Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

The involuntary or coerced sterilisation of people with disabilities in Australia

The attached submission responds to the Committee's call for public comment regarding the involuntary or coerced sterilization of people with disabilities in Australia.

The submission is prefaced by a summary of issues and key recommendations that address concerns regarding legal frameworks and practice on a national basis.

The submission draws on graduate research and teaching regarding medical law. It also draws on forthcoming publication in specialist fora. It is made on a personal basis rather than on behalf of the University of Canberra

As background, I teach Torts Law and Mental Health & the Law units in the Law School at the University of Canberra. I am admitted as a Legal Practitioner in the Supreme Court of the ACT. I have a particular interest in professional practice in the health sector, in the operation of tribunals and courts in dealing with people who have disabilities, and questions regarding the autonomy and liability of patients and health service providers. I have postgraduate qualifications in both law and medical sciences.

I would be pleased to assist the Committee by discussing aspects of the submission in more detail.

Yours sincerely

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14 February 2013

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A Submission to the Community Affairs References Committee

February 14th, 2013

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Summary and key recommendations

Sterilisation of people lacking capacity should be extremely rare; however, there may be some circumstances under which it is in the best interests of the person concerned, and, rather than denying that person their best chance of living a life of dignity and meaning by categorically banning the procedure, this submission instead argues that appropriate safeguards should be put in place to ensure that it truly is in their best interests.

Detailed responses to the questions posed by this enquiry requires consideration of many critical areas of law and medical ethics, including, but not limited to, issues of consent and autonomy; human rights; child welfare; court jurisdiction; and the role of the state in intervening in the private lives of citizens.

A key focus of this response will be on sterilisation of children who lack capacity to make legally recognised decisions about their own health and welfare. The delegated decision making frameworks in place in other legal contexts will be discussed, and contrasted with the practice that appears to have arisen in this area, and also the existing legal framework regarding sterilisation of intellectually disabled children, which is fragmented, fraught with jurisdictional issues, and in desperate need of reform, not least because anecdotal evidence, and Medicare data, suggests that in many cases the procedure is currently being performed without lawful authority, potentially exposing the health care providers involved to criminal and civil penalties, as well as loss of professional registration and accreditation.

This submission argues that development of uniform legislation on this issue is a necessity, and should be undertaken as a priority. At a minimum, this legislation should prohibit sterilisation of children or adults lacking capacity without the authorisation of the relevant court (Family or State Supreme Court in the case of children, Guardianship Tribunal or court in the case of adults lacking capacity), unless it is performed to prevent an immediate or inevitable serious risk of harm to the person, or threat to their life. The test for authorisation should incorporate the 'best interests' test guidelines developed by Nicholson CJ in *Re Marion* (2),[1] and include a requirement that it be used as a treatment of last resort. Sterilisation on children prior to the onset of menstruation should not be authorised; nor should sterilisation purely for the purposes of contraception or menstrual management, absent any special clinical risks associated with pregnancy, childbirth, or increased infection.

Detailed recommendations are as follows:

[1] *Re Marion* (No 2) (1994) FLC 92-448.

RECOMMENDATION 1:

In light of criticisms regarding the uncertainty created by application of the test of *Gillick* competence, the potential for the courts to overrule the decisions of a *Gillick*-competent child, and the irreversible nature of the procedure, legislation should require all decisions pertaining to sterilisation of a child in the absence of clinical necessity to prevent or minimise a substantial risk of serious harm to the child, should be deferred to the court for review and authorisation.

RECOMMENDATION 2:

Hospitals, doctors, and agencies providing support services to families and carers of people with intellectual disabilities or mental illness that deprives them of capacity, or children, should immediately be reminded that performing such procedures in the absence of an imminent threat to life or health without the approval of the court is illegal, and that people involved can potentially face penalties including incarceration, cancellation of professional accreditation and registration, and civil penalties.

RECOMMENDATION 3:

Rather than referring to 'non-therapeutic' sterilisation, legislation should be used to clarify the circumstances under which authorisation to sterilise a minor will be granted: if the sterilisation is clinically necessary to prevent or minimise a substantial risk of harm to the child. This recognises the existing common law position in which practitioners who perform sterilisation to prevent immediate risk to the child's life or imminent serious risk to their health are protected from liability; and parents are authorised to consent to clinically required sterilisation to prevent an overwhelmingly likely, but not necessarily immediate, serious threat to the child's health from occurring.

RECOMMENDATION 4:

Tribunals, courts and healthcare providers be required to submit records of any sterilisation procedures performed on minors or adults with suspected lack of capacity, with or without authorisation, maintaining patient confidentiality where appropriate, past and future, to the Department of Health for appropriate monitoring and reporting, to determine the true frequency of the procedure being sought and performed. These reports should be reconciled to ensure that all procedures reported by healthcare providers a) match orders of the court or tribunal, or b) justify the procedure in the absence of authorisation.

RECOMMENDATION 5:

At a minimum, uniform legislation should be passed ensuring that all applications must meet the same criteria, regardless of the jurisdiction they are heard in. Legislation should, at a minimum, contain a 'best interests' test based Nicholson CJ's guidelines, considering not just the person's medical welfare, but also their psychological, educational, and social best interests. Legislation should also require that, where ascertainable, the wishes of the person are taken into consideration. A further safeguard ensuring that sterilisation truly is an option of last resort is also required. In keeping with

this, it is most unlikely that authorisation would be granted for sterilisation of minors within the first 2-3 years of the commencement of menstruation.

RECOMMENDATION 6:

The discretion of judges to appoint an independent representative to act on behalf of the best interests of the child in any proceeding relating to authorisation of sterilisation should be removed. Appointment of a representative under these circumstances should be mandatory.

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Terms of Reference

The terms of reference of the enquiry are noted. Parts of the submission addressing each term, or commentary on why the submission has not addressed it, are detailed below.

The terms of reference:

The involuntary or coerced sterilisation of people with disabilities in Australia, including:

(a) the types of sterilisation practices that are used, including treatments that prevent menstruation or reproduction, and exclusion or limitation of access to sexual health, contraceptive or family planning services;

- *Recommendation 3 suggests clarifying the meaning of the term 'non-therapeutic', as many 'non-therapeutic' sterilisations are being sought for purposes that are clinically relevant. (See page 16)*
- *Domestic anti-discrimination legislation makes it unlawful to discriminate against people on the grounds of their disability. This prohibition against discrimination extends to access to the services described above.*

(b) the prevalence of these sterilisation practices and how they are recorded across different state and territory jurisdictions;

- *Recommendation 4 suggests that both legal and medical organisations involved in sterilisation be required to submit data to a central repository for reconciliation and reporting, to overcome the data limitation currently hindering informed discussion on the scope of the issue.*
- (c) the different legal, regulatory and policy frameworks and practices across the Commonwealth, states and territories, and action to date on the harmonisation of regimes;
  These are discussed extensively throughout the submission.

(d)whether current legal, regulatory and policy frameworks provide adequate:

(i)steps to determine the wishes of a person with a disability,
(ii)steps to determine an individual's capacity to provide free and informed consent,
(iii) steps to ensure independent representation in applications for sterilisation procedures where the subject of the application is deemed unable to provide free and informed consent, and
(iv)application of a 'best interest test' as it relates to sterilisation and reproductive rights;
This is the content addressed in Recommendations 5 and 6. These terms are discussed extensively in the submission.

(e) the impacts of sterilisation of people with disabilities;

This is beyond the scope of the current submission, as it is outside the expertise of the author.

(f) Australia's compliance with its international obligations as they apply to sterilisation of people with disabilities;

This is discussed in the submission

(g) the factors that lead to sterilisation procedures being sought by others for people with disabilities, including:

(i) the availability and effectiveness of services and programs to support people with disabilities in managing their reproductive and sexual health needs, and whether there are measures in place to ensure that these are available on a non-discriminatory basis,

(ii) the availability and effectiveness of educational resources for medical practitioners, guardians, carers and people with a disability around the consequences of sterilisation, and

(iii) medical practitioners, guardians and carers' knowledge of and access to services and programs to support people with disabilities in managing their reproductive and sexual health needs;

This is beyond the scope of the current submission, as it is outside the expertise of the author, noting, however, a need to remind medical practitioners and support services that performance of sterilisation in other than emergency circumstances on minors or adults lacking capacity without authorisation is unlawful (Recommendation 2); and that services and programs identified in (i) above are subject to prohibitions against discrimination on the basis of disability under the Anti-discrimination laws.

(h) any other related matters.

Acknowledgements

The author wishes to start by thanking the committee for the opportunity to make a submission to this enquiry, as it is a longstanding issue of concern, and is of critical importance as a legal, medical, and ethical issue. The author also wishes to thank Mr Bruce Arnold, Dr Susan Priest, and Ms Jennifer Glover for their valuable discussion and editorial assistance in preparation of this submission. All views and any errors contained within are her own.

Part 1: Consent to medical treatment in Australia

1. Bodily integrity is a fundamental human right. In *Schloendorff v Society of New York Hospital*,[2] Cardozo J. famously stated: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault".[3] This statement has been approved by the courts in Australia, summarising the position in both civil and criminal law, that a doctor who performs a procedure without consent commits a trespass against the patient, and is liable in criminal and civil law.[4]
2. Protection for doctors who perform medical procedures without the consent of the patient (or the person with parental responsibility for the child, in the case of children) when it is necessary to preserve the life of the patient, or prevent a serious permanent disability occurring, and it is impracticable to obtain consent, is provided by legislation[5] and common law.[6]
3. Consent is inextricably linked with the concept of autonomy. Autonomy is the idea that individuals should be able to make their own choices and decisions about their own destiny, free from unnecessary interference- 'unnecessary', because nearly all decisions are influenced, to some extent, by external factors – very rarely are they purely the product of the individual's will.[7]
4. Informed decision-making is an expression of autonomy, as well as intentional action. However not all people are autonomous actors. Two critical elements in autonomous decision-making are *liberty* -independence from controlling influences- and capacity.[8]

Liberty

5. Liberty requires that the decision made- to consent, or withhold consent- to a procedure be made free from external or inappropriate influence. Examples of such influences relevant in the context of the enquiry might be pressure being applied by a carer to a person to consent to sterilisation specifically for the purpose of reducing the carer's care burden with respect to hygiene and management of menstruation. In this example, the carer's workload should not be a key factor in decision-making, certainly not at the expense of the best interests of the patient,

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[2] *Schloendorff v Society of New York Hospital* 105 N.E. 92 (1914).
[3] Ibid, 93.
[4] *Department of Health & Community Services v JWB & SMB* ("Marion's Case") [1992] HCA 15; (1992) 175 CLR 218.
[5] See e.g. *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 13.
[6] *Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 479 at [14]. Also, the common law doctrine of necessity provides a defence to civil claims of battery arising under those circumstances.
[7] Tom Beauchamp and James Childress, *Principles of Biomedical Ethics* (Oxford University Press, 6th ed, 2009) 101.
[8] Ibid, 100.

and it would be an inappropriate use of position for a carer to seek to influence a person's decision-making for these reasons.

6. Factors such as undue, or inappropriate, influence are not specific to decision-making by disabled people; however in the event of a competent disabled person seeking sterilisation, steps should be taken to ensure that their decision-making has not been inappropriately influenced in this way.[9]

Capacity

7. Under common law, now reflected in statute in some jurisdictions, there is a presumption of capacity for adults.[10] This presumption can be challenged, but a challenge to the presumption requires that the person challenging it persuades a legal forum, such as a guardianship board, that the person lacks capacity,[11] in the absence of other legally-mandated means of addressing the issue.[12]
8. The term 'capacity'- the ability of an individual to make valid choices, thereby expressing their autonomy- is often used interchangeably with 'competence'.[13] An alternative view described 'capacity' as the individual's ability to make decisions in general, and 'competence' as their ability to make a specific decision. By illustration: an adult with capacity has the ability to make decisions about their health and welfare. However, in the absence of sufficient information being provided by a doctor, they may not be competent to decide between two alternative treatment options. It is the provision, and comprehension, of this information that is the basis of 'informed consent'.[14]
9. Criteria for demonstrating capacity and competence are variable, but usually include the following elements:
    a. Ability to understand the context of the decision, including relevant facts, or basic information specific to the decision;
    b. Ability to evaluate the reasonable implications and consequences of the decision;
    c. Ability to assess the risks and benefits of the decision via reasoning; and
    d. Ability to communicate that a reliable and consistent decision has been made.[15]

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[9] Article 12 of the *Convention on the Rights of Persons with Disabilities* specifically imposes an obligation on states to implement safeguards to ensure that persons with disability exercising capacity are doing so free from undue influence or conflicts of interest.
[10] *Re MB* [1997] 2 FCR 514 per Butler-Schloss LJ at 553.
[11] See e.g. *Guardianship and Management of Property Act 1997* (ACT) s 7, and equivalent provisions in other jurisdictions.
[12] E.g. appointment of enduring powers of attorney in accordance with *Powers of Attorney Act 2006* (ACT), and equivalent provisions in other jurisdictions. Note also that some jurisdictions provide a legislated hierarchy for appointment of delegated decision makers in the absence of an official appointment by the patient or a tribunal e.g. *Guardianship and Administration Act 1986* (Vic) ss 37, 39.
[13]Nick O'Neill and Carmelle Peisah, *Capacity and the Law* (Sydney University Press, 2011) at [1.1].
[14] Above, note 6. The High Court was critical of the term 'informed consent', indicating that it incorrectly shifted the focus of enquiry from understanding of the patient, to provision of information by the doctor. Nonetheless in spite of the criticism, the term appears to have been accepted by legislators.
[15] Above, note 13, at [1.2].

10. Traditionally, women, children, and the mentally ill or intellectually disabled have been denied capacity, a position which has softened in recent years. Women are now recognised as having full legal capacity; the capacity of children and mentally ill and intellectually disabled individuals is now assessed on a case-by-case basis. In the absence of capacity, an alternative decision-maker capable of making valid decisions is either appointed, or recognised by law.[16]

Children

11. The most common alternate decision-maker found in the case of children are parents. Under the *Family Law Act 1975* (Cth) 'parental responsibility' is defined as 'all the duties, powers, responsibilities and authority which, by law, parents have in relation to children'.[17] Section 61C entitles parents to exercise parental responsibility, subject to the orders of the court, over children under the age of 18.
12. In the absence of a suitable parent, the court can make parenting orders conferring parental responsibility onto another person. [18]
13. The power conferred by parental responsibility is not, however, absolute- rather, it is limited to those powers which are recognised by law. There are some decisions that the court has held parents simply cannot lawfully make on behalf of their children, including decisions about some forms of medical treatment, including sterilisation. [19]
14. Parental responsibility, particularly with respect to decision-making powers exercised on behalf of the child, diminishes with age. In *Gillick v West Norfolk & Wisbech Area Health Authority*,[20] the House of Lords determined that a child under the age of 18 could provide valid consent- without requiring the additional consent of parent- to medical care, provided the child understood the actions and consequences of the decision they were making. Lord Scarman described the test for competence, now referred to as *Gillick* competence, as follows:

> "(T)he parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law."

15. Lord Scarman also said:

[16] Above, notes 11 and 12.
[17] *Family Law Act 1975* (Cth) s 61B.
[18] *Family Law Act 1975* (Cth) ss 61D, s64C.
[19] Above, note 4.
[20] *Gillick v West Norfolk & Wisbech Area Health Authority* [1985] UKHL 7.

> "Parental rights clearly do exist, and they do not wholly disappear until the age of majority. Parental rights relate to both the person and the property of the child - custody, care, and control of the person and guardianship of the property of the child. But the common law has never treated such rights as sovereign or beyond review and control. Nor has our law ever treated the child as other than a person with capacities and rights recognised by law. The principle of the law, as I shall endeavour to show, is that parental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child." 21

16. The validity of the child's decision has also been recognised in cases involving a child's refusal to receive further treatment for a potentially terminal disease- in those cases, the knowledge and experience of the child, and their understanding of the consequences of refusing treatment have been key issues before the court.[22] The decision in *Gillick* was held to represent the legal position in Australia.[23]
17. In its 2008 report, *Young People and Consent to Health Care*, the New South Wales Law Reform Commission identified two main areas of uncertainty related to the *Gillick*-competence test. These were the level of understanding required of a young person in order to demonstrate *Gillick* competence, and the residual decision-making power exercised by apparent over a *Gillick*-competent minor. [24]
18. The *Gillick* test has also been criticised for requiring a higher standard of comprehension from children than from adults, as children are required to make a 'reasonable' decision, whereas the decision of an adult must only be 'reasoned' to be valid.[25]
19. Chief Justice Nicholson, in applying the *Gillick* test in *Re Alex*, described the situation as follows: "The circumstances in which a child or young person has the right to make his or her own decisions as to medical treatment are far from precise."[26]
20. It has also been noted that the *Gillick* tests is essentially a legal test, but it is generally applied by healthcare workers, and its application is rarely subjected to the scrutiny of the courts.[27]
21. It is also important to note that the courts, exercising their inherent *parens patriae* jurisdiction (State Supreme courts) or statutory welfare jurisdiction (Family Court) can override a competent parent or child's decision if they deem it is in the best interests of the child for them

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[21] Ibid.
[22] *Minister for Health v AS* [2004] WASC 286.
[23] Above, note 4.
[24] New South Wales Law Reform Commission, *Young People and Consent to Health Care (NSWLRC Report 119)* (New South Wales Law Reform Commission, 2008) at 4.11-4.15.
[25] Jamie Potter, Rewriting the competency rules for children: Full recognition of the Young Person as a rights-bearer'' (2006) 14(1) *Journal of Law and Medicine* 64
[26] *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* [2004] FamCA 297 at [155].
[27] Above note 25.

to do so. Examples of this jurisdiction being exercised include cases involving children and blood transfusions, bone marrow donations, and refusal of treatment.[28]

22. Additionally, although there are some procedures the court has held are outside the scope of parental authorisation, they are within the court's *parens patriae*, or welfare, jurisdiction. These procedures definitively include sterilisation of a minor,[29] but treatment to prevent the onset of puberty in children with gender dysphoria,[30] termination of a minor's pregnancy,[31] withdrawal of life support,[32] orders not to resuscitate,[33] and consenting to treatment of a minor with an aggressive or terminal disease with a unapproved experimental therapy or drug[34] are all decisions that the court has found fall within its jurisdiction. [35]
23. To date all the reported court cases involving sterilisation have related to children with profound intellectual disability, when there was no question of the child being a *Gillick*-competent minor, or ever becoming a competent adult. There is currently no evidence to suggest that it is being authorised for children with mild disability, although in the absence of solid data it is difficult to tell.
24. However, the potential for the procedure to be sought for children who are closer to the threshold of *Gillick* competence exists.

RECOMMENDATION 1:

In light of criticisms regarding the uncertainty created by application of the test of Gillick competence, the potential for the courts to overrule the decisions of a Gillick-competent child, and the irreversible nature of the procedure, legislation should require all decisions pertaining to sterilisation of a child in the absence of clinical necessity to prevent or minimise a substantial risk of serious harm to the child, should be deferred to the court for review and authorisation.

Mentally ill/intellectually disabled adults

25. If the person has never had capacity- for example, a child with a congenital intellectual disability, or one sustained during childhood- or has lost their capacity, a guardian can be formally appointed to make decisions on their behalf.[36] The guardian can be a parent or other relative, or a friend, or a statutory office holder, such as the public trustee (for financial

[28] Above, note 22.
[29] Above, note 4.
[30] Above, note 26; *Re Alex* [2009] FamCA 1292; *Re Rosie (Special medical procedure)* [2011] FamCA 63.
[31] *State of Queensland v B* [2008] QSC 231.
[32] *Re Baby D* [2011] FamCA 176.
[33] *Re Natalie* [2012] NSWSC 1109.
[34] *Re Baby A* [2008] FamCA 417
[35] See the guardianship laws 'special' or 'prohibited' procedures. It is likely that a procedure that is specifically excluded from the powers of a guardian would similarly be excluded from the powers of a parent.
[36] *Guardianship and Management of Property Act 1991* (ACT); *Guardianship Act 1987* (NSW); *Guardianship and Administration Act 2000* (Qld); *Guardianship and Administration Act 1993* (SA); *Guardianship and Administration Act 1995* (Tas); *Guardianship and Administration Act 1986* (Vic); *Guardianship and Administration Act 1990* (WA).

decisions) or the public advocate (for welfare and healthcare decisions) or the equivalents, depending on the jurisdiction. Guardianship powers can also be split between guardians, allowing specific guardians to exercise specific responsibilities, or allowing multiple guardians to exercise responsibility across multiple areas. The three most common heads of guardianship power are financial management, healthcare or medical, and welfare.

26. The healthcare and welfare powers are the two most relevant for this discussion. The welfare power of guardians authorises them to make decisions about living arrangements, employment and education. The healthcare powers authorise guardians to make decisions about the health and medical treatment of the protected person. Reserved from the healthcare decision-making power awarded to a guardian are decisions associated with 'special' or 'prohibited' procedures. These generally include decisions about participating in medical research programs, fertility treatments, and some aspects of end of life decision-making, but always include sterilisation or contraception.[37] Consent for these procedures must be obtained via an order for the relevant guardianship tribunal or court for that jurisdiction. In the event that a child who was '*Gillick*' competent prior to their illness or disability expressed a desire for a certain person to become their guardian, evidence of that wish could be presented to the tribunal. The tribunal is required to take consideration of those wishes into account, but not at the expense of the person's best interests.
27. In the event that the person previously had capacity, and they had the opportunity to nominate a delegated decision-maker to act on their behalf, that decision-maker can be authorised to make those decisions. This occurs most commonly through appointment of an Enduring Power of Attorney, or equivalent.[38] In the context of the current paper, this situation would cover a person who had previously had capacity, and then lost capacity, as the result of sustaining a brain trauma in a motor vehicle accident, or through a stroke, or similar.
28. A competent adult can execute a Power of Attorney, or Enduring Power of Attorney, at any time, identifying the person they wish to act as a delegated decision maker of their behalf. A Power of Attorney is terminated in the event of the person's loss of capacity; an enduring Power of Attorney continues beyond any loss of capacity, and is, therefore, a far more useful tool for those planning for any future loss of capacity. An Enduring Power of Attorney, like the powers assigned by a guardianship tribunal, can authorise an individual to make decisions on behalf of another across a range of fields, or limited to certain areas, often healthcare, financial matters, and welfare issues. Additionally, an enduring Power of Attorney allows the person making it to limit its use to specific issues- for example, a person may not want their

[37] *Guardianship and Management of Property Act 1991* (ACT) s 70; *Guardianship Act 1987* (NSW) ss 36(1)(b), 45; *Guardianship and Administration Act 2000* (Qld) s 68; *Guardianship and Administration Act 1993* (SA) s 61; *Guardianship and Administration Act 1995* (Tas) ss 39(1), 44-45; *Guardianship and Administration Act 1986* (Vic) ss 39(1)(a), 42B, 42E; *Guardianship and Administration Act 1990* (WA) s 57.
[38] See e.g. *Powers of Attorney Act 2006* (ACT) ss 7 and 8.

health Power of Attorney to be able to authorise a blood transfusion, in the event that one is recommended. Note, however, that Enduring Powers of Attorney cannot be authorised to consent to certain procedures, including sterilisation and termination of pregnancy.[39]

29. In the absence of a validly appointed Enduring Power of Attorney, an application seeking appointment of a guardianship, following the process outlined in the legislation can be lodged with the relevant court or tribunal. In some jurisdictions, legislation also provides a hierarchy of relationships under which delegated decision-making powers can be exercised.[40] Although this may be of some utility in the short term in the health context, it will be of limited benefit in the long term if it becomes evident that decisions about financial or welfare matters need to be made.

Summary of decision-making in the context of people with disabilities

30. For the reasons discussed above, there is great variability in who has the legal right to provide consent to the sterilisation.

If the person is free from disability….

31. In the absence of any questions about their capacity, and provided they are an adult, a healthcare provider is legally entitled to perform a sterilisation procedure on the basis that it has been validly authorised.
32. If the person is a child, they may be deemed to be *Gillick* competent. They may be able to consent to the procedure, however that consent could be overturned by the courts exercising the *parens patriae* jurisdiction in the event that someone challenges the child's decision. Seeking a court order authorising the procedure provides healthcare providers with protection against liability in the event that the consent is overturned; however it does require that the court be satisfied that the procedure be in the best interests of the child. An alternative is to wait until the child reaches the age of 18.
33. It is worth ensuring that the decision being made by the person truly is a reflection of their own wishes, and that they have not been subjected to any inappropriate influence in making that decision, prior to relying on it.

If the person is physically, but not intellectually disabled or mentally ill…

34. The same principles apply- they are entitled to the presumption of capacity (as adults) or entitled to demonstrate their *Gillick* competence (as children).

[39] See e.g. *Powers of Attorney Act 2006* (ACT) ss 35 and 37(1).
[40] Above, note 12.

If the person is intellectually disabled, or mentally ill…

35. It must first be established whether they have capacity. In the case of children, this requires meeting the requirements for *Gillick* competence; in adults, it requires the understanding needed to provide valid consent outline above. If the child is *Gillick* competent, they can provide valid consent, in spite of their intellectual disability or mental illness, subject to the intervention of the court under the *parens patriae* jurisdiction, in the same way as it applies to a competent child without mental illness or intellectual disability.
36. In the event that a child is not *Gillick* competent, normally a parent, or otherwise appointed responsible adult decision-maker, would be able to provide consent. However sterilisation is one area where the courts have held that parental consent is insufficient. This reservation of power to the courts raises some significant issues in Australia, with respect to jurisdiction, under the Constitution. These issues will be further addressed below.
37. In the event that the person is an adult without capacity, the legislation in each jurisdiction provides that neither a guardian nor an Enduring Power of Attorney can provide consent to sterilisation procedures. In the event that these procedures are sought, the decision is remitted to either the Guardianship tribunal, or the *parens patriae* jurisdiction of the relevant Supreme Court, who will either issue an order authorising the procedure, or deny the application, depending on whether the procedure is in the best interests of the person.

Part 2: Sterilisation

38. The *Oxford Concise Medical Dictionary* defines sterilisation as "a surgical operation or any other process that induces sterility in men or women", and provides the examples of hysterectomy and bilateral oophorectomy (surgical removal of both ovaries) as "100% effective and permanent" for women, along with occlusion or ligation of the Fallopian tubes, or vasectomy in men. [41] Gonadectomy (removal of the testes) is also a surgical procedure performed on males resulting in sterilisation, although this is a consequence of, rather than purpose for, performing the procedure. The *Butterworth's Australian Legal Dictionary* defines sterilisation as "the medical procedure by which a person is rendered unable to reproduce".[42]
39. Contraception, by way of contrast, is defined more broadly, as 'any method of procreation prevention',[43] and includes both permanent measures, such as those associated with sterilisation, and impermanent measures, including hormonal treatment and physical barriers preventing conception.
40. Case law on sterilisation in Australia has refined its definition further: in *Re Marion*, the majority stated that sterilisation requiring the authorisation of the court "requires invasive,

[41] *Oxford Concise Medical Dictionary* (Oxford University Press, 8th ed).
[42] *Butterworths Australian Legal Dictionary* (LexisNexis Butterworths, 1st ed, 1997) 1117.
[43] *Butterworths Australian Legal Dictionary* (LexisNexis Butterworths, 1st ed, 1997) 263

irreversible and major surgery".[44] They also excluded sterilisation "which is a by-product of surgery appropriately carried out to treat some malfunction or disease".[45]

41. Most of the applications before the courts documented in the cases discussed throughout relate to applications for hysterectomy (removal of uterus) of girls. Some also seek bilateral oophorectomy. The latter is not sought as commonly because removal of the ovaries can trigger other problems associated with early menopause, and osteoporosis; however, in cases where hormonal fluctuations are thought to be triggering epileptic seizures, oophorectomy is sought as a way of countering those fluxes. Very few cases (*Re Sean* and *Russell; re Sally*) have sought gonadectomy (removal of the testes).[46]

'Therapeutic' vs 'non-therapeutic' sterilisation

42. Importantly, the majority in *Re Marion* explicitly disapproved of the use of the terms "therapeutic" and "non-therapeutic" to make the necessary distinction between sterilisation requiring the authorisation of the court, and sterilisation made lawful by reason of necessity to prevent death or serious harm to the person, on the grounds of uncertainty. In spite of this disapproval, the terminology has stuck, and in this context is potentially misleading, and of limited utility.
43. The term 'therapeutic' itself is difficult to define. Pertaining to 'therapy', it is not clear whether legally it is limited to clinical treatment of a physical disorder, or whether it can encompass broader aspects of health and welfare, such as minimising emotional or behavioural disturbances.
44. Sterilisation is sought for many reasons, including treatment of physical and psychological disorders, as well as for the purpose of permanently eliminating the reproductive capacity of the individual. Physical disorders it is sought for include management of painful or heavy menses; complications associated with menstruation; and abnormal pathology of the uterus or other reproductive organs, such as cancer or fibroids.
45. Sterilisation is also sought by some people as part of the process of gender reassignment. Other patients seek it as part of a treatment program to assist with gender-related psychological disorders, while still others view it simply as a failsafe permanent barrier against conception.
46. The applications seeking sterilisation of intellectually disabled children reported in Australia cite a mix of reasons for seeking the procedure, including management of seizures aggravated by menstruation,[47] clinical and behavioural issues associated with menstruation, hygiene and

[44]Above, note 4, at 49.
[45] Ibid, at 48.
[46] *Re Sean* and *Russell (Special Medical Procedure)* [2010] FamCA948; *Re: Sally (Special Medical Procedure)* [2010] FamCA 237.
[47] Above, notes 1 and 4; *P v P* [1994] HCA 20; *Re Elizabeth* (39) (1989) 13 Fam LR 47; (1989) FLC 92-023

associated risk of infection,[48] and factors such as dignity,[49] fear,[50] and ability to participate in life-enriching activities including hydrotherapy without regular interruption necessitated by menstruation.[51]

47. Some applications referred to prevention of pregnancy as a reason (but not the sole reason) for seeking sterilisation. In *P v P*, the Human Rights and Equal Opportunity Commission argued that sterilisation should never be authorised for the purposes of contraception alone.[52] This reflected earlier comments by Warnick J in *Re Sarah*, who stated:

> "it does seem reasonable to observe that there is certainly no correlation between sterilisation and removal of risk of abuse, as distinct from one potential consequence",[53]

and Brennan J in *Re Marion*:

> "Those who are charged with the responsibility for the care and control of an intellectually disabled girl.... have a duty to ensure that the girl is not sexually exploited or abused. ....It is unacceptable that an authority be given for the girl's sterilisation in order to lighten the burden of that duty, much less to allow for its neglect. ....Such a situation bespeaks a failure of care, and sterilisation is not the remedy for such failure".[54]

48. The court in *P v P*, however, declined to adopt that position, instead focussing on the consequences pregnancy would have, and the lack of understanding of pregnancy held by the girl, rather than the risk of sexual intercourse or assault. They also warned of the risks of establishing blanket prohibitions, such as those proposed by the Commission.[55]
49. Where contraception has been cited as a reason for seeking the application, and authorisation has been granted, the application has also cited compelling clinical reasons for granting the application, and it is primarily these reasons which have persuaded the court to make the order.
50. The majority in *Re Marion* preferred to categorise the distinction on the basis of whether the procedure was required to treat malignancy or disease of the organs, with the secondary consequence of causing sterilisation. However the utility of this test is also questionable, as frequently treatment is sought to prevent or minimise the consequences of abnormal function of the organs, albeit not life threatening, e.g. anaemia resulting from heavy menstruation;

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[48] *Re Katie* [1995] FamCA 130.
[49] Ibid.
[50] *Re a Teenager* (38) (1988) 94 FLR 181; 13 Fam LR 85; (1989) FLC 92-006.
[51] Above, note 48.
[52] *P v P* [1994] HCA 20.
[53] *(Re L and M)* (1993) 17 Fam LR 357 at 366 (sub nom L and GM v MM; Director-General, Department of Family Services and Aboriginal and Islander Affairs (1994) FLC 92-449 at 80, 675) (Re Sarah)
[54] Above note 4, at paragraph 23.
[55] Above, note 53, paragraphs 76-78.

hormonal flux triggering epileptic or other seizures, and authorisation of sterilisation for all of these purposes has been found to fall within the court's jurisdiction.

51. Furthermore, the 'emergency' aspect which renders lawful performance of the procedure without consent is not an adequate criterion for determining whether court authorisation is required. In *Re Sean and Russell*, the Family Court found that court authorisation was not required for performance of a gonadectomy on two infant males, as a means of preventing testicular malignancy to which their genetic disorder exposed them to heightened risk.[56] In that instance there was no suggestion that either boy had malignant cells, or was at imminent risk of developing cancer; however medical evidence indicated that there was an overwhelming chance that they would do so at some point in the future. The court found that under those circumstances, parents could consent to the procedure without the authorisation of the court.[57]
52. Mischaracterisation of Australia's legal position as permitting 'non-therapeutic' sterilisation of minors has also led to extensive criticism in the international community, with several countries criticising Australia's position as failing to comply with international obligations.

When can it lawfully be performed?

53. Sterilisation, performed under emergency circumstances to preserve the life or prevent serious permanent disability, in circumstances where it is impractical to delay the procedure in order to obtain consent is, therefore, a procedure for which doctors cannot be held liable, regardless of whether the patient in question has a pre-existing disability. As such, it falls outside the scope of the present enquiry.
54. In the absence of an imminent or inevitable threat of death or serious harm to the patient, consent becomes the factor which distinguishes between lawful performance of a medical procedure, and unlawful performance of a medical procedure, including sterilisation.
55. A competent adult – disabled or otherwise – can give valid consent authorising the procedure to be performed on themselves, including for purely contraceptive purposes, without invoking the jurisdiction of the court.
56. If the person is a minor, or there are questions about the capacity of the person to provide consent to the procedure, the authorisation of a court or tribunal must be obtained before the procedure is performed.
57. Parents are generally NOT able to consent to sterilisation of a minor, in the absence of virtual certainty of the child sustaining serious life-threatening harm in future in the event of the procedure not being performed. This was the fundamental decision of the majority in *Re Marion*, and the modification applied in *Re Sean and Russell*.

[56] Above, note 46.
[57] Ibid.

58. Guardians, health attorneys, and Enduring Powers of Attorney ARE NOT able to consent to the sterilisation of an adult lacking capacity. Sterilisation falls within the category of special medical procedures identified under legislation as requiring the authorisation of the courts or the guardianship tribunal of the relevant jurisdiction.[58]

RECOMMENDATION 2:

Hospitals, doctors, and agencies providing support services to families and carers of people with intellectual disabilities or mental illness that deprives them of capacity, or children, should immediately be reminded that performing such procedures in the absence of an imminent threat to life or health without the approval of the court is illegal, and that people involved can potentially face penalties including incarceration, cancellation of professional accreditation and registration, and civil penalties.

RECOMMENDATION 3:

Rather than referring to 'non-therapeutic' sterilisation, legislation should be used to clarify the circumstances under which authorisation to sterilise a minor will be granted: if the sterilisation is clinically necessary to prevent or minimise a substantial risk of harm to the child. This recognises the existing common law position in which practitioners who perform sterilisation to prevent immediate risk to the child's life or imminent serious risk to their health are protected from liability; and parents are authorised to consent to clinically required sterilisation to prevent an overwhelmingly likely, but not necessarily immediate, serious threat to the child's health from occurring.

Part 3: International Human Rights Obligations and sterilisation

59. There are several key themes running through International Human Rights instruments that are particularly relevant to the current enquiry. These include freedom from discrimination, the right to found a family, and the right to participate in any relevant proceedings, and have the wishes of the relevant person taken into consideration.
60. International Human Rights instruments particularly relevant to the sterilisation of disabled people in Australia include the Universal Declaration of Human Rights (UDHR)[59], the Convention to Eliminate Discrimination Against Women (CEDAW),[60] the Convention on the Rights of the Child (CROC),[61] the Convention on the Rights of People with Disabilities

[58] *Guardianship and Management of Property Act 1991* (ACT) s 70; *Guardianship Act 1987* (NSW) ss 36(1)(b), 45; *Guardianship and Administration Act 2000* (Qld) s 68; *Guardianship and Administration Act 1993* (SA) s 61; *Guardianship and Administration Act 1995* (Tas) ss 39(1), 44-45; *Guardianship and Administration Act 1986* (Vic) ss 39(1)(a), 42B, 42E; *Guardianship and Administration Act 1990* (WA) s 57. All specifically identify 'sterilisation' as external to the scope of powers to be exercised, except Northern Territory, which specifies 'contraception'.

(CRPD),[62] the International Covenant on Civil and Political Rights (ICCPR),[63] and the International Covenant on Economic, Social, and Cultural Rights (ICESCR).[64]

Freedom from Discrimination

61. Protections against discrimination on the grounds of disability or gender can be found in: Article 2 of the CROC (sex and disability); Article 5 of the CPRD (disability); Article 6 of the CPRD (women and disability); Article 7 of the CPRD (children and disability); Article 26 of the ICCPR ('discrimination on the basis of 'other status'- including disability).
62. Furthermore, domestic legislation (the *Disability Discrimination Act 1992* (Cth), and state and territory equivalents) make it unlawful to discriminate on the basis of a person's disability.

Right to found a family

63. The right to found a family and/or retain fertility is protected under Article 16 of the UDHR; Article 23 of the CPRD; Article 23(2) of the ICCPR; and Article 16 (1) (e) of CEDAW.
64. Right to bodily integrity, and freedom from cruel or inhumane treatment
65. The right to bodily integrity is protected under Article 17 of the CPRD; Articles 19 and 37 (a) of CROC, Article 16 of CPRD, and Article 7 of ICCPR all provide protection against violence, inhumane, cruel or degrading treatment, exploitation or abuse.
66. In Australia, the common law, and legislation in some jurisdictions, prohibits unlawful interference with the physical integrity of another, resulting in both civil and criminal liability.

Representation and right to have wishes heard

67. Article 12 of CROC provides all children who are capable of forming views the right to express those views on matters concerning them, including in judicial and administrative proceedings. Article 7 (3) of CPRD states that the views of disabled children should be given due weight on an equal basis with other children; Article 12 of CPRD recognises that people with disabilities have legal capacity, and requires States Parties to provide the support required to enable people with disabilities to realise that capacity, and implement safeguards to protect against abusive conflict of interest and undue influence situations. Article 7(2) of CPRD also requires that the best interests of the child be a primary consideration in all actions concerning children with disabilities.
68. The right to independent representation for children in proceedings related to an application for sterilisation will be discussed further below. Although it is reflected in the *Family Law Act*, it is currently a discretionary power, rather than mandated requirement.
69. Legislation dealing with persons under the protection of guardianship and mental health tribunals generally includes a requirement that efforts are made to ascertain a person's wishes, and that those wishes are taken into account, before a decision affecting a person is made.[65]

Criticisms of Australia's position

70. Critics of sterilisation frequently argue that the practice is discriminatory because it is specifically targeted at a) women, b) children, and c) disabled people. Any discussion of the relationship between sterilisation and human rights must necessarily acknowledge the argument of feminists that sterilisation is a gendered issue, based on the far greater frequency with which sterilisation is performed on women than men (reflected in the courts reports dealing with applications for sterilisation). Other groups focus on the effect it has on disabled people, noting that it is virtually unthinkable that an order for the sterilisation of a child without a disability would be made by the court. Still others who advocate on behalf of disabled women and girls note, as is reflected in Article 6(1) of CPRD, that disabled women and girls are subject to discrimination on multiple bases.[66]
71. Opponents of feminist criticisms reject the argument that sterilisation is inherently discriminatory, instead arguing that it is simply a matter of biology, rather than any calculated or subconscious program of oppression and discrimination. Similarly, some commentators and judges have taken the view that it is inappropriate to apply the comparator test- asking whether the same order would be granted in respect of a person without a disability- because of the enormity of the disability affecting the people the orders are being sought for.[67]
72. In *P v P* (2), the Court rejected the use of the 'but for' or comparator, test in applications for authorisation,[68] stating:

> "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 enquiry away from where it should be, i.e. whether it is in her best interests that the procedure be performed."[69]

73. It is beyond the scope of the current submission to delve deeply into arguments on either side of this divide; instead, I will comment briefly on some of the comments passed by the international community about Australia's current position with respect to sterilisation in light of International Human Rights Instruments.
74. Australia has been criticised in several international fora by human rights bodies for its failure to prohibit non-therapeutic sterilisation of minors, or sterilisation of minors in the absence of a risk to life or other serious harm.

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[65] *Guardianship and Management of Property Act 1991* (ACT) s 70; *Guardianship Act 1987* (NSW) ss 36(1)(b), 45; *Guardianship and Administration Act 2000* (Qld) s 68; *Guardianship and Administration Act 1993* (SA) s 61; *Guardianship and Administration Act 1995* (Tas) Ss 39 (1), 44-45; *Guardianship and Administration Act 1986* (Vic) ss 39(1)(a), 42B, 42E; *Guardianship and Administration Act 1990* (WA) s57.
[66] Women With Disabilities Australia, 'Sterilisation of Women and Girls with Disabilities: An update on the issue in Australia' (Women With Disabilities Australia, 2011) Available at : http://www.wwda.org.au.
[67] *In the Matter Of: P Appellant and P Respondent and Legal Aid Commission of New South Wales Separate Representative and Human Rights and Equal Opportunity Commission Intervener* [1995] FamCA 44.
[68] Ibid, at paras 92-101.
[69] Ibid, at para 100.

75. As discussed above, some of this criticism may be the result of uncertainty about the term 'non-therapeutic'. However, in spite of this, some of the criticisms remain.
76. The CEDAW Committee, in its concluding remarks at the 46th Session, raised concerns about the ongoing practice of sterilisation of women and girls with disabilities in Australia, and encouraged Australia to pass national legislation prohibiting the practice. [70]
77. Similarly, a number of participating countries in the Universal Periodic Review of the United Nations Human Rights Council commented on Australia's position with respect to sterilisation of children and adults with disabilities. While some of those criticisms are possibly attributable to confusion over the term 'non-therapeutic', others, most notably those of Denmark, do not reflect the terminology.[71]

Part 4: Prevalence of non-consensual sterilisation

78. The current enquiry appears to have been triggered, at least in part, by a perceived disconnect between the numbers of sterilisation procedures being performed on minors, and the number of court decisions authorising them. According to a report commissioned by the Department of Health, Housing and Aging in 1992 Medicare reporting showed that 262 hysterectomies were performed on women aged 19 or under between 1986 and 1991. Based on the relative rarity of gynaecological disorders affecting women in this age group, the report's authors concluded that a significant number of the procedures were performed on intellectually disabled women. Later reporting by Brady and Grover[72] claimed that while only 17 sterilisations had been authorised by courts and tribunals since 1992, data indicated that at least 1045 procedures had been performed. This finding was criticised in the 2000 Senate Report on 'Sterilisation of Women and Young Girls with an Intellectual Disability'; data presented in the report from the Health Insurance Commission indicated a total of 11 sterilisations being performed on women under 18 between mid-1996 and mid-1999, while data from the Australian Institute of Health and Welfare indicated that only 22sterilisations were performed on minor girls diagnosed with an intellectual disability between 1993 and 1999. These data have also been criticised, largely on the basis of inaccuracy in the datasets from which the data was obtained. Anecdotal evidence, reported by Brady in 1995, also suggested that some sterilisations were being mis-reported as appendectomies.

[70] At paragraphs 42-43.
http://daccess-ddsny.un.org/doc/UNDOC/GEN/N10/485/48/PDF/N1048548.pdf?OpenElement
[71] At paragraphs 86.39
http://www.un.org.au/files/files/Draft%20report%20of%20the%20Working%20Group%20on%20the%20Universal%20Periodic%20Review%20-%20Australia.pdf
[72] Susan Brady and Sonia Grover, 'The Sterilisation of Girls and Young Women in Australia - A legal, medical and social context', Report to HREOC and Federal Disability Discrimination Commissioner, December 1997.

79. What is clear, however, is that there really is no accurate data on which an estimation of the frequency of sterilisation of minors can be made; furthermore, ANY number of sterilisations in excess of the reported decisions of courts and tribunals should be raising concerns.
80. There are two possible explanations for the discrepancies in numbers: either sterilisations are being authorised by the courts, and not reported, or sterilisations are being performed without the approval of the courts.
81. There is some evidence to support the first explanation being at least partly responsible. Peisah and O'Neil note that while New South Wales legislation requires publication of all guardianship tribunal decisions relating to sterilisation, legislation in other jurisdictions does not. Some tribunals have not released any decisions, even though the procedure is within their decision making powers, and it is likely that it is being exercised, while others have produced reasons for decisions in specific cases.[73] The frequency with which authorised sterilisation is performed on protected adults is, therefore, unclear.
82. The Family and state courts both have the power to anonymise any judgments before they are reported, and, given the sensitive nature of discussion about sterilisation, it is appropriate to do so to protect the privacy of those concerned.[74] Nonetheless, the public interest in reporting on the activities of the courts, in particular on sensitive issues relating to human rights, as this issue does, demands that judgements be released. It seems unlikely that any discrepancy in number is solely attributable to the court's failure to report on applications for sterilisation; nonetheless, comprehensive reporting by the courts would make it easier to monitor and record any discrepancies occurring with regard to this practice.
83. The second explanation seems far more likely. As the court identified in *Re Marion*, it is costly, traumatic, and complex for families to apply to the courts for authorisation of procedures such as sterilisation. It is also, however, noteworthy that the former Chief Justice of the Family Court, Alistair Nicholson, criticised these comments extracurially on the bass that they failed to appreciate the Family Court's powers to act as an inquisitorial forum, rather than an adversarial one, in the case of applications such as those seeking sterilisation.[75] Furthermore, many families view the intervention of the courts as an infringement of their parental rights. Nonetheless, the High Court in *Re Marion* found that these considerations did not outweigh the imperative of making sure that the decision reached was the right one, and that the court was the only body vested with the power to authorise sterilisation under the circumstances.

[73] Above, note 13, Chapter 15 [15.7]
[74] S121, *Family Law Act* 1975 (Cth).
[75] Alastair Nicholson, Margaret Harrison and Danny Sandor, 'The role of the Family Court in Medical Procedure Cases' (1996) 2 *Australian Journal of Human Rights* 42.

84. It is understandable, perhaps, that some families and practitioners may seek to perform the procedure without subjecting themselves to the expense and burden of court proceedings; however it is also unacceptable. That they may be doing so may justify changes to the law in this area, with a view to minimizing the financial and emotional burden placed on families in this situation, but it does not justify turning a blind eye to those who have performed it without seeking lawful authorisation.

RECOMMENDATION 4:

Tribunals, courts and healthcare providers be required to submit records of any sterilisation procedures performed on minors or adults with suspected lack of capacity, with or without authorisation, maintaining patient confidentiality where appropriate, past and future, to the Department of Health for appropriate monitoring and reporting, to determine the true frequency of the procedure being sought and performed. These reports should be reconciled to ensure that all procedures reported by healthcare providers a) match orders of the court or tribunal, or b) justify the procedure in the absence of authorisation.

Part 5: The Legal Framework

85. Uncertainty about the legal requirements of seeking authorisation for sterilisation of a person lacking capacity are a plausible explanation for the reluctance of families to obtain the sanction of the courts before the procedure is performed.
86. In the case of incompetent adults, the process is reasonably similar in most jurisdictions. Sterilisation is typically a medical procedure which falls outside the scope of activities a guardian or Enduring Power of Attorney is empowered to authorise; consequently, in the event that it is recommended, an application must be lodged with the appropriate guardianship tribunal, who will assess the application and make an order. As part of their deliberations, the tribunal must consider the wishes of the person involved, but their paramount concern remains the best interest of the person- where the person's best interests are in conflict with their wishes, the best interests will prevail.
87. The situation with respect to minors is far more complex, and identification of the appropriate jurisdiction to hear an application depends on a complex matrix of factors, including the marital status of the child's parents, the child's age, and their state of residence.

Re Marion

88. The 1992 decision in *Re Marion*[76] represented the first time the question of who had the authority to authorise the sterilisation of an intellectually disabled minor was raised before the High Court. Prior to *Re Marion*, four cases involving sterilisation procedures on intellectually

[76] Above note 4.

disabled girls had been brought before lower courts: *Re Jane,*[77] *Re S,*[78] *Re a Teenager*[79]*,* and *Re Elizabeth*.[80]

89. In all four earlier cases, an application was brought by a third party seeking to prevent a planned sterilisation procedure. In all four cases, it has been presumed by those involved, namely parents and healthcare providers, that parental consent was sufficient authorisation for the procedure. In *Re Jane* and *Re Elizabeth*, the court found that parental consent was not sufficient, and that the authorisation of the courts was required; while in *Re S* and *Re a Teenager* the alternative position, that parental consent was sufficient, was found.
90. In *Re Marion*, the application was brought by the parents of the child, and on appeal the case raised a number of questions:

> "(1) Can the Applicants as joint guardians of the child (Marion) lawfully authorise the carrying out in the Northern Territory, of a sterilisation procedure upon the said child without an order of a Court?
> (2) If no to question 1, does the Family Court of Australia have jurisdiction:
> (a) to authorise the carrying out of such a procedure;
> or
> (b) to enlarge the powers, rights or duties of the Applicants as guardians of the said child to enable them to lawfully authorise the carrying out of such a procedure; or
> (c) to approve the consent of the Applicants, as guardians of the said child, to the proposed procedure to make the procedure lawful?
> (3) Which (if any) of the steps referred to in (a), (b) or (c) of question 2 is required by law?"[81]

91. The majority of the court, Justices Mason, Dawson, Toohey and Gaudron, found that 1) parents could not authorise sterilisation without an order of the court; 2) a) the Family Court did have jurisdiction to authorise sterilisation, b) but did not have jurisdiction to empower Marion's guardians to authorise sterilisation, c) or to approve the guardians consent to make it lawful, although in issuing authorisation the Family Court could permit the guardians to provide any consent that was still required, and 3) that the authorisation of the Family Court was required by law.[82]
92. The majority considered the scope of parental powers under the *Family Law Act 1975* (Cth) as it was in force at the time, in some detail. Section 63E outlined the powers and responsibilities of guardians and custodians, vesting 'responsibility for the long-term welfare of the child' and 'all the powers, rights and duties that are, apart from this (sic) Act vested by law or custom in

[77] *Re Jane* (1988) 94 FLR 1; 85 ALR 409; [1989] FLC 92-007; (1988) 12 Fam LR 662.
[78] *Between: the Attorney-General of Queensland and Parents Re S* [1989] FamCA 80; (1990) FLC 92-124.
[79] Above, note 50.
[80] *Re Elizabeth* [1989] FamCA 20.
[81] Above, note 4, at [2].
[82] Ibid, at 87.

the guardian of a child' in the guardian of the child, as distinct from a person granted custody under the Act.

93. In determining the scope of the 'welfare' power of guardians under the Act, they considered the situation in other countries, notably the United States of America, New Zealand, Britain, and Canada. It noted, with approval, comments by Lord Brandon in *Re F*, a United Kingdom House of Lords decision dealing with the sterilisation of a mentally ill adult, about the 'special features' of sterilisation that make court involvement 'highly desirable':

> "These features are: first, the operation will in most cases be irreversible; secondly, by reason of the general irreversibility of the operation, the almost certain result of it will be to deprive the woman concerned of what is widely, and as I think rightly, regarded as one of the fundamental rights of a woman, namely, the right to bear children; thirdly, the deprivation of that right gives rise to moral and emotional considerations to which many people attach great importance; fourthly, if the question whether the operation is in the best interests of the woman is left to be decided without the involvement of the court, there may be a greater risk of it being decided wrongly, or at least of it being thought to have been decided wrongly; fifthly, if there is no involvement of the court, there is a risk of the operation being carried out for improper reasons or with improper motives; and, sixthly, involvement of the court in the decision to operate, if that is the decision reached, should serve to protect the doctor or doctors who perform the operation, and any others who may be concerned in it, from subsequent adverse criticisms or claims."[83]

94. It also discussed the features of decision-making about sterilisation which distinguish it from decision-making about other procedures which fall within the scope of parental powers. The Court identified these features as firstly "the significant risk of making the wrong decision, either as to a child's present or future capacity to consent or about what are the best interests of a child who cannot consent, and secondly, because the consequences of a wrong decision are particularly grave".

95. Having established that parents lack the requisite power to authorise sterilisation, the majority then considered whether the Family Court had jurisdiction to authorise it.

[83] *Re F* (1990) 2 AC, at 56.

The Constitution and the *Family Law Act*

96. The *Family Law Act 1975*[84] is Commonwealth legislation. Under the Constitution, the Commonwealth only has the power to legislate on specific topics. In the absence of either an identifiable source of legislative power under the Constitution, or a specific referral of power to legislate on a topic by the States, Commonwealth legislation will be invalid. Notably, however, if the States pass legislation on a topic which is not the exclusive domain of the Commonwealth, but is within the Commonwealth's legislative powers, the State legislation is only invalid to the extent of the inconsistency, and in the event of the Commonwealth legislation being repealed, the State legislation which was previously invalid is once again enlivened.[85]
97. Section 52 identifies the topics on which the Commonwealth exclusively can legislate, while section 51 identifies the topics on which both the States and the Commonwealth can legislate, but Commonwealth legislation will prevail in the event of any inconsistency.[86] Included in those, at 51(xxi), are marriage, and at 51(xxii) divorce and matrimonial causes, including parental rights, and the custody and guardianship of infants. Apart from in the context of marriage and matrimonial powers, the Commonwealth has no power to legislate with respect to children under the Constitution.
98. This clearly creates difficulties with respect to the *Family Law Act* in general, and the sterilisation of minors in particular.

The *parens patriae*, or welfare jurisdiction of the Family Court

99. Prior to the 1983 amendment[87] of the *Family Law Act*, the Family Court's jurisidiction with respect to a child was restricted to issues of 'custody, guardianship, maintenance and access'. Under the *Amendment Act*, 'welfare' was introduced into the Act to permit the Court to hear matters pertaining to the welfare of a child,[88] jurisdiction which was maintained at the time of *Re Marion*.[89] This vested the courts with a jurisdiction analogous to the equitable *parens patriae* jurisdiction.[90]
100. The *parens patriae* jurisdiction arose at equity from the King's obligation to take responsibility for his subjects. It is a welfare jurisdiction, allowing the King as 'the ultimate

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[84] *Family Law Act* 1975 (Cth).
[85] George Williams, 'Human Rights Under the Australian Constitution', 2002, Oxford University Press, at pg 12.
[86] *Commonwealth of Australia Constitution Act* s 109
[87] *Family Law Amendment Act* 1983 (Cth).
[88] S 64(1), *Family Law Act* 1975 (Cth).
[89] *Family Law Act 1975* (Cth) s 67ZC provides the court with the jurisdiction to make orders relating to the welfare of children. When making these orders, the child's best interests, as defined in s60CB to 60CG, are the paramount consideration.
[90] The key difference between a 'true' *parens patriae* jurisdiction, and the welfare jurisdiction conferred on the Family Court is that the welfare jurisdiction does not require a wardship order to be made as a preliminary to bringing the child within the jurisdiction.

parent of the people' to intervene and make, or override, decisions about vulnerable subjects if required. The jurisdiction remains part of the inherent jurisdiction of the State Supreme Courts, except where specifically excluded by legislation.

101. The scope of the *parens patriae* jurisdiction was a topic of contention amongst the judges in *Re Marion*; the majority concluded that it was wider than the scope of parental authorisation, and that the Family Court could, therefore, exercise it in authorising sterilisation.[91] Brennan J, in the minority, disagreed, arguing that at most it had the same scope as parental authorisation.[92]
102. Nonetheless, the majority agreed that, with respect to children of a marriage, the Family Court had jurisdiction to authorise sterilisation under its welfare or *parens patriae* jurisdiction.
103. This specific reference to children 'of a marriage' hinted at concern over difficulties that could potentially arise under similar circumstances, when the child involved was not a child 'of a marriage', but instead was an ex-nuptial child. These concerns were specifically discussed by the High Court in *obiter* in *P v P*,[93] even though the case arose in the context of legislative inconsistencies between the State of New South Wales and the Commonwealth.

Legislative inconsistency and s109 of the Constitution

104. *Re Marion* involved an application for sterilisation of a child who resided in the Northern Territory. As such, the court was not required to consider in detail the effect of any inconsistencies between State and Commonwealth legislation. Furthermore, the Northern Territory had no legislation dealing with sterilisation of a minor, meaning that the court could avoid considering the issue entirely.
105. In *P v P*, however, the High Court was asked to rule on the effect of inconsistencies arising under Part 5 of the New South Wales *Guardianship Act*, which sought to 'exclude the jurisdiction of any court other than the State Supreme Court with respect to medical welfare matters relating to incapable persons over the age of 16. As a practical matter, the effect of the State scheme is, if the Family Court is bound to observe its provisions in the exercise of its welfare jurisdictions, to remove the medical welfare component from that jurisdiction in so far as it relates to incapable New South Wales children of a marriage who are aged 16 or more'.[94]
106. The majority of the High Court found that those sections of the *Guardianship Act* which purported to exclude the jurisdiction of the Family Court from considering applications for sterilisation of an incapable child over the age of 16 were invalid to the extent of the inconsistency under s 109 of the Constitution. Furthermore, the court noted that in passing the 1983 Amendment to the *Family Law Act* conferring the welfare jurisdiction on the Family Court did not, the Parliament did not intend to deprive the State Supreme Court of its inherent

[91] Above, note 4, at paragraph 81.
[92] Ibid, at paragraph 20.
[93] Above, note 52.
[94] Ibid, per Mason CJ, Deane Toohey and Gaudron JJ at [24].

parens patriae jurisdiction, nor did it intend the Family Court's jurisdiction to be subordinate to the State jurisdiction. Rather, the amendment operated in such a way that both jurisdictions existed concurrently.

107. In *P v P*, therefore, it was held that the applicant's order from the Family Court authorising the sterilisation of her 16 year old intellectually disabled daughter was valid, even though it had been authorised by a court not empowered to grant such authorisations under the New South Wales Act.

Ex-nuptial children

108. An issue which is alluded to by the minority in *P v P*, but not in the majority judgement, is that of ex-nuptial children.[95]

109. In *Re Marion*, Justices Mason CJ, Dawson, Toohey and Gaudron JJ stated: ((17).):

> "It is clear enough that a question of sterilization of a child of a marriage arises out of the marriage relationship and that the sterilization of a child arises from the custody or guardianship of a child. Therefore, jurisdiction to authorize a sterilization is within the reach of power of the Commonwealth."[96]

110. This statement was approved in *P v P* by the majority, who said:

> "Those comments constitute an integral part of the reasoning of the majority in Marion's Case. They are, in any event, plainly correct."[97]

111. However this position was criticised by the minority as flawed, with both Justices Brennan and Dawson referring with approval to the comments of Stephen J in *R v Lambert; Ex parte Plummer*, who stated:

> "In our federation, the Commonwealth has some legislative power, concurrently with the States, with respect to the custody of infants. At the same time the States possess and exercise wide powers to legislate for the welfare of children, including the manner of their upbringing. From this distribution of legislative powers collisions between State and Federal laws may result, but the occasion for them will be much reduced if custody is recognized for what it is: the right of the guardian to make and carry out such choices concerning a child's upbringing as, in the case of any particular child, the current state of the general law, whether State or Federal, permits. State laws which only operate to restrict the choices open to guardians regarding children's upbringing, being laws which apply generally to all members of the community or to all children in the community, can then be seen to provide no occasion for collision. There will then, for example, be no question of conflict between State educational or criminal laws and a federal law under which custody is

[95] S60F-HB of the *Family Law Act 1975* (Cth) identifies who are children 'of a marriage' for the purposes of the Act.
[96] Above, note 4.
[97] Above, note 52 per Mason CJ, Deane Toohey and Gaudron JJ at [15].

> given to a particular parent: State laws which prevent that parent from keeping his child at home, untaught, or from being sent to a reformatory, will then not be seen to conflict with the parent's federally conferred custody."[98]

112. Justice Dawson went further:[99]

> "There should be no need to point out that that power is not a power to make laws with respect to children, the welfare of children, or even the welfare of children of a marriage. But that is something which tends to be forgotten due to the wide terms in which the *Family Law Act* is cast. A law is not a law with respect to marriage simply because it deals with the welfare of a child of a marriage. As Gibbs CJ said
> in *Fountain v Alexander*[100]:
>
> > "The power of the Parliament to make laws with respect to marriage does not extend to laws for the protection or welfare of the children of a marriage except in so far as the occasion for their protection or welfare arises out of, or is sufficiently connected with, the marriage relationship."
>
> In deciding whether a law dealing with the welfare of the children of a marriage has a sufficient connection with the marriage relationship it is important to bear in mind that the marriage relationship, including the responsibility of caring for children arising from that relationship, does not exist in a vacuum. Married persons and their children live their lives within a framework of laws, both State and Federal, which govern their behaviour and may touch upon their welfare, but which are not connected with marriage."

113. The minority, therefore, clearly expressed some doubt as to whether it was an appropriate extension of the marriage power to apply it to decision-making with respect to the incompetent child of a marriage, simply because they were a child of a marriage.
114. Nonetheless, this argument was not accepted by the majority, and so the Family Court retains jurisdiction to authorise sterilisation of incompetent children of marriage.
115. It remains unclear, however, exactly what the status of an application for sterilisation of a child who is NOT a child of a marriage would be. Clearly the marriage power cannot be extended to encompass them- that would indeed be stretching the interpretation of the Constitution. The unsatisfactory result of this is that children are likely to be treated differently under existing law based on the marital status of their parents, which cannot in reality have much practical bearing on the issue at all: after

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[98] *R v Lambert; Ex parte Plummer* (1980) 146 CLR 447 per Stephen J at 461
[99] Above, note 52 per Dawson J at [6]
[100] *Fountain v Alexander* [1982] HCA 16; (1982) 150 CLR 615 at 627; see also *Marion's Case* above note 4, at 261.

all, the decision-making competency of a child is in no way connected with whether they are nuptial or ex-nuptial children.

116. This is by no means a new distinction. In the late 1980's, the States passed legislation ceding the power to make orders about the custody and maintenance of ex-nuptial children to the Family Court, to resolve the situation where the same family, containing both nuptial and ex-nuptial children, had to seek orders from both State and Commonwealth courts to resolve custody and maintenance disputes.[101] The States were overt, however, in not ceding their welfare power with respect to ex-nuptial children to the Commonwealth.[102]

117. Currently, an application pertaining to a nuptial child can be brought before either a State Supreme Court (or guardianship board or tribunal, if the jurisdiction has been delegated under legislation), or the Family Court. Sterilisation of children deemed to be 'of a marriage' can be authorised by the Family Court; however, under s 109 of the Constitution, the orders of the State Supreme Courts will only be invalidated in the event that they are inconsistent with the Commonwealth law. There is nothing inconsistent about seeking orders authorising sterilisation from two separate courts, especially in the event that the first court declines to make the order sought, and the second court agrees to it – only one set of orders would exist. Any inconsistency only arises in the event that orders are made, and the two jurisdictions reach inconsistent conclusions. In the event of inconsistency between jurisdictions, an order from the Family Court would be held to prevail over an order from the State Supreme Court, under s 109.

118. This creates the potential for forum-shopping- either an applicant doesn't obtain the order they sought in the Supreme Court, so tries their luck in the Family Court; or a disgruntled party, having unsuccessfully argued against the order being granted, then applies for an ex tempore injunction from the Family Court to invalidate the Supreme Court order, pending a hearing in the Family Court. It is worth emphasising that the two courts are operating in separate hierarchies, and so both are exercising original jurisdiction; argument would have to be heard de novo, thereby increasing delay, expense and, potentially, the trauma associated with court proceedings for all involved, including the child. This is clearly unacceptable.

119. An ex-nuptial child, however, is restricted to the jurisdiction of the State Supreme Court, or authorised tribunal, alone, as the Family Court has no jurisdiction over ex-nuptial children. Due to the inadequate power of the Commonwealth to legislate for all children, based on the Constitutional limitations above, ex-nuptial children fall exclusively within the jurisdiction of

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[101] See e.g. s3 *Commonwealth Powers (Family Law- Children) Act* 1986 (NSW); *Commonwealth Powers (Family Law- Children) Act* 1986 (Vic); *Commonwealth Powers (Family Law- Children) Act* 1990 (QLD); *Commonwealth Powers (Family Laws) Act* 1987 (Tas); s3 *Commonwealth Powers (Family Law) Act* 1986 (SA).
[102] Seymour, John, "The Role of the Family Court of Australia in Child Welfare Matters" [1992] FedLawRw 1; (1992-1993) 21(1) Federal law Review 1.

the States. An order authorising sterilisation by the Supreme Court is, essentially, a last resort, barring appeal to a higher level court within the same jurisdiction, which requires evidence that the court made an error of law in issuing the order.

120. The law as it currently exists with respect to sterilisation of minors is a jurisdictional disaster. At the present time, parallel systems operate for children on the (arbitrary) basis of their parent's marital status at the time of their birth. Clearly, there is great potential for different treatment to be afforded to nuptial and ex-nuptial children as a result of this situation.

121. The most easily achieved solution would be an agreement between the States and the Commonwealth to pass uniform legislative provisions on the issue, clearly identifying the grounds under which sterilisation orders will be made. This would ensure that, at least, there is consistency between the orders made with respect to nuptial children in both jurisdictions, and that the same legal tests are also being applied with respect to ex-nuptial children.

122. Other options would require significant wrangling between the States and the Commonwealth, not least of all because they would require one or other party to cede power.

123. One option would be for the Family Court to cede its welfare power with respect to children of a marriage to the States. This would ensure that all children were dealt with by the same court in respect to these applications; however the welfare power encompasses more than just sterilisation orders. To avoid becoming fragmented, the whole power would need to be ceded- this would compound the already present difficulty of dealing with welfare matters in the Family Court where the States also have jurisdiction over welfare – for example, the problem with the Family Court making order with respect to a child of a marriage who is also a custodial ward of the state. Additionally, consistency across jurisdictions, again via implementation of uniform legislation, would be highly desirable as a means of avoiding forum shopping, or addressing jurisdictional situations arising where the child's parents reside in different states. Alternatively, legislation authorising the States to exercise Family Court jurisdiction in this matter could be passed, under s77 (iii) of the Constitution.[103]

124. The opposite arrangement – the States allowing the Family Court to exercise their *parens patriae* jurisdiction – would be held to be unconstitutional in the wake of *Re Wakim*, a case which found that the Commonwealth courts could not exercise state jurisdiction.[104]

125. Alternatively, and perhaps least likely of all, the States could cede some or all of their Welfare power to the Commonwealth. If they were to cede the portion of the power relating specifically to ex-nuptial children to the Commonwealth further fragmentation of the welfare powers, with all children being caught between state and commonwealth jurisdiction, would result. The consequences of this would be marginal in comparison to the legal and political wrangling that would ensue if the Commonwealth sought to assume the entirety of the welfare

[103] *Commonwealth of Australia Constitution Act*
[104] *Re Wakim* [1999] HCA 27; 198 CLR 511; 163 ALR 270; 73 ALJR 839.

power, necessitating as it would that ALL child welfare matters- including management of wards of the state, and child protection matters, would become Commonwealth responsibilities, necessitating a reallocation of state and commonwealth funds.

The 'Best interests' test

126. Under s 67CZ(2) of the *Family Law Act 1975* (Cth), the best interests of the child are the court's paramount consideration in making orders regarding the welfare of a child. Sections 60CB-CG of the *Family Law Act 1975* (Cth) identify the criteria for determining what the 'bests interests' of a child are. Some of the criteria listed are relevant to orders about a child's welfare, while others relates specifically to other kinds of order.

127. In *Re Marion*, the majority stated the following:

> "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. We have already said that it is not possible to formulate a rule which will identify cases where sterilisation is in his or her best interests. But it should be emphasised that the issue is not at large. Sterilisation is a step of last resort. And that, in itself, identifies the issue as one within narrow confines.
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> In the context of medical management, "step of last resort" is a convenient way of saying that alternative and less invasive procedures have all failed or that it is certain that no other procedure or treatment will work. The objective to be secured by sterilisation is the welfare of the disabled child. Within that context, it is apparent that sterilisation can only be authorised in the case of a child so disabled that other procedures or treatments are or have proved inadequate, in the sense that they have failed or will not alleviate the situation so that the child can lead a life in keeping with his or her needs and capacities.
>
> It is true that the phrase "best interests of the child" is imprecise, but no more so than the "welfare of the child" and many other concepts with which courts must grapple. As we have shown, it is confined by the notion of "step of last resort", so that, for example, in the case of a young woman, regard will necessarily be had to the various measures now available for menstrual management and the prevention of pregnancy. And, if authorisation is given, it will not be on account of the convenience of sterilisation as a contraceptive measure, but because it is necessary to enable her to lead a life in keeping with her needs and capacities. With the range of expertise available to them, judges will develop guidelines to give further content to the phrase "best interests of the child" in responding to the situations with which they will have to deal. "[105]

128. Those criteria which are relevant broadly reflect the guidelines developed by Nicholson CJ in *Re Marion* (No 2),[106] and endorsed by the Full Court in *P v P*.[107] They were initially stated by Nicholson CJ as follows:

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[105] Above note 4, paragraphs 73-75.

(i) the particular condition of the child which requires the procedure or treatment;
(ii) the nature of the procedure or treatment proposed;
(iii) the reasons for which it is proposed that the procedure or treatment be carried out;
(iv) the alternative courses of treatment that are available in relation to that condition;
(v) the desirability of and effect of authorising the procedure for treatment proposed rather than available alternatives;
(vi) the physical effects on the child and the psychological and social implications for the child of :
(a) authorising the proposed procedure or treatment
(b) not authorising the proposed procedure or treatment
(vii) the nature and degree of any risk to the child of:
(a) authorising the proposed procedure or treatment
(b) not authorising the proposed procedure or treatment
(viii) the views (if any) expressed by:
(a) the guardian(s) of the child;
(b) a person who is entitled to the custody of the child;
(c) a person who is responsible for the daily care and control of the child;
(d) the child;
to the proposed procedure or treatment and to any alternative procedure or treatment.

129. Although the 'best interests' test has been included in the Commonwealth legislation, and is part of the common law *parens patriae* jurisdiction, it is possible that states who have legislated to reform the jurisdiction may have removed it as a criterion, either intentionally or unintentionally.

130. In *Capacity and the Law* Peisah and O'Neil comment that in at least one case in New South Wales, the 'best interests' test has been read into the legislation.[108] In discussing the decision of Bryson J in *JLS v JES,*[109] the authors commented that the judge read a 'best interests' test, above and beyond the stated test of medical necessity, into the legislation in making his decision.[110]

131. The High Court's views about the concept of 'last resort' acting as a boundary on the test of the child's best interests has not necessarily had the effect that may be envisioned. In its submissions as intervener in *P v P (No 2)*,[111] the Human Rights and Equal Opportunity Commission specifically called on the court to prohibit sterilisation of a minor prior to the commencement of menstruation.[112] Those calls were rejected by the Family Court, who

[106] Above note 1.
[107] Above note 52, paragraph 129.
[108] Above, note 13 at [15.7.1].
[109] *JLS v JES* (1996) 20 Fam LR 485.
[110] Above, note 13 at [15.7.1].
[111] Above, note 67 per Nicholson CJ, Fogarty and Finn JJ at [131-135]

focussed instead on the traumatic effect menstruation had been found to have had on some other girls for whom orders had been sought.

132. This is a fundamentally flawed idea: while it is entirely understandable that the court would seek to minimise the trauma experienced by girls under these circumstances, it is by no means the case that ALL intellectually disabled girls will be affected in this way. To pre-emptively authorise sterilisation of a minor before menstruation begins is inconsistent with the concept of it being a 'step of last resort'. The risk that a girl might be traumatised, as a consequence of being exposed to a phenomenon that she is yet to encounter is too remote to justify the procedure. Furthermore, it prematurely deprives her of the right to attempt to manage any issues which may- not necessarily will- manifest in a less invasive way.
133. In contrast, there have been other cases where the court has deferred making an order until such time as all options with a reasonable chance of succeeding have been tried, in the interests of ensuring that it truly is an option of last resort.[113]

RECOMMENDATION 5:

At a minimum, uniform legislation should be passed ensuring that all applications must meet the same criteria, regardless of the jurisdiction they are heard in. Legislation should, at a minimum, contain a 'best interests' test based Nicholson CJ's guidelines, considering not just the person's medical welfare, but also their psychological, educational, and social best interests. Legislation should also require that, where ascertainable, the wishes of the person are taken into consideration. A further safeguard ensuring that sterilisation truly is an option of last resort is also required. In keeping with this, it is most unlikely that authorisation would be granted for sterilisation of minors within the first 2-3 years of the commencement of menstruation.

'Independent representation'

134. Division 10 of Part VII of the *Family Law Act* gives the court the discretion to order independent representation of the child's interests in proceedings where the child's best interests or welfare are paramount or relevant considerations to the proceedings.
135. This discretion is, evidently, available to the court in any application for an order authorising sterilisation, as such orders trigger both the court's welfare jurisdiction, and consideration of the child's best interests.
136. However, in spite of the High Court's observation that in cases of this nature there is potential for the best interests of the child to conflict with the legitimate interests of other family members,[114] judges are still exercising this power as a discretionary one.[115]

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[112] Ibid, at [135].
[113] *MG (Medical Consent)* [2004] TASGAB 5
[114] *Re Marion*
[115] *Re Angela*, at 36-42.

137. It is notable that several international instruments dealing with vulnerable people in court proceedings, including the Convention on the Rights of the Child, and the Convention on the Rights of Persons with Disabilities, call for those parties protected by the instruments call for independent representation.

138. It is also notable that in some jurisdictions, the Public Advocate, or an independent legal representative, is required to represent the interests of the protected person at any non-emergency proceedings before guardianship or mental health tribunals, to ensure that the person's best interests are adequately represented. Such safeguards should be extended to ensure that the best interests of children are represented similarly.

RECOMMENDATION 6:

The discretion of judges to appoint an independent representative to act on behalf of the best interests of the child in any proceeding relating to authorisation of sterilisation should be removed. Appointment of a representative under these circumstances should be mandatory.

Attempts at law reform

139. The High Court, in *Re Marion* in 1992, called for legislative intervention to reform the law on this issue.[116] Calls by numerous others of note, including the former Chief Justice of the Family Court,[117] the Family Law Council,[118] the Human Rights and Equal Opportunity Commission,[119] and a variety of advocacy groups[120] have echoed this recommendation. It has also been the subject of reporting by the Senate, a frequent topic of reporting at international human rights fora, and the focus of several attempts at reform by the Standing Committee of Attorneys-General.

140. The Australian Guardianship and Administration Council, in 2006, in light of the lack of legislative reform in the area, drafted a *Protocol for Special Medical Procedures (Sterilisation)*,[121] with the express objective of achieving as much consistency as possible between jurisdictions,[122] noting that there were significant jurisdictional differences between applications, and incorporated both the 'best interests' test,[123] and the 'last resort'[124] element of the High Court's decision in *Re Marion*.

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[116] Above, note 4: Mason, Dawson, Toohey and Gaudron JJ at [54]; Brennan CJ at [36].
[117] Former Chief Justice Nicholson, Interview with ABC's The World Today, 1st November 2012 http://www.abc.net.au/news/2012-11-01/former-chief-judge-calls-for-sterilisation-law/4346148
[118] Brady, Grover, and Briton (1994) Sterilisation and Other Medical Procedures in Children
[119] Susan Brady and Sonia Grover, 'The Sterilisation of Girls and Young Women in Australia - A legal, medical and social context', Report to HREOC and Federal Disability Discrimination Commissioner (Human Rights and Equal Opportunity Commission, 1997).
[120] See e.g. People with Disability Australia Incorporated 'Standing Committee of Attorneys-General Sterilisation of Children with an Intellectual Disability Issues Paper Draft Model Bill', (2006), available at: http://www.wwda.org.au/sterpwda06.htm
[121] http://www.agac.org.au/images/stories/agac_sterilisation_protocal_30_mar_09.pdf
[122] Ibid, Pg 5, 3.1(b).
[123] Above, note 121Pg 5, 3.2(a).
[124] Above, note 121Pg 5, 3.2(e).

141. In 2004, the Standing Committee of Attorneys-General (SCAG) released an issues paper on the non-therapeutic sterilisation of minors with a decision-making disability. This paper reflected the agreement of the Committee at a meeting in 2003 that a "nationally consistent approach to the authorisation procedures required for the lawful sterilisation of minors with a decision-making disability is appropriate."[125] This issues paper was followed by the release in 2006 of the draft *Children with Intellectual Disabilities (Regulation of Sterilisation) Bill*. [126]

142. The draft Bill was not progressed with. The SCAG Communique of 28 March 2008 reveals that the Attorneys-General decided not to pursue uniform legislation further at the time, as they felt that the issue which triggered the addition of the topic to their agenda had been adequately addressed. As a consequence, they agreed to remove sterilisation of minors from the agenda. [127] It has remained largely off the national political agenda until the current enquiry.

[125]Standing Committee of Attorneys-General Sterilisation of Children with an Intellectual Disability: Issues paper 2004 (at 1).

[126] Western Australian draft version of the Bill, accessed at http://www.wwda.org.au/sterbill06.pdf

[127] http://www.plra.com.au/News/SCAG_article.pdf