

# 8. Welfare of the child

## This guidance note contains:

### Mandatory requirements

- Extracts from the HFE Act 1990 (as amended)
- Extracts from licence conditions

### HFEA guidance

- Scope of the welfare of the child provision ■
- The welfare of the child assessment process
- Factors to take into account during the assessment process
- Obtaining further information during the assessment process
- Refusing treatment
- Record keeping

### Other legislation, professional guidelines and information

➔ Refer to principles 1, 4, 6, 7 and 10

■ Section includes interpretation of mandatory requirements



## Mandatory requirements

### Human Fertilisation and Embryology (HFE) Act 1990 (as amended)

Section 13 (5): A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth.

Section 2 (1) ... “treatment services” means medical, surgical or obstetric services provided to the public or a section of the public for the purpose of assisting women to carry children.

### Licence conditions

T56 A woman must not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth.



## HFEA guidance

### Scope of the welfare of the child provision



#### Interpretation of mandatory requirements

8A

No treatment services regulated by the HFEA (including intrauterine insemination – IUI) may be provided unless account has been taken of the welfare of any child who may be born as a result (including the need of that child for supportive parenting) and of any other child who may be affected by the birth.

**8.1** This guidance note applies to all fertility treatments regulated by the HFEA, including IUI. Centres providing treatments that are not regulated by the HFEA but that fall within the definition of ‘treatment services’ (see above) may also find this guidance note helpful.



### The welfare of the child assessment process

- 8.2** The centre should have documented procedures to ensure that proper account is taken of the welfare of any child who may be born as a result of treatment services, and any other child who may be affected by the birth.
- 8.3** The centre should assess each patient and their partner (if they have one) before providing any treatment, and should use this assessment to decide whether there is a risk of significant harm or neglect to any child referred to in 8.2.
- 8.4** If the child is not to be raised by the carrying mother (ie, in a surrogacy arrangement), the centre should assess both those commissioning the surrogacy arrangement and the surrogate (and the surrogate's partner, if she has one) in case there is a breakdown in the surrogacy arrangement.

See also guidance note:

- [14 – Surrogacy](#)

- 8.5** Assessments do not need to be done on gamete or embryo donors (except those commissioning a surrogacy arrangement), or in cases where gametes are being stored for later use.
- 8.6** The centre should repeat the assessment if:
- (a) the centre has been out of contact with the patient for two years or more
  - (b) the patient has a new partner
  - (c) a child has been born to the patient since the previous assessment, or
  - (d) the centre has reason to believe that the patient's medical or social circumstances have changed significantly.
- 8.7** Those seeking treatment are entitled to a fair assessment. The centre is expected to consider the wishes of all those involved, and the assessment must be done in a non-discriminatory way. In particular, patients should not be discriminated against on grounds of gender, race, disability, sexual orientation, religious belief or age.

See also guidance note:

- [29 – Treating people fairly](#)

- 8.8** If patients have referred themselves for treatment, the centre should take all reasonable steps to verify the identity of those seeking treatment with appropriate evidence (eg, passport or photocard driving licence).
- 8.9** The centre should take a medical and social history from each patient and their partner (if they have one). Where appropriate, the patient and their partner may be interviewed separately. The information gathered should relate to the factors in paragraphs 8.10–8.12 below.

### Factors to take into account during the assessment process

- 8.10** The centre should consider factors that are likely to cause a risk of significant harm or neglect to any child who may be born or to any existing child of the family. These factors include any aspects of the patient's or (if they have one) their partner's:
- (a) past or current circumstances that may lead to any child mentioned above experiencing serious physical or psychological harm or neglect, for example:
    - (i) previous convictions relating to harming children



### 8.10 (cont)

- (ii) child protection measures taken regarding existing children, or
- (iii) violence or serious discord in the family environment
- (b) past or current circumstances that are likely to lead to an inability to care throughout childhood for any child who may be born, or that are already seriously impairing the care of any existing child of the family, for example:
  - (i) mental or physical conditions
  - (ii) drug or alcohol abuse
  - (iii) medical history, where the medical history indicates that any child who may be born is likely to suffer from a serious medical condition, or
  - (iv) circumstances that the centre considers likely to cause serious harm to any child mentioned above.

### 8.11 When considering a child's need for supportive parenting, centres should consider the following definition:

'Supportive parenting is a commitment to the health, well being and development of the child. It is presumed that all prospective parents will be supportive parents, in the absence of any reasonable cause for concern that any child who may be born, or any other child, may be at risk of significant harm or neglect. Where centres have concern as to whether this commitment exists, they may wish to take account of wider family and social networks within which the child will be raised.'

### 8.12 If the child will not be raised by the carrying mother, the centre should take into account the possibility of a breakdown in the surrogacy arrangement and whether this is likely to cause a risk of significant harm or neglect to any child who may be born or any existing children in the surrogate's family.

## Obtaining further information during the assessment process

### 8.13 The centre should obtain consent from the prospective patient (and their partner if they have one) to approach any individuals, agencies or authorities for any factual information required for further investigation if:

- (a) information provided by the patient (and their partner if they have one) suggests a risk of significant harm or neglect to any child
- (b) the patient (and their partner if they have one) has failed to provide any of the information requested
- (c) the information the patient (and their partner if they have one) has provided is inconsistent, or
- (d) there is evidence of deception.

A refusal to provide consent to disclosure of information should not, in itself, be grounds for denying treatment but the centre should take this into account in deciding whether to provide treatment. The centre should discuss with the patient (and their partner if they have one) the reason for refusing to provide consent.

### 8.14 If information has been provided in confidence to a member of staff, the staff member should seek consent from the information provider to discuss it with other staff. If such consent is refused and the member of staff considers the matter to be crucial to a decision, they should use their discretion, based on good professional practice, in deciding whether to break that confidence. In line with professional guidance, patients should normally be informed of the decision to break confidence and the reasons for it, before the information is shared with other members of staff.



### Refusing treatment

- 8.15** The centre should refuse treatment if it:
- (a) concludes that any child who may be born or any existing child of the family is likely to be at risk of significant harm or neglect, or
  - (b) cannot obtain enough information to conclude that there is no significant risk.
- 8.16** In deciding whether to refuse treatment, the centre should:
- (a) take into account the views of all staff who have been involved with caring for the patient (and their partner if they have one), and
  - (b) give the patient (and their partner if they have one) the opportunity to respond to the reason or reasons for refusal before the centre makes a final decision.
- 8.17** If treatment is refused, the centre should explain, in writing, to the patient (and their partner if they have one):
- (a) why treatment has been refused
  - (b) any circumstances that may enable the centre to reconsider its decision
  - (c) any remaining options, and
  - (d) opportunities for obtaining appropriate counselling.

### Record keeping

- 8.18** In all cases, the centre should record in the patient's medical records the information it has considered during the assessment. If further information has been sought or discussion has taken place, the record should reflect the views of those consulted in reaching the decision and the views of the patient (and their partner if they have one).



## Other legislation, professional guidelines and information

- Welfare of the Child patient history form can be found at – [www.hfea.gov.uk/docs/Welfare\\_of\\_the\\_child\\_patient\\_history\\_form.pdf](http://www.hfea.gov.uk/docs/Welfare_of_the_child_patient_history_form.pdf)