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Developments in Modern Family Law

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Surrogacy – Current Legislation and Imminent Reform

In England and Wales, single individuals, same-sex and heterosexual couples are all eligible to apply for a Parental Order following the birth of their surrogate-born child. Although wholesale reform might be on the horizon for domestic arrangements, unless and until implemented, judges rely upon creative interpretations to ensure that the current legislation does not prevent the welfare of the child being placed at the centre of any surrogacy arrangement. The legislative framework is set out below.

Surrogacy Arrangements Act 1985 (SAA)

This outdated, but still valid, Act prohibits commercial surrogacy arrangements but permits those that are altruistic or compensatory. This Act makes it illegal to broker or negotiate a surrogacy arrangement on a commercial basis[1] and prescribes a criminal sanction for those who engage in profit-making surrogacy contracts.[2] This legislation also makes clear that surrogacy contracts are not legally recognised and are, therefore, unenforceable.[3]

Human Fertilisation and Embryology Act 1990 (HFEA 1990)

This Act[4] introduced the Parental Order; a legal mechanism bespoke to surrogacy that, subject to specific criteria being met, enables the court to extinguish the parental rights of the surrogate (and any other legal parent) and simultaneously confer parental rights on the intended parents.

Human Fertilisation and Embryology Act 2008 (HFEA 2008)

This legislation expanded the remit of HFEA 1990 to allow married or unmarried same-sex couples to apply for a Parental Order following the birth of their surrogate-born child.

The criteria for a Parental Order, as prescribed in s.54 HFEA 2008[5] is as follows:

i. the application must be submitted by two applicants with a durable family relationship;
ii. at least one of the applicants must have a genetic link to the child;
iii. the applicants must apply for a Parental Order within six months of the child's birth (although case law has now enabled late applications, including an application more than 20 years later);[6]
iv. at the time of application, the child must be living with the intended parents;
v. one or both of the applicants must be domiciled in the United Kingdom, the Channel Islands or the Isle of Man;
vi. the intended parents must be over 18 years of age; and
vii. the surrogate (and any other legal parent of the child) must consent to the issuing of the Parental Order. For consent to be considered valid it must be given more than six weeks after the birth.

Once all the statutory eligibility criteria are met, the court is obliged to consider the child's lifelong welfare pursuant to s.1 Adoption and Children Act 2002. In the face of outdated legislation, the Court frequently relies upon this "catch-all" provision to ensure the best interests of the child are paramount in any decision made.

Human Rights Act 1998 (HRA)

The introduction into UK law of the HRA obliged the courts of England and Wales to interpret domestic legislation so that it is compatible with an individual's right to respect for private and family life under Article 8 of the European Convention on Human Rights (ECHR).

The case of *X, Re* [2020] EWFC 39[7] is a stark example of the court "reading down" HFEA 1990 to ensure legislative compatibility and safeguard the welfare of the child. In this unusual and distressing case, the biological father died unexpectedly before his child, conceived through surrogacy, was born. His wife, who was not genetically affiliated to the child, was not eligible to apply for a Parental Order under s.54 HFEA 2008. Mrs Justice Theis considered that her judicial hands were tied: an application for a Parental Order is not discretionary and there were no other orders available to the court that offered a solution that was "*fair and reasonable*" in all the circumstances of this case.

An Adoption Order would have created something of a "*legal fiction*" (as s.67 Adoption and Children Act 2002 states that the effect of an Adoption Order is such that the adopted person is to be treated in law as if born as the child of the adopter and this would not properly reflect the reality of the surrogacy arrangement in this case). Further, a Child Arrangements or Special Guardianship Order in favour of the intended mother would result in her only securing parental responsibility for the child's minority, would not extinguish the child's relationship with the surrogate and her husband and would leave the child's deceased biological father a legal stranger to the child.

Mrs Justice Theis concluded that "reading down" the HFEA legislation, such that there was no inconsistency with "*the underlying thrust of the 2008 legislation*", would provide the most appropriate order for this child. Accordingly, Theis J found that the intended mother could apply for a Parental Order and this was duly granted.

HFEA 2008 (Remedial Order) 2018

Following the case of *Re Z (A child) (No 2)* [2016] EWHC 1191 (Fam),[8] HFEA 2008 was updated and amended[9] so that single individuals could apply for and, subject to satisfying the remaining criteria under s.54, obtain Parental Orders for their surrogate-born children.

Adoption and Children Act 2002

This legislation imposed a mandatory obligation upon the court so that where the criteria of ss54 (1)–(8) HFEA 2008 are satisfied, the court must also have regard to the child's lifelong welfare needs pursuant to s.1 Adoption and Children Act 2002.[10]

Legal parenthood

S.33 (1) HFEA 2008[11] defines the legal mother of the child as the "*woman who is carrying the child or has carried the child as a result of the implantation in her of an embryo or of sperm and ova*". The surrogate (as a gestational carrier) will be deemed the legal mother of the child unless and until the intended parents obtain a Parental Order. This remains the case, irrespective of whether the surrogate child is born abroad and the intended mother is named on a foreign Parental Order and/or birth certificate.

HFEA 2008 sets out circumstances where legal paternity will accrue to the non-biological or second father: e.g., if the surrogate is married, the common law presumption of legitimacy prevails so the husband of the surrogate will be the legal father and have parental rights over the child. To rebut this presumption of legitimacy, the surrogate must demonstrate, on the balance of probabilities, that the child is not the child of the marriage and that there is no genetic affiliation between the child and the husband of the surrogate.

Proposed legislative and regulatory reform

On 29 March 2023, the Law Commission of England and Wales together with the Scottish Law Commission published a joint report outlining recommendations for legal reform in respect of surrogacy arrangements.[12] The report, along with a draft Surrogacy Bill[13] outlined a new regulatory scheme to provide to greater safeguards, clarity and certainty over the surrogacy process.

The principal recommendation is the introduction of a "new pathway"; a regulatory route for domestic, altruistic and compensatory surrogacy arrangements, under which intended parents would be recognised as the child's legal parents at birth as opposed to having to wait months to obtain a Parental Order. To access this pathway, intended parents and surrogates would need to follow a set of regulations overseen by non-profit Regulated Surrogacy Organisations (with those being regulated by Human Fertilisation and Embryology Authority (HFEA)). Safeguarding criteria needing to be actioned prior to embryo transfer will include background checks, health screening and criminal records checks, independent legal advice and implications counselling.

Another proposed reform centres around a more robust framework regarding payments to surrogates. The report defines categories of acceptable payments to the surrogate, such as those in respect of lost earnings, travel and pregnancy support.

Further reforms include (i) increasing the minimum age of the surrogate to 21 years old, (ii) the dilution of the domicile criteria, such that it will suffice if one of the intended parents is either habitually resident or domiciled in England and Wales, and (iii) the creation of a surrogacy register, where surrogate-born children will be able to obtain information about their genetic and gestational origins. The proposed recommendations for reform, however, do not extend to incorporate "double donation": when the surrogate is implanted with an embryo created from a donor egg and donor sperm. Commercial surrogacy will also remain prohibited. Intended parents engaged in international surrogacy arrangements will fall outside of the pathway: there will be no automatic recognition of foreign parentage orders or birth certificates and intended parents will still be obliged to apply to the court for a Parental Order in order to have parental rights for their child conferred upon them.

The report and draft Bill awaits Parliamentary debate and at the time of writing there is no indication as to whether or when the proposed reforms will be implemented.

On a wider scale, there is no international legal framework regulating how parentage of children born through surrogacy in one country is recognised in another. Whilst the Hague Conference on Private International Law (HCCH) is working towards a possible future treaty,[14] whereby signatory countries could resolve cases of "limping legal parentage" (where foreign legal parentage of children born through surrogacy is not recognised domestically), progress is very slow.[15]

Transgender Rights

Transgender rights in England and Wales have attracted significant controversy after a string of high-profile cases and the independent review, by Dr Hilary Cass (published in April 2024),[16] led to the closure of the flagship NHS Gender Identity Clinic at the Tavistock and Portman NHS Foundation Trust.

In line with the Cass Review, on 12 March 2024, NHS England announced a significant change to their clinical policy,[17] namely that puberty blockers would not be offered to minors as a routine commissioning treatment option, having concluded that there was not enough evidence to support their safety or clinical effectiveness. Puberty blockers will now only be prescribed on the NHS if the minor is participating in a clinical trial.[18] Two new NHS treatment centres have been set up in place of the Tavistock, offering a very different model of care in line with the new clinical policy: a more holistic approach with a range of pathways and with primary intervention in the form of psychological support as opposed to medication.

Consent of a minor and the parent(s)

Consent of adolescents under 16 – "Gillick" competence

It is established case law that a minor under the age of 16 may be competent to consent to medical treatment if they are found to be "Gillick" competent. In the seminal case of *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, Lord Scarman stated:

> *"I would hold as a matter of law that the parental right to determine whether or not their minor child below the age of 16 will have medical treatment, terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed … until the child achieves the capacity to consent, the parental right to make decisions continues…"*

Thus, in all but the most exceptional circumstances, it was determined that physicians, not judges, should determine whether a child under 16 has the capacity to consent to treatment. However, in respect of the provision of NHS treatment for those under 16, following the Cass Review, the consent of a minor will be subject to national policy guidelines.

The consent of a minor aged 16–17

S.8 (1) Family Law Reform Act 1969 sets out the statutory presumption that young persons aged 16 and 17, unless found to lack capacity in accordance with the Mental Capacity Act 2005, may consent to medical treatment, including surgery (but provision to NHS treatment will be in line with the Cass Review).

Who determines the validity of consent in gender affirmation/re-assignment cases – physician or judge?

A young person's capacity to consent to gender treatment was considered in the case of *Bell v Tavistock and Others* [2020] EWHC 3274 (Admin). The claimant, Quincy Bell (aka Kiera), was prescribed hormones to block the progression of puberty aged 16 and commenced surgical treatment to transition from female to male (this included a double mastectomy). However, upon regretting her course of action, she terminated the treatment. Quincy, who was left without breasts, a deep voice, facial hair and affected sexual function, blamed the Gender Identity Development Service (GIDS), stating that the clinicians should have challenged her desire to transition to male more rigorously.

At first instance, the Divisional Court made a declaration as to the "relevant" information that a child under 16 would have to understand in order to consent to puberty blockers. Part of this guidance stated that clinicians "may well consider" that it is not appropriate to treat 14–15-year-olds without the involvement of the court and that, for 16–17-year-olds, an application to the court would be appropriate if there were any doubt about the long-term interests of the patient. GIDS successfully appealed. On appeal, the court determined that it was for physicians, not judges, to exercise their judgment in respect of medical treatment; knowing how important it was for the patient's consent to be obtained properly in line with the particular needs of the individual seeking treatment.

The role of parental consent

The case of *AB v CD and others* [2021] EWHC 741 established that the parents of a trans-adolescent could consent to complex medical interventions on behalf of their child.

XY, born male and aged 15 at the time of the judgment, had been under the care of GIDS. XY was seen in clinic by Professor Butler in April 2019 when she was 13 years old. Professor Butler noted that "[XY] has been declared competent to consent and has signed consent forms voluntarily". Whilst her parents also signed the relevant forms consenting to treatment, Professor Butler proceeded on the basis of XY providing valid consent. In light of a concern that gender treatment would be interrupted or halted, the parents brought an application to court: the mother, AB, sought a declaration that she and CD (the father) could consent in law on behalf of XY to the administration of puberty blockers. Mrs Justice Lieven stated that:

- the parents' right to consent to treatment on behalf of the child continues even when the child is "Gillick" competent to make the decision, save where the parents are seeking to override the decision of the child – a parent's right to determine treatment cannot trump or overbear the decision of a "Gillick" competent child. Thus, the physicians could lawfully advise and treat the child without the parents' consent (noting that, in this matter, the parents did consent);
- however, where a child is not "Gillick" competent, or the child cannot reach a decision for whatever reason, the parents continue to have parental responsibility (and thus the right) to give valid consent; and
- puberty blocking treatment does not fall into a special category of medical treatment for children that requires court approval and for which the parents are unable to give lawful consent. However, in certain circumstances, for example, if parents feel pressured by their child to consent to puberty blockers, or the child's physicians disagree how to proceed, the case should be referred to court.

How do these decisions sit (i) alongside the recommendations in the Cass Review, and (ii) in respect of treatment from overseas private providers?

***O v P & Anor* [2024] EWHC 1077 (Fam)**

In this matter, Mrs Justice Judd considered applications for Q, born female but who identified as male and aged 16 years. Q's parents had divorced some 10 years previously and in 2020, Q informed them both that he was transgender. Q's father accepted this, but his mother did not.

The dispute related to private treatment provision. The mother sought a declaration that the prescribing of puberty blockers or gender affirming hormones by a private provider must be subject to the oversight of the court and that the Court of Appeal decision in *Bell v Tavistock and Portman NHS Foundation Trust and other* [2021] EWCA Civ 1363 and the decision in *AB v CD* [2021] EWHC 741 were outdated and not able to survive the recommendations of the Cass Review. The father and Q invited the court to dismiss the proceedings on the basis that Q should be assessed and then left to make decisions as to any treatment offered on his own with the assistance of treating clinicians.

Decision: Judd J found that pursuant to s.8 Family Law Act 1969, Q was entitled to consent to his own treatment whether or not the parents agree. Further, when considering the mother's position, Judd J acknowledged the findings in the Cass Review and noted that not all provisions in the Cass Review were applicable when considering private treatment (for example, where medical treatment decisions are to be considered by a national Multi-Disciplinary Team). Judd J found that the findings in the Cass Review did not oblige her to depart from the landmark decisions in *Bell v Tavistock and Others* [2020] EWHC 3274 and *AB v CD and others* [2021] EWHC 741.

Important judgment relating to hormone treatment provided by offshore, online and unregulated private clinics

This issue was considered in detail in the matter of [2024] EWHC 922 (Fam) before the President of the Family Division, Sir Andrew MacFarlane. J, the child at the centre of these proceedings, was 16.5 years old, assigned female sex at birth ("natal female") but who had regarded himself for some time as male ("affirmed male"). In January 2023, J commenced a

course of cross-hormone treatment and thereafter, he was scheduled to receive injections of testosterone every three months. The last injection was in August 2023, with the next scheduled for November 2023; however, with the agreement of all parties, treatment was halted pending the outcome of the legal proceedings.

The principle issues concerned (i) J's capacity to consent to receiving hormone treatment, and (ii) whether the Court should, in any event, exercise its powers under the inherent jurisdiction and/or the Children Act 1989 to prevent further hormone treatment. The case was complicated by the treatment programme being established by an internet provider "Gender GP" rather than the NHS. Both parents, J, his Guardian and the Court had significant concerns over the involvement of Gender GP ("*a highly abnormal and frankly negligent approach*") with J only having one direct consultation with an unregistered counsellor before receiving a private prescription for testosterone at a dangerously high dose. Ultimately, there was little for the Court to determine as whilst J's father was opposed to any young person under 18 years of age being prescribed cross-hormone treatment, he accepted that J would undergo an assessment by a new London-based private clinic "Gender Plus" – a process that could last six months.

However, MacFarlane P[19] took the opportunity to state that he was eager not to overreach his remit in this matter, noting that "*[t]he law, and the approach of the courts, with respect to issues arising in cases of gender dysphoria is still very much in the process of development. In the absence of intervention by Parliament, the court should be careful to move forward on a case by case, decision by decision, basis so that the approach under the common law is developed incrementally as may be required, rather than by judicial diktat [...]. The court, particularly in a novel and sensitive area such as this, must be particularly cautious not to be drawn into academic discourse and or presume to lay down the law beyond that which is necessary to determine any current dispute. To do so would be to risk trespassing, impermissibly, on the role of Parliament*".

Donor Identification

Individuals who donated their sperm, eggs or embryos at a UK HFEA licensed clinic between 1 August 1991 and 31 March 2005 did so believing they would remain anonymous. However, a significant legislative change in the form of the HFEA (Disclosure of Donor Information) Regulations 2004[20] gives donors who donated prior to 2005 the opportunity to remove their anonymity. This law was introduced after HFEA consulted with donor-conceived individuals; the timing of which coincided with the increasing popularity of direct-to-consumer genetic testing kits and ancestry websites, which resulted in donor-conceived individuals discovering information about their donors and circumventing the anonymity provisions.

For children over 16 and who were donor-conceived at a UK licensed clinic, they will be able to obtain information such as (i) the donor's physical characteristics (height, weight, eye, hair and skin colour), (ii) the year and country of his birth, (iii) his and his parents' ethnicity, (iv) his marital status, (v) relevant personal and medical history, and (vi) additional information that may have been provided by the donor; for example, his religion and reasons for donating.

However, donor-conceived children over 18 will be able to request *identifying* information; for example, the donor's full name, date of birth and town of birth, their most recent address on the HFEA register and other information about the donor that is held, including other identifying information. Applications for information made to the HFEA are free of charge and responses should be sent to the donor-conceived child within 20 working days of the application for information being made. Donors have no legal rights or responsibilities towards the individuals conceived via their donation, provided they donated through a licensed UK fertility clinic.

HFEA reform on the horizon

The HFEA has outlined significant reform to HFEA 1990: the primary legislation that governs the fertility sector. A public consultation ended on 14 April 2023, leading to 15 proposals[21] setting out where the law in this area should be modernised in the interests of patients, professionals and researchers and the arena of patient safety and promoting good practice, access to donor information, consent and scientific developments.

Posthumous Conception – Cases of Interest

S.39 HFEA 2008[22] governs the use of a man's sperm or an embryo created with his sperm after his death and states:

"*(1) If—*

(a) the child has been carried by W as a result of the placing in her of an embryo or of sperm and eggs or her artificial insemination,

(b) the creation of the embryo carried by W was brought about by using the sperm of a man after his death, or the creation of the embryo was brought about using the sperm of a man before his death but the embryo was placed in W after his death,

(c) the man consented in writing (and did not withdraw the consent)—

(i) to the use of his sperm after his death which brought about the creation of the embryo carried by W or (as the case may be) to the placing in W after his death of the embryo which was brought about using his sperm before his death, and

(ii) to being treated for the purpose mentioned in subsection (3) as the father of any resulting child,

(d) W has elected in writing not later than the end of the period of 42 days from the day on which the child was born for the man to be treated for the purpose mentioned in subsection (3) as the father of the child, and

(e) no-one else is to be treated—

(i) as the father of the child by virtue of section 35 or 36 or by virtue of section 38(2) or (3), or

(ii) as a parent of the child by virtue of section 42 or 43 or by virtue of adoption,

then the man is to be treated for the purpose mentioned in subsection (3) as the father of the child.

(2) Subsection (1) applies whether W was in the United Kingdom or elsewhere at the time of the placing in her of the embryo or of the sperm and eggs or of her artificial insemination.

(3) The purpose referred to in subsection (1) is the purpose of enabling the man's particulars to be entered as the particulars of the child's father in a relevant register of births."

S.40 HFEA makes a similar provision in respect of the use of donated sperm.

In the recent tragic case of *Re X (Catastrophic Injury: Collection and Storage of Sperm)* [2022] EWCOP 48, Mr Justice Poole was concerned with an application for a declaration for X's sperm to be extracted and stored. X, a young man aged 22, suffered an unexpected and catastrophic stroke from which he was not expected to recover. His parents applied to the Court of Protection for a declaration that it was lawful for the hospital to extract and store his sperm (with a view to using in fertility

treatment in due course). Poole J, finding that it was not in X's best interests to make the declarations, dismissed the application. The judgment provides helpful commentary on the court's approach to the extraction, storage and use of sperm in posthumous conception cases. At paragraph 33 of the judgment, Poole J noted:

> "*Having considered all the circumstances, applying section 4 of the MCA, and considering whether the interference with X's Art 8 rights is necessary and proportionate, I have decided to refuse the application. It would not be in X's best interests to make the declarations sought. Assessment of his best interests involves not merely an analysis of the risks and benefits of the proposed procedure, but also of X's past and present wishes and feelings, his views and beliefs, and his autonomy. His right to privacy and to self-determination in relation to reproduction must be considered. There is no evidence before the court to persuade me that X would have wished for his sperm to be collected and stored in his present circumstances. I cannot accept that there should be a default position that sperm should be collected and stored in such circumstances as being generally in a person's best interests. I cannot conclude that making the declarations as sought would be in accordance with X's wishes, values or beliefs. The process of collecting X's sperm is physically invasive and there is no evidence that X would have consented to it or would have agreed to its purpose. I take into account the views of his parents about X's best interests. However, weighing all the relevant matters in the balance I conclude that it is not in X's best interests to make the declarations sought. The declarations if made would lead to a significant interference with his Article 8 rights and I am not persuaded that the interference would be necessary or proportionate. I therefore dismiss the application.*"

In an earlier case, *Y v A Healthcare Trust* [2018] EWCOP 18, Mrs Justice Knowles was also concerned with an application involving a dying man (Z). The application was brought by Y, Z's partner and mother of their son, for (i) a declaration that, notwithstanding her husband's incapacity and his inability to consent, it was lawful and in his best interests for his sperm to be retrieved and stored prior to his death, and (ii) an order pursuant to s.16 Mental Capacity Act 2005 directing that a suitable person should sign the relevant consent form for the storage of Z's sperm on her husband's behalf. A significant factor was that Y and Z had struggled to conceive a second child naturally and had been referred to a fertility clinic by their GP and had attended initial meetings at the fertility clinic where posthumous conception was discussed. Y sought to retrieve Z's sperm before he died so that their son could have a brother or sister. Knowles J noted that:

> "*Prior to attending for their fertility clinic appointment in May 2018, the couple completed a large number of forms, a small portion of which were appended to Y's statement. Y recalled that the forms asked the couple which types of fertility treatment they wished to undertake, including collection of Y's eggs and Z's sperm, their storage and use in fertility treatment. It was clear from the contents of Y's statement that the couple discussed the storage of their genetic material and the uses to which this material might be put, including the creation of embryos and the ethics of discarding the same. Additionally, the couple talked specifically about what would happen if one of them were to die. Y's statement recorded that Z had talked about the storage of his sperm and what would happen if he died, her recollection being that this issue had been raised specifically in the clinic form which he had to complete. Y recalled asking Z specifically what they would do if he died whilst they were having fertility treatment on the evening that they completed the clinic consent forms. Z told Y that he was happy for her to do it – that is, have the treatment – if it was what she wanted. Y said to Z that she would want to go ahead with treatment because she wanted their son to have a brother or sister and she recalled Z being in complete agreement with her about this issue.*"

As Y also sought permission from the court to authorise that a suitable person execute the relevant consents for the storage of Z's sperm, the provisions of HFEA 1990 applied (HFEA 1990). S.3 HFEA 1990 deals with the consents to use or store gametes, embryos or human admixed embryos. Consent by a person who is unable to sign because of illness, injury or physical disability may comply with the requirement of HFEA 1990 subparagraph 1(2) as to signature "*if it is signed at the direction of the person unable to sign, in the presence of the person unable to sign and in the presence of at least one witness who attests the signature*".

Knowles J was persuaded that before Z's accident, Z and Y had a settled intention to have a brother or sister for their son, that they had sought fertility treatment and were under the care of a physician in order to receive that treatment, and that Z had discussed with Y the posthumous use of his sperm and had agreed to posthumous use, and permitted the application.

The judge concluded: "*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. I also declared that the court was satisfied that the requirements of Schedule 3 to the 1990 Act in relation to consent were met in those circumstances. My order provided for a relative to sign the relevant consents in accordance with the provisions of subparagraph 1(2) of Schedule 3 to the 1990 Act.*"

Conclusion

The above cases demonstrate the remarkable breadth of decisions the family courts are tasked with determining in this brave new world; one where law, public policy, medical advances and ethics are so intricately entwined. Many updating legislative and regulatory reforms are on the horizon. However, until the reforms are implemented, faced with outdated legislation, Judges will continue to rely upon judicial ingenuity in their interpretations of the legislative framework. They are also most likely to continue to determine issues on a case-by-case basis, when faced with unchartered waters, with the child's needs as their paramount consideration.

Endnotes

1 S.2 (1) Surrogacy Arrangements Act (SAA) 1985.

2 S.2 (2) SAA 1985.

3 S.1A SAA 1985.

4 https://www.legislation.gov.uk/ukpga/1990/37/contents

5 https://www.legislation.gov.uk/ukpga/2008/22/section/54

6 *X v Z* (Parental Order Adult) [2022] EWFC 26.

7 *X, Re* [2020] EWFC 39: https://www.casemine.com/judgement/uk/5ecb46ed2c94e005a3091543

8 https://assets.publishing.service.gov.uk/media/5a9fd62240f0b64d7d48f318/annex-d-parental-orders-for-a-single-person-equality-assessment.pdf

9 The Human Fertilisation and Embryology Act 2008 (Remedial) Order 2018.

10 https://www.legislation.gov.uk/ukpga/2002/38/section/1

11 https://www.legislation.gov.uk/ukpga/2008/22/section/33

12 https://lawcom.gov.uk/project/surrogacy

13 https://s3-eu-west-2.amazonaws.com/cloud-platform-e218f50a4812967ba1215eaecede923f/uploads/sites/30/2023/03/3.-Surrogacy-draft-bill.pdf

14 HCCH | The Parentage / Surrogacy Project: https://www.hcch.net/en/projects/legislative-projects/parentage-surrogacy

15 This HCCH project began in 2010.

16 https://cass.independent-review.uk/home/publications/final-report

17 https://www.england.nhs.uk/publication/clinical-policy-puberty-suppressing-hormones

18 https://www.england.nhs.uk/wp-content/uploads/2024/03/clinical-commissioning-policy-prescribing-of-gender-affirming-hormones.pdf

19 Paragraphs 53 and 56: https://www.judiciary.uk/wp-content/uploads/2024/05/Approved-Judgment-Re-J-1-May-2024.pdf

20 https://www.legislation.gov.uk/uksi/2004/1511/contents/made

21 https://www.hfea.gov.uk/about-us/modernising-the-regulation-of-fertility-treatment-and-research-involving-human-embryos/modernising-fertility-law/#summary-of-recommendations

22 https://www.legislation.gov.uk/uksi/2004/1511/contents/made

Sarah Williams is a Partner in the Payne Hicks Beach Family Law Department and Head of the Surrogacy, Adoption and Modern Family Law Practice. In addition to her formidable expertise in fertility/assisted reproductive technologies and modern families' law, Sarah is a specialist in children law matters, often with an international and public law dimension and concerning vulnerable individuals. Sarah is ranked in *Chambers & Partners* and *The Legal 500* and is an integral member of the team which won Family Law Team of the Year at the *Chambers* High Net Worth Awards 2024. Sarah is also shortlisted as Family Law Commentator of the Year 2024 at the forthcoming *LexisNexis* Family Law Awards. Sarah is described as having an "*encyclopaedic knowledge of the law*" and in *The Legal 500* and *Chambers and Partners* as a "*stand out individual*" and "*one of the most highly respected lawyers... spearheading applications of law to new and emerging family forms*". Sarah is an annual guest lecturer on Law and Ethics at King's College, London and is regularly called upon to speak at international conferences and contribute to the national press (*The Times*, *The Financial Times*, the *BBC* and *The Guardian*) and specialist family law journals, particularly those with an international dimension.

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