Brighton and Sussex University Hospitals NHS Trust

Management of Surrogacy

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Key Principles

A protocol is a set of measurable, objective standards to determine a course of action. Professional judgement may be used in the application of a protocol.

Scope

The purpose of this guideline is to ensure good planning for surrogate parents and the children of surrogate parents and to ensure we have robust sensitive plans in place for antenatal planning, labour and postnatal period and ensure that the safeguarding team are aware of any changes to the plans to ensure the families achieve the best outcomes from the arrangements in place.
In the event of a request for surrogacy all staff should be aware of the legal requirements on the commissioning and surrogate parents. This guidance is relevant to obstetricians, gynaecologists, and paediatricians, IVF Practitioners, Midwives, neonatal nurses.

Responsibilities

Health Care Staff:

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this protocol

Management:

- To ensure the protocol is reviewed as required in line with Trust and National recommendations
- To ensure the protocol is accessible to all relevant staff

1 Introduction

Surrogacy is a way for a childless couple to become parents, with a surrogate mother carrying the child. It is legal in the UK providing the surrogate receives no payment beyond her reasonable expenses.

Professionals need to be aware of the law regarding surrogacy and the rights of the parties involved. At birth the surrogate mother has parental responsibility (PR) which can only be transferred to the commissioning couple via the legal process. Only the surrogate mother can give consent until this process is completed.

This policy/guideline is an effort to explore the idea of surrogacy, taking into account the (2007) amendments to the Human Fertilisation and Embryology Act (HFEA) and the Surrogacy Arrangements Act of 1985. Whilst it would be impossible to cover all aspects of the surrogacy process, it aims to cover the main issues, current laws and advice to healthcare professionals.

2 Principles

Offer care in a non-judgmental and supportive manner. Maintain accurate and contemporaneous records of discussions and decisions reached. Confidentiality is vital and disclosure should be made on a need to know basis. Any reference to the surrogacy arrangement in the medical notes should only be made after discussion with and permission from the surrogate mother.
The needs of the surrogate mother should always be a priority and all (final) decisions rest with her. Information requested by the commissioning parents must be sanctioned by the surrogate mother and documented in the medical notes.

3 Definitions

3.1 **Surrogacy**
Surrogacy is the practice whereby one woman (the surrogate mother) becomes pregnant, carries and gives birth to a child for another person(s) (the commissioning couple) as the
result of an agreement prior to conception that the child should be handed over to that person after birth.

3.2 **Commissioning couple (Intended parents)**
The commissioning couple are the people who wish to bring up the child after his or her birth. They may both be the genetic parents, or one of them may be, or neither of them may be genetically related to the child. The woman for whom the child is to be carried (the 'commissioning mother') may be the genetic mother in that she provides the egg. The genetic father may be the husband or partner of the commissioning mother, or he may be an anonymous donor. (DOH 1998).

3.3 **Surrogate mother**

Types of Surrogacy:

3.3.1 Partial surrogacy means the host surrogate becomes pregnant using her own eggs and sperm from the commissioning couple. This can be achieved either through IUI (Intrauterine Insemination) or IVF (In-vitro Fertilisation) treatment.

3.3.2 Full surrogacy means that the host surrogate will carry a pregnancy as a result of embryo transfer after IVF treatment. The embryos may have resulted using commissioning couple sperm and eggs or any combination of donated sperm &/or eggs.

Please also refer to the terms of the Human Fertilisation and Embryology Act 1990.

4 Accountabilities and Responsibilities

Whilst the confidentiality of the commissioning and surrogate parents should be upheld there will need to be certain communications to ensure staff are not complicit in any illegal act and that all health staff, who need to know, are informed. Please see flowchart in Appendix A.

5 Surrogacy and the Law

The legal framework for surrogacy is the Surrogacy Arrangements Act of 1985, amended in the Human Fertilisation and Embryology Bill of 2007. The intentions of the Surrogacy Arrangement Act of 1985 are summarized below:

5.1 Surrogacy is an agreement arranged before the pregnancy begins, with intent for another person to assume parental rights. Pregnancy is determined to begin at the time of insemination or embryo transfer.

5.2 No person with any commercial interest in the surrogacy arrangement may initiate or negotiate any part of the surrogacy proceedings.

5.3 It is illegal to advertise to seek or become a surrogate, through any form of the UK media.

5.4 Any person breaching (5.2) and (5.3) above is liable for punishment, either a fine or by imprisonment.

5.5 Should staff become suspicious that the parties are involved in a commercial arrangement, they should contact the Lead for Safeguarding children for further advice and guidance.

The 2007 amendments clarify that non-profit making organisations (such as the agencies which have a strong prevalence in many agreements today) are allowed to take part in the negotiations necessary for a successful surrogate pregnancy. Non-profit making

organizations are allowed to advertise their services.

Surrogacy UK website provides detailed advice on all aspects of surrogacy: http://www.surrogacyuk.org/ http://www.surrogacyuk.org/Downloads/Guide to Surrogacy UK for Healthcare Professionals.pdf

6 Parental Responsibility: Who are the Child's Legal Parents?

The Human Fertilisation and Embryology Act 1990 (2) section 27, states that the legal mother is always the surrogate mother regardless of genetic makeup and she is legally responsible for the child until such time as the intended parents adopt or seek a parental order.

The surrogate has the legal right to keep the child, even if it is not genetically related to her.

Surrogacy arrangements are not legally enforceable, even if a contract has been signed and the expenses of the surrogate have been paid.

The surrogate will be the legal mother of the child unless or until parenthood is transferred to the intended mother through a parental order or adoption after the birth of the child. This is because, in law, the woman who gives birth is always treated as the mother.

There are two methods through which parental responsibility may be transferred.

1. A parental order can be made if the case satisfies section 30 of the Human Fertilisation and Embryology Act. These are a set of criteria including a requirement that the parents are married to each other, aged over 18, domiciled in the UK and that the child is genetically related to one or both parents.

2. An application may be made to adopt the child under the Adoption Act 1976.

    - The baby should be assigned a legal Children's Guardian to act in the child's interests, until the legal responsibility is transferred, who has a responsibility to ensure that the criteria of section 30 of the Human Fertilisation and Embryology Act 1990 are fulfilled.
    - The process is allowed to take up to six months from the date of birth.
    - If, after the baby is born, the surrogate mother decides she does not want to hand the baby over at the end of the pregnancy, she cannot be forced to do so. The Brazier report estimates that in 4-5% of cases, a surrogate refuses to give the child to the commissioning couple, and in these cases the commissioning couple are almost certain to fail in any legal proceedings.
    - If, after the baby is born the commissioning parents do not want the baby, social services should be contacted and legal advice sought.
    - The Children's Guardian is also required to ensure that there are no contraindications to transfer of parental responsibility as set out in the Adoption

Act. This process is often aided by specialist legal teams.

- The Brazier Report, an independent government review in 1998, raises some issues regarding the legal transfer of parental responsibility. In the vast majority of cases the commissioning couple begin to take care of the baby from birth, hence are already looking after the baby by the time a Children's Guardian is assigned.
- From a child welfare perspective it is very difficult to remove the baby from the commissioning parents unless the strongest of contraventions to the aforementioned acts is proven.
- BSUH staff should ensure that if there is any cause for concern that they take advice from the Safeguarding children's named doctor or nurse / midwife.

6.1 **Same sex couples:**

6.1.1 Marriage (same sex Couples) Act 2013 set up a framework to allow same sex couples to achieve legal recognition of their relationship. Civil partners may apply to adopt the child or apply for a residence order.

6.1.2 In the United Kingdom have the right to adopt since 2002, following Adoption and Children Act 2002

6.2 **Foreign commissioning parents and British Surrogate**

6.2.1 If neither commissioned parents is domiciled in the UK, they will not be eligible to apply for a parental Order. Adoption would therefore be the only available option to obtain legal parenthood.

7 Payment Rules

To satisfy section 30 of the 1990 Human Fertilisation and Embryology Act the commissioning couple must ensure that "no money other than expenses has been paid in respect of the surrogacy arrangement unless authorised by the court".

The document: Surrogacy: Review for Health Ministers of current arrangements for Payments and Regulation, 1988 gives a definition of acceptable expenses:

- Maternity clothing
- Counselling fees
- Healthy Food
- Legal Fees
- Domestic help
- Life and disability insurance
- Travel to and from hospital / Clinic
- Expenses
- Telephone and postal expenses
- Ovulation and pregnancy tests

- Overnight accommodation
- Insemination and IVF costs
- Child Care to attend hospital/clinic
- Medicines and Vitamins
- Any time taken off work by the surrogate mother (if employed at the time of insemination/embryo transfer) should be taken in accordance with medical advice and statutory requirements.

8 Commissioning Issues

Our local Clinical Commissioning Group (CCG) will not fund surrogacy.

Surrogacy UK, one of the two non-profit surrogacy agencies in the UK, estimates the cost of a cycle of IVF surrogacy is in excess of £6000 and IVF may not be successful at first attempt.

9 Procedures and Actions to Follow

The immediate postnatal period is a time of great emotional upheaval, which may be compounded in a surrogacy arrangement and great sensitivity is required in handling both the surrogate and commissioning parents. Where there is conflict the midwife must focus her care on the surrogate mother and baby.

- A child born to a surrogate mother must be registered as her child.
- The commissioning parents, even if they have taken the child, have no legal relationship with it and no rights in law until a parental order has been made or unless the commissioning father is named on the birth certificate.
- The HFEA advises that, until the parental order comes into force, strictly speaking it is the legal mother who should give consent for screening of the newborn. To confirm who has PR (check section 5&6)
- Commissioning or intended parents will apply for a parental order (if the genetic makeup of the baby comes from either or both of them) or an adoption order where gametes from either of the commissioning parents have not been used. Until this time (6 weeks – 6 months) the legal mother is the surrogate mother.
- Handing over the baby will take place following discussion and agreement with the surrogate mother. The outcome of this discussion and agreement must be documented in the maternal and neonatal records.
- The handover should take place outside of the maternity unit and no maternity staff should be involved with the handover, other than providing follow up care to the mother and baby after they return home.
- The surrogate mother is cared for as per routine postnatal care guidelines. Her G.P. is notified of her discharge home.
- The commissioning mother and baby are notified to the appropriate community midwife, health visitor and G.P. She may be prescribed Metoclopramide 10 mg tds from 27 weeks of the host surrogate pregnancy to be able to breast feed the baby. The commissioning mother can also start to double pump from 26 weeks of the host

surrogate pregnancy.

- As the Surrogate Mother is the legal mother at birth, the baby cannot be removed from the hospital by the commissioning parent(s) without her consent. Staff should ensure they have written consent from the Surrogate Mother before handing over the baby and that this is done, wherever practicable, in the presence of the Surrogate Mother and the commissioning parent(s). Staff should consider whether the Duty Social Worker should be informed of the Surrogacy arrangement to ensure that both the Surrogate Mother and the commissioning parent(s) are able to receive support and advice in the post natal period where appropriate." "The commissioning parent(s) should not be admitted as a patient of the Trust. If the surrogate mother requests that the commissioning parent(s) be permitted to stay with her until the baby is discharged, this should be accommodated and recorded in the notes. Where, following birth, the Surrogate Mother delegates responsibility for the child to the Intended Parents, this should be written clearly in the medical notes. If this is the case, wherever possible, the intended mother may be accommodated separately with the baby in a side room on the postnatal ward. Parenting support and advice will then be provided to the commissioning parent(s) until the baby is discharged. This arrangement must be recorded in the surrogate mothers notes and also the baby's notes, stating that this is the request of the surrogate mother. The commissioning parent(s) presence on the ward should then be recorded in the ward day book. If this is not possible, owing to capacity, the baby will be transferred for care in TMBU /SCBU where the commissioning parent(s) may visit in place of the surrogate mother.

Midwives

9.1.1 The midwife should be informed of the status of the pregnancy and this should be recorded in the maternity hand held notes & medical notes, including who has parental responsibility (see above section 5 & 6).

9.1.2 It is important for the midwife at booking to ascertain who are the baby's biological parents, including where relevant, details of the donor sperm and / or egg. This will be relevant in order to assess relevant family history and risk assess for inherited diseases. For combined screening and the quadruple test, risk assessment is based on the age of the biological mother.

9.1.3 The midwife should establish whether the surrogate mother is married. If she is married then she and her husband hold parental responsibility until the legal process of transfer PR is complete.

9.1.4 If the surrogate mother is not married the midwife should establish that the (commissioning donor) father is registered on the baby's birth certificate when the baby is born. Only then will he hold parental responsibility.

9.1.5 The midwife should notify the health visitor and GP of the baby's status as above so that any consents required will be requested from the person holding parental responsibility (see section 5 & 6). This is particularly important for the early immunisations which are due before the legal process may have been finalised or if the baby requires immediate/ early surgery or treatments.

9.1.6 It may be relevant for the midwife to complete safeguarding information paperwork.

9.1.7 It is important to recognise that the Trust's duty of care is to the Surrogate Mother. The Trust owes no duty to the commissioning parent(s). All applicable antenatal care should be provided to the Surrogate Mother in the usual way. The commissioning parent(s) can be involved in this process provided that the Surrogate Mother consents to this" and "The Surrogate Mother has the right to make all decisions relating to her antenatal care. It is important to remember that the child is not recognised as a "person" until birth and therefore, the rights of the mother should take precedence over the interests of the unborn child.

9.2 **Medical Staff / Nursing and Midwifery**

9.2.1 When a baby is to be discharged and transferred to the commissioning parents who live in another part of the country, staff should ensure that the health staff in the new area are aware of the status of the baby and that there is full communication with the new area midwife and health visitor.

9.2.2 If any staff identify that the due legal process has not been followed they should notify the police.

9.2.3 If any staff have concerns for the safety or welfare of the baby they must follow the Sussex Safeguarding and Child Protection Procedures and make a referral to the appropriate local Children's Social Care and notify the Safeguarding Children's Named Doctor/ Nurse/Midwife.

10 Mental Capacity of the Surrogate Mother to make decisions

Should staff have any concerns regarding the mental capacity of the Surrogate Mother to make decisions about her pregnancy, a formal assessment of capacity should be performed (staff are advised to follow the Trust's consent policy). In the event that the Surrogate Mother lacks capacity to make a particular decision, treatment should be given having regard to the best interests of the Surrogate Mother – however, staff are advised to consult the Trust's Lead on the Mental Capacity Act prior to administering non-emergency treatment in such circumstances.

11 What if the Surrogate Mother Changes her Mind?

If the Surrogate Mother changes her mind and wishes to keep the baby, the Trust must respect her wishes. In this situation, the Courts will usually allow her to keep the baby. If there is disagreement between the Surrogate Mother and the commissioning parent(s), the Lead for Safeguarding Children should be contacted.

12 What if the Child becomes ill and is in need of treatment?

Where possible, decisions about the baby's treatment should be made jointly, by the Surrogate Mother and the commissioning parent(s) in conjunction with the health professionals. In most circumstances, the Surrogate Mother will hand over responsibility to the Intended Parents on an informal basis, at birth. However, the Surrogate Mother remains legally responsible for the baby until a Parental Order has been confirmed or the baby has been legally adopted by the commissioning parent(s). The commissioning parent(s) have no legal rights over the baby until this time.

13 Equality and Human Rights Statement

The Trust recognises the diversity of the local community and those in its employment. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriate to their need.

14 References

Brazier Report: Surrogacy: Review For Health Ministers Of Current Arrangements For Payments And Regulation. DH 1998

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/684275/surrogacy-guidance-for-intended-parents-and-surrogates.pdf

Human Fertilisation and Embryology Authority. Code of Practice http://www.hfea.gov.uk/code.html

Surrogacy UK http://www.surrogacyuk.org/ http://www.surrogacyuk.org/Downloads/Guide_to_Surrogacy_UK_for_Healthcare_Professionals.pdf

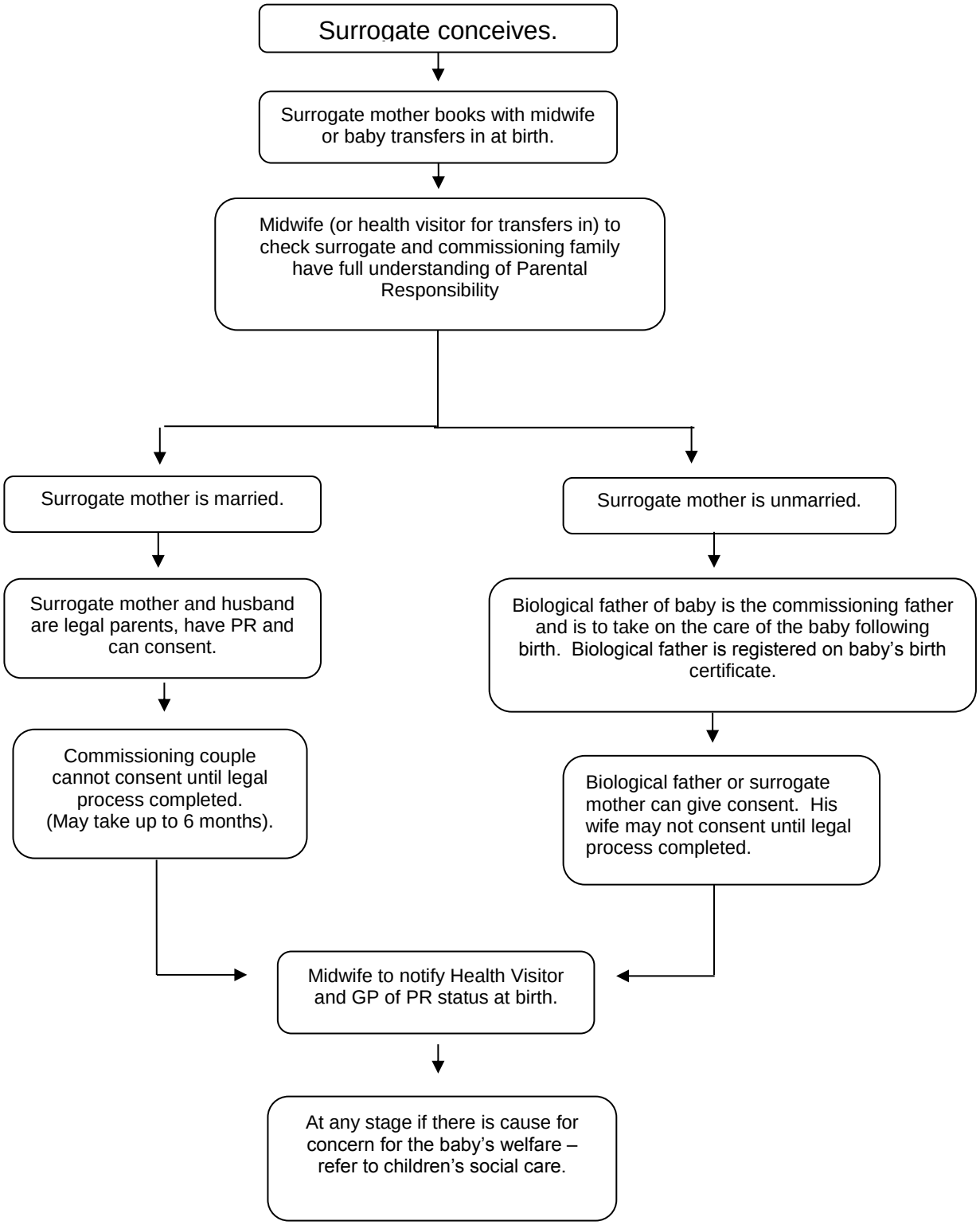
www.hfea.gov.uk/399.html#guidanceSection3945: Legal parenthood: surrogacy **Appendix**

COTS Surrogacy in the UK. www.surrogacy.org.uk

The Adoption & Children Act 2002

Reame, N E & Parker, P J (1990) surrogate pregnancy: clinical features of 44 cases. American Journal of Obstetrics and Gynecology 16(2): 1220-1225 Civil partnership act 2004

15 Appendix A – Flowchart: Staff Responsibilities in Surrogacy



16 Appendix B: Surrogacy Checklist

Booking appointment or when clinician becomes aware of surrogacy			
Date Documentation related to surrogacy commenced			
Surrogate mother is married		Yes	No
Names of the commissioning parents			
Who are the biological parents for screening purposes			
Is there a children's guardian allocated?		Yes	No
HV informed of the surrogacy		Yes	No
GP informed of the surrogacy		Yes	No
At birth & postnatal			
The surrogate mother is cared for as per routine postnatal care guidelines.			
As the Surrogate Mother is the legal mother at birth, the baby cannot be removed from the hospital by the commissioning parent(s) without her consent.			
Does the surrogate mother agree the commissioning parents can visit/stay? (record in the notes)		Yes	No
Does the surrogate mother delegate responsibility for the child to the commissioning parents … record in the notes		Yes	No
Staff should ensure they have written consent from the Surrogate Mother before handing over the baby and that this is done, wherever practicable, in the presence of the Surrogate Mother and the commissioning parent(s).		Yes	No
The commissioning parent(s) presence on the ward should then be recorded in the ward day book. If this is not possible, owing to capacity, the baby will be transferred for care in TMBU /SCBU where the commissioning parent(s) may visit in place of the surrogate mother.		Yes	No
If the surrogate mother is not married the midwife should establish that the (commissioning donor) father is registered on the baby's birth certificate when the baby is born so he can have parental responsibility.		Yes	No
HV informed of the birth		Yes	No
GP informed of the birth		Yes	No
Check address where baby is being taken to so the new HV/GP can be alerted.		Yes	No
The commissioning mother and baby are notified to the appropriate community midwife, health visitor and G.P.		Yes	No
New address			
The handover should take place outside of the maternity unit and no maternity staff should be involved with the handover, other than providing follow up care to the mother and baby after they return home.			