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# **Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia**

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**To: Senate Standing Committee on Community Affairs**

**16 April 2013**

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## **Introduction**

### **Who We Are**

The Law Institute of Victoria (LIV) is the peak body for the Victorian legal profession. The LIV represents over 17,000 members. Through its Administrative Law and Human Rights Section, the LIV currently represents 2,413 members. Through its Family Law Section, the LIV currently represents 2,290 members. Through its Young Lawyers Section, the LIV currently represents 7,505 members. This submission is a collaboration between the Administrative Law and Human Rights, Family Law and Young Lawyers Sections based on the experiences of the members of the Administrative Law and Human Rights Section Disability Law Committee, Family Law Section Executive Committee and Young Lawyers Section Law Reform Committee.

### **What We Do**

The LIV actively seeks to advocate justice for all and influence the development and implementation of policy and legislative reform through various submissions to State and Federal Government Ministers and Shadow Ministers, State and Federal Government Parliamentarians, Commonwealth Public Servants, regulatory bodies, statutory bodies, policy advisors and State and Federal agencies.

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## Executive Summary

There is an extensive body of law governing the provision of health care services generally, the consumers of which will necessarily include adults and children. Decisions about the provision, withholding and selecting of medical treatment will often have important consequences which are not only physical, but also psychological, social, cultural and economic, for those being treated<sup>1</sup>. The current legal position regarding the sterilisation of people with disabilities in Australia varies between jurisdictions. Under current Australian law, only the Family Law Courts or a guardianship tribunal can authorise an irreversible medical procedure. In Victoria, Western Australia and the Northern Territory, the Family Law Courts have exclusive jurisdiction to determine special medical procedures such as sterilisation matters for children. In addition, New South Wales, South Australia, Queensland and Tasmania has conferred concurrent jurisdiction with regard to sterilisation decisions on their respective Guardianship Tribunal, Guardianship Board, Guardianship and Administration Tribunal and Guardianship and Administration Board. Despite the legislative framework that has been set out for decision making in relation to sterilisation, there is reason to believe that many unlawful sterilisations continue to be performed in Australia<sup>2</sup>.

## Background

On 20 September 2012, the Senate referred the matter of the involuntary or coerced sterilisation of people with disabilities to the Senate Community Affairs Committees for inquiry and report. The Terms of Reference were as follows:

1. 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;
  - b) The prevalence of these sterilisation practices and how they are recorded across different state and territory jurisdictions;

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<sup>1</sup> Geoff Monahan and Lisa Young, *Children and the Law in Australia* (2008) Lexis Nexis Butterworths Australia at 433.

<sup>2</sup> Tom Altobelli, *Family Law in Australia Principles and Practice* (2003) Lexis Nexis Butterworths Australia at 349.

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- 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;
  - 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;
    - iv. Application of a 'best interest test' as it relates to sterilisation and reproductive rights;
  - e) The impacts of sterilisation of people with disabilities;
  - f) Australia's compliance with its international obligations as they apply to sterilisation of people with disabilities;
  - 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; and
  - h) Any other related matters.
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2. Current practices and policies relating to the involuntary or coerced sterilisation of intersex people, including:
    - a) Sexual health and reproductive issues; and
    - b) The impacts on intersex people.

The LIV has a proactive commitment to promoting human rights. We welcome the opportunity to provide a submission to the Senate Standing Committee on Community Affairs Inquiry into the involuntary or coerced sterilization of people with disabilities in Australia. The LIV is grateful to the Senate Standing Committee on Community Affairs for the extension that was granted to 16 April 2013.

## **Previous Submissions**

The LIV has undertaken extensive past advocacy relating to sterilisation, highlighted below in our previous submissions. They are summarised in Annex 1.

## **Human Rights Perspective**

There are numerous conventions which address involuntary or coerced sterilization as a violation of human rights:

- The Convention on the Rights of Persons With Disabilities;
- The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- The Convention on the Elimination of All Forms of Discrimination against Women;
- The International Covenant on Civil and Political Rights;
- The Convention on the Rights of the Child;
- The International Covenant on Economic, Social and Cultural Rights; and
- The International Convention on the Elimination of All Forms of Racial Discrimination

A full dissertation regarding human rights in this context is beyond the scope of this submission. The LIV submits that two key human rights are pivotal:

1. The right to bodily integrity including full enjoyment of sexual and reproductive health; and
2. The right to full and informed consent to medical treatment.

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## Limitations of Human Rights

### a) Adults with a Disability

#### Capacity

Consent to medical treatment is valid only if it is given by a person who is competent, has sufficient information to make a decision and is acting voluntarily<sup>3</sup>. If a patient is not competent to make medical decisions for him or herself then, before treatment can be provided to him or her, consent or authorisation must be obtained from some other source. Indicators of capacity appear in the landmark decision of *Burke, R (on the application of) v The General Medical Council Rev 1, Court of Appeal - Administrative Court* [2005] QB 424 ('Burke's case').

#### ***Burke, R (on the application of) v The General Medical Council Rev 1, Court of Appeal - Administrative Court* [2005] QB 424**

The facts of Burke were as follows:

Leslie Burke suffered from a condition which was gradually progressive, meaning he would need artificial nutrition and hydration eventually. He was expected to remain competent until the final stages of the condition. He was concerned that before those final stages, the General Medical Council ('GMC') Guidelines may lead to doctors withdrawing artificial nutrition and hydration when he wished to continue to receive it no matter the pain and suffering. Against this background, in July 2004 Leslie Burke sought a judicial review of the Guidance. He was successful and Munby J granted six declarations, three of which related specifically to Mr Burke, while the others declared a number of specific paragraphs in the GMC Guidance unlawful. In response the GMC appealed and, in allowing the appeal, the Court of Appeal set aside all six declarations made by Munby J.

The central point of Leslie Burke's claim was that while he was competent to decide for himself at the time, he wished to influence medical decisions to be made about him once he lost mental capacity. The issue in Burke was who and how best interests are assessed. Justice Munby's lengthy discussion of the relationship between autonomy, best interests and the patient's wishes was held to be unhelpful by the Court of Appeal, which described the concept of best interests as depending on the context within which it is used, but not being 'of much relevance when considering the situation with which we are

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<sup>3</sup> Ibid at 434.

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concerned<sup>4</sup>. The Court of Appeal held that “*essentially capacity is dependent upon having the ability, whether or not one chooses to use it, to function rationally, having the ability to understand, retain, believe and evaluate (i.e process) and weigh the information that is relevant to the subject matter*”<sup>5</sup>.

### **Substitute Decision Making**

In Victoria in the case of adults with a disability who are unable to consent to sterilisation, authorisation to perform a sterilisation procedure may be obtained from the Victorian Civil and Administrative Tribunal or from a Court having an inherent *parens patriae* jurisdiction<sup>6</sup>.

### ***Victorian Civil and Administrative Tribunal***

In Victoria, the Victorian Civil and Administrative Tribunal (‘VCAT’) is vested with jurisdiction to hear matters under the *Guardianship and Administration Act 1986* (Vic) (‘GA Act’). Part 4A - Medical and Other Treatment, Division 4 of the GA Act deals with ‘special procedures’, one of which is the procedure which will result in permanent infertility. A person must not purport to give consent to the continuation of a special procedure or a further special procedure under section 42F, or to a medical research procedure or to any medical or dental treatment on behalf of a patient or represent to a registered practitioner that he or she is authorised to give such consent knowing that he or she is not authorised to give such consent or without reasonable grounds for believing that he or she is authorised to give such consent<sup>7</sup>. Subject to section 42A, a registered practitioner must not carry out, or supervise the carrying out of, any special procedure on a patient unless the Tribunal has consented to the carrying out of that procedure or the person responsible with authority to consent to the continuation of the procedure or a further special procedure under section 42F has consented to the carrying out of that procedure<sup>8</sup>. A registered practitioner who, in good faith, carries out, or supervises the carrying out of, a special procedure on a patient in the belief on reasonable grounds that the requirements of the Division have been complied with and in reliance on a consent given by another person whom the registered practitioner believed on reasonable grounds was authorised to give such consent or a purported consent but was not so authorised is not guilty of assault or battery or, professional misconduct; or liable in any civil proceedings for assault

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<sup>4</sup> Hazel Biggs, ‘Taking Account of the Views of the Patient’ But Only if the Clinician (and the Court) Agrees - R Burke v General Medical Council Case Commentary’ *Child and Family Law Quarterly* (1 June 2007) 4.

<sup>5</sup> Burke, R (on the application of) v The General Medical Council Rev 1, Court of Appeal - Administrative Court [2005] QB 424 at 41 – 42.

<sup>6</sup> In Victoria, all such matters are determined by VCAT.

<sup>7</sup> *Guardianship and Administration Act 1986* (Vic) section 42.

<sup>8</sup> *Guardianship and Administration Act 1986* (Vic) section 42G(1).

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or battery<sup>9</sup>. Section 39 of the GA Act provides that consent to the carrying out of a special procedure on a patient may be given by the Tribunal. Section 40 of the GA Act provides that a consent given in accordance with this Part in respect of the carrying out of a special procedure, a medical research procedure or any medical or dental treatment on a patient has effect as if the patient had been capable of giving consent to the carrying out of the procedure or treatment and the procedure or treatment had been carried out with the consent of the patient. Section 42B(1) of the GA Act states that an application for the consent of the Tribunal to the carrying out of any special procedure on a patient may be made by the person responsible for the patient or, any person who, in the opinion of the Tribunal, has a special interest in the affairs of the patient. Section 42B(2) of the GA Act provides that if an application for consent is made under this Division, the patient is a party to the proceedings. The Tribunal must give notice of an application, of the hearing of the application and of any order, directions or advisory opinion of the Tribunal in respect of the application to the Public Advocate and any other person whom the Tribunal considers has a special interest in the affairs of the patient<sup>10</sup>. The Tribunal may in consultation with the Public Advocate and the Secretary to the Department of Justice and with the approval of the Governor in Council issue and make available to members of the public guidelines specifying situations in which applications may be made to the Tribunal under this Division<sup>11</sup>. The Tribunal must commence to hear an application within 30 days after the day on which the application is received by the Tribunal<sup>12</sup>.

### **Best Interests**

On hearing an application, the Tribunal may consent to the carrying out of a special procedure only if it is satisfied that the patient is incapable of giving consent, the patient is not likely to be capable, within a reasonable time, of giving consent and the special procedure would be in the patient's 'best interests'<sup>13</sup>. For the purposes of determining whether any special procedure would be in the best interests of the patient, the following matters must be taken into account by the Tribunal:

- The wishes of the patient, so far as they can be ascertained;
- The wishes of any nearest relative or any other family members of the patient;
- The consequences to the patient if the treatment is not carried out;

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<sup>9</sup> *Guardianship and Administration Act 1986* (Vic) section 42G(2).

<sup>10</sup> *Guardianship and Administration Act 1986* (Vic) section 42B(3).

<sup>11</sup> *Guardianship and Administration Act 1986* (Vic) section 42C.

<sup>12</sup> *Guardianship and Administration Act 1986* (Vic) section 42D.

<sup>13</sup> *Guardianship and Administration Act 1986* (Vic) section 42E.

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- Any alternative treatment available;
  - The nature and degree of any significant risks associated with the treatment or any alternative treatment;
  - Whether the treatment to be carried out is only to promote and maintain the health and well-being of the patient;
  - Any other matters prescribed by the regulations.

## **b) Children with a Disability**

### **Capacity**

A distinction needs to be drawn between adults and children with a disability. The body of law governing medical decision making in Australia is underpinned by two, occasionally competing policy considerations<sup>14</sup>:

- 1) Respect for patient's autonomy; and
- 2) The protection of patient's welfare<sup>15</sup>.

While health care providers treating children will generally owe them the same, or similar, duties that are owed to adult patients, some special considerations will arise specifically in relation to children<sup>16</sup>. In the case of children with a disability, the issue turns on whether a child with a disability can consent to medical treatment on his or her behalf and if a child with a disability is unable to make such medical decisions, who is the appropriate entity or person to make those decisions. There are two approaches to determining competency of children:

1. **Status based approach** – Individuals will be deemed to be either competent or incompetent based on whether they belong to a particular class of persons; and/ or
2. **Functional assessment** – Individuals will be deemed to be either competent or incompetent based on their actual decision making abilities and capabilities.

In Australia, the legal assessment of competency at common law combines elements of both the status based approach and functional assessment but with an emphasis on the

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<sup>14</sup> Geoff Monahan and Lisa Young, *Children and the Law in Australia* (2008) Lexis Nexis Butterworths Australia.

<sup>15</sup> J Devereux and M Parker, *Competency Issues for Young Persons and Older Persons* in I Frecklton and K Peterson, *Disputes and Dilemmas in Health Law* (2006) Federation Press.

<sup>16</sup> Geoff Monahan and Lisa Young, *Children and the Law in Australia* (2008) Lexis Nexis Butterworths Australia.

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latter – adults are presumed to be competent, whereas children are not<sup>17</sup>. Children’s competency is emergent in nature, developing in accordance with each child’s intellectual and emotional maturity<sup>18</sup>. If a disabled child is not competent, he or she will be unable to make any valid decision regarding their medical treatment. If a disabled child is competent, the extent to which he or she can exercise full autonomy is subject to statutory limitation. Deciding about the treatment of children generally can raise complex and problematic issues in which the balance is not easily struck. Former Chief Justice Nicholson in *Re Alex*<sup>19</sup> stated that “*the circumstances in which a child or young person has the right to make his or her decisions as to medical treatment are far from precise*”. The resolution of these difficulties is not assisted by the paucity of the case law regarding medical treatment decision making for minors in Australia<sup>20</sup>.

***Gillick v West Norfolk and Wisbech Area Health Authority and Anor (1985) 3 All ER 402 (HL)***

‘Gillick competence, test or standard’ is a term originating in England used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. The Gillick competence, test or standard is based on a decision of the House of Lords in the case *Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402 (HL)* (‘Gillick’). The case is binding in England and Wales, and has been approved in Australia, Canada and New Zealand. The facts of Gillick were as follows:

In 1977, as part of wider reform of the National Health Service, Parliament enacted a statutory provision requiring the Secretary of State to arrange the provision of contraceptive substances and appliances, within England and Wales. No age limit was prescribed. Three years later, a memorandum of guidance, issued by the former Department of Health and Social Security (DHSS) was amended to address the approach to be taken to those under the age of sixteen years. The guidance discouraged the provision of such services to children, urging physicians to take special care not to undermine parental authority and expressed the hope that a doctor or other professional would always seek to persuade the child to involve her parents. The guidance came under the scrutiny of Victoria Gillick, a mother of ten including five daughters aged one to thirteen. Although none of her daughters had sought any advice on contraception or abortion, Ms Gillick was concerned at the prospect of her parental authority being

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<sup>17</sup> Geoff Monahan and Lisa Young, *Children and the Law in Australia* (2008) Lexis Nexis Butterworths Australia at 437.

<sup>18</sup> Geoff Monahan and Lisa Young, *Children and the Law in Australia* (2008) Lexis Nexis Butterworths Australia.

<sup>19</sup> (2004) 31 Fam LR 503 at 529.

<sup>20</sup> Geoff Monahan and Lisa Young, *Children and the Law in Australia* (2008) Lexis Nexis Butterworths Australia at 433.

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disturbed without her knowledge. Ms Gillick wrote to her local health authority seeking confirmation that no advice on contraceptive or abortive treatment would be given to her daughters without her express knowledge and consent. The authority, bound by the guidance, did not consider itself able to offer such a guarantee. Mrs Gillick forbid the local authority from giving such advice or treatment to any of her daughters without her consent. When this did not prompt the requisite response, Mrs Gillick began a nation wide petition before taking her case to court.

The issue before the House of Lords was whether the minor involved could give consent. Lord Scarman required that a child could consent if he or she fully understood the medical treatment that is proposed, "*As a matter of Law the parental right to determine whether or not their minor child below the age of sixteen will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed*". Although Mrs Gillick failed in her application, her case was a landmark decision and has far reaching implications not only within the law but also for social, educational and health services providers<sup>21</sup>.

### **Post Gillick**

Following the decision in Gillick and prior to the decision in Marion's case (discussed below), there were four Australian decisions concerning sterilisation:

1. *Re a Teenager* (1988) 94 FLR 181 (*'Re a Teenager'*);
2. *Re Jane* (1989) 13 Fam LR 47 (*'Re Jane'*);
3. *Re Elizabeth* (1989) FLC 92 – 023 (*'Re Elizabeth'*); and
4. *Attorney- General (QLD) v Parents (Re S)* (1989) 98 FLR 41 (*'Re S'*).

The above four decisions involved sterilisation of minor females. The Family Court of Australia in *Re a Teenager* and *Re S* held that it was unnecessary for parents, as guardians, to seek approval from a Court to authorise sterilisation of a minor and that parental consent was sufficient. In *Re Jane* and *Re Elizabeth* however, the Court held that consent was required.

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<sup>21</sup> Ian McDougall, *Cases that Changed our Lives* (2010) Lexis Nexis.

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***Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's Case) (1992) 175 CLR 218***

The High Court of Australia gave specific and strong approval for the Gillick decision in *Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's Case) (1992) 175 CLR 218*. The facts of Marion's case were as follows:

The parents of a fourteen year old girl sought a court order authorising the sterilisation (by hysterectomy) of their daughter, who was profoundly intellectually impaired and who also suffered from deafness and epilepsy. In the alternative, they sought a declaration that it would be lawful for them to consent to that treatment. The purpose of the proposed treatment was to prevent pregnancy and menstruation, and to stabilise hormonal fluctuations, all of which were said to have adverse psychological and behavioural consequences for Marion.

The principal issue before the Courts in both Gillick and Marion's case was the scope of the parent's capacity to consent to treatment on their children's behalf and in Marion's case, the further issue of the Court's power to authorise medical treatment for a child. The majority of the Full Court of the Family Court of Australia (former Chief Justice Nicholson in dissent) held that guardians could lawfully consent to the sterilisation procedure of a disabled child. The High Court (Justices Deane and McHugh dissenting) endorsed the view that the power and authority embodied in the concept of parental responsibility dwindles as the child's maturity increases, "*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 ... A minor is, according to this principle, capable of giving informed consent when he or she 'achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'*"<sup>22</sup> and that parents cannot give consent to a sterilisation procedure. The ruling holds particularly significant implications for the legal rights of minor children in that it is broader in scope than merely medical consent. It lays down that the authority of parents to make decisions for their minor children is not absolute, but diminishes with the child's evolving maturity; except in situations that are regulated otherwise by statute, the right to make a decision on any particular matter concerning the child shifts from the parent to the child when the child reaches sufficient maturity to be capable of making up his or her own mind on the matter requiring decision. When a child has sufficient understanding to make a decision about his or her welfare is a question of fact to be assessed in each case, and which is dependent neither on the attainment of a particular age nor upon whether a child suffers from a disability. There is

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<sup>22</sup> *Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's Case) (1992) 175 CLR 218 at 237.*

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little guidance as to what matters a disabled child must appreciate in order to understand fully what is being proposed. It is not clear what level of understanding the child must display to be considered mature<sup>23</sup>. The matters that the Courts may be willing to take into account in assessing whether a child has sufficient understanding and intelligence to enable him or her to understand fully what is proposed include the child's:

- Chronological, mental and emotional age;
- Understanding of the nature and consequences of the proposed treatment and related advice;
- Maturity, including his or her intellectual development and life experience;
- Ability to appreciate the wider ramifications of his or her decision, including the effects of that decision on others, moral and family issues (including the child's relationship with his or her parents), and emotional consequences (including the long term impact) of the decision<sup>24</sup>.

The High Court in Marion's case found that it was not sterilization per se that required court approval, finding "*... it is necessary to make it clear that, in speaking of sterilization in this context, we are not referring to sterilization which is a by-product of surgery appropriately carried out to treat some malfunction or disease. We hesitate to use the expressions "therapeutic" or "non-therapeutic", because of their uncertainty. But it is necessary to make the distinction, however unclear the line may be.*" [emphasis added]

### **Post Marion's Case**

Following the High Court's decision in Marion's case, in 1995 section 67ZC was inserted into the Family Law Act, which made it clear that in addition to the jurisdiction of the Court to determine parenting matters in relation to children (such as where a child lives following the separation of the child's parents), the Family Court also has jurisdiction "to make orders relating to the welfare of children". This confirms the vesting in the Family Court of the *parens patriae* jurisdiction referred to in Marion's case.

The former Chief Justice of the Family Court in *Re Alex: Hormonal Treatment for Gender Dysphoria Disorder (2004) FLC 93-175* confirmed that the requirement for court approval pursuant to section 67ZC is not limited to cases involving sterilisation, but extends to any 'special medical procedure'. Subsequently the Rules of the Family Court have been

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<sup>23</sup> Eithne Mills, *Family Law* (2001) Butterworths Australia.

<sup>24</sup> Geoff Monahan and Lisa Young, *Children and the Law in Australia* (2008) Lexis Nexis Butterworths Australia at 440.

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amended, in line with Marion's case, to define a medical procedure application as one "seeking an order authorising a major medical procedure for a child that is not for the purpose of treating a bodily malfunction or disease." (see the Dictionary to the Family Law Rules).

The distinction between a sterilization that is the by product of medical intervention to treat another bodily malfunction or disease, and a sterilization that is being sought for non-therapeutic reasons was recently considered by the Family Court in *Re: Sean and Russell (Special Medical Procedures)* (2010) FamCA 948.

In *Re: Sean and Russell (Special Medical Procedures)* (2010) FamCA 948 ('Sean and Russell'), two families applied to the Family Court for authorisation to perform gonadectomies on children aged eighteen months and three and a half years. Both children suffered from the rare disease known as *Denys-Drash* Syndrome, the key features of which are kidney disease, propensity to develop cancerous tumours of the gonads and male pseudohermaphroditism. The medical evidence was such that the removal of the gonads of each child was necessary to prevent cancer. A side effect of the surgery was that both children would be rendered infertile. Justice Murphy considered the rationale for having the Family Court, rather than parents, make certain medical decisions in respect of children. His Honour stated, "*In my view, the law should tread very lightly in seeking to intrude in, or impose itself upon, those decisions. It would in my respectful view be sad indeed if the courtroom was to replace a caring, holistic environment within which approach by parents and doctors alike could deal with the (admittedly extremely difficult) medical and other decisions that need to be made*"<sup>25</sup>. He found that Court approval was not necessary in this case, as the sterilization of both children was a by product of the surgery needed to treat a bodily malfunction or disease.

### **Substitute Decision Making**

In the case of children with a disability, authorisation to perform a sterilisation procedure may be obtained from the patient's parent, carer or appointed guardian or from a Court having an inherent or statutory *parens patriae* jurisdiction. Each of these will be addressed in turn.

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<sup>25</sup> *Re: Sean & Russell (Special Medical Procedures)* [2010] FamCA 948 at 91.

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## **State and Territory Supreme Courts**

The Family Court of Australia and State and Territory Supreme Courts have jurisdiction to make orders in respect of children's welfare. The power of the Courts to make orders is not limited to the competent decisions of a minor which may be overridden by a Court exercising its welfare jurisdiction<sup>26</sup>. State and Territory Supreme Courts exercise the inherent jurisdiction of the Crown known as *parens patriae* (parent of a country). *Parens patriae* jurisdiction lies in the historical power of the Crown to take care of the person and property of those who are unable to do so for themselves. Any person having the care of a child, including medical practitioners, can invoke the welfare jurisdiction of the courts and apply for a declaration as to what will constitute the child's best interests<sup>27</sup>. The scope of the Court's welfare powers are wide:

*"The parens patriae jurisdiction of the Courts is essentially protective in nature and although broad, is to be exercised cautiously. Its existence and exercise are founded on a need to act on behalf of those who are in need of care and cannot act for themselves. In exercising its parens patriae jurisdiction, the paramount consideration is the promotion of the health or welfare of the subject of the exercise of the jurisdiction"*<sup>28</sup>.

The jurisdiction of the Court is not limited to a supervisory role but rather a direct power protecting the interests of those who cannot do so themselves and as such, extends beyond the powers residing in parents<sup>29</sup>.

## **Family Law Courts**

The Family Court of Australia exercises an identical statutory jurisdiction to the *parens patriae* jurisdiction under section 67ZC(1) of the *Family Law Act 1975* (Cth). The child can be the child of a married or a de facto relationship.

## **Best Interests**

In the exercise of the welfare power under the *Family Law Act 1975* (Cth) or the power to make parenting orders, the subject child's best interests must be the paramount

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<sup>26</sup> *Director – General, New South Wales Department of Community Services v Y* (1999) NSWSC 644 at 99 – 103 and *Minister for Health v AS* (2004) 33 Fam LR 233 at 20.

<sup>27</sup> *Minister for Health v AS* (2004) 33 Fam LR 233 at 17.

<sup>28</sup> *MAW v Western Sydney Area Health Service* (2000) 49 NSWLR 231 at 18 per O'Keefe J.

<sup>29</sup> *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 at 260.

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consideration<sup>30</sup>. The term 'best interests' is prescribed in Section 60CC of the *Family Law Act 1975* (Cth) to include the following matters:

- The benefit to the child of having a meaningful relationship with both of the child's parents;
- The need to protect the child from physical or psychological harm from being subjected to, or exposed to, abuse, neglect or family violence;
- Any views expressed by the child and any factors (such as the child's maturity or level of understanding) that the court thinks are relevant to the weight it should give to the child's views;
- The nature of the relationship of the child with each of the child's parents and other persons (including any grandparent or other relative of the child);
- The extent to which each of the child's parents has taken, or failed to take, the opportunity to participate in making decisions about major long-term issues in relation to the child and to spend time with the child and to communicate with the child;
- The extent to which each of the child's parents has fulfilled, or failed to fulfill, the parent's obligations to maintain the child;
- The likely effect of any changes in the child's circumstances, including the likely effect on the child of any separation from either of his or her parents or any other child, or other person (including any grandparent or other relative of the child), with whom he or she has been living;
- The practical difficulty and expense of a child spending time with and communicating with a parent and whether that difficulty or expense will substantially affect the child's right to maintain personal relations and direct contact with both parents on a regular basis;
- The capacity of each of the child's parents and any other person (including any grandparent or other relative of the child) to provide for the needs of the child, including emotional and intellectual needs;

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<sup>30</sup> *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 at 270, 280.

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- The maturity, sex, lifestyle and background (including lifestyle, culture and traditions) of the child and of either of the child's parents, and any other characteristics of the child that the court thinks are relevant;
  - If the child is an Aboriginal child or a Torres Strait Islander child, the child's right to enjoy his or her Aboriginal or Torres Strait Islander culture (including the right to enjoy that culture with other people who share that culture) and the likely impact any proposed parenting order under this Part will have on that right;
  - The attitude to the child, and to the responsibilities of parenthood, demonstrated by each of the child's parents;
  - Any family violence involving the child or a member of the child's family;
  - If a family violence order applies, or has applied, to the child or a member of the child's family - any relevant inferences that can be drawn from the order, taking into account the nature of the order, the circumstances in which the order was made, any evidence admitted in proceedings for the order, any findings made by the court in, or in proceedings for, the order and any other relevant matter;
  - Whether it would be preferable to make the order that would be least likely to lead to the institution of further proceedings in relation to the child; and
  - Any other fact or circumstance that the court thinks is relevant.

The 'best interests' test is objectively applied on a case by case basis rather than as a 'reasonable or ordinary child in the circumstances' test. The nature and purpose of a 'best interests' inquiry will necessarily shape the relative significance of the various considerations such as the potential for medical treatment to save or significantly extend the child's life, the burden and invasiveness of the treatment, the suffering associated with the child's life and condition and the capacity for the child to experience and appreciate joy, meaningful interaction and relationships with others. While certain factors will commonly feature in certain types of determination relating to sterilisation of minors, the Courts have been vigilant in maintaining that no particular consideration should take on such significance that it is seen to qualify or circumscribe the best interests test as the paramount consideration in the exercise of the court's welfare powers<sup>31</sup>. The LIV appreciates that the breadth of the 'best interests' principle has the advantage of allowing

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<sup>31</sup> *Portsmouth Hospitals NHS Trust v Wyatt* (2005) 1 WLR 3995 at 88.

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the court to respond to each child's individual circumstances but also has the disadvantage of being uncertain in its application<sup>32</sup>.

The issue for this Inquiry turns on when there should be limitations on human rights of persons with a disability and if a person with a disability is unable to make such medical decisions, who is the appropriate entity to determine those limitations and upon what grounds. In terms of the latter issue, the LIV believes that a Court or administrative Tribunal is the appropriate arbiter, but there are differing views as to which Court or Tribunal is most appropriate. The Administrative Law and Human Rights Section posit that VCAT and the State and Territory Supreme Courts are the most appropriate forum to deal with disputes relating to sterilization of adults and children with a disability. The Administrative Law and Human Rights Section submit that VCAT and the State and Territory Supreme Courts are a more cost effective jurisdiction than the Family Court and proceedings are conducted in an inquisitorial manner. The Family Law Section posit that as the Family Court deals with disputes pertaining to children's rights, the Family Law Courts are best placed to deal with disputes relating to the sterilization of children with a disability, including the potential for cases involving children where the parents do not agree on the proposed treatment. The Family Law Section endorses the comments of Chief Justice Bryant in her separate submission to the Inquiry about the particular skills and expertise of Family Court Judges in dealing with disputes concerning children. The Family Court has also developed a special case management process for dealing with applications concerning special medical procedures, not just cases involving sterilization, which includes a 'hot tub' approach to taking evidence from medical practitioners that enables the Court, the witnesses and the parties to the litigation to 'debate' the complexities of the treatment proposed. The LIV notes that each authority has merits in the determination of disputes relating to adults and children with a disability. As such, the LIV does not make any specific recommendation in this regard.

## **Key Recommendations**

The LIV refers to the submission made to the Inquiry by Women with Disabilities Australia (WWDA) titled, 'Dehumanised: The Forced Sterilisation of Women and Girls with Disabilities in Australia' (March 2013) ('WWDA submission'). The LIV endorses the following recommendations made in the WWDA submission.

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<sup>32</sup> *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 at 270, 296.

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### **Recommendation 1**

As an immediate action, in keeping with the human rights treaties to which Australia is a party, and consistent with the recommendations to the Australian Government from the United Nations *Committee on the Elimination of Discrimination Against Women* (CEDAW/C/AUS/CO/7), the *Committee on the Rights of the Child* (CRC/C/15/Add.268; CRC/C/AUS/CO/4), the *Human Rights Council* (A/HRC/17/10), along with the *International Federation of Gynecology and Obstetrics (FIGO) Guidelines on Female Contraceptive Sterilization* (2011); recommendations of the *World Medical Association (WMA)* (2011) and the *International Federation of Health and Human Rights Organisations (IFHHRO)* (2011), and the February 2013 Recommendations of the *UN Special Rapporteur on Torture* (A/HRC/22/53) **enact national legislation prohibiting, except where there is a serious threat to life, the use of sterilisation of girls, regardless of whether they have a disability, and of adult women with disabilities in the absence of their fully informed and free consent.** Such legislation must prohibit the removal of a child or adult with a disability from Australia with the intention of having a forced sterilisation procedure performed.

The LIV agrees with recommendation 1, save that any Federal legislation enacted should:

- 1) Include a statutory definition of a 'sterilisation' procedure;
- 2) Specify which therapeutic and/or non-therapeutic sterilisation procedures the prohibition applies to;
- 3) Apply equally to disabled males, females and intersex;
- 4) Prescribe any exceptions in which sterilisation is acceptable; and
- 5) Vest jurisdiction in a Court or Tribunal to order injunctive relief and authorise the Australian Federal Police to place disabled adults and minors on the Airport Watch List.

Each of these will be addressed in turn.

### **Definition of Sterilisation**

Current comparative definitions of sterilisation are varied. The Law Reform Commission of Western Australian defines a sterilisation procedure as one which renders an otherwise

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healthy and presumed fertile person incapable of being a parent<sup>33</sup>. The LIV submits that formulating an appropriate statutory definition of sterilisation should necessarily involve extensive consultation with identified key stakeholders and reflect medical, legal and sociological perspectives.

### ***Statutory Definitions***

'Sterilisation' is not expressly defined in the *Guardianship and Administration Act 1986* (Vic), *Guardianship Act 1987* (NSW), *Guardianship and Administration Act 1995* (Tas), *Guardianship and Management of Property Act 1991* (ACT) and *Adult Guardianship Act 1988* (NT). The *Guardianship and Administration Act 1986* (Vic) doesn't define sterilisation, but it does provide a definition in section 3 of a special procedure as 'any procedure that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out'. Schedule 2 Section 9 of the *Guardianship and Administration Act 2000* (Qld) defines 'sterilisation' as the health care of an adult who is, or is reasonably likely to be, fertile that is intended, or reasonably likely, to make the adult, or ensure the adult is, permanently infertile. The Queensland Act provides examples of sterilisation procedures being endometrial ablation, hysterectomy (the surgical removal of the uterus and cervix), tubal ligation (surgically severing or tying the fallopian tubes) and vasectomy (surgically severing the vas deferentia). The Queensland Act goes one step in definition sterilisation to not include health care primarily to treat organic or disease of the adult. Section 3 of the *Guardianship and Administration Act 1993* (SA) defines 'sterilisation' as any treatment given to a person that results in, or is likely to result in, the person being infertile. Section 56 of the *Guardianship and Administration Act 1990* (WA) defines 'procedure for sterilisation' as not including a lawful procedure that is carried out for a lawful purpose other than sterilization but that incidentally results or may result in sterilization.

### ***Protocols***

The Australian Guardianship and Administration Committee ('AGAC') *Protocol for Special Medical Procedures (Sterilisation)* outlines guiding principals for who can make the application, the content of the application, the questions that are considered by the Tribunal and the determination. The protocol defines sterilisation as a "surgical intervention that results either directly or indirectly in the termination of an individual's capacity to reproduce". In turn, the AGAC Protocol defines a "sterilisation procedure" to mean those "medical interventions which are known or are reasonably likely in all the

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<sup>33</sup> Women with Disabilities Australia, *Sterilisation of Women and Girls with Disabilities: A Literature Review* (1999) <http://www.wvda.org.au/steril.htm>

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circumstances, to cause sterilisation whether or not that is the purpose for which they are carried out."

### **Definition of Therapeutic and Non – Therapeutic Sterilisation**

'Therapeutic Sterilisation' is defined as an operation intended to benefit the health of the subject<sup>34</sup>. 'Non – Therapeutic Sterilisation' is defined as sterilisation which is performed for reasons other than to treat a medical condition or disease<sup>35</sup>. Non - therapeutic sterilisation includes menstrual management and termination of unplanned pregnancy resulting from sexual abuse. There are many forms of sterilisation that ensure that women and men are either temporarily rendered infertile or remain permanently infertile<sup>36</sup>. The LIV submits that Federal legislation should sufficiently specify the sterilisation procedures to which the Act applies. This is particularly important in order to avoid the problem identified by Justice Murphy in *Re Sean and Russell* of health providers seeking Court approval in order to protect themselves against future litigation - *"Also, it would not only be sad but, potentially, an abuse of this court's process if a decision from this court was sought by a third party in respect of a proposed procedure or proposed treatment which was plainly within the bounds of parental responsibility. An example might be where the sole purpose of such an application was as a protection against the prospect of future litigation."*

### **Gender Discrimination**

The LIV has a proactive commitment to promoting diversity generally. The LIV notes that sterilisation procedures can be applied to disabled men, women and intersex in the absence of their fully informed and free consent. Federal legislation prohibiting sterilisation should not discriminate on the basis of gender. A statutory prohibition on the sterilisation of persons with a disability should apply equally to males, females and intersex.

### **Exceptions**

The LIV reiterates its sentiments expressed in its submission to the Standing Committee of Attorneys-General dated June 2004 that *"... it is appropriate to include an exclusionary definition of 'medical treatment' that is intended to remediate a life-threatening condition"*. The LIV also appreciates that circumstances may exist whereby sterilisation procedures may need to be performed on disabled persons in the absence of their free and informed

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<sup>34</sup> [http://blurblog.typepad.com/files/eugenics\\_woodside\\_4.pdf](http://blurblog.typepad.com/files/eugenics_woodside_4.pdf).

<sup>35</sup> Women with Disabilities Australia, *Standing Committee of Attorneys – General (SCAG): Issues Paper on the Non Therapeutic Sterilisation of Minors with a Decision Making Disability* (2004) <http://www.wwda.org.au/scagpap1.htm>

<sup>36</sup> *Ibid.*

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consent. Such life - preserving circumstances may include severe pain management. The LIV submits that a determination of 'exceptional circumstances' should be borne by a Tribunal or Court vested with jurisdiction under the Act and that the Tribunal or Court should be afforded a wide discretion in doing so to avoid appealable error.

### **Removal of Adults or Minors from Commonwealth of Australia**

The LIV submits that Federal legislation should give Tribunals and Courts exercising jurisdiction under the Act the power to provide injunctive relief and grant Orders authorising the Australian Federal Police ('AFP') to place an adult or minor on the Airport Watch List. The Airport Watch List system is currently designed to prevent children whose parents are involved in family law proceedings being removed from Australia without the consent of the Family Law Courts. The Watch List is in effect at all international sea ports and airports.

Generally, the system is used for matters where there is an actual fear that the child may be removed from the Commonwealth of Australia. Sections 65Y and 65Z of the *Family Law Act 1975* (Cth) provide that a child who is subject to family law proceedings or a residence, care or contact specifying non-removal from Australia must not be removed from the Commonwealth of Australia. There is provision for an exception to these sections under Sections 65Y (2) and 65Z (2) which provide for a child to be removed from Australia with the consent in writing (authenticated as prescribed) of each party. Approval to remove a child from Australia may also be obtained via a new court order. A party who removes or attempts to remove a child from the Commonwealth of Australia may be sentenced up to three (3) years imprisonment. The Australian Federal Police's role in the family law process is to act on specific orders of the Court such as Recovery Orders, Warrants of Arrest and Writs of Possession.

The LIV suggests that a clause be included in the legislation to the effect that an adult or minor with a disability from Australia whose parent, carer or guardian intends to have a forced sterilisation procedure performed must not be removed from the Commonwealth of Australia. To place a person's name on the watch list, a party should be required to obtain a Tribunal and/ or Court Order that directs the AFP to place the name of the person with a disability on the Airport Watch List. The direction from the Tribunal and/ or Court must be specific and not implied. If a party desires to take the disabled person out of the Commonwealth of Australia, they should be permitted to travel only with an Order of the Tribunal or Court. If there is still a genuine need to keep the person with a disability on the Airport Watch List, the Tribunal or Court can make an Order which allows travel for a

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certain period of time with a certain party. A person's name should be removed from the Airport Watch List only with a Tribunal or Court Order. That Order must discharge the Order or specific paragraph which restrained the parties from removing the person from Australia and/or direct the AFP to remove the person from the Airport Watch List. A person's name will be removed from the Airport Watch List when the AFP receives a Tribunal or Court Order to that effect. If there is no longer a fear that a person will be taken out of Australia, it is recommended that a party obtain a Discharge Order to avoid future difficulties at Australian Ports. The LIV further submits that a criminal penalty should result for a party who removes or attempts to remove a person from the Commonwealth of Australia.

### **Recommendation 2**

In consultation with women with disabilities, and as a matter of urgency, establish and adequately resource a National Task Force to develop a **Policy and Framework for Transitional Justice and Redress** to address the forced and coerced sterilisation of women and girls with disabilities in Australia. Such a policy and framework must be consistent with the *United Nations Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law (A/RES/60/147)*, the *Convention on the Rights of Persons With Disabilities (A/RES/61/106)* and other relevant international standards and frameworks. The following elements as articulated under the *Convention Against Torture [and Other Cruel, Inhuman or Degrading Treatment or Punishment]*, must be included: measures of reparation, satisfaction and guarantees of non-repetition as well as compensation, rehabilitation and recovery.

The LIV agrees with recommendation 2. Forced, coerced or involuntary sterilisation of people with disabilities encompasses a plethora of medical, legal and sociological issues. The consequences of former forced sterilisation would be best addressed by a national framework. Accordingly, the LIV submits that a national policy framework must be created following extensive consultation with identified key stakeholders. This is inclusive of males, females and intersex persons with a disability. Save for children, historically the Commonwealth has had a limited role in policy development regarding forced sterilisation of persons with a disability. The Commonwealth has a responsibility in developing a national framework to assist the states and territories to address the consequences of past forced sterilisation policies and practices.

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### **Recommendation 3**

In developing measures of **rehabilitation and recovery** for those affected by forced sterilisation practices and other violations of their reproductive rights and freedoms, women and girls with disabilities must be actively consulted to identify the full range of rehabilitation and recovery measures required, which may include for example:

- Specialised counselling, psychological, and social programs, services and supports; provision of legal services, supports and assistance for survivors;
- Specialised women's health, allied health and medical programs, services and supports;
- Specialised and targeted violence and sexual assault prevention services, programs and support;
- Specialised reproductive and sexual health education and training services and programs;
- Processes for memorialising and documenting the experiences, stories and histories of those affected.

The LIV agrees with recommendation 3.

### **Recommendation 4**

Issue a **formal apology** that identifies the discriminatory actions, policies, culture and attitudes that result in forced and coerced sterilisation of people with disabilities and that acknowledges, on behalf of the nation, the harm done to those who have been forcibly sterilised and experienced other violations of their reproductive rights. The formal apology must be developed in consultation with those affected and their allies, and satisfy the five criteria for formal apologies as articulated by the Canadian Law Commission, which include:

- Acknowledgment of the wrong done or naming the offence.
- Accepting responsibility for the wrong that was done.
- The expression of sincere regret and profound remorse.
- The assurance or promise that the wrong done will not recur.
- Reparation through concrete measures.

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The LIV agrees with recommendation 4. The LIV submits that a national apology from the Federal government is a desirable step in reconciliation and healing creating a profound and positive effect on those who have been affected by forced sterilisation of persons with a disability. The LIV recommends that official apologies should include statements that take responsibility for the past policy choices made by institutions' leaders and staff and not be qualified by reference to values or professional practice during the period in question, should be accompanied by undertakings to take concrete actions that offer appropriate redress for past mistakes and be presented in a range of forms and be widely published.

#### **Recommendation 5**

Provide **financial reparation** to women and girls with disabilities who have been forcibly sterilised. In establishing a scheme for financial reparation, the Australian Government should examine similar models used in Canada, Sweden and the US, including the *North Carolina Justice for Sterilization Victims Foundation*, established in 2010.

The LIV believes that recommendation 5 is worthy of further consideration.

#### **Recommendation 10**

As a matter of urgency, and consistent with recommendations from other key Australian disabled people's organisations, establish and adequately resource an independent, statutory, **national protection mechanism** for 'vulnerable' and/or 'targeted' adults, where the requirement for mandatory reporting is legislated.

The LIV agrees with recommendation 10. The LIV submits that mandatory reporting of persons with a disability suspected of being at risk of having a sterilisation procedure performed in the absence of their free and informed consent should be incorporated within the proposed Federal legislation explored under recommendation 1. The LIV envisages that a mandatory reporting division of the Federal legislation would encompass persons to whom the mandatory reporting would apply, notification of risk of having a sterilisation procedure performed in the absence of their free and informed consent, referral to and investigation by the appropriate authority.

#### **Relevant Persons**

The LIV submits that the provisions would require mandatory reporting about a person with a disability who is, or is likely to be, unable to communicate to another person a

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complaint about having a sterilisation procedure performed or is, or is likely to be, unable to understand the nature of the sterilisation procedure in order to make a complaint about it.

### **Notification Requirements**

The LIV suggests that if a prescribed person suspects on reasonable grounds that a relevant person has been, or is at risk of having a sterilisation procedure performed, or has had a sterilisation procedure performed, in the absence of their free and informed consent and the suspicion is formed in the course of the person's work (whether paid or voluntary) or of carrying out official duties, the person must notify an appropriate authority in the State or Territory of that suspicion as soon as practicable after he or she forms the suspicion which should be accompanied by a statement of the observations, information and opinions on which the suspicion is based. The LIV submits that a prescribed person should include the following:

- A medical practitioner;
- A registered or enrolled nurse;
- An alternative health practitioner;
- A pharmacist;
- A dentist;
- A psychologist;
- An educator;
- A social worker;
- A police officer;
- A minister of religion;
- A physiotherapist; and/or
- A health practitioner within the meaning of the Health Practitioner Regulation National Law.

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## Conclusion

The LIV is grateful for the opportunity to provide comment and we would appreciate the opportunity for further input as required.

## Annex 1 – LIV Previous Submissions

### Non Therapeutic Sterilisation of Minors with a Decision Making Disability

On 2 August 2003, the Standing Committee of Attorneys-General (SCAG) agreed that a nationally consistent approach to the authorisation procedures required for the lawful sterilisation of minors should be adopted. The non - therapeutic sterilisation of minors with a decision - making disability has been on the agenda of SCAG since the early 1990s. The issues paper, *Non Therapeutic Sterilisation of Minors with a Decision Making Disability* was prepared for the SCAG Working Group and former Victorian Attorney-General Rob Hulls. In April 2004, SCAG Working Group and former Victorian Attorney-General Rob Hulls sought a response to the paper from the LIV. In June 2004, the LIV made submissions in relation to that paper. In our submission the LIV advocated for the following:

*“The proposed uniform decision-making principles should be based on the Australian Guardianship Administration Committee (‘AGAC’) principles as those principles closely reflect, in plain language, various obligations under international instruments in relation to rights and protections for people with a disability. The decision-making principle should have a legislative basis and therefore be set out in the Bill. It would be appropriate, although less preferred, for the principles to be scheduled to the Act or merely refer to the AGAC principles ... It is appropriate for the Bill to include a definition of ‘special medical treatment’, although the wording of the Victorian Guardianship and Administration Act 1986 ‘procedure’ is to be preferred as it more accurately describes the intervention objectively and does not infer that is an intervention to treat a condition. Following this, it is appropriate to include an exclusionary definition of ‘medical treatment’ that is intended to remediate a life-threatening condition ... It is submitted that the authority to develop guidelines (by AGAC or another body from time to time) should be included in legislation with the detail of the guidelines not to be included in legislation. This will allow the guidelines to be appropriate for consistency,*

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*but adaptable for local jurisdiction, and responsive to amendment once operationalized”.*

The SCAG Working Group reviewed the submissions and developed a draft model Bill for adoption nationally.

### **Sterilisation of Children with an Intellectual Disability**

In September 2006 the Department of Justice again sought a response from the LIV in relation to a draft model Bill, *Children with Intellectual Disabilities (Regulation of Sterilisation) Bill 2006* ('draft model Bill'). The draft model Bill provisions set out the criteria and procedures in authorising the sterilisation of children who have an intellectual disability to the extent that the child is incapable of giving informed consent to sterilisation procedure. The draft model Bill follows the High Court's decision in *Re Marion* (1992) 175 CLR 218 (*Re Marion*) and the 1997 Human Rights and Equal Opportunity Commission report on the sterilisation of minors. On 8 November 2006, the LIV provided a submission to the Victorian Department of Justice advocating for the following:

*“The LIV submits and proposes that:*

- The Bill should remove any reference to a disability type, i.e. intellectual disability and more correctly refer to what the Bill is intended to cover, that is, sterilisation of minors with a decision-making disability;*
- If a functional definition of disability were adopted the Bill should also by express intention provide that a sensory or physical impairment is not a disability that would fall within the legislation;*
- The maximum penalty for performing a special procedure should be set at two years imprisonment and a fine of 240 penalty units, an equivalent penalty to that under the Guardianship and Administration Act 1986 (as amended in 2006);*
- As well as a financial penalty, the Bill should include a provision that unauthorised non-therapeutic sterilisation performed by a medical practitioner should amount to professional misconduct to be investigated and considered by the relevant professional disciplinary board;*

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- *There must be codification of the law regarding therapeutic sterilisation so that it is certain that the same criteria apply to the exercise of authority by the Tribunal, the Supreme Court, the Family Court and the High Court;*
  - *The process by which the Tribunal is to establish what is in the person's best interests be codified and to give some guidance as to when a procedure is definitely not in a person's best interests;*
  - *The Bill include a statutory right of intervention by the Public Advocate where he/she has not appointed to investigate and report under clause 18;*
  - *The Bill should clarify the status of the intervener as a party to the proceedings;*
  - *The extent to which the Bill binds the Supreme and Family Courts is clarified; and*
  - *The development of guidelines under the regulatory making power is imperative to ensure national consistency”.*

## **Guardianship Review**

On 20 May 2010, the LIV provided a submission to the Victoria Law Reform Commission regarding a review of the *Guardianship and Administration Act 1986* (Vic). In that submission, the LIV advocated for the following:

*“LIV recognises continuing need for substitute decision-making laws for the reasons outlined in response to questions 1 and 2 above. We do, however, believe that reform is necessary to ensure a comprehensive and integrated system that promotes advance planning (including enduring powers of attorney and advance directives) and provides for tribunal made orders (such as guardianship and administration) only where necessary. As identified above, the issue of capacity and the level of support or intervention required should be viewed on a continuum. Substitute decision-making laws address only one end of a spectrum of mechanisms that should aim to promote the exercise of autonomy to the greatest extent possible through supported decision-making and the provision of resources*

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*to enable people with impaired decision-making ability to make their own informed decisions”.*

### **LIV Response to Guardianship Final Report**

On 10 December 2012, the LIV provided a submission to the Victorian Attorney – General as a response to the Victorian Law Reform Commission (the Commission) Guardianship *Final Report* (the Final Report). In our submission, the LIV advocated for, “A legislative test for incapacity, rather than relying on the common law, will provide greater accountability for those people undertaking capacity assessments, so that subjective judgements and opinions are insufficient to make a finding that a person lacks capacity”.