaghan, above n 7; PK Lowe and E Lee 'Advocating alcohol abstinence to pregnant women: some observations about British policy' (2010) 12 Health, Risk & Society 301.

[84]Criminal responsibility is based on notions of free will and rationality: see N Lacey et al *Reconstructing Criminal Law* (London: Weidenfeld and Nicholson, 1990); D Husak *Philosophy of Criminal Law* (Rowman and Littlefield, 1987).

[85]Honoré, above n 48, p 138 but see more generally pp 121–142.

[86]E Cave *The Mother of All Crimes: Human Rights, Criminalization and the Child Born Alive* (London: Routledge, 2018) pp 86–88 and p 94. See also Wilkinson et al, above n 63, at 431.

[87]A Evenski 'The use of incarceration and forced detention as a method of fetal protection for substance-abusing pregnant women' (2001) 58 Current Surgery 402, at 403.

[88]This is largely for reasons of policy. See G Dingwall *Alcohol and Crime* (Cullompton: Willan, 2006).

[89]J Tolmie 'Alcoholism and criminal liability' (2001) 64 Modern Law Review 688, at 688. The cases of *Tandy* [1989] 1 All ER 267 and *Wood* [2008] EWCA Crim 1305 were considered by some to adopt an overly restrictive approach requiring that virtually every drink consumed had to be done so involuntarily (as a result of an irresistible craving).

[90]Above n 78.

[91]See generally S Popova et al 'The economic burden of fetal alcohol spectrum disorder in Canada in 2013' (2016) 51 Alcohol and Alcoholism 367; Greenmeyer et al, above n 29.

[92]WHO, above n 55.

[93]M Verweij and A Dawson 'The meaning of "public" in public health' in M Verweiji and A Dawson (eds) *Ethics, Prevention and Public Health* (Oxford: Clarendon Press, 2017) p 18.

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certain behaviours.[94] The WHO's Global Alcohol Action Plan 2022–2030, and the Global Strategy to Reduce the Harmful Use of Alcohol both direct particular attention to alcohol consumption by women of childbearing age and pregnant women.[95] In endorsing international resolutions such as WHO's Global Strategy to Reduce the Harmful Use of Alcohol and the Action Plan, states bind themselves to reduce the incidence of PAE. NICE's Quality Standard and SIGN 156 can be seen as part of the English and Scottish state's effort to fulfil obligations to reduce FASD.[96] They also suggest an increasing positioning of PAE as a public harm, a shift which both highlights the genuine possibility that criminalisation of PAE will be called for, and bolsters a potential argument for treating PAE as a public wrong.

We have set out how an argument for approaching PAE as a public wrong apt for criminal sanction might be mounted. This outline has drawn entirely upon mainstream legal analysis, epidemiological evidence and developments in public and clinical health. In many respects the arguments for criminalisation represent a natural extension of the public health discourse on PAE. The current public health focus clearly takes the issue of PAE from a matter of private regulation for the woman into one in which the woman herself is publicly regulated.[97] Given the resources available to support an 'in principle' case for criminalising PAE, a possible shift from a solely public health response to one in which there is a role for criminal law does not appear improbable. However, according to Duff et al's framework, the case for criminalising an act goes beyond establishing an 'in principle' case.[98] A proponent of criminalisation must consider countervailing principles and the practicality and costs of criminalisation. We contend that it is at these stages that the alarming implications of criminalising PAE are clearest, and a powerful defence against criminalisation can be most readily mounted.

5. Stage two: countervailing principles

Calls to criminalise PAE would have to confront the impact upon the rights and interests of women. As recognised in *Re F (In Utero)*, subjecting a pregnant woman to controls for the benefit of her unborn child would impact upon her liberty.[99] Numerous commentators focus on the significant detrimental impact of criminalisation upon women's autonomy.[100] Peak and Del Papa highlight potential limitations on women's rights to privacy, bodily integrity, and equal protection.[101] Armstrong also takes up the issue of unequal treatment and discrimination, observing that criminalisation would render alcohol consumption illegal for one category of adults – pregnant women.[102] Of course the way in which women's rights are valued and weighed in this particular context can be affected by societal

[94]J Coggan *What Makes Health Public?: A Critical Evaluation of Moral, Legal and Political Claims in Public Health* (Cambridge: Cambridge University Press, 2012) p 22.

[95]WHO, above n 55; Resolution of The Sixty-Third World Health Assembly WHA63.13 Global strategy to reduce the harmful use of Alcohol (2010), at 3(1). WHO's Global Strategy defines harmful drinking as 'drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large'.

[96]NICE, above n 8; Scottish Intercollegiate Guidelines Network, above n 8.

[97]Lee et al, above n 14.

[98]Duff et al, above n 1.

[99][1998] 2 All ER 193, at 200–201 per Balcombe LJ.

[100]McNolty and Garrett, above n 67, at 19; E Armstrong 'Drug and alcohol use during pregnancy: we need to protect, not punish, women' (2005) 15 Women's Health Issues 45, at 45.

[101]K Peak and F Del Papa 'Criminal justice enters the womb: enforcing the "right" to be born drug free' (1993) 21 Journal of Criminal Justice 245.

[102]Armstrong, above n 100. See also Peak and Del Papa, ibid, at 255 who note that laws punishing pregnant women for injuring their foetuses would only apply to women and so could be viewed as discriminatory. It is worth recalling the arguments advanced by McLachin J (as she then was) in the Canadian decision of *Dobson (Litigation Guardian) v Dobson* 1999 2 SCR 753 at [87], which considered the issue of maternal civil liability. She argued that 'women should not be penalized because it is their sex that bears children …To say that broad legal constraints on the conduct of pregnant women do not constitute unequal treatment because women choose to become pregnant is to reinforce inequality by the fiction of deemed consent and the denial of what it is to be a woman'.

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expectations of motherhood and by the sense that there is a competing right/interest to weigh against the woman's – that of the foetus. Both of these factors, however, require careful consideration, as the former can result in the undervaluing of women's rights and the latter encourages inappropriate balancing and trade-offs.

As noted above, the pervasive narrative of motherhood is one of sacrifice in which a woman is expected to put the needs of the child/foetus first.[103] And yet, English courts have tended to reject infringement of a woman's autonomy on the grounds of risk to the foetus.[104] In *Re (MB)* Lady Butler Sloss held that a competent woman has an absolute right to refuse medical treatment for whatever reason, even where that may lead to death or serious injury to the unborn child.[105] To do otherwise would be 'an unwarranted invasion of the right of the woman to make a decision'.[106] In *St George's Healthcare NHS Trust v S* the Court of Appeal, grounding its reasoning in autonomy, reaffirmed the view expressed in *Re (MB)* that the court could not order a competent woman to undergo medical treatment, even where the life of a viable foetus was at risk.[107] It was stated that the perceived needs of the foetus did not prevail over the rights of the woman.[108] As explained by Rebecca Bailey-Harris, these decisions demonstrate the strength of a woman's right to autonomy and bodily integrity and a strong desire to prevent any erosion of those rights.[109]

It is recognised that a duty to refrain from drinking alcohol could be distinguished from cases of forced surgical intervention. Being required to forgo alcohol for the sake of one's child could be seen as a less physically invasive interference with a woman's rights than being forced to undergo a medical procedure. However, a duty to abstain from alcohol would apply for the full term of a pregnancy (if not longer, accounting for time spent trying to conceive or when a risk of conception exists); restrict women's daily life and expose women to ongoing scrutiny in private everyday contexts and interactions with health professionals. In those senses it would represent a significant incursion into private life, and one to which non-pregnant people (or those unlikely to become pregnant) would not be subject.

Attempts to subject pregnant women to '"the harassing interference" of "inquisitive officials"' have met with objections grounded in women's privacy interests since at least the early twentieth century, when campaigns to make pregnancy a notifiable condition in Britain provoked widespread opposition.[110] Midwives of the time, concerned in particular about the effects of increasing surveillance on working class women, emphasised that the pregnant woman is neither 'drain nor dairy, and could not be inspected as such'; rather, she is a 'normal human being, with opinions, tastes, fancies, and rights of her own'.[111] A sphere free of public scrutiny enables more than choosing according to

[103]See McNolty and Garrett, above n 67; Milne, above n 68.

[104]A notable exception being *Re S (Adult: Surgical Treatment)* [1993] 1 FLR 26 where the court overrode a pregnant woman's refusal of medical treatment on religious grounds and authorised a Caesarean section. *In Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649 Lord Donaldson of Lymington MR had queried whether a woman's refusal would be respected in cases where that choice would lead to the death of a viable foetus.

[105]*R MB (An Adult: Medical Treatment)* [1997] EWCA Civ 3093. Note that the comments were strictly obiter as the woman concerned was found to lack capacity. A different approach is taken when the woman is found to lack capacity. In such cases the objection to medical intervention is frequently overridden – see for example *Norfolk and Norwich Healthcare Trust v W* [1996] 2 FLR 613; *Rochdale Healthcare NHS Trust v C* [1997] 1 FCR 274; *Tameside and Glossop Acute Services NHS Trust v CH* [1996] 1 FLR 762. Sometimes decisions as to whether a woman lacked capacity have been questionable. In the *Rochdale Healthcare NHS Trust v C* case the woman had previously had a Caesarean section and said that she would rather die than undergo the same procedure again. The patient was capable of understanding the proposed treatment but Johnson J held that she was not competent because she was in the throes of labour with all the pain and emotional stress that that involved.

[106][1997] EWCA Civ 3093, at [31].

[107][1998] 3 WLR 936, at [957].

[108]Ibid.

[109]R Bailey-Harris 'Pregnancy, autonomy and the refusal of medical treatment' (1998) 114 Law Quarterly Review 550.

[110]S Al-Gailani '"The mothers of England object": public health, privacy and professional ethics in the early twentieth-century debate over the notification of pregnancy' (2018) 33 Social History of Medicine 18 at [32].

[111]Ibid, at [39].

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one's tastes. As Cohen argues, 'it enables situated subjects to navigate within pre-existing social and cultural matrices, creating spaces for … self-making'.[112] Criminalisation of PAE would impact all pregnant women regardless of their practices concerning alcohol, because it would remove a domain of choice in which women can forge and express selfhood and a relationship with the potential future child. Its expressive force would be to reduce the standing of pregnant women as holders of rights deserving of legal protection, rendering them akin to 'foetal containers' and therefore non-persons.[113] It would diminish women's private sphere and invite further and likely more intrusive surveillance of women by health professionals and others. The rights of women thus present a significant counterbalance to the possible in principle argument that we have sketched above.

Attention must also be given to the discourse around foetal rights and interests. As previously mentioned, the foetus receives limited protection under the criminal law and is not considered to have legal personality until birth. However, in *St George's Healthcare NHS Trust v S* the court stated that the foetus was 'not nothing', it was definitely human, and it was not simply an integral part of the mother.[114] The interests of the foetus could not accordingly be subsumed entirely within the interests of the mother. This sort of reasoning easily slips into a narrative of maternal–foetal divide in which the interests of one are seen as conflicting/competing with the other.[115] Fovargue and Miola expressed concern that the 'conferring of interests' upon the foetus would provide the necessary 'justification' for breach of the woman's autonomy.[116] However, to consider the pregnant woman and the foetus as wholly separate entities in a potentially antagonistic relationship belies the physical reality of pregnancy. The woman and her foetus are separate organisms that exist in a unique symbiotic relationship.[117] Yet, it is only the woman that has full legal personality and all its associated rights and interests. Therefore, cases of conflict do not pitch one person's rights against another's, necessitating balance and trade-offs. Any conflict is, at best, between the rights and interests of the woman and the best interests of the foetus.[118] These do not weigh equally on the scales. A woman's rights and interests trump any interests a foetus may be said to have.[119] The full legal personality of the woman would be seriously threatened were she to be allocated legal duties towards her foetus. Brazier, while accepting a woman has a moral responsibility towards the child she is carrying, warns strongly against equating this responsibility to a legal obligation and suggests that certain conduct 'lies in a realm where the law ought not to intervene'.[120] Moreover, it would be wrong for the 'unequal physical burden of pregnancy necessitated by biology' to be used as a basis for violating women's rights to autonomy, privacy and bodily integrity.[121]

Societal interest and public policy also provide a strong counterargument to criminalisation of PAE; much as they did when maternal civil liability for prenatal injury was being considered by the Law Commission during the 1970s.[122] At that time the Commission made a provisional proposal that

[112]J Cohen 'What is privacy for?' (2013) 126 Harvard Law Review 1904, at 1911.

[113]G Annas 'Pregnant women as fetal containers' (1986) 16 Hastings Center Report 13.

[114][1998] 3 All ER 673, [1998] 3 WLR 936, at [952].

[115]Armstrong, above n 100, at 47 contends that we must reject the motion of maternal-foetal conflict – 'The pregnant woman and the foetus are not separate entities whose interests and welfare are oppositional. Punishing the pregnant woman does nothing to protect her unborn child. The simple fact is that healthy women make healthy mothers make healthy babies.'

[116]S Fovargue and J Miola 'Policing pregnancy: implications of the Attorney General's Reference (No 3 of 1994)' (1998) 6 Medical Law Rev 265, at 288. See also Peak and Del Papa, above n 101, at 254 who note 'Conferring separate fetal rights may lead to violations of the mother's right to privacy, bodily integrity equal protection and parental autonomy.'

[117]*AGs Ref (No 3 of 1994)* [1997] UKHL 31 and *St George's Healthcare NHS Trust v S* [1998] 3 All ER 673.

[118]E Flagler et al 'Bioethics for clinicians: 12 ethical dilemmas that arise in the care of pregnant women: rethinking "maternal-fetal" conflicts' (1997) 156 Canadian Medical Association Journal 1729.

[119]See N Priaulx 'Pre(natal) crime: pregnant women, substance abuse and the law' (2015) 83 Medico-Legal Journal 43.

[120]Brazier, above n 70, at 390–391.

[121]McNolty and Garrett, above n 67, at 19. See also Bewley, above n 64, pp 134–135, who notes that 'nobody can directly help the fetus, or relieve the pregnant woman of her obligation, even temporarily'. Bewley argues that a mother-to-be should have no greater obligations than a mother-that-is.

[122]Law Commission *Injuries to Unborn Children* (LCCP 47, 1973).

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where a child suffers prenatal injury caused by its mother's negligence the child should be able to recover damages from her.[123] After consultation, the strength and depth of opposition to the idea of maternal liability became clear. For example, the Bar Council expressed its objection in the following terms:

> we recognise that logic and principle dictate that if a mother's negligent act or omission during or before pregnancy causes injury to a foetus, she should be liable to her child when born for the wrong done. But we have no doubt at all that in any system of law there are areas in which logic and principle ought to yield to social acceptability and natural sentiment and that this particular liability lies in such an area.[124]

A number of social policy grounds were said to justify the lack of civil redress against a mother, despite the fact that civil liability made sense 'in principle'. It was claimed that to allow legal liability against the mother would detrimentally impact the mother-child relationship and would have negative impacts on wider family relationships. There was particular concern that it could be used by a father as a weapon in family disputes. It was also noted that mothers may not be able to afford the compensation awarded and that such awards were likely to cause financial hardship to the rest of the family.[125] The Commission concluded that there should be no right of action by a child against its own mother for prenatal injury caused by the mother's negligence, the only exception to this being in the context of injuries caused through negligent driving by the mother.[126] This was given effect in the Congenital Disabilities (Civil Liability) Act 1976.[127]

In *CP* the Court of Appeal referred to the approach taken in civil law regarding a maternal duty of care and, while noting 'the different public interests at play as between tort and criminal law', considered alignment on this issue to be beneficial.[128] Lord Dyson stated it would be incoherent if a child was unable to claim compensation from its mother for injury inflicted during pregnancy, but the mother could be found criminally liable for causing that harm.[129] Furthermore, Lord Dyson found that the policy reasons justifying the lack of civil redress against the mother also supported the lack of criminal sanction for maternal conduct during pregnancy (save for the already recognised statutory exceptions under section 58 of the Offences Against the Person Act 1861 and section 1 of the Infant Life (Preservation) Act 1929).[130]

It is therefore suggested that the arguments for criminalising PAE diminish in appeal when confronted with the countervailing principles supplied by the rights of women, the legal status of the foetus, and wider societal interests and public policy considerations. These countervailing principles point strongly against criminalisation of PAE despite the 'in principle' argument supporting criminal sanction outlined above.

6. Stage three: practicality and costs

Proponents of criminalisation must establish its practicality and the justifiability of its costs. We raise doubts about criminalisation of PAE's effectiveness as a deterrent; its effects upon child and maternal

[123]At [34]. The Law Reform Commission recognised that many would find the ideal of maternal liability or a child suing its mother as socially unacceptable, at [27].

[124]Law Commission *Report on Injuries to Unborn Children* (Law Comm No 60, 1974) p 22.

[125]See generally PJ Pace 'Civil liability for prenatal injuries' (1997) 40 Modern Law Review 141.

[126]Above n 125 and the Congenital Disabilities (Civil Liability Act) 1976, s 2. The unborn child acquired no rights under the Act: only the born child has a right of action in respect of injuries caused prenatally. See further Fortin, above n 59.

[127]See the Congenital Disabilities (Civil Liability) Act 1976, s 1(1). Third parties may be liable to the born child for injuries that occurred prior to birth through a form of derivative liability – if the third party could be shown to be liable in tort law to the mother. Fortin, above n 59, describes this exception as 'illogical' and suggests that the existence of a separate fund from which to pay compensation (insurance) helps explain if not justify the approach taken here.

[128][2014] EWCA Civ 1554, at [47] per Lord Justice Treacy.

[129]At [66].

[130]At [67].

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health and its workability. Arguments regarding the deterrent effect of the criminal law on the individual rest upon ideas of free will, choice and control that may not reflect the lived experience of many pregnant women. In this regard Nicky Priaulx refers to the 'fallacy of choice and rational risk benefit' which suggests that pregnant women who engage in heavy alcohol use will actively weigh up the risk of criminal sanction and instead choose a 'clean pregnancy'.[131] Many pregnant women (especially those with addiction issues) would struggle to engage with, or act consistently upon, this rational risk assessment. In this sense it seems unfair, as well as futile, to hold such people criminally liable. Furthermore, this emphasis on individual responsibility overlooks the fact that broader social, environmental and structural factors may significantly limit the choices that are available to women.[132] It has been found that some women drink alcohol during pregnancy as a means of dealing with adverse life experiences (poverty, unwanted and unplanned pregnancies, domestic violence and abuse).[133] Instead there can often be a tendency to focus on the immorality or unmotherly nature of such behaviour rather than focus on its social and clinical determinants.[134] Of course, it is far easier to demonise the woman than to seek to alter social and structural influences on women's drinking in pregnancy.[135]

Criminalisation may also endanger the health of women and children as fear of prosecution could result in women choosing to forgo prenatal healthcare.[136] This unintended consequence of criminalisation is likely to occur most amongst the group of women in greatest need of medical help and treatment – those struggling with addiction.[137] The resulting lack of engagement with healthcare professionals is harmful for the woman and the foetus and would most likely result in poorer health outcomes for both.[138] Alternatively, women may not provide accurate accounts of alcohol consumption during prenatal check-ups for fear of being 'turned in' by their doctors or midwives.[139] Such withholding of information will mean that essential healthcare and support is not provided and lead to poorer health outcomes for the woman and child.[140] Another possible negative consequence of criminalisation is that the woman's relationship with her healthcare providers is undermined.[141] The criminalisation of PAE would shift the relationship between pregnant woman and healthcare professionals from one of care to one of (even greater) surveillance: the health of the foetus becomes the primary concern and the healthcare professional 'polices' women's behaviour.[142] In this context, admissions of alcohol consumption in prenatal health check-ups become evidence of wrongdoing by the woman and healthcare advice on the dangers of alcohol consumption helps establish the woman's knowledge of risk and blameworthiness (as seen in *CP*). The focus on prosecution as opposed to education, support and treatment ultimately does more harm than good.[143] In short, if criminalisation is partly aimed at protecting the foetus from harm, it is likely to be highly ineffective at doing so. Indeed, it may make harm more likely.

[131]Priaulx, above n 119, at 44.

[132]Bell et al, above n 16; Paone and Alperen, above n 2, at 107. Paone and Alperen make this point in relation to drug use but it stands in relation to alcohol.

[133]Bell et al, above n 16, at 163; Armstrong, above n 100, at 46; Popova et al 'Why do women consume alcohol while pregnant or breastfeeding' (2022) 41 Drug and Alcohol Review 759.

[134]See Paone and Alperen, above n 2.

[135]See Paone and Alperen, above n 2. Other aims of criminalisation such as incapacitation and rehabilitation are also unlikely to be achieved by criminalising PAE. See Duso and Stogner, above n 82.

[136]Armstrong, above n 100, at 47.

[137]Peak and Del Papa, above n 101; Armstrong, above n 100; B Bennett 'Pregnant women and the duty to rescue: a feminist response to the fetal rights debate' (1991) 9 Law Context: A Socio-Legal Journal 70; H Flynn Bell 'In utero endangerment and public health: prosecution vs treatment' (2001) 36 Tulsa Law Journal 649; Priaulx, above n 119.

[138]Armstrong, above n 100, at 45.

[139]E Thompson 'The criminalisation of maternal conduct during pregnancy: a decision making model for lawyers' (1989) 64 Indiana Law Journal 357, at 370.

[140]Ibid. See also Duso and Stogner, above n 82.

[141]Thompson, above n 139. See also Duso and Stogner, above n 82.

[142]Thompson, above n 139. See also Duso and Stogner, above n 82.

[143]Flynn Bell, above n 137.

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Finally, there are practical difficulties when it comes to establishing causation that may mean criminalisation of PAE is unworkable. Priaulx highlighted difficulties with evidencing the cause of prenatal harm, describing it as 'a potential causal mess'.[144] In contrast to most criminal offences which involve a clearly identifiable instance of harm (a punch, a stabbing), FASD involves developmental injuries. Foetal development is complex and multifactorial.[145] While evidence shows that continuous heavy alcohol use during pregnancy or binge drinking is likely to lead to FASD, it has also been shown that FASD does not occur in all such cases.[146] Given that there is no definitive neurodevelopmental profile that clearly distinguishes FASD from other neurodevelopmental disorders,[147] there is a risk that a FASD diagnosis is unduly influenced by known or suspected PAE.[148] Moreover, while FASD cannot occur in the absence of alcohol consumption during pregnancy, other contributing factors have been identified.[149] Genetic and epigenetic factors, maternal factors (such as the mother's age, body size, number of previous pregnancies and births) and socioeconomic factors appear to influence the likelihood that a child exposed to alcohol prenatally will develop FASD.[150] Many of these additional contributory factors to FASD are outside the control of the woman and will likely occur most frequently for women from a minority background and/or lower socio economic status. Meurk et al found that women from upper socio-economic groups were more likely to drink alcohol during pregnancy but have significantly lower rates of FASD.[151] Criminalisation of PAE resulting in FASD would not therefore capture equally all cases of risky alcohol consumption but likely only criminalise those already disadvantaged women.[152]

Conclusion

The prevention of FASD is increasingly framed as a high priority public health issue, necessitating both preventative and responsive action by the state. When the current highly precautionary and intrusive public health approach is coupled with existing societal expectations about motherhood and appropriate behaviour during pregnancy there is potential for the public response to this issue to be taken to its extreme – criminalisation. Recognising this danger, we sought to explore by means of a Duffian analysis how criminalisation of such conduct might be justified. We focused on cases of PAE where FASD was subsequently diagnosed as we judged this was where the argument for criminalisation and the urge to criminalise would be strongest. Through consideration of the key elements of a public wrong, we found it possible to construct an 'in principle' argument for criminalisation. PAE could be positioned as a harmful setback of interests, a wrongful harm and a public wrong.

However, consideration of countervailing principles, in the main the rights and interests of women but also societal interest and public policy, seriously challenge the appropriateness and proportionality of criminalisation.[153] Further challenges to the 'in principle' argument were exposed by examining the practicality and costs of recourse to criminal sanction (the unlikely deterrent effect, the likely

[144]Priaulx, above n 119, at 45.

[145]D Sacks 'Determinants of fetal growth' (2004) 4 Current Diabetes Reports 281.

[146]Popova et al, above n 4.

[147]S Petryk et al 'Prenatal alcohol history – setting a threshold for diagnosis requires a level of detail and accuracy that does not exist' (2019) 19 BMC Pediatrics 372.

[148]Priaulx, above n 119.

[149]P May and J Gossage 'Maternal risk factors for fetal alcohol spectrum disorders: not as simple as it might seem' (2011) 34 Alcohol Research and Health 15.

[150]Ibid.

[151]C Meurk et al 'A bio-social and ethical framework for understanding fetal alcohol spectrum disorders' (2014) 793 Neuroethics 337, at 338–339.

[152]This was the experience in the US when addressing drug-taking during pregnancy: see D Roberts 'Punishing drug addicts who have babies: women of color, equality, and the right to privacy' (1991) 104 Harvard Law Review 1419.

[153]See V Tadros 'Crimininalisation and regulation' in R Duff et al *The Boundaries of Criminal Law* (Oxford: Oxford University Press, 2010):'we might conclude that, although some conduct is harmful, publicly wrongful, and in principle

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endangerment of the health of the woman and the foetus and the difficulties and potential dangers around establishing a causal link between PAE and FASD when FASD is a diagnosis of correlation and the impact of PAE on the child can be affected by numerous other factors). As recognised by Bowden, the moral judgement of pregnant women will continue to push on the door to maternal criminal liability.[154] It also focuses attention on an overly individualised understanding of the problem of PAE which leads to FASD. This, we strongly suggest, is something that must be resisted. It would be far better to concentrate on education, support and treatment than on prosecution.[155] Not only is this far more likely to prevent and reduce the harm of PAE but it can help preserve liberty, bodily integrity and privacy.

deserving of punishment, we ought not to criminalize it because this is a disproportionate response to the conduct we are concerned with'.

[154]C Bowden 'Is a relational approach required to close the door on criminal liability for maternal prenatal conduct? (2020) 2 Journal of Medical Law and Ethics 3.

[155]J Robertson 'Protecting intended children from harmful prenatal conduct' (2016) 16 American Journal of Bioethics 14–15, at 14.

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