

Regulating posthumous reproduction in the Netherlands and the UK

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I. Introduction

Posthumous reproduction (PR) is changing the way in which we create and conceptualize families, disrupting the traditional chronology and context in which families are developed via a combined use of assisted reproductive technologies (ART) and cryopreservation technology. There has been a steadily growing worldwide interest in posthumous reproduction.¹ Partly in response to this, in August 2018 the Nederlandse Vereniging voor Obstetrie & Gynaecologie² (NVOG) and the Vereniging voor Klinische Embryologie³ (KLEM) jointly published professional guidelines, Modelreglement Embryowet,⁴ on current issues facing the medical profession. The Modelreglement includes extensive guidance on the clinical regulation of posthumous reproduction (PR), that attracted media attention upon publication⁵ and offers an opportunity to reflect on how to regulate this sensitive area of reproduction.

Posthumous reproduction is a rare occurrence in the Netherlands – clinics receive 'between one to a few'⁶ requests each year, and these applications appear to be relatively uncontroversial.⁷ However, as public awareness of the possibilities offered through posthumous reproduction increases, the Netherlands, like other jurisdictions, can expect to encounter not only an increase in requests, but also requests within increasingly complex factual matrices. It is in anticipation of precisely this that the Modelreglement was issued. Given the Netherlands is in the relatively early stages of developing a more detailed policy and regulatory framework for posthumous reproduction, it is helpful to reflect on how other jurisdictions that have taken a similar regulatory approach have fared, and in particular how they have handled the hard cases that push the limits of the law. Thus, this article engages in a brief comparison between the legal situation in the Netherlands and in the UK (specifically, England & Wales).⁸ The latter is a good comparator for several reasons: a) it operates a similar regulatory approach of conditional acceptance of PR, the condition being (prior) consent; b) both jurisdictions, at the time of writing, must operate within the same European supranational legal frameworks, namely European Convention on Human Rights and European Union jurisprudence;⁹ and c) the UK boasts a detailed and mature framework that continues to be tested through caselaw. The latter point is where the two jurisdictions differ: a) the Dutch regulations are fairly new, and b) the Netherlands does not have an equivalent body of caselaw informing the jurisprudence on PR. Engaging with the UK experience can offer some insight into how a regulatory approach conditional on (prior) consent of the deceased can fare.¹⁰

This article proceeds as follows: I begin with a brief exposition of the recently published Dutch guidelines and the current legislative position in the Netherlands (part II). Likewise, I summarize the relevant UK guidelines and legislative position (part III). I draw out the similarities and points of difference between the two regimes in these sections as they emerge.¹¹ I then look at how the UK regime has been challenged in recent years through caselaw (part IV), and part V comprises my conclusions.

II. Law and regulation: the Netherlands

The guidelines set out in the Modelreglement¹² are intended to supplement the framework set out in the Dutch Embryo Act¹³ (note that PR is in fact reflected on in the Memorandum to the Embryo Act, s. 3.3.4).¹⁴ The Modelreglement sets out the position of the professional bodies vis-à-vis 'current dilemmas' fertility practitioners are facing, together with practical guidelines. Although not legally binding, the document is influential and expected to be followed by practitioners; professional guidelines developed by the NVOG are specifically referred to in the Memorandum to the Embryo Act at section 3.3.4 as the standard to be followed.

It is worth pointing out that the Modelreglement is not the first of its kind; a Modelreglement Embryowet was published in 2004 by NVOG¹⁵ in which PR is specifically addressed (chapter 4, Modelreglement 2004). The general approach towards PR adopted in both the 2004 and 2018 documents is clear and unchanged – the explicit, written (prior) consent of the deceased is required for the use of his/her gametes and embryos posthumously. In order to gain a better understanding of the policy development vis-à-vis PR in the Netherlands some of the key differences between the 2004 and 2018 Modelreglements will be drawn out below. First however, it is necessary to examine the details of the Modelreglement 2018.

Chapter 5 of the Modelreglement sets out the position on posthumous reproduction;¹⁶ the key points are as follows. Section 5.1 defines 'posthumous reproduction'. The document follows a standard definition referring to situations where conception takes place after the death of one or more of the persons from whom the gametes or embryo originated. This could occur using existing cryopreserved (frozen) gametes or embryos, or gametes can be freshly harvested from a dying/deceased person, preserved and stored to be used later.¹⁷ The latter scenario, as noted in the Modelreglement, is not explicitly covered by the law in that it is neither forbidden nor regulated, leaving a significant loophole in the jurisprudence on PR. In reading the Modelreglement, it is helpful to conceptualize PR as a two-stage process: i) procurement of reproductive cells; ii) the use of the procured reproductive cells in fertility treatment. Importantly, the document makes clear at the outset that the posthumous use of retained reproductive cells and embryos requires the written consent of the progenitor, as per Articles 7 and 8(3) of the Dutch Embryo Act.

Section 5.2 sets out the various situations in which cryopreserved gametes and embryos may be used. Essentially, the right to use

cryopreserved gametes and embryos can be asserted by a) the surviving partner (female or male, including situations requiring the involvement of a surrogate) or b) other interested party. The latter particularly refers to situations where the reproductive material has been donated to another person/couple as intended parent(s). No specific mention is made of requests for the material from the parents of the deceased, despite the fact that such requests are occurring more frequently, with notable cases arising in the UK,¹⁸ China,¹⁹ India,²⁰ Israel,²¹ America,²² and most recently, France.²³ Given the topical and controversial nature of this issue, it is odd that the organizations did not take the opportunity to specifically clarify their stance on this point. At present it is unclear as to whether by specifically not mentioning requests from the deceased's parents they are ruling out such requests, or simply evading the issue. That said, it is arguable that the parents of the deceased could qualify as the aforementioned 'interested party'; whether or not they in fact do is a matter for future clinical and judicial interpretation. Furthermore, how much latitude does the deceased have in giving his/her consent to the posthumous use of his/her gametes?

The organizations make clear in section 5.3 that consideration of the moral and ethical issues pertaining to PR are beyond the scope of the Modelreglement, which focuses purely on the law. Section 5.3 states that although PR is deemed morally acceptable, in any given instance it is up to the individual practitioner(s) or the clinic/hospital handling the request as to whether it will be permitted. The precise grounds on which a practitioner/clinic can proceed or refuse to carry out all or part of the PR process are not elucidated. For instance, can clinicians refuse to carry out the procedure invoking conscientious objection to PR? Article 2(3) (f) of the Embryo Act requires all healthcare establishments to produce protocols outlining their policy on PR. Nonetheless, section 5.3 outlines the following factors that ought to be considered in any application for PR: the 'autonomy (sic.)' of the deceased,²⁴ the extent to which emotions have driven the decision-making process of the surviving partner, the psychosocial consequences for all involved, and the various legal implications. These factors are – perhaps intentionally – vague and would be of little real assistance to the clinic facing a time-pressured request (for example, the short window of time in which sperm retrieval is possible after death) under any circumstance, let alone a novel or difficult situation (a claim asserted by a parent or sibling, for example).

It is a missed opportunity that the NVOG and KLEM did not engage directly with the ethical issues underlying PR and explain their position; doing so might have offered clearer direction in cases that do not follow the relatively straight-forward fact-patterns envisaged. PR is after all an ethical issue, and the policy position adopted in the Modelreglement implies certain ethical positions – it is impossible to separate the law from the ethics. In the context of the document, lengthy, detailed rules are not necessarily called for, however elucidating the underlying ethical positions can help derive principles, and these in turn can help guide behaviour offering both clarity and flexibility, particularly in hard/unusual cases.

Section 5.4 discusses the more controversial scenario of posthumous gamete procurement. Under Dutch law gamete procurement from a dead/dying person is not explicitly regulated; accordingly, caution is strongly urged. Interestingly, the document does state that 'certainly in the absence of written consent from the person concerned, there is no place for the collection of reproductive cells'.²⁵ This appears to apply to both deceased and comatose persons and whether there are exceptional situations that arguably merit relaxing the consent provisions (certainly, this seems to be the approach in the UK – see further below) remains unknown. Prior consent provisions limit PR considerably.²⁶ Most instances of PR occur following an accident or sudden illness, and most people will not have thought about the posthumous use of their gametes, let alone recorded their wishes in the appropriate form.²⁷ It is precisely the lack of consistency and clarity over legal requirements for the retrieval of gametes, and the consequences of unlawful retrieval thereof, that has confused UK law (see further below). Again, it is regrettable that the organizations did not take the opportunity to explore this crucial issue at greater length. Requests for PR following a sudden death is a common scenario and one that has directed much of the caselaw in the UK (see below). A considered and clear response to this scenario rather than simply urging caution would have been welcome.

Once the gametes are obtained and placed in storage, they come under the jurisdiction of the Embryo Act. As per Articles 7 and 8, stored gametes must be destroyed as soon as the clinic/centre storing them becomes aware of the originator's death, unless written consent permitting posthumous storage (and use) was provided. Likewise, embryos must be destroyed as soon as the clinic becomes aware of one or both progenitors' death, unless they have provided written consent to posthumous storage (and use). Here, 'use' refers to either personal reproductive use or scientific research. This section reiterates compliance with the rules governing gamete donation and surrogacy (elaborated on in Chapter 4 of the same document) where necessary. Finally, subject to the appropriate consents being in place, the document recommends that the maximum limit is offered for the storage of gametes of deceased persons, whilst remaining cognizant of the professional guidelines on the age and health of the woman seeking to establish the pregnancy.

Section 5.5 draws attention to the psychosocial aspects of PR: i) the welfare of the future child, and ii) the grieving process. Whilst acknowledging the limited empirical data on both of these issues the document sets out the position as follows. Firstly, due attention must be given to the welfare of the future child, particularly the fact that s/he will grow up without one or both biological parent(s). That said, this fact in itself is not necessarily an obstacle to PR. Secondly psychological counselling (with a qualified expert in PR) is essential for the surviving partner to understand the implications of going through with PR for him/herself and the future child and to clarify his/her wishes. Importantly, a gap of one year is recommended between the death of the gamete provider and commencing fertility treatment using the deceased's reproductive material. Finally, Section 5.6 recommends consulting a legal expert regarding the inheritance implications. Strangely, the Modelreglement is silent on the issue of birth registration and legal parenthood in cases of PR, despite these being obvious and important follow-on queries for those considering PR.²⁸

Although the central position – conditional acceptance of PR – remains the same, the 2004 and 2018 Modelreglementen differ on a number of issues. Firstly, the Modelreglement 2018 takes account of the current state-of-the-art in fertility treatment, namely, cryopreservation of female gametes. The 2004 regulations focus solely on posthumous sperm and embryo use, and while the cryopreservation and posthumous use of eggs is cited a future possibility, it is not one that is specifically considered (section 4.1). Secondly, the wording of the 2018 document expressly includes same-sex couples, and their position is aligned with that of heterosexual couples. Although the 2004 document is not necessarily limited to heterosexual couples, same-sex couples are not mentioned; the clarity and alignment offered in the Modelreglement 2018 is therefore welcome.

Thirdly, the Modelreglement 2004 places significant emphasis on the 'risks of *single motherhood* after post-mortem reproduction' – section 4.3 is dedicated to this issue alone. The focus on single motherhood reflects the technological state-of-the-art in 2004 when egg freezing was neither a viable, nor widely available, option.²⁹ The risks enumerated focus on the well-being of the future child (being brought up in a single-parent household, being deliberately born after the death of his/her biological father), and psychological condition of the surviving party following the loss of a partner. The extent of these concerns are

reflected in the practice guidelines: a gap of two years (as opposed to one year in the Modelreglement 2018) is suggested between the death of the gamete provider and commencing fertility treatment (s. 4.4).

Fourthly, surviving partners are unequivocally discouraged from using frozen embryos (created using their deceased partner's gametes) in treatment requiring a surrogate: 'Because little experience has been gained with both post-mortem reproduction and high-tech surrogacy, the Committee considers this option undesirable for the time being.' (s. 4.5) No explanation is given as to why transferring the embryo to a surrogate is more risky or 'undesirable' than transferring it to the surviving female partner (the latter practice is not discouraged, rather treated in the same manner as posthumous sperm use, s. 4.3, 4.4). The effect of this position – which is not carried forward in the Modelreglement 2018 – is to discriminate infertile female surviving partners and male surviving partners. Finally, the 2004 document does acknowledge some of the consequences for legal parenthood. In sum, the current Modelreglement offers a much-needed update to its predecessor, both in terms of taking account of developments in medical science, and societal developments *a propos* the changing concept of 'family'.

During the intervening years between the two Modelreglementen PR has remained an issue of interest for law and policy makers.³⁰ In 2012 the second evaluation of the Embryo Act together with the first evaluation of the Donor Data Artificial Fertilization Act was published.³¹ The committee specifically explored the posthumous donation of reproductive material, and expressed no fundamental objection to the practice. Notably, the posthumous donation of frozen eggs in particular (for fertility treatment or research purposes) was positively encouraged as a way of addressing the egg shortage. Increasing the supply of eggs was seen to outweigh concerns for future donor-conceived children not being able to contact their donor/biological parent.³² Recommendation 33 of the evaluation suggests the option of posthumous donation be included in storage agreements.³³

Most recently, the Staatscommissie Herijking ouderschap (State Commission on Parenthood Review) considered PR in its report, 'Kind en ouders in de 21ste eeuw'.³⁴ The report highlighted the importance of prior consent in order to safeguard the 'right to self-determination of the deceased, because that right of self-determination also extends to the use of his or her gametes or embryos after death'.³⁵ Referencing the Modelreglement 2004, the report reiterates the undesirability of a surviving party transferring an embryo, created using the deceased reproductive material, to a surrogate in order to have a child. The Modelreglement 2004 cited the limited experience of IVF-surrogacy in the context of posthumous reproduction (*i.e.* using cryopreserved material) as a reason for caution; the 2016 report echoes, 'That experience is still limited'.³⁶ Yet, the report does not elaborate on what these limitations are, and whether they have changed since 2004. By 2016 when the report was published, scientific and medical experience using IVF, cryopreserved material, and surrogacy services for fertility treatment was certainly not 'limited'. Admittedly, the social experience of using ART specifically for PR purposes was and is more limited – but this is gradually increasing world-wide with no ill consequences reported to date,³⁷ rather the opposite.³⁸

III. Law and regulation: the UK

The Human Fertilisation and Embryology Authority (HFEA) oversees inter alia the regulation of posthumous reproduction in the UK. An independent, arms-length regulator, established under section 5 of the Human Fertilisation and Embryology Act 1990 (HFE Act), the HFEA implements the HFE Act 1990 (as amended), HFE Act 2008 and related legislation. The HFEA's Code of Practice (hereafter 'the Code') is an essential component of the regulatory regime; offering detailed guidance to fertility clinics and research institutes on legal compliance.³⁹ The legal status of the Code is unclear;⁴⁰ although in theory it is not legally binding (breaching the Code is not a criminal offense), failure to observe the standards set in the Code is taken seriously. Both the Code and the Modelreglement fall within the category of non-binding professional guidelines that have acquired *de facto* legal quality through explicit government approval.

Like the Netherlands, posthumous reproduction is not illegal per se in the UK; rather it is conditionally allowed. It is potentially a criminal offense to procure, store, or use a person's gametes without his/her written, effective consent.⁴¹ In the case of already cryopreserved gametes and embryos, prior written, effective consent to continued storage and use after death is required. In the case of obtaining gametes from a comatose person, ideally, prior written consent is needed. In the absence of this, the laws and guidelines governing medical treatment apply, namely, that adults lacking capacity must be treated in their best interests. The case of *L v. Human Fertilisation and Embryology Authority*⁴² clarified that gametes do not fall under the jurisdiction of the Human Tissue Act 2004; the deceased's next of kin, friend or close relative cannot give consent to procure, store or use the deceased's gametes in the way they can for all other organs and human tissue. As in the Netherlands where the Embryo Act governs retained gametes and embryos, the jurisdiction of the HFE Act commences regarding the storage and use of retained reproductive material.

The regulatory framework on posthumous reproduction in the UK is for the most part clear: written, effective consent of the gamete provider is required at every stage. Professional bodies in the Netherlands are recommending a substantively similar regime via the Modelreglement. Both countries offer a relatively clear and liberal framework⁴³ within which PR is allowed under certain conditions, namely with the consent of the gamete provider. This approach attempts to balance the exercise of procreative liberty of the surviving party whilst safeguarding the deceased's posthumous interests over his/her body and its materials (this might mean engaging in gamete procurement and fertility treatment or refraining from doing so). Similarly, both countries require consideration of the welfare of the future child. And both countries are opting to regulate this tricky field through a mixture of legislation and professional guidelines. As a common law country, the UK has a significant additional source of law: legal judgments. Despite the clarity of the legislation and guidelines for the most part, the case law on PR has both highlighted blind-spots in the law, and thrown the legal regime into a state of confusion; the Netherlands would do well to take heed.

IV Challenging the law on PR: the UK experience

The UK's history of PR began for all intents and purposes with the seminal case of *R v. HFEA, ex parte Blood*⁴⁴ Here, following Mr Blood's sudden illness (meningitis) and deterioration into a coma, Mrs Blood surgically harvested her husband's sperm. After his death she wished to be inseminated with the stored sperm. By that time it had come to light that Mr Blood had not provided written, effective consent as to the storage and use of his sperm posthumously, so continued storage and use of the material in the UK was unlawful and an offense under the HFE Act. Furthermore, it was arguable that the retrieval itself was unlawful. Adult patients who lack capacity must be treated in their best interests;⁴⁵ given Mr Blood would never recover it is unclear that undergoing the sperm retrieval process was in fact in his best interests (it served no therapeutic purpose, nor was it entirely clear that he would have wished to procreate under these particular circumstances – save Mrs Blood's evidence). The Court of Appeal acknowledged as much, but following Article 49 of the EC Treaty (right to receive treatment in another Member State)⁴⁶ allowed the export of the sperm to another jurisdiction (namely, Belgium) where the gamete providers consent was not necessary. *Blood*

was seen as an extraordinarily exceptional case, and the CA pronounced that ‘there should be, after this judgment has been given, no further cases where sperm is preserved without consent’.⁴⁷

Despite this, in 2008 *L v. HFEA* came before the courts. This case had a fact-pattern remarkably similar to that of *Blood*. L’s husband, H, died unexpectedly during routine surgery. L sought and obtained an emergency court order to clinically retrieve and store his sperm. It later transpired that the court order was given on the basis of misinformation about the jurisdiction of the Human Tissue Act 2004⁴⁸ (see above), and given H had not provided written consent as to the storage and use of his sperm after death, to do so would be unlawful. L challenged this, and following *Blood* and the application of Article 49 EC Treaty was successful in obtaining permission to export the sperm abroad for use.⁴⁹ L also argued that the HFEA’s strict effective consent requirements for storage and use of the sperm interfered with her right to private and family life under Article 8 of the European Convention on Human Rights (ECHR). The court acknowledged the engagement of L’s Article 8 right. However, in light of the European Court of Human Rights’ (ECtHR) decision in *Evans*,⁵⁰ the court concluded that the HFEA’s consent requirements for storage and use were not incompatible with Article 8, falling within the margin of appreciation. Note that the engagement and implementation of rights under Article 8 is of consideration for the Netherlands as well, although this was not explicitly acknowledged in the guidelines. A brief aside: significantly, for both the UK and the Netherlands, the ECtHR recently considered posthumous reproduction in the case of *Petithory Lanzmann*.⁵¹ The ECtHR ruled that a French court’s refusal to allow the petitioner (Dominique Petithory Lanzmann) to export her deceased son’s cryopreserved sperm to a fertility clinic in Israel in order to use it to conceive grandchildren (using a donor egg, and surrogate) was not incompatible with Article 8.⁵²

L did not settle the law on PR in the UK; quite the opposite. Charles J acknowledged the uncertainty in the law vis-à-vis a) posthumous gamete retrieval and b) the conundrum that once gametes have been retrieved, the lawfulness or not of the retrieval is besides the point - ‘water under the bridge’ to quote Charles J.⁵³ Since *L* a number of cases have arisen. *R (on the application of M)* is notable as the application was brought by the deceased’s grandparents regarding the use of her cryopreserved eggs. Here, retrieval was not at issue. Rather, the case turned on whether appropriate consents for storage and use (namely, with donor sperm, exported abroad) were in place. The CA ruled in favour of the deceased’s parents, who have exported the eggs in question to the US for use.

Most recently, the case of *Y and Z* came before the courts. It is telling that this case was not contested between the parties; rather it was a matter of fulfilling legal formalities. The facts are: following a road traffic accident Z suffered catastrophic brain injury and massive internal abdominal injuries. The clinical prognosis was that he would never recover function, awareness, consciousness or breathe independently. Z’s wife, Y, sought to retrieve his sperm (to be used in fertility treatment) prior to the removal of life support via the Mental Capacity Act 2005 (MCA).⁵⁴ The judge issued an order pursuant to s.16 MCA directing that a suitable person should sign the relevant consent forms on Z’s behalf for the retrieval, storage and use of his sperm.

From the caselaw enumerated above, two areas require clarification: i) the law on retrieval of gametes from dead or dying persons (particularly consent requirements; *Blood*, *L*, *Y and Z*), and ii) the degree of specificity required in the written consents viz. storage and use (as per *R(M)*). In both areas, but particularly (i) the UK and the Netherlands can go further in clarifying the law through issuing specific, detailed guidance. A large part of the difficulty lies in the issue of timing. Gametes must be procured as swiftly as possible after death, or before life support is switched off; understandably, there may not be enough time for protracted legal discussions and applications to the court. Thus, gametes may be unlawfully retrieved, albeit in good faith, (*Blood*; *L*). And, once retrieved it seems that pragmatism prevails: given the gametes have been procured and preserved, it is best that the retrieval procedure was not performed in vain. Certainly, this is the approach that the UK courts and authorities have taken. Destroying sperm samples on the basis of unlawful retrieval in *Blood* and *L* was never considered by either the HFEA or the courts. Smajdor summarizes the situation thus: ‘First, obtaining sperm from a dead or dying man who has not given prior consent is of questionable legality. Second, even if sperm has been obtained without consent, it may be taken abroad and used nevertheless. This second fact constitutes a powerful incentive for disregarding the first...’⁵⁵ A framework that is both coherent and enforceable is necessary.

In the UK a combination of clinical ignorance of the law, haste and above all, overwhelming sympathy for grieving surviving partner/parent has obscured the clear functioning of the law. The confusion that pervades the UK common law jurisprudence on PR might not arise (at least not to the same extent) in the Netherlands for simple reason that the latter is a civil law jurisdiction: the Dutch courts have less scope and flexibility than the UK courts do to engage in creative judicial reasoning and law-making in order to construe consent ‘after the fact’, or ‘game’ the rules to evade consent requirements. Nonetheless, for the Netherlands the lesson to learn from the UK experience is to address PR in a more detailed manner, considering more complex factual matrices and the operation of the law therein.

V. Conclusion

The publication of the Modelreglement 2018 offers a good opportunity to reflect on the regulation of PR both in the Netherlands and abroad. Here, I have focused on the regulatory frameworks of the Netherlands and the UK, two jurisdictions that take a similar approach, but differ in age. Although both countries are engaged in the regulation of PR, further guidance on the law is required from both jurisdictions, particularly in relation to posthumous gamete retrieval, and anticipation of requests from those other than the deceased’s surviving spouse/partner. As public awareness of PR increases in the Netherlands, it is reasonable to assume so too will requests to use this form of ART. It is therefore critical to set out a careful and detailed framework governing PR. What can be learned from the UK experience is that clarity and consistency is key in navigating this ethically and emotionally sensitive area, particularly given the importance of timing in conducting retrieval procedures. Finally, there is an important public policy point to be made regarding raising awareness of the conditions under which PR is allowed. Given the UK and the Netherlands demand prior written consent (although as we have seen, in the UK this is not always enforced), and given that consideration of PR is not a commonplace concern for most people,⁵⁶ it is imperative to raise awareness of the reproductive options available and the applicable law and regulations, so that citizens have the best chance of planning their reproductive and family lives in an informed manner.

Noten

¹ See the following recent news stories: S. McDermott, ‘I Never Met My Daughter’s Dad - She Was His Dying Wish’, *BBC News* (22 May 2019), www.bbc.com/news/stories-48281662 (last accessed 24 July 2019); Liam Stack, ‘Parents of West Point Cadet Fatally Injured in Accident Obtain Order to Preserve His Sperm’, *The New York Times* (6 March 2019), www.nytimes.com/2019/03/05/nyregion/west-point-peter-zhu-death.html (last accessed 14 April 2019); L. Bever and A. Chiu, ‘A

Cadet Died in a Tragedy. Now His Parents Can Use His Sperm to Create His Child, a Judge Rules', *The Washington Post* (22 May 2019), www.washingtonpost.com/health/2019/05/21/cadet-died-tragedy-now-his-parents-can-use-his-sperm-create-his-child-judge-rules/ (last accessed 5 February 2020).

2 Translates as 'Dutch Association for Obstetrics and Gynaecology'.

3 Translates as 'Association for Clinical Embryology'.

4 Modelreglement Embryowet, Nederlandse Vereniging voor Obstetrie & Gynaecologie & Vereniging voor Klinische Embryologie (27 August 2018), www.nvog.nl/wp-content/uploads/2018/08/Modelreglement-Embryowet-NVOG-en-KLEM-definitief-augustus-2018.pdf (last accessed 31 July 2019). Translates as 'Model Regulation Embryo Act' and hereafter referred to as 'Modelreglement'.

5 'Gynaecologists Urge "reticence" in Use of Dead Men's Sperm', *DutchNews.nl - Live* (6 September 2018), www.dutchnews.nl/news/2018/09/gynaecologists-urge-reticence-in-use-of-dead-mens-sperm/ (last accessed 29 June 2019); Maud Effting & Gijs Herderscheë, 'Gynaecologen: dode man mag geen zaad "doneren" voor verwekken baby', *de Volkskrant* (5 September 2018), <www.volkskrant.nl/gs-b65f7558> (last accessed 29 June 2019).

6 'Gynaecologists Urge "reticence" in Use of Dead Men's Sperm' (n 5); Herderscheë (n 5).

7 Reported instances and litigation are few and far between leading to the inference of a lack of controversy; an exceptional example is found in: J.L. Epker, Y.J. de Groot and E.J.O. Kompanje, 'Ethical and Practical Considerations Concerning Perimortem Sperm Procurement in a Severe Neurologically Damaged Patient and the Apparent Discrepancy in Validation of Proxy Consent in Various Postmortem Procedures', *Intensive Care Medicine* 2012, vol. 38, p.1069.

8 Please note that I do not follow a strict comparative law methodology; rather, this article presents an informal comparison between the regulation of PR in the UK and the Netherlands, and should be read as such. Please also note that within the UK context I refer to English and Welsh law only. I do not cover the law in Scotland and Northern Ireland, although some of what is discussed here will also apply to those jurisdictions.

9 By the time this paper is published the UK will be in the transition period of leaving the European Union. Although EU law and the jurisdiction of the European Court of Justice is ending for the UK, the jurisprudence developed to date remains relevant for the analytic purposes of this paper, and for other EU Member States, of which the Netherlands is one.

10 Other jurisdictions have taken different approaches: Germany, Sweden, Italy, France, Hungary, Slovenia, Norway, Malaysia and Taiwan have banned it outright. In the UK, the Netherlands and Greece PR is legal with the prior consent of the deceased. Israel operates a particularly permissive framework based on presumed consent in certain circumstances. There is wide state variation in countries operating federal systems of governance, such as Australia, America and Canada with some states regulating PR through the framework on assisted reproduction and others through the framework on organ donation. Finally, in many countries, PR is simply unregulated. Sources: Browne Lewis, *The Ethical and Legal Consequences of Posthumous Reproduction: Arrogance, Avarice and Anguish* (Routledge 2016), p. 30-31; K. Tremellen and J. Savulescu, 'A Discussion Supporting Presumed Consent for Posthumous Sperm Procurement and Conception', *Reproductive BioMedicine Online* 2015, vol. 6, p. 30.

11 See my caveat in footnote 8.

12 The Modelreglement was put together at the request of Health Minister Hugo de Jonge, due to the rapid advances in ART.

13 Embryowet (20 juni 2001) wetten.overheid.nl/BWBR0013797/2019-04-02 (last accessed 31 July 2019).

14 Embryowet. [Explanatory Memorandum to the Dutch Embryos Act]. Tweede Kamer der Staten Generaal, vergaderjaar 2000-2001, 27 423, nr. 3. 2000.

15 Kwaliteitsinstituut voor de Gezondheidszorg CBO (2003), Modelreglement Embryowet, Alphen aan de Rijn: Van Zuiden Communications B.V. Hereafter referred to as 'Modelreglement 2004'.

16 I thank Lisette van ten Haaf for her invaluable assistance in checking and amending the 'google translate' translation of the Modelreglement 2018 from Dutch into English.

17 The less controversial situation whereby conception takes place, and the father/second parent dies during the course of the pregnancy is explicitly not covered (s.5.2). No mention is made of the situation where the pregnant woman herself is kept on life support in order to deliver the baby.

18 *R (on the application of M) v. Human Fertilisation and Embryology Authority* [2016] EWCA Civ 611 (CA).

19 Fei Lanfang and Zhou Peng, 'The Law Itself Is Not Above Human Beings: Comments on China's First Case on Frozen Embryos', *International Journal of Law, Policy and the Family* 2015, vol. 29, p. 260.

20 'Woman Uses Dead Son's Sperm for IVF Grandchildren - BioNews', www.bionews.org.uk/page_96375 (last accessed 14 April 2019).

21 'Israeli Court Allows Use of Dead Soldier's Sperm - BioNews', www.bionews.org.uk/page_90274 (last accessed 12 April 2019); 'Landmark Case Allows Israeli Family to Freeze Their Dead Daughter's Eggs - BioNews', www.bionews.org.uk/page_93128 (last accessed 14 April 2019). But see also: 'Court Rules Israeli Parents Cannot Use Dead Son's Sperm - BioNews', www.bionews.org.uk/page_95875 (last accessed 14 April 2019).

22 Stack (n 1); Bever and Chiu (n 1).

23 ECHR 12 November 2019 (*Petithory Lanzmann v. France*) no. 23038/19.

24 I acknowledge the absurdity of referring to the ‘autonomy of the deceased’, however this is the language used in the Modelreglement (‘de autonomie van de overledene’). A better approach would have been to refer to the deceased’s *interests* (on which see: N. Hyder-Rahman, ‘Consent and the protection of the deceased’s interests in posthumous reproduction’ (5 February 2020). Available at SSRN: <http://ssrn.com/abstract=3532696>, and more generally: D. Sperling, *Posthumous Interests: Legal and Ethical Perspectives* (Cambridge University Press, 2008).

25 Modelreglement, s. 5.4 p. 33

26 Consideration of the type of consent we should demand, and whether or not we ought to demand consent at all, while important to the discussion is a) beyond the scope of this commentary (but see: Hyder-Rahman (n 24)) and b) a moot point as the provisions are already effective.

27 In part due to this Kelton Tremellen and Julian Savulescu argue for a shift in policy towards presumed consent: Tremellen and Savulescu (n 9); K. Tremellen and J. Savulescu, ‘Posthumous Conception by Presumed Consent. A Pragmatic Position for a Rare but Ethically Challenging Dilemma,’ *Reproductive Biomedicine & Society Online* 2016, vol. 3, p. 26. PR requests using existing cryopreserved gametes or embryos are less problematic as the progenitor would have been prompted to consider posthumous use during the administration of the retrieval and storage procedures.

28 In the UK, Diane Blood (see further below) fought a second legal battle to have her late husband (whose sperm she posthumously retrieved and used) named on the birth certificates of her two sons. She argued *inter alia* the engagement of the ECHR Art. 8 right to private and family life. The case did not go to judgment. As a result of campaigning by Mrs Blood, in 2003 the UK amended the HFE Act 1990 to allow her to name her late husband on their children’s birth certificates. See: ‘Diane Blood Has Human Rights Success - BioNews’, www.bionews.org.uk/page_88876 (last accessed 29 June 2019). The Human Fertilization and Embryology Act 2008 (Part 2) further updated the law on parenthood in light of assisted reproduction, www.legislation.gov.uk/ukpga/2008/22/contents (last accessed 5 February 2020). The rules of parentage are set out in Book 1 of the Dutch Civil Code (Law of Persons and Family Law), particularly Arts. 1:197-1:207, www.dutchcivillaw.com/civilcodebook01.htm (last accessed 5 February 2020). For a clear explanation of the law on parentage under the Dutch Civil Code see: M. Vonk, *Children and their Parents* (Antwerp, Oxford: Intersentia 2007) particularly p. 53-56 referring specifically to PR and parentage, and the consequences thereof. Briefly, at present the situation in the UK and the Netherlands is similar: a man whose sperm (including embryos created using his sperm) is used to conceive a child after his death may be named as the legal father for the purposes of birth registration only (*i.e.* there are no consequences vis-à-vis the deceased’s estate), provided all the relevant consents for the use of his reproductive material were obtained prior to death. However, if a woman’s eggs are used to conceive a child after she has died, she will not be named as the legal mother on the birth certificate. In both the Netherlands and the UK, the woman who gives birth (in this instance, the surrogate) is automatically acknowledged as the legal mother (Art. 1:198 DCC and s. 33 HFE Act (2008) respectively) – though this can subsequently be transferred through a parental order or adoption. In both jurisdictions then, the law is not aligned with the practical possibility of posthumous motherhood that current cryopreservation and assisted reproduction techniques offer. The complexities of attributing legal parenthood in the context posthumous reproduction, though vitally important, remain outside the scope of this paper.

29 For instance, it was not until 2012 that the ASRM deemed the practice no longer ‘experimental’: The Practice Committees of the American Society for Reproductive Medicine and the Society for Assisted Reproductive Technology, ‘Mature oocyte cryopreservation: a guideline’, *Fertility and Sterility* 2012, vol. 99, p. 37-43. The first successful pregnancy using a cryopreserved human egg was reported in 1986: C. Chen, ‘Pregnancy after human oocyte cryopreservation’, *Lancet* 1986, vol. 327(8486), p. 884-886. The first successful pregnancy using the vitrification method of freezing was reported in 1999: L. Kuleshova *et al.*, ‘Birth following vitrification of small number of human oocytes’, *Human Reproduction* 1999, vol. 14(12), p. 3077-3079.

30 In addition to the documents discussed here see also: Vonk (2007); T. Oudhof, ‘Het belang van het kind bij kunstmatige voortplanting’, *Tijdschrift voor Familie en Jeugdrecht* 2002, vol. 11, p. 288-298; E. Loeb & J.C. van Straaten, ‘Voortplanting van de mens anno’, *NJB* 1984, vol. 33.

31 Evaluatie Embryowet en Wet donorgegevens kunstmatige bevruchting (Den Haag: ZonMw, September 2012), https://publicaties.zonmw.nl/fileadmin/zonmw/documenten/Jeugd/Evaluatie_Regelgeving/Evaluatie_Embryowet_en_Wet_donorgegevens_ (last accessed 5 February 2020).

32 Evaluatie Embryowet (2012) p. 255.

33 Evaluatie Embryowet (2012) p. 255. A similar view viz. male gametes has recently been articulated here: N. Hodson & J. Parker, ‘The ethical case for non-directed post-mortem sperm donation’, *Journal of Medical Ethics*, 2020, vol. .0, p. 1-4.

34 Staatscommissie Herijking Ouderschap, ‘Kind en ouders in de 21ste eeuw’ (December 2016).

35 Kind en ouders in de 21ste eeuw, see s. 4.2.5, p.114-115.

36 Kind en ouders in de 21ste eeuw, p.114-115.

37 Hyder-Rahman (n 24).

38 McDermott (n 1).

39 HFEA Code of Practice (9th edn), HFEA (January 2019, London), www.hfea.gov.uk/media/2793/2019-01-03-code-of-practice-9th-edition-v2.pdf (last accessed 31 July 2019).

40 Under s. 25 of the HFE Act, the HFEA must maintain a Code of Practice, and further, under s. 8(cb) the HFEA must encourage compliance with the Code and can issue clinics Directions on specific issues with which they must comply. See: E. Jackson, *Medical Law: Text, Cases, and Materials* (Oxford University Press, 2013), p. 804-805.

41 Code of Practice, p. 44-45.

42 [2008] EWHC 2149 (Fam).

43 For comparison, Israel operates an arguably more liberal framework, regulating PR via a system of presumed consent (see: S. Simana, 'Creating Life after Death: Should Posthumous Reproduction Be Legally Permissible without the Deceased's Prior Consent?', *Journal of Law and the Biosciences*, 2018, vol .5, p. 329). On the other hand, France has an arguably less liberal framework where the *Parpalaix* case (*Parpalaix c. CECOS* [Tribunal de Grande Instance de Creteil (1 Ch.cir) August 1, 1984) triggered a ban on PR altogether.

44 [1997] 2 WLR 806 (CA).

45 *Re F* (Mental Patient: Sterilisation) [1990] 2 AC 1. Note that as *Blood* came before the courts prior to the Mental Capacity Act 2005 (discussed below) the principle of best interests referred to in that context was the common law principle established by the House of Lords in *Re F*. On the history and development of the principle of best interests in the UK see: H.J. Taylor, 'What are "best interests"? A critical evaluation of "best interests" decision-making in clinical practice', *Medical Law Review* 2016, vol. 24(2), p. 176-205.

46 Treaty Establishing the European Community (Consolidated version 2002), <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A12002E%2FTXT> (last accessed 31 July 2019).

47 Lord Woolf MR at para.61, *ex parte Blood*.

48 The harvesting and use of reproductive tissue does not fall within the remit of the HTA 2004; a qualifying relative cannot give consent for such tissue to be obtained from the deceased.

49 The EC Treaty applies to the Netherlands too and would form part of the regulatory regime governing PR – a fact that is not noted in the Modelreglement.

50 ECHR (Grand Chamber) 10 April 2007 (*Evans v. United Kingdom*) no. 6339/05.

51 ECHR 12 November 2019 (*Petithory Lanzmann v. France*) no. 23038/19.

52 Art. L. 2142-2 of the Code de la santé publique (French Public Health Code) only authorizes fertility treatment for living, heterosexual couples in order treat infertility or prevent the transmission of serious illness to the future child, or conjugal partner. Exportation is only allowed if the conditions of Art. L. 2142-2 are met. The petitioner ('PL') argued that Art. L.2142-2 interfered with her son's right under Art. 8 to decide how and when to become a parent (he had, according to PL's evidence, wished for his sperm to be used posthumously to conceive 'his' child), and her own Art. 8 right to become a grandparent. The ECtHR ruled that the prohibitions to posthumous reproduction and export in Art. L. 2142-2 were not incompatible with Art. 8. Furthermore, PL's son's right to decide how and when to become a parent is a non-transferable right and cannot be asserted by PL on his behalf. Finally, ECtHR ruled that Art. 8 does not encompass the right to become a grandparent. The impact of this landmark ruling on the legal, social and ethical dimensions of PR within Europe and beyond remains to be seen.

53 *L v. HFEA*, Charles J at para.148 See also *ex parte Blood*, Lord Woolf MR, at para. 29.

54 Here again it is difficult to see how such a procedure is in the patient's best interests (s.1 MCA). See also n. 32 above.

55 'Posthumous Retrieval of Gametes: A Case of Deja vu? - BioNews', www.bionews.org.uk/page_91659 (last accessed 30 June 2019).

56 Those undergoing fertility treatment will be prompted to consider PR, others will not necessarily have a similar prompt. The practical matter of how to raise awareness is not within the scope of this paper, although one could envisage prompts in place at when writing or amending a will, living will, advance directives, organ and tissue donation wishes, and other critical moments, such as applying for a marriage licence, pre- and post-nuptial agreements, obtaining a driver's license etc.