IN THE MATTER OF AN ADVICE FOR BIRTHRIGHTS

A. INTRODUCTION

1. I have been asked to advise Birthrights on the legal position concerning the recording or streaming of the ultrasound examination at antenatal scan appointments. This issue has come to the fore more acutely owing to the Covid-19 coronavirus pandemic and the restrictive measures imposed by the Government to seek to limit the spread of the virus.

2. The provision of maternity services was significantly curtailed during the first wave of the pandemic. A majority of maternity units significantly reduced antenatal and postnatal appointments and stopped attendance of support partners at antenatal scans. Although there has been gradual reinstatement of in-person attendance of support partners in a phased approach, the approach is not consistent across NHS trusts and hospitals across the UK. As the UK was hit by a second, and now third wave of the pandemic, there continues to be reports that NHS trusts and hospitals have maintained the practice of not allowing support partners to attend antenatal appointments.

3. Where pregnant women are unable to have their support partner attend their antenatal appointments in-person, many have requested to film or stream the ultrasound examination on their mobile phones so that their partner or family members are still able to remain involved. A number of NHS trusts have, however, been refusing these requests in a blanket fashion, without consideration of the views and needs of the pregnant woman and her family. The exclusion of support partners from experiencing the pregnancy scan and other important antenatal appointments with the pregnant women has already been a source of frustration. For many, excluding family members from being involved through streaming, or watching a recording of the appointment feels even more alienating for the pregnant woman, all at an incredibly important and transformative time in the lives of the women and their families. This is particularly so when women receive unexpected or devastating news at antenatal scans, and have to make extremely difficult decisions without the support of their partners, at a highly vulnerable time.

4. The purpose of this Opinion is to provide Birthrights my view as to the legality of NHS trusts refusing to allow requests from pregnant women and their families for streaming or recording of ultrasound examinations when partners cannot be in attendance, and the

potential considerations to ensure that development of local NHS policy and practice take proper account of the views and needs of pregnant women and their families.

B. LEGAL AND POLICY OVERVIEW

B.1. National Health Service Act 2006

5. The NHS is composed of a large number of public bodies, all of which have different functions and, on occasions, overlapping responsibilities. NHS bodies can broadly be divided into 4 types, namely: overarching national NHS bodies; commissioners of NHS services; providers of NHS services; and regulators which supervise the performance of those individuals and public bodies who commission or provide NHS services and body that oversee the performance of NHS bodies.

6. The Secretary of State for Health and Social Care ("SSHSC") sits at the apex of the NHS and retains ministerial responsibility to Parliament for promoting a comprehensive health service to secure the improvement in people's physical and mental health and in the prevention, diagnosis and treatment of physical and mental illnesses: section 1 of the National Health Service Act 2006 ("NHS 2006"). In order to promote a comprehensive service, clinical commissioning groups and the NHS Commissioning Board (known as "NHS England") have a duty to provide a range of services to meet the reasonable requirements of patients for services as well as making arrangements to provide primary care, dental and pharmaceutical services. By s. 3(1) NHS Act 2006, this includes "*such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as he considers are appropriate as part of the health service"*.

7. NHS trusts are created under Chapter 3 of Part 2 of the NHS Act 2006. They enter into services contracts with CCGs to provide a wide range of community, mental health and hospital services to patients: see further para 18 to Sched 4, NHS Act 2006.

8. The SSHSC has the power to issue Directions to an NHS Trust under s. 8 NHS Act 2006 which, if lawfully made, imposes specific legal obligations on NHS Trusts to do things or provide services, or to cease to do something or cease to provide a service as specified in the Direction. No direction has been issued by the SSHSC in respect of the arrangements for arrangements at ultrasound and other antenatal appointments for expectant mothers and their families.

B.2. Policy Context

9. There is a wealth of evidence demonstrating the importance of partner attendance in maternity care, not just during birth, but more generally across maternity services.

10. The World Health Organisation recommends the involvement of a companion during pregnancy, birth and the postpartum period as an effective intervention to improve both maternal and new-born health outcomes, and to promote gender equality[1], a recommendation that they have re-iterated during the COVID-19 pandemic.[2] According to the World Health Organisation, studies investigating the effect of interventions to engage partners in the antenatal care pathway have reported improvements in antenatal care attendance, couple communication and shared decision making.

11. NHS England's guidance, *Supporting pregnant women using maternity services during the coronavirus pandemic*[3] also highlights at paragraph 4 that support that pregnant women are able to obtain from a partner, relative or friend through pregnancy and childbirth *"facilitates emotional wellbeing and is a key component of safe and personalised maternity care. Women should therefore have access to support at all times during their maternity journey and trusts should facilitate this, while keeping the risk of transmission of the virus within NHS maternity services (including to pregnant women, other service users and staff) as low as possible. This means welcoming the woman and her support person, and regarding them as an integral part of both the woman and baby's care throughout and not as a visitor."*

B.3. Guidance on patient recordings

12. The National Institute for Health and Care Excellence (NICE), at the direction of the Department of Health and Social Care, has produced a quality standard for patient experience in the adult NHS services[4] and guidance on improving the experience of care for

[1] World Health Organisation (2015). Recommendations on health promotion interventions for maternal and newborn health. Accessed at: https://apps.who.int/iris/bitstream/handle/10665/172427/9789241508742_report_eng.pdf;jsessionid=73942A42785904A4947C00FE84E7F4F8?sequence=1

[2] World Health Organisation (2020). Companion of choice during labour and childbirth for improved quality of care: evidence-to-action brief. Accessed at: https://apps.who.int/iris/bitstream/handle/10665/334151/WHO-SRH-20.13-eng.pdf?ua=1

[3] Latest version published on 14 December 2020. Accessed at: https://www.england.nhs.uk/coronavirus/publication/supporting-pregnant-women-using-maternity-services-during-the-coronavirus-pandemic-actions-for-nhs-providers/

[4] NICE (2012, updated 2019). Patient experience in adult NHS Services: Quality Standard. Accessed at: https://www.nice.org.uk/guidance/qs15

people using adult NHS services[5] to operate alongside the standards, the theory behind which is that a good patient experience has a correlation with patient safety and clinical effectiveness. Of most relevance are:

13. **Quality Statement 4 (Individualised Care): People using adult NHS services experience care and treatment that is tailored to their needs and preferences**. This standard seeks to ensure that *"the human nature of healthcare is not lost"* by ensuring that patients have the opportunities to discuss their needs and preferences.

14. Para 1.3.6 of the accompanying guidance draw attention to the reality that patients may have different views from healthcare professionals about the balance of risks, benefits and consequences of treatment.

15. **Quality Statement 5 (Preferences for sharing information): People using adult NHS services have their preferences for sharing information with their family members and carers established, respected and reviewed throughout their care.** This requires that health trusts and establish and respect patients' preferences for sharing information with family members and carers.

16. Para 1.3.10 of the guidance emphasises the importance of giving the patient the opportunity indicate their views on how they would like their partner and family members to be involved in key decisions about their condition and treatment. Para 1.5 outlines ways of ensuring effective communications with the patient, including (at para 1.5.4), doing so through and alongside family members, and at para 1.5.16, *"asking the patient whether they want to be accompanied at consultations by a family member, friend or advocate, and whether they would like to take notes and/or an audio recording of the consultation."*

17. **Quality Statement 6 (Decision making): People using adult NHS services are supported in shared decision making**. This highlights the importance of healthcare professionals recognising that many patients want to be active in their own care and should be facilitated to contribute to the decision-making process about their condition, social services, attitudes to risk, values and preferences.

18. The General Medical Council ("GMC") and the British Medical Association ("BMA") have both published information for doctors on patient recordings.

[5] Accessed at: https://www.nice.org.uk/guidance/cg138/resources/patient-experience-in-adult-nhs-services-improving-the-experience-of-care-for-people-using-adult-nhs-services-pdf-35109517087429

19. GMC guidance, *Decision Making and Consent*[6] states at para 27 that patients need relevant information to be shared in a way that they can understand and retain. To facilitate this, doctors should *"accommodate a patient's wishes if they would like to recover a discussion"* and *"if they would like anyone else – a relative, partner, friend, carer or advocate – to be involved in discussions and / or to help them make decisions."* Recordings made by patients are *"owned by them and do not have to be stored with their medical records."*

20. The BMA guidance on *Patients recording consultations"*[7] states that *"in some circumstances, permitting a patient to record a consultation who may otherwise struggle to remember or understand is likely to amount to a reasonable adjustment requirement under equality legislation"* and *"we believe there is significant benefit for both patients and doctors in supporting consensual recordings."* The benefits identified in the guidance includes *inter alia*: enabling patients to remember important advice, particularly where there are language barriers; giving patients more time to process information, when they may have been distressed, and including patients' family members in their care and decision making. The consensual recording of consultations formed part of the recommendations and actions for improvement in the Cumberlege Report, *First Do No Harm*, published in July 2020.

21. The Cumberlege Report[8] sets out at para 2.24 an expectation for the documenting of every patient-clinician consultation about consent. As part of this, the benefit of patient recordings is considered:

> "*Both the patient and clinician's discussion, comments and concerns should be noted. Today's mobile technology makes it easy for every planned conversation about patient consent to be audio or video recorded by the patient (with the agreement of both parties). This allows the patient to take away and reflect upon the conversation, which benefits both patients and clinicians. In future this record should also be stored with the patient's electronic health record*."

22. This is repeated as a recommendation on page 59 of the report where it is stated that conversations around consent "*should be audio or video recorded to allow the patient to take it away and reflect upon it*".

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[6] Accessed at: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent
[7] Accessed at: https://www.bma.org.uk/advice-and-support/ethics/confidentiality-and-health-records/patients-recording-consultations
[8] Accessed at: https://www.immdsreview.org.uk/Report.html

23. Similarly, the Medical Defence Union suggests that recording an appointment means more information is retained, which in turn aids effective communication and benefits both the clinician and the patient[9].

Privacy / confidentiality concerns

24. The GMC's guidance on making video and audio records requires doctors to obtain patients' consent. The guidance, however, does not address the reverse scenario of patients making records of the consultation. However, pursuant to section 36 of the Data Protection Act 1998, *"personal data processed by an individual only for the purposes of that individual's personal, family or household affairs are exempt from data protection principles."* Thus generally speaking, no consent is required of the health professional before a patient may record the consultation but only if it falls within the ambit of personal use. Similarly, where the recording is made by the patient of her own consultation, given the information disclosed during that consultation is confidential to the patient, the patient's recording, with or without consent of the health professional, does not constitute a breach of confidentiality.

25. Nevertheless, the BMA and MDU guidance both stress the desirability of the patient seeking the doctor's agreement, as a matter of courtesy and respect and as such an approach would be more likely to lead to a positive and trusting relationship.

B.4. The position of the Society and College of Radiographers ("SoR") on patient recordings

26. Prior to the pandemic, the SoR's guidance on the recording of images and clinical discussions by patients was set out in *'The Recording of Images and Clinical Discussions by Patients during Diagnostic Imaging, Interventional Procedures and Radiotherapy Treatment'*, dated January 2019.[10] The guidance is advisory in nature, *"not to dictate local policy but to provide background information and to discuss general principles … [to] allow local authorities to be determined that are able to take account of all relevant circumstances…"* Similar to the GMC and BMA guidance, the SoR guidance acknowledges at para 2.6 that "*there can, however, be very good reasons for these requests*

[9] Accessed at: https://www.themdu.com/guidance-and-advice/journals/good-practice-june-2014/patients-recording-consultations

[10] The Recording of Images and Clinical Discussions by Patients During Diagnostic Imaging, Interventional Procedures and Radiotherapy Treatment, https://www.sor.org/sites/default/files/document-versions/2019.1.13_re-draft_recording_of_images_final.pdf

and it can help patients make informed choices. For example, some patients may have hearing or learning difficulties; for some their first language may not be English. It is also the case that without a recording of what may be a critical clinical discussion at a time of great stress for the patient, much of what has been said to them may be forgotten or confused."

27. The guidance highlights "special considerations" relating to requests to record obstetric ultrasound examinations at paragraph 4.2 and in separate guidance entitled *NHS obstetric ultrasound examination: Guidance on sale of images, foetal sexing, commercial considerations and requests to record*.[11] Both describe requests to record as usually made *"to provide a record for 'social' and not clinical discussion reasons"*. The guidance goes on to state that *"very high levels of concentration"* are required of the sonographer during obstetric ultrasound examinations. Video recording therefore *"can be very distracting"* and can create tensions, lead to misunderstandings and risk errors being made during the examination: para 5.2 of the *NHS obstetric ultrasound examinations* guidance.

28. Chapter 5 of the *NHS obstetric ultrasound examination* guidance concludes by recognising that there can be good reasons why a patient wishes to record a clinical discussion, consultation or treatment. Although permission would not be required for a patient to make an audio or video recording of a diagnostic imaging examination, the guidance states that common courtesy suggests that agreement should be sought via a verbal request. The guidance cautions against requests which may increase risks to patients. The guidance concludes that hospital departments should develop local policies and procedures for requests to make video/audio recordings. The SoR guidance does not explicitly prohibit video or audio recordings, but the general tone of both sets of guidance is a wariness of requests for audio or video recording of obstetric ultrasound examinations.

29. It is important to read the guidance in its proper context. Both sets of guidance were issued in 2019, prior to the Covid-19 pandemic, at a time when, most likely, the SoR did not contemplate the situation pregnant women now find themselves, where they are not allowed to have their support partner attend the scan with them owing to public health concerns related to the pandemic. Thus the request to record may well be in some part for the "social" aspects of the appointment, but not necessarily entirely so: see the circumstances envisaged by the GMC and BMA when patients may benefit from being able to record an

[11] Accessed at: https://www.sor.org/learning/document-library/nhs-obstetric-ultrasound-examinations-guidance-sale-images-fetal-sexing-commercial-considerations

appointment so they can digest the information and understand the clinical advice in their own time.

30. In light of the pandemic, the SoR, in collaboration with the Royal College of Midwives (RCM), the Royal College of Obstetricians and Gynaecologists (RCOG), and the British Medical Ultrasound Society (BMUS), produced a joint statement on the recording of ultrasound examinations "*to offer guidance to members, providers and service users"*[12].

31. The Statement states at the outset that it is advisory, *"to support local policy decisions in ultrasound departments and private practice, to ensure that government recommendations are met, while still providing woman centred care within the challenging environments of the Covid-19 pandemic."* It recognises that under normal circumstances, women often bring their partner or another companion with them to the ultrasound examination for support and to share the experience. That became difficult during the pandemic with best practice guidance recommending the performing of the examination as quickly as possible, and the limiting of the number of people in the ultrasound examination room, to reduce the chance of virus transmission from staff to women and vice versa.

32. The Statement describes the ultrasound scan as a clinical examination but does recognise that the scan is "*an important step in [parents] developing a sense of attachment with their unborn baby*", so long as that aspect does not impede on the clinical aspect of the examination. The Statement affirms the previous guidance's recommendation against video recording of ultrasound scans under normal circumstances, and confirms that even in the current pandemic, the SoR do not recommend virtual attendance by partners or companions through online video calls such as FaceTime and Skype, or the filming of the examination.

33. Three reasons are given in the Statement for taking this position, which appear to be specifically directed at a woman holding a mobile phone to film the ultrasound monitor:

    1. Guidance suggests aiming for the shortest possible examination times to reduce risk, as scans are often carried out in small and poorly ventilated rooms7, with the woman and sonographer in close contact. It is also important to ensure that examination times are not extended, to keep busy antenatal ultrasound clinics, where there are current staffing pressures, running as smoothly as possible.

    2. Holding a mobile phone in this way leads to a taut abdomen, which makes scanning extremely difficult, if not impossible. It might also impede the ultrasound practitioner's position, making it difficult to acquire some views.

[12] Accessed at: https://www.sor.org/sites/default/files/document-versions/obstetric_ultrasound_examinations_dug_the_covid-19_pandemic_1.pdf

3. It is not usual practice to support filming of entire medical or diagnostic examinations. Filming an entire procedure may increase the risk of distraction for the practitioner and thus lengthen the examination procedure.

34. The Statement goes on to express support for allowing women to share their experience of the ultrasound scan with their partner (or other family members or friends), such as an offer to save a short 10–30 second cine clip of the foetus at the end of selected examinations. This could then be recorded by the woman while the scan report is being completed. Allowing a recording of the cine clip would ensure that the woman has control over their image data and can share with it with family after the examination.

35. The Statement, however, recognises that there will be cases when unexpected findings are discovered during the examination. In these circumstances, the Statement urges local policy to be in place that would ensure the woman has the support she needs during discussions about the findings. In these circumstances, it might be appropriate to involve a partner or family member in the counselling via video or telephone call (whichever the woman chooses).

C. OPINION

36. Although NHS powers as to how services such as antenatal scans are arranged are broad, the rule of law requires a public body, in the formulation of policy, to take all reasonable steps to acquaint itself with the relevant information to enable it to make an informed policy decision: *Secretary of State for Education and Science v Tameside MBC* [1975] AC 1014 at 1065B.

37. It appears that NHS trusts and hospitals have simply adopted the SOR Statement as a rule on prohibiting streaming and recording during antenatal appointments. Public Health Wales' guidance[13] explicitly refers to the reasons given in the SoR Statement for why women *"will not be able to video/ phone / live stream the ultrasound examination"*.

38. Such a policy position is, in my view, legally flawed:

39. **First**, it is wrong to treat the SoR Statement as a hard and fast rule prohibiting the use of streaming or recording during antenatal scans. It is clear from the language used that it is a

[13] Accessed at: https://phw.nhs.wales/services-and-teams/screening/antenatal-screening-wales/files/faqs-about-your-pregnancy-scan-during-the-covid19-pandemic-nov-2020-pdf/

recommendation. Whilst I would accept that a recommendation made by four professional medical bodies, the SoR, RCOG, RCM and BAUS, has force, it is still a recommendation and no more. Treating it as a hard and fast rule wrongly elevates its status.

40. Of course, the recommendation is a highly relevant piece of evidence that must be taken into account and weighed in the balance in policy formulation, but it is not the only one. Other relevant pieces of evidence include, in particular, the NICE, GMC and BMA guidance, canvassed above, which draw out the benefits for patient care of permitting the recording of clinical appointments. That set of guidance gives particular examples of circumstances where patients have disabilities or other barriers (such as language), which may mean they need more time to digest information given them in the clinical appointment and make an informed decision about their care. Permitting a patient to record their appointment may importantly enable to do so. The NICE Quality Standards, in particular, draw out the strong policy reasons in favour of doing so, which include: taking a patient-centred approach to clinical care; enabling the patient to participate in shared decision-making about their care; and in turn building trust in the doctor-patient relationship.

41. Additionally, the clinical and other benefits of partner participation in antenatal appointments are also highly relevant considerations. This includes:

    41.1. compelling evidence that having a support partner present at antenatal appointments improves maternal and foetal outcomes for pregnant women, a finding backed by clinical studies and by the World Health Organisation, even in the context of the pandemic; and

    41.2. evidence of potential harm and risk of harm to pregnant women and their families of not facilitating partner participation at important clinical junctures of a woman's pregnancy journey. One of the case studies included in the papers I have been provided tells of a woman whose scan detected foetal abnormalities but she was not allowed to call her partner because of the trust's rigid policy of prohibiting the use of streaming or recording. She subsequently had a miscarriage which devastated her but felt she was unable to draw on her partner's full support because he did not experience the same trauma timeously with her.

42. I cannot see evidence that suggests that the NHS trusts which have policies prohibiting streaming / recording have taken into account the above factors into account when

formulating their policies. The Public Health Wales guidance only explicitly refers to the SoR statement and nothing else.

43. In my view, by simply adopting the SoR's recommendation as a hard and fast rule, the NHS will have acted unlawfully in closing its mind to all relevant and available evidence that it is required to address in its policy formulation on streaming / recording during antenatal appointments: *British Oxygen Co. Ltd. v Minster of Technology* [1969] 2 W.L.R. 892, [1971] A.C. 610, 625 per Lord Reid. The primacy of ensuring patient shared decision-making (NICE Quality Standard 6) does not operate only in individual patient decision-making but also in policy formulation. The failure to take account of patients' wishes, the well-established clinical benefits for maternity health, and the benefits for doctor-patient relationship would be a significant omission in policy formulation and unlawful.

44. **Second**, NHS trusts which have relied on the SoR recommendation as a definitive rule have misunderstood the recommendation itself. Whilst the SoR's strong starting point is that recording / streaming should not normally be encouraged during antenatal scans, the Statement itself recognises that there will be cases that constitute an exception to the general rule. The example given in the Statement arises where the scan identifies unexpected or concerning findings. It rightly acknowledges that in those circumstances, steps should be taken to ensure that the pregnant woman is able to involve her partner or family member for support and to participate, via a video or telephone call, in the clinical discussion. The Statement is right to ensure that streaming or recording in these circumstances may in fact facilitate important clinical discussions, rather than impede them.

45. It is a well-established principle of public law that a policy must allow for exceptions to the general rule: see eg *In re Findlay* [1985] AC 318 per Lord Scarman at p336; *R v North West Lancashire Health Authority* [2000] 1 WLR 977 per Auld LJ at p991, adopted in *R (PO and Ors) v LB of Newham* [2014] EWHC 2561 (Admin). The policies that I have seen are formulated rigidly and admit no exception, contrary to basic principles of lawful policy formulation.

46. **Third**, and as is apparent from some of the correspondence I have seen between women and their NHS trusts concerning the use of streaming / recording during antenatal scans, NHS trusts appear to be relying on the reasons given in the SoR Statement to justify their policies without considering for themselves whether those reasons found a legitimate basis for a complete prohibition.

47. As highlighted above, there is a well-established body of clinical evidence showing that partner participation in antenatal appointments and through a woman's pregnancy improves maternal and foetal health. Indeed, the RCM and RCOG are themselves active proponents of gradually reinstating in-person maternity care and partner attendance in recognition of the importance, for pregnant women, to have support from a person of their choosing at all stages of their maternity journey.[14] Notably, in being proponents of partner participation during antenatal care, the WHO, the RCM and the RCOG have treated partner involvement as clinically significant; the role of the partner is not just social in nature.

48. Thus, the question of whether streaming / recording should be permitted during antenatal appointments where, by reason of Covid-19 restrictions, a support partner is unable to attend an antenatal appointment with the pregnant woman, is clinical in nature. The clinical nature of partner participation appears to have been ignored or disregarded in the SoR Statement. NHS trusts which have relied on the reasons given in the SoR Statement have failed to address their minds to this important clinical question.

49. When properly understood and dissected, it is my view that none of the reasons given in the SoR Statement provide an answer to this important clinical question or a basis for outweighing the important clinical benefit for maternity health of facilitating partner participation at antenatal appoints.

    49.1. The Statement asserts that recording or streaming would be highly distracting for the sonographer, but does not explain why this would be any more distracting then the normal circumstances where the partner attends in-person with the pregnant woman at the appointment.

    49.2. Poor ventilation in examination rooms seem to be a logistics issue; as the NHS guidance issued in December 2020 on supporting pregnant women access maternity services states, trusts should give consideration to "*moving care to larger rooms where social distancing can more easily be maintained*" and "*introducing one-way systems where feasible and proactively managing the risk of queue and pinch points that may compromise social distancing*": para 24.

[14] Accessed at: https://www.rcog.org.uk/en/news/pregnant-women-allowed-partner-support-at-all-times-in-updated-nhs-guidelines/

49.3. Concerns about extending appointment times or adding to staff pressures again appear to be logistics issues which need to be considered in the course of risk assessments that the NHS guidance requires trusts to carry out: para 21.

49.4. Whilst waiting areas are not designed with social distancing, that is again a practical matter which the NHS guidance suggests that trusts may be able to find creative solutions to address, such as encouraging women to attend their appointments on time, allowing ample time for each appointment, spacing them out to manage the risk of ques and asking women to wait outside the hospital if they arrive early: paras 24 and 25.

49.5. As for the suggest that holding a mobile phone way lead to a taut abdomen which makes scanning difficult, there is again no reason why practical solutions such as the arranging of a device to which the mobile phone can be attached, so the woman does not have to hold it whilst being scanned, cannot be considered or arranged.

49.6. The NHS guidance has already set out clear recommendations for managing potential public health risks of transmission from the pregnant woman to hospital staff and visa versa. Lateral flow testing is now being made available to NHS trusts, and according to the NHS guidance, each trust is being provided with sufficient tests for use in maternity as well as other services, including for staff and patient testing.

49.7. Providing a woman with a 10-30 second clip of the scan does not fully address the clinical importance of facilitating proper patient participation in shared decision-making about their maternity care and of facilitating individualised patient care.

50. **Fourth**, the outright refusal to make arrangements to enable pregnant women to involve their partners in the antenatal appointments, either by streaming or recording the appointments would, in my view, engage Article 8 of the European Convention on Human Rights ("ECHR") and the right to of both parents' to their private and family life. It is my view that it will be difficult to identify any clear or proportionate justification for taking such extreme measures, particularly given strong policy reasons for encouraging and facilitating partner attendance as clinically beneficial to maternal and foetal health. I have already set out above why I consider that the reasons cited in the SoR do not found sound justification for a rigid policy on the use of streaming / recording of antenatal appointments.

51. The SoR Statement does not press confidentiality or privacy of the sonographer as justification for an outright prohibition; the GMC and BMA guidance quite clearly and correctly explain why the use of recording or streaming does not in and of itself breach confidentiality (because the confidential medical information discussed is that of the patient who wants the recording / streaming in the first place). It also explains clearly, by reference to the Data Protection Act, why recording / streaming for personal use also does not engage data protection principles.

52. I agree with all of the guidance in their advice to patients to seek consent of the healthcare professional involved as a matter of common courtesy and because it contributes to strengthening trust between the doctor and patient. There is no reason such a principle cannot be incorporated into a policy on the use of streaming and recording during antenatal appointments.

53. But I cannot see a basis upon which these concerns could provide proportionate justification for an outright prohibition of the use of streaming and recording, if the consequence of such a prohibition is to preclude partner participation at clinically important junctures of a woman's pregnancy.

54. **Fifth**, in my view, based on the material I have seen, an NHS trust which imposes an outright prohibition on streaming / recording of antenatal appointments, in circumstances where the woman is unable to have a support partner in attendance risks falling in breach of the Public Sector Equality Duty ("PSED") under section 149 of the Equality Act 2010. Under s. 149 of the Equality Act 2010, the NHS trust, is required to consider three equality objectives both when formulating policy, and when making decisions at an individual level (i.e. in response to a request for a pregnant woman to stream the appointment so that her partner can participate). The three objectives are:

    54.1. eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

    54.2. advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

    54.3. foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

55. "Protected characteristics" as defined under section 149(7) of the Equality Act 2010 includes sex, pregnancy and maternity.

56. Case law on the PSED sets out the following principles on what a relevant body must do to fulfil its obligation to have due regard to the aims set out in the PSED: (*R (on the application of Brown) v Secretary of State for Work and Pensions* [2009] P.T.S.R. 1506)

    56.1. Those in public authorities who have to take decisions that do or might affect the protected classes – including women - must be aware of their duty.[15]

    56.2. The "due regard" duty must be fulfilled in advance of a particular policy that will or might affect the protected classes being adopted. It is an essential preliminary to lawful public decision making.[16] Attempts to justify a decision as being consistent with the exercise of the duty when it was not, in fact, considered before the decision will not be enough to discharge the duty.[17]

    56.3. Compliance with the duty involves a conscious approach and state of mind.[18] Such can only occur where the decision maker is aware of the duty.[19]

    56.4. It is good practice for the policy or decision maker to keep an adequate record showing that they had considered the PSED and any relevant questions.[20] If records are not kept it may make it more difficult, evidentially, for a public authority to persuade a court that it has fulfilled the duty imposed.[21]

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[15] See also *R (Watkins – Singh) v Governing Body of Aberdare Girls' High School* [2008] A.C.D. 88, [114], per Silber J.
[16] *R (Elias) v Secretary of State for Defence* [2006] 1 WLR 3213, [274], per Arden LJ; R (C) v Secretary of State for the Home Department [2009] Q.B. 657, [49], per Buxton LJ.
[17] *R (C) v Secretary of State for Justice* [2009] Q.B. 657, [49], per Buxton LJ.
[18] See for example, *R (Harris) v LB Haringey* [2011] P.T.S.R. 931, [27], per Pill LJ; *R (Bailey) v LB Brent* [2012] EqLR 168, [74]-[75], [83]; *R (Hurley and Moore) v Secretary of State for Business Innovation & Skills* [2012] A.C.D. 50, [72], per Elias LJ.
[19] Building on previous case-law in *R (Chavda) v Harrow LBC* [2008] A.C.D. 31. See also: *R (Baker) v Secretary of State for Communities and Local Government* [2008] LGR 239; *R (Hurley and Moore) v Secretary of State for Business Innovation & Skills* [2012] A.C.D. 50, [73], per Elias LJ; *R (Rahman) v Birmingham City Council* [2011] EqLR 705.
[20] *R (Baker) v Secretary of State for Communities and Local Government* [2008] LGR 239, [38], per Dyson LJ.
[21] *R (BAPIO Action Limited) v Secretary of State for the Home Department* [2007] EWHC 199 (Admin), [69]; *R (Luton BC and O'rs) v Secretary of State for Education* [2011] EqLR 481, [113].

57. There does not appear to be any evidence – and certainly none that is publicly available - that demonstrates that Public Health Wales, for example, has addressed its mind to the three statutory objectives under s. 149(1) Equality Act 2010 when deciding to prohibit the use of streaming or recording in antenatal appointments when the woman is unable to have a support partner present in-person.

58. It would be properly arguable that a breach of PSED ought, together with the other failures identified above, require an NHS trust to undertake a proper assessment of its approach to the use of streaming or recording of antenatal appointments when in-person partner participation is not possible, consistent with the statutory equality objectives. I consider it highly likely that NHS trusts which fail to do so would be acting in breach of the PSED.

59. **Sixth**, and if pregnant women are treated differently to other patients requiring ultrasound scans by reason of it being an obstetrics scan, depending on the explanation given by the NHS trust, such an approach may be considered discriminatory in breach of Article 14 ECHR read with Article 8, or alternatively under the domestic law provisions, i.e. s. 13 (direct discrimination), which arises if a person is treated less favourably because of a protected characteristic, and s. 19 (indirect discrimination), which arises if an apparently neutral policy or practice disproportionately disadvantages a person or a class of persons (e.g. pregnant women).

D. CONCLUSION

60. For the reasons outlined above, I am of the view that a blanket prohibition on the use of streaming or recording during antenatal appointments in circumstances where the support partner is unable to attend in-person with a pregnant woman is likely to be unlawful, discriminatory and violate both Articles 8 and 14 ECHR.

61. My conclusion does not mean that NHS trusts cannot produce policies that impose caveats or limitation to the circumstances in which a pregnant woman's request to use streaming or recording may be permitted. The important take away point is that NHS trusts should not treat the SoR recommendation as a hard and fast rule, and they are expected to undertake their own assessment of the parameters for dealing with such requests. Equally important is the need to elicit and take proper account of the views and needs of the pregnant woman and her support partner.

62. I have sought, in this advice, to identify the key (but non-exhaustive) factors that an NHS trust ought to take into account in policy formulation in this area. I hope that these factors may also assist in policy advocacy work carried out by Birthrights and its partners with local NHS trusts.

63. Should you wish to discuss any of the above, please do not hesitate to contact me in chambers.

Dated 21 January 2021

SHU SHIN LUH
Doughty Street Chambers