Submission to the Senate Community Affairs References Committee Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia

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This submission is made to the Senate Community Affairs References Committee's inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia.

1. Introduction and Recommendations

The focus of this submission is the current *legal framework* for the involuntary sterilisation of people with disability in Australia pursuant to a legal order (ie the legal framework found in Part VII of the *Family Law Act 1975* (Cth) and the state and territory guardianship legislation[1]). As such these submissions relate principally to terms of reference (c) and (d) of the Inquiry.

Proceeding from the key recommendation that the involuntary or coerced sterilisation of people with disability must be prohibited through legislation, these submissions show that the current legal framework must be fundamentally reformed in order to introduce *national legislation that explicitly prohibits the involuntary and coercive sterilisation* of people with disability. Analysis of the current legal framework shows that involuntary sterilisation is currently *authorised* and hence *regulated* by the law and as such the current legal framework is limited to the extent that its mere finetuning can ever effectively *prohibit* involuntary sterilisation.

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[1] This submission focuses on the NSW guardianship jurisdiction. For an overview of the various state and territory guardianship jurisdictions, see Nick O'Neill and Carmelle Peisah, *Capacity and the Law* (Sydney University Press, 2011) ch 12, ch 15. See also Lesley Naik, 'Sterilising Without Consent: Intellectually Disabled Children and Unauthorised Sterilisation' (2012) 37(3) *Alternative Law Journal* 175.

These submissions complement rather than replicate the existing literature on the sterilisation of people with disability that focus on the empirical, social, systemic and human rights reasons why involuntary and coerced sterilisation per se is violent and discriminatory, and in turn why it should be prohibited. These submissions specifically complement this by showing how the *law itself* (rather than the application by the law of social-based stereotypes of disability) is currently implicated in the involuntary and coerced sterilisation of people with disability in Australia, and thus why the law in relation to sterilisation must be *fundamentally reformed* to explicitly prohibit the involuntary and coerced sterilisation of people with disability and to limit the current jurisdictional scope of the Family Court and the state and territory guardianship tribunals to regulate this sterilisation.

1.1 Recommendations

This submission supports the position on sterilisation held by a number of disability and human rights organisations that sterilisation is an act of violence, a form of social control, is discriminatory and constitutes a violation of multiple human rights. For example, Mendéz, the Special Rapportuer on torture and other cruel, inhuman or degrading treatment or punishment, states that:

> *Forced sterilization is an act of violence, a form of social control, and a violation of the right to be free from torture and other cruel, inhuman, or degrading treatment or punishment.* [2]

This submission makes a number of recommendations to the Inquiry based on this conception of sterilisation. These recommendations are focused on the *law* (although this is not intended to deny the importance of social, economic and political reforms). Many of these recommendations are drawn from the existing literature of disability and human rights organsations, whilst others have been added in order to take account of the nuances of the current *legal framework* of sterilisation.

[2] Juan E Mendéz, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc A/HRC/22/53 (1 Feburary 2013), [48]. See also Australian Human Rights Commission, 'The Involuntary or Coerced Sterilisation of People with Disabilities in Australia: Australian Human Rights Commission Submission to the Senate Community Affairs References Committee' (Australian Human Rights Commission, 2012); Women With Disability Australia et al, 'Sterilization of Women and Girls with Disabilities: A Briefing Paper' (Global Campaign to Stop Torture in Health Care, 2011).

These recommendations are as follows:

(1) Consent to sterilisation must be required by law, regardless of disability:

(a) 'The free and informed consent of the woman herself is a requirement for sterilization.' [3]

(b) 'Family members, legal guardians, carers, medical practitioners, and/or government or other public officers, cannot consent to sterilization on any woman's behalf.'[4] This includes if this sterilisation is "authorised" by the court or tribunal.

(c) 'Perceived mental incapacity, including medically or judicially determined mental incapacity, does not invalidate the requirement of free and informed consent of the woman herself as the sole justification for the sterilization.'[5]

(d) The law should *never* distinguish between individuals on the basis of capacity or disability in order to permit sterilisation specifically of people with disability in order to permit sterilisation specifically of people with disability.[6]

(2) Involuntary and coercive sterilisation must be prohibited and criminalised by national legislation:

(a) National legislation must be enacted to criminalised except where there is a serious threat to life or health, (i) the sterilisation of children (regardless of whether they have a disability), and (ii) the sterilisation of adults with disability in the absence of their fully informed and free consent.[7]

[3] Women With Disability Australia et al, above n 2, 4.

[4] Ibid 4.

[5] Ibid 4.

[6] Juan E Mendéz, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc A/HRC/22/53 (1 Feburary 2013) [66].

[7] Australian Human Rights Commission, above n 2, 4. See similarly Letter from Women with Disability Australia to Shauib Chalklen, Anand Grover, Rashida Manjoo & Juan E Méndez, 22 June 2011, 4.

(b) Legislation in the family and guardianship jurisdictions that currently regulate sterilisation should be amended accordingly to explicitly prohibit involuntary or coerced sterilisation.

(c) Criminal procedure and evidence law should also be reformed to prevent attrition of prosecutions of sterilisation-related offences, particularly those that might result from the perceived incapacity of the victim.[8]

(d) Consideration should be given to the reform of the criminal law in order to minimise the risk that sterilisation-related prosecutions will be impeded by the abuse of the defence of medical necessity.[9] Careful consideration should also be given to the requisite mental element of sterilisation-related offences in order to account for the fact that involuntary and coerced sterilisation can still be violent and discriminatory and unlawful *regardless* of the absence of malicious intent on the part of the parent / care-giver or doctor and regardless of it occurring in familial and medical contexts.

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[8] This is particularly the case given that the very legal notion of incapacity that currently permits the lawful involuntary sterilisation of people with disability in its manifestation in evidence laws has also prevented retention of sexual assault cases of victims with intellectual disability. See, for example, the issues facing people with disability who are victims of sexual assault: Jennifer Keilty and Georgina Connelly, 'Making a Statement: An Exploratory Study of Barriers Facing Women With an Intellectual Disability When Making a Statement About Sexual Assault to Police' (2001) 16(2) *Disability & Society* 273; Suellen Murray and Anastasia Powell, 'Sexual Assault and Adults with a Disability: Enabling Recognition, Disclosure and a Just Response' (Australian Centre for the Study of Sexual Assault, 2008); Suellen Murray and Melanie Heenan, 'Reported Rapes in Victoria: Police Responses to Victims with a Psychiatric Disability or Mental Health Issue' (2012) 23(3) *Current Issues in Criminal Justice* 353. See also the recent media attention in relation to some South Australian cases of child sexual abuse of victims with intellectual disability: ABC Radio National, 'Justice Denied to Intellectually Disabled Victims of Sexual Abuse', *The World Today*, 8 January 2013 (Nance Haxton).

[9] The UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (whilst noting the need for an evolving approach to medical necessity *within* human rights jurisprudence itself), and has stated:

'The doctrine of medical necessity continues to be an obstacle to protection from arbitrary abuses in health-care settings. It is therefore important to clarify that treatment provided in violation of the terms of the Convention on the Rights of Persons with Disabilities – either through coercion or discrimination – cannot be legitimate or justified under the medical necessity doctrine.': Juan E Mendéz, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc A/HRC/22/53 (1 Feburary 2013), [34].

See, also the medical necessity case concerning conjoined twins *Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] 1 Fam 147, and the critique of this decision in the context of problematic ideas around disability and personhood in Kristin Savell, 'Mother of the Legal Person' in Susan James and Stephanie Palmer (eds), *Visible Women: Essays in Feminist Legal Theory and Philosophy* (Hart, 2002) 29; Margrit Shildrick, *Dangerous Discourses of Disability, Subjectivity and Sexuality* (Palgrave Macmillan, 2009).

(e) Reforms to the law to prohibit involuntary and coerced sterilisation must explicitly state that the exception to prohibition in relation to 'serious threat to health or life' is to be construed narrowly and, in particular, it does not extend to perceived threats relating to menstruation and pregnancy and any associated mental health, behavioural and care issues.[10]

(3) National legislation should provide avenues for redress and support for women who have been involuntarily or coercively sterilised:

(a) 'National legislation should provide redress to women and girls with disabilities who have been sterilised without their consent. Work in this area would include:

(i) the provision of financial compensation and an official apology for discrimination;

(ii) the provision of specialised funding for qualified counsellors through a recognised body ... to provide ongoing counselling and support to women with disabilities who are survivors of forced sterilisation;

(iii) the provision of specialised funding ... to support survivors of forced sterilisation with their claims to financial compensation.'[11]

(4) Women and girls with disability, and their representative organisations, should be included in the development of all legislation relating to sterilisation.[12]

[10] This submission supports the recommendation that: 'Sterilization for prevention of future pregnancy does not constitute a medical emergency and does not justify departure from the general principle of free and informed consent. This is the case even if a future pregnancy may endanger a woman's life or health.': Women With Disability Australia et al, above n 2, 4.

[11] Letter from Women with Disability Australia to Shauib Chalklen, Anand Grover, Rashida Manjoo & Juan E Méndez, 22 June 2011, 4.

[12] Women With Disability Australia et al, above n 4.

(5) The government should address the underlying factors that drive sterilisation:

(a) This includes the 'cultural, social, and economic factors that drive the sterilisation agenda'.[13]

(b) The government should also address, through law reform, the underlying *legal* factors that drive the sterilisation agenda. This includes the legal concept of capacity, the legal structuring of interpersonal violence and bodily violability in terms of the relationships between consent and capacity (and how ideas of disability and gender are embedded in this), and the ways in which legal *incapacity* gives rise to forms of intervention and violence that are not possible or necessary, and are unlawful, in relation to people without disability.

2. The Current Legal Framework for Involuntary Sterilisation Authorises Legal Violence Against People with Disability

The current legal framework for the involuntary sterilisation of people with disability is centred on the *regulation* rather than prohibition of sterilisation. That is, the current legal framework is focussed on authorising involuntary sterilisation in relation to people who cannot consent and in so doing making lawful instances of violence that would otherwise be unlawful. It is submitted that because of this the current legal framework requires broad scale reform to shift from a legal framework of *regulation* to a framework of complete prohibition.

The argument that the current legal framework regulates rather than prohibits sterilisation is based on the centrality to the legal status of interpersonal violence and bodily violability of the interrelationship between the concepts of consent and capacity. The criminal law generally prohibits interpersonal violence, except where it is consented to.[14] For example, in the leading decision on sterilisation in the Family Court's welfare jurisdiction, a number of the judges in their reasons for judgments discuss how consent renders violence that would

[13] Letter from Women with Disability Australia to Shauib Chalklen, Anand Grover, Rashida Manjoo & Juan E Méndez, 22 June 2011, 4. See similarly Australian Human Rights Commission, above n 2, 4-5.

[14] Noting, of course the uncertainty around exceptions to consensual violence in relation to assault occasioning actual bodily harm or grievous bodily harm: see, eg, *Brown* [1994] 1 AC 212.

otherwise be unlawful and would constitute a criminal assault into lawful violence that does not attract criminal penalty.[15] Mason CJ, Dawson, Toohey and Gaudron JJ state that '[c]onsent ordinarily has the effect of transforming what would otherwise be unlawful into accepted, and therefore acceptable, contact'.[16] It is for this reason that *involuntary* sterilisation is prima facie unlawful, because in not being voluntary it is without the *consent* of the individual subject to the procedure.

This notion of consent is the foundation for the legal framework in relation to the involuntary sterilisation specifically of people with disability. Consent is structured around capacity – to be able to consent an individual must have decision making capacity. Individuals with disability who are deemed to lack decision making capacity are then considered *incapable of consenting* to sterilisation. The current legal framework overcomes the possible unlawfulness of involuntary sterilisation specifically in relation to people with disability and decision making incapacity by specific legal procedures that authorise and in turn render lawful what would otherwise be unlawful violence. These are an order relating to the welfare of a child pursuant to the Family Court's welfare jurisdiction authorising a parent to consent to a child's sterilisation or, in the case of New South Wales, an order by the Guardianship Tribunal consenting to sterilisation that is substituted for the individual's own consent or lack of consent. The incapacity of the subjects of sterilisation is considered in law to provide a legitimate basis for enabling others to make the decision whether to consent to sterilisation. As such, in relation to people without decision making capacity, the sterilisation remains involuntary vis-a-vis their own lack of consent, but is lawful despite this because a third party has consented on their behalf (it is lawful involuntary sterilisation).

Thus, it follows from the current legal framework that the law renders *regulates rather than prohibits involuntary sterilisation of people with disability*, and this is possible because of an underlying relationship in the law itself between consent and capacity that structures interpersonal violence and bodily violability.

Two points follow from this relevant to law reform. First, in order to realise the recommendation made in Part 1 above in relation to the prohibition of the involuntary or

[15] *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 (*Marion's Case*) 232-233 (Mason CJ, Dawson, Toohey and Gaudron JJ); 265-267 (Brennan J); 309-310 (McHugh J).

[16] Ibid 233.

coerced sterilisation of people with disability, national legislation must be introduced that explicitly prohibits involuntary and coerced sterilisation because the current legal framework *does not prohibit* sterilisation. The second point is that reforming the law to prohibit sterilisation involves unpacking the underlying ideas within the law on which lawful involuntary sterilisation of people with cognitive disability is currently based, ie the relationship in the law itself between consent and capacity and how this structures violence and bodily violability, and the assumptions about disability and gender that are embedded within this (a point which is returned to below in Part 3).

It also follows from the current legal framework for sterilisation that involuntary sterilisation pursuant to a court or tribunal order is not only a form of violence[17] but is specifically a form of *legal violence*. Legal violence is violence that is specifically made possible by and authorised by the law.[18] Sterilisation is legal violence because without the court or tribunal order (and the legislation giving jurisdiction to the court and tribunal to make such an order), the involuntary sterilisation of people with disability is not lawfully possible and if committed could be unlawful and attract criminal penalty.

At the core of the idea of 'legal violence' is a relationship between the 'word' of law – legal interpretation and resulting judgement and court order – and the 'deed' of violence itself – the act of a non-legal/judicial actors pursuant to the order.[19] In the case of involuntary sterilisation pursuant to a court or tribunal order, even though the act or 'deed' of sterilisation is carried out by the medical profession at the instigation of family members or care givers, it is important to acknowledge that it is the legal order itself and the legislation pursuant to which this order is made, ie the 'words' of sterilisation, that make the deed of sterilisation possible and lawful.

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[17] See Part 1 and n 2 above.

[18] Hunter has specifically identified court ordered sterilisation of young women with intellectual disability as a form of legal violence: Rosemary Hunter, 'Law's (Masculine) Violence: Reshaping Jurisprudence' (2006) 17 *Law and Critique* 27 ,33.

On legal violence generally Robert Cover, 'Violence and the Word' (1986) 95 *The Yale Law Journal* 1601; Austin Sarat, 'Situating Law Between the Realities of Violence and the Claims of Justice' in Austin Sarat (ed), *Law, Violence, and the Possibility of Justice* (Princeton University Press, 2001) 3; Austin Sarat and Thomas R Kearns, 'Introduction' in Austin Sarat and Thomas R Kearns (eds), *Law's Violence* (The University of Michigan Press, 1992) 1.

[19] An example offered by Cover is the distinction between the judge's sentence and the actual administration of the sentence by prison officers: Cover, above n 18.

This is an important point in the context of law reform because it directs attention specifically to the law's role in involuntary sterilisation. It shows the need to reform the *law* (as opposed to merely changing views or societal attitudes, medical ethical practices etc) to render sterilisation *unlawful* – to stop the *words* that preface the violent and lawful *deeds* of sterilisation. Until the *law* is changed to explicitly prohibit sterilisation, justice and legal institutions will continue to have a key role in the legal violence of involuntary sterilisation, and more broadly the legal framework for the regulation of involuntary sterilisation of people with disability will remain a poor reflection on the integrity and humanity of the Australian legal system itself.

It is submitted that in the current legal framework the violence of involuntary sterilisation is masked by its legal and medical character. Recognising this is important to the extent that the masking of violence might obscure the need to prohibit involuntary sterilisation because the current legal framework appears to be humane, therapeutic and beneficial. First, its authorisation by a court or tribunal gives involuntary sterilisation a sense of legitimacy because the determination of a sterilisation application through a fair procedure transforms the violence into a just and humane intervention. This is evident in the following quote from the reasons for judgment of Mason CJ, Dawson, Toohey and Gaudron JJ in *Marion's Case*[20]:

> *There are, in our opinion, features of a sterilisation procedure or, more accurately, factors involved in a decision to authorise sterilisation of another person, which indicate that, in order to ensure the best protection of a child, such decision should not come within the ordinary scope of parental power to consent to medical treatment. Court authorisation is necessary and is, in essence, a* procedural safeguard.[21]

Here, the reference to 'procedural safeguard' suggests sterilisation itself is acceptable, so long as it follows a fair (and legal) procedure.

The legal violence of involuntary sterilisation is masked by the characterisation of sterilisation in the current legal framework as a 'special medical procedure'. The law is not a neutral mirror of a reality outside of itself, but rather actively produces ways of understanding

[20] *Marion's Case* (1992) 175 CLR 218.

[21] Ibid, 249 (emphasis added).

society through how it names and classifies individuals and phenomena. The classification of involuntary sterilisation as *medical* can neutralise in terms of scientific objectivity and therapeutic benefit the power dynamics and discriminatory ideas that frame sterilisation and the reasons for its use specifically and exclusively in relation to people (and more specifically females) with disability. When it is medicalised, sterilisation is more easily seen as benign and therapeutic,[22] as opposed to violent or discriminatory. Yet, the possibility for sterilisation to be violent or discriminatory, regardless of it being carried out by the medical profession, is clear from the comments made by the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment:

> *The Special Rapporteur recognizes that there are unique challenges to stopping torture and ill-treatment in health-care settings due, among other things, to a perception that, while never justified, certain practices in health-care may be defended by the authorities on the grounds of administrative efficiency, behaviour modification or medical necessity. ...*
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> *... medical treatments of an intrusive and irreversible nature, when lacking a therapeutic purpose, may constitute torture or ill-treatment when enforced or administered without the free and informed consent of the person concerned. This is particularly the case when intrusive and irreversible, non-consensual treatments are performed on patients from marginalized groups, such as persons with disabilities, notwithstanding claims of good intentions or medical necessity.*
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> *It is ... necessary to reaffirm that the Convention on the Rights of Persons with Disabilities offers the most comprehensive set of standards on the rights of persons with disabilities, inter alia, in the context of health care, where choices by people with disabilities are often overridden based on their supposed "best*

[22] Maosn CJ, Dawson, Toohey and Gaudron JJ in *Marion's Case* even note 'to characterise intervention comprising sterilisation as "medical treatment" is already to make assumptions and to narrow the inquiry': ibid 232. They later comment that the question of sterilisation 'has been "medicalised" to a great degree and that one concern that emerges from this is that 'the decision to sterilise, at least where it is to be carried out for contraceptive purposes, and especially now when technology and expertise make the procedure relatively safe, is not merely a medical issue' and as reflected in some of the cases 'the consequences of sterilisation are not merely biological but also social and psychological': ibid 251.

> *interests", and where serious violations and discrimination against persons with disabilities may be masked as "good intentions" of health professionals.*[23]

In a similar vein, WWDA (citing International Federation of Gynaecology and Obstetrics (FIGO) Guidelines) states that:

> *Forced sterilisation constitutes an act of violence whether committed by individual practitioners or under institutional or governmental policies. Healthcare providers have an ethical response in accordance with the guidelines on Violence Against Women.*[24]

Moreover, it follows from the legal characterisation of sterilisation as a medical procedure that the law can then view the subject of a sterilisation related court application as a medicalised body constituted by their biological and psychological processes as opposed to a social and politicised body invested with rights.[25] For example in the sterilisation case of *Re Angela*[26], Justice Cronin stated

> *The evidence is that the procedure is urgent and necessary. As such, it is a matter that requires health consideration now. The longer term consequences are less relevant despite the irreversibility of the procedure because ... Angela is never going to have the benefits of a normal teenage and adult life. As such, the immediate issue is the more critical. A fundamental consideration is also the risks to Angela's life as well as her general health.*[27]

Incidentally, in the case of *Re Angela*, the judge did not consider it necessary to appoint an Independent Children's Lawyer to Angela because the judge was of the view that the medical evidence had thoroughly investigated all of the issues.[28] Thus, the medicalisation of

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[23] Juan E Mendéz, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc A/HRC/22/53 (1 Feburary 2013), [13], [32], [61].

[24] Letter from Women with Disability Australia to Shauib Chalklen, Anand Grover, Rashida Manjoo & Juan E Méndez, 22 June 2011, 4.

[25] Linda Steele, 'Making Sense of the Family Court's Decisions on the Non-Therapeutic Sterilisation of Girls with Intellectual Disability' (2008) 22(1) *Australian Journal of Family Law* 1.

[26] *Re Angela (Special Medical Procedure)* (2010) 43 Fam LR 98.

[27] Ibid [50].

[28] Ibid, [36]-[42].

sterilisation has ramifications for court evidence and procedure (eg the reliance predominantly or only evidence of medical or psychological experts[29]) which in turn can have a powerful role in shaping the facts or 'reality' that mediate the determination of applications for sterilisation-related orders.

Therefore, it is submitted that in introducing national legislation to prohibit legislation (and in turn to ensure appropriate legal safeguards to prevent the abuse of medical necessity defences in relation to any prosecutions pursuant to a prohibition law),[30] the assumptions that the law and medicine are humane and non-violent must be unpacked,[31] otherwise there is a risk that the regulation of sterilisation will continue to be seen as permissible.

3. In the Current Legal Framework Involuntary Sterilisation is a Form of Disability-Specific Legal Violence

Additional to being legal violence, it is submitted that in the current legal framework involuntary sterilisation pursuant to a court or tribunal order is a *disability-specific* form of legal violence. By this it is not meant merely that the sterilisation is in fact only ordered by courts and tribunals in relation to people with disability nor that the law draws on social stereotypes of disability in deciding on a particular application for a sterilisation-related order. Rather, it is meant here in a legal sense: (i) the legal mechanisms for involuntary sterilisation apply exclusively to people with decision making incapacity, (ii) decision

[29] See, eg, Steele, above n 25, 10-11.

[30] See above n 9.

[31] See, for example, the statement by the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment:

'Both this mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment. Forced interventions, often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged "best interest" of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment. Concern for the autonomy and dignity of persons with disabilities leads the Special rapporteur to urge revision of domestic legislation allowing for forced interventions. ': Juan E Mendéz, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc A/HRC/22/53 (1 Feburary 2013) [64].

For a critique of the incapacity vis-a-vis disability, see Steele, above n 25, 16-21.

making incapacity in relation to sterilisation relates to people with disability,[32] and (iii) the legal concept of capacity results in legal distinctions in treatment of individuals on the basis of disability such that involuntary sterilisation is unlawful in relation to people with capacity because their sterilisation can only be lawful when it is voluntary by dint of their consent.

It is submitted that seeing involuntary sterilisation as disability-specific legal violence is important for law reform purposes because it draws attention to the significance of aspects internal to the law itself to the current discriminatory regulation of the violence of sterilisation, specifically the structuring of the law's approach to interpersonal violence around the interrelated concepts of capacity, consent and bodily inviolability. This is opposed to seeing its disability-specific nature as being attributable only to social ideas about disability external to the law itself and which leaves untouched ideas around which the law is structured.[33]

The problematic relationships between disability, capacity and consent have been noted by the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, who has specifically identified legally authorised interventions based on incapacity as discriminatory and, further, has stated that incapacity and the inability to consent should never be the basis for medical interventions and violence that otherwise require consent[34]:

> *Millions of people with disabilities are stripped of their legal capacity worldwide, due to stigma and discrimination, through judicial declaration of incompetency or merely by a doctor's decision that the person "lacks capacity" to make a decision. Deprived of legal capacity, people are assigned a guardian or other*

[32] See Minkowitz's criticism of the equating of disability with incapacity in relation to nonconsensual psychiatric interventions: Tina Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free from Nonconsensual Psychiatric Interventions' (2007) 34(2) *Syracuse Journal of International Law and Commerce* 405, 408.

[33] For a discussion of the significance of social ideas around disability, see Carolyn Frohmader, 'Moving Forward and Gaining Ground: The Sterilisatio nof Women and Girls with Disabilities in Australia' (Women with Disabilities Australia, 2012), 6-13; Steele, above n 25.

[34] Juan E Mendéz, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc A/HRC/22/53 (1 Feburary 2013) [66], see also [85] recommendation (e). See also Commitee on the Rights of Persons with Disabilities, *Consideration of Reports Submitted by States Parties Under Article 35 of the Convention: Concluding Observations of the Committee on the Rights of Persons with Disabilities*, UN Doc CRPD/C/ESP/CO/1 (19 October 2011). [34].

> *substitute decision maker, whose consent will be deemed sufficient to justify forced treatment.*
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> *... criteria that determine the grounds upon which treatment can be administered in the absence of free and informed consent should be clarified in the law, and no distinction between persons with or without disabilities should be made. Only in a life-threatening emergency in which there is no disagreement regarding absence of legal capacity may a health-care provider proceed without informed consent to perform a life-saving procedure.*[35]

The discrimination embedded within the law's framework itself at the level of its very structure again points to the need to not only introduce national legislation explicitly prohibiting involuntary or coerced sterilisation but also in the process to unpack the foundational legal concept of capacity itself, as well as the relationships between disability, capacity and consent. This will involve moving beyond the idea of capacity as *protective* (ie as preventing the unjust imposition of legal responsibilities and obligations on individuals with disability who are perceived as vulnerable *within society*) to a more critical approach that looks at how the concept of capacity itself renders individuals who are deemed 'incapable' vulnerable to violence from *within the law* itself.[36]

It is submitted that a further fundamental step in reforming the law to prohibit involuntary or coerced sterilisation of people with disability is to acknowledge that individuals with disability do *not* constitute a distinct category of legal subjects who should be legitimately subject to distinct forms of violence that are automatically considered unacceptable in relation to people without disability. It follows from this that in reforming the law to prohibit sterilisation, it is insufficient to only acknowledge that social ideas in relation to disability result in the inappropriate and discriminatory application of laws, but rather must acknowledge that there is discrimination within the law itself that results in the delineation of people with disability as a distinct class of legal subjects.

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[35] Juan E Mendéz, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc A/HRC/22/53 (1 Feburary 2013) [64]-[65].

[36] Cf the valorisation of the capacity-based approach in Christopher Ryan, 'One Flu Over the Cuckoo's Nest: Comparing Legislated Coercive Treatment for Mental Illness with that for Other Illness' (2011) 8 *Bioethical Inquiry* 87.

The case law on sterilisation in the welfare jurisdiction is replete with constructions of people with disability as a separate category of legal subjects in such a way that renders them fundamentally, naturally and absolutely distinct from people with ability, as to be incomparable, and that *this* inability to compare these two categories means that discrimination against people with disability vis-a-vis sterilisation is incomprehensible and this legitimises the violence done to them through sterilisation (despite this being a violence deemed inappropriate in relation to people without disability).

For example, in the case of *Re P*[37] the full Family Court rejected a 'but for' test in determining court applications for sterilisation related orders, ie comparing people with disability to those without disability (ie but for the disability would X be sterilised?), stating that:

> *We disagree with the concept of such a test in these cases. While it may be superficially attractive to impose this sort of a test upon the basis that it is non-discriminatory and equates the intellectually handicapped person with the non-intellectually handicapped, we think that upon analysis it has the opposite effect.*
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> *To apply it is, in our view, conceptually incorrect. We consider it is both unrealistic and contrary to the intention of the majority judgment in Marion's case to deal with a particular aspect of the child's needs and capacities as though it existed in isolation from other needs and capacities.*
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> *We are unconvinced that there is any relevant conclusion to be drawn with regard to the best interests of a particular child by an artificial exercise which compartmentalises a finding of fact about an* immutable characteristic *and then hypothesises that it were not so. Lessli's intellectual disability* cannot be isolated as a factor and then "subtracted" from *the constellation of facts about her, any more than one can simply imagine that she no longer suffers from epilepsy, or that she is infertile, or that she is not a female. Realistically, the effect of each of these factors is interactive and cumulative and it is their combined presence in the child which has led to the application before the Court.*

[37] *Re P* (1995) 126 FLR 245.

> *The responsibility to assess the child's best interests is not furthered by compartmentalising one or more of her attributes and measuring the appropriateness of the proposed treatment against a hypothetical child. The fact of a distinction may be shown, but this is not a conclusion which satisfies the necessary inquiry. We read the majority's reference in Marion's case to determining whether a procedure is a step of last resort in the context of a child's needs and capacities, to this effect, that is, requiring an appreciation of the interaction of that child's abilities and disabilities when considering the proposed treatment.*[38]

The reference here to 'immutable' suggests that disability is an unchangeable and natural phenomenon, rather than socially contingent, and one which permeates the very self ('cannot be subtracted') in order to render an individual *fundamentally* different and *incomparable* to someone without a disability. The court went on to construct individuals without disability as 'normal', which further renders people with disability as incomparable because they are implicitly abnormal and hence in an absolutely converse relationship with normality:

> *If applied literally the test would mean that sterilisation could never be authorised other than for therapeutic medical reasons, because one would never contemplate the sterilisation of an intellectually* normal *17-year-old other than for such reasons.*
>
> *This is readily explicable upon the basis that an intellectually* normal *17-year-old female, albeit suffering from epilepsy, can reasonably contemplate the likelihood that she may wish to engage in sexual intercourse for the purpose of having a child or children at any time during the next 35 years of her life, more commonly than not in the context of a marriage or like relationship and to raise and nurture such child or children. Further, she can consider and on advice decide upon the best method of contraception for her and to take or not take contraceptives as she sees fit and to decide whether or not to have sexual intercourse as she sees fit. Finally, she can decide upon her own sterilisation, if not at the age of 17, at a time when she either decides as a mature adult that she does not wish to have a child or at a time when she does not wish to have further children.*

[38] Ibid (emphasis added).

> *None of these considerations apply to a child like Lessli. She cannot contemplate marriage, having children, raising a family, deciding upon contraception or sterilisation, nor can she even understand her own sexuality or the reason why she menstruates.*
>
> *In our view it is illusory and misleading to even attempt to equate her position and to do so entirely shifts the focus of the inquiry away from where it should be, that is, whether it is in her* best interests *that the procedure be performed.*[39]

These excerpts clearly show the absolute distinction made on the basis of disability between people with and without disability, and the additional characterisation of this in terms of normality and abnormality, all of which means that individuals with disability can be legitimately subject to a form of violence that would be incomprehensible to people without disability. Moreover, the focus on an individual's best interests isolates them from comparison.

This is also evident in the reasons for judgment of Mason CJ, Dawson, Toohey and Gaudron JJ in *Marion's Case*:

> *In arguing that there are kinds of intervention which are excluded from the scope of parental power, the Commonwealth submitted that the power does not extend to, for example, the right to have a child's foot cut off so that he or she could earn money begging, and it is clear that a parent has no right to take the life of a child. But these examples may be met with the proposition that such things are forbidden* because it is inconceivable that they are in the best interests of the child. *Even if, theoretically, begging could constitute a financially rewarding occupation, there is* a presumption that other interests of the child must prevail. *Thus, the overriding criterion of the child's best interests is itself a limit on parental power. None of the parties argued, however, that sterilisation could never be said to be in the best interests of a child with the result that it could never be authorised. On the contrary, the question whether parental power is limited only arises because the procedure may be authorised. But, the question whether it is in the best interests of the child and, thus, should be authorised is*

[39] Ibid (emphasis added).

> not susceptible of easy answer *as in the case of an amputation on other than medical grounds.*[40]

Here the judges draw a distinction between amputation, which is seen as inevitably and unquestionably *never* in a child's best interests and hence *absolutely* impermissible, and sterilisation, which could be in a child's best interests (there being 'no easy' or absolute answer that it is wrong in a particular case and hence it follows that it is wrong regardless of the particular facts). Again, there is an assumption that it is the disability that renders people with disability a distinct category of legal subjects and in turn renders permissible violence and bodily violability specifically against people with disability.

The case law around sterilisation not only shows a relationship between disability and violence, but also a more specific relationship between gender disability and violence. That is, the permissibility of sterilisation as disability-specific violence is not only linked to a particular construction of disability legal personhood as fundamentally and absolutely distinct and inviting more violence, but additionally the gendered nature of this personhood and the permissibility of gendered forms of violence. By this it is meant that involuntary sterilisation would not only never be done on a person without disability but also that an intervention involving a similar degree of violence would never be contemplated in relation to other male gendered or gender neutral body parts or functions. For example, Hayes and Hayes state:

> *No reasonable [medical] practitioner would undertake an operation for colostomy because the patient smeared faeces around the house – why is the smearing of menstrual blood considered so much more abhorrent and untreatable by education, conditioning and behaviour modification techniques?*[41]

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[40] *Marion's Case* (1992) 175 CLR 218, 240 (emphasis added).

See similarly Deane J: '... one can think of equally obvious examples where parental authority would not extend to authorize surgery for other than conventional medical purposes even though it was thought by the parents to be for the ultimate welfare of an incapable child. The surgical amputation of the right hand of a child who was an habitual "pickpocket" might conceivably be seen by parents who were fanatical biblical literalists as being justified as conducive to the child's overall welfare. The authorization of such an operation would be beyond parental authority, however, for the reason that *it could not, according to the standards of our society, properly be seen as so justified.* Similarly, there are circumstances in which it is plain that, according to the general standards of our society, surgery involving sterilization of an incapable child for reasons other than the conventional medical ones of preventing death or treating or preventing physical illness *is or is not* clearly in the interests of the welfare of the child.': ibid, 297 (emphasis added).

[41] Susan C Hayes and Robert Hayes, *Mental Retardation: Law, Policy and Administration* (The Law Book Company Limited, 1982) 80.

Brady similarly states that:

> *The child will no longer bleed for five days a month. However, she will continue to urinate and defecate each day for the rest of her life. This is a greater nursing management problem. Why is there an inconsistency of approach to menstruation as opposed to other bodily functions?*[42]

The disabled *and* gendered nature of the legal subjects of sterilisation is evident in *Marion's Case*[43] in the gender-neutral examples that sterilisation is compared with.

It is submitted that legal reforms to prohibit sterilisation *must* be founded upon the unpacking of disability as a legal category that is absolutely and naturally distinct from ability and how this level of the law's ordering of subjects into distinct and incomparable legal spaces means that the violence of sterilisation is incomparable, and in turn non-discriminatory and legitimate. So long as these ideas remain undisturbed, it will be impossible to see the involuntary sterilisation of people with disability as wrong, in and of itself, which will support its continued regulation and impede efforts to reform the law to prohibit involuntary or coerced sterilisation.

4. Jurisdiction and Sterilisation

This part shifts from the broad legal contours of involuntary sterilisation to the specific jurisdictions within which the current regulation of violent and discriminatory involuntary sterilisation is located: the Family Court's welfare jurisdiction and the state and territory guardianship jurisdictions. Jurisdiction in a technical sense 'is often used to describe the

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See similarly *Re Jane* (1988) 94 FLR 1 where a distinction is made between sterilisation (as implicitly a legitimate procedure for abnormal girls) and other female gendered or gender neutral procedures committed against 'normal' girls:

'The consequences of a finding that the court's consent is unnecessary are far reaching both for parents and for children. For example, such a principle might be used to justify parental consent to the surgical removal of a girl's clitoris for religious or quasi cultural reasons, or the sterilisation of a perfectly healthy girl for misguided, albeit sincere, reasons. Other possibilities might include parental consent to the donation of healthy organs such as a kidney from one sibling to another.': ibid, 26.

[42] Susan Brady, 'Invasive and Irreversible' (1996) 21(4) *Alternative Law Journal* 160, 162.

[43] *Marion's Case* (1992) 175 CLR 218.

amenability of the defendant to the reach of a court's process'[44] and to the 'authority to decide'.[45] Contrary to this orthodox approach, an important preliminary point that underlines the submissions in Part 4 is that jurisdiction and its limits actually generate ways of understanding individuals and phenomena that are conducive to rendering necessary and legitimate legal interventions and violence within that jurisdiction against people with disability. In this part it is submitted that there are particular problems specifically with these jurisdictions that point to additional reasons why the present legal framework must be reformed to explicitly prohibit sterilisation, and more specifically why this must involve new national legislation prohibiting involuntary or coerced sterilisation and the amendment of legislation in the existing jurisdictions to explicitly place involuntary sterilisation beyond their jurisdictional scope.[46]

a. Family Court's Jurisdiction

Sterilisation in the Family Court's welfare jurisdiction involves an order in relation to a child's welfare under Pt VII and specifically s 67ZC of the *Family Law Act 1975* (Cth). The contours of the welfare jurisdiction, notably it being structured around the relations between parent and child, points to the need to the need to reform the current family law framework. Reforms should involve amending the *Family Law Act 1975* (Cth) so that it explicitly states that an order made under s 67ZC cannot be made in relation to the involuntary sterilisation of children except where there is a serious threat to health or life and, in particular, that this does not include perceived or actual threats relating to menstruation and pregnancy and the associated behavioural, mental health and care issues.

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[44] *Minister for Immigration and Multicultural and Indigenous Affairs v B* (2004) 219 CLR 365, [6].

[45] Ibid, [6] citing *Ah Yick v Lehmert* (1905) 2 CLR 593, 603; *Baxter v Commissioners of Taxation (NSW)* (1907) 4 CLR 1087, 1142.

[46] As Steele has stated: '... the concentration on the question of the constitutional validity of the Family Court's jurisdiction in relation to sterilisation has marginalised the question of the social or ethical validity of the court's power to authorise such procedures. While jurisdiction, 'the authority to decide', is central to the legal legitimacy of the court's decision-making power, it says nothing of the social or ethical legitimacy of that decision.: Steele, above n 25, 34.

For a critical approach to jurisdiction that broadly informs the analysis in this part, see Shaunnagh Dorsett and Shaun McVeigh, *Jurisdiction* (Routledge, 2012).

Family Court authorisation of involuntary sterilisation of people with disability is shaped by the nature of the welfare jurisdiction. Most fundamentally, this jurisdiction concerns the relations between children and their parents and parental responsibilities in relation to their children.[47] Since the High Court's decision on *Minister for Immigration and Multicultural Affairs v B*[48] it has been consistently held that the Family Court's jurisdiction to make an order relating to sterilisation is not related to the welfare of the child at large, but is specifically related to a child's welfare in the context of familial relations between parents and children and parental responsibility for the welfare of their children.[49] As Bryant CJ and Strickland J (O'Ryan J agreeing) recently stated in the Family Court decision of *Re Bernadette*:[50]

> *Pt VII is concerned with the relationship between parents and children and parents' duties in respect of their children or, put another way, the orders under s 67ZC, particularly in relation to the subject matter arising in* Marion's *case and*

[47] Ibid, 11-16.

[48] *Minister for Immigration and Multicultural and Indigenous Affairs v B* (2004) 219 CLR 365.

In *Minister for Immigration and Multicultural and Indigenous Affairs*, the court considered the scope of the welfare power provided by s 67ZC of the *Family Law Act 1975* (Cth) in the specific context of Family Court orders sought by the parents of 5 children held in immigration detention directing the Minister to release these children. The court held that the Family Court does not have jurisdiction under the *Family Law Act 1975* (Cth) to make orders against the Minister or other third parties relating to the treatment of the children in immigration detention. For example, Gummow, Hayne and Heydon JJ stated that 'in its terms, s 69ZH confines the operation of s 67ZC to the parental responsibilities of the parties to a marriage for a child of the marriage.': ibid, [105], see also [53]-[54], [74], [110], [176]-[177], [204], [207]. In their reasons for judgment concluded that the Family Court's welfare jurisdiction was limited by s 67ZH which 'confines the operation of s 67ZC to the parental responsibilities of the parties to a marriage for a child of the marriage': ibid [74]. In their reasons of judgement, Gleeson CJ and McHugh J were of the view that the Family Court's welfare jurisdiction was not at large, and did not extend to the making of orders binding on third parties even when it would advance the welfare of the child to do so ibid, [28], [50]-[54]. See also the subsequent application of this decision concerning the limitation of the court's welfare jurisdiction to parental responsibility, in a variety of reported Family Court decisions. For example, in the recent decision of *Re Baby D (No 2)* Young J stated that 'It is clear from the reasoning of the majority in *Marion's* case, and the application of *MIMIA v B* in subsequent decisions of this court, that s 67ZC is limited by s 69ZH to the parental responsibilities of the parties to a marriage for a child of the marriage': *Re Baby D (No 2)* (2011) 258 FLR 290, [193]. See also *Re Alex* (2009) 298 FLR 312, [113]-[130]; *Re Sean and Russell (Special Medical Procedures)* (2010) 258 FLR 192, [66]-[75]; *Re Inaya (Special Medical Procedure)* (2007) 213 FLR 278, [48]-[53].

[49] 'The welfare jurisdiction of the court is not at large and is dependent upon its attachment to a provision in Pt VII of the Act to create a "matter" within the meaning of ss 75 or 76 of the Constitution.': *Re Alex* (2009) 298 FLR 312 [121], referring to *Minister for Immigration and Multicultural and Indigenous Affairs v B* (2004) 219 CLR 365. For background to the Constitutional grounding of jurisdiction in a 'matter', see ibid [6]-[22].

[50] *Re Bernadette* (2011) 249 FLR 294.

> *like cases (of which this is one) is essentially supervisory of parental responsibility.*[51]

It follows from the nature and limits of the jurisdiction that individuals who are the subjects of sterilisation-related applications can only be known within this jurisdiction as *children* and in terms of their *relationship to their parents*.[52] It is submitted that this has the effect of freezing time in terms of that individual's life course, and this easily folds into the construction of people with intellectual disability as 'eternal children'.[53] This in turn supports the narrow focus on those individuals as asexual, sexually vulnerable, incapable of ever being parents, and as a burden of care, which are factors going towards sterilisation being considered in the 'best interests' of children with disability. As such, whilst the best interests test itself is incredibly problematic[54] (not least of all because it sees sterilisation as in the best interests of a child with disability depending on the facts of a particular case, rather than *never* in a child's best interests), it is important to appreciate how the jurisdiction within which this test is located itself generates possibilities and limits to how this test can be approached. In turn, it is not sufficient to reform the law by simply finetune the existing 'best interests' in this jurisdiction to be less discriminatory, because the jurisdiction itself is part of the problem – any test within this jurisdiction will still result in the regulation of a practice that should instead be prohibited.

There are two further issues that follow from the Family Court's welfare jurisdiction, to which this submission now turns.

i. Court Ordered Involuntary Sterilisation as Lawful Family Violence

One effect of the nature of the Family Court's jurisdiction as structured around the parent/child relationship, when taken in conjunction with the point made above in part 2 concerning court ordered involuntary sterilisation as legal violence, is that the Family Court's

[51] Ibid, [55], see also [45]-[54].

[52] Steele, above n 25, 11-16.

[53] Ibid, 11-14.

[54] See ibid, 21-29.

welfare jurisdiction currently authorises family violence. In a speech given during the 56th Session of the Commission on the Status of Women, Sex Discrimination Commissioner Elizabeth Broderick has referred to sterilisation as a form of family violence, stating that

> *The Australian Law Reform Commission recently recommended that a common definition of family violence be inserted into all relevant Commonwealth laws a definition that includes: conduct that is violent, threatening, coercive and controlling, or intended to cause a family member to be fearful; and a non-exhaustive list of examples of physical and non-physical conduct. In such a definition, types of family violence experience by people with a disability may include:* forced sterilisation *and abortion; specific types of abuse related to their disability such as withholding equipment, food and medication; and financial exploitation.*[55]

Involuntary sterilisation is arguably a form of family violence because of the role of parents in instigating and consenting to the procedure (although the procedure itself is carried out by the medical profession and does not necessarily involve any malicious intent on the part of parents or doctors). It is submitted here that the nature of the Family Court's welfare jurisdiction renders this family violence *lawful* because it is authorising the parent's consent to this procedure, rather than prohibiting this form of violence altogether. For example, in *Marion's Case*[56] Mason CJ, Dawson, Toohey and Gaudron JJ explain the role of the court:

> *It is necessary to consider the precise function of a court when it is asked to authorise the sterilisation of an intellectually disabled child. It is to be remembered that what is sought it not the court's consent as, for example, the signing of hospital forms, but its authorisation.*
>
> *The function of a court when asked to authorise sterilisation is to decide whether, in the circumstances of the case, that is in the best interests of the child.*[57]

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[55] Elizabeth Broderick, 'Violence Against Women with a Disability in Rural Australia' (Paper presented at the Rural Women and Girls with Disabilities: Economic Empowerment & Political Participation, United Nations Headquarters, New York, 2012) <http://humanrights.gov.au/about/media/speeches/sex_discrim/2012/20120322_csw_disability.html>.

[56] *Marion's Case* (1992) 175 CLR 218.

[57] ibid, 259.

Thus, even though the court is limiting the ability of parents to make these decisions at large, the Court is not prohibiting involuntary sterilisation outright, but rather simply regulating when it will be authorised (ie when this family violence will be lawful) based on the best interests test. This is additionally problematic because one of the purposes of Pt VII of the *Family Law Act 1975* (Cth) and the best interests test is to protect children from family violence. Gleeson CJ and McHugh J stated 'the various divisions and subdivisions of Pt VII show that the main object of the part is to require parents to act in ways that will advance the best interests of their children' and that 'when construed as a whole' there is nothing in Pt VII to 'suggest that the part was intended to give the Family Court a general jurisdiction over children with the power to make an order against individuals whenever the best interests of a child require such an order to be made'.[58] The best interests test, which must be the 'paramount consideration'[59] when the court decides whether to make an order pursuant to s 67ZC including one relating to sterilisation under s 67ZC[60], is premised on the protecting children from family violence. Section 60B giving the objects of Part VII states that

> *(1) The objects of this Part are to ensure that the best interests of children are met by:*
>
> ...
>
> *(b)* protecting children *from physical or psychological harm from being subjected to, or exposed to, abuse, neglect or* family violence*; ...*[61]

On the one hand, in the Family Court's welfare jurisdiction sterilisation in the context of the parent-child relationship *can* be in the best interests of a child with disability *and* in certain circumstances it is specifically in the child's best interests because of the heightened vulnerability to child sexual assault.[62] On the other hand, the welfare jurisdiction is supposed to protect children from family violence. As such, the current jurisdictional framework

[58] *Minister for Immigration and Multicultural and Indigenous Affairs v B* (2004) 219 CLR 365, [28].

[59] *Family Law Act 1975* (Cth) s 60CA.

[60] *Re Baby D (No 2)* (2011) 258 FLR 290, [171].

[61] 'Family violence' is defined in s 4AB(1) as 'violent, threatening or other behaviour by a person that coerces or controls a member of the person's family (the *family member*), or causes the family member to be fearful' and in s 4AB(2) as including 'assault'.

[62] On the issue of sexual assault see discussion in Steele, above n 25, 27-28.

results in a contradictory situation where the Family Court can authorise an act of family violence (in the form of involuntary sterilisation of a child with disability) pursuant to a test that has as part of its purported purpose the protection of children from family violence and at times additionally on the basis that sterilisation (itself a form of family violence) is purportedly protecting a child from the effects of other forms of violence (in the form of child sexual assault). The Family Court's 'supervisory' jurisdiction over parents vis-a-vis involuntary sterilisation means it not only fails to protect children from family violence, but actually permits and legitimises a form of family violence that, by the contours of its very jurisdiction, it should in fact be protecting children from.[63]

Thus, the current legal framework of sterilisation in the Family Court's welfare jurisdiction must be reformed in order to explicitly exclude from the scope of this jurisdiction the making of an order in relation to the welfare of a child under s 67ZC of the *Family Law Act 1975* (Cth) in relation to sterilisation, except where there is a serious threat to life or health. In turn, these reforms must explicitly state that this exception is to be interpreted narrowly and in particular does not extend to perceived threats relating to menstruation, pregnancy and related behavioural, mental health and care issues.

ii. Depoliticising, Privatising and Individualising Sterilisation

It follows from the scope and limits of the Family Court's welfare jurisdiction that orders made pursuant to s 67ZC in being limited to the parent/child relationship rather than their welfare at large depoliticises, privatises and individualises the circumstances giving rise to the sterilisation application and it legitimises a legal outcome focused on medical intervention and violence on a child's body as opposed to resource allocation to families or systemic change to the economic, social and political status of people with disability in society.[64]

It has been held that in the welfare jurisdiction the Family Court cannot bind third parties. In *Minister for Immigration and Multicultural and Indigenous Affairs v B*[65] Gleeson CJ and

[63] From a slightly different angle, see Brennan J's dissenting comments concerning the relationship between the welfare jurisdiction and involuntary non-therapeutic sterilisation as criminal conduct: *Marion's Case* (1992) 175 CLR 218, 284-285.

[64] Steele, above n 25, 14-16, 21-23, 33.

[65] *Minister for Immigration and Multicultural and Indigenous Affairs v B* (2004) 219 CLR 365.

McHugh J stated that whilst the court under s 67ZC has jurisdiction to make an order 'that is binding on a parent',

> *[n]othing in [s 67ZC] or in the rest of Pt VII, however, suggests that the Family Court has jurisdiction to make orders binding on third parties whenever it would advance the welfare of a child to do so. Nothing in s 67ZC, or in Pt VII generally, imposes – expressly or inferentially – any duty or liability on third parties to act in the best interests of or to advance the welfare of a child. Except where Pt VII expressly imposes obligations on third parties – for example, ss 65M, 65N and 65P – that Part is concerned with the relationship between parents and children and parents' duties in respect of their children.* [66]

Their Honours further stated in relation to the application made by the parents in relation to the Minister's responsibilities to their children in immigration detention that:

> *The orders sought in the present case are not concerned with the relationship between the parents of the children. They do not seek to enforce duties or obligations owed by the parents to the children. ... The object of the orders in the present case is to require the minister to take or to refrain from taking action in respect of the children. Nothing in Pt VII gives any support for the making of such an order or orders against the minister. Consequently, no provision or combination of provisions in Pt VII defines the jurisdiction of the Family Court with respect to a matter involving the minister.*[67]

It follows from this decision the Family Court does not have jurisdiction to order the state to provide disability support services, respite care, or financial assistance to families, or to engage in broader systemic changes around discrimination against people with disability.[68] Thus, the welfare jurisdiction makes sterilisation a private family issue as opposed to a systemic and political issue, an obligation of parental care for their child as opposed to an obligation of the state to provide support and resources, and hence the child's body becomes

[66] Ibid, [52]. See also *Secretary, Department of Health and Human Services v Ray* (2010) 45 Fam LR 1 , [88]-[90] (case concerning whether an order under s 67AC could bind the Secretary of the Department of Health and Human Services such that an order could be made to join him to Family Court proceedings concerning the parental responsibility and future living arrangements of two children).

[67] *Minister for Immigration and Multicultural and Indigenous Affairs v B* (2004) 219 CLR 365, [53].

[68] Ibid, 14-15.

the appropriate target of (a violent) intervention as opposed to society being identified as the target of systemic change.[69]

b. Guardianship Jurisdiction

The other jurisdiction relevant to the current legal framework for involuntary sterilisation of people with disability is the state and territory guardianship jurisdictions (as stated in Part I above, this submission focuses on the NSW guardianship jurisdiction). It is acknowledged that the literature suggests that there might be some advantages to these jurisdictions over the Family Court's welfare jurisdiction in relation to the legal authorisation of sterilisation.[70] Yet, this is a really a matter of degree and ultimately this jurisdiction also fails to prohibit involuntary sterilisation of people with disability and thus mere finetuning of this jurisdiction cannot by itself accommodate the recommendations made in this submission.

i. Disability and Substituted Decision Making

The NSW guardianship jurisdiction is a jurisdiction only for people without decision making capacity, and this is typically equated to those with a cognitive or mental health disability.[71]

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[69] In his separate reasons for judgment, Callinan J stated 'No matter how extensive the powers conferred by s 51(xxi) and (xxii) may be, the powers of the Family Court with respect to children are powers in relation to, or arising out of married (either currently or previously) *parentage* of children, or of unmarried *parentage* of them on a reference by the states. Those powers do not comprehend a general discretionary welfare power over any or all children, whether of a marriage or not, exercisable in such a way as to override any or all other powers over children, such as to detain them in immigration detention, or rehabilitative, reformative, or penal institutions. The Family Court may no more do this than it could exercise a jurisdiction in tort or contract in order to advance the welfare of a child.': ibid, [215] (emphasis in original).

[70] See, eg, Brady, above n 42; Susan Brady, 'The Sterilisation of Children with Intellectual Disabilities: Defective Law, Unlawful Activity and the Need for a Service Oriented Approach' (1998) 33(2) *Australian Journal of Social Issues* 155; David Tait, Terry Carney and Kirsten Deane, 'Legal Regulation of Sterilisation: The Role of Guardianship Tribunals in NSW and Victoria' (1994) 8 *Australian Journal of Family Law* 141.

[71] For example, in their book on guardianship law, O'Neill and Peisah state that capacity is related to 'cognitive abilities': O'Neill and Peisah, above n 1, ch 1, 4. It is thus an internal, individualised characteristic. In a section on 'What sort of disorders compromise capacity?' that:

Any disorder causing acute or chronic impairment of cognitive function might potentially compromise capacity. Such disorders include:

1. Intellectual disability

2. Cognitive impairment, either associated with

In this jurisdiction, involuntary sterilisation through guardianship legislation can *only ever* apply to people with disability and decision making incapacity.[72] The jurisdiction can never substitute the decision/consent for an individual without disability and with decision making capacity, regardless of the views held in relation to the appropriateness of the decisions made by such an individual. Thus, at its jurisdictional level the Guardianship Tribunal can only ever permit involuntary sterilisation against people with disability. This reflects the points raised in Part 2 above in relation to disability-specific legal violence – even though the Guardianship Tribunal might be considered favourable because it caters specifically for people with disability, in the context of its jurisdiction over sterilisation this is actually resulting in the regulation of legal violence exclusively against people with disability.

A further point is that the NSW guardianship jurisdiction provides a substituted decision making specifically for people with disability without decision making capacity.[73] A variety of United Nations human rights bodies have urged states to replace substituted decision making regimes with *supported* decision making regimes, on the basis that the former are discriminatory and contrary to a number of human rights.

> *In all legal systems, capacity is a condition assigned to agents that exercise free will and choice and whose actions are attributed legal effects. Capacity is a rebuttable presumption; therefore, "incapacity" has to be proven before a person can be designated as incapable of making decisions. Once a determination of incapacity is made, the person's expressed choices cease to be treated meaningfully. One of the core principles of the Convention on the Rights of Persons with Disabilities, is "respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons"*

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a. head injury;

b. neurodegenerative diseases such as dementia ... ; or

c. delirium which is a transient reversible perturbation of cognitive function due to medical illness.

3. Mental illness such as schizophrenia, depression, bipolar disorder, usually in their acute phases.: ibid, ch 1, 4-5.

[72] In the context of the Guardianship Tribunal, this is limited to individuals who are 'incapable of giving consent to the carrying out of medical or dental treatment': *Guardianship Act 1987* (NSW) s 34.

[73] O'Neill and Peisah, above n 1, ch 12, 7.

> *(art. 3(a))). The Committee on the Rights of Persons with Disabilities has interpreted the core requirement of article 12 to be the replacement of substituted decision-making regimes by supported decision-making, which respects the person's autonomy, will and preferences.*[74]

In a similar vein, the Committee on the Rights of Persons with Disabilities has stated in relation to Spain:

> *The Committee recommends that the State party review the laws allowing guardianship and trusteeship, and take action to develop laws and policies to replace regimes of substitute decision-making by supported decision-making, which respects the person's autonomy, will and preferences. It further recommends that training be provided on this issue for all relevant public officials and other stakeholders.*[75]

Thus, the recommendations made in Part 1 of this submission cannot be accommodated by the finetuning of the Guardianship Tribunal because it is fundamentally discriminatory towards people with disability by dint of its substituted decision making.

ii. Broad Approach to Serious Damage to Health

To order sterilisation the Tribunal must be satisfied 'that the treatment is the most appropriate form of treatment for promoting and maintaining the patient's health and well-being'[76] and that the treatment is necessary 'to save the patient's life' or 'to prevent serious damage to the patient's health'.[77] The literature suggests that the NSW guardianship jurisdiction gives a broad interpretation to what constitutes the prevention of serious damage to health, as was

[74] Juan E Mendéz, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc A/HRC/22/53 (1 Feburary 2013) [27]. For an application of this approach in the context of psychiatric treatment , see Minkowitz, above n 32; Tina Minkowitz, 'Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities' in Bernadette McSherry and Penelope Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing, 2010) 151.

[75] Commitee on the Rights of Persons with Disabilities, *Consideration of Reports Submitted by States Parties Under Article 35 of the Convention: Concluding Observations of the Committee on the Rights of Persons with Disabilities*, UN Doc CRPD/C/ESP/CO/1 (19 October 2011). [34].

[76] *Guardianship Act 1987* (NSW) s 45(1).

[77] Ibid, s 45(2).

discussed in general terms in Part 2 above. O'Neill & Peisah (formerly both of the Guardianship Tribunal) state:

> *If the proposed treatment is necessary to save the person's life, approval will be given without delay as a result of an urgently organised hearing. Usually the question is whether the treatment is necessary to prevent serious damage to the person's health. This involves a consideration of both the person's physical and their psychological health together with the form of sterilising treatment proposed. Matters that will be considered include evidence about* anaemia *and its effect on the person, the* nature and extent of any bleeding *and if the bleeding is heavy and prolonged and its effect on the person's physical and* psychological health. *Also relevant is any evidence of the negative consequences of the use of particular reversible treatments as well as* behavioural problems *that appear related to the* person's menstruation *and the nature and extent of those problems. Again, evidence of the consequences of no treatment is relevant.*[78]

From these comments it is clear that serious damage to health is liberally interpreted to extend to mental health and behavioural problems, and notably those linked to menstruation. In a similar way, Tait, Carney and Deane (writing in the earlier years of the NSW Guardianship Tribunal) suggest that '[w]hile "health" is not defined, it could be interpreted in the broad way used by Justice Brennan [in *Marion's Case*] to include effects on the mind and self-image'[79] and that '[t]he goal of "preventing damage" may similarly be interpreted in a broad way' suggesting that it might extend to damage to a young women's health from experiencing 'menstrual flows'.[80] Again, reinforcing comments made in Part 2 above, it is evident that serious damage to health has embedded within it gendered and disabled stereotypes around the pathology of the behaviour and responses of females with disability.[81]

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[78] O'Neill and Peisah, above n 1, ch 15, 21 (emphasis added).

[79] Tait, Carney and Deane, above n 70, 155.

[80] Ibid, 155.

[81] For example, O'Neill and Peisah refer to a Guardianship Tribunal case relating to menstruation – 'the Tribunal gave its consent to a hysterectomy for a 17 year old woman who had a severe level of intellectual disability and who had heavy and prolonged periods which appeared to have significant impact on her behaviour. Medications had either been unsuccessful or were unlikely to assist her.': O'Neill and Peisah, above n 1, ch 15, 21.

5. Conclusion

This submission has made a series of recommendations in relation to the recognition of and prohibition of the involuntary and coerced sterilisation of people with disability as a violent and discriminatory practice which is presently authorised and legitimised by the law.

This submission has specifically recommended the introduction of national legislation prohibiting the involuntary or coerced sterilisation of people with disability except where there is a serious threat to life or health. It has additionally recommended that the existing legal framework in the Family Court welfare jurisdiction and state and territory guardianship jurisdictions be reformed in order to explicitly exclude from the scope of these jurisdictions the making of orders in relation to sterilisation except where there is a serious threat to life or health. In turn, all of these reforms must explicitly state that the 'serious threat' exception is to be interpreted narrowly and in a non-discriminatory manner, and in particular that it does not include perceived threats relating to menstruation, pregnancy and related behavioural, mental health and care issues.

Associated with these legal reforms, this submission has also emphasised the need to unpack the underlying ideas around disability and gender that are embedded within the structure of the law itself, including the legal concept of capacity, the relationship between capacity and consent in the legal structuring of interpersonal violence and bodily violability and the classification of people with disability as a fundamentally, absolutely and naturally different category of legal subjects who cannot be compared against people without disability. Whilst changing social stereotypes is an important part of reforms, reform must also turn to the problematic and discriminatory ideas about disability within the law itself.

More deeply, for these reforms to be possible and for prohibition to be successful, the foundation of these reforms must be based on an acknowledgement that sterilisation is in and of itself wrong, violent and discriminatory, regardless of an individual's disability and regardless of whether it is court order and/or is conducted in medical or familial contexts. Part of this involves an official apology for Australia's history of involuntary or coerced sterilisation (and ideally other disability-specific practices such as institutionalisation and forced psychiatric treatment). Until this is done, the Government is implicitly positioning involuntary or coerced sterilisation not as a reprehensible and regrettable historical practice, but as an ongoing and legitimate social, medical *and legal* practice.