

Welfare of the child and the assessment of those seeking treatment

General obligations

HUMAN FERTILISATION AND EMBRYOLOGY ACT 1990

Section 13

(1) The following shall be conditions of every licence under paragraph 1 of Schedule 2 to this Act...

(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 a father) and of any other child who may be affected by the birth.

Section 2

(1) In this Act, '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.

Scope of the welfare of the child provision

3.1 There is a general presumption in favour of providing treatment for patients who seek it. However, in accordance with the requirements of the Act to take account of the welfare of any child who may be born as a result of treatment, treatment centres should assess the risk of harm to the welfare of such a child or any existing children in the family. Where it is judged that the child is likely to experience serious harm, treatment should not be provided.

3.2 Treatment centres are expected to take into account the welfare of any child who may be born as a result of treatment and of any other child who may be affected by the birth before providing **any treatment service**, as defined in section 2 of the Human Fertilisation and Embryology (HFE) Act. Treatment services should be understood to include any treatment, including surgery and the administration of drugs, carried out in a licensed centre which is provided for the purpose of assisting women to carry children. In order to take the welfare of the child into account, centres are expected to consider any relevant information they receive in their decision about whether or not to provide treatment services.

Welfare of the child risk assessments

3.3 Treatment centres are expected to carry out an assessment of risk of harm to the welfare of the child before providing **any licensed treatment or any unlicensed treatments which involve the handling or manipulation of gametes outside of the body**. This does not include the donation of gametes or embryos (except in surrogacy arrangements, see 3.5) or the storage of gametes for later use.

3.4 Treatment centres are expected to carry out a welfare of the child risk assessment on each patient before treatment is provided (as defined in 3.3 above).

3.5 Where the child will not be raised by the carrying mother (i.e. in a surrogacy arrangement), an assessment should be carried out both on the commissioning couple and the surrogate (and her partner, if she has one).

3.6 Treatment centres are expected to repeat the welfare of the child risk assessment where:

- (i) there has been a gap of two years or more in contact between the clinic and the patient(s); or
- (ii) there has been a change of partner; or
- (iii) a child has been born to the patient(s) since the previous assessment; or
- (iv) where the centre has reason to believe that there has been a significant change in the patient's medical or social circumstances.

Relevant risk factors to take into account

3.7 Those seeking treatment are entitled to a fair assessment. Treatment centres are expected to conduct the assessment with skill and care, and have regard to the wishes of all those involved.

3.8 In order to take into account the welfare of the child, treatment centres are expected to consider factors which are likely to cause serious physical, psychological or medical harm, either to the child to be born or to any existing child of the family. These factors should include:

- (i) Any aspect of the patient's past or current circumstances which means that either the child to be born or any existing child of the family is likely to experience serious physical or psychological harm or neglect. Such aspects might include:
 - (a) previous convictions relating to harming children;
 - (b) child protection measures taken regarding existing children; or
 - (c) serious violence or discord within the family environment.
- (ii) Any aspect of the patient's past or current circumstances which is likely to lead to an inability to care for the child to be born throughout its childhood or which are already seriously impairing the care of any existing child of the family. Such aspects might include:
 - (a) mental or physical conditions; or
 - (b) drug or alcohol abuse.
- (iii) Any aspect of the patient's medical history which means that the child to be born is likely to suffer from a serious medical condition.

- (iv) Any other aspects of the patient's circumstances which treatment centres consider to be likely to cause serious harm to the child to be born or any existing child of the family.

3.9 Where the child will have no legal father, the treatment centre is expected to assess the prospective mother's ability to meet the child's/children's needs and the ability of other persons within the family or social circle willing to share responsibility for those needs.

3.10 Where the child will not be raised by the carrying mother, treatment centres are expected to take into account the possibility of a breakdown in the surrogacy arrangement and whether this is likely to cause serious harm to the child to be born or any existing children in the surrogate's family.

Information to be provided to patients

3.11 Centres are reminded that patients shall not be provided with treatment services, nor can they be considered to have given effective consent, unless they have been provided with such relevant information as is proper. This information is expected to include the nature, purpose and implications of the proposed treatment (see Part 5 for details of this information), particularly relating to donor conception treatment, egg sharing arrangements and surrogacy arrangements.

The assessment process

3.12 Where patients have referred themselves for treatment, treatment centres are expected to take all reasonable steps to verify the identity of those seeking treatment by appropriate evidence (e.g. passport, photocard driving licence or birth certificate).

3.13 Treatment centres are expected to take reasonable steps to determine who will have parental responsibility for the child or children which may be born as a result of treatment and take reasonable steps to determine the person or persons responsible for raising such child or children.

3.14 Treatment centres are expected to take a medical and social history from each patient and see each couple together and, where appropriate, separately. The information gathered from the patient(s) should relate to the relevant risk factors to be taken into account, as identified at 3.8 above.

3.15 Where the information gathered from the patient(s) is considered by the centre to suggest that serious harm may be caused, treatment centres are expected to obtain the consent from the prospective patient(s) to approach any individuals, agencies or authorities for such further factual information as the centre deems to be required to investigate the matter further. Further information is expected to be sought where information provided by the patient suggests that serious harm may be caused to the child; where prospective patient(s) have failed to provide any information requested; where the information is inconsistent or where there is evidence of deception. Refusal by the patient(s) to give such consent is a factor to be taken into consideration in the decision about whether to provide treatment. The refusal

should not, itself, be grounds for denying treatment, although centres are expected to discuss with the patient(s) the reason for the refusal.

3.16 In circumstances in which further information has been collected, treatment is expected to be refused if the centre concludes that either the child to be born or any existing child of the family is likely to experience serious physical, psychological or medical harm or where the treatment centre is unable to obtain sufficient further information to conclude that there is no significant risk.

3.17 In deciding whether to refuse treatment, treatment centres are expected to take into account views from all staff who have been involved with the care of the patient(s). The patient(s) are expected to be given the opportunity to respond to adverse information and objections before a final decision is made.

3.18 Where adverse information has been provided in confidence to a member of staff, consent is expected to be sought from the information provider to discuss it with other members of staff. Where such consent is refused but the member of staff considers the matter to be crucial to the decision to be taken, the member of staff is expected to use his or her discretion based upon good professional practice before breaking that confidence. In line with professional guidance, patients should normally be informed of the decision to break confidence and the reasons for it, before information is shared with other members of staff.

3.19 Where treatment is refused, treatment centres are expected to:

- (i) Explain the reasons for such refusal to the woman and, where appropriate, her partner, together with any circumstances which may cause the centre to reconsider its decision; and
- (ii) Explain any remaining options; and
- (iii) Explain opportunities for obtaining appropriate counselling.

Written records

3.20 Treatment centres are expected to have clear written processes and criteria for assessing the risk to the welfare of any child which may be born or any existing child of the family.

3.21 Treatment centres are expected in all cases to record in writing information that has been considered in respect of the welfare of the child. Where further information has been sought or discussion taken place, the record is expected to reflect the views of those who were consulted in reaching the decision and the views of those seeking treatment.

Surrogate pregnancy*

3.24 Treatment centres are expected to consider the use of assisted conception techniques to produce a surrogate pregnancy only where the commissioning mother is unable for physical or other medical reasons to carry a child or where her health may be seriously impaired by doing so.

* The attention of treatment centres is drawn to the Parental Orders (Human Fertilisation and Embryology) Regulations 1994 and (in Scotland) the Parental Orders (Human Fertilisation and Embryology) (Scotland) Regulations, which provide that parental rights and obligations in respect of surrogacy arrangements may be transferred from the birth parents to the commissioning parents. Appendix D of this Code of Practice sets out the conditions which must be fulfilled before an application may be made, and also contains information about birth registration in these circumstances.

Elements of the guidance to be moved to another section

The following elements of Part 3 of the current Code should be preserved, but moved to another section, as they are not relevant to welfare of the child assessments.

0.1 Women over 35 and men over 45 are expected – like all patients – to be offered clinical advice and counselling at the outset. Advice and counselling is expected to focus on the implications of age for success in treatment. Gametes of patients in these age groups are expected to be used only for their own or their partner's treatment.

0.2 Gametes for use in treatment may only be taken from patients under the age of 18 in the following exceptional circumstances:

- (i) If it is the intention to use such gametes for the patient's own treatment or for the use of the patient's partner; and
- (ii) If the centre is able to satisfy itself that the patient is capable of giving and actually gives effective consent to the use or storage of those gametes.

0.3 Sperm to be used for the purposes of research may be taken from a male under the age of 18 only if the centre is able to satisfy itself that the donor is capable of giving, and actually gives, effective consent to such use.

0.4 It is expected that eggs shall not to be taken from a female under the age of 18 for the purposes of storage or licensed research without informing the HFEA.

Additional information for those seeking an egg sharing arrangement

0.5 Treatment centres are expected to ensure that:

- (i) Care is taken in the selection of egg providers in egg sharing arrangements; and
- (ii) Egg providers are fully assessed and medically suitable; and
- (iii) The treatment offered is the most suitable available to satisfy the needs of the egg provider and recipient(s)

0.6 Treatment centres are expected to offer counselling to egg providers and recipients and to the partners of women donating and receiving eggs and any other individuals directly affected. There is expected to be the opportunity for the donor to receive counselling from a different counsellor from the one providing counselling to the recipient.

0.7 Treatment centres are expected to provide any additional impartial support (e.g. a member of the nursing staff not involved in the treatment of either donor or recipient) to all parties during the egg sharing cycle.

Amendments to Part 5 of the Code of Practice (Information)

Preparation and information for those receiving treatment with donor gametes or embryos

5.6 There is evidence that finding out suddenly, later in life, about donor origins can be emotionally damaging to children and to family relations. Therefore, it should be made clear to individuals seeking treatment with donor gametes or embryos that telling their child/children about their origins early in childhood is in their welfare interests. Clinics should encourage and prepare patients to be open with their children from an early age about the circumstances of their conception. Counselling should be offered as a matter of course. Individuals seeking treatment with donated gametes and embryos are expected to receive information about:

- (i) the importance of sharing information with the child/children about their donor origins from an early age; and
- (ii) the value that counselling may provide for patients to explore the implications of treatment and particularly how information may be shared with their child/children.

5.7 In addition, individuals are expected to receive information about the genetic and other screening which people providing gametes undergo at the recruiting centre, in particular:

- (i) the sensitivity and specificity of the tests carried out; and
- (iii) the possibility that a screened provider of gametes may be a carrier of a genetic disease or infection; and
- (iv) the availability of genetic screening (especially if the people providing gametes at the centre are not screened for cystic fibrosis).

5.8 In addition, individuals are expected to receive information about legal parentage and the collection and provision of information, specifically:

- (i) who will be the child's legal parent(s) under the HFE Act and other relevant legislation (see also paragraph 6.33). Nationals or residents of other countries, or individuals treated with gametes obtained from foreign donors, are expected to be informed that the law in other countries may be different from that in the United Kingdom; and
- (ii) information which centres must collect and register with the HFEA in respect of the donors and the extent to which that information may be disclosed to people born as a result of donation; and
- (iii) a child's right to seek information about its origins upon reaching the age of 18 years, or younger if contemplating marriage at an earlier age.