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**Tuarascáil ar an nGrinnscrúdú Réamhrechtach ar Scéim Ghinearálta an
Bhille um Atáirgeadh Daonna Cuidithe**

Iúil 2019

JOINT COMMITTEE ON HEALTH

**Report on Pre-Legislative Scrutiny of the General Scheme of the
Assisted Human Reproduction Bill**

July 2019

[32H0027]

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Chair's Foreword



Dr. Michael Harty T.D.
(Rural Independent Technical Group)

The General Scheme of the Assisted Human Reproduction (AHR) Bill is an ambitious piece of legislation which proposes to provide a legal framework for AHR treatments and, in addition, sets out provisions for the establishment of a regulatory authority.

The Committee conducted pre-legislative scrutiny earlier this year and is generally supportive of the objectives of the draft legislation. In this report the Committee has made a number of recommendations regarding some of the key areas which arose during its examination.

The Committee wishes to extend its gratitude to all witnesses who attended our public sessions and to all stakeholders who submitted written submissions. The Committee also acknowledges the Department of Health and its associated bodies for their work in preparing the bill, the staff of the Library and Research service, who assisted in the preparation of this report, and the clinics providing AHR treatment.

Finally, the Committee recognises that central to this topic, which has both legal and societal implications, are individuals with very complex, human and emotive situations. It is essential that a regulatory and statutory framework is established that supports, protects and assists both persons in need of AHR treatment and children born as a result of AHR treatment. It is also important that the legislation provides sufficient autonomy to clinicians and users in order to address complex and individual conditions.

A handwritten signature in black ink that reads "Dr. Michael Harty T.D." followed by a stylized flourish.

Dr. Michael Harty, T.D.
Chair
Joint Committee on Health
10 July 2019

Executive Summary

The General Scheme of the Assisted Human Reproduction Bill sets out to provide a specific regulatory framework for Assisted Human Reproduction (AHR) treatments and services in Ireland. AHR treatment is available in Ireland, however the provision of services remain largely unregulated. This legal vacuum has created difficulties for individuals seeking AHR services, clinicians providing AHR treatment and children born as a result of AHR treatment.

The Bill includes provisions for gamete and embryo donation, surrogacy, pre-implantation genetic diagnosis (PGD), embryo and stem cell research and posthumous assisted reproduction. The Bill also proposes for the establishment of a regulatory body, the Assisted Human Reproduction Regulatory Authority (AHRRA) and details its functions in the context of the oversight and regulation of compliance with the proposed legislation, including the issuing of licences to AHR treatment providers and researchers.

The Joint Committee on Health conducted its pre-legislative scrutiny through a series of four meetings which took place on 17 January 2018, 28 February 2018, 19 December 2018 and 27 February 2019.

A wide range of stakeholders attended these meetings including officials from public bodies, representatives of AHR treatment providers and patient advocates. The Committee also invited written submissions on the Bill and received in-depth analysis and opinions by stakeholders. The Committee also received a large number of written submissions from a variety of stakeholders. These are viewable online and provide further consideration.

A number of the recommendations in this report advocate for increasing autonomy to clinicians and, in some situations, it may be more appropriate for some decisions to be left between patients and their doctors where guidelines drawn up by the Authority can assist in achieving best outcomes..

Technological advancements are likely to impact upon AHR and will require ongoing changes to the legislative framework of AHR. As such, it may be more appropriate that most of these technical and medical provisions are regulated by way regulation as this will allow more flexible changes. The report also recommends further examination regarding a number of provisions which witnesses noted as potentially problematic, such as the status of children born under international surrogacy treatments and inconsistencies regarding the treatment of children born before and after 36 months through Posthumous Assisted Reproduction

treatment. The Committee notes that AHR is a continually developing field and recommends post-enactment scrutiny of the implementation of the legislation.

The Committee welcomes the objectives of the General Scheme and its attempts to provide a statutory framework to assist people who require assistant human reproduction treatment. The Committee also supports the provision that the welfare of a child, born through AHR treatment, will be paramount in the legislation.

The Committee is cognisant that Assisted Human Reproduction is a sensitive and complex issue and the Bill as drafted will most likely be subject to further amendment during its passage through both Houses.

Glossary

Term	<i>Explanation / Meaning in this Paper</i>
Assisted Human Reproduction (AHR)	All treatment or procedures that involve the handling of gametes and embryos for the purposes of establishing a pregnancy;
Cloning (reproductive)	Production of a human being that is genetically identical to another (by the nuclear substitution from a human adult somatic cell or child cell, or by artificial embryo splitting).
Commercial Surrogacy	A surrogacy arrangement in which the surrogate mother is paid for being a surrogate (as distinct from expenses relating to the surrogacy).
Cryopreservation	Procedure used to preserve and store embryos, sperm and or ova by freezing to very low temperatures.
Donor Assisted Human Reproduction (DAHR)	An assisted human reproduction procedure using a donated gamete(s) (sperm and/or egg).
Donor Conceived (DC) person	a person born as a result of a DAHR procedure
Embryo	Means a human embryo formed by the fertilisation of a human egg by a human sperm;
Embryonic Stem Cells	Embryonic stem cells – cultured embryonic cells that can proliferate indefinitely and differentiate into many different cell types and tissues.
Egg/Oocyte donation	The donation of eggs for use by another person /people in AHR or for research
Gamete (human)	Means: (a) a human sperm (spermatozoa), which is formed in the body of and provided by a man, or (b) a human egg (ova), which is formed in the body of and provided by a woman.
Intending parent(s)	Means, in relation to an AHR treatment procedure, a person who intends to be the parent of any child born as a result of that procedure;
Intra Uterine Insemination (IUI)	Artificial insemination is a treatment for infertility, when a couple cannot conceive a baby. It involves directly inserting sperm into a woman's womb.
In Vitro Fertilisation (IVF)	<i>In Vitro</i> Fertilisation – a method of assisted human reproduction that surgically removes an ovum (egg) from a woman's ovary and combines it with sperm in a laboratory. If the ovum is fertilised the resulting embryo is subsequently placed in the woman's uterus where implantation may take place.
Ovum (Egg)	Female reproductive cell.
Pluripotent Stem Cells	Cells that can generate all cell types in a foetus and in the

	adult that are capable of self-renewal. Pluripotent stem cells are not capable of developing into an entire organism.
Pre-Implantation Genetic Diagnosis PGD:	Means a procedure for genetically testing embryos for specific genetic or chromosomal mutations prior to transfer involving the biopsy of embryos to remove one or more cells, and selection of embryos for transfer on the basis of the results from the analysis.
Posthumous Assisted Human Reproduction (PAR)	Refers to the use of a person's gametes (sperm or eggs), or an embryo created using a person's gametes, in an AHR treatment procedure after his or her death.
Regenerative medicine (also known as therapeutic cloning)	Regenerative medicine (also known as therapeutic cloning) involves the creation of a cloned embryo using non-diseased donor cells from a patient with a degenerative disease or disorder. The objective is to use the cloned embryo to generate a stem cell line (immortalising those cells) that, in turn, can be used to generate a particular tissue for treatment of the disease in question.
Sex selection	Refers to any procedure carried out in order to increase the probability, or ensure that a human embryo will be of a particular sex;
Spermatozoa (Sperm)	Gametes produced by the male gonads.
Sperm donation	The donation of sperm for use by another person/people in AHR or for research
Stem cells	Cells that have the ability to divide indefinitely and to give rise to specialised cells as well as to new stem cells with identical potential.
Surrogacy	The process where a woman agrees to carry a child for another person(s).

Recommendations

The Committee recommends as follows:

1. That provision is made for a review of the operation of the legislation and that a related report be brought to the Houses of the Oireachtas within twelve months of the enactment of the Bill.
2. The provisions relating for counselling to be mandatory for all recipients of Assisted Human Reproductive (AHR) treatment be deleted. In that regard, the Committee is supportive of the availability of counselling services for all AHR treatment but recommends that, in some situations, the decision to undertake such services is more appropriately decided between a clinician and the person(s) availing of AHR treatment.
3. That the legislation makes provision to allow for the Minister to regulate for age limits within AHR treatment which would then enable the Authority to issue guidelines.
4. That further consideration be given to the number of embryos allowed in each AHR treatment. The Committee recommends that the provisions underpinning the number of embryos to be transferred during IVF should be subject to guidelines which should be underpinned by secondary legislation. The Committee also recommends that more autonomy should be provided to clinicians, with regard to the number of embryos used in each AHR treatment, in the case of specific scenarios.
5. That an ethics committee to be established as part of the oversight and governance by the Board of the Authority, which would be responsible for examining and determining issues relating to the welfare of children, as set out in the provisions under Head 6(1) of the Bill.
6. That further clarity be provided in respect to the provision dealing with the welfare of the child. The Committee acknowledges that the term 'welfare', as used in the Bill, may have a different criteria to the term 'best interests' as defined in the explanatory note.
7. That further consideration be given to the provisions regarding surrogacy (Part 6), with specific attention to:
 - inconsistencies with may arise relating to international surrogacy arrangements and in particular to parentage issues with may arise for children born through ISA
 - the proposed ban on providing legal or practical advice to people who intend to enter into surrogacy arrangements other than those permitted under the

proposed legislation

- only providing for gestational surrogacy within the provisions for surrogacy. The Committee notes the argument of stakeholders that the provision to only provide for this approach is too restrictive, excludes many people from accessing surrogacy arrangements and is not consistent with other provisions within the General Scheme.
- supporting international collaboration with the view of examining complex issues such as the transfer of parentage. The Committee also supports entering bilateral or multilateral agreements to recognise and introduce standards in relation to international surrogacy.

8. In relation to Part 3 of the General Scheme (gamete and embryos), that:

- further consideration be given to the proposed time limits for storage of gametes and embryos. The Committee recommends that provision is made to allow specific cases, such as those of children undergoing cancer treatment, additional dispensation.
- the availability of medical information to donor-conceived people be provided where it would indicate that they are predisposed to certain disease(s).
- that further clarification be provided by the Department of Health on whether or not egg-sharing is allowable under the General Scheme.

9. Further consideration be given to Part 4 of the Bill, regarding Posthumous Assisted Reproduction (PAR), and specifically to:

- inconsistencies with regard to excluding male surviving partners (in opposite sex and same sex couples) from accessing posthumous AHR treatment.
- inconsistencies regarding the treatment of children born before and after 36 months through PAR treatment, specifically with regard to parentage and inheritance rights.

10. With regard to Part 5 of the General Scheme (pre-implantation genetic diagnosis):

- that Pre-implantation Genetic Diagnosis should be included in any public provision/ funding of AHR treatment,
- that adequate resources be made available to ensure that the appropriate number of geneticists and genetic counsellors are available to fulfil the provisions of the General Scheme.

11. That further consideration be given regarding the powers and functions of the Authority (Part 8), with specific attention given to:

- investigating consumer complaints
- protecting against financial exploitation

- collecting and providing information regarding success rates between service providers and providing information on infertility and related support
- protecting the financial interests of patients in the case of the closure of a service provider and a role in safeguarding patients' gametes/ embryos
- amending the proposed powers of the Authority to include a research function, specifying that it will conduct and publish research on services, demand, patient experience, short and long-term health and well-being on patients and children born through AHR and the broader social, ethical, health, legal and economic implications of AHR.

1. Introduction

1.1 Pre-Legislative Scrutiny (PLS) of the General Scheme

The General Scheme of the Assisted Human Reproduction Bill was approved (and published) by the Government on 3 October 2017.

On 11 October 2017, the Minister of Health, Mr Simon Harris TD, wrote to the Joint Committee on Health, referring the Bill for pre-legislative scrutiny.

The Joint Oireachtas Committee on Health conducted pre-legislative scrutiny of the General Scheme of the Bill at four meetings which occurred on:

- 17 January 2018¹
- 28 February 2018²
- 19 December 2018³
- 27 February 2019⁴

These meetings were attended by officials from the Department of Health and representatives of the Health Service Executive, the Irish Fertility Society, the Merrion Fertility Clinic, the National Fertility Centre in Rotunda Hospital, University College Cork, Trinity College Dublin, the National Infertility Support and Information Group, LGBT Ireland and advocates of donor-conceived person's perspective.

A full list of each stakeholder and the date on which they attended the Committee's meeting is detailed in **Appendix 2: Public Meeting List of Witnesses**.

The Committee also issued a public call for submissions. [These can be viewed here](#).⁵

1.2 Why Legislate

Ireland has no national legislation to govern Assisted Human Reproduction and much of the framework concerning AHR is impacted by case law and other legislation, namely:

- procedures regarding the handling, storing and testing of sperm and eggs are subject to EU Regulations and are overseen by the Health Products Regulatory Authority

¹ https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2018-01-17/3/

² https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2018-02-28/3/

³ https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2018-12-19/2/

⁴ https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2019-02-27/2/

⁵ https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_health/submissions/2019/2019-07-10_submissions-report-on-pre-legislative-scrutiny-of-the-general-scheme-of-the-assisted-human-reproduction-bill_en.pdf

- the Children and Family Relationship Act 2015 provides for an end to anonymous gamete donation and the registration of donors. (These parts of Act have not yet commenced)
- children's rights and the protection of their welfare and best interests are established principles in Irish law (Constitution⁶ and legislation⁷)

1.3 Background to Legislation

The Department of Health (the Department) stated that the purpose of the proposed assisted human reproduction (AHR) legislation is to provide for the regulation of a range of practices, including:

- gamete (sperm or egg) and embryo donation for assisted human reproduction (AHR) and research;
- surrogacy;
- pre-implantation genetic diagnosis (PGD) of embryos;
- posthumous assisted reproduction; and
- embryo and stem cell research.

The General Scheme also provides for an independent regulatory authority for AHR. The Department explained that:

“An important aim of the legislation is promote and ensure the health and safety of parents, and children born as a result of AHR treatment, as well as other parties who may be involved such as donors and surrogates. In this regard consideration of the welfare and best interests of children born through AHR is a key principle underpinning the Scheme.”⁸

⁶ Article 42(A)

⁷ Including Child Care Act 1991, the Children Act 2001 and the Children and Family Relationship Act 2005

⁸ <https://health.gov.ie/blog/press-release/government-approves-the-drafting-of-the-assisted-human-reproduction-bill/>

2. Summary of the General Scheme

The Bill consists of 9 parts which are divided into 86 Heads.

General Scheme of the Assisted Human Reproduction Bill 2017

Part 1	PRELIMINARY AND GENERAL
Part 2	GENERAL PRINCIPLES General Principles that apply in the context of all AHR treatments and procedures, including requirements regarding informed consent and counselling.
Part 3	GAMETE AND EMBRYO DONATION Conditions relating to an individual or couple donating his/her or their gametes and embryos for use in AHR treatment by others and/or for use in research and relating to people accessing AHR treatment involving donated material.
Part 4	POSTHUMOUS ASSISTED REPRODUCTION Provides for posthumous assisted reproduction (PAR) in certain circumstances, whereby gametes provided by a deceased person, or embryos created using those gametes, may be used in AHR treatment for that person's surviving spouse, civil partner or cohabitant.
Part 5	PRE- IMPLANTATION GENETIC DIAGNOSIS AND SEX SELECTION Permitting pre-implantation genetic diagnosis (PGD), sex selection (for medical purposes) and human leucocyte antigen (HLA) ⁹ matching in the context of AHR treatment, provided certain eligibility criteria are fulfilled.
Part 6	SURROGACY Outlining the specific conditions under which surrogacy will be permitted, including a requirement for all surrogacy agreements to be pre-authorised by the Regulatory Authority. These provisions also put in place a court-based mechanism through which the parentage of a child born through surrogacy may be transferred from the surrogate (and her husband, if applicable) to the intending parent(s).
Part 7	EMBRYO AND STEM CELL RESEARCH Stipulating the conditions under which research involving embryos, embryonic stem cells and induced pluripotent stem cells may be permitted, subject to licence, as well as prohibiting specific associated practices, such as reproductive cloning.

⁹ Head 31 - Human leucocyte antigen (HLA) matching refers to the use of PGD for the purpose of testing and selecting embryos that would result in a child whose tissue was compatible with that of an existing, sick child;

Part 8 **ASSISTED HUMAN REPRODUCTION REGULATORY AUTHORITY**

Providing for the establishment of the Assisted Human Reproduction Regulatory Authority and detailing its functions in the context of the oversight and regulation of compliance with the proposed legislation, including the issuing of licences to AHR treatment providers and researchers.

Part 9 **OFFENCES, PENALTIES AND PROCEEDINGS**

3. Key Issues

Following its scrutiny of the General Scheme of the Assisted Human Reproduction Bill, the Committee recommends that further examination be given to a number of key issues. For further consideration, all submissions to the Committee are available online.¹⁰

3.1 Post-Enactment Scrutiny

The Committee recognises the nature of the developing field of science and medicine in fertility treatment and recommends that the Bill, when enacted, be subject to post-enactment scrutiny.

The Committee notes Section 164(A) of the Standing Orders of Dáil Éireann which states that following twelve months of the enactment of the Bill, the Minister “shall provide a report which shall review the functioning of the Act and which shall be laid in the Parliamentary Library.”¹¹

1. The Committee recommends that the Bill specifically provides for a review of the operation of the legislation and that a related report be brought to the Houses of the Oireachtas within twelve months of the enactment of the Bill.

3.2 Counselling

Head 8 of the Bill provides for counselling to be mandatory for intending users of AHR treatment and services. Stakeholders agree that counselling should be available and encouraged; however, there is debate on whether such services should be compulsory for all users. For example, the Irish Fertility Society, representing health professionals working in fertility clinics, opposes counselling being made mandatory except in the cases of donor gamete or embryo treatment, surrogacy or posthumous conception.¹²

¹⁰https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_health/submissions/2019/2019-07-10_submissions-report-on-pre-legislative-scrutiny-of-the-general-scheme-of-the-assisted-human-reproduction-bill_en.pdf

¹¹ http://data.oireachtas.ie/ie/oireachtas/parliamentaryBusiness/standingOrders/dail/2017/2017-01-17_consolidated-standing-orders-of-dail-eireann_en.pdf

¹² Submission (18) Irish Fertility Society, February 2018,

The Committee also notes the view of the representative of the National Fertility Centre, Rotunda Hospital who stated that counselling should be available and encouraged but not mandatory. The representative cited feedback from a “significant number of patients” who expressed that “they did not believe it (counselling) was either necessary or helpful”. The representatives added that “many patients did find it helpful, but we found that the patients who self-directed counselling got more from it than the patients who were forced into doing it.”

2. The Committee recommends that the provisions relating for counselling to be mandatory for all recipients of Assisted Human Reproductive (AHR) treatment be deleted. In that regard, the Committee is supportive of the availability of counselling services for all AHR treatment but recommends that, in some situations, the decision to undertake such services is more appropriately decided between a clinician and the person(s) availing of AHR treatment.

3.3 Age Limits

There are several provisions within the Bill which are restricted to recipients and donors of a specific age range. These include:

- Recipients of AHR treatment must be aged between 21 years and 47 years old.¹³
- Egg donors must be between 18 years and 35 years old.¹⁴
- Sperm donors must be aged between 18 years and 40 years old.¹⁵
- A surrogate mother must be aged between 25 years and 47 years old.¹⁶

The Committee heard concerns from some stakeholders that the age limits within the Bill are too restrictive¹⁷ and that each individual case should be reviewed on its own merits. The Committee is also cognisant that as AHR and medical technology advances, some restrictions may no longer be appropriate. It was deemed, by many stakeholders, that the requirement for age limits was important but that it may be more appropriate for age limits to

¹³ Head 6(3) & (4)

¹⁴ Head 12 (1)

¹⁵ Head 12(1)

¹⁶ Head 38(1)

¹⁷ Included in submissions: (16) Irish Clinical Embryologists, (18) National Fertility Society and (11) Fiona Duffy

be managed within guidelines assigned by the regulatory authority.¹⁸ This would allow a continuing debate and analysis and may facilitate alternation if appropriate.

3. The Committee recommends that the legislation makes provision for the Minister to regulate for age limits within AHR treatment which would then enable the Authority to issue guidelines.

3.4 Limits on the Number of Embryos

Head 10 provides for a limit of one embryo to be transferred to a woman's uterus as part of IVF treatment or two embryos in some cases. This policy is proposed in order to control the number of multiple births (which are regarded as undesirable due to negative health impacts on mothers and children).

The Committee acknowledges stakeholders' concerns that rather than embryo transfer limits being provided for in legislation it should be the subject of regulatory guidance, with some leeway for clinicians to decide to transfer more embryos on a case-by-case basis.

4. The Committee recommends that further consideration be given to the number of embryos allowed in each AHR treatment. The Committee recommends that the provisions underpinning the number of embryos to be transferred during IVF would be subject to guidelines which should be underpinned by secondary legislation. The Committee also recommends that more autonomy should be provided to clinicians, with regard to the number of embryos used in each AHR treatment, in the case of specific scenarios.

¹⁸ Included in submission 18: Irish Fertility Society and 23: National Woman's Council of Ireland (NWC)

3.5 Welfare of the Child

The Bill states that “AHR treatment may be provided to a person and his or her partner, if he or she has one, subject to a consideration of the welfare of any child who would be born as a result of the proposed treatment”.¹⁹ It also states that in all decisions regarding AHR treatment, “due regard shall be given to the health and wellbeing of children born as a result of such treatments”.

The Committee notes stakeholder’s concerns regarding the substantial onus placed upon individual clinics to determine whether treatment can be provided and whether there are concerns regarding the welfare/ best interests of a child.

Representatives of the Irish Fertility Society agreed that the responsibility placed on individual AR clinics was too onerous and that “decisions about refusal to provide treatment much be backed up by an ethics committee and that the whole process must be supported by statutory legislation”.

There is also concern among stakeholders that “it is not clear what ‘account has been taken of what the welfare of any child’ means” and that “although guidance will be issued by the regulatory authority on this matter, some basic principles in the Act would be welcome.”²⁰

For example, Head (1) refers to the welfare of the child which is defined in the Children First Act 2015 as “the moral, intellectual, physical, emotional and social welfare of the child”. In contrast, the Explanatory Note states that AHR services are subject to the best interests of the child, which is a different concept and potentially, a different level of assessment.²¹

5. The Committee recommends that an ethics committee to be established as part of the oversight and governance by the Board of the Authority, which would be responsible for examining and determining issues relating to the welfare of children, as set out in the provisions under Head 6(1) of the Bill.
6. The Committee recommends that further clarity be provided in respect to the provision dealing with the welfare of the child. The Committee acknowledges that the term ‘welfare’, as used in the Bill, may have a different criteria to the term ‘best interests’ as defined in the explanatory note.

¹⁹ Head 6 (1)

²⁰ Professor Deirdre Madden

²¹ “Best interests” must be the paramount consideration by the courts of guardianship, custody or access of/to a child. This principle is defined in the Constitution [Article 42(A)2,2] and the Children and Family Relationship Act 2015 [Part 1(7)]

3.6 Surrogacy

At present there is no legislation providing for or prohibiting surrogacy in Ireland. The General Scheme sets out the provision of surrogacy under the following conditions.

- Treatment takes place only in Ireland
- The surrogate is ordinarily resident in Ireland
- The surrogate has previously given birth
- The surrogate is aged 25-47 years
- It is gestational only (surrogate does not provide the egg)
- At least one intending parent provides a gamete (egg or sperm)
- The arrangement is non-commercial (this head does not distinguish between international and domestic surrogacy)
- A 'surrogacy agreement' has been approved in advance by the regulator

Part 9 of the Bill states that a person who contravenes the listed prohibitions (including commercial surrogacy) has committed an offence and shall be liable to fines and/or prison terms.

3.6.1. International Surrogacy

There is no official data or reliable source recording the number of children born as a result of surrogacy arrangements in Ireland or born abroad and brought to Ireland. However, it is acknowledged that many Irish people avail of surrogacy services outside of the jurisdiction. There is concern also that there is a risk of exploitation, especially of women in poorer countries where the economic return makes the provision of surrogacy services attractive and those services may be the subject of coercion.

The General Scheme prohibits commercial surrogacy agreements²² but does not distinguish between domestic and international commercial surrogacy arrangement, which implies that all commercial surrogacies are prohibited. This may bring a number of issues:

- There may be issues regarding a court granting a Parental Order to intending parents following an International surrogacy arrangement (ISA). As a result, the child may be left in a situation of “limping legal parentage” whereby the child experiences a number of problems (e.g. inheritance complications, lack of clarity in divorce, custody disputes). Further complications may arise in relation to refusal of social security benefits, family leave (e.g. maternity/ paternity/ parental) and refusal to grant health insurance to the child.

²² Head 40

- Under Head 36 a surrogacy is only permitted, amongst other criteria, where it is a domestic surrogacy and subsection 4 makes it an offence to engage in surrogacy that does not meet these conditions. It is therefore conceivable that ISA's will not be recognised as legitimate arrangements and constitute an offence. However the Department of Foreign Affairs has pre-existing guidelines on travel documents for children born under ISAs.²³ It is unclear whether the General Scheme will impact upon these guidelines.
- One of the main reasons for not legislating for international surrogacy is to avoid supporting potentially exploitative practices that would not be permitted in Ireland. However, representatives argued that the enactment of the Bill is unlikely to prevent Irish citizens from accessing surrogacy treatment from abroad. It was suggested to the Committee that domestic surrogacy, subject to the parameters set out in the General Scheme, will not be sufficient to meet demand and people will continue to travel abroad to seek out international surrogacy arrangements²⁴.
- Head 36(2) proposes that it would not be permitted to provide any technical, medical or professional service that would help to facilitate a surrogacy other than as provided for under the General Scheme. The explanatory notes states that this:

“Would include providing legal or practical advice on a professional basis to people seeking to engage in surrogacy abroad or in commercial surrogacy.”²⁵

A number of stakeholders objected to the proposed ban on professionals assisting/advising people who intended to enter into surrogacy arrangements other than those permitted under the proposed legislation, suggesting that it would be unethical for doctors to refuse to treat a patient seeking surrogacy overseas.²⁶

3.6.2 Traditional v Gestational Surrogacy

Head 39 (3)(b) provides that in permitted surrogacy arrangements the resulting child should have a genetic link with one of the intending parents. Witnesses argued that “the rationale

²³ <https://www.dfa.ie/media/dfa/alldfawebsitemedia/childrens-issues-surrogacy-guidance-document.pdf>

²⁴ Submission (24) Professor Deirdre Madden

²⁵ Page 92.

²⁶ Submission (31) Waterstone Clinic

for such a requirement appears to be that it is needed to ‘legitimise the relationship.’ And to protest against parents ‘commissioning’ children for adoption.”²⁷

The General Scheme seeks to only permit gestational surrogacy, where the surrogate mother is not genetically related to the child, and differs to what is termed ‘traditional surrogacy’, where the surrogate woman’s egg would be fertilised with either the intending father’s sperm or a donor’s sperm. This approach also favours the genetic connection over other forms of parenthood. However, there a number of arguments against this approach.

- Such conditions are not required for other AHR treatments for Ireland, where a woman can give birth to a child with no genetic link.
- The approach excludes single people and couples who cannot produce gametes from surrogacy arrangements.
- It disregards other forms of gaining parenthood, such as gestation. The report of the Commission on AHR 2005 stated that:

“Both genetics and gestation play a necessary and equally important role in bringing the child into existence. It is argued that by choosing one over the other, the law is imposing an artificial primacy that is arbitrary and illogical”.
- The Committee also heard from stakeholders that “the evidence available does not suggest that traditional surrogacy arrangements are any more unstable than non-genetic arrangements” and that a surrogate’s other children “.already consider children born from a surrogacy arrangement to be part of their kinship”.²⁸
- There is also an argument that IVF is necessary for gestational pregnancy and not traditional surrogacy (where inter-uterine insemination (IUI) can be used). IVF entails greater health risks than IUI to the surrogate mother and higher costs.²⁹

²⁷ Submission (6) Dr Katherine Wade

²⁸ Submission 13: Hayley Mulligan

²⁹ IBID

3.6.3 Transfer of Parentage

The General Scheme provides that transfer of parenthood in a permitted surrogacy arrangement would occur by way of a parental order issued by the courts. This could be applied for between six weeks and six months after the birth of the child.

Alternatively a pre-birth judicial agreement would enable for intending parents to be presumed as the child's parents from the moment of birth. This model was recommended by the Commission on Assisted Human Reproduction (although not a unanimous recommendation) and was supported by a number of stakeholders.

The Committee notes that the transfer of parentage in the General Scheme is similar to that used in the UK. However, the UK Law Commission is currently re-examining its legislation concerning international surrogacy, regulation and the transfer of parentage with a view of developing law reform recommendations within three years.³⁰

The Committee is mindful of the fact that there is no established best practice with regard to the transfer of parentage. The Hague Conference on International Private Law is currently examining parentage and surrogacy³¹ and in February 2019 called for uniform private international law (PIL) with regard to legal parentage.³²

The Committee is supportive of collaborating with such work and, while acknowledging that many issues are particular to Ireland's context, it is worthwhile supporting efforts to create an international best practice model that is based on broader research, empirical evidence and ethical and moral considerations. Such work may result in more effective policy, agreements and legislation that could be applied across international jurisdictions.

The Committee acknowledges that the issues regarding the transfer of parentage in cases of surrogacy are complex with substantial implications for parents and children born through AHR. There are many opposing opinions on the matter and each one raises ethical and legal challenges. The Committee is aware that the debate regarding the transfer of parentage will be discussed in further during the political process of the Bill.

³⁰ <https://www.lawcom.gov.uk/surrogacy-laws-set-for-reform-as-law-commissions-get-government-backing/>

³¹ <https://www.hcch.net/en/projects/legislative-projects/parentage-surrogacy>

³² <https://assets.hcch.net/docs/55032fc1-bec1-476b-8933-865d6ce106c2.pdf>

7. The Committee recommends that further consideration be given to the provisions regarding surrogacy (Part 6), with specific attention to:

- inconsistencies with may arise relating to international surrogacy arrangements (ISA) and in particular to parentage issues with may arise for children born through ISA
- the proposed ban on providing legal or practical advice to people who intend to enter into surrogacy arrangements other than those permitted under the proposed legislation
- only providing for gestational surrogacy within the provisions for surrogacy. The Committee notes the argument of stakeholders that the provision to only provide for this approach is too restrictive, excludes many people from accessing surrogacy arrangements and is not consistent with other provisions within the General Scheme.
- supporting international collaboration with the view of examining complex issues such as the transfer of parentage. The Committee also supports entering bilateral or multilateral agreements to recognise and introduce standards in relation to international surrogacy.

3.7 Gamete and Embryos Donation

Part 3 (Heads 11-22) of the General Scheme provides for the conditions and consents required to allow for the donation of gametes (eggs and sperm) and embryos.

3.7.1 Donor Anonymity / Birth Certificates

Head 14 specifies that donor-assisted AHR will be subject to the provisions of the General Scheme in addition to the provisions of the Children and Family Relationships Act 2015, which prohibits anonymous donation and seeks to clarify parentage of children born as a result of donor-assisted human reproduction (DAHR). The 2015 Act also provides for the establishment of a Register.³³

There is debate regarding the prohibiting of anonymous donation with support by some representatives for both anonymous and identifiable donations³⁴, however the Committee notes the Council of Europe Legal and Human Rights Committee's opinion that:

“The right to know one's biological origins and to have them recognised is considered by the Court as an integral part of the right to respect for private life”.

Section 39(4) of the 2015 Act provides that when a donor-conceived person aged 19 or over applies for their birth certificate it will be issued along with a note telling them that there is additional information relating to them on the Register. While some stakeholder supported this provision, other stakeholders had concerns regarding this approach. The Irish Fertility Counsellors Association (IFCA) stated:

“[The] IFCA supports the rights of a donor-conceived child to have information about their genetic origins; however, the possible psychological impact of this information being conveyed in a public office, by an untrained staff member, without adequate supports is very concerning. An annotation, even if it were not specific could lead to a breach of data protection and confidentiality, and would likely raise questions from prospective employers, heads of educational establishments and future spouses.”³⁵

The Committee acknowledges that these provisions are outside of this General Scheme but notes that they do impact significantly upon many of the provisions of the Bill and may require further consideration.

³³ Known as the National Donor-Conceived Person Register. Section 33 of the 2015 Act

³⁴ Submission of (31) Waterstone Clinic

³⁵ Submission of (17) Irish Fertility Counsellors Association

3.7.2 Access to Family Medical History for Donor-Conceived People

The issue of medical information on donors was raised at the Committee hearing on 19 December 2018 with some stakeholders advocating for donor-conceived people to be able to access medical information about their donor where it would indicate that they are predisposed to certain disease(s)³⁶. Dr Joanne Rose argued that it should be mandatory for all offspring to be updated on any relevant medical information, with reference to ‘Narelle’s Law’³⁷ in Victoria, Australia, an amendment to Victoria’s AHR legislation allowing for donor-conceived people access to identifying information on their gamete donor(s) retrospectively (i.e. including those who donated when anonymity was protected).

The NISIG representative spoke of difficulties for parents of donor-conceived children presenting family history to their children’s treating doctors. She stated:

“The doctor may say that the hospital needs specific information. Can the person go back to the [fertility] clinic, or how does he or she get the information? That needs to be looked at.”³⁸

Prof Deirdre Madden considered that an obligation could be placed on fertility clinics to maintain up-to-date health information on donors, in so far as they can.³⁹

3.7.3 Time Limits on Storage – Gametes and Embryos

A number of stakeholders⁴⁰ drew attention to the proposed time limits for storage of gametes (10 years) and embryos (5 years).⁴¹ The Committee acknowledges the particular implications for children who undergo cancer treatment and the argument that in such cases, ten years may not be enough time for them to have formed their families.

3.7.4 Egg-Sharing

The practice of ‘egg-sharing’ is one whereby women who are undergoing AHR treatments consent to sharing extracted eggs that are additional to those needed for their own treatment. In some fertility clinics (it is not clear whether this practice is undertaken in Ireland) a woman sharing eggs in this way may receive a discount on the cost of her own treatment or some free treatment.

³⁶ Oireachtas Debate, Joint Oireachtas Committee, [19 December 2018](#).

³⁷ Named for Ms Narelle Grech, who died in 2013 from hereditary bowel cancer, and who had spent 15 years searching for her donor.

³⁸ Appearing before the Oireachtas Joint Committee on Health, [19 December 2018](#).

³⁹ IBID

⁴⁰ Submission of (23) National Woman’s Council of Ireland (NWCI) (22) National Infertility Support and Information Group (NISIG) and (16) Irish Clinical Embryologists

⁴¹ Head 22 (8)(a)

Stakeholders were unclear on whether or not egg sharing is permissible under the General Scheme.

8. The Committee, with regard to Part 3 of the General Scheme (gamete and embryos), recommends that:

- further consideration be given to the proposed time limits for storage of gametes and embryos. The Committee recommends that provision is made to allow specific cases, such as those of children undergoing cancer treatment, additional dispensation.
- the availability of medical information to donor-conceived people be provided where it would indicate that they are predisposed to certain disease(s).
- further clarification be provided by the Department of Health on whether or not egg-sharing is allowable under the General Scheme.

3.8 Posthumous Assisted Reproduction

Part 3 of the General Scheme (Heads 23-28) provides for posthumous AHR involving gamete or embryos of a deceased person in certain circumstances. The Bill proposes that PAR is allowed under the following specific conditions:

- the deceased person had specifically consented
- only a female surviving partner may use and must carry pregnancy herself
- the surviving person receives counselling and consents to treatment
- a minimum of one year has passed since the death
- if donor gametes are used, the embryo must have been created during the lifetime of the deceased.

A number of concerns were raised by stakeholders during the Committee's pre-legislative scrutiny. These include:

- (a) concerns regarding the exclusion of male surviving partners (in opposite sex and same sex couples) who debated that the Bill is discriminatory towards male patients. The representative of LGBT Ireland added that Bill was opaque with regard to same sex couples noting:

“It is unclear what would happen where a male partner in a same sex relationship wishes to preserve his sperm for use after his death in a surrogacy arrangement involving the man's partner and a surrogate.”

- (b) concerns regarding Head 27, which sets out that children born up to 36 months after the death of the deceased person (whose gamete or embryo has been used) would have the deceased person recognised as their parent. Some stakeholders consider that this limit may be problematic. For example, if a patient has 2 children born under PAR but at different time periods, the children would be treated differently, with regard to parentage and inheritance rights.

9. The Committee recommends that further consideration be given to Part 4 of the Bill, regarding Posthumous Assisted Reproduction (PAR), and specifically to:

- inconsistencies with regard to excluding male surviving partners (in opposite sex and same sex couples) from accessing posthumous AHR treatment.
- inconsistencies regarding the treatment of children born before and after 36 months through PAR treatment, specifically with regard to parentage and inheritance rights.

3.9 Pre-implantation Genetic Diagnosis and Sex Selection

Heads 29 to 34 of the General Scheme provide for pre-implantation genetic disease (PGD) and sex selection.

Head 30 provides that PGD would be permitted only:

- in cases where there is a significant risk of a child being born with a serious genetic disease that is included on a list to be established and maintained by the regulatory authority; and
- where each intending parent provides consent (specific requirements regarding information provision and mandatory counselling are set out in Head 34).

Any other PGD would be prohibited. Any person who provides PGD in contravention of this would commit an offence. The explanatory note to this head provides more detail on the level of disease to be included, stating PGD will be allowed:

“... in cases where there is a significant risk of a child being born with a serious genetic disease that causes: severe physical or mental disability or illness; a high risk of shortened life expectancy; and for which there is no cure or limited effective treatment available.”

The notes also states that the regulatory authority would issue licences to treatment providers to conduct PGD. The regulatory authority would also set criteria for screening to be allowed – and these:

“should relate to the severity of the specific disease in question and its impact on health, well-being and quality of life of the person to be born (e.g. potentially fatal or severely disabling).”⁴²

3.9.1 Funding

The issue of funding for PGD arose in a number of written submissions provided to the Committee. The submission of the Waterstone Clinic stated that:

“We feel PGD deserves to be funded by the State as it is capable of preventing a lifetime of illness for children.”⁴³

⁴² Explanatory note to Head 30 of the General Scheme.

⁴³ Submission of (31) Waterstone Clinic

The General Scheme does not provide for funding of AHR, although the Department of Health has stated that it is advancing plans for public delivery and funding of AHR treatment.⁴⁴ There is merit in considering whether Pre-implantation Genetic Diagnosis should be included in any public provision/ funding as it has the potential to prevent children being born with certain genetic disorders.

3.9.2 Genetics and Genetic Counselling

Many stakeholders noted a need for or shortage of geneticists and genetic counsellors in Ireland. The representatives of Irish Fertility Society stated:

“Genetic screening of adults and awareness of genetic risk (or transmitting genetic disease) is increasing rapidly. IFS members working in PGD programmes are appalled at the lack of an adequate number of clinical geneticists and genetic counsellors in Ireland. This deficit imposes unacceptable delays on couples anxious to begin PGD treatment and must be addressed urgently.”

10. The Committee recommends, with regard to Part 5 of the General Scheme (pre-implantation genetic diagnosis):

- that Pre-implantation Genetic Diagnosis should be included in any public provision/ funding of AHR treatment,
- that adequate resources be made available to ensure that the appropriate number of geneticists and genetic counsellors are available to fulfil the provisions of the General Scheme,

⁴⁴ Oireachtas Debate, Joint Committee on Health [17 January 2018](#)

3.10 Assisted Human Reproduction Regulatory Authority

Part 8 of the Bill provides for the establishment, functions and related matters of an Assisted Human Reproduction Regulatory Authority (AHRRA). Stakeholders suggested that further functions of the Authority should be included in the General Scheme. These include:

- A specific statutory duty to investigate patient complaints⁴⁵
- To protect patients against financial exploitation including that associated with additional but unproven tests and treatments.⁴⁶
- To collect and provide information regarding success rates between service providers and in providing information on infertility and related support.⁴⁷
- A role in protecting the financial interests of patients in the case of the closure of a service provider and a role in safeguarding patients' gametes/ embryos (or whether the existing powers of the HPRA provide for this).⁴⁸
- Amending the proposed powers of the Authority to include a research function, specifying that it will conduct and publish research on services, demand, patient experience, short and long-term health and well-being on patients and children born through AHR and the broader social, ethical, health, legal and economic implications of AHR.

11. The Committee recommends that further consideration be given regarding the powers and functions of the Authority (Part 8), with specific attention given to:

- investigating consumer complaints,
- protecting against financial exploitation,
- collecting and providing information regarding success rates between service providers and providing information on infertility and related support,
- protecting the financial interests of patients in the case of the closure of a service provider and a role in safeguarding patients' gametes/ embryos
- amending the proposed powers of the Authority to include a research function, specifying that it will conduct and publish research on services, demand, patient experience, short and long-term health and well-being on patients and children born through AHR and the broader social, ethical, health, legal and economic implications of AHR.

⁴⁵ Submission of (23) NCWI

⁴⁶ Included in submissions (18) Irish Fertility Society and (31) Waterstone Clinic

⁴⁷ Submission (23) NCWI

⁴⁸ Submission (23) NISIG

Appendix 1: Membership of the Joint Committee on Health

Deputies:

- Stephen Donnelly (Fianna Fáil)
- Bernard Durkan (Fine Gael)
- Dr Michael Harty [Chairman] (Rural Independent Technical Group)
- Alan Kelly (Labour)
- Kate O'Connell (Fine Gael)
- Margaret Murphy O'Mahony (Fianna Fáil)
- Louise O'Reilly (Sinn Féin)

Senators:

- Colm Burke (Fine Gael)
- John Dolan (Civil Engagement Technical Group)
- Rónán Mullen (Independent)
- Dr Keith Swanick (Fianna Fáil)

Appendix 2: Public Meeting List of Witnesses

Date	Witnesses	Debate
17 January 2018	Ms Geraldine Luddy, Department of Health Dr Tony Holohan, Department of Health Mr Paul Ivory, Department of Health Mr Liam Woods, Health Service Executive. Dr Colm Henry, Health Service Executive. Dr. Jerome Coffey, Health Service Executive. Dr. Peter McKenna, Health Service Executive.	See Debate
28 February 2018	Dr. John Waterstone, President of the Irish Fertility Society. Professor Mary Wingfield, Institute of Obstetricians and Gynaecologists. Dr. John Kennedy, National Fertility Centre, Rotunda Hospital.	See Debate
19 December 2018	Professor Deirdre Madden, School of Law, University College Cork, and former member of the Commission on Assisted Human Reproduction. Professor Nóirín Hayes, School of Education, Trinity College Dublin and former member of the Commission on Assisted Human Reproduction. Ms Marian Barnard and Ms Gillian Keegan, National Infertility Support and Information Group. Ms. Emma O’Friel and Dr. Joanna Rose, Donor-conceived persons’ perspectives.	See Debate
27 February 2019	Ms Paula Fagan, Chief Executive, LGBT Ireland. Dr Lydia Bracken, Legal Advisor to LGBT Ireland.	See Debate

Appendix 3: Written Submissions

In December 2017, the Joint Committee on Health published a request for written submissions regarding AHR services. The Committee received 31 submissions which were considered in its pre-legislative scrutiny. [These can be viewed here.](#)

Appendix 4: Terms of Reference of Committee

A) Functions of the Committee [derived from Standing Orders – DSO 84A and SSO 70A]

(1) The Committee shall consider and report to the relevant House(s) on-

- (a) such aspects of the expenditure, administration and policy of a Government Department or Departments and associated public bodies as the Committee may select, and
- (b) European Union matters within the remit of the relevant Department or Departments.

(2) The Select Committee appointed by Dáil Éireann is joined with a Select Committee appointed by Seanad Éireann (to form a Joint Committee) for the purposes of the functions set out in this Standing Order, other than at paragraph (3), and to report thereon to both Houses of the Oireachtas.

(3) Without prejudice to the generality of paragraph (1), the Select Committee shall consider, in respect of the relevant Department or Departments, such—

- (a) Bills,
- (b) proposals contained in any motion, including any motion within the meaning of DSO 187,
- (c) Estimates for Public Services, and
- (d) other matters

as shall be referred to the Select Committee by the Dáil, and

- (e) Annual Output Statements including performance, efficiency and effectiveness in the use of public moneys, and
- (f) such Value for Money and Policy Reviews as the Select Committee may select.

(4) Without prejudice to the generality of paragraph (1), the Joint Committee may consider the following matters in respect of the relevant Department or Departments and associated public bodies:

- (a) matters of policy and governance for which the Minister is officially responsible,
- (b) public affairs administered by the Department,
- (c) policy issues arising from Value for Money and Policy Reviews conducted or commissioned by the Department,
- (d) Government policy and governance in respect of bodies under the aegis of the Department,

- (e) policy and governance issues concerning bodies which are partly or wholly funded by the State or which are established or appointed by a member of the Government or the Oireachtas,
- (f) the general scheme or draft heads of any Bill
- (g) any post-enactment report laid before either House or both Houses by a member of the Government or Minister of State on any Bill enacted by the Houses of the Oireachtas,
- (h) statutory instruments, including those laid or laid in draft before either House or both Houses and those made under the European Communities Acts 1972 to 2009,
- (i) strategy statements laid before either or both Houses of the Oireachtas pursuant to the Public Service Management Act 1997,
- (j) annual reports or annual reports and accounts, required by law, and laid before either or both Houses of the Oireachtas, of the Department or bodies referred to in subparagraphs (d) and (e) and the overall performance and operational results, statements of strategy and corporate plans of such bodies, and
- (k) such other matters as may be referred to it by the Dáil from time to time.

(5) Without prejudice to the generality of paragraph (1), the Joint Committee shall consider, in respect of the relevant Department or Departments—

- (a) EU draft legislative acts standing referred to the Committee under DSO 114 and SSO 107, including the compliance of such acts with the principle of subsidiarity,
- (b) other proposals for EU legislation and related policy issues, including programmes and guidelines prepared by the European Commission as a basis of possible legislative action,
- (c) non-legislative documents published by any EU institution in relation to EU policy matters, and
- (d) matters listed for consideration on the agenda for meetings of the relevant EU Council of Ministers and the outcome of such meetings.

(6) Where the Select Committee appointed by Dáil Éireann has been joined with a Select Committee appointed by Seanad Éireann, the Chairman of the Dáil Select Committee shall also be the Chairman of the Joint Committee.

(7) The following may attend meetings of the Joint Committee, for the purposes of the functions set out in paragraph (5) and may take part in proceedings without having a right to vote or to move motions and amendments:

- (a) members of the European Parliament elected from constituencies in Ireland, including Northern Ireland,
- (b) members of the Irish delegation to the Parliamentary Assembly of the Council of Europe, and
- (c) at the invitation of the Committee, other members of the European Parliament.

(8) The Joint Committee may, in respect of any Ombudsman charged with oversight of public services within the policy remit of the relevant Department or Departments, consider—

- (a) such motions relating to the appointment of an Ombudsman as may be referred to the Committee, and
- (b) such Ombudsman reports laid before either or both Houses of the Oireachtas as the Committee may select: Provided that the provisions of DSO 111F apply where the Committee has not considered the Ombudsman report, or a portion or portions thereof, within two months (excluding Christmas, Easter or summer recess periods) of the report being laid before either or both Houses of the Oireachtas.

B) Powers of the Committee [derived from Standing Orders – DSO 85, 114 and 116 and SSO 71, 107 and 109]

The Joint Committee has:-

- (1) power to take oral and written evidence and to print and publish from time to time minutes of such evidence taken in public before the Committee together with such related documents as the Committee thinks fit;
- (2) power to invite and accept oral presentations and written submissions from interested persons or bodies;
- (3) power to appoint sub-Committees and to refer to such sub-Committees any matter comprehended by its orders of reference and to delegate any of its powers to such sub-Committees, including power to report directly to the Dáil and to the Seanad;
- (4) power to draft recommendations for legislative change and for new legislation;
- (4A) power to examine any statutory instrument, including those laid or laid in draft before either House or both Houses and those made under the European Communities Acts 1972 to 2009, and to recommend, where it considers that such action is warranted, whether the instrument should be annulled or amended;

- (4B) for the purposes of paragraph (4A), power to require any Government Department or instrument-making authority concerned to submit a Memorandum to the Committee explaining any statutory instrument under consideration or to attend a meeting of the Committee for the purpose of explaining any such statutory instrument: Provided that such Department or authority may decline to attend for stated reasons given in writing to the Committee, which may report thereon to the Dáil;
- (5) power to require that a member of the Government or Minister of State shall attend before the Committee to discuss policy for which he or she is officially responsible: Provided that a member of the Government or Minister of State may decline to attend for stated reasons given in writing to the Committee, which may report thereon to the Dáil and Seanad: and provided further that a member of the Government or Minister of State may request to attend a meeting of the Committee to enable him or her to discuss such policy;
- (6) power to require that a member of the Government or Minister of State shall attend before the Committee to discuss proposed primary or secondary legislation (prior to such legislation being published) for which he or she is officially responsible: Provided that a member of the Government or Minister of State may decline to attend for stated reasons given in writing to the Committee, which may report thereon to the Dáil and Seanad: and provided further that a member of the Government or Minister of State may request to attend a meeting of the Committee to enable him or her to discuss such proposed legislation;
- (6A) power to require that a member of the Government or Minister of State shall attend before the Committee and provide, in private session if so requested by the member of the Government or Minister of State, oral briefings in advance of meetings of the relevant EU Council of Ministers to enable the Committee to make known its views: Provided that the Committee may also require such attendance following such meetings;
- (6B) power to require that the Chairperson designate of a body or agency under the aegis of a Department shall, prior to his or her appointment, attend before the Committee to discuss his or her strategic priorities for the role;
- (6C) power to require that a member of the Government or Minister of State who is officially responsible for the implementation of an Act shall attend before a Committee in relation to the consideration of a report under DSO 164A and SSO 157A;
- (7) subject to any constraints otherwise prescribed by law, power to require that principal office-holders in bodies in the State which are partly or wholly funded by the State or which are established or appointed by members of the Government or by the Oireachtas shall attend meetings of the Committee, as appropriate, to discuss issues for which they are officially responsible: Provided that such an office-holder may decline to attend for stated reasons given in writing to the Committee, which may report thereon to the relevant House(s);

- (8) power to engage, subject to the consent of the Houses of the Oireachtas Commission, the services of persons with specialist or technical knowledge, to assist it or any of its sub-Committees in considering particular matters; and
- (9) power to undertake travel, subject to—
 - (a) such recommendations as may be made by the Working Group of Committee Chairmen under DSO 108(4)(a) and SSO 104(2) (a); and
 - (b) the consent of the Houses of the Oireachtas Commission, and normal accounting *procedures*.

In accordance with Articles 6 and 8 of Protocol No. 2 to the Treaty on European Union and the Treaty on the Functioning of the European Union (Protocol on the Application of the Principles of Subsidiarity and Proportionality) as applied by sections 7(3) and 7(4) of the European Union Act 2009, the Committee has the power-

- (a) to consider whether any act of an institution of the European Union infringes the principle of subsidiarity [DSO 116; SSO 109]; and
- (b) to form a reasoned opinion that a draft legislative act (within the meaning of Article 3 of the said Protocol) does not comply with the principle of subsidiarity [DSO 114 and SSO 107].

C: Scope and context of activities of the Committee

In addition to the powers and functions that are given to Committees when they are established, all Oireachtas Committees must operate within the scope and context of activities in Dáil Standing Order 84 and Seanad Standing Order 70 as set out below.

- A Committee may only consider such matters, engage in such activities, exercise such powers and discharge such functions as are specifically authorised under its orders of reference and under Standing Orders;
- Such matters, activities, powers and functions shall be relevant to, and shall arise only in the context of, the preparation of a report to the relevant House(s).
- A Committee shall not consider any matter which is being considered, or of which notice has been given of a proposal to consider, by the Committee of Public Accounts pursuant to DSO 186 and/or the Comptroller and Auditor General (Amendment) Act 1993;
- A Committee shall not consider any matter which is being considered, or of which notice has been given of a proposal to consider, by the Joint Committee on Public Petitions in the exercise of its functions under DSO 111A(1); and
- A Committee shall refrain from inquiring into in public session or publishing confidential information regarding any matter if so requested, for stated reasons given in writing, by—
 - (i) a member of the Government or a Minister of State, or
 - (ii) the principal office-holder of a body under the aegis of a Department or which is partly or wholly funded by the State or established or appointed by a member of the Government or by the Oireachtas:

Provided that the Chairman may appeal any such request made to the Ceann Comhairle, whose decision shall be final.