***Jennings v HFEA* [2022] EWHC 1619 (Fam) Case Commentary: Schrödinger's Complete Consent Forms**

INTRODUCTION

Assisted reproductive technology (ART) has facilitated the creation of diverse family forms, allowing many to create the family forms they desire, while simultaneously generating new understandings of reproduction, parenthood and family. Advances in cryopreservation have in turn radically changed the delivery of ART, providing those seeking fertility treatment with increased flexibility with regards to when and how they reproduce. Cryopreservation[1] has also allowed for the birth of a child whose genetic parent(s) are deceased. The possibility of posthumous reproduction raises many of the most challenging, difficult and sensitive legal and ethical issues encountered in reproductive medicine.[2]

The UK was the first jurisdiction to introduce a regulatory scheme for ART, comprised of the Human Fertilisation and Embryology Act 1990 (HFE Act 1990) and the establishment of the Human Fertilisation and Embryology Authority (HFEA). The HFE Act 1990 remains one of the most extensive and detailed legal frameworks governing ART, frequently identified as the 'gold standard' for other jurisdictions.[3] The HFE Act 1990, as amended by the Human Fertilisation and Embryology Act 2008 (HFE Act 2008), regulates, *inter alia*, the storage, use and export of gametes and embryos.

Effective consent and concern for the welfare of the putative child are considered the 'twin pillars' of the regulatory framework established by the HFE Acts.[4] Schedule 3 of the HFE Act 1990 outlines the requirements for effective consent to fertility treatment:

> An embryo the creation of which was brought about *in vitro* must not be used for any purpose unless there is an effective consent by each relevant person in relation to the embryo to the use for that purpose and the embryo is used in accordance with those consents.[5]

Paragraph 2(1)(b) of Schedule 3 requires the provision of consent to specify the use of gametes or embryos in providing treatment services to persons not including the person giving consent, as in a surrogacy arrangement. Paragraph 6(2) stipulates that embryo transfer to a surrogate may not occur 'unless there is an effective consent by

[1] Cryopreservation is a method of storing live cells and other biological samples at very low temperatures for later use.
[2] Gulam Bahadur, 'Death and Conception' (2002) 17 Hum Reprod 2769, 2769.
[3] Robert H Blank, 'The United Kingdom: Regulation through a National Licencing Authority' in Ivar A Bleiklie, Malcolm L Goggin and Christine Rothmayr (eds), *Comparative Biomedical Policy: Governing Assisted Reproductive Technologies* (1st edn, Routledge 2004) 120; Sarah Franklin and Celia Roberts, *Born and Made: An Ethnography of Preimplantation Genetic Diagnosis* (Princeton University Press 2006) 40.
[4] *Leeds Teaching Hospital NHS Trust v A* [2003] EWCA 259 (QB) para 20; *Natalie Evans v Amicus Healthcare Ltd, Howard Johnston, Royal United Bath Hospital NHS Trust, The Secretary of State for Health, the Human Fertilisation and Embryology Authority. Lorraine Hadley v Midland Fertility Services, Wayne Hadley, the Secretary of State for Health, the Human Fertilisation and Embryology Authority* [2003] EWHC 2161 (Fam), [2004] 1 FLR 67 at para 37; *Natalie Evans v Amicus Healthcare Ltd and Others (Secretary of State for Health intervening)* [2004] EWCA (Civ) 727 at para 21; also Sally Sheldon, 'Evans v Amicus Healthcare; Hadley v Midland Fertility Services—Revealing cracks in the "twin pillars"?' (2004) 16 CFLQ 437.
[5] Human Fertilisation and Embryology Act 1990 Schedule 3, para 6(3).

each relevant person in relation to the embryo.' Paragraph 1(1) states that any consent under Schedule 3 'must be in writing and … signed by the person giving it.'[6]

Until recently, most posthumous assisted reproduction cases concerning a lack of consent were initiated by widows (seeking posthumous retrieval/use of their deceased husbands' sperm) or parents wanting to use their deceased child's gametes in fertility treatment. These cases include *R v Human Fertilisation and Embryology Authority, ex parte Blood*,[7] *L v Human Fertilisation and Embryology Authority*,[8] *Y v A Healthcare Trust*,[9] and *R (on the application of M) v Human Fertilisation and Embryology Authority*.[10] *Jennings v Human Fertilisation and Embryology Authority*[11] is a landmark case, as it marks the first time a male applicant has initiated a posthumous assisted reproduction case, seeking court permission for a surrogacy arrangement involving the use of an embryo created with his deceased wife's gametes in a situation where she had not provided written consent for this antemortem. The question at the heart of this case was whether written and signed consent by the person giving it was necessary to satisfy the requirements listed in Schedule 3 of the HFE Act 1990.

This commentary argues that the requirement for effective consent to be 'written and signed' is a legal formality, rather than a necessary requirement for accessing fertility treatment, including posthumously. As such, the realist approach adopted by Theis J in *Jennings* was correct and did not 'go against the grain'[12] of the legislation. First, we present the relevant facts of the case at hand. Second, we differentiate *Jennings* from previous posthumous reproduction cases. From here, we demonstrate how the purposes for which consent is required—that is, respecting autonomy and ensuring the lawfulness of the provided treatment—can be satisfied even where consent is unwritten and unsigned, albeit in very limited circumstances.

A. BACKGROUND

Ted Jennings (J) and his wife, Fern-Marie Choya (C), married in 2009 and after experiencing difficulties conceiving, they underwent three unsuccessful *in vitro* fertilisation (IVF) cycles between 2013-2014, using embryos created from their own gametes.[13] In 2016, two spontaneous pregnancies ended in miscarriages. In 2018, the couple undertook their final IVF cycle together. C underwent a single embryo transfer and was expecting twins when, in February 2019, she died unexpectedly from a uterine rupture at 18 weeks' gestation. As the couple had one cryopreserved embryo left in storage, J sought a declaration from the court that it would be lawful for him to use the remaining embryo in a surrogacy arrangement.

[6] Paragraph 1(2) allows exceptions in the absence of capacity, where consent may be signed *at the direction of the person unable to sign* (our emphasis).
[7] *R v Human Fertilisation and Embryology Authority, ex parte Blood* [1997] 2 All ER 687.
[8] *L v Human Fertilisation and Embryology Authority* [2008] EWHC 2149.
[9] *Y v A Healthcare Trust* [2018] EWCOP 18.
[10] *R (on the application of M) v Human Fertilisation and Embryology Authority* [2016] EWCA Civ 611.
[11] *Jennings v Human Fertilisation and Embryology Authority* [2022] EWHC 1619 (Fam).
[12] *Ghaidan v Godin-Mendoza* [2004] UKHL 30.
[13] The relevant facts are set out in *Jennings*, n 11 above, from [7].

Prior to their final treatment, J and C were given a set of consent forms to complete, including internal clinic forms and HFEA proforma forms. C completed the HFEA WT consent form and J completed the HFEA MT consent form.[14] J's MT consent form recorded his consent to their embryo's use in C's treatment in the event of his death; C would have been able to have their embryo transferred into her, since he had consented to the posthumous use of his genetic material.

Crucially, at the time, the MT form asked directly whether the person whose sperm was used in fertility treatment would consent to their stored sperm or embryos being used after their death—presumably this had been included in response to earlier cases discussed below. However, unlike the MT form, the WT consent form did not provide any opportunity for C to consent to the use of a partner-created embryo for J's continuing treatment (which would necessarily entail a surrogacy arrangement) if she died. Instead, section 6.2 of the WT form that she signed stated that, depending on the circumstances, an additional form would need to be completed and advised patients to speak to their clinic for more information. It did this in a section titled 'other uses' (meaning other than for training purposes) and did not specifically or clearly mention a male partner posthumously accessing surrogacy. J argued that C was not provided with the relevant information or opportunity to provide the necessary written consent for *his* use of the embryo in the event of her death. Additionally, the HFEA Code of Practice in place at the relevant time had not outlined that clinics should inform women of the need to complete additional forms in order for their partner to be able to use jointly-created embryos in the event of their death.[15] J argued that the court could infer that had C been informed and offered the additional HFEA WSG form,[16] she would have provided her written consent to the posthumous use of their embryo in treatment with a surrogate. C's consent was not recorded in writing due to the lack of opportunity arising from the lack of clarity in the HFEA forms and the clinic's failure to provide the additional relevant information. J also claimed that his rights to private and family life under Article 8 of the European Convention on Human Rights (ECHR) were engaged and that being prevented from using the remaining embryo constituted significant interference with this right.

The HFEA opposed the declaration sought, maintaining that C had not provided effective written consent at the relevant time to allow for the couple's remaining embryo to be used by J in a posthumous surrogacy arrangement. The HFEA submitted that C had sufficient information and opportunity to provide that written consent, while simultaneously acknowledging that their WT form alone did not allow for C to consent to the posthumous use of her embryos created by J. Their submission—that there was

[14] The WT form is signed by a person who is having fertility treatment using embryos created outside the body (in vitro) with their eggs. The MT form is signed by a person whose partner is having fertility treatment using embryos created outside the body with their sperm. The WT and MT forms supposedly demonstrate informed written consent for the use and storage of sperm, eggs and embryos in those contexts and give those signing the opportunity to outline what they would want to happen those eggs, sperm or embryos if they die or become mentally incapacitated.
[15] Human Fertilisation and Embryology Authority, *Code of Practice* (8th edn, 2009).
[16] The form that records consent to the use of embryos (created outside the body with the eggs of the signatory) in a surrogacy arrangement. As the couple was not contemplating surrogacy at the time that they were undergoing IVF themselves, it was unlikely that giving consent for the embryos use in surrogacy would have occurred to C.

the opportunity to provide consent despite the relevant form not allowing for this consent to be recorded—makes the situation sound rather like Schrödinger's Complete Consent Forms. As explained above, the WT form that C signed only briefly mentioned 'other uses' for gametes and embryos as an afterthought, as seen in ***Figure 1***, below.

Following *Jennings*, in August 2022, the HFEA updated its consent forms, including the WT form. The updated WT form now includes an expanded section on the posthumous use of gametes and embryos, separating out their potential use in a partner's treatment—specifically mentioning surrogacy—from training purposes. As can be seen from ***Figure 1***, the updated form requires the individual filling in the form to acknowledge the need to fill out additional forms and speak with the clinic.

6.2 **Do you consent to embryos (already created outside the body with your eggs) being used for training purposes?**

Please note that embryos can only be used if the sperm provider has also given his consent.

If you die Yes No

If you become mentally incapacitated Yes No

Other uses for your eggs or embryos

If you wish your eggs or embryos to be used in someone else's treatment if you die or become mentally incapacitated, please speak to your clinic for more information. Depending on your circumstances, you will need to complete one of the following: • 'Your consent to donating your eggs' (WD form), • 'Your consent to donating embryos' (ED form), • 'Your consent to providing eggs or embryos created with your eggs for your partner's treatment' (WPT form), or • 'Women's consent to the use and storage of eggs or embryos for surrogacy' (WSG form).

(a)

6.2 **In the event of your death, do you consent to your embryos being used and stored for your partner's treatment?**

You should be aware that embryos can only be used if the sperm provider (your partner or sperm donor) has also given consent.

If treatment would involve a surrogate, then additional consent forms and screening tests **must** have been completed before you die to allow treatment to take place. It is important to speak to your clinic about this.

Yes No

If you have answered 'yes', indicate how long you consent to storage of your embryos after your death:

For 10 years from the date of your death, or

For a shorter period - specify the number of years (not exceeding 10 years after your death):

(b)

Figure 1: HFEA WT forms (a) from 2021 (b) from August 2022

Additionally, the HFEA issued a General Direction, used where there has been a change in procedure, with this version on consent indicating that additional steps must be taken (and additional forms competed) should the person signing the form contemplate that they might wish their embryos to be used by their partner in the event of their death was also provided.[17] Should a patient wish to do so, additional costs are incurred, as consent to the use of embryos in a surrogacy context (or transfer to a female partner) requires additional screening (as donors).

Theis J disagreed with the HFEA and noted that had the need to complete additional forms and/or undergo additional screening to ensure that the embryo could be used in

[17] Human Fertilisation and Embryology Authority, *Directions Given Under the Human Fertilisation and Embryology Act 1990 (As Amended) — Consent* (Ref 0007, Version 12 (1 August 2022)).

the event of her death been pointed out to C at the time of her treatment, she would have plainly agreed. It was not made clear on the WT form at the time what exactly would be required. Thus, C's lack of consent was due to the lack of relevant information and/or a sufficient opportunity to discuss it with the clinic.[18] With regards to posthumous surrogacy, Theis J found that C's consent could be inferred: 'if that opportunity had been given, that consent by that person would have been provided in writing.'[19] On the Article 8 claim, Theis J agreed J's right had been interfered with in the circumstances where such consent was inferred, and that the interference was 'significant, final and lifelong'.[20]

B. PRECEDENT

Until *Jennings*, disputes pertaining to a lack of consent to posthumous assisted reproduction had been brought by widows seeking posthumous retrieval of their deceased husbands' sperm or parents wanting their deceased child's gametes to be used in fertility treatment. *Jennings* may be differentiated from these previous cases for two main reasons:

(1) There was no gamete retrieval sought, as the embryo concerned was already created.
(2) The applicant is a widower requiring the assistance of a surrogate.

In November 1996, one of the pioneers of IVF, Professor Lord Robert Winston, introduced a Private Member's Bill into the House of Lords, to afford some discretion with regards to consent. The Human Fertilisation and Embryology (Amendment) Bill aimed to relax the requirement for written consent in certain, albeit unspecified, circumstances, however, it did not receive government support. A few short months later, the absence of written consent for gamete retrieval and export were the subject-matter in *R v Human Fertilisation and Embryology Authority, ex parte Blood*.[21] At Diane Blood's request, sperm was retrieved from her comatose husband, without his formal written consent. While section 4(1)(b) of the HFE Act 1990 provided an exception to the requirement for formal written consent—where sperm was used in treatment services for the benefit of the couple together—the HFEA countered that posthumous use of her husband's sperm would be akin to the use of donor sperm, and thus required written consent. Accordingly, the use of his sperm would be unlawful under the HFE Act 1990 and Diane Blood requested permission not to use the sperm in the UK, but to export the frozen sample to Belgium under Articles 59 and 60 of the Treaty establishing the European Economic Community (EC Treaty) for use in her fertility treatment. The Court of Appeal ruled in her favour, and Diane Blood was granted an export license by the HFEA,[22] allowing her to use the sperm and have two children.

[18] *Jennings* (n 11), para 90.
[19] Ibid, para 104.
[20] Ibid, para 102.
[21] *Blood* (n 7).
[22] HFE Act 1990 s 24(4).

In February 1997, responding to the media frenzy surrounding *Blood*, then-Health Minister Tessa Jowell announced a review of the consent provisions encompassed within the HFE Act 1990.[23] She noted that, despite Parliament's intention that the HFEA exercise discretion, '[a] straitjacket [had] been created where none was intended.'[24] Professor Sheila McLean undertook this review, considering the 'quality' of various forms of consent and their underpinning legal and philosophical assumptions.[25] This review recommended that the provisions of HFE Act 1990 requiring written consent for the use of gametes should remain in force and unchanged, as the Act's 'requirement for written consent, therefore, needs to be seen in the light of what it is that the Act is actually capable of controlling or designed to cover.'[26] McLean went on to argue that as posthumous reproduction could not be seen as life-saving or preventing a deterioration in health, 'it seems unlikely that it would fall within the necessity exception to the general rules of consent.'[27]

In 2003, the House of Commons Science and Technology Committee scrutinised the HFE Act 1990,[28] and two years later, in 2005 the Department of Health undertook a public consultation exercise on possible changes to the law. The Department of Health published a report in 2006 detailing policy proposals for the Government to present to Parliament.[29] This led to the 2008 reforms to the HFE Act, introduced to update and ensure the regulatory framework remained 'fit for purpose'.[30] The requirement for written consent was considered, and ultimately it was decided that:

> The Government has considered whether these requirements remain an appropriate matter for the law, and has concluded that they provide a clear and valuable protection of the wishes of patients and donors.[31]

As a result, despite implementing other reforms to the 1990 Act, the HFE Act 2008 retained the need for written consent from gamete providers, without alternative forms suggested and no exceptions to consent permitted. In part, this approach was due to the McLean Review's conclusion that the provisions for written consent for the use of gametes should remain in force.

Nearly a decade after *Blood*, in *L v Human Fertilisation and Embryology Authority*[32] similar facts arose. Again, the claimant's late husband had not provided written consent for the posthumous use of his gametes, such that exporting the sample was necessary. Though Charles J was not satisfied 'that it would be possible to lawfully remove, or authorise the removal of, gametes from a dead person (who has not given

[23] HC Deb, 30 October 1996, vol 284: Human Fertilisation and Embryology Authority col 599.
[24] Ibid col 600.
[25] Sheila A. M. McLean, 'Post-mortem human reproduction: legal and other regulatory issues' (2002) 9 J Law Med 429.
[26] Sheila A. M. McLean, 'Consent and the Law: Review of the Current Provisions in the Human Fertilisation and Embryology Act 1990 for the UK Health Ministers' (1997) 3 Hum Reprod Update 593 para 6.17
[27] Ibid para 9.16.
[28] Science and Technology Committee, *Developments in Human Genetics and Embryology: Fourth Report of the Science and Technology Committee, Session 2001-02* (HC 791, 2002)
[29] Department of Health, Review of the Human Fertilisation and Embryology Act: Proposals for revised legislation (including establishment of the Regulatory Authority for Tissue and Embryos) (Cm 6989, 2006).
[30] Ibid foreword by Caroline Flint MP, then-Parliamentary Under Secretary of State for Public Health.
[31] Ibid para 2.28.
[32] *L v HFEA* (n 8).

an effective advance consent to this),' he made a substituted judgment that the deceased 'would have agreed' to the posthumous use of his sperm based on the widow's statement.[33] This inference was made on the basis that the claimant and the deceased had discussed their desire for another child with friends, had taken professional advice less than a week before his death, and the deceased had mentioned IVF. Furthermore, the deceased's family supported the claimant's use of his gametes to have another child.[34]

In 2018, *Y v A Healthcare Trust*[35] was a reported Court of Protection case dealing with an application to retrieve and store the sperm of a dying man (Z) who had suffered a catastrophic brain injury and severe internal injuries following a motorcycle accident, despite Z not providing specific consent for this. The application was made by his wife (Y), with whom he had already had one child. Evidence showed that they had struggled to conceive a second child and had begun the process of seeking fertility treatment, including completing clinic consent forms and having a conversation about the posthumous use of Z's sperm should the need arise, prompted by said forms. Sympathy for the claimant, who had told the court that not allowing her claim '"would leave an irreplaceable hole" in her life, the life of her son and the lives of their family',[36] was also evident, allowing the order to be granted to reflect the dying man's best interests. Knowles J allowed Y's application, saying:

> Z lacked capacity to provide his written consent for fertility treatment for the purposes of the 1990 Act, such written consent being required for the storage and use (but not for the retrieval) of his gametes. Notwithstanding that Z lacked capacity, I declared that it was lawful for a doctor to retrieve his gametes and lawful for those gametes to be stored both before and after his death on the signing of the relevant consents [for] storage and use and that it was lawful for his gametes and any embryos formed from his gametes to be used after his death.[37]

In the aforementioned cases, the courts were presented with a *fait accompli*; further interference with the widows' reproductive autonomy was perhaps therefore not justifiable. Notwithstanding the requirement in the HFE Act 1990 to assess the welfare of the child which until 2008 required clinics to consider the child's 'need for a father,'[38] the claimants in these cases were able to use their deceased partners' sperm to have children as part of their joint parenthood project. Reflecting on *Blood*, Hazel Biggs noted how Diane Blood was constructed by the media and judicial system as the epitome of a "good" mother, with a distinct focus on how she would 'be the perfect

[33] Ibid at paras 33, 158, 161.
[34] Ibid, para 33. Note that shortly after *L*, another case involving a widow's posthumous use of her deceased husband's sperm made headlines BioNews, 'Woman conceives IVF baby using dead husband's sperm' (*BioNews—Progress Educational Trust*, 2004) <https://www.progress.org.uk/woman-conceives-ivf-baby-using-dead-husbands-sperm/> accessed 14 March 2023.
[35] *Y v A Healthcare Trust* (n 9).
[36] Ibid, para 10.
[37] Ibid, para 27.
[38] HFE Act 1990 s 13(5). Note this was a much criticised requirement: see eg: Emily Jackson, 'Rethinking the Preconception Welfare Principle' in Kirsty Horsey and Hazel Biggs (eds), *Human Fertilisation and Embryology: Reproducing Regulation* (Routledge Cavendish 2006) 47-67.

mother [with] no question as to her right to bear the child of her dead husband.'[39] Widowhood is highly gendered,[40] thus the question of women's posthumous use of their husband's gametes is 'particularly emotive, as it brings together states which are normally apart in the life course (motherhood and widowhood).'[41]

While interference with widows' reproductive autonomy required a high burden of proof, the same cannot be said with regards to widowers. As mentioned above, a second fundamental difference between these cases and *Jennings* is that the women claimants would be the ones receiving fertility treatment – and becoming mothers— unlike the applicant in *Jennings*, who requires a surrogate to be able to use the couple's remaining embryo. Posthumous use of gametes requiring the use of a surrogate is not novel to the courts, having arisen previously in three English cases. However, these cases reflected the *parents* of the deceased wanting to use their child's gametes in fertility treatment, purportedly in order to fulfil their children's evidenced parenthood project.

R (on the application of M) v Human Fertilisation and Embryology Authority,[42] the world's first posthumous grandchild case, is one example. There, the parents of a deceased woman sought the HFEA's permission to export their daughter's frozen eggs to the US, to be fertilised with donor sperm to create embryos that would be transferred into the grand/mother's womb. Their daughter had been diagnosed with cancer aged 21, and had wanted to undergo IVF treatment. Though she was too ill to do so, she underwent removal and cryopreservation of three eggs, which she described as '[going] through the IVF to save [her] eggs.'[43] Her mother had suggested she act as her daughter's surrogate, and the daughter 'accepted this with gratitude.'[44] The HFEA rejected the request, and in a judicial review of the decision, the High Court held that decision to be lawful and rational. Ouseley J distinguished the case from *Blood*, pointing to a lack of '*sufficiently* informed consent.'[45]

On appeal, Arden LJ held that the HFEA's decision was flawed considering evidence indicating that the deceased had in fact wanted her mother to carry her genetic child posthumously and to bring it up as her grandchild. Deciding in favour of the grand/parents, Arden LJ stated 'there is nothing in law to prevent [the HFEA] from making appropriate inferences from the evidence or on the basis of the inherent probabilities of the case.'[46] Despite the unlawfulness of accessing *treatment* in the UK, informal conversations between the deceased and family members could be 'cobbled

[39] Hazel Biggs, 'Madonna Minus Child. Or — Wanted: Dead or Alive! The Right to Have a Dead Partner's Child' (1997) 5 Fem Legal Stud 225, 230-34.
[40] Glennys Howarth, '"Just live for today": Living, caring, ageing and dying' (1998) 18 Ageing Soc 673, 684.
[41] Bob Simpson, 'Making "Bad" Deaths "Good": The Kinship Consequences of Posthumous Conception' (2001) 7 JRAI 1, 12.
[42] *Mr & Mrs M v HFEA* (n 10).
[43] Ibid, para 13.
[44] Ibid, para 9.
[45] *R (on the application of IM and MM) v Human Fertilisation and Embryology Authority* [2015] EWHC 1706 (Admin), para 79 (emphasis added).
[46] *Mr & Mrs M v HFEA* (n 10), para 73.

together' as evidence of a wish to export gametes abroad for posthumous conception, with her mother acting as a surrogate.[47]

Much like the widows' cases discussed above, individual autonomy was favoured over the second pillar of the regulatory framework, concern for the welfare of the child. In the High Court, Ouseley J noted that the HFEA:

> did not reach its decision on the basis of any adverse view about the mother carrying her daughter's fertilised egg through pregnancy to birth, nor, save in relation to [the deceased daughter's] understanding of the risks to her mother, about the mother's age, now 58. Nor did it reach its decision forming any adverse view about the welfare or upbringing of any future child.[48]

As the grand/mother was 58, she was unable to access treatment in HFEA-licensed clinics,[49] thereby requiring the frozen eggs to be exported to allow for their use. Though there is no legally imposed upper age limit for receiving fertility treatment in the UK, clinics impose their own limits, usually around menopause. In part this is due to the second 'twin pillar' of the HFE Acts—concern for the welfare of the putative child. The 2008 reforms to the HFE Act amended the wording from 'need for a father' to the need for 'supportive parenting.'[50] It is often not considered to be in a child's best interests to be born to parents who are less likely to survive as the child reaches adulthood.[51] Despite this, there are no upper age limits for adoption orders or Parental Orders within the UK's legislative schemes; indeed, in the Joint Law Commissions' Final Report on surrogacy, they note that 'age is not an effective way of seeking to protect the wellbeing of the child,' and propose that while there should not be an upper age limit for intended parents, age should be factored into the welfare of the child assessment.[52]

In contrast, *Jennings* does not give rise to concern for the welfare of the putative child—in principle—in light of policy decisions and previous cases dealing with solo parents through fertility treatments. For example, only a few years previously, notwithstanding potential concern arising from the fact that the child would be "motherless" *Re Z (A Child) (No 2)*[53] resulted in a 2018 Remedial Order inserting a new section 54A into the HFE Act 2008, allowing single individuals to apply for Parental Orders following surrogacy, and ensuring the 2008 Act was compatible with the ECHR.[54] Furthermore, Theis J had already been responsible for many of the

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[47] Ibid, para 84.
[48] *IM and MM v HFEA* (n 45), para 5.
[49] Human Fertilisation and Embryology Authority, *Code of Practice* (9th end, rev Jul 2022)
[50] Human Fertilisation and Embryology Act 2008 s 14, amending HFE Act 1990 s 13(5).
[51] See e.g., coverage of Patricia Rashbrook; BioNews, 'UK woman will have baby at 63' (*Progress Educational Trust— BioNews*, 5 May 2006) <https://www.progress.org.uk/uk-woman-will-have-baby-at-63/> accessed 13 March 2023; also see *Dickson v the United Kingdom* 46 EHRR 41, where concern for the welfare of the child was due in part to the putative parent's advanced age (51) was deemed a legitimate concern.
[52] Law Commission, *Building Families Through Surrogacy: A New Law; Volume II: Full Report* (HC 1237, SG/2023/77, Law Comm No 411, Scot Law Com No 262, 2023) para 6.80.
[53] *Re Z (A Child) (No 2)* [2016] EWHC 1191 (Fam).
[54] Human Fertilisation and Embryology Act 2008 (Remedial) Order 2018.

"progressive" surrogacy cases seen in recent years, adopting a purposive reading of the relevant legal framework.[55]

Looking at posthumous assisted reproduction cases, judges have been more sympathetic where the applicants are potential mothers wanting to continue a joint parenthood project as widows. In these cases, interference with reproductive autonomy is not deemed justifiable, and requires a higher burden of proof. It may have been assumed that the matrifocal nature of legal parenthood and the need for someone to give birth may have played some part, however *Jennings* demonstrates that in reality, judges' sympathy hinges on the presence of *evidenced* parenthood projects, as well as some evidence of posthumous consent.

C. INFORMATION PROVISION

In *Jennings*, Theis J held: 'the reference to written consent is an evidential rule with the obvious benefits of certainty but it is not inviolable.'[56] Indeed, as the previous section demonstrates, where 'judicial sympathy is engaged, judicial creativity may be able to circumvent a literal statutory interpretation.'[57] This section focuses on how surveying the relevant case law, in cases of posthumous assisted reproduction, a lack of written and signed consent has been interpreted as a lack of *opportunity* or a lack of relevant information. This is because the purposes for which consent is required—respecting autonomy and ensuring the lawfulness of the provided treatment—are still satisfied even where consent is unwritten.

Posthumous reproduction only follows from procreative autonomy if posthumous reproduction implicates the same interests, values, and concerns that reproduction entails; otherwise put, establishing whether deceased individuals are autonomous. Some argue that death 'extinguishes autonomous decision-making'[58]: a deceased person is no longer able to pursue any goals or engage in any act of self-determination. For example, Harris argues that

> Autonomy involves the capacity to make choices, it involves acts of the will and the dead have no capacities – they have no will, no preferences, wants nor desires, the dead cannot be autonomous and so cannot have their autonomy violated. [59]

Alternatively, Conway argues autonomy can be violated after death. Though the deceased are unable to exercise choice, recognising their interests and choices regarding posthumous events adheres to their autonomy, by permitting people to

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[55] See for example: *Re N (Surrogacy: Enduring Family Relationship; Child's Home)* [2019] EWFC 21; *W v Y* [2021] EWFC 119; *Re Z (A Child)* [2022] EWFC 18; *X v Z (Parental Order: Adult)* [2022] EWFC 26; Sarah Jane Toledano and Kristin Zeiler, 'Hosting the Others' Child? Relational Work and Embodied Responsibility in Altruistic Surrogate Motherhood' 18 Feminist Theory 159

[56] *Jennings* (n 11), para 101.

[57] Anne Morris and Sue Nott, 'Rights and Responsibilities: Contested Parenthood' (2009) 3 JSWFL 3, 9. This has been evidenced in several surrogacy cases where aspects of ss 54, 54A have been circumvented in judgments, where it would be in the best interests of the child to do so, as discussed above at fn 55.

[58] Alison Douglass and Ken Daniels, 'Posthumous Reproduction: A Consideration of the Medical, Ethical, Cultural, Psychosocial and Legal Perspectives in the New Zealand Context' (2002) 5 Med L Int'l 259, 266.

[59] John Harris, 'Law and the Regulation of Retained Organs: The Ethical Issues' (2002) 22 Leg Stud 527, 531.

express their own character and values in a posthumous context (as we see with wills).[60]

A stronger sense of respecting autonomy involves contributing, when possible, to the attainment of autonomously chosen goals, and as the dead cannot accomplish their own goals, respecting their autonomy requires the living to do so in their place,[61] using any evidence to piece together their desired ambitions. Following on from this, where a person focused 'on the possibility and found sufficient meaning in reproducing after death,'[62] then the lack of formally written consent should not hinder their autonomy, where there is evidence of their wishes.

That certain actions must be documented in writing and signed serves various functions: it identifies the signatory, it indicates the signatory's intention to be bound to the contents of the document, and it provides a written record should a dispute arise. When performed for legal reasons, the meaning of the signature is irreducible to what is written, and must be understood within the context of the act of writing.[63] However, judges have also pragmatically interpreted consent to ensure that a lack of signature on one of the proforma HFEA forms does not impede a couple's posthumous reproductive wishes, as evidenced by the Scottish case *B v University of Aberdeen*.[64] This case differs from *Blood* and *L*, first, because the sperm was already in storage and the couple had been undergoing fertility treatment and second, the deceased had inserted a clause into his will to provide his widow with his 'donation of sperm … for as long as possible, and for as long as she may wish.'[65] The question was whether this satisfied the requirements of Schedule 3 of the HFE Act 1990. The Inner House reached the decision that the will, either alone or alongside the other completed HFEA forms, satisfied the requirements for consent.

In *Y*, Knowles J stated:

> The consent provisions are carefully drawn for sound public policy reasons, namely that consent is central to effective regulation in this area. They are couched in the imperative for that very reason.[66]

In *Warren v Care Fertility (Northampton) Limited and Other*,[67] a deceased man had consented to the storage of his sperm, and it was his recognised wish and intention the sample should be stored beyond the ten-year storage period. As he had been diagnosed with a brain tumour and received radiotherapy, resulting in his premature infertility, his gametes could be stored for up to 55 years. However, the clinic had not advised him of the formal steps needed to ensure lawful extended storage of his sample. Hogg J ruled in favour of the widow, having 'no doubt that had [the deceased]

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[60] Heather Conway, *The Law and the Dead* (Routledge 2016) 146.
[61]John A Robertson, 'Posthumous Reproduction' (1994) 69 Ind L J 1027, 1031.
[62] Ibid 1033.
[63] Trish Luker, 'Law's signature acts' in Katherine Biber, Trish Luker and Priya Vaughan (eds), Law's Documents: Authority, Materiality, Aesthetics (Routledge 2021) 138, 140.
[64] *B v University of Aberdeen* [2020] CSIH 62
[65] Ibid at para 7.
[66] *Y v A Healthcare Trust* (n 9), para 16.
[67] *Warren v Care Fertility (Northampton) Limited and Other* [2014] EWHC 602 (Fam).

had the relevant information and the opportunity he would have consented to a period beyond 10 years.'[68]

The HFE Act does not specify what information must be provided for effective consent, nor does it require a person receive *all* relevant information in the abstract.[69] Instead, the Act specifies that a person must receive 'such relevant information as is proper,' and provision of 'proper counselling about the implications of taking the proposed steps.'[70] An analogy with what information is required for consent to medical treatment more broadly may be drawn. Following *Montgomery v Lanarkshire Health Board*,[71] a doctor has a duty to take reasonable care to ensure that patients are aware of any material risks, not all risks, involved in proposed treatment. For this purpose, the test of materiality is whether, in the circumstances of a particular case, a reasonable person in the patient's position would be likely to attach significance to the risk. In *Mr & Mrs M v HFEA*,[72] discussed above, Arden LJ found that the deceased daughter's lack of information about the risks to her mother and the fact that her mother would been the legal mother was 'not a matter of such significance as outweighs the evidence of consent.'[73]

In *Jennings*, the HFEA argued that C had sufficient information and opportunity to give written consent.[74] Lisa Cherkassky argued that Theis J overstepped by inferring C's consent, despite J's admission that C 'did not turn her mind to posthumous surrogacy at all—it was not even discussed between [them]'.[75] However, as seen at ***Figure 1(a)*** above, the WT form at the material time did not provide any opportunity for a woman to consent to the use of partner-created embryo during the course of her partner's treatment—using a surrogate—in the event of her death. The mere instruction to "speak to your clinic" about uses of gametes/embryos other than for research and training is not an obvious indication of the steps that C needed to take to enable J to use their remaining embryo—especially since she would have to consent specifically to the surrogacy—nor would it have flagged the additional costs incurred as a result. Additionally, there *was* evidence that the couple had considered a continuation of their joint parenthood project—in circumstances where C would be able to have the embryo transferred into her in the event of J's death, as prompted by the HFEA MT form he completed and signed.

Judges are able to consider broader evidence in determining the deceased person's wishes where there is a lack of written consent and allow treatment to occur abroad. They do not permit illegal activity, but can facilitate the circumvention of the regulatory framework. In *Jennings*, Theis J held that C's lack of consent emerged from a lack of

[68] Ibid, para 97.
[69] Nor that the *exact* HFEA forms should be completed, if the correct inferences regarding consent can be drawn (see *Y v Z* [2022] EWFC 157).
[70] HFE Act 1990, Schedule 3 para 3(1)(b).
[71] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.
[72] *Mr & Mrs M v HFEA* (n 4).
[73] Ibid, para 83.
[74] *Jennings* (n 11), para 5.
[75] Lisa Cherkassky, '*Jennings v Human Fertilisation and Embryology Authority*: Posthumous Surrogacy with Inferred Consent' (2023) 139 LQR 19, 22.

relevant information and/or a sufficient opportunity to discuss it with the clinic, with regards to posthumous surrogacy: 'if that opportunity had been given, that consent by that person would have been provided in writing.'[76] Fertility clinics ought to be under a duty to ensure that relevant information is provided during the consent process, akin to the test of materiality articulated in *Montgomery*. This duty is even more pressing given that 'individuals will embark upon these procedures desperate for conception and the birth of a child'.[77]

The value of posthumous reproduction lies in the importance that individuals placed on the fate of their progeny after they have passed.[78] In *Jennings*, C had specifically contemplated her death and, in relation to the twin pregnancy she was carrying, 'was adamant that the [twins] should be saved in the event there had to be a choice between her and the children.'[79] It was therefore clear that she placed importance on being able to determine their fate in the event of her death. With one embryo remaining in storage, after the loss of earlier pregnancies and four rounds of IVF, C also explicitly refused consent to embryos created using her eggs being used for training purposes in the event of her death or incapacity on the final WT form she signed, despite her earlier WT forms recording her consent to this. This indicates that she intended that the final embryo would be 'saved' to be used if required by the couple. Given the multiple failed IVF attempts, J and C had discussed other options, including surrogacy, and C's sister had offered to act as their surrogate.[80] Additionally, the final HFEA MT form (which J admitted had in fact been filled out by C) recorded J's consent to C's use of their remaining embryo in her treatment, should he die.

Jennings can be contrasted with the subsequent case of *Re X (Catastrophic Injury)*.[81] The parents (V and W) of X, a 22-year-old man in intensive care following a stroke, with no realistic chance of recovery, sought a declaration that it would be lawful for a doctor to retrieve and store X's sperm after his death and that his father, V, could sign the relevant consent forms—as he lacked capacity. However, they were unable to evidence that X would have consented to fathering children after his death; they were only able to stress his expressed wish to eventually become a father.[82] Poole J agreed with the HFEA and the Official Solicitor, finding that the consent requirements outlined in Schedule 3 of the HFE Act 1990 could not be met. Relying on *Jennings*, the HFEA argued that there was no evidence in this case to suggest that X was denied the opportunity to consent to posthumous use or storage of his sperm.[83] Interestingly, this approach implicitly debases the HFEA's own argument in *Jennings*, by recognising that lack of opportunity to consent—which at the time it had argued was not the case—was the fatal flaw. Poole J further distinguished this case from *Y v A Healthcare Trust*, finding that:

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[76] *Jennings* (n 11), para 104.
[77] *ARB v IVF Hammersmith* [2018] EWCA Civ 2803, para 53.
[78] Robertson, 'Posthumous Reproduction' (n 61) 1031-33
[79] *Jennings* (n 11), para 93.
[80] Ibid, para 21.
[81] *Re X (Catastrophic Injury: Collection and Storage of Sperm)* [2022] EWCOP 48.
[82] Ibid, para 11.
[83] Ibid, para 20.

> There is no advance decision in this case nor is there any evidence as to X's views and beliefs as they might have been relevant to a decision such as this.

Poole J added:

> It is one thing to have a consistent and heartfelt desire to be a living, caring father. It is quite another thing to wish to have one's sperm collected and stored when unconscious and dying, with a view to the possibility of the sperm being used for conception after one's death, and without having expressed any view when living about how the sperm should be used.[84]

Currently, *evidenced* parenthood projects, where in some way it can be shown that a couple[85] or individual[86] had wanted that project to continue after their death in such a way that may be interpreted as posthumous consent, have carved an exception to the legislative 'twin pillars'. As solo parenthood projects cannot by themselves (any longer) invoke welfare of the child considerations, the only pillar remaining is the requirement of written and signed consent. For posthumous use, it appears this requirement can be sidestepped, in a way that is reminiscent of the purposive readings of the Parental Order requirements[87] and the parentage declarations granted following erroneously completed HFEA forms.[88]

CONCLUSION

In 2022, Ipsos carried out a nationally representative online survey on behalf of the charity Progress Educational Trust. 60% of respondents agreed that it should be permissible for a deceased person's stored gametes to be used for conception by a partner.[89] Pursuing fertility treatment where one genetic parent is deceased causes discomfort to some. The legal discussions surrounding *Jennings*[90]—and the arguments presented on behalf of the HFEA—reveal that this discomfort is heightened where a widower is involved. Perhaps it seems less unnatural for a woman to seek to continue on the reproductive path that had been jointly pursued before the death—and maybe this is even clearer in a situation where a sibling birth is sought.[91] To some extent, this may explain judges' tendency to relax the rules and allow sperm retrieved from a dying or deceased partner (as in *Blood* and *L*) to be exported for use in treatment. However, where there is such obvious evidence about the couple's joint intentions, and where the complicated nature of the HFEA proforma forms resulted in missing written consent, *prima facie*, it is unclear why the applicant's status as a

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[84] *Y v A Healthcare Trust* (n 9), para 11.
[85] As in *Blood* (n 7), *L v HFEA* (n 4), *Warren* (n 67), *Y v A Healthcare Trust* (n 9), *Jennings* (n 11).
[86] *Mr & Mrs M v HFEA* (n 4).
[87] See fn 55.
[88] See *Re HFEA (Cases A, B,C, D, E, F, G and H Declaration of Parentage)* [2015] EWHC 2602 Fam; *Re the Human Fertilisation and Embryology Act 2008 (Cases P, Q, R, S, T, U, W and X)* [2016] EWHC 2273 (Fam); *Re Human Fertilisation and Embryology Act 2008 (Cases Y, Z, AA, AB and AC)* [2017] EWHC 784 (Fam).
[89] Progress Educational Trust, *Fertility, Genomics and Embryo Research: Public Attitudes and Understanding* (June 2022) 14.
[90] See Cherkassky, '*Jennings*: Posthumous Surrogacy' (n 75).
[91] And perhaps it also explains the willingness of the Court of Appeal in *Mr & Mrs M v HFEA* (n 4) to entertain the idea of the project being continued via the grand/mother acting as surrogate for her daughter, when in theory at least it could be argued that the case brought by the grand/mother was part of her own grief and treatment potentially not in the child's best interests (unless the existence vs non-existence argument is considered, which is outside the scope of this note).

widower rather than widow should result in more discomfort as in *Jennings*. It is only upon further analysis that it becomes clear the extent to which judicial understandings of parental roles remain influenced by gendered—and heteronormative—ideals.[92]

There is evidence that J and C had contemplated undertaking a surrogacy arrangement as part of their fertility treatment, as C's sister had offered to be their surrogate. As such, J requiring a third party—a surrogate—to continue his fertility treatment, should not be seen as a (legal) hurdle.

While *Jennings* evidently sets a precedent, it is unlikely that it will lead to a sudden rush of posthumous surrogacy cases, as J's situation was so fact specific.[93] A putative father in similar situations would need to find a surrogate, though this is not an impossibility, as explained above. In the UK, single individuals are eligible for a Parental Order following surrogacy, where they have a genetic link to the child born, and the Joint Law Commissions' Full Report on surrogacy is clear that single individuals are included within their proposed 'pathway to parenthood'.[94] In any case, the updated HFEA proforma consent forms for women now discuss the posthumous use of gametes and embryos, separating out their potential use in a partner's treatment—and specifically mentioning surrogacy. It is therefore clear that the requirement for effective consent to be 'written and signed' is a legal formality, rather than a necessary requirement for accessing fertility treatment, even posthumously. Therefore, it should no longer be possible for a parenthood project to be hindered by Schrödinger's Complete Consent Forms.

[92] See, for further discussion on the gendered nature of legal parenthood: Julie McCandless and Sally Sheldon, 'The Human Fertilisation and Embryology Act (2008) and the Tenacity of the Sexual Family Form' (2010) 73 MLR 175; Alan Brown, *What is the Family of Law?: The Influence of the Nuclear Family* (Hart Publishing 2019); Zaina Mahmoud and Elizabeth Chloe Romanis, 'On Gestation and Motherhood' (2023) 31 Med L Rev 109; Kirsty Horsey and Emily Jackson, 'The Human Fertilisation and Embryology Act 1990 and Non-Traditional Families' (2023) *OnlineFirst* MLR.

[93] In fact, at para 104 in *Jennings*, Theis J specifically states 'This is a case very much on its own particular facts. I agree…it will not open any floodgates.'

[94] *Building Families through Surrogacy: Full Report* (n 52) para 1.97.