



**THE LAW REFORM COMMISSION
OF WESTERN AUSTRALIA**

Project No 77 Part II

Consent To Sterilisation Of Minors

REPORT

OCTOBER 1994

The Law Reform Commission of Western Australia was established by the *Law Reform Commission Act 1972*.

Commissioners

Chairman

Mr P G Creighton BJuris (Hons) LLB (Hons) (Western Australia) BCL (Oxford)

Members

Ms C J McLure BJuris (Hons) LLB (Hons) (Western Australia) BCL (Oxford)

Dr P R Handford LLB (Birmingham) LLM PhD (Cambridge)

Officers

Executive Officer and Director of Research

Dr P R Handford

Research Officers

Mr M G Boylson LLB (Western Australia)

Mr A A Head LLB (Western Australia)

Staff

Mrs S K Blakey

Ms K L Chamberlain

Mr L McNamara BA (Murdoch)

Miss M A Ryan

The Commission's offices are at:

11th floor, London House
216 St George's Terrace
Perth Western Australia 6000

Telephone: (09) 481 3711

Fax: (09) 481 4197

To: **HON CHERYL EDWARDES MLA**
 ATTORNEY GENERAL

In accordance with the provisions of section 11(3)(b) of the *Law Reform Commission Act 1972*, I am pleased to present the Commission's report on Consent to Sterilisation of Minors.

P G CREIGHTON
Chairman

25 October 1994

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Table of Abbreviations

DSC	Disability Services Commission (formerly Authority for Intellectually Handicapped Persons)
Discussion Paper	Law Reform Commission of Western Australia, Discussion Paper on <i>Medical Treatment for Minors</i> (Project No 77 1988)
Family Law Council Discussion Paper	Family Council <i>Sterilisation and Other Medical Procedures on Children: Discussion Paper</i> (1993)
Law Commission Consultation Paper	Law Commission <i>Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research</i> (Consultation Paper No 129 1993)
<i>Marion's Case</i>	<i>Secretary, Department of Health and Community Services v JWB and SMB</i> (1992) 175 CLR 218. Page references are to the majority judgment of Mason CJ, Dawson, Toohey and Gaudron JJ unless otherwise stated.
<i>P v P</i>	<i>P v P</i> (1994) 120 ALR 545. Page references are to the majority judgment of Mason CJ, Deane, Toohey and Gaudron JJ unless otherwise stated.
Panel Report	Intellectual Disability Review Panel <i>Report to the Minister for Community Services Victoria on Menstrual Suppressants</i> (1992)
<i>Analysis of Australian Policy</i>	G Carlson and others <i>Menstrual Management and Fertility Management for Women Who Have Intellectual Disability and High Support Needs: An Analysis of Australian Policy</i> (2nd ed 1994).

PART I: THE PROBLEM

Chapter 1

INTRODUCTION

1. GENERAL

1.1 This Report deals with consent to the sterilisation of minors. It is submitted as part of a general reference given to the Commission to examine the law relating to medical treatment for minors.¹

1.2 The Commission acknowledges with gratitude the assistance given to it by Rhonda Griffiths, who acted as consultant, and also by former research officers Ann Blake and Wayne Briscoe, who worked on the Report in its earlier stages.

2. THE PROBLEM SUMMARISED

1.3 This Report is concerned with the question whether sterilisation of children should be permissible, and if so, in what circumstances; and whether parents should be able to consent to such a procedure or whether it should be carried out under the authority of a court. "Sterilisation" in this context means medical treatment which has the effect of causing the child to become infertile.

1.4 In *Marion's Case* in 1992, the High Court of Australia considered the question of parents' ability to consent to medical treatment for their child, generally and in the context of sterilisation. The High Court held that although parents may consent to medical treatment for their children, this authority does not extend to treatment which would not be in the child's

¹ The reference requires the Commission to inquire and report on the adequacy of the existing civil and criminal law in Western Australia as to -

- (a) the age at which minors should be able to consent, or refuse to consent, to medical treatment;
- (b) the means by which such consent, or refusal of consent, to treatment should be given;
- (c) the extent to which, and the circumstances in which, the parents, guardians or other persons or institutions responsible for the care and control of minors should be informed of such consent, or refusal of consent, to treatment;
- (d) the extent to which, and the circumstances in which, the persons referred to in (c) should be able to consent, or refuse to consent, to treatment on behalf of a minor.

In 1988 the Commission issued a Discussion Paper on this reference: see para 1.7 below.

interests.² It ruled that parents cannot consent on behalf of their child to medical treatment which has sterilisation as its primary objective. However, the High Court confirmed that parents can consent to medical treatment for a disease or abnormality which might incidentally have the effect of causing the patient to become infertile.

1.5 The position is different when the proposed sterilisation procedure involves an adult. An adult may consent to a sterilisation procedure being performed on himself or herself. Many legislatures around the world have protected adults who are not capable of deciding for themselves whether to undergo a sterilisation by prohibiting sterilisation of such people without the authority of a court or board.³

1.6 In this Report the Commission considers whether the present law as to consent to sterilisation of children as laid down in *Marion's Case* is satisfactory, and if not how it should be amended by legislation.

3. PROGRESS OF THE INQUIRY

(a) Discussion Paper

1.7 In 1988 the Commission released a Discussion Paper entitled *Medical Treatment for Minors* (the "Discussion Paper"). This was primarily concerned with the general issue of medical treatment for children, and with who has the capacity to consent to it. In normal circumstances, parents can give lawful consent to medical treatment proposed for their children. Questions arise as to when children are sufficiently mature to consent to treatment for themselves and thus override the authority of their parents.⁴ The Commission made provisional proposals as to how maturity should be defined for this purpose.

² *Marion's Case* at 240.

³ The first jurisdiction to pass such legislation was the Canadian province of Alberta: (Alberta) *Dependent Adults Act 1976* (see now RSA 1980 c D-32). In Western Australia Pt 5 Div 3 of the *Guardianship and Administration Act 1990* provides that sterilisation of an intellectually disabled person for non-therapeutic reasons cannot be carried out except under the authority of the Guardianship and Administration Board: see paras 3.10-3.14 below.

⁴ The High Court in *Marion's Case* approved *Gillick v West Norfolk & Wisbech Area Health Authority* [1986] AC 112, in which the House of Lords (the highest court in England) affirmed the maturity principle. According to the High Court, *Gillick* held that "parental power to consent to medical treatment on behalf of a child diminishes gradually as the child's capacities and maturity grow and that this rate of development depends on the individual child": *Marion's Case* at 237.

1.8 The Commission recognised that sterilisation might be a special case. The question of sterilisation of children was referred to in the Discussion Paper in the following terms:

"[R]emoval of the capacity to procreate is of such significance that it is desirable that intellectually handicapped or psychiatrically disturbed children, male or female, should be afforded the same protection as intellectually handicapped or psychiatrically disturbed adults, and that the leave of a court exercising an appropriate guardianship jurisdiction should be required before sterilisation is performed."⁵

1.9 A number of submissions received in response to the Discussion Paper referred to the question of the sterilisation of children, in particular the sterilisation of children who are intellectually disabled. In the light of this and of developments in the law subsequent to the issue of the Discussion Paper,⁶ the Commission decided to prepare a separate Report on the sterilisation of minors.

(b) *Marion's Case*

1.10 In August 1990 further work on this Report was suspended to await the decision of the High Court in *Marion's Case*. In this case, the parents of a severely physically and mentally disabled girl made application to the Family Court of Australia for authorisation for her to undergo sterilisation. The trial judge, Nicholson CJ, referred the matter to the Full Court of the Family Court as a case stated in order that the question of law could be settled.⁷ From the Full Court of the Family Court an appeal was taken to the High Court, which heard the matter in April 1991 and gave its decision in May 1992. In subsequent proceedings in the Family Court, Nicholson CJ determined that sterilisation would be in Marion's best interests.⁸

1.11 Before the decision in this case, the law concerning the sterilisation of children had been unclear as a result of conflicting decisions in the Family Court of Australia.⁹ These decisions made it uncertain whether parents had the power to consent to sterilisation procedures on behalf of their children. Only two States, New South Wales and South Australia, have legislated to prohibit sterilisation procedures from being performed on children without a court order.¹⁰

⁵ Discussion Paper para 6.30.

⁶ See para 1.11 below.

⁷ *Re Marion* (1991) 14 Fam LR 427 (Nicholson CJ, Strauss and McCall JJ).

⁸ *Re Marion* (No 2) (1992) 17 Fam LR 336.

⁹ See the review of the authorities in *Marion's Case* at 240-244, and paras 3.16-3.25 below.

¹⁰ See paras 3.48-3.59 below.

1.12 Much legal uncertainty was removed by the decision of the High Court in *Marion's Case*. It held by a majority that the parents or guardians of a child do not have the power in all circumstances to authorise or "consent" to the sterilisation of a child. The High Court distinguished sterilisation as a by-product of surgery proposed for the treatment of some malfunction or disease from treatment of a healthy person to cause infertility, requiring court consent only in the latter instance. This is the distinction between therapeutic and non-therapeutic sterilisation. The Court said:

"We hesitate to use the expressions 'therapeutic' and 'non-therapeutic', because of their uncertainty. But it is necessary to make the distinction, however unclear the dividing line may be."¹¹

Thus the parents of a child can consent on behalf of their child to medical treatment which incidentally causes sterilisation, as long as the treatment is medically necessary. Sterilisation itself, however, is not a medical treatment which can be justified in the same way as treatment for an illness or disease or injury. The distinction between therapeutic and non-therapeutic medical treatment is an important one, about which the High Court judges were themselves divided.¹²

1.13 On the general question of parental authority to consent to medical treatment, the decision in *Marion's Case* settles the law as respects all children. But as regards the specific issue of sterilisation, *Marion's Case* itself and all the other reported cases concerning sterilisation procedures involve intellectually disabled children. There have been no examples of parents seeking to exercise authority to arrange for sterilisation of children who are not so disabled, nor is it anticipated that there is any likelihood that any parents will seek to make such an arrangement.

¹¹ *Marion's Case* at 250. For further discussion see paras 6.7-6.22 below.

¹² The joint judgment of the majority of the High Court (Mason CJ, Dawson, Toohey and Gaudron JJ), which found that parents could not authorise non-therapeutic sterilisation of their child, was at odds with the minority judgments of Brennan J, who rejected any provision for non-therapeutic sterilisation, which in his view could not be authorised by parents or by the court, and McHugh and Deane JJ, who found that in certain circumstances (the details of which differ as between the two judgments) parents could consent even to non-therapeutic sterilisation procedures without court authorisation.

(c) The High Court's recommendation to legislatures

1.14 In determining that it is mandatory for parents to obtain an order of a court for permission to carry out a non-therapeutic sterilisation on an intellectually disabled child, the majority judgment in *Marion's Case* stated:

"[W]e acknowledge that it is too costly for most parents to fund court proceedings, that delay is likely to cause painful inconvenience and that the strictly adversarial process of the court is very often unsuitable for arriving at this kind of decision. These are clear indications of the need for legislative reform, since a more appropriate process for decision-making can only be introduced that way. The burden of the cost of proceedings for parents would in the meantime, of course, be alleviated by the application being made by a relevant public body pursuant to s 63C(1) of the *Family Law Act*."¹³

1.15 This Report reviews the law relating to consent to sterilisation of children and considers in particular the implications of the High Court's decision in *Marion's Case* and how the recommendation of the Court that "a more appropriate process for decision-making ... be introduced" may be implemented in Western Australia.

(d) Public submissions

1.16 Following the High Court's decision in *Marion's Case*, the Commission invited submissions from the public. Advertisements inviting submissions were placed in *The West Australian* and *The Australian*. The advertisement explained that the High Court had decided that parents of children with intellectual disabilities could not consent to sterilisation on the child's behalf, but had to apply to the Family Court for permission. The issue was given considerable media publicity, and a number of television, radio and newspaper interviews were conducted by Commission officers.

1.17 The Commission received a large number of written and oral submissions. An important and substantial proportion of submissions received were from parents. Parents' submissions reflected a range of views. Some believed that their rights as parents should not

¹³ *Marion's Case* at 253. S 63C(1) of the *Family Law Act 1975* (Cth) allows any person who has an interest in the welfare of the child to institute proceedings under the Act. This includes a public body such as, in Western Australia, the DSC or the Department of Community Development. Such public bodies would presumably only make an application if the institution considered that sterilisation was appropriate.

be restricted by any limitation on the medical procedures which they might authorise to be carried out on their children, and that it should be possible for them to consent to sterilisation, even for non-therapeutic or social reasons.¹⁴ Other parents agreed that parental authority should not be limited but took the opposite view about sterilisation; they considered that sterilisation was not a procedure which they would authorise for their children under any circumstances. A view of a third group of parents was more in tune with the High Court's approach. This group considered that the interests of their children might require them to consider sterilisation, but that because the decision was a difficult one, they would welcome advice and information and a process which did not leave the decision solely in their hands.

1.18 The Commission also received substantial and careful submissions from government, non-governmental organisations, representative medical bodies, individual practitioners in the health industry, religious groups and interested individuals. The submissions received are listed in Appendix I.¹⁵

4. CONSTITUTIONAL IMPLICATIONS

1.19 This Report is concerned with the law in Western Australia. However, the law on sterilisation is partly Commonwealth and partly State law. To state it simply, the *Commonwealth Family Law Act 1975* is concerned with children of a marriage. The Family Court of Australia exercises jurisdiction under the *Family Law Act*. Ex-nuptial children are dealt with under State law. State laws can only affect children of a marriage so long as the law is not inconsistent with the Commonwealth Act. These matters, which are of some complexity, are dealt with in Chapter 4.

1.20 Two States, New South Wales and South Australia, have legislation dealing with the sterilisation of children,¹⁶ but in *P v P* the High Court held that the *New South Wales Guardianship Act 1987*, in so far as it purported to prohibit the carrying out of a sterilisation in New South Wales except in accordance with its provisions, was inconsistent with the *Family Law Act* and therefore invalid.

¹⁴ Such a view is directly contrary to the law as laid down in *Marion's Case*. Medical practitioners acting on the consent of parents in such circumstances would be at risk of criminal prosecution and civil proceedings by the child (personally or through the child's guardians).

¹⁵ Where specific submissions from individuals are referred to in the text of the Report, confidentiality is observed by not naming the individuals. The submissions received from public and private organisations are referred to by name.

¹⁶ See paras 3.48-3.59 below.

1.21 In October 1993 the Family Law Council¹⁷ issued a discussion paper dealing with sterilisation and other medical procedures performed on children. This paper reviews the difficulties arising from the overlapping of Commonwealth and State laws in this area.¹⁸ The Family Law Council was due to submit its final report in September 1994.

5. THE ISSUES

1.22 The problem of sterilisation of minors which the Commission has identified for consideration in this Report, and the invitation of the High Court in *Marion's Case* to introduce a more appropriate process for decision-making, raise the following issues for discussion:

- (1) Whether sterilisation of children should be prohibited in all circumstances.
- (2) If there is not to be an absolute prohibition on sterilisation, whether the power to permit sterilisation should be limited, for example to cases where it is necessary to deal with a life-threatening condition, or to cases where it is done for therapeutic reasons; or whether there should be no such limitations, thus making it possible for sterilisation to be permitted even where it is non-therapeutic.
- (3) The principles which determine when permission to sterilise should be granted.
- (4) Whether decisions concerning sterilisation should simply be a matter for the parents or guardians of the child concerned, in the same way as decisions regarding all other forms of medical treatment for non-mature children¹⁹ or whether sterilisation should be regarded as an exceptional case where treatment cannot be carried out unless authorised by some independent body.²⁰

¹⁷ A body established under s 115 of the *Family Law Act 1975*(Cth) to make recommendations concerning the working of the Act and other matters of family law.

¹⁸ Family Law Council Discussion Paper paras 3.25-3.33, 5.01-5.23.

¹⁹ See paras 3.3 and 3.30 below.

²⁰ Under the present law, parents or guardians may make the decision when sterilisation is therapeutic. In cases of non-therapeutic sterilisation court consent is required.

- (5) If sterilisation is to require the consent of some independent body, whether that body should be a court, as required by the present law as laid down by the High Court in *Marion's Case*, or some other kind of tribunal or statutory body.
- (6) Whether the scheme should be limited to children with intellectual disabilities, or should apply to all children.
- (7) Whether the proposed scheme is consistent with the principles under which the Australian Constitution apportions responsibility for matters affecting children between the Commonwealth and the States.

6. CONTENTS OF THE REPORT

1.23 Part I deals with the present law and practice relating to consent to the sterilisation of children, and the problems that have arisen. The present law is dealt with in Chapter 3, and the constitutional difficulties in Chapter 4. Part II examines the issues listed in the previous paragraph and puts forward proposals as to how they might be dealt with by Western Australian legislation. Part III reviews these proposals and other possible alternatives in the light of the constitutional difficulties dealt with in Chapter 4, and sets out the Commission's recommendations.

Chapter 2

THE PRACTICE OF STERILISATION

1. DEFINING STERILISATION

2.1 A sterilisation procedure is one which renders an otherwise healthy and presumed fertile person incapable of being a parent:¹ a woman will be unable to conceive a child, and a man will be unable to ejaculate sperm so as to father a child.

(a) Sterilisation procedures

(i) Female

2.2 The usual method of sterilisation for a woman is tubal ligation.² There are two methods of tubal ligation: laparoscopic ligation and surgical ligation. Other procedures which involve sterilisation are described below.³

2.3 After undergoing a sterilisation procedure, a woman may still carry gametes (mature sexual reproductive cells). But for the procedure, the female gamete (an ovum) could still unite with a male gamete (sperm) to form a fertilised egg. Tubal ligation involves severing or tying the fallopian tubes which would otherwise carry the fertilised egg to the womb for implantation.⁴

(ii) Male

2.4 In the case of male sterilisation only one method is in practical use, that of vasectomy, in which the vas deferens, the duct that conducts sperm from the testis, is cut. After some

¹ That is, in the usual way. Modern reproductive technology can be used to assist women who have been sterilised by tubal ligation to have a child.

² Dr B Roberman, Chairman, Health Care Committee, Royal Australian College of Obstetricians and Gynaecologists, advised the Commission that "Australian women resort to sterilization a lot earlier than a number of places overseas because of the various medical and social factors; we appear to have a very high number of women who regret this and seek tubal reanastomosis." Tubal ligations are the most common cause of medico-legal action: S Bender *Tubal Sterilisation* (1990) *Journal of Obstetrics and Gynaecology* 432.

³ Paras 2.6-2.11.

⁴ In *Re M (A Minor)*. (*Wardship: Sterilization*) [1988] 2 FLR 497 and *Re p (A Minor)* (*Wardship: Sterilization*) [1989] 1 FLR 182, there was some expert evidence to the effect that tubal ligation by occlusion of the fallopian tubes (ie the use of clips) was reversible in a majority of cases.

years sperm ceases to be produced, but the testes continue to produce the male sex hormone testosterone. Sperm produced before production shuts down are viable, but have no way of escaping from the man's body.

(b) Procedures which go beyond sterilisation

(i) Males

2.5 A method of male sterilisation performed from antiquity is castration, being the removal of the testes or male sex organs themselves.⁵ However, this procedure goes beyond sterilisation to affect the sexuality of the male concerned. Performed before puberty, the male does not develop normally since the production of male sex hormone is prevented. Performed after puberty, secondary sexual characteristics may be affected in that the male may cease to grow a beard and may develop breasts. Since the voices of castrated males did not deepen at puberty, in Italy until the 20th century certain male children were castrated in order to provide singers for the 'castrati' parts in Italian opera, and for the Vatican and other church choirs. Oriental rulers employed eunuchs, castrated males, as keepers of their harems.

(ii) Females: ovariectomy

2.6 The equivalent operation on females is removal of the ovaries. The ovaries are the gonads or sex organs, responsible for the production of the ripe ovum each month and the production in the body of the female sex hormones progesterone and oestrogen. These hormones are responsible for the development of secondary sexual characteristics such as breasts, fat and body hair. Because removal of the ovaries has only been possible with modern surgical techniques, there is no equivalent social history of the performance of this surgery on females for reasons which might be equated to those for which it was performed on males. However, removal of the ovaries is a well-known procedure in the treatment of women for gynaecological abnormalities and disease. In sexually mature women, removal of the ovaries causes the immediate onset of the menopause. Removal of the ovaries may result in ovarian hormone deficiency, which would require long-term hormone replacement therapy. This is

⁵ The medical term is orchiectomy.

currently a controversial treatment for menopausal women, and its long-term effects on young women have not been researched.⁶

2.7 Premature menopause caused by ovariectomy may require subsequent treatment to deal with the loss of production of female hormones. Such treatment is controversial. Ovariectomy has not been performed for the purpose of sterilisation (although the surgery has that effect) since a more efficacious method of sterilisation, namely tubal ligation, is available. This does not interfere with the person's sexuality or require subsequent long-term hormone therapy.

(iii) *Hysterectomy*

2.8 Hysterectomy is the surgical removal of the body and cervix of the uterus. The procedure can be effected by three different methods, each quite distinct, with distinctive risk factors and different recovery consequences for the patient.⁷ It is not a sterilisation procedure as such: there are just as effective and far less invasive procedures available, in particular, tubal ligation. However hysterectomy has the effect of sterilising the woman, since she becomes infertile and cannot bear a child, and it also causes the cessation of menstruation. Hysterectomy is indicated as a treatment for major gynaecological pathology.⁸ In the past the procedure was performed on women who had completed childbearing and who were suffering a variety of conditions some of which might be connected to their history of childbearing. The prevalence of this surgery has dropped in recent years,⁹ and a recent report has questioned its long-term effects:

"No research has been identified which investigates the long term effects of hysterectomy ...on young women over a long period time."¹⁰

⁶ *Analysis of Australian Policy* para 2.3.3.

⁷ Abdominal hysterectomy, vaginal hysterectomy and laparoscopic hysterectomy.
⁸ Panel Report 5.

⁹ The procedure was very popular 20 years ago but now "better educated and higher occupational status women are less likely to have a hysterectomy. ...indicating the need to investigate aspects of the decision making process leading to hysterectomy: M J Schofield and others *Prevalence and Characteristics Of Women Who Have Had a Hysterectomy in a Community Survey* (1991) 31(2) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 153, 157.

¹⁰ *Analysis of Australian Policy* para 2.5.5. Early medical treatments of necessity are experimental. It is claimed that the first abdominal surgery was an ovariectomy performed in 1809: P Weideger *Female Cycles* (1977) 60.

2.9 Hysterectomy is not likely to be recommended in cases where there is obesity, poor general health or any other disease, as these factors increase risks:¹¹

"Surgical risks are often surprising to those who do not perform surgery, including physicians in other fields who routinely refer people to gynaecologists for sterilization procedures.

Approximately 1 in every 1,000 laparoscopies (the most common method used today for tubal sterilization) results in some form of major intra-abdominal injury, including perforation of the colon, small intestine, uterus, broad ligament, or other pelvic organs, aorta, vena cava, and iliac vessels. Infections also may occur even after this 'small' operation. The anaesthetic risk for laparoscopy is similar to that with any other procedure requiring general anaesthetic, implying that 1 in every 10,000 patients undergoing general anaesthesia may die from that anaesthesia. Finally, there is a risk of failure of any tubal ligation procedure (between 1 and 3 per 100). ...

Potential complications of hysterectomy are even more serious. If all cases are considered, approximately 1 in every 1,000 people undergoing hysterectomy, for whatever reason, dies from the procedure. ...Haemorrhage rate results in 1 to 3 per 100 persons undergoing hysterectomy requiring blood transfusion, which entail a 2% to 10% risk of exposure to hepatitis types B and C, and a 1 in approximately 158,000 theoretical risk of AIDS transmission. ...The infection risk for hysterectomy ranges anywhere between 5% and 20%, and the rate of injury to surrounding organs is greater than that seen with laparoscopic tubal procedures. The most serious of these is damage to the ureters, occurring in somewhere between 1 in every 100 and 1 in every 200 hysterectomies performed."¹²

2.10 If the purpose of a medical procedure is to effect sterilisation of a patient, then hysterectomy is not the preferred treatment. However, hysterectomy has been used with the intention of causing both sterilisation and permanent cessation of menstruation.

(iv) *Endometrial ablation*

2.11 Another surgical method of causing the cessation of menstruation and, incidentally, sterilisation is endometrial ablation. This involves removal of the lining of the uterus, the endometrium, by searing it with a laser. Menstruation and pregnancy should no longer be possible. The procedure has only been available for a few years.¹³

¹¹ Panel Report 5.

¹² T E Elkins and H F Andersen *Sterilization of Persons with Mental Retardation* (1992) 17 *Journal of the Association for Persons with Severe Handicaps* 19, 24.

¹³ See M Wingfield and others *Endometrial Ablation: An Option for the Management of Menstrual Problems in the Intellectually Disabled* (1994) 160 *Medical Journal of Australia* 533; M Wingfield and others *Gynaecological Care for Women with Intellectual Disability* (1994) 160 *Medical Journal of Australia* 536.

2. THE PRACTICE OF STERILISING THE INTELLECTUALLY DISABLED

2.12 The sterilisation of intellectually disabled people became more acceptable once the survival rates from invasive major surgery improved in the early 20th century.¹⁴ Commentators in the United States have identified three historical phases in policies concerning sterilisation:

"The first was evident early in this century, when state laws encouraged compulsory sterilization of persons who were mentally handicapped, and judicial decisions gave approval to such actions based on eugenic principles and societal interests.

The second phase was marked by growing social disapproval of mandatory sterilization. This became manifest in 1942, when the US Supreme Court proclaimed reproduction to be a fundamental human right. In many jurisdictions this decision initiated legislative and judicial actions that prohibited sterilization of persons with mental disabilities. In 1979 federal regulations denied the use of federal funds for the sterilization of any mentally incompetent person.

" As the third phase of public policy now emerges, widely differing viewpoints are expressed in state laws, which permit sterilization in some cases, prohibit it in others, or most commonly, offer no legal guidance. In each of these phases serious abuses and injustices have been committed: either persons who were objectively capable of parenting but who were incorrectly considered incapacitated were deprived of their procreative rights, or persons for whom pregnancy was a serious burden or harm were denied opportunity for a full range of contraceptive options."¹⁵

2.13 In the early years, public confidence in the sterilisation procedure was such that it came to be regarded as a means of managing the care of the intellectually disabled, and especially for the purpose of preventing them from having their own children. The policy of preventing the "feeble-minded" from reproducing was based on the pseudo-science of eugenics (particularly prevalent in the United States), according to which all intellectual disability was inherited and could thus be passed on from generation to generation. This idea

¹⁴ T E Elkins and H F Andersen *Sterilization of Persons with Mental Retardation* (1992) 17 *Journal of the Association for Persons with Severe Handicaps* 19,19.

¹⁵ American Academy of Paediatrics Committee on Bioethics *Sterilization of Women Who are Mentally Handicapped*, reproduced in Appendix 7 of *Analysis of Australian Policy* (footnotes omitted). See also J Goldhar *The Sterilization of Women with an Intellectual Disability* (1991) 10 *U Tas LR* 157, 161-164; M D A Freeman *Sterilising the Mentally Handicapped* in M D A Freeman (ed) *Medicine, Ethics and the Law* (1988) 55, 56-60.

was held despite the fact that such disabilities appeared in families without any evidence of prior genetic abnormality.¹⁶

2.14 The "science" of eugenics has now been discredited. It has been stated that "[c]urrent studies indicate that as many as 90% of offspring of parents with mental retardation have normal intelligence".¹⁷ There are particular conditions which do have a genetic base, and an individual, whether disabled or not, may seek genetic counselling.¹⁸ However, in spite of the increase in knowledge in this area, a number of submissions received by the Commission demonstrated that many parents were concerned about the possibility that their child's disability might be passed on to any offspring of that child.

2.15 Although the excesses of the United States were avoided in Australia in that there was no specific legislation demanding sterilisation, procedures were performed on adults with the permission of parents or next of kin, where the justifications given for the procedures can now be seen as highly suspect. The procedures were performed for the benefit and convenience of caregivers, rather than the interests of the women concerned.¹⁹

2.16 During the last decade reports and publications have focused attention on the human rights abuses constituted by non-therapeutic sterilisations.²⁰ In the submissions received by the Commission in relation to this reference, a number of commentators referred to the experiences of people working in the field of the intellectually disabled who had come across

¹⁶ T E Elkins and H F Andersen *Sterilization of Persons with Mental Retardation* (1992) 17 *Journal of the Association for Persons with Severe Handicaps* 19, 20.

¹⁷ *Ibid*, referring to M W G Brandon *A Survey of 200 Women Discharged from a Mental Deficiency Hospital* (1960) 106 *Journal of Mental Science* 355; A and M Craft *Sex Education and Counseling for Mentally Handicapped People* (1983) 22-26. According to Elkins and Andersen, as early as 1949 Deutsch had stated that the vast majority of persons with mental retardation (approximately 89%) are born to normal parents: A Deutsch *The Mentally Ill in America* (2nd ed 1949).

¹⁸ M D A Freeman *Sterilising the Mentally Handicapped* in M D A Freeman (ed) *Medicine, Ethics and the Law* (1988) 55, 78 cautions against any concessions to genetic counselling arguments. The practice of genetic diagnosis was discussed by L Sullivan *The Genetic X factor*, *The Bulletin* 2 March 1993, 40. She reviewed practices and comment in Australia and overseas and concluded that screening of fetuses to detect abnormality does not have a high enough rate of certainty of success to justify the destruction of those which were normal. The possible screening to detect Down's Syndrome in fetuses carried by (mothers under 37, she suggested, would result in terminations of more normal pregnancies than those affected by the syndrome.

¹⁹ J Goldhar *The Sterilization of Women with an Intellectual Disability* (1991) 10 *U Tas LR* 157, 177.

²⁰ NSW Anti-Discrimination Board *Discrimination and Intellectual Handicap* (1981); Committee on Rights of Persons with Handicaps (C H Bright Chairman) *The Law and Persons with Handicaps* Vo 2 *Intellectual Handicaps* (1981) (South Australia); *Report of the Minister's Committee on Rights and Protective Legislation for Intellectually Handicapped People* (E Cocks, Chair) (1982) (Victoria); T Carney and P Singer *Ethical and Legal Issues in Guardianship Options For Intellectually Disadvantaged People* (Human Rights Commission Monograph Series No 2 1986).

people who had been sterilised, often when the person concerned was quite young. In some of these cases, there was a firm view that the person who had been sterilised would have been able to care for a child competently, and in some of these cases, the denial of the opportunity to reproduce was a source of great regret to the person sterilised.

2.17 Even as those in authority became more aware of the abuse of human rights in sterilisations carried out on those incapable of consent, parents were continuing to insist on their children being sterilised.²¹ The role which parents have played in this area has been criticised:

"The reason why sterilizations have continued is simple. Hysterectomies, tubal ligations and, to a much lesser extent, vasectomies, have been used as an alternative to education and independence training by parents unable to come to terms with their children's sexuality".²²

3. THE FREQUENCY OF STERILISATION IN WESTERN AUSTRALIA

2.18 In Western Australia, the Disability Services Commission (formerly the Authority for Intellectually Handicapped Persons, also known as Irrabeena) has 5,000 people registered who are eligible for services. Some 1,200 people reside in its facilities (some directly state-owned, others private facilities which are State funded) and some 500 in independent accommodation with support from visiting DSC staff. Respite care for clients who normally live with parents or other family is also provided.

2.19 Not all people on the DSC register receive services from DSC. Some are cared for by private organisations such as the ACTN Foundation which has approximately 3000 members, being families with a disabled member. Other families who have a disabled member have no ongoing contact with a service provider agency.²³

2.20 As far as is known, the number of notified sterilisation procedures carried out in Western Australia is quite low. DSC reports that maybe one sterilisation a year is performed on adult women under its care.²⁴ Health Commission figures indicate that 14 hysterectomies were performed on girls under 20 in Western Australia between 1986 and 1993, a rate of only

²¹ See J Goldhar *The Sterilization of Women with an Intellectual Disability* (1991) 10 U Tas LR 157, 177.

²² Ibid.

²³ Most people who have an intellectual disability have a mild impairment.

²⁴ DSC submission.

about two per year.²⁵ It is not possible to have any certainty as to how often such procedures have been performed in the past or whether the statistics available are entirely accurate.²⁶ However, informed opinion suggests that no hospital authority in Western Australia is likely to allow the performance of sterilisation procedures on a child without ensuring that proper authority has been obtained. Informed opinion also suggests that sterilisations for non-therapeutic reasons are not performed on children in Western Australia.²⁷

2.21 DSC has developed protocols concerned with sexuality and contraception for the intellectually disabled.²⁸ Condom use is promoted as meeting contraceptive requirements as well as concerns in relation to public health.²⁹

4. REASONS FOR STERILISATION

2.22 One reason why people seek sterilisation for intellectually disabled females in their care is the fear that they will become pregnant. In the words of Elkins and Andersen:

"In the case of sterilization requests, family or care providers requesting the sterilization for a person with mental handicaps frequently do so because of the great burden of anxiety and concern that they have regarding the person's chance of becoming pregnant in the future. This is especially true in the case of older parents who know that they will not outlive their child with mental retardation. They fear that their child may one day be sexually abused or enticed into pseudo-consenting sexual activity that would result in pregnancy and a newborn that would then be a burden on some other family or on society. There are situations in which the burden of this anxiety appears to destabilize a family and make them essentially non-functional. Parents may become excessively protective of their children with mental retardation because of these fears, stifling any effort at community integration, socialization, and even normalization to prevent any unwarranted sexual encounter. It is in these instances that physicians may feel that the most compassionate thing to do for an entire family is to proceed with a sterilization of the family member who is mentally

²⁵ See Appendix II, and see also the statistics in Family Law Council Discussion Paper paras 2.17-2.19. Contrast the high incidence of hysterectomies being carried out in Queensland, which was commented upon in *Analysis of Australian Policy* para 4. According to the Health Commission statistics, 105 hysterectomies on girls under 20 were performed on girls in Queensland between 1986 and 1993. Over the same period there were 63 such procedures in New South Wales and 33 in Victoria.

²⁶ Compare the position in the United Kingdom: "Just how many young persons have been sterilised in Britain is something that will never be known": M D A Freeman *Sterilising the Mentally Handicapped* in M D A Freeman (ed) *Medicine, Ethics and the Law* (1988) 55, 59.

²⁷ DSC advice is that, at least over the past five years, no instances are known of non-therapeutic sterilisation of children.

²⁸ Authority for Intellectually Handicapped Persons [now DSC] *AIH Policy on Human Relations and Sexuality Education as it applies to Irrabeena Services*, Information series No 3 (1987).

²⁹ DSC submission.

retarded. It is this kind of decision-making process that is most susceptible to 'sterilization abuse' of persons with mental retardation." ³⁰

2.23 However, it is clear that parents seeking sterilisation orders are not always concerned only with contraception. In particular, parents have been worried about the effect on their daughters of experiencing normal female sexuality and maturity, the commencement and continuation of the menstrual cycle. Some forms of sterilisation, such as hysterectomy, can eliminate menstruation. Menstruation can also be suppressed by chemical means.³¹

2.24 Traditionally, there has been a kind of taboo attached to menstruation. Menstruating women and girls were separated from the rest of the community by customs and practices as part of religious and cultural observances.³² Although menstruation is no longer accompanied by notions of primitive taboo in our society, commentators have suggested that the taboo has been replaced by a silence about the menstrual cycle.³³ This is reflected in the fact that some submissions received by the Commission were ostensibly concerned with the usual reason for sterilisation in the wider community, that of contraception, but revealed an underlying, though often unexpressed, interest in sterilisation as a means of dealing with the difficulties, real or anticipated, of managing their daughter's menstrual cycle.

2.25 The medical profession now acknowledges that menstrual pain is a serious problem for many women and girls. In a review of the medical literature in 1992 it was said that the symptoms of painful periods or dysmenorrhoea are experienced by 60 per cent of women among widely different socio-cultural groups.³⁴ Although it is established that pain associated with the menstrual cycle can be a problem for women and girls, the degree to which women and girls are otherwise affected by their menstrual cycle remains a matter of considerable controversy.

³⁰ T E Elkins and H F Andersen *Sterilisation of Persons with Mental Retardation* (1992) 17 Journal of the Association for Persons with Severe Handicaps 19,23.

³¹ See paras 2.28-2.44 below.

³² Both Judaism and Islam have strict observances in relation to a woman's menstrual period: see S Laws *Issues of Blood: The Politics of Menstruation* (1990) 27, and see also other anthropological data reviewed at 23-25. See also P Weideger *Female Cycles* (1977) 95,197.

³³ See S Golub (ed) *Lifting the Curse of Menstruation: A Feminist Appraisal of the Influence of Menstruation on Women's Lives* (1983).

³⁴ J T E Richardson *The Menstrual Cycle: Cognition, and Paramenstrual Symptomatology* in J T E Richardson (ed) *Cognition and the Menstrual Cycle* (1992) 1, 5.

2.26 Research on the effect of the menstrual cycle is ongoing. A British Psychological Society project³⁵ was concerned to establish whether there is any evidence which could objectively confirm the popularly held view that menstruation has an effect upon a female's ability to carry out normal functions, that is, the degree to which women are subjected in a negative manner to "hormonal fluxes".³⁶ The research confirms that women who suffer period pain have real pain with a physiological and biological basis which can be successfully treated. As regards "hormonal fluxes" during the rest of a woman's menstrual cycle, the researcher commented that most menstruating women tend to experience a variety of physical, psychological, and behavioural changes during the period between ovulation and menstruation. However it is only in modern times that they have been acknowledged to any degree within the general culture or identified by clinicians as a characteristic feature of the premenstrual phase.³⁷

2.27 In spite of research such as this, there is still a widespread assumption that menstruation is somehow different from other medical problems and needs to be dealt with differently. Hayes and Hayes comment:

"Hygienic 'reasons' for sterilisation appear to reflect the medical profession's inadequate knowledge of training in social and self-help skills for retarded people, as well as a general coyness about menstruation. No reasonable medical practitioner would undertake an operation for colostomy because the patient smeared faeces around the house - why is the smearing of menstrual blood considered so much more abhorrent and untreatable by education, conditioning and behaviour modification techniques? The application of the principle of the least restrictive alternative seems tragically ignored in the area of sterilisation."³⁸

5. MENSTRUAL SUPPRESSION

2.28 It has been seen that sterilisation is sometimes sought for the purpose of eliminating menstruation. This is achieved by a hysterectomy, or perhaps by ovariectomy or endometrial

³⁵ See J T E Richardson (ed) *Cognition and the Menstrual Cycle* (1992).

³⁶ In *Marion's Case*, the case stated by Nicholson CJ (quoted at 221) suggested that ovariectomy was necessary, inter alia, to prevent "hormonal fluxes".

³⁷ J T E Richardson *The Menstrual Cycle: Cognition, and Paramenstrual Symptomatology* in J T E Richardson (ed) *Cognition and the Menstrual Cycle* (1992) 1, 6-7.

³⁸ S C Hayes and R Hayes *Mental Retardation: Law, Policy and Administration* (1982) 80. The Law Reform Commission of Canada has noted that, for intellectually disabled females, urinary and faecal control are much more troublesome in terms of personal hygiene than menstruation: Law Reform Commission of Canada *Sterilisation: Implications for Mentally Retarded and Mentally Ill Persons* (Working Paper 24 1979) 34. McHugh J in *Marion's Case* at 321 referred to this point.

ablation. Alternatively, menstruation can be suppressed by chemical means. In such cases, unlike sterilisation, the suppression of menstruation is not irreversible.

(a) Methods of menstrual suppression

2.29 Temporary suppression of menstruation can be brought about by the administration of steroid hormones, either oestrogen and progesterone in combination or progesterone alone.

2.30 The ordinary contraceptive pill is an oestrogen-progesterone combination. For most women, taking the contraceptive pill in the usual way for 21 days out of every 28 will reduce the menstrual flow. If the contraceptive pill is taken continuously, menstruation will be suppressed in most cases.³⁹

2.31 Alternatively, menstruation can be suppressed by the administration of progesterone. The most commonly prescribed drug is norethisterone.⁴⁰ This drug is not approved as a contraceptive but is approved for treatment of several gynaecological conditions including dysfunctional bleeding, pre-menstrual syndrome and endometriosis. A side-effect of this medication is that "there may be androgenic (masculinising) effects in females, eg loss of scalp hair, development of excessive facial hair, acne or changes in libido".⁴¹

2.32 Another drug containing the hormone progesterone is depo-provera.⁴² This is administered by injection every three months.

"It will induce menstrual suppression in 50% of women within 1 year and this incidence increases steadily with prolonged usage. However, a significant minority (10-15%) will experience prolonged or frequent episodes of scanty bleeding."⁴³

³⁹ The Panel Report states:

"[C]ontinuous use of the combined pill was the second most commonly used form of contraception [in the institutions surveyed by the Panel]. Staff were reported as frequently disposed to administer such medication continuously with the additional consequence of menstrual suppression, even though these women were neither sexually active nor presenting with medical conditions requiring hormone therapy or menstrual suppression": Panel Report 8.

⁴⁰ The Panel Report states (at 10) that norethisterone is currently the most common method of menstrual suppression in institutions under the control of Community Services Victoria, and that this has possibly come about because of reduction in the use of depo-provera.

⁴¹ Ibid.

⁴² A depot injectable preparation of medroxyprogesterone acetate (DMPA).

⁴³ Panel Report 11.

This drug is indicated for the treatment of renal, breast and endometrial cancer and endometriosis. In August 1994 it became generally available in Australia as a contraceptive.⁴⁴ Its disadvantages for use as a menstrual suppressant are that it may increase obesity or trigger depression.⁴⁵

2.33 It has been noted that contraceptive preparations available in Australia are quite limited compared to those available elsewhere.⁴⁶ This applies particularly to injectable contraceptives which are regarded as being of limited availability in Australia. Yet depo-provera is registered as a contraceptive in 83 countries and NET-EN (norethisterone oenanthate) in 57 countries. Other injectable contraceptives are widely available overseas. Norplant, a contraceptive treatment whereby long acting progesterone is implanted in tubes giving reliable contraception for five years, is widely used overseas.⁴⁷ Cyclofem, a monthly injectable contraceptive, was in late 1992 expected to become available overseas in the near future.⁴⁸

(b) Current practice

2.34 It is clear that intellectually disabled women and girls may experience special problems in relation to their menstrual cycles. That parents and caregivers have difficulty in coping with the extra support needs of intellectually disabled women and girls at menstruation is no doubt why such woman and girls are sometimes prescribed drugs to suppress menstruation. There have been widespread institutionalised practices which have been based on the belief that menstrual suppression is appropriate management of the menstrual cycles of such females. Such practices are not common in the wider community. Menstrual management practices in the wider community are relevant when considering the menstrual management of the disabled.

⁴⁴ "Contraceptive beats row" *The West Australian*, 29 August 1994.

⁴⁵ Panel Report 11-12. DSC informed the Commission that "The use of Depo Provera is restricted to adults who are capable of consenting. This is a small proportion of women who fear that they will forget to take the 'pill' and seek Depo Provera as a substitute." DSC submission,

⁴⁶ Australia was described as being a Third World country when it came to contraceptive choice and lagging behind by 30 years: *Contraceptive Choices '30 Years behind the Times' The Weekend Australian* 30-31 January 1993.

⁴⁷ Advice of Dr B Roberman, Chairman, Health Care Committee, Royal College of Obstetricians and Gynaecologists, 15 April 1993.

⁴⁸ Data from *International Planned Parenthood Federation International Medical Advisory Panel Statement on Injectable Contraception* (1992) IPPF Medical Bulletin Vol 26 No 6, 4.

2.35 The management of the menstrual cycle of the intellectually disabled has been the subject of guidelines developed by DSC based on the principle that girls can be taught to care for themselves during menstruation.⁴⁹ DSC reports that it follows the advice of the Royal Australian College of Obstetricians and Gynaecologists concerning menstrual suppressants and that depo-provera is only administered to patients who can give appropriate consent. Some DSC clients are subsequently cared for by the general medical community.

2.36 Studies have shown how even a severely disabled child can be trained to care for herself during menstruation.⁵⁰ Submissions received by the Commission relating to the experience of DSC and other agencies suggest that most girls can be taught to care for themselves at the time of menstruation, though many will need major assistance.

(c) Submissions

2.37 A number of those who made submissions to the Commission, including parents and health care professionals, were concerned about the effects and the long-term consequences of commonly prescribed menstrual suppressants. Particular concern was expressed at the use of depo-provera, because it is still considered an experimental drug and its long-term consequences are unknown. Other respondents recounted problems resulting from the use of norethisterone as a menstrual suppressant. Some respondents expressed concern about mood and behavioural swings associated with hormonal changes throughout the menstrual cycle which may make it difficult for girls to manage their own behaviour. Others referred to the fact that many children are currently on other medication to control conditions they suffer. Parents were concerned about long term medication and the possibility of difficulties arising from the child being given a number of medications. More generally, the submissions raised concern that information about the facts and consequences of various treatments is difficult to obtain and that seeking help in dealing with menstrual management is difficult.

2.38 The submissions reveal the complexity of determining a policy for the management of the fertility and menstruation of intellectually disabled people. They suggest that even in institutions which are dedicated to providing the support that intellectually disabled require, menstrual suppression is preferred to giving extra care at menstruation. Most parents reported

⁴⁹ DSC submission, quoted in para 9.17 below.

⁵⁰ See C Llewellyn-Scorey *Training in Menstrual Management*, reproduced in *Analysis of Australian Policy* Appendix 1.

themselves able to care for their children at home, both in protecting them from unwanted sexual intercourse and managing menstruation; their concerns were directed at the child's interaction with the outside community and their placement in institutional care.

(d) The Victorian Panel Report

2.39 In 1992 the Victorian Intellectual Disability Review Panel submitted a report to the Minister for Community Services on the use of menstrual suppressants in Victorian institutions. Such institutions provide long term care for significantly intellectually disabled females. A major finding of the Panel was that there had been blanket administration of drugs causing menstrual suppression to women in institutions who did not require this medication for contraceptive purposes and for whom the medication was prescribed without their consent. The purpose of administering the medication was for the ease of management of the menstrual cycle of the women, that is, for the convenience of the staff caring for them. The Panel found that the drugs depo-provera and norethisterone were being used in Victoria without routine gynaecological screening.

2.40 It was the conclusion of the Panel in its Report that it was illegal to prescribe drugs for women not capable of consent in order to suppress menstruation. The Panel found that suppression of menstruation in these circumstances amounted to a restraint, prohibited under the Victorian *Intellectually Disabled Persons' Services Act 1986*.⁵¹

2.41 The incidence of women having proper medical or behavioural need for menstrual suppression was found by the Panel in its Report to be quite limited.⁵² The Panel recommended that the following factors would need to be satisfied before such medication should be prescribed:

- "1. [T]here is a clearly defined gynaecological illness or condition which requires treatment for which menstrual suppressants are indicated. ..., and

⁵¹ See Panel Report 32-34. The Report points out that s 44 of the Act only authorises the use of restraint in those circumstances where an eligible person causes injury either to herself or other people or persistently destroys property. It is argued that the use of medical and surgical suppressants in circumstances where they are not required for medical reasons may constitute a restraint within this provision. To the extent that no consent is given to such treatment by the women concerned or those in charge of them it would appear that such medical treatment would be unlawful at common law in any event.

⁵² Id 34. The use of menstrual suppressants for behavioural reasons such as "distress at bleeding, hygiene, incontinence, smearing blood" did not constitute justification: id 35.

2. the diagnosis has been made by a general practitioner or gynaecologist/obstetrician, and is a current diagnosis, and
3. the purpose of the medication is to treat the symptoms of the illness/condition rather than behaviours associated with menstruation, and
4. the medication is not used for the dual purpose of (3) above as well as for the purpose of managing or controlling the behaviour of the person."

The Panel said that if any of the four criteria were not met, the medication would constitute a chemical restraint.⁵³

2.42 The Report thus gives a strong focus to the question of providing adequate support for girls and women at times of menstruation, and identifies menstrual suppression practices as being an abuse of the rights of the women and girls concerned. In supporting the principle that intellectually disabled women and girls should not have their menstruation suppressed, either chemically or surgically, unless there are proper medical grounds for this treatment, the Victorian Panel Report validates the requirement that service providers are responsible for providing adequate care for women and girls as it is required at menstruation.

2.43 The recommendations of the Panel Report have been supported by DSC in Western Australia.⁵⁴

(e) Conclusion

2.44 In the Commission's view, there is an important distinction between reversible and irreversible treatment. The Commission's recommendations in this Report are confined to the irreversible elimination of menstruation by surgical means.⁵⁵ However, the Commission is also concerned about the use of chemical means of menstrual suppression, and endorses the views of the Victorian Panel Report that such medication should only be resorted to in limited and carefully controlled circumstances.

⁵³ Id 27.

⁵⁴ Advice 11 February 1993.

⁵⁵ Note the evidence in recent English cases that tubal ligation may be reversible in certain cases: see n 4 above. Nearly all the cases discussed in this Report involve operations such as hysterectomy which are clearly irreversible.

Chapter 3

THE LAW AND THE REGULATION OF STERILISATION

1. INTRODUCTION

3.1 This Chapter reviews the law relating to consent to medical treatment, in so far as it is relevant to decisions about sterilisation.¹ In Western Australia, as in most Australian jurisdictions, there is legislation under which sterilisation of the intellectually disabled or other adults incapable of consent cannot be carried out without authorisation from a court or board. In relation to children, this issue is regulated by the common law as laid down by the High Court in *Marion's Case*.² Only in two States, New South Wales and South Australia, are there specific statutory provisions applicable to children.³ In other countries, the attitude of the law to the problem of consent to the sterilisation of minors varies widely.⁴

(a) Consent to medical treatment generally

3.2 In order to treat a patient within the law a doctor must first obtain the consent of his or her patient. The classic statement of the common law is that of Cardozo J in *Schloendorff v Society of New York Hospital*:

"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, for which he is liable in damages."⁵

3.3 The common law recognises that the power of parents includes the capacity to give consent to medical treatment on behalf of their child.⁶ Historically the law of domestic relations gave a father more or less absolute power over his children, but this power is now recognised as inconsistent with children's rights. However, parental powers are now interpreted as a responsibility to make decisions and to provide generally for children. This responsibility is overtaken once a child becomes mature. Mature children can make decisions

¹ For a general discussion of the law relating to consent to medical treatment, with particular reference to children, see Discussion Paper Ch 2; Discussion Paper Appendix III.

² See paras 3.26-3.33 below.

³ See paras 3.48-3.59 below.

⁴ See Appendix III.

⁵ (1914 NY) 105 NE 92, 93.

⁶ See the discussion in *Marion's Case* at 236-239; see also 290-295 per Deane J, 314-315 per McHugh J.

about medical treatment on their own behalf, even though they have not reached the age of legal adulthood.⁷

3.4 Without the consent of the patient (or the parents of a non-mature child) the actions of a medical practitioner and others involved in medical treatment would generally be in breach of criminal and civil law, and might also involve disciplinary proceedings.

3.5 The major civil remedies available to a person who has been the subject of medical treatment without his or her consent are the three torts of trespass to the person - assault, battery and false imprisonment. These are also crimes.⁸ Assault is conduct by the defendant which causes the plaintiff to apprehend the infliction of bodily harm. Battery is the actual application of force to the person of the plaintiff. False imprisonment is the wrongful detention of a person against that person's will. Battery is the tort which has the most significant role in relation to medical practice:

"If it can be shown that no valid consent protected a procedure, battery can supply a strict liability basis for the compensation of medical mishaps."⁹

3.6 If a child is incapable of consenting, it is the consent of the parents or guardian which excuses liability in trespass. If the child is capable of consenting and does so, then there will be no liability, even if the parents do not consent.

3.7 Where a medical practitioner fails to give the patient sufficient information about the medical procedure and its attendant risks, this may not vitiate the patient's consent so as to give rise to an action for battery, but an action may be brought in negligence.¹⁰ In *Rogers v Whitaker*,¹¹ the High Court considered the information required to be provided by medical

⁷ *Gillick v West Norfolk & Wisbech Area Health Authority* [1986] AC 112, adopted as part of the Australian common law in *Marion's Case* at 237-238.

⁸ See *Criminal Code* ss 313 (common assaults), 333 (deprivation of liberty).

⁹ A M Dugdale and K M Stanton *Professional Negligence* (2nd ed 1989) para 11.64.

¹⁰ See eg *F v R* (1982) 29 SASR 437; *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553. In a recent Victorian case, which was settled without judgment being entered, a medical centre admitted liability to a woman who was mildly to moderately intellectually disabled and who alleged that she had been sterilised without her consent: *Hospital Pays \$90,000 for Forced Sterilisation* *The West Australian* 9 April 1994. In her statement of claim, the plaintiff alleged that she had been taken to the hospital under duress and that the operation was performed without her lawful or informed consent. She claimed that the hospital had failed to ensure that she understood the nature and consequences of the operation, including that it was irreversible, or that consent was provided by someone who lawfully had power to give it. The events took place before the establishment of the Victorian Guardianship and Administration Board in 1986, on which see para 3.9 below.

¹¹ (1992) 175 CLR 479.

practitioners to discharge the duty of care placed on them by the law of negligence. In the following passage the High Court explained the interaction between this obligation and the consent required to negative battery:

"Whether a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often a decisive, role to play; whether the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends upon medical standards or practices [N]o special medical skill is involved in disclosing the information, including the risks attending the proposed treatment. . . .

Anglo-Australian law has rightly taken the view that an allegation that the risks inherent in a medical procedure have not been disclosed to the patient can only found an action in negligence and not in trespass; the consent necessary to negative the offence of battery is satisfied by the patient being advised in broad terms of the nature of the procedure to be performed."¹²

(b) Medical treatment for adults incapable of consent: the special case of sterilisation

3.8 An adult who is impaired, for whatever reason, to the degree that he or she is unable to comprehend the nature of medical treatment which may be required will not be able to give consent to any such treatment. However, where treatment is required in an emergency, a doctor's duty to safeguard life allows treatment without consent.¹³ The *Criminal Code* provides medical practitioners with protection from criminal prosecution for carrying out a surgical operation in such circumstances.¹⁴ The *Guardianship and Administration Act 1990* provides that where urgent treatment of an adult incapable of giving consent is required, a medical practitioner may provide the treatment if the parent or person who apparently has the care and control of the person presented for treatment consents to it.¹⁵ "Urgent treatment" is defined as "treatment that in the opinion of the practitioner concerned is necessary to save the life of the person to whom the treatment is to be given".¹⁶

¹² Id 489-490.

¹³ A M Dugdale and K M Stanton *Professional Negligence* (2nd ed 1989) para 11.73. There is a concept of "implied consent" but this cannot be applied to those who were incapable before the emergency arose. In *T v T* [1988] Fam 52, Wood J granted a declaration that a severely mentally handicapped woman who suffered from epilepsy and had been found to be 11 weeks pregnant should have her pregnancy terminated and at the same time be sterilised. The judge held that although there was no express or implied consent, it was in the woman's best interests that she be treated without delay and, in the exceptional circumstances of the case, the doctors were justified in performing the operation.

¹⁴ *Criminal Code* s 259.

¹⁵ S 119(1).

¹⁶ S 119(4).

3.9 Where it appears that a person is incapable of looking after his or her own health and safety, the Guardianship and Administration Board may make an order for the appointment of a guardian¹⁷ who can give a "substituted consent" to medical treatment on behalf of the disabled adult.¹⁸ An application for the appointment of a guardian may be made by any person who is considered by the Board to have a proper interest in the welfare of the disabled person concerned. Similar procedures are provided in most other Australian jurisdictions.¹⁹

3.10 Sterilisation, dealt with in Part 5 Division 3 of the *Guardianship and Administration Act*,²⁰ is a medical procedure which is specifically prohibited unless performed in accordance with the authority of the Board. The Board cannot consent to a sterilisation procedure unless it is satisfied that it is in the best interests of the person concerned that the procedure be carried out.²¹ Since the definition of sterilisation excludes therapeutic medical treatment which incidentally causes sterilisation,²² the Board's authorisation is required for non-therapeutic sterilisation only.²³

3.11 Section 4(2) of the Act sets out general principles which are to be observed by the Guardianship and Administration Board in the performance of its functions:

- "(a) The primary concern of the Board shall be the best interests of any represented person, or of a person in respect of whom an application or a request for leave to apply is made.
- (b) Every person shall be presumed to be capable of
 - (i) looking after his own health and safety;
 - (ii) making reasonable judgments in respect of matters relating to his person;
 - (iii) managing his own affairs; and
 - (iv) making reasonable judgments in respect of matters relating to his estate,
 until the contrary is proved to the satisfaction of the Board.

¹⁷ S 43(1).

¹⁸ S 45(2)(d) (other than treatment in an approved hospital under the *Mental Health Act 1962*).

¹⁹ *Guardianship and Management of Property Act 1991*(ACT); *Guardianship Act 1987*(NSW); *Adult Guardianship Act 1988* (NT); *Guardianship and Administration Act 1993* (SA); *Guardianship and Administration Board Act 1986* (Vic).

²⁰ Ss 56-63 (Limitations on sterilisation of person under guardianship or where application for guardianship made).

²¹ S 63.

²² S 56 provides:

"procedure for the sterilization' does not include a lawful procedure that is carried out for a lawful purpose other than sterilization but that incidentally results or may result in sterilization".

²³ There is no equivalent limitation in the legislation of the other Australian jurisdictions listed in n 19.

- (c) A guardianship or administration order shall not be made if the needs of the person in respect of whom an application for such an order is made could, in the opinion of the Board, be met by some other means less restrictive of the person's freedom of decision and action."

However, it has been suggested that the general principle in section 4(2)(c) does not apply to Division 3:

"It is arguable that this section is limited in its application to guardianship and administration orders only and therefore does not apply in relation to separate applications for sterilisation."²⁴

3.12 An application to the Board for its consent to the carrying out of a procedure for sterilisation of a represented person can be made by the represented person, his or her guardian or the Public Guardian.²⁵ It is not lawful for a person to carry out or take part in a sterilisation procedure knowing that an application for a guardianship order has been made but not yet determined.²⁶

3.13 Advance notice of a hearing by the Board of an application for consent to carry out sterilisation must be given to the applicant, the represented person, the nearest relative of the represented person, his or her guardian, the Public Guardian, and any other person who, in the opinion of the executive officer of the Board, has a sufficient interest in the proceedings.²⁷ An application to the Board for its consent to the carrying out of a sterilisation procedure is to be heard as a matter of urgency.²⁸

3.14 The Board has now heard a small number of applications for consent to a proposed sterilisation, but has not yet given its consent in any case.²⁹ Directions have been issued by the Chairperson of the Board providing for a minimum of three Board members to be present

²⁴ J Blackwood *Sterilisation of the Intellectually Disabled: The Need for Legislative Reform* (1991) 5 AJFL 138, 163 n 147. By contrast, the *Guardianship and Administration Board Act 1986* (Vic) s. 4(2) provides specifically that:

"It is the intention of Parliament that the provisions of this Act be interpreted and that every function, power, authority, discretion, jurisdiction and duty conferred or imposed by this Act is to be exercised or performed so that

(a) the means which is the least restrictive of a person's freedom of decision and action as is possible in the circumstances is adopted . . .".

The *Guardianship Act 1988* (NT) s 4(a) is practically identical.

²⁵ *Guardianship and Administration Act 1990* s 59(1). The Public Guardian is an office established under s 91 of the Act.

²⁶ S 57(2).

²⁷ S 60(1).

²⁸ S 62.

²⁹ Advice from Public Guardian's Office, 13 October 1994.

at any such hearings, including the Chairperson, a medical member of the Board and one other.³⁰

2. THE STERILISATION OF CHILDREN: MARION'S CASE

(a) The law before *Marion's Case*

3.15 There are no statutory provisions in Western Australia relating to sterilisation of children. Accordingly, the authority of parents to consent to such medical treatment on behalf of their children is governed by the common law.

3.16 The law relating to sterilisation and the question of who might authorise such procedures was unclear before the High Court decision in *Marion's Case*. There were four reported decisions of single judges of the Family Court. *Re Jane*³¹ and *Re Elizabeth*³² decided that a court's authority was required before sterilisation could be performed. *Re a Teenager*³³ and *Re S*³⁴ decided that parents could provide authority themselves without the sanction of a court. The latter authorities were in conflict with authoritative but not binding decisions from overseas, in particular Canada.³⁵

3.17 In the first Australian case, *Re a Teenager*, the next friend of a 15 year old girl with severe mental disabilities applied to the Family Court to restrain her parents from permitting a hysterectomy to proceed. The girl had a mental age of two and a half with no prospect of progressing much further. It was accepted that she would never marry and that a pregnancy would have a detrimental effect on her. For her own sake, any pregnancy would most likely be terminated. The reason given for the proposed procedure was the view that the child's menstruation was likely to have a serious effect on her development and quality of life. In particular, it was alleged that the child had a phobic reaction to blood and that allowing her to experience normal menstruation would possibly involve psychological danger. It was suggested that it would be difficult to control or prevent the child's menstruation with

³⁰ S 56A provides that only the Full Board may make determinations relating to sterilisations. The Full Board means the Board constituted so as to consist of the chairperson or the deputy chairperson, and two other members: s 3(1).

³¹ (1988) 12 Fam LR 662.

³² (1989) 13 Fam LR 47.

³³ (1988) 13 Fam LR 85.

³⁴ (1989) 13 Fam LR 660.

³⁵ In *Re Eve* (1986) 31 DLR(4th) 1, the Canadian Supreme Court held that non-therapeutic sterilisation should not be permitted on those incapable of consent: see Appendix III paras 2-5.

medication or injections and that she would not be able to acquire the necessary skills to manage her menstruation herself.

3.18 In view of the fundamental human rights involved, the Family Court granted an application by the Human Rights and Equal Opportunity Commission to intervene. The Commission has a mandate to protect the rights of children, the handicapped and the intellectually disabled.³⁶

3.19 Cook J observed that the case revealed an intensity and diversity of attitudes and beliefs as to the appropriateness of the proposed operation:

"Among the lawyers, the doctors, the psychologists, the social workers, the teachers and the less qualified but no less interested other persons all involved in presenting this case to the court, disputation reigns. None of this controversy is lacking in genuineness."³⁷

3.20 Deciding the case in favour of parental consent Cook J said:

"[I]t is not legitimate to contend that only a court, such as the Family Court, can make the decision for hysterectomy, made by the parents of the child. So far as the *Family Law Act* is concerned, prima facie thoughtful, caring and loving parents, acting in concert, aided by appropriate medical advice have a right and indeed a duty to make decisions as to medical treatment including major operations in respect to the children of their marriage, whether such children are normal or are mentally handicapped. There must be some clear and obvious factors, over and above those usually attendant on such operative treatment, before any form of interference by the court at the behest of the child or any other person, is justified. To hold otherwise would bring about serious damage to the role and functions of parents caring for children in a family situation."³⁸

3.21 Shortly after this decision, legislation came into effect in New South Wales which removed parental authority and provided that sterilisation had to be authorised by the

³⁶ The *Human Rights and Equal Opportunity Commission Act 1986* (Cth) sets up the Human Rights Commission which has, among other things, responsibility "to inquire into any act or practice that may be inconsistent with or contrary to any human right": s 11(1)(f). The United Nations Declarations of the Rights of the Child, on the Rights of Mentally Retarded Persons, and on the Rights of Disabled Persons are set out in Schedules 3, 4 and 5 of the Act. The United Nations Convention on the Rights of the Child does not form part of Australian law, a matter regretted by commentators: see Hon Justice Nicholson (Chief Judge of the Family Court of Australia) *The Medical Treatment of Minors and Intellectually Disabled Persons - United Nations Convention on the Rights of the Child, Article 23* (Paper given to the First World Congress on Family Law and Children's Rights, Sydney, 4-9 July 1993).

³⁷ *Re a Teenager* (1988) 13 Fam LR 85, 89-90.

³⁸ Id 120.

Guardianship Board or the Supreme Court, and could only be permitted in defined circumstances.³⁹

3.22 Nicholson CJ in the second Australian case to deal with the question of sterilisation of an intellectually disabled child, *Re Jane*,⁴⁰ strongly criticised the judgment of Cook J in *Re a Teenager* for laying "undue emphasis upon the rights of parents in a case in which he was required to regard the child's welfare as paramount".⁴¹

3.23 In *Re Jane* the Acting Public Advocate of Victoria instituted proceedings on behalf of a 17 year old girl (Jane), seeking an injunction restraining her parents from permitting a hysterectomy or other sterilising procedure on her without court approval. On the evidence, Nicholson CJ accepted that Jane had the mental age of a child of two with negligible prospects that she would improve; that physically she suffered from, amongst other things, recurrent urinary tract infections; that she had little language and communication skills and needed assistance for nearly all the normal functions of living including supervision continually during toileting. At the time of the hearing Jane had not yet menstruated, but the court accepted the medical evidence that she would in due course. Nicholson CJ found that Jane would experience great difficulties in coping with menstruation, that she was at risk of sexual assault and unwanted pregnancy, and that she would have no understanding of the connection between the sexual act and pregnancy, pregnancy itself or childbirth. Further, it was found that less invasive methods of contraception such as tubal ligation or pharmacological control would not be appropriate in Jane's case, and that special training programs for menstrual management would not be appropriate and given the medical evidence would not be for her benefit. Nicholson CJ ultimately held that Jane's proposed hysterectomy should be permitted because it was in her "best interests and welfare".⁴² The welfare of the child was to be the paramount consideration.

³⁹ *Guardianship Act 1987* (NSW) (originally entitled the Disability Services and Guardianship Act) Pt 5; *Children (Care and Protection) Act 1987* s 20B. See paras 3.49-3.53 below.

⁴⁰ (1988) 12 Fam LR 662.

⁴¹ Id 687.

⁴² Id 690. Similarly, in *Re a Teenager* (1988) 13 Fam LR 85, Cook J at 130 was satisfied "that the paramount considerations of the child's welfare are best served by operative treatment as distinct from any of the 'alternative' treatments or management proposals". In *Re Elizabeth* (1989) 13 Fam LR 47 Ross-Jones J at 63 held that it was "in Elizabeth's welfare and best interests that the operation should be permitted"; and in *Re S* (1989) 13 Fam LR 660 Simpson J at 670 concluded that "the welfare of S requires the hysterectomy . . . I have had regard to the interference with a fundamental human right and to the consequences to the child by my finding that the prevention (by radical surgery) of the normal process of menstruation is necessary to negate a significant deterioration in the quality of the child's life."

3.24 As to the issue of consent, Nicholson CJ held that:

"[T]he law at least establishes that parental consent is insufficient where a medical procedure involves interference with a basic human right such as a person's right to procreate, unless it is clear that the interference is occasioned by some medical condition which requires such treatment."⁴³

3.25 Nicholson CJ's approach was followed by Ross-Jones J in *Re Elizabeth*.⁴⁴ Simpson J in *Re S*⁴⁵ took a similar view to that of Cook J in *Re a Teenager*.

(b) The High Court's decision in *Marion's Case*

3.26 The law relating to consent to the sterilisation of children is now to be found in the decision of the High Court in *Marion's Case*. In this case the parents of Marion (a 14 year old intellectually handicapped girl) applied to the Family Court for authority to have her sterilised by a hysterectomy and an ovariectomy. The trial judge, Nicholson CJ, referred the case to the Full Court of the Family Court for rulings on the law before deciding whether Marion should be sterilised. In the Full Court⁴⁶ there was a divergence of opinion between the judges as to whether court authority was required before the parents could have the procedure carried out. The Secretary of the Northern Territory Department of Health and Community Services appealed to the High Court, arguing that the guardian of a child has no power to authorise the sterilisation of a child and that an application to a court for authorisation of such an operation was mandatory. The High Court considered and determined the law, but did not decide if the procedure should be performed on Marion, remitting that decision to the Family Court for its determination.⁴⁷

3.27 The High Court decided, by a majority of four to three, that the parents or guardians of a child only have the power to authorise the sterilisation of a child in cases where it is therapeutic, that is, where sterilisation occurs as a by-product of surgery carried out to treat

⁴³ (1988) 12 Fam LR 662, 690.

⁴⁴ (1989) 13 Fam LR 47.

⁴⁵ (1989) 13 Fam LR 660.

⁴⁶ *Re Marion* (1990) 14 Fam LR 427 (Nicholson CJ, Strauss and McCall JJ).

⁴⁷ The Family Court eventually determined the matter in favour of carrying out the sterilisation, concluding that it was in Marion's best interests: *Re Marion (No 2)* (1992) 17 Fam LR 336: see further paras 7.27-7.31.

some malfunction or disease. In cases of sterilisation carried out for other purposes non-therapeutic sterilisation court consent was required.⁴⁸

3.28 As a result of this case, the Registry of the Family Court of Australia made practice directions to provide for a speedy hearing of applications for orders for sterilisation.⁴⁹

(i) *The majority judgment*

3.29 The decision of the majority of the High Court (Mason CJ, Dawson, Toohey and Gaudron JJ) in *Marion's Case* provides the most authoritative statement of the common law in Australia relating to the medical treatment of children and parental rights and powers. The majority said that each person has a right to "personal inviolability".⁵⁰ Medical treatment, to be lawful, must be consented to.⁵¹ Sterilisation was within the category of medical treatment to which a person with full legal capacity can competently consent.⁵²

3.30 The majority confirmed that parental powers to consent to medical treatment on behalf of a child depend on the maturity of the individual child and diminish gradually as the child's capacities and maturity grow.⁵³ This view follows the House of Lords decision in *Gillick v West Norfolk & Wisbech Area Health Authority*.⁵⁴ The majority acknowledged that a child is 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".⁵⁵

3.31 The majority said that it would be wrong to presume that an intellectually disabled child is, by virtue of his or her disability, incapable of giving a competent and operative

⁴⁸ As to the appropriate order, see *A Dickey Form of Relief for Sterilisation of a Child* (1993) 67 ALJ 47.

⁴⁹ See *Family Law Rules* O 23B.

⁵⁰ *Marion's Case* at 253.

⁵¹ Id 234.

⁵² Ibid. Denning LJ (dissenting) in *Bravery v Bravery* [1954] 1 WLR 1169, 1180 held that sterilisation was an unlawful act to which consent gave no defence. The majority in that case (Evershed MR and Hodson LJ) dissociated themselves from his observations.

⁵³ *Marion's Case* at 236-237.

⁵⁴ [1986] AC 112. The High Court was of the opinion that *Gillick* reflects the common law in Australia. In that case it was held that a girl under 16 had the right to seek contraceptive advice and treatment against the express view of her mother. The House of Lords ruled that parental power to consent to medical treatment on behalf of a child diminishes gradually as the child's capacities and maturity grow, and that this rate of development depends on the individual child.

⁵⁵ *Marion's Case* at 237, quoting Lord Scarman in *Gillick* at 189. On these general aspects of the High Court's decision see P Parkinson *Children's Rights and Doctors' Immunities: The Implications of the High Court's Decision in Re Marion* (1992) 6 AJFL 101. For discussion of these issues prior to *Marion's Case* see Discussion Paper Chs 34. In New South Wales and South Australia the matter is governed by legislation: see paras 3.48-3.59 below.

consent to treatment.⁵⁶ In reaching this conclusion the majority acknowledged that the intellectually disabled are not a heterogeneous group and "since most intellectually disabled people are borderline to mildly disabled, there is no reason to assume that all disabled children are incapable of giving consent to treatment".⁵⁷ Thus, the level of understanding required by a child to give a valid consent to medical treatment, even for such a serious operation as a non-therapeutic sterilisation, is potentially within the capacities of a mildly intellectually disabled child.⁵⁸

3.32 Where a child is incapable of making a decision about medical treatment for any reason, including minority, parents or guardians may consent to the treatment on the child's behalf in a wide range of circumstances.⁵⁹ Parental consent, when effective, is an exception to the need for personal consent to medical treatment⁶⁰ However, the majority held that there is an exception to the ability of parents to consent to the medical treatment of their children where the medical treatment involves non-therapeutic sterilisation.⁶¹

3.33 In describing why non-therapeutic sterilisation does not come within the authority of parents to consent to on behalf of their child, the majority referred to the features of a sterilisation procedure which distinguished it from other medical treatment. It noted that sterilisation requires "invasive, irreversible and major surgery"⁶² but that, unlike other surgery, sterilisation is a special case because of the significant risk of making the wrong decision (a risk contributed to by the complexity of the question of consent, the role played by the medical profession in the decision to sterilise, and the fact that the decision might involve not only the interests of the child but also the possible conflicting interests of other family

⁵⁶ *Marion's Case* at 238.

⁵⁷ *Ibid.*

⁵⁸ P Parkinson *Children's Rights and Doctors' Immunities: The Implications of the High Court's Decision in Re Marion* (1992) 6 AJFL 101, 104 notes that strictly, the High Court's discussion of the mature minor rule was obiter in relation to *Marion's Case*, since it was not contended that Marion would be capable of giving informed consent:

"Nonetheless, it was an important step in the reasoning of the majority, since the possibility that an intellectually disabled minor might have the capacity to give a legally valid consent (or to withhold such consent) to medical treatment, was a reason why court approval should be necessary as a procedural safeguard."

⁵⁹ However, the Court noted that the overriding criterion to be applied in the exercise of parental authority on behalf of a child is the welfare of the child: *Marion's Case* at 240. This is a limitation on parental power.

⁶⁰ *Id* 235.

⁶¹ *Id* 249-253. Note *Re L and M* (1993) 17 Fam LR 357 where Warnick J at 359 suggested that it was the fundamental right to personal inviolability which was the basis of the rule that court authorisation is necessary in such cases.

⁶² *Marion's Case* at 250.

members) and because the consequences of a wrong decision were particularly grave, especially because of the resulting inability to reproduce.⁶³

(ii) *The dissenting judgments*

3.34 Brennan J, one of the three dissenting judges, saw no role for a court to play in matters of sterilisation. He found that it was lawful for parents to authorise sterilisation of a child for therapeutic purposes, but that non-therapeutic sterilisations could not be lawfully permitted either by parents or by a court, since a court acting in the place of parents had no greater authority than parents did.⁶⁴

3.35 The other dissenting judges, Deane and McHugh JJ, were prepared to concede a wider scope to parental authority than either the majority or Brennan J. For Deane J,⁶⁵ the scope of parental consent to sterilisation extended not only to cases where surgery was immediately necessary for the preservation of life or the treatment or prevention of grave physical illness, but also to cases involving the sterilisation of a girl where the following conditions were satisfied:

- (1) the child is so profoundly intellectually disabled that she is not and never will be capable of being a party to a mature human relationship involving informed sexual intercourse, of responsible procreation or of caring for a child;
- (2) the surgery is necessary to avoid grave and unusual problems and suffering involved in menstruation which has either commenced or is virtually certain to commence in the near future;
- (3) the surgery must be a treatment of last resort, in the sense that no alternative and less drastic treatment would be appropriate and effective;
- (4) there must be competent medical advice from a multidisciplinary team that the above conditions are satisfied.⁶⁶

⁶³ Id 250-252.

⁶⁴ Id 276-277.

⁶⁵ Id 305.

⁶⁶ Deane J referred to the New Zealand case of *Re X* [1991] 2 NZLR 365 (see Appendix III para 38) as one where these four conditions would be satisfied.

In any other circumstances, court approval would be required. This would include sterilisation for contraceptive purposes.

3.36 McHugh J⁶⁷ suggested that parental consent to sterilisation was valid if it would advance or protect the child's welfare. Sterilisation would only be for the child's welfare if the circumstances were so compelling and likely to endure that they justified the invasive surgery involved. This would be so if failure to sterilise was likely to result in:

- (1) the child's physical or mental health being seriously jeopardised;
- (2) the suffering of pain, fear or discomfort of such severity and duration or regularity that it is not reasonable to expect the child to endure it;
- (3) a real risk that an intellectually disabled child will become pregnant and she does not, and never will, have any real understanding of sexual relationships or pregnancy.

Unlike Deane J, McHugh J refused to regard the categories as closed. He suggested that there might be other analogous categories where the circumstances were so compelling that sterilisation would be for the child's welfare.

(c) Difficulties arising from the High Court's decision

3.37 A decision to undergo a sterilisation procedure would be a most difficult one for a mature adult to make. Detailed information about the procedure and its short-term and long-term consequences would need to be made available to the patient and the patient would have to be able to comprehend the information. It is possible that a very mature and otherwise competent older child would have the same ability as a mature competent adult to understand and comprehend what was involved in the proposed sterilisation procedure. It is highly unlikely, however, that a child with anything less than those qualities would be able to give consent. In practical terms it has even been suggested that no child should receive a non-

⁶⁷ *Marion's Case* at 320-321.

therapeutic sterilisation without the authorisation of a court even if he or she does have sufficient intellectual ability to consent on her behalf. As Parkinson observes:

"For while it is implicit in the judgment that a doctor could accept the consent of a minor with a sufficient degree of intellectual development, (the requirement of court authorisation was only laid down as a safeguard to parents who thought that such an operation would be in the child's best interests), no doctor could be certain that, as a matter of law, the child did have a sufficient degree of intellectual maturity to give an informed consent in relation to so controversial a medical treatment. Because of the uncertainties involved, the High Court insisted on a court authorisation."⁶⁸

The majority of the High Court made specific reference to the necessity for legislative change to provide for the sterilisation of children.⁶⁹

3.38 The High Court did not settle any guidelines on which a decision for sterilisation might be made, beyond the adoption of the "best interests of the child" as the determining criterion.⁷⁰ The Court rejected the narrower approach favoured by the Canadian Supreme Court in *Re Eve*,⁷¹ an approach followed by Brennan J in his minority judgment, which held that non-therapeutic sterilisation should not be authorised by a court and was beyond the power of parental authority.⁷²

(d) Comment on the decisions: Analysis of Australian Policy

3.39 A study by four researchers at the University of Queensland has analysed the policies adopted in Australia in relation to menstrual and fertility management of intellectually disabled women.⁷³ Their report provides a valuable perspective on the cases discussed above. It considered the clinical basis on which sterilisation was sought in those cases.⁷⁴ The evidence which had been put forward to support the case for sterilisation of the children

⁶⁸ P Parkinson *Children's Rights and Doctors' Immunities: The Implications of the High Court's Decision in Re Marion* (1992) 6 AJFL 101, 118.

⁶⁹ See para 1.14 above.

⁷⁰ However, detailed guidelines were proposed by Nicholson CJ when the issue of whether sterilisation was in Marion's best interests was finally determined in *Re Marion* (No 2) (1992) 17 Fam LR 336.

⁷¹ (1986) 31 DLR(4th) 1: see Appendix III paras 2-5.

⁷² *Marion's Case* at 288.

⁷³ *Analysis of Australian Policy*. This report recommended, inter alia, that:

- (1) State Departments of Education and other relevant service provision organisations should design and implement policies on menstrual preparation and management, and associated fertility management and human relations issues (Recommendations 1 and 2).
- (2) The development of approaches which prepare women for menstruation must involve social and educational considerations as well as medical considerations (Recommendation 4).

⁷⁴ It also considered some of the cases from other jurisdictions dealt with in Appendix III.

concerned was examined critically in light of the behavioural knowledge and expertise of the authors.⁷⁵

3.40 The report shows that there is a considerable body of expertise in the management of the intellectually disabled in respect of which evidence in the courts was very limited, if not significantly discounted. It raises serious questions about the experimental nature of treatment of young girls with surgical procedures rendering them sterile which are otherwise only prescribed in carefully established clinical circumstances for the treatment of gynaecological abnormalities and disease.⁷⁶

3.41 The report considered the reasons given for menstrual elimination in the court cases and the assumption that menstruation was a frightening experience. The authors commented that:

"Family members and staff members of young women who have intellectual disability and high support needs, have indicated that many of these young women react neutrally (without apparent distress or confusion), to the onset of their menstruation".⁷⁷

The study discussed possible phobic responses to the sight of blood and referred to research on desensitisation procedures. Though Cook J in *Re a Teenager*⁷⁸ suggested that intervention to dispel fears about blood would not be certain of success, the authors refer to research in which, in each of the 12 cases reviewed by the researchers, the outcome of intervention was successful.⁷⁹

⁷⁵ See also G Carlson and J Wilson *Is Menstruation a Taboo? Managing Menstruation: The Mother's Perspective* (paper given at World Congress of the International Association for the Scientific Study of Mental Deficiency, Queensland, 1992), a study of the circumstances of 30 intellectually disabled women in the light of information given by their mothers, which provides a contrasting group to the children who were the subjects of the court cases.

⁷⁶ "Removal of the ovaries may result in '. . . complete ovarian hormone deficiency with increased risk of ischaemic heart disease and osteoporosis'. . . . Ovarian hormone deficiency would require long term hormone replacement therapy. Hormone replacement therapy is currently a controversial treatment for menopausal women . . . , and its long term effects do not appear to have been researched for young women": *Analysis of Australian Policy* para 2.3.3. "Several research articles suggest possible long term effects of hysterectomy for premenopausal women": id para 2.5.5. See also Panel Report 5: "[H]ysterectomy and endometrial ablation should only be contemplated where necessary to treat major pelvic pathology."

⁷⁷ *Analysis of Australian Policy* para 2.3.1.

⁷⁸ (1988) 13 Fam LR 85, 127.

⁷⁹ *Analysis of Australian Policy* para 2.3.1, referring to H J Jackson *Current Trends in the Treatment of Phobias in Autistic and Mentally Retarded Persons* (1983) 9(4) *Australia and New Zealand Journal of Developmental Disabilities* 191.

3.42 The report stressed the seriousness of removing the ovaries of a young woman. The statement in *Marion's Case* that removal of the ovaries was "to stabilize and prevent hormonal fluxes with consequential stress and behavioural problems"⁸⁰ was not accepted as a reason for surgery which would create a necessity for long term hormone therapy.⁸¹ The evidence given in *Re Marion (No 2)*, when the Family Court finally determined that sterilisation was in Marion's best interests, is a little more specific: it was suggested that ovariectomy would stabilise and prevent hormonal fluxes in the premenstrual stage which would thus reduce seizures and the prospect of brain damage.⁸²

3.43 The authors commented on the fact that ovariectomy may make it necessary for a woman to take daily medication, in the form of artificial (steroid) hormones, over a long period.⁸³ This did not receive much consideration in the judgments in *Marion's Case*. However, more details are available in the judgment of Nicholson CJ in *Re Marion (No 2)*.⁸⁴ He said that hormone replacement therapy could overcome side effects such as interference with the development of sexual characteristics, the risk of osteoporosis and cardiovascular disease. The evidence was that there were no short or long term side effects of such therapy. Epilepsy was a complicating factor in *Marion's Case*.⁸⁵ However, females with epilepsy do not routinely require ovariectomy. There are several cases in which young women suffering epilepsy have been able to take medication for contraceptive and menstrual suppression purposes without aggravating the epilepsy.

3.44 The report discussed how the intellectually disabled experienced menstruation.⁸⁶ The authors considered that the courts had a negative view about the success of skill development in handling menstruation.⁸⁷ It was noted that in each of the cases, reference was made to the "mental age" of the child, but:

"[T]he use of mental age and IQ scores for people who have severe intellectual disabilities has been criticised. . . . These indicators often do not accurately identify the person's current abilities or potential to learn. Mental age equivalents do not take into account previous opportunities for learning and the 'splintering' of skill areas. For

⁸⁰ *Marion's Case* at 221.

⁸¹ *Analysis of Australian Policy* para 2.3.3.
⁸² (1992) 17 Fam LR 336, 343 per Nicholson CJ.

⁸³ *Analysis of Australian Policy* para 2.3.3.
⁸⁴ (1992) 17 Fam LR 336, 353.

⁸⁵ See *Marion's Case* at 221.

⁸⁶ *Analysis of Australian Policy* para 2.3.4.

⁸⁷ *Id* para 2.3.5.

example, social awareness or language comprehension may outstrip self-care skills and verbal language skills."⁸⁸ 8

3.45 The study considered the question whether women and girls who have serious disability should be sterilised so that they do not become pregnant if they are sexually abused.⁸⁹ The report commented:

"The actual chances of an individual woman who has intellectual disability and high support needs becoming pregnant, are not easy to assess. Is it sufficient to assume that an attractive appearance and affectionate behaviour, will lead to pregnancy, as is assumed in several of the cases?"⁹⁰

As it points out, the research suggests that an abuser is likely to be known to the woman⁹¹ and that therefore the risk of abuse is increased if a woman is sterilised.

3.46 The report concluded that evidence in the cases which have been heard by the courts has been dominated by a medical view. It noted:

"In recognition that a disability is not an illness, services for people who have intellectual disability have moved away from a medical model, towards more educational approaches and normalised lifestyle approaches. It appears that content relevant to these changing foci has been absent from medical training curricula. . . . It cannot be assumed that medical professionals have an accurate knowledge of current practices in services to people who have intellectual disability and high support needs on which to base their menstrual and fertility management predictions and advice."⁹²

3.47 The difficult position of parents, and the fact that parents seeking orders for sterilisation from the courts were anticipating problems in management, were recognised.

The report suggested that:

"[C]omprehensive information about all menstrual and fertility management approaches and the possibility of unknown long term effects of surgical or pharmaceutical approaches, does not appear to be readily available to parents [C]ounseling which assists parents to consider their concerns and fears about their daughter's menstruation and potential to become pregnant does not appear to be integrated into service delivery. . . . Some care providers have stated that menstrual

⁸⁸ Ibid.

⁸⁹ Id para 2.4.1.

⁹⁰ Ibid.

⁹¹ See A Chamberlain and others *Issues in Fertility Control for Mentally Retarded Female Adolescents: Sexual Activity, Sexual Abuse, and Contraception* (1984) 73(4) Paediatrics 445.

⁹² *Analysis of Australian Policy* para 2.5.4.

management does not necessarily have to be complicated, time consuming or stressful."⁹³

3. STATE LEGISLATION ON STERILISATION OF CHILDREN

3.48 In most Australian jurisdictions, consent to the sterilisation of children is governed by the common law principles discussed above. Only two States, New South Wales and South Australia, have enacted legislation prohibiting sterilisation of children in similar terms to the prohibitions which apply in respect of adults. The validity of those provisions is now affected by the recent High Court decision in *P v P*.⁹⁴

(a) New South Wales

3.49 In New South Wales there are two statutes which limit the circumstances in which sterilisations may be performed on children. Which statute applies depends on the age of the individual concerned.

(i) Under 16

3.50 Section 20B of the *Children (Care and Protection) Act 1987* prohibits the performance of "special medical treatment" (defined as including any medical treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out⁹⁵) on a child under the age of 16 except by a registered medical practitioner, if the medical practitioner is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child in order to save the child's life or to prevent serious damage to the child's health, or if the Supreme Court consents to the carrying out of the treatment.⁹⁶ However, the Supreme Court can only give consent to the carrying out of such treatment on a child under 16 where it is satisfied that it is necessary to carry out the treatment in order to save the child's life or to prevent serious damage to the child's health.⁹⁷

⁹³ Id para 2.6.

⁹⁴ See paras 4.15-4.19 below.

⁹⁵ S 20B(3).

⁹⁶ S 20B(2).

⁹⁷ S 20B(2A). The level of satisfaction required is the civil onus: *Re M (an infant)* (1992) FLC 92-318. Gee J said at 79,403 that in applying this test he had to have regard "to the care and caution to be exercised in the application of that onus to the extent of what has been called 'comfortable satisfaction' in accordance with the judgment of Dixon J . . . in the case of *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pages 361 and 362".

(ii) *Over 16 but under 18*

3.51 The Guardianship Board established pursuant to the *New South Wales Guardianship Act 1987* has jurisdiction in respect of persons who are incapable of consenting to their own medical treatment⁹⁸ and this jurisdiction includes persons of or above the age of 16.⁹⁹ The objects of the provisions dealing with medical treatment are:

- "(a) to ensure that people are not deprived of necessary medical or dental treatment merely because they lack the capacity to consent to the carrying out of such treatment; and
- (b) to ensure that any medical or dental treatment that is carried out on such people is carried out for the purpose only of promoting and maintaining their health and well-being."¹⁰⁰

3.52 Sterilisation is dealt with by the provisions of the Act which regulate "special treatment", which is defined as including "any treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out".¹⁰¹ Special treatment cannot be carried out unless the Guardianship Board consents,¹⁰² and the Board cannot consent unless it is satisfied that the treatment is necessary to save the patient's life or prevent serious damage to the patient's health.¹⁰³ The only exception to the requirement of Board consent is where a medical practitioner carrying out or supervising the treatment considers that sterilisation is necessary as a matter of urgency to save the patient's life or to prevent serious damage to the patient's health.¹⁰⁴ Except in such circumstances, the sterilisation of children of or above the age of 16 is prohibited.¹⁰⁵

⁹⁸ *Guardianship Act 1987* (NSW) (originally entitled the *Disability Services and Guardianship Act*) Pt 5. Pt 5 is prescribed pursuant to s 60H of the *Family Law Act 1975* (Cth): see Family Law Regulations Schedule 5.

⁹⁹ S 34(1).

¹⁰⁰ S 32.

¹⁰¹ S 33(1).

¹⁰² S 36(1).

¹⁰³ S 45(2).

¹⁰⁴ S 37(1). In addition, s 36(2) provides that once the Board has consented to special treatment, a guardian may consent to continuing or further special treatment if the Board has authorised the guardian to give such consent. This provision applies principally to experimental treatments, which are also defined as "special treatment" by s 33(1).

¹⁰⁵ S 35(1).

3.53 The conditions under which a child of 16 or above may be sterilised are thus broadly the same as for children under 16.¹⁰⁶ The wider test of "best interests of the patient" is excluded by the focus on the need to establish that there must be a risk of serious damage to the patient's health. The New South Wales Board's experience is that it is difficult to establish that serious damage to a person's health would result if no sterilisation procedure were to be performed. It has also been noted that the Board cannot look at a person's capacity to reproduce and at quality of life issues. The Board has approved few, if any, sterilisations of children between the ages of 16 and 18.

(iii) *Procedure before the Board*

3.54 When a person applies to the Board for its consent to medical treatment for the sterilisation of a person unable to consent on his or her own behalf to such a procedure, the applicant with an information sheet on vasectomy, tubal ligation or hysterectomy, as appropriate. These information sheets set out the criteria upon which the Board must decide each case and forewarn the applicant about the type of information which it will require during the decision making process and the matters which it will be taking into account. In each case the Board considers the ability of the person to consent to the treatment, the views of the person about the treatment, the need for it and whether the treatment proposed is the most appropriate treatment.

3.55 Applicants before the Board cannot be represented by a lawyer without the leave of the Board.¹⁰⁷ The Board may grant leave for legal representation in difficult cases where there may be intractable views, but generally people are content to represent themselves once they understand that the Board is concerned to act in the interests of the disabled person, rather than on the basis that one or other of the parties before it wins. In some instances, the Board may refuse a person's request that they be given leave to be represented by a lawyer but the lawyer may be permitted to remain present during the proceedings.¹⁰⁸ The procedure before the Board is informal and non-adversarial.¹⁰⁹ The Investigation and Liaison Branch of the Board must ensure that all relevant witnesses and evidence are before the Board at the time of the hearing. The Branch carries out investigations into all applications to perform

¹⁰⁶ See para 3.50 above.

¹⁰⁷ *Guardianship Act 1987* (NSW) s 58(1).

¹⁰⁸ Julie Lulham, Legal Officer, Guardianship Board (telephone interview 25 March 1993).

¹⁰⁹ See *Guardianship Act 1987* (NSW) s 55. Publication of the proceedings is prohibited: s 57.

special medical treatments for persons with a disability. After an application has been processed in the Registry, the application is allocated to an Investigation and Liaison Officer who liaises with family, friends and service providers who may have an interest in the application. The officer coordinates the provision of assessment reports for the Board and prepares a detailed written report for the Board on the results of the investigation.

(b) South Australia

(i) The law

3.56 Under Part 5 of the *South Australian Guardianship and Administration Act 1993*¹¹⁰ the consent of the South Australian Guardianship Board is required for "prescribed treatment" (which includes sterilisation¹¹¹) to be carried out¹¹² on persons who, by reason of their mental incapacity, are incapable of giving effective consent.¹¹³ The only exception is where there are imminent risks to life or health.¹¹⁴ Failure to comply with this requirement is an offence.¹¹⁵

3.57 The legislation requires the Board to be satisfied that stated conditions have been met before giving its consent:

"The Board cannot consent to a sterilization unless -

- (a) it is satisfied that it is therapeutically necessary for the sterilization to be carried out on the person;
- or
- (b) it is satisfied -
 - (i) that there is no likelihood of the person acquiring at any time the capacity to give an effective consent;
 - (ii) that the person is physically capable of procreation; and
 - (iii) that -
 - (A) the person is, or is likely to be, sexually active, and there is no method of contraception that could, in all the circumstances, reasonably be expected to be successfully applied; or

¹¹⁰ This legislation replaced Part IVA of the *Mental Health Act 1977* (SA) (inserted in 1985). At the date of this Report the *Guardianship and Administration Act 1993* had not been proclaimed, but its proclamation was expected shortly. This Report discusses the South Australian law on the basis that the new legislation is in force. The new legislation does not make any substantive change to the law concerning sterilisation of either children or adults.

¹¹¹ S 3(1).

¹¹² S 61(1).

¹¹³ S 58.

¹¹⁴ S 62.

¹¹⁵ S 61(1).

- (B) in the case of a woman, cessation of her menstrual cycle would be in her best interests and would be the only reasonably practicable way of dealing with the social, sanitary or other problems associated with her menstruation,

and has no knowledge of any refusal on the part of the person to consent to the carrying out of the sterilization, being a refusal that was made by the person while capable of giving effective consent and that was communicated by the person to a medical practitioner."¹¹⁶

(ii) *Procedure before the Board*

3.58 The practice of the South Australian Board under the legislation is to require the following information before making a decision -

- (1) An application form similar to that required by the New South Wales legislation.
- (2) A consent information form, including background information on the subject of the application and detailed information on the reasons for the sterilisation. Matters which may be relevant to the latter were listed as follows -
 - * medical problem;
 - * sexual activity (current level of sexual activity and potential risks);
 - * fertility (evidence of fertility/infertility);
 - * contraception (what has been tried and what are the options available);
 - * menstruation (physical and behavioural management problems);
 - * child rearing skills (ability to care for child);
 - * capacity to improve skills/understanding in any of the above areas;
 - * capacity to consent in the future;
- (3) A medical report.
- (4) If the patient is a female, a report from a specialist gynaecologist.

¹¹⁶ S 61(2).

- (5) Detailed reports, assessments and recommendations from such further medical practitioners, psychologists, educators and social workers as the applicant considers relevant.¹¹⁷

3.59 In relation to every application for sterilisation, the Board has a list of 11 items which it takes into account¹¹⁸ -

- (1) The age of the person.
- (2) The results of a full investigation by competent professionals experienced with the person.¹¹⁹ The Board also usually requires an independent opinion - usually by the Government-funded Family Planning Centre.¹²⁰
- (3) At the hearing the Board must satisfy itself that the patient is incapable of giving consent.¹²¹
- (4) The views of the principal carer. This is usually a parent or the supervisor of a community house. The Board is keen to hear their views in order to get a complete history of the disabled person's menstrual management problems.
- (5) The health of the person and the possibility of physical damage.
- (6) The ability to care for children. The Board considers this to be an aspect of the "best interests" of the person. If the person is unable to care for children and the child has to be taken away, the resulting distress to the person may be disastrous.

¹¹⁷ No substantive departures in terms of practice are expected under the new legislation: advice of Executive Officer, 9 August 1993.

¹¹⁸ Information provided by Carolyn Richards, Chairman of the Board, 3 August 1992.

¹¹⁹ Usually the person is a client of the Department of Disability Services and these reports will be made by the people looking after him or her, at minimal cost.

¹²⁰ The Board will not consider sterilisation until all other options have been considered. The Chairman can only recall two applications relating to children since 1979. By the time a girl starts to menstruate and has tried all alternatives for contraception and menstrual management, it is most likely that she will be an adult. The Board is keen for girls to try depo-provera for three or four years. The use of oral contraceptives is easily discarded as an option for severely disabled persons.

¹²¹ If the patient is nervous, hearings can be held informally. Where the patient can express an opinion, a major concern of the Board is whether he or she is simply parroting other people's opinions. It is not unusual for a doctor to refer these matters to the Board rather than risk making a wrong decision about the ability of the person to consent.

- (7) The sexual activity of the person.
- (8) The ability of the person to reproduce. This is often difficult to assess; Down's Syndrome males have been assumed to be sterile although there has been one recorded case where such a person did father a child.
- (9) That a pregnancy would not be intended by a competent person if in financial and social circumstances similar to those of the person with the disability.
- (10) The likelihood of the person being able to give consent in the future.
- (11) Every opportunity is given to the person to express his or her own views. The Board often has advocates appearing before it - non-lawyers acting on behalf of the person with disabilities.

Chapter 4

CONSTITUTIONAL CONSIDERATIONS

1. DIVISION OF RESPONSIBILITY BETWEEN COMMONWEALTH AND STATES

4.1 As a result of the provisions of the Australian Constitution, there is a large measure of overlap between the respective powers of the Commonwealth and the States in respect of children, but nevertheless some important differences exist.¹

(a) The general position

(i) Commonwealth power

4.2 Commonwealth power to legislate in respect of children is derived from section 51 of the Constitution, which gives the Commonwealth Parliament power to make laws for the peace, order and good government of the Commonwealth with respect to:

"(xxi) Marriage:

(xxii) Divorce and matrimonial causes: and in relation thereto, parental rights, and the custody and guardianship of infants".

4.3 This means that the Commonwealth may legislate only with respect to children of a marriage.² In all other cases, legislation with respect to children is the responsibility of the States. However, it is possible for the States to refer to the Commonwealth the power to legislate with respect to children born outside marriage.³

4.4 In the case of the Territories, the Commonwealth has power to legislate for all children by virtue of section 122 of the Constitution, which gives it power to make laws for the government of the Territories.

¹ See A F Dickey *Family Law* (2nd ed 1990) Ch 2.

² As defined in *Family Law Act 1975* (Cth) ss 4(1) and 60A.

³ S 51 (xxxvii) of the Constitution gives the Commonwealth power to legislate with respect to matters referred to it by the States.

4.5 The Commonwealth has exercised these legislative powers by enacting the *Family Law Act 1975*, which confers jurisdiction in respect of Commonwealth family law matters on the Family Court of Australia. As respects children, the Family Court of Australia is given power to make orders for the custody and guardianship of, and access to, a child of the marriage.⁴ Since 1983 its jurisdiction has been extended to include orders for the protection of the welfare of a child of a marriage.⁵ In *Marion's Case* the High Court confirmed that the Family Court, exercising jurisdiction under the *Commonwealth Family Law Act 1975*, has power to make orders with respect to sterilisation, as orders made in respect to the welfare of a child of a marriage.⁶

4.6 All States except Western Australia have now transferred their powers relating to custody and guardianship of and access to children to the Commonwealth.⁷ The effect of this referral of power is that in relation to custody, guardianship and access one court, the Family Court of Australia, can now exercise jurisdiction over both nuptial and ex-nuptial children, whereas previously jurisdiction over ex-nuptial children had to be exercised by the Supreme Courts of the States. However, there has been no referral of powers relating to the welfare of children, and so there is still no power under the *Family Law Act* to consent to the sterilisation of ex-nuptial children. This contrasts with the position in the Territories, where the Family Court of Australia has full jurisdiction over all children, including jurisdiction to authorise sterilisation.⁸

4.7 The Commonwealth has chosen not to legislate for children in State care. Under section 60H of the *Family Law Act*, the Family Court of Australia, and any other court exercising jurisdiction under the Act, cannot make an order (other than for maintenance) in

⁴ *Family Law Act 1975* (Cth) s 63(1); see also ss 63E-63F.

⁵ *Family Law Act 1975* (Cth) s 64(1), as amended by *Family Law Amendment Act 1983* (Cth) s 29. See *Marion's Case* at 255. See J Seymour *The Role of the Family Court of Australia in Child Welfare Matters* (1992) 21 Fed L Rev 1.

⁶ *Marion's Case* at 254-258. The *Family Law Amendment Act 1983* (Cth) effected a vesting in the Family Court of the substance of the "parens patriae" jurisdiction: id 257. The parens patriae (literally "father of the country") jurisdiction is that possessed by the Supreme Courts of the States and Territories to make orders and give directions in all matters affecting the custody, guardianship and welfare of infants, whether born in or out of wedlock. It is derived from jurisdiction formerly exercised by the Court of Chancery in England. See generally id 279-280 per Brennan J.

⁷ The enabling State legislation is *Commonwealth Powers (Family Law - Children) Act 1986* (NSW); *Commonwealth Powers (Family Law Children) Act 1990* (Qld); *Commonwealth Powers (Family Law) Act 1986* (SA); *Commonwealth Powers (Family Law) Act 1987* (Tas); *Commonwealth Powers (Family Law Children) Act 1986* (Vic). *Family Law Act 1975*(Cth) s 60E(1)-(2) provides that the provisions of Part VII apply to the jurisdiction so referred.

⁸ The jurisdictional provisions in Part VII of the *Family Law Act 1975* (Cth) are made applicable in relation to the Territories by s 60E(3).

relation to a child who is under the guardianship, or in the custody or care and control, of a person under a child welfare law except in stated circumstances.⁹ A child welfare law is a law of a State or Territory prescribed for the purposes of this definition.¹⁰ Nothing in the Act, and no decree made under the Act, affects the operation in relation to the child of a child welfare law.¹¹ As a result, State child welfare legislation relating to such matters as adoption and children's courts continues to apply, notwithstanding that the *Family Law Act* has jurisdiction otherwise broad enough to encompass these areas. The provision which enables State legislation to retain validity notwithstanding the scope of the *Family Law Act* was described in the majority judgment in *Marion's Case* as a "self-imposed limitation".¹² As regards sterilisation, the effect of this provision is that the Family Court of Australia would not make an order authorising the sterilisation of a nuptial child in State care.

4.8 Under the Jurisdiction of Courts (Cross-vesting) Acts passed in 1987 by the Commonwealth and all States and Territories, the Family Court of Australia has and may exercise original and appellate jurisdiction with respect to State matters.¹³

(ii) *State power*

4.9 States have power to legislate for all children, whether born in or out of marriage. However, by section 109 of the Constitution, where there is inconsistency between Commonwealth and State law, Commonwealth law prevails to the extent of the inconsistency. This means that States may legislate for children of a marriage only to the extent that such legislation is not inconsistent with Commonwealth law. This restriction does not apply to laws for the welfare of ex-nuptial children (because the Commonwealth does not have power

⁹ Id s 60H(1).

¹⁰ Id s 60.

¹¹ Id s 60H(2)(e).

¹² *Marion's Case* at 263.

¹³ *Jurisdiction of Courts (Cross-vesting) Act 1987* s 4(2), and similar provisions in the equivalent legislation of the other States; *Jurisdiction of Courts (Cross-vesting) Act 1987* (Cth) s 9(2). In *Re M (an infant)* (1992) FLC 92-318, Gee J in the Family Court of Australia granted an application for the performance of a hysterectomy on a 15 year old girl under the *Children (Care and Protection) Act 1987* (NSW) s 20B (see para 3.50 above), exercising cross-vested jurisdiction under the *Jurisdiction of Courts (Cross-vesting) Act 1987* (NSW) s 4(2). The applicant also relied on the Family Court's welfare jurisdiction, but the judge held that as he proposed to make the order under the cross-vested State jurisdiction it was not necessary or useful to make the order under the welfare jurisdiction. (The case preceded the High Court's decision in *Marion's Case*, and it appears that the judge was influenced by uncertainty as to the existence of the welfare jurisdiction in such circumstances - uncertainty which has now been resolved by the decisions in *Marion's Case* and *P v P*.)

to legislate in this area)¹⁴ or to laws prescribed under section 60H (because the Commonwealth has chosen not to exercise its legislative power).¹⁵

(b) The position in Western Australia

4.10 In Western Australia, the federal family law jurisdiction conferred on the Family Court of Australia by the *Family Law Act* is exercised by the Family Court of Western Australia.¹⁶ This gives that court the power to make orders with respect to custody and guardianship of, access to, and the welfare of, children of a marriage. The Family Court of Western Australia also has the non-federal family law jurisdiction conferred on it by the *Family Court Act 1975* or any other Act.¹⁷ Subject to the *Family Law Act*, this includes jurisdiction in respect of the custody, guardianship of, access to, and welfare of all children, whether children of a marriage or ex-nuptial children.¹⁸ Since there has been no reference of powers in Western Australia, it is under the latter head that the Court has jurisdiction to make orders with respect to ex-nuptial children.¹⁹ The Court thus has jurisdiction over all children in Western Australia.²⁰

4.11 The Supreme Court of Western Australia retains its *parens patriae* jurisdiction, under which it can make orders relating to the guardianship, custody or welfare of infants.²¹

4.12 In the exercise of its federal jurisdiction, the Family Court of Western Australia can authorise the sterilisation of a child of a marriage in accordance with the principles stated in *Marion's Case*. In the exercise of the non-federal jurisdiction conferred on it by the *Family Court Act*, the Court can authorise the sterilisation of ex-nuptial children and children in State care.

¹⁴ See para 4.6 above.

¹⁵ See para 4.7 above.

¹⁶ This is confirmed by *Family Court Act 1975* s 27(1). See A Dickey *Jurisdiction without Tears: A Guide to the Jurisdiction of the Family Court of Western Australia* (1994) 24 UWALR 17.

¹⁷ Id s 27(2).

¹⁸ S 27(2)(b).

¹⁹ The different position in Western Australia as regards ex-nuptial children produces some anomalies, for example where such children are taken interstate, or because ex-nuptial fathers in Western Australia, unlike those in the other States, do not have joint guardianship with the mothers of their children and have no rights in respect of such children unless declared by the court. See A Dickey *Validity of Adelaide Custody Orders for Ex-nuptial Children from Western Australia* (1994) 68 ALJ 526.

²⁰ The *Jurisdiction of Courts (Cross-vesting) Act 1987* (Cth) does not invest the Family Court of Western Australia with the general jurisdiction of the Family Court of Australia. (Compare the position of the Family Court of Australia: see para 4.8 above.)

²¹ See A Dickey *The Supreme Court's Parens Patriae Power in Western Australia* (1993) 67 ALJ 149. See also n 5 above.

2. THE VALIDITY OF STATE LEGISLATION ON STERILISATION OF CHILDREN

4.13 It is clear from the examination of Commonwealth and State powers in the area of family law set out above²² that the States can pass legislation dealing with the sterilisation of ex-nuptial children and State wards. It is less clear whether and to what extent the States can legislate concerning the sterilisation of children of a marriage. Two States, New South Wales and South Australia, have enacted legislation purporting to prohibit the sterilisation of intellectually disabled children without authority.²³ The New South Wales Act provided that sterilisation was permissible only where urgently necessary to save the patient's life or prevent serious damage to the patient's health. Under the South Australian legislation, sterilisation may be authorised in a wider variety of situations, both therapeutic and non-therapeutic, but requires the consent of the Guardianship Board except where there are imminent risks to life or health.

4.14 The constitutional validity of that legislation was uncertain until recently. The issue of inconsistency did not arise in *Marion's Case* because the Family Court of Australia was dealing with a case which arose in the Northern Territory.²⁴ The Court was only concerned with the validity of the Commonwealth law. There was no Northern Territory legislation equivalent to that found in New South Wales or South Australia, and in any case the Family Court of Australia has full power over all children in Territories by virtue of the provisions referred to above.²⁵ The High Court referred to the possibility of conflict between the legislation in New South Wales and South Australia and the *Family Law Act*, but did not have to decide the issue.²⁶

4.15 The issue of inconsistency between State and Commonwealth law in the matter of sterilisation arose directly in the recent High Court case of *P v P*. In this case, the mother of a 16 year old intellectually disabled girl, who had the mental ability of a child of between three and seven years of age, applied to the Family Court of Australia for an order authorising the sterilisation of her daughter. The marriage between the mother and the girl's father had been

²² Paras 4.2-4.9.

²³ See paras 3.48-3.59 above.

²⁴ See *P v P* at 553-554.

²⁵ Para 4.4.

²⁶ *Marion's Case* at 263.

ended by divorce, but the father, though nominally the defendant to the application, indicated that he supported it. The case proceeded on the basis that the medical treatment would be carried out in New South Wales, but neither party had applied to the New South Wales Guardianship Board for an order under the *New South Wales Guardianship Act 1987*. The Chief Judge of the Family Court stated a case for the opinion of the Full Court, and the proceedings were then removed into the High Court.

4.16 The High Court held that States could legislate for the sterilisation of children of a marriage, notwithstanding the provisions of the *Family Law Act*. A majority of the Court (Mason CJ, Deane, Toohey and Gaudron JJ), in a joint judgment, held that the jurisdiction conferred by the *Family Law Act* was intended to coexist with jurisdiction conferred under State laws. State laws could therefore empower some State body to authorise sterilisation. However, such laws could not remove the jurisdiction conferred on the Family Court of Australia by the *Family Law Act*. To the extent that the *New South Wales Guardianship Act* purported to prohibit the carrying out of medical treatment authorised by the Family Court of Australia under the *Family Law Act*, it was invalid.²⁷

4.17 The majority judgment also indicates two other limits to State legislative power:

- (1) A State cannot alter the grounds on which the Family Court of Australia exercises the *parens patriae* jurisdiction conferred by the *Family Law Act*.
- (2) The order of any body invested with State jurisdiction to authorise sterilisation will be invalid if it is inconsistent with any order of the Family Court of Australia acting under the *Family Law Act*.

4.18 The effect of *P v P* is that States may create additional jurisdiction to authorise sterilisation, but they cannot remove or alter the existing powers of the Family Court of

²⁷ McHugh J delivered a separate judgment affirming the propositions endorsed by the majority, but he would have gone a step further: in his view section 63A of the *Family Law Act* evinced a legislative intention that State law could not confer jurisdiction on a State court in matters concerning the welfare of a child of a marriage, and that the jurisdiction conferred on the *New South Wales Guardianship Board by the Guardianship Act* was saved only by virtue of the fact that it was not a "court" when it determined an application. Brennan and Dawson JJ dissented. Brennan J repeated the views he expressed in *Marion's Case* to the effect that the Family Court could not authorise non-therapeutic sterilisation. Both judges held that there was no inconsistency between the *Family Law Act* and the New South Wales legislation, because the jurisdiction of the Family Court with respect to the welfare of a child of the marriage does not extend to those matters placed under the regime established by the State legislation.

Australia under the *Family Law Act*. Therefore, any State attempt to narrow the circumstances in which sterilisation of nuptial children may be authorised by prescribing criteria more restrictive than those applied in *Marion's Case* will be ineffective. The only means by which jurisdiction conferred by the *Family Law Act* could be altered or withdrawn would be by amendment to the *Family Law Act*.²⁸

4.19 The relevant provisions of the *New South Wales Guardianship Act* are prescribed for the purposes of section 60H of the *Family Law Act*.²⁹ However, the child who was the subject of the proceedings in *P v P* was not a child under the guardianship or in the custody or care and control of a person under a child welfare law. It was therefore accepted that section 60H did not exclude the jurisdiction of the Family Court to make the proposed order.³⁰

²⁸ *In Public Guardian v MA*, unreported, Northern Territory Supreme Court, 11 April 1990 (*CCH Australian Health and Medical Law Reporter* para 17-570), Asche CJ rejected an argument that the *Family Law Act* applied to adult children as well as infant children (the term "child" generally being defined in relation to parentage rather than age) and therefore the powers given to Northern Territory courts under the *Adult Guardianship Act 1988* (NT) to authorise the sterilisation of persons of 18 or above were invalid. The case involved an application by the parents of a 19 year old intellectually disabled woman to have her sterilised in view of her difficulty in coping with menstruation and the inappropriateness of her ever becoming pregnant. The parents had been appointed as legal guardians of their daughter under the *Adult Guardianship Act*. The Northern Territory Public Guardian applied to the Northern Territory Supreme Court for a determination of whether the court could make an order under this Act in view of the powers under the *Family Law Act*. It was held that the *Adult Guardianship Act* was the appropriate legislation under which to deal with matters relating to the welfare of a person of 18 or over.

²⁹ Family Law Regulations Schedule 5. The *Children (Care and Protection) Act 1993* (NSW), s 20B of which deals with the sterilisation of children under 16, is also prescribed under s 60H, as is the *Mental Health Act 1977* (SA) (the predecessor to the *Guardianship and Administration Act 1993* (SA), on which see para 3.56-3.57 above). For section 60H see para 4.7 above.

³⁰ *P v P* at 559.

PART II: THE COMMISSION'S IDEAL SCHEME

Chapter 5

INTRODUCTION

1. OUTLINE OF THE SCHEME

5.1 The High Court in *Marion's Case* invited State legislatures to enact legislation introducing a more appropriate process for making decisions about the sterilisation of children.¹ In Part II of this Report the Commission, accepting that invitation, sets out what it sees as the ideal scheme for regulating such decision-making.

5.2 Under the Commission's ideal scheme, decisions about sterilisation would be made by an appropriate decision-making body, in an informal setting. That body would be guided in its decisions by the principle that it should act in the child's best interests. Sterilisation should however only be ordered as a matter of last resort. Except in case of emergency, no sterilisation should be permitted to take place in Western Australia unless permission had been granted by the decision-making body. (This would mean that it would no longer be possible for the Family Court to permit sterilisation.) This scheme of regulation would cover all sterilisations, whether sought for therapeutic reasons or otherwise.

2. ORGANISATION OF PART II

5.3 In Chapter 6 the Commission discusses whether the circumstances in which the sterilisation of children should be permitted should be limited to specific situations or categories. Chapter 7 considers the principles by which sterilisation decisions should be made. Chapter 8 discusses which person or body should make such decisions, and Chapter 9 deals with procedural and other consequential matters.

5.4 The problem discussed in this Report ordinarily arises in relation to intellectually disabled children, and accordingly the Commission's discussion in Chapters 6 to 9 focuses primarily on such children. However, the scheme envisaged by the Commission would

1 *Marion's Case* at 253.

extend to all children and not just the intellectually disabled. This aspect of the scheme is dealt with in Chapter 10.

Chapter 6

WHETHER STERILISATION SHOULD BE PERMISSIBLE

1. SHOULD STERILISATION BE PROHIBITED?

6.1 The first issue is whether the sterilisation of children should ever be permitted in any circumstances. It is only if the conclusion is reached that there are some circumstances where sterilisation may be justifiable that it becomes necessary to discuss issues such as the principles on which the decision should be made, or who should make it.

6.2 In this Chapter the Commission discusses three potential limits on the scope of permissible sterilisation:

- (1) that there should be a total prohibition on sterilisation;
- (2) that sterilisation should be permissible only where it is necessary to deal with a life-threatening condition;
- (3) that sterilisation should be permissible only where it is therapeutic, that is to say, where its purpose is to cure or alleviate some disease or abnormality.

2. A TOTAL PROHIBITION?

6.3 No one advocates a total prohibition on sterilisation. The Commission received a large number of submissions, demonstrating that many individuals and groups saw the issue of sterilisation as one of considerable importance, and wide differences of opinion were evident. However, even those who were most strongly opposed to sterilisation made an exception for sterilisation which is an unavoidable consequence of treatment for a life-threatening illness or disease.¹ The Commission regards this as indicative of the approach to be applied: it recognises that the interest of the child in retaining his or her reproductive capacity can be outweighed by other considerations relevant to the child's welfare. The task of the law is to identify the circumstances where that balance favours sterilisation. It must

¹ Eg the Right to Life Association, Western Australia.

prohibit sterilisation where the justification is insufficient, yet also ensure that the child is not deprived of beneficial treatment because of incapacity to consent.

3. ONLY IN LIFE-THREATENING SITUATIONS?

6.4 The most restrictive view represented in the submissions was that sterilisation should not be permissible except where necessary to save the life of the person concerned. In any other circumstances, it was suggested, sterilisation "is utterly destructive of the intellectually handicapped person's human dignity, and treats them as objects whose rights can be abrogated, including their right to fertility, simply because of who they are".²

6.5 Such arguments suggest that sterilisation is justifiable only where the alternative is death. This would deprive the child of treatment that could enhance his or her overall well-being and dignity. There are cases where sterilisation may be the only effective solution to the problems presented, for example where the problem is the need to cure or alleviate a disease or illness that is not life-threatening, and where the benefit to the child in having that problem solved outweighs the child's interest in retaining his or her reproductive capacity. The decision as to what is beneficial must be made by identifying the applicable principles and carefully considering all the circumstances. Such an approach in no way reduces handicapped persons to the status of objects whose rights can be abrogated simply because of who they are. On the contrary, it focuses on the needs of each particular individual, weighing all the factors in the balance.

6.6 The argument that sterilisation should not be countenanced except in cases where a person is suffering from a life-threatening medical condition is also inconsistent with the policy of the existing law as laid down by the High Court in *Marion's Case*, which permits sterilisation in a much wider range of circumstances, both where it is therapeutic and where it is not. Even Brennan J, one of the dissenting judges, who would have imposed greater limits on sterilisation than the majority, was prepared to accept that therapeutic sterilisations might be justifiable in certain circumstances, and he did not confine his approval to cases where the treatment was necessary to deal with life-threatening medical conditions.³ In its more recent decision in *P v P*, the High Court suggested that the distinction between life-threatening cases

² Submission of the Right to Life Association, Western Australia.

³ See para 3.34 above.

and others would be difficult to apply in a borderline case.⁴ Legislation on the sterilisation of intellectually disabled adults imposes no such limitation,⁵ and even the very narrowly circumscribed legislation on child sterilisation in New South Wales⁶ is not limited to life-threatening medical conditions: it permits sterilisation where it is necessary to prevent serious, but not life-threatening, damage to health.⁷

4. ONLY IF THERAPEUTIC?

(a) The distinction between therapeutic and non-therapeutic sterilisation

6.7 Though it would be inappropriate to limit the ambit of permissible sterilisation to cases where the condition which necessitates the operation is life-threatening, it may be suggested that sterilisation should be allowed only where it is a necessary part of treatment for some other condition. This is the distinction between therapeutic and non-therapeutic sterilisation. Where medical treatment is given and infertility is the consequence of the treatment but is not its primary objective, the treatment is said to be therapeutic, because its aim is the cure or alleviation of some disease or abnormality.⁸ Generally, such treatment will be directed at a disease or abnormality which would have serious consequences for the patient if not treated, for example endometriosis. That sterilisation of the patient may be the result of treatment in such circumstances is regrettable, but in the context of the threat to life or health the fact that sterilisation is a consequence of the treatment is accepted. Where, on the other hand, sterilisation is the primary objective of the treatment, and there is no disease or abnormality, the treatment is said to be non-therapeutic.⁹ In *P v P* the High Court, in discussing this distinction, referred to non-therapeutic sterilisation as "planned sterilisation".¹⁰

⁴ *P v P* at 552.

⁵ See paras 3.10-3.14 above.

⁶ See paras 3.49-3.53 above.

⁷ It should also be noted that under existing law any legislative scheme prohibiting sterilisation, either in all cases or in all cases except those in which it is necessary to treat a life-threatening medical condition, would be ineffective, because *P v P* holds that any State law which seeks to prohibit sterilisation in circumstances in which the Family Court of Australia, exercising the jurisdiction conferred on it by the *Family Law Act 1975* (Cth), can decree that sterilisation is in a child's best interests, is invalid to the extent that it would prohibit such treatment: see paras 4.13-4.19 above.

⁸ See also *Marion's Case* at 250: "[I]n 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." Brennan J defined the distinction in somewhat different terms: id 269.

⁹ An example of a proposed non-therapeutic procedure in another area is that of a South Australian case in which a social worker intervened to prevent the removal of all the teeth of an institutionalised mentally retarded child: *S C Hayes and R Hayes Mental Retardation: Law, Policy and Administration* (1982) 79.

¹⁰ *P v P* at 553.

(b) The present law

6.8 Limiting sterilisation to cases where it is therapeutically necessary would be in line with the law in Canada, as laid down by the Canadian Supreme Court in *Re Eve*.¹¹ It is also the position endorsed by Brennan J in his dissenting judgment in *Marion's Case*.¹² However, it is not consistent with the present law in Australia as laid down by the majority of the High Court in that case. The High Court clearly indicated that both therapeutic and non-therapeutic sterilisations could be authorised in appropriate cases. However, the majority judgment endorsed the distinction between therapeutic and non-therapeutic sterilisation for the purpose of determining whether court proceedings are necessary, ruling that it is only in cases where sterilisation is non-therapeutic that prior court authorisation needs to be obtained.¹³ Two of the dissenting judges, Deane and McHugh JJ, would have gone further and allowed sterilisation without court proceedings in certain cases where it was non-therapeutic.¹⁴

(c) The Commission's view

6.9 The Commission is not in favour of confining permissible sterilisations to those that are therapeutic, for the following reasons.

(i) Difficulties of drawing the distinction

6.10 Some medical treatment is indisputably therapeutic, whilst other medical treatment is indisputably non-therapeutic. In between, there is a grey area in which there is difficulty in determining whether treatment is therapeutic or not. Because there is no clear dividing-line, classifying treatment as therapeutic or non-therapeutic treatment can present problems of considerable difficulty, and for this reason the distinction has been criticised both by lawyers and by doctors. The majority in *Marion's Case* recognised the problems inherent in making this distinction,¹⁵ saying that they hesitated to use the expressions "therapeutic" and "non-

¹¹ (1986) 31 DLR(4th) 1: see Appendix III paras 2-5.

¹² At 269-277. He repeated this view in his dissenting judgment in *P v P* at 565-569.

¹³ Id 250-252. The High Court endorsed the earlier Australian case of *Re Jane* (1988) 12 Fam LR 662, in which Nicholson CJ's conclusion that court consent was required rests on the characterisation of the sterilisation as non-therapeutic: id 689-690.

¹⁴ See paras 3.35-3.36 above.

¹⁵ *Marion's Case* at 250. The majority were referring to the problem of marking off the cases in which sterilisation should require court approval. Despite the problems of making the distinction, they concluded that it was necessary to make it for this purpose. In *P v P* the majority regarded the distinction

therapeutic" because of their uncertainty, and that the dividing line was unclear. Deane J, one of the dissenting judges, suggested that the borderline between therapeutic and non-therapeutic treatment was far from precise and, particularly where psychiatric illness was involved, might be all but meaningless. He considered that surgery involving the sterilisation of a young intellectually disabled girl to avoid the special and aggravated problems of menstruation would not appear to him to be for conventional medical purposes, though it was often described as being for therapeutic purposes.¹⁶

6.11 Medical submissions made to the Commission pointed out the difficulties involved in making the distinction. The Director of Medical Services at King Edward Memorial Hospital said:

"There are two other features of the High Court decision [in *Marion's Case*] which we feel require either change or refinement. The first is the difference that is made between sterilisation as a procedure itself, and sterilisation as a result of another medical procedure. The reality of the situation often is that intellectually handicapped girls have difficulty with personal hygiene associated with menstruation and with avoiding pregnancy. The operation of choice to cover both these conditions is a hysterectomy. The medical staff are unsure in this case which is the major indication and thus we are unsure as to whether Family Law Court or parental consent is required."

6.12 It is true that the existing law employs the distinction:¹⁷ at common law, the parents of a child can consent to therapeutic sterilisation, but not where it is non-therapeutic.¹⁸ A similar rule applies to the guardian of an intellectually handicapped adult under the *Guardianship and Administration Act 1990*.¹⁹ But in borderline cases, it is possible to seek the authorisation of a court whose powers are not circumscribed by the distinction. In other words, the problem of the "grey area" is overcome by referring the matter to a body whose power is not defined by reference to the distinction.

as "more precise" than that between treatment necessary to save life or prevent serious damage to health and other cases: *P v P* at 552.

¹⁶ Id 296-297. Note however *Re K* and *Public Trustee* (1985) 19 DLR(4th) 255 (cited with approval in *Re Eve* (1986) 31 DLR(4th) 1, 22) where a court ordered that a hysterectomy be performed on a seriously retarded girl on the ground that it was therapeutic. The chief factor in this decision was the child's alleged phobic aversion to blood, which it was feared would seriously affect her when she began to menstruate. This case was followed in *Re X* [1991] 2 NZLR 365, where the court held that a hysterectomy to prevent menstruation was justified.

¹⁷ "The distinction between therapeutic and non-therapeutic is well known to medicine, medical law and medical ethics": I Kennedy *Patients, Doctors and Human Rights* in R Blackburn and J Taylor (eds) *Human Rights for the 1990s: Legal Political and Ethical Issues* (1991) 81, 102.

¹⁸ See paras 3.26-3.33 above.

¹⁹ S 56.

6.13 This solution is employed in practice. In the advice given by the Royal Australian College of Obstetricians and Gynaecologists to its members prior to *Marion's Case*, the College recommended that they should not rely on making a distinction between therapeutic and non-therapeutic sterilisation to determine whether court approval should be obtained when a hysterectomy is proposed to be performed, but should obtain court approval in all cases except where surgery was required in life-threatening circumstances.²⁰

6.14 The difficulty of making a distinction between therapeutic and non-therapeutic sterilisations was also commented on critically in the DSC submission, in which it was suggested that there were likely to be differences of view on what was therapeutic. For example, some doctors might argue that a hysterectomy to treat heavy bleeding was therapeutic.

6.15 The prospect of difficult borderline cases might not in itself be sufficient reason for rejecting the view that sterilisation be permitted only if therapeutic. However the Commission considers that the problem of defining the concept in such a way that it is clearly understood and consistently applied is one factor weighing against drawing the line in these terms.

(ii) *There are cases where sterilisation for non-therapeutic reasons is justifiable*

6.16 To permit sterilisations only when they are justifiable for therapeutic reasons would be too restrictive a policy to adopt. In the Commission's view, it cannot be assumed that a child's welfare will be enhanced only where sterilisation is therapeutically necessary. There are going to be cases, such as *P v P*,²¹ where the argument for sterilisation does not rest on the need for therapeutic treatment, but on problems such as those resulting from menstruation or the need to avoid pregnancy, which pose special difficulties for intellectually disabled girls and women.

²⁰ Provided to the Commission by Dr B Roberman, Chairman, Health Care Committee, Royal Australian College of Obstetricians and Gynaecologists. This advice has been under review since the High Court decision in *Marion's Case*.

²¹ See also *Re L and M* (1993) 17 Fam LR 357, paras 7.32-7.36 below.

6.17 This of course is not to say that sterilisation should be the accepted procedure in such cases. On the contrary, great caution should be exercised before resorting to sterilisation as the solution to the problem. There are two considerations which the Commission sees as particularly important here.

6.18 The first is that decisions about sterilisation should be seen to uphold the principle of equality in the provision of medical treatment. An intellectually handicapped child has the right to be treated the same as other children to the greatest extent that his or her condition permits. This right is upheld by two United Nations Declarations, the Declaration on the Rights of Mentally Retarded Persons²² and the Declaration of the Rights of the Child,²³ and the United Nations Convention on the Rights of the Child.²⁴ Even though these instruments recognise that intellectually handicapped children have special needs,²⁵ they endorse the principle of treating them equally with those who are not so disabled.²⁶ International conventions do not become a part of Australian domestic law until specifically so incorporated by domestic legislation, even though Australia has ratified the convention.²⁷ Nonetheless, these important statements of principle constitute compelling arguments in favour of treating intellectually disabled children in exactly the same way as all other children, to the greatest extent that it is possible to do so.

²² Australia became a signatory on 20 December 1971.

²³ Australia became a signatory on 20 December 1959.

²⁴ Australia became a signatory on 20 November 1989. See Hon Justice Nicholson *The Medical Treatment of Minors and Intellectually Disabled Persons - United Nations Convention on the Rights of the Child*, Article 23 (Paper given to the First World Congress on Family Law and Children's Rights, Sydney, 4-9 July 1993).

²⁵ Principle 5 of the Declaration of the Rights of the Child provides:

"The child who is physically, mentally or socially handicapped shall be given the special treatment, education and care required by his particular condition."

Article 23(2) of the Convention on the Rights of the Child deals with the rights of mentally or physically disabled children to special care and the right of their caregivers to appropriate assistance. Article 23(3) says that such assistance should be provided free of charge, whenever possible, taking into account the financial resources of the parent or others caring for the child, and that it: "shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child achieving the fullest possible integration and individual development, including his or her cultural and spiritual development."

²⁶ Item 1 of the Declaration on the Rights of Mentally Retarded Persons provides:

"The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings."

Article 23(1) of the Convention on the Rights of the Child provides:

"States Parties recognise that a mentally or physically disabled child should enjoy a full and decent life in conditions that ensure dignity, promote self-reliance, and facilitate the child's active participation in the community."

²⁷ See *Young v Registrar, Court of Appeal (No 3)* (1993) 32 NSWLR 262, 272-274 per Kirby P. The Declaration of the Rights of the Rights of the Child and the Declaration on the Rights of Mentally Retarded Persons are contained in Schedules 3 and 4 of the *Human Rights and Equal Opportunity Commission Act 1986* (Cth), but this is not sufficient to incorporate them into Australian domestic law.

6.19 Inevitably, it is only in respect of intellectually disabled children that sterilisation is likely to be sought. Children who are not intellectually disabled would not be sterilised except where such a procedure was necessary to deal with a life-threatening medical condition. No one has argued that sterilisation procedures should be carried out on healthy children of full intellect, or physically disabled children of full intellect; or that such procedures would be lawful in such circumstances.²⁸ Since there would be no question of non-therapeutic sterilisation for a normal child, intellectually disabled children should not be sterilised for non-therapeutic reasons unless there is no possible alternative.

6.20 The second consideration is that decisions to sterilise intellectually disabled children, when considered in the light of their subsequent history, have sometimes been incorrect, as submissions made to the Commission confirm. There are people who underwent sterilisation at a time when the opinion of those around them was that they were disabled to the extent that this procedure was in their interests, and that such people would not have the capacity to consent for themselves. Subsequent events showed that this assessment of the individuals was wrong. These experiences illustrate that decisions to sterilise, even though well-meaning, sometimes have very unfortunate results because the procedure can never be undone.

6.21 Sterilisation should thus be permissible only in cases in which the principles discussed by the Commission in Chapter 7 are satisfied. The onus on those seeking to justify sterilisation should be heavy, especially in cases where it is non-therapeutic.

(d) Utility of the distinction

6.22 For the reasons stated, the Commission is not in favour of prohibiting non-therapeutic sterilisations. However, it is inevitable that in the course of identifying the principles that govern whether sterilisation is in the child's best interests, therapeutic and non-therapeutic sterilisation will require separate analysis. Chapter 7 thus draws a distinction for some purposes between sterilisations that are indisputably therapeutic and those that are not. The difficulty in borderline cases is met by providing that unless the decision-making body is

²⁸ In *Marion's Case* the majority judgment (at 240) referred to the example of parents having a child's foot cut off so the child could earn money begging. The High Court suggested that this would be beyond the limits of parental authority, because parents could only authorise medical treatment which was in the child's best interests.

satisfied that the procedure is clearly therapeutic, it can only authorise sterilisation if the more stringent requirements for non-therapeutic cases are carried out.

6. CONCLUSION

6.23 The Commission therefore concludes that a legislative scheme regulating the sterilisation of children should not seek either to prohibit all such sterilisations or to regulate them by a process of categorisation, whether by reference to concepts of danger to life or therapeutic treatment.

Chapter 7

PRINCIPLES BY WHICH THE DECISION SHOULD BE MADE

1. INTRODUCTION

7.1 Under the Commission's ideal scheme, sterilisation would not be permitted except with the permission of an appropriate decision-making body. In Chapter 6 the Commission proposed that the cases in which sterilisation should be permissible should not be limited by reference to particular categories, such as the distinction between therapeutic and non-therapeutic treatment. However, decisions about sterilisation need to be made in accordance with principles which will ensure that all relevant factors are taken into account, and that sterilisation is permitted only in cases where it is really necessary and is the most desirable alternative from the point of view of the child's interests. In this Chapter the Commission makes proposals as to what those principles should be.

7.2 The Commission proposes that the key principle governing such decisions should be the child's best interests. It is implicit in this principle that sterilisation should not be permitted except as a matter of last resort.

2. BEST INTERESTS

(a) The best interests principle

(i) *The present law*

7.3 Under the existing law, decisions about sterilisation are made according to what is in the child's best interests. *Marion's Case* made it clear that this was the appropriate test, whether the decision was the responsibility of parents or of an independent body such as a court. The majority, who confined the parental role to cases involving therapeutic sterilisations, said that parental authority to make decisions on behalf of the child was limited to matters which were in the child's best interests.¹ Courts, who were responsible for making the decision in all other cases, likewise had to decide whether, in the circumstances of the

¹ *Marion's Case* at 240.

case, it was in the child's best interests.² Two of the dissenting judges, Deane and McHugh JJ, who would have conceded a greater scope to parental authority, stated that this authority was limited to acts which would protect and advance the welfare of the child.³ Brennan J, the other dissenting judge, also recognised that courts making decisions about children had to discover what was in the child's best interests.⁴

7.4 The proposition endorsed in *Marion's Case* is a well-established test which courts dealing with children have followed for many years. The best interests principle was the foundation of the *parens patriae* jurisdiction over children exercised by courts of equity.⁵ The High Court recognised that the welfare jurisdiction given to the Family Court of Australia by the Commonwealth *Family Law Act 1975* was essentially similar in nature to the *parens patriae* jurisdiction, and that the governing principle was the child's best interests.⁶

7.5 Legislation conferring guardianship jurisdiction over adults with disabilities generally provides for courts or boards making decisions about medical treatment for such persons to apply the best interests principle. The *Western Australian Guardianship and Administration Act 1990*, for example, provides:

"The Board may, by order, consent to the sterilization of a represented person if it is satisfied that the sterilization is in the best interests of the represented person."⁷

In addition to these specific provisions about medical treatment, guardianship legislation lays down general principles under which courts or boards exercising jurisdiction under the legislation are to operate.⁸ Such tribunals are generally required to act in the best interests of the represented person. The South Australian legislation, which applies in similar terms to adults and children who suffer from mental incapacity,⁹ expressly adopts a best interests principle in relation to sterilisation for menstrual management purposes: the Guardianship

² Id 259.

³ Id 295, 301 per Deane J, 316, 320 per McHugh J.

⁴ Id 270.

⁵ See Ch 4 n 6.

⁶ *Marion's Case* at 258-259.

⁷ S 63(1). See also *Guardianship and Management of Property Act 1991* (ACT) s 70(1)(c); *Adult Guardianship Act 1987* (NT) s 21(8); *Guardianship and Administration Board Act 1986* (Vic) s 42. The *Guardianship Act 1987* (NSW) s 44 (1) requires the Board to be satisfied that the treatment is "appropriate".

⁸ *Guardianship and Administration Act 1990* s 4; see also *Guardianship and Management of Property Act 1991* (ACT) s 3; *Guardianship Act 1987* (NSW) s 4; *Adult Guardianship Act 1988* (NT) s 4; *Guardianship and Administration Board Act 1986* (Vic) s 4(2).

⁹ *Guardianship and Administration Act 1993* (SA) s 58.

Board must be satisfied, inter alia, that cessation of a woman's menstrual cycle would be in her best interests.¹⁰ However, there is no equivalent provision applying to sterilisation for contraceptive purposes.¹¹

7.6 Much other legislation concerning children expressly adopts the best interests principle,¹² and this principle also underlies international conventions such as the Convention on the Rights of the Child. Article 3(1) provides:

"In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration."

(ii) *The Commission's view*

7.7 The Commission affirms the approach generally taken by courts and other bodies which have to make decisions affecting the welfare of children. Under its proposed scheme, the most important principle that should be applied in determining whether sterilisation of a child should be permitted is whether it is in the child's best interests. In this and the next two sections of this chapter the Commission discusses the application of this principle.

(b) The interests of the child and the interests of others

(i) *The present law*

7.8 Regarding the best interests of the child as paramount necessarily means excluding the interests of others, except to the extent that they have a bearing on the child's interests. This was emphasised by Brennan J in his judgment in *Marion's Case*. He said that taking into account outside influences, such as the interests of those who bear the burden of caring for the child, would tend to distort a dispassionate and accurate assessment of the true interests of the

¹⁰ S 61(2)(b)(iii)(B).

¹¹ See s 61(2)(b)(iii)(A). The *Guardianship Act 1987* (NSW), which applies both to adults and children of 16 or over, prohibits sterilisation of children except where it is necessary to preserve life or prevent serious damage to health. There is therefore no room for a best interests test.

¹² Eg *Child Welfare Act 1947* s 47B(3); see also *Family Court Act 1975* s 28(2). See *Marion's Case* at 269-270 per Brennan J.

child.¹³ In his view, the best interests test necessarily identified the child as the person whose interests are in question, and excluded outside factors.¹⁴

7.9 Recent cases show that this is the way in which the best interests test is being applied by the Family Court of Australia. In *Re Marion (No 2)*,¹⁵ Nicholson CJ, in the course of deciding whether sterilisation would be in Marion's best interests, considered (inter alia) the argument that the carrying out of the proposed procedures would make Marion easier to care for. He said:

"Without wishing to diminish the validity of these concerns on the part of the parents, it must be remembered that these are proceedings where the welfare of the child is paramount. As I said in *In Re Jane . . .*, the decision cannot be made to suit the convenience of caregivers, however valid their concerns may be. . . . However it may be valid to take such matters into account in circumstances where the caregivers may be unable to continue to care for the child if the procedure is not carried out. In such circumstances it may be that the welfare of the child could require the carrying out of such a procedure if the alternative were the institutionalisation of the child or the absence of any other caregiver It is however unnecessary to consider this question in this case."¹⁶

7.10 In *Re L and M*,¹⁷ Warnick J held that applying the principle that the best interests of the child was the first and paramount consideration did not exclude other considerations, but merely subordinated them. Other considerations, such as the wishes of the parents, were simply factual matters to which a value would be ascribed, depending on the facts of the case. But all other facts and values had to be viewed from the perspective of the best interests of the child. This interpretation was inspired not only by the statements of the majority in *Marion's Case* but also those of Brennan J.

(ii) *The Commission's view*

7.11 Some submissions made to the Commission suggested that the person or body responsible for making decisions about sterilisation should take into account not just the best interests of the child but also the interests of others, such as family members or the

¹³ *Marion's Case* at 272.

¹⁴ Id 270.

¹⁵ (1992) 17 Fam LR 336. For further discussion of the case see paras 7.27-7.31 below.

¹⁶ Id 352-353.

¹⁷ (1993) 17 Fam LR 357, 371-372. For further discussion of the case see paras 7.32-7.36 below.

community. The quality of life of the child was considered by a number of parents and siblings to be directly related to the quality of life of the family as a whole.¹⁸

7.12 The extra demands which care of the disabled exact from a family cannot be underestimated. Some families may be more stoic than others, but no judgment can be made which underestimates the contribution families make to the care of their disabled family members. However, in the Commission's view the governing principle that sterilisation must be in the best interests of the child necessarily excludes the taking into account of the interests or circumstances of others, except to the extent that they have a bearing on the incapacitated person's individual interests.

7.13 The Law Commission in its Consultation Paper on mentally incapacitated adults came to the same conclusion. It said:

"The concern that the sterilisation of incapacitated women might be prompted by the convenience of those caring for them is one of the reasons why safeguards are desirable before such operations are carried out. Similar considerations may apply in cases such as organ donation, or hysterectomies for the purpose of menstrual management. In more routine cases it may be right to stress that if the interests of others are involved they should be recognised openly. However, we find it difficult to see how to acknowledge this where it is inevitable, without encouraging it where it is not. We consider that the interests of other people should be relevant only to the extent that they affect the interests of the patient."¹⁹

3. APPLICATION OF THE BEST INTERESTS TEST: THE ISSUE OF CAPACITY

(a) Capacity to give informed consent

7.14 An issue of prime importance in the assessment of best interests in cases involving the proposed sterilisation of a child is whether the child has capacity to give informed consent.

¹⁸ A particular concern of some respondents was the effect of menstrual management of their disabled child on the family - including the embarrassment caused by the inability of the child to maintain an appropriate level of hygiene in the company of others, and the inability of the parents and others to assist.

¹⁹ Law Commission Consultation Paper para 3.58.

(i) *The present law*

7.15 It is a fundamental principle of medical treatment that it should not be administered without the consent of the patient. This principle applies in the case of all patients, both adults and children. Adults can of course give consent in person, and some children can also consent in person: the High Court in *Marion's Case*²⁰ affirmed the principle laid down by the House of Lords in *Gillick v West Norfolk & Wisbech Area Health Authority*²¹ that a mature minor can consent to medical treatment on his or her own behalf.

7.16 The High Court recognised that an intellectually disabled child was not by reason of that intellectual disability automatically incapable of consenting to medical treatment on his or her own behalf.²² It pointed out that there are degrees of intellectual disability, and that many children who are on the borderline or only mildly intellectually disabled can consent to at least some forms of medical treatment. The High Court, it seems, contemplated that this principle would hold good even where the medical treatment in question was a sterilisation procedure, although cases in which an intellectually disabled child nevertheless has a sufficient understanding and intelligence to understand fully the nature and implications of a proposed sterilisation are likely to be exceedingly rare.²³

7.17 Where a child does not have capacity to consent to the medical treatment proposed, due either to immaturity or intellectual disability, the child's parents or guardians can ordinarily consent on his or her behalf. However, *Marion's Case* made it clear that there are some kinds of medical treatment, such as a non-therapeutic sterilisation, which require the

²⁰ At 237-238.

²¹ [1986] AC 112.

²² This conclusion is also supported by a recent Victorian case in which a hospital agreed to pay damages to an intellectually disabled woman who was sterilised without her lawful or informed consent: *Hospital pays \$90,000 for forced sterilisation* *The West Australian* 9 April 1994 (see Ch 3 n 10). A doctor who made a submission to the Commission commented on the issue of consent in relation to the treatment of the intellectually disabled as follows:

"The issue of treatment of any kind for people with intellectual disabilities is beset with difficulties, as a doctor cannot treat anyone, except in the case of life threatening emergency, without the patient's fully informed consent. In some illnesses, the treatment is standard, and the benefits of therapy far outweigh the risks. It may therefore be fairly easy to explain what treatment is thought to be best, and the person with an intellectual disability may well understand enough to give fully informed consent. Also, the family or legal guardian may well be happy with the proposed therapy, so there is no dispute, and no challenge, legal or otherwise, of the doctor's plan of treatment. . . . Community and professional representatives should make such major decisions on behalf of a person with an intellectual disability only if that person is unable, after long-term education and counselling, to make the decision for him/herself and to give fully informed consent."

²³ See P Parkinson *Children's Rights and Doctors' Immunities: The Implications of the High Court's Decision in Re Marion* (1992) 6 AJFL 101, 118, quoted at para 3.37 above.

consent of a court rather than a parent. It is in this context that a court may be called on to decide whether sterilisation is in a child's best interests. The importance of capacity in the assessment of this issue is underlined by recent decisions. In *Re Marion (No 2)*,²⁴ when Nicholson CJ came to make a final determination of whether sterilisation was in Marion's best interests, the first issue he dealt with was whether she had capacity to give informed consent. He held that all the evidence pointed to a conclusion that she did not have such capacity.²⁵ In *Re L and M*,²⁶ in which Warnick J had to assess whether sterilisation was in the best interests of a 17 year old intellectually handicapped and physically disabled girl called Sarah, the first finding he made was that Sarah lacked the capacity to make a decision about sterilisation, and that this incapacity was unlikely to change in the foreseeable future.²⁷

7.18 The principles that operate in relation to medical treatment are simply applications of a more general principle that the intellectually disabled should be able to make, or contribute to, decisions about their lives whenever possible. This is recognised by adult guardianship legislation. The *Guardianship and Administration Act 1990* provides that:

"Every person shall be presumed to be capable of -

- (i) looking after his own health and safety;
- (ii) making reasonable judgments in respect of matters relating to his person . . .

until the contrary is proved to the satisfaction of the Board."²⁸

Similar provisions are to be found in the legislation of other jurisdictions²⁹

²⁴ (1992) 17 Fam LR 336.

²⁵ Id 349.

²⁶ (1993) 17 Fam LR 357.

²⁷ Id 370.

²⁸ *Guardianship and Administration Act 1990* s 4(2)(b).

²⁹ *Guardianship and Management of Property Act 1991* (ACT) ss 3(2)(a), 70(1)(b), 70(3)(a); *Guardianship Act 1987* (NSW) s 4(d), 44(2)(a)(i); *Adult Guardianship Act 1988* (NT) ss 4(c), 21(6)-(7); *Guardianship and Administration Board Act 1986* (Vic) ss 4(2)(c), 41.

(ii) The Commission's view

7.19 Under the Commission's ideal scheme, the issue of whether the child has capacity to give informed consent would remain fundamental. The first issue which the decision-making body should determine is whether the child has such capacity. If such capacity is found to exist, then it should permit sterilisation only if the child has personally consented.

(b) Future capacity

7.20 What has been said above relates to the capacity of the child at the time of the proceedings. But it may be just as important to ask whether a child who does not have the necessary capacity at the time of the proceedings has ever had such capacity in the past, or might acquire that capacity in the future.

(i) The present law

7.21 Under the present law, the child's likely future capacity is a relevant issue, as shown by the practice of the Family Court of Australia. In *Re L and M*,³⁰ where the application by the parents to have their child sterilised was clearly based on their fears that she might become pregnant, Warnick J specifically found that the child lacked the capacity to make a decision about sterilisation and that this incapacity was unlikely to change in the foreseeable future.³¹

7.22 The issue of future capacity is specifically dealt with in the South Australian legislation regulating the making of sterilisation decisions by the Guardianship Board. The legislation applies both to children and to adults. Where the Board is not satisfied that the sterilisation is therapeutically necessary, the conditions which must be established to the satisfaction of the Board include:

- (1) that there is no likelihood of the person acquiring at any time the capacity to give an effective consent;

³⁰ (1993) 17 Fam LR 357.

³¹ Id 370.

- (2) that the Board has no knowledge of any refusal on the part of the person to consent to the carrying out of the sterilisation, being a refusal that was made by the person while capable of giving effective consent and that was communicated by the person to a medical practitioner.³²

This rules out sterilisation for the purposes of preventing pregnancy or to deal with menstrual problems unless there is evidence that the child has never had and never will have capacity to consent.

7.23 The South Australian legislation confines these extra requirements to cases of non-therapeutic sterilisation. It would not make sense for sterilisation on therapeutic grounds to be ruled out where the child lacked the present capacity to consent but might possibly be able to do so in the future.

(ii) *The Commission's view*

7.24 The Commission is of the view that its ideal scheme should incorporate a similar requirement, applying, as in South Australia, only in cases where the decision-making body is not satisfied that the sterilisation is therapeutic. In such cases the decision-making body should be satisfied that the child not only lacks capacity to consent to the treatment at the time of the application, but also that there is no likelihood of such capacity being acquired in the future, and that there is no evidence that the child has refused to consent to sterilisation at any time in the past when capable of giving effective consent.

4. OTHER FACTORS IN THE ASSESSMENT OF BEST INTERESTS

7.25 The assessment of best interests necessitates the taking into account of many other factors besides the question of capacity.

(a) **The present law**

7.26 The majority in *Marion's Case* recognised that the best interests principle is imprecise though, as they said, "no more so than the `welfare of the child' and many other concepts with

³² *Guardianship Act 1993 (SA)* s 61(2)(b)(i) and (iii). See also *Guardianship and Management of Property Act 1991(ACT)* s 70(1)(b).

which courts must grapple".³³ They did not think that it was possible to formulate a rule which would identify cases where sterilisation was in the child's best interests,³⁴ but looked to judges to develop guidelines to give further content to the concept of best interests in responding to individual cases.³⁵ They suggested that the best interests of the child would ordinarily coincide with the wishes of the parents, though in an exceptional case a court might make an order that was contrary to the parents' wishes.³⁶ In any case, they saw the best interests test being confined by the notion of last resort.³⁷

7.27 When the issue of whether Marion should be sterilised was once again raised before the Family Court in *Re Marion (No 2)*,³⁸ Nicholson CJ accepted the responsibility placed upon him by the High Court and set out in some detail the way in which he thought the best interests test should be applied.

7.28 In his assessment of best interests, Nicholson CJ gave special importance to the child's right to medical treatment under conditions of equality.³⁹ He accepted submissions made to him that in a case where there were strong medical reasons in support of a particular medical operation, refusal of that operation to a person with an intellectual disability might constitute discrimination on the grounds of disability if it could be made available consensually to a person of normal intellect. It was in recognising the child's right to medical treatment under conditions of equality that the provisions of various international instruments⁴⁰ could best be given effect.

7.29 Nicholson CJ then proceeded to consider a number of factors which were relevant in determining whether the procedure was in the best interests of the child.⁴¹ They were:

"(i) the particular condition of the child which requires the procedure or treatment;

³³ *Marion's Case* at 259.

³⁴ *Ibid.*

³⁵ *Id* 260.

³⁶ *Ibid.* See eg *Re L and M* (1993) 17 Fam LR 357, paras 7.32-7.36 below.

³⁷ See paras 7.66-7.71 below.

³⁸ (1992) 17 Fam LR 336.

³⁹ *Id* 351.

⁴⁰ See para 6.18 above.

⁴¹ (1992) 17 Fam LR 336, 351-352. Nicholson CJ referred to the factors he set out in his own decision in *Re Jane* (1988) 12 Fam LR 662, but suggested that these were encompassed in the considerations now set out in this case where the concerns were much wider than the consequences of menstruation, pregnancy and fertility.

- (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 or treatment proposed rather than the 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."

7.30 Having analysed these factors in the light of the evidence before him, Nicholson CJ came to the conclusion that because Marion's cognitive functioning was seriously impaired, with no prospects for improvement, and because there were no alternatives, an ovariectomy should be authorised to stem the effect of seizures. Having so found, and given the evidence of the physical and social consequences of continued menstruation, there was good reason to order a hysterectomy and no basis not to do so.⁴² In coming to these conclusions he applied the well-known test, generally accepted in civil cases, that it was necessary to be satisfied on clear and convincing evidence.⁴³

⁴² (1992) 17 Fam LR 336, 354-355. He also concluded that the procedures proposed for Marion were a step of last resort in order to minimise the potential for further neurological damage. On last resort see paras 7.66-7.71 below.

⁴³ *Briginshaw v Briginshaw* (1938) 60 CLR 336.

7.31 In the light of these conclusions, Nicholson CJ said that it became unnecessary to consider the competing considerations relating to control of menstruation and the possibility of pregnancy. He said:

"Ironically enough, this case probably falls into the category of cases where the court's consent is unnecessary since, on the facts as I have found them, the procedure was required for medical and therapeutic reasons. It was nevertheless both prudent and correct for the applicants to have sought the consent of the court, as this issue (whether the procedures were required for medical or therapeutic purposes) could well have been the subject of controversy."⁴⁴

7.32 Another recent decision, *Re L and M*,⁴⁵ provides a further example of the court assessing whether it is in the best interests of an intellectually disabled child that she be sterilised - with the opposite outcome to that reached in *Re Marion (No 2)*. Sarah, the child in this case, was 17 years old. She was physically disabled and intellectually handicapped. She had lived in a home for handicapped children since she was 14 months old. Since she did not suffer from any malfunction or disease for which sterilisation is a treatment or in the treatment of which sterilisation is a consequence, court authorisation for sterilisation was plainly required, and Sarah's parents made application to the Family Court for this procedure to be carried out. The parents, who for various reasons were unable to care for her at home, were nonetheless concerned for her welfare and particularly about the prospect of her becoming pregnant. Warnick J however held that, since his task was to decide the matter according to the best interests of the child as the first and paramount consideration, factors such as the wishes of the parents had to be subordinated to this consideration and were simply one of the matters that had to be taken into account.⁴⁶

7.33 Referring to the factors identified by Nicholson CJ in the earlier case of *Re Jane*,⁴⁷ Warnick J made a number of findings, including

- (1) Sarah was unable to understand reproduction, contraception and birth, and that inability was permanent;
- (2) she could not possibly care for a child;

⁴⁴ (1992) 17 Fam LR 336, 355.

⁴⁵ (1993) 17 Fam LR 357.

⁴⁶ See para 7.10 above.

⁴⁷ (1988) 12 Fam LR 662: see n 37 above.

- (3) a decision against sterilisation at this time did not remove the possibility of such a procedure in the future.⁴⁸

7.34 Warnick J then proceeded to apply the best interests test, referring, as did Nicholson CJ in *Re Marion (No 2)*, to the need to be satisfied on clear and convincing evidence.⁴⁹ He referred specifically to a number of matters, including whether the proposed procedure would increase Sarah's capacity to enjoy life, whether it was necessary to enable her to move to residential-style accommodation, the effect of sterilisation on her health, whether her parents' wishes were met (which was not something that would impact on her), and the risks of the operation. On the strength of these considerations, the judge came to the provisional conclusion that sterilisation was not in Sarah's best interests.⁵⁰

7.35 The judge then considered the primary consideration motivating the application, which was the removal of the risk of pregnancy. He said that it was probable, but not certain, that Sarah could become pregnant; that she could only become pregnant as a result of advantage being taken of her; that there were substantial safeguards against the possibility of abuse; that the effect of pregnancy on her could not be gauged with any confidence, but she would not have any understanding of the condition; that if she became pregnant and the pregnancy was not terminated, there was a possibility of difficulty in managing her epilepsy; that there was a possibility of harm to the foetus, either from her medication or as a result of her seizures; and that sterilisation did not have to be performed immediately, but remained an option if circumstances changed.

7.36 Warnick J decided that these considerations did not, when weighed in the balance, displace his provisional conclusion that sterilisation was not in Sarah's best interests. He said:

"To make a decision in this case, in favour of sterilisation, would be virtually equivalent to establishing a policy that all females, with profound disabilities resembling those afflicting Sarah, should be sterilised. There is nothing substantial about the risk, nor clearly detrimental to Sarah about pregnancy, which justifies the interference with personal inviolability, unless it be that where there is any risk (as there always must be) sterilisation should occur.

⁴⁸ (1993) 17 Fam LR 357, 370. It was at this point that Warnick J also made a finding about Sarah's capacity: see para 7.17 above.

⁴⁹ See para 7.30 above.

⁵⁰ (1993) 17 Fam LR 357, 373-374.

I cannot think that such an approach is consistent with human dignity, the fundamental nature of the right to personal inviolability, and the responsibility of the capable for the incapable.

When the position is so put, the `negative premise' that the `right to reproduce' is of no `value' to Sarah does not `counter-balance' the positive duty to ensure the protection of the fundamental right to personal inviolability. If from the procedure there were real benefits to capacity to enjoy life or quality of life, then the fact that the right to reproduce was valueless would take on significance in the equation.⁵¹

(b) Issues

7.37 The issues for the Commission, in determining how the assessment of best interests should be carried out under its ideal scheme, are:

- (1) whether there should be any guidelines to assist the decision-maker in assessing whether sterilisation is in the child's best interests;
- (2) if so, whether those guidelines should be set out in statutory form;
- (3) what the guidelines should be.

7.38 The Family Law Council Discussion Paper reviews the issue whether sterilisation decisions should simply be determined by reference to a broad concept such as best interests, or a more specific set of factors.⁵² The Council suggests that a list of relevant factors would include:

- * The young person's quality of life;
- * The young person's right to bodily integrity;
- * Any threat to the person's life in the absence of surgical intervention;
- * The concerns of the parents, carers and others involved in the care of the child;
- * Any relevant medical condition;
- * Any less invasive procedure that would achieve the same intended purpose.⁵³

⁵¹ Id 374.

⁵² Paras 4.17-4.34.

⁵³ Para 4.33.

7.39 Similar lists of factors can be found in existing legislation dealing with the medical treatment of disabled people. For example, the Australian Capital Territory legislation on the medical treatment of adults provides that:

"In determining whether a particular procedure would be in the person's best interests, the matters that the Tribunal shall take into account include

- (a) the wishes of the person, so far as they can be ascertained;
- (b) what would happen if it were not carried out;
- (c) what alternative treatments are available;
- (d) whether it can be postponed because better treatments may become available....."⁵⁴

7.40 In other jurisdictions, such directions are not statutory but are contained in guidelines drawn up by the decision-maker, for example the directions issued by the Official Solicitor in England.⁵⁵

7.41 The Commission's preference is to assist the decision-maker by giving some guidance in statutory form as to how the best interests principle ought to be applied. The Commission has rejected any limitation on sterilisation to cases where it is carried out for therapeutic reasons.⁵⁶ This means that the best interests test has to be capable of application in a wide range of situations in which the factors to be taken into consideration vary considerably. In the paragraphs that follow, the Commission discusses the main situations in which sterilisation is likely to be sought and how the best interests principle should be applied in each case.

⁵⁴ *Guardianship and Management of Property Act 1991* (ACT) s 70 (3). The *Guardianship Act 1987* (NSW) s 44(2) lists matters to which the Board must have regard in deciding whether medical treatment is "appropriate".

⁵⁵ See Appendix III para 23.

⁵⁶ See paras 6.7-6.22 above.

(c) Cases where sterilisation is therapeutically necessary

7.42 In a case where it is clear that sterilisation is a necessary element in the treatment of some malfunction or disease, then it is likely to be in the child's best interests. In the words used by McHugh J in *Marion's Case*, when failure to carry out the procedure is likely to result in the child's physical or mental health being seriously jeopardised, or in the suffering of pain, fear or discomfort of such severity and duration or regularity that it is not reasonable to expect the child to suffer that pain, fear or discomfort, the circumstances are so compelling that they justify the carrying out of the procedure.⁵⁷ When in *Re Marion (No 2)*⁵⁸ the Family Court finally determined that sterilisation was in Marion's best interests, Nicholson CJ came to the conclusion that it was a case where sterilisation was probably necessary for therapeutic reasons.

(d) Sterilisation and the avoidance of pregnancy

(i) In general

7.43 Sterilisation is often sought for reasons which are based on the undesirability of an intellectually disabled girl becoming pregnant, and its possible consequences. The important question here is whether the desirability of avoiding pregnancy is sufficient in itself to establish that sterilisation is in the child's best interests, or whether something more is required.

7.44 Under the *South Australian Guardianship and Administration Act 1993*, the avoidance of pregnancy is a sufficient reason for sterilisation in such circumstances. If the Guardianship Board is satisfied that a woman is physically capable of procreation and that there is no likelihood of her ever acquiring the capacity to give an effective consent, and has no knowledge of any refusal by her to consent to the sterilisation made while she was capable of giving effective consent, it can consent to a sterilisation if the woman is, or is likely to be,

⁵⁷ *Marion's Case* at 321. McHugh J was discussing the circumstances in which parental consent would be sufficient, but the Commission finds his formulation an appropriate way of identifying cases in which a decision-making body could hold that sterilisation was in a child's best interests. The *South Australian Guardianship and Administration Act 1993* contains a similar provision. It sets out a number of alternative conditions on which the Guardianship Board can consent to sterilisation, one of which is that the Board is satisfied that it is therapeutically necessary for a sterilisation to be carried out on that person: *Guardianship and Administration Act 1993*(SA) s 61(2)(a).

⁵⁸ (1992) 17 Fam LR 336, 355.

sexually active, and there is no method of contraception that could in all the circumstances reasonably be expected to be successfully applied.⁵⁹

7.45 The Commission does not agree with this view, because it gives insufficient weight to factors such as bodily integrity, human dignity and the child's quality of life. In the words of Brennan J's dissenting judgment in *Marion's Case*:

"To accord in full measure the human dignity that is the due of every intellectually disabled girl, her right to retain her capacity to bear a child cannot be made contingent on her imposing no further burdens, causing no more anxiety or creating no further demands. If the law were to adopt a policy of permitting sterilization in order to avoid the imposition of burdens, the causing of anxiety and the creating of demands, the human rights which foster and protect human dignity in the powerless would lie in the gift of the those who are empowered and the law would fail in its function of protecting the weak."⁶⁰

7.46 There are several reasons why the risk of pregnancy should not in itself justify sterilisation.

- (1) Protection from unwanted pregnancy can generally be provided by contraceptive measures short of sterilisation.
- (2) In some cases the risk of pregnancy is due to a failure to provide proper care. In such cases, what is required is better care, and sterilisation should not be seen as a substitute.⁶¹
- (3) Sterilisation will not prevent abuse, and may in fact increase the risk of abuse occurring.⁶²

7.47 The Commission therefore agrees with the view of the Family Law Council in its discussion paper that sterilisation of children under 18 is never justifiable solely as a means of contraception or solely to prevent the consequences of sexual abuse.⁶³

⁵⁹ *Guardianship and Administration Act 1993* (SA) s 61(2)(b).

⁶⁰ *Marion's Case* at 276.

⁶¹ See Brennan J in *Marion's Case* *ibid*.

⁶² See Warnick J in *Re L and M* (1993) 17 Fam LR 357, 366.

⁶³ Family Law Council Discussion Paper para 4.35.

(ii) The likelihood of giving birth to an intellectually disabled child

7.48 A few submissions advocated sterilisation of girls with intellectual disabilities on the basis that they were likely to give birth to intellectually disabled children. However, the Commission rejects arguments for sterilisation based on eugenic considerations. The "eugenic argument" has long been outmoded. The question of whether a person may have a tendency or condition which may be passed genetically to their children depends on the nature of the condition from which the person suffers. Studies have shown that there is no basis for a belief that intellectual disability is inherited.⁶⁴ The Commission supports the view of the Family Law Council that any attempt to justify sterilisation by arguments based on the predicted quality of offspring is totally inappropriate.⁶⁵

7.49 Furthermore, such arguments do not give proper weight to factors such as human dignity which the Commission has identified as indicating that sterilisation is not ordinarily in a child's best interests.

(iii) Inability to care for children

7.50 A number of submissions based a case for allowing sterilisation on the ground that persons suffering from intellectual disability would be unable to cope with bringing up a child. Variants of this argument were that if an intellectually disabled girl became pregnant the girl's parents would end up having to take care of the baby themselves, or that it would be necessary to consider abortion, or giving up the child for adoption or fostering. Although at law there are no obligations on grandparents to care for their grandchildren, in practice it appears that this is what happens in many cases. Some parents expressed dismay at the possibility of having to care for a young child after having had to raise their own intellectually disabled child, often in difficult circumstances, though others felt that it was part of their responsibility for the actions of their children.

⁶⁴ There are some specific conditions which can be passed on but studies have shown that 90% of intellectually disabled parents have children who do not suffer from intellectual disability: see para 2.14 above.

⁶⁵ Family Law Council Discussion Paper para 4.35. See also Bush J in *Re M (A Minor) (Wardship: Sterilization)* [1988] 2 FLR 497, 498-499:

"We are the victims of the European history of operations of this kind in the way in which some countries and some regimes have misused this kind of operation for eugenic purposes. It is, therefore, right that we in this country should be particularly watchful that we do not go down that road, and that people should not be sterilized merely because they are severely handicapped or weak, or likely to give birth to children who may equally be so."

7.51 However, other submissions took an opposing view. Some parents expressed a belief that their intellectually disabled children would be able to have a family of their own successfully. Other submissions criticised the assumption that an intellectually handicapped person would be incapable of providing necessities for a child, and emphasised that qualities such as love and compassion were as important as intellect.⁶⁶

7.52 In the Commission's view, no assumption should be made that the intellectually disabled will be unable to raise their own families.

(iv) *Conclusion*

7.53 The desirability of avoiding pregnancy or the consequences of anticipated sexual abuse is insufficient, without more, to establish that sterilisation is in the child's best interests. Eugenic considerations, or an assumption that the intellectually disabled will be unable to care for their offspring, likewise do not establish a case for permitting sterilisation.

7.54 However, there may be special circumstances in which the need to avoid pregnancy would be sufficient to establish that sterilisation would be in the child's best interests. This would be so if, despite the best attempts of the girl's carers, there is a real and enduring risk of her becoming pregnant, and her level of intellectual disability is such that she does not and never will have understanding of pregnancy, birth and motherhood, so that she will suffer trauma which women who understand maternity would not experience. According to McHugh J in *Marion's Case*, one instance in which parents should be able to consent to sterilisation is where:

". . . the failure to carry out the procedure is likely to result in a real risk that an intellectually disabled child will become pregnant and she does not, and never will, have any real understanding of sexual relationships or pregnancy. In such a case, to speak of a fundamental right of reproduction is meaningless. The human dignity of an intellectually disabled child is not advanced, and indeed is denied, by allowing her (by, what is in point of law, rape) to become pregnant and to give birth in circumstances which she cannot understand and which may result in a frightening ordeal for her not only at the time of birth, but for many months prior thereto.⁶⁷

⁶⁶ Submission of Right to Life Association, Western Australia.

⁶⁷ *Marion's Case* at 321.

The same argument might apply where an intellectually disabled girl would have enough understanding of motherhood to be distressed at her inability to care for the child after its birth.

7.55 The Commission endorses McHugh J's approach, even though it was intended for the slightly different purpose of defining when the circumstances of the case were so compelling that parents should be allowed to consent to a non-therapeutic sterilisation without court intervention. In the Commission's view, McHugh J's words appropriately illustrate the circumstances in which sterilisation on grounds associated with pregnancy would, despite considerations of bodily inviolability and human dignity, be in the child's interests.

(e) Sterilisation and menstrual management

7.56 Menstruation is a more immediate consequence of sexual maturity than the possibility of conception. A major focus of arguments in favour of sterilisation is the problem of menstrual management as it relates to intellectually disabled young girls. Again, the issue is whether the avoidance of menstrual difficulties is a sufficient justification for saying that sterilisation is in a child's best interests.

7.57 The South Australian guardianship legislation dealing with the sterilisation of intellectually disabled children and adults appears to accept that menstrual management can be a sufficient reason for sterilisation. Sterilisation of a woman will be permitted if "cessation of her menstrual cycle would be in her best interests and would be the only reasonably practicable way of dealing with the social, sanitary or other problems associated with her menstruation".⁶⁸ The only other requirements are that the Guardianship Board be satisfied that the woman is physically capable of procreation; that she is, or is likely to be, sexually active;⁶⁹ that there is no likelihood of her ever acquiring the capacity to give an effective consent; and that it has no knowledge of any refusal by her to consent to the sterilisation made while she was capable of giving effective consent.⁷⁰

⁶⁸ *Guardianship and Administration Act 1993* (SA) s 61(2)(b)(iii)(B).

⁶⁹ Quaere whether being physically capable of procreation or being likely to be sexually active are relevant in cases based on menstrual difficulties.

⁷⁰ *Id* s 61(2)(b).

7.58 Arguments justifying sterilisation of intellectually disabled girls on the basis of the problem of menstrual management featured prominently in many of the submissions made to the Commission. It was suggested that sterilisation would avoid the difficulties for the child and her caregivers, whether parents or an institution, which would have to be faced with the onset of the child's menstrual cycle. These difficulties include the inconvenience of physically managing menstruation, hygiene and toileting, the effect of all this on the behaviour of such girls, and the problem of parents or institutions providing care to deal with their increased support needs.

7.59 Some respondents said, more generally, that sterilisation would enhance the quality of life of a female child with an intellectual disability. Many of the concerns expressed about the child's current or future quality of life related to problems that the child was experiencing with her menstrual cycle or anticipated problems if menarche had not commenced.

7.60 The submission of the Director of Medical Services, King Edward Memorial Hospital, lent some support to these arguments. The Director said:

"The reality of the situation often is that intellectually handicapped girls have difficulty with personal hygiene associated with menstruation and with avoiding pregnancy. The operation of choice to cover both these conditions is a hysterectomy."

7.61 In spite of these arguments, there are good reasons why considerable caution should be exercised before accepting the problem of menstrual management as something which justifies the sterilisation of intellectually disabled girls. The Victorian Panel Report contains a clear recommendation that intellectually disabled girls should not be sterilised for menstrual management purposes,⁷¹ and Analysis of Australian Policy counsels against regarding sterilisation as the automatic response in such cases, showing that the risks of sterilisation are considerable, and that there are other ways of dealing with the problem.⁷² The Family Law Council Discussion Paper in general supports these views.⁷³

7.62 The Commission supports the findings of these inquiries. It recognises that normal healthy children are unlikely to be sterilised for menstrual management purposes, and that it is therefore undesirable to treat intellectually disabled girls any differently. Parents of

⁷¹ Panel Report vi-vii (Recommendation 6).

⁷² See paras 3.45-3.47 above.

⁷³ Family Law Council Discussion Paper paras 4.26-4.27.

intellectually disabled children are often not aware of the implications of sterilisation or of the range of alternatives, and that there is a great need for better education and training and increased support for parents dealing with this difficulty.

7.63 The problem of menstrual management does not therefore in itself support a finding that sterilisation is in a child's best interests. However, it may do so if there are special circumstances. In formulating those circumstances, the Commission endorses the words of Deane J in *Marion's Case*:

"[T]he surgery must be necessary to avoid grave and unusual problems and suffering which are or would be involved in menstruation which has either commenced or which is virtually certain to commence in the near future. These problems could arise from inability to comprehend or cope with pain; a phobic aversion to blood; a complete inability to cope with the problems of hygiene with psychiatric or psychological consequences; or any of a variety of other possible complications. The problems or suffering which would result from menstruation must be such that it is plain that, according to general community standards, it would be quite unfair for the child and ultimate adult to be required to bear the additional burden of them."⁷⁴

Deane J was identifying a case in which, in his opinion, parents should be able to make a sterilisation decision without court intervention. His was, of course, a dissenting judgment. However, the Commission finds that Deane J's formulation appropriately identifies a third case in which sterilisation would be in the child's best interests.

(f) The Commission's view

7.64 In the Commission's view, in order to give proper weight to the competing considerations in the cases discussed above, there should be a presumption that sterilisation would not be in the child's best interests. This presumption is based on the importance of considerations such as the child's right to bodily integrity, human dignity and the child's quality of life. The presumption would be rebuttable only in the following three situations:⁷⁵

- (1) where failure to carry out a procedure involving sterilisation is likely to result in the child's physical or mental health being seriously jeopardised, or in the suffering of pain, fear or discomfort of such severity and duration or regularity

⁷⁴ *Marion's Case* at 305.

⁷⁵ These rebutting circumstances are based on principles outlined by McHugh and Deane JJ in their dissenting judgments in *Marion's Case*: see paras 3.35-3.36 above.

that it is not reasonable to expect the child to suffer that pain, fear or discomfort;

- (2) if -
 - (a) failure to carry out the procedure is likely to result in a real risk that a girl under 18 will become pregnant;
 - (b) she does not, and never will, have any real understanding of sexual relationships, pregnancy or motherhood; and
 - (c) allowing her to become pregnant and give birth in such circumstances is likely to cause her to suffer trauma, prior to, at the time of or after the birth, which it would not be reasonable to expect her to suffer;
- (3) if
 - (a) a girl under 18 has commenced menstruation or is virtually certain to commence menstruation in the near future; and
 - (b) the procedure is necessary to avoid grave and unusual problems or suffering which are or would be involved in menstruation and which are such that, according to general community standards, it would be unfair to require the child to bear the additional burden of them.

Even if the decision-making body found that the case came within one of the above situations, it should be open to it to hold that in the light of other factors it was not in the child's best interests to be sterilised.

7.65 The approach of the Commission is not unlike that adopted by Warnick J in *Re L and M*⁷⁶ Having come to a provisional conclusion that sterilisation was not in the best interests of the child in question, he examined the main reason for making the application, which was to remove the risk of pregnancy. He considered a number of issues relating to the consequences

⁷⁶ (1993) 17 Fam LR 357: see paras 7.32-7.36 above.

of a possible pregnancy but concluded that they did not displace his provisional conclusion that sterilisation was not in the child's best interests.

5. LAST RESORT

(a) The present law

7.66 The High Court in *Marion's Case* adopted the principle that sterilisation should not be authorised except as a step of last resort. The majority said:

"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 sterilization is the welfare of the disabled child. Within that context, it is apparent that sterilization can only be authorized 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."⁷⁷

7.67 The High Court pointed out that the last resort principle confined the ambit of the best interests test, saying:

"As we have shown, [the best interests principle] 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 authorization 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."⁷⁸

Thus, to justify sterilisation of a child, it is not enough to show that sterilisation is in the child's best interests: it must also be clear that no other alternative offers a practicable solution to the problem.

⁷⁷ *Marion's Case* at 259. Deane J at 305 also adopted the last resort principle as one of the tests determining when non-therapeutic sterilisation could be authorised by parents.

⁷⁸ Id 259-260. Nicholson CJ in *Re Marion (No 2)* (1992) 17 Fam LR 336, 350 also emphasised the importance of the principle that sterilisation is a step of last resort, and that this consideration limited the best interests test.

7.68 The last resort principle is recognised by medical practice. There is a long-established rule of medicine that treatment should do no harm.⁷⁹ The last resort principle is simply a development of this general rule. So, for example, in the context of the intellectually disabled, the "least harmful alternative" has been described as an appropriate measure of providing care, especially for those who cannot consent for themselves.⁸⁰

7.69 The last resort principle is also found in legislation on adult guardianship in Western Australia and elsewhere. Most of the Australian guardianship statutes refer specifically to the principle that all decision-making under the legislation is to be based on establishing that "the means which is the least restrictive of a person's freedom of decision and action as is possible in the circumstances is adopted".⁸¹ It is clear that this principle applies in making decisions about sterilisation.⁸² The English Law Commission in its Consultation Paper on the possible adoption of similar legislation in England suggested that the decision-making forum should take into account "whether there is an alternative to the proposed treatment, and in particular whether there is an alternative which is more conservative or which is less intrusive or restrictive".⁸³

⁷⁹ "I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them": W H S Jones *The Doctor's Oath*, quoted in *Butterworths Medical Dictionary* (2nd ed 1978) 812. "General agreement exists among physicians that medical treatment of any kind should be provided as much as possible with a sense of *beneficence* (that is the will to do good for someone) and with a desire to do no harm (*primum non nocere*):" T E Elkins and H F Andersen *Sterilization of Persons with Mental Retardation* (1992) 17 *Journal of the Association for Persons with Severe Handicaps* 19, 24. See also J D Wilson and others (eds) *Harrison's Principles of Internal Medicine* (12th ed 1991) 10-11.

⁸⁰ T E Elkins and H F Andersen *Sterilization of Persons with Mental Retardation* (1992) 17 *Journal of the Association for Persons with Severe Handicaps* 19, 24. However, the Director of Medical Services at King Edward Memorial Hospital questioned why sterilisation should always be regarded as the step of last resort for girls or women experiencing problems with menstruation. In his view, the test should be whether or not sterilisation is the preferred or best option for the particular girl at the time in question, since "[i]t seems wrong in principle to offer these people other than the best possible treatment".

⁸¹ *Guardianship and Administration Board Act 1986* (Vic) s 4(2)(a). Similar provisions are contained in *Guardianship and Management of Property Act 1991* (ACT) s 3(2)(d); *Guardianship Act 1987* (NSW) s 4(b); *Adult Guardianship Act 1988* (NT) s 4(a).

⁸² In Western Australia, however, the position may be a little different. The *Guardianship and Administration Act 1990* s 4(2), which sets out the general principles to be observed by the Guardianship and Administration Board in exercising its jurisdiction, provides, inter alia:

"(c) A guardianship or administration order shall not be made if the needs of the person in respect of whom an application for such an order is made could, in the opinion of the Board, be met by other means less restrictive of the person's freedom of decision and action."

It has been suggested that this provision, because it is limited to guardianship and administration orders, does not apply to applications for adult sterilisation: J Blackwood *Sterilisation of the Intellectually Disabled: The Need for Legislative Reform* (1991) 5 *AJFL* 138, 163 n 147.

⁸³ Para 4.10.

7.70 In South Australia, the legislation setting out the jurisdiction of the Guardianship Board to deal with persons lacking mental capacity applies equally to adults and children.⁸⁴ It requires the Board, before it gives its consent to sterilisation, to be satisfied that stated conditions have been met.⁸⁵ These conditions include, in the case of sterilisation for contraceptive reasons, that the woman is likely to be sexually active and there is no method of contraception which in the circumstances could reasonably be expected to be successfully applied, and as regards sterilisation for menstrual management purposes, that the deciding body must be satisfied that cessation of a woman's menstrual cycle is the only practicable way of dealing with the problems she is experiencing. These requirements are in effect a statutory application of the last resort principle to particular situations.

(b) The Commission's view

7.71 The Commission is of the view that sterilisation should be permitted only as a step of last resort. In this respect it agrees with the view of the High Court in *Marion's Case*, and recognises that the last resort principle commands general acceptance both in legislation dealing with the sterilisation of the intellectually disabled, and the care of such people generally, and in medical practice. In the ideal scheme proposed in this Part of the report, even if the presumption that sterilisation is not in the child's best interests has been rebutted, before sterilisation can be allowed to proceed the decision-maker should be satisfied that it is a step of last resort and that there is no other realistic alternative.

⁸⁴ *Guardianship and Administration Act 1993* (SA) s 58.

⁸⁵ S 61(2).

Chapter 8

RESPONSIBILITY FOR THE DECISION

1. WHO SHOULD MAKE THE DECISION?

(a) Introduction

8.1 If, as proposed by the Commission, sterilisation of intellectually disabled children should be permissible in carefully defined circumstances, where consistent with the principles outlined in Chapter 7, it becomes necessary to determine who should make the decision. On the one hand, the decision could be left in the hands of the individual concerned (if capable of making the decision), or the parents or guardians. Such a decision would of course be made with the assistance of appropriate medical advice.¹ If this were the solution adopted, then decisions about sterilisation would be made in exactly the same way as any other medical treatment decisions.² On the other hand, the law could require that decisions about sterilisation should be made only by an independent body such as a court or tribunal. In this case, the law would be placing sterilisation decisions in a special category, outside the ambit of parental decision-making responsibility.

8.2 The High Court in *Marion's Case* decided by a majority that sterilisation was not a decision to which parents could consent on their child's behalf³ except where it was carried out for therapeutic reasons.⁴ Non-therapeutic sterilisations required court authorisation.⁵ The law recognised the role which parents have in caring for their children, but responsibility for children does not give parents the right to make all decisions for them, and in particular does not give parents the right to determine issues relating to their children's fertility. However, a decision parents wish to make for their child, particularly a child who is intellectually disabled, may indeed be in the interests of the child, and in those circumstances the court may well authorise sterilisation. In the words of the majority judgment:

¹ Cook J in *Re a Teenager* (1988) 13 Fam LR 85, 120 referred to the parents acting with the aid of appropriate medical advice. The Australian Medical Association (Western Australia) in its submission to the Commission proposed that sterilisation decisions could be made by parents with specialist medical support.

² See para 3.3 above.

³ *Marion's Case* at 253.

⁴ Id 250.

⁵ Ibid.

"In the circumstances with which we are concerned, the best interests of the child will ordinarily coincide with the wishes of the parents".⁶

8.3 It is instructive to contrast the ruling in *Marion's Case* with the position in other jurisdictions. It is notable that the Canadian Supreme Court in *Re Eve*⁷ considered that decisions to sterilise an intellectually disabled child could be made by a parent or guardian, though only if the sterilisation was therapeutic: non-therapeutic sterilisation cannot be permitted, either by a court or by anyone else. The law in New Zealand also permits such decisions to be made by a guardian, whether the sterilisation is classified as therapeutic or not.⁸ By contrast the position in the United States⁹ is that decisions about the sterilisation of children must be made by a court. The law in the United Kingdom is closer to the Australian law as determined in *Marion's Case*: court consent is not necessary in cases involving therapeutic sterilisation, but is highly desirable, if not absolutely necessary, in all other cases.¹⁰

8.4 The Commission, in requesting submissions following the High Court decision in *Marion's Case*, raised the question whether the law in Western Australia should allow sterilisation decisions to be made by parents, or whether such decisions should be made only by a court or by some independent body other than a court. The Commission received a large number of submissions, which revealed a wide range of views. Some respondents believed that parents should be able to make decisions about the fertility of their children without any external authority being involved. Others maintained that such decisions should be made by an independent tribunal. Yet others suggested further alternatives, for example, leaving the decision to a doctor. Even within these broad general categories, there was considerable variety - for example, as to whether parents should be required to seek the assistance of medical or other professionals, or act according to a set of guidelines, or get confirmation of the decision from another source, and as to the kind of independent tribunal to which the decision-making power should be entrusted.

⁶ Id 260. For an example of a case where the best interests of the child and the wishes of the parents did not coincide, see *Re L and M* (1993) 17 Fam LR 357.

⁷ (1986) 31 DLR(4th) 1: see Appendix III paras 2-5.

⁸ See Appendix III paras 37-38.

⁹ Id paras 27-28.

¹⁰ Id paras 17-26.

(b) Arguments in favour of leaving sterilisation decisions in the hands of parents

8.5 The Commission received many submissions, from parents of intellectually disabled children and others, in favour of allowing parents to make sterilisation decisions. In the Commission's view, the most important arguments in favour of leaving the decision to parents are as follows.

(i) Sterilisation is no different from other medical treatment decisions

8.6 Sterilisation is a major operation entailing permanent loss of the ability to reproduce.¹¹ Some submissions suggested, however, that there were other kinds of medical treatment that were just as serious, if not more so. One example cited was open-heart surgery. There is no serious suggestion that parents lack the capacity to make decisions about whether or not such a procedure should be carried out on their child.

(ii) Parents have formidable responsibilities

8.7 Parents who provide care for their disabled children undertake an enormous task which has no parallel in the wider community. Children who do not suffer such disabilities are usually educated and trained outside their family home, such education and training being the responsibility of persons other than their parents. Thus many people and organisations share in the socialisation of children in schooling and through cultural, sporting and other organisations. Although special schools and other organisations attempt to provide a parallel experience for disabled children, it is clear that the burden remains disproportionately on the parents and families of such children.

8.8 In having to deal with the fertility and sexual maturity of their children, the parents of disabled children are placed in a unique situation. For other parents, the signs of sexual maturity indicate the imminent independence of their child. For the parents of a disabled child, such signs indicate the beginning of a new and perhaps even more difficult type of

¹¹ Recent English cases in which there was evidence that tubal ligation is reversible in a majority of cases (see Ch 2 n 4) do not affect the importance of the fact that in all other instances sterilisation is irreversible.

dependency. At this time, the earlier grief which accompanied realisation of the fact of their child's disability may return.¹²

8.9 The magnitude of the burden borne by the parents of intellectually disabled children, particularly in facing the problems of fertility and sexual maturity, was made clear by many of the submissions received by the Commission. Similarly, this burden has been appreciated by judges hearing applications from parents in court cases both in Australia and elsewhere. In *Marion's Case* the High Court said: "There is no doubt that caring for a seriously handicapped child adds a significant burden to the ordinarily demanding task of caring for children".¹³

8.10 Many parents maintained that in these circumstances they, and they alone, knew what was best for their child. One commented: "Only parents know what is best for their child and courts should not interfere. Parents would not treat such a decision lightly." Another said: "The responsibility for making decisions for the intellectually handicapped must never be taken out of the hands of caring parents, except in perhaps a few cases, as they have lived with these people and know intimately what their needs are."

8.11 Other submissions pointed out that parents were expected to deal with the consequences of a decision whether or not to sterilise; and that difficult problems could ensue if an independent body responsible for making the decision refused to sanction sterilisation against the wishes of the parents. The parents would not "own" the decision, and yet would have the responsibility of coping with its results. Some submissions suggested that a decision to sterilise an intellectually disabled child might be the key factor which made it possible for parents to continue to care for the children at home, rather than have the child go into an institution.

(iii) *The sensitive nature of the issue*

8.12 It was emphasised in a number of submissions that sterilisation is a sensitive matter, one which many parents may prefer to keep private rather than expose it to the scrutiny of some independent tribunal.

¹² In the field of the care of the intellectually disabled, it is acknowledged that every birthday and milestone has special poignancy for the parents of disabled children; sexual maturity is a significant milestone.

¹³ *Marion's Case* at 251-252.

(iv) *The costs and delays of court proceedings*

8.13 Court proceedings can be long drawn out, expensive and stressful. There is an assumption that application to a judicial body given the task of making decisions about sterilisation will involve considerable delay and cost.

(c) **Arguments against leaving the decision to parents**

8.14 Though there are undoubtedly a number of persuasive arguments in favour of allowing parents to make decisions about the sterilisation of intellectually disabled children, there are powerful arguments against this view. The four majority judges in *Marion's Case*¹⁴ gave three main reasons for their decision that court authority was required before an intellectually disabled child can be sterilised for non-therapeutic reasons -

(1) Sterilisation requires invasive, irreversible and major surgery. This factor alone was not sufficient - as the High Court pointed out, the same could be said of appendectomy or some cosmetic surgery, which fell within the scope of parental powers to consent. However, two other factors took sterilisation outside the ambit of this power:

(2) The significant risk of a wrong decision being made, either about the child's present or future capacity to consent, or about what were the best interests of a child who could not consent. Three considerations contributed to the significance of this risk:

(i) The complexity of the question of consent.

(ii) The role of the medical profession in sterilisation decisions. The High Court counselled against placing absolute faith in doctors, and emphasised that the decision to sterilise was not just a medical decision.¹⁵

¹⁴ Id 250-252.

¹⁵ The law has now recognised that the standard of care owed by doctors for the purposes of the law of negligence is not simply a matter of medical judgment. In *Rogers v Whitaker* (1992) 175 CLR 479, the

- (iii) The fact that the decision to sterilise an intellectually disabled child involved the interests of a number of people which could possibly be conflicting: the child, the parents, and other family members.

- (3) The grave consequences of a wrong decision, both in the resulting inability to have children and because of the possibility that sterilised intellectually disabled persons would see themselves as having some kind of reduced status.

8.15 The Commission supports these arguments, many of which were reflected in submissions to the Commission which supported reference to some kind of independent body. Submissions said that sometimes people had been sterilised and later regretted it; that it was easy to misdiagnose a person as being intellectually disabled, or intellectually disabled to a greater degree than they in fact are; that it is very difficult to predict a child's future ability to consent; and that, at least where sterilisation is contemplated for contraceptive reasons, it deals with the consequences and not the problem. Other submissions balanced out arguments in support of leaving decisions to parents, pointing out for example that there was a need for education and support, and that much could be done to minimise the unwieldiness of court proceedings and produce streamlined procedures for dealing with sterilisation applications. Yet other submissions expressed fears for the position of doctors carrying out sterilisations in accordance with parents' wishes in circumstances which were later judged to be inappropriate.

8.16 There are two further arguments which in the Commission's view support entrusting decisions about sterilisation to an independent body such as a court, rather than leaving them to parents. The first is the importance of the decision being made. Sterilisation may be said to destroy an important part of a person's social and biological identity - the ability to reproduce. It affects not only the health and welfare of the individual but the well-being of all society.¹⁶ The Commission agrees with Professor Ian Kennedy's view that "[d]ecisions of such gravity cannot be left to private arrangement without the formal involvement of society

High Court disapproved the principle stated in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 that "a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice" (Lord Scarman in *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, 881).

¹⁶ See *Re Grady* (1981 NJ) 426 A 2d 467, 471-472, quoted in Appendix III para 27.

through some institution".¹⁷ The second is that the difficult task of applying the principles set out in Chapter 7 is likely to be better performed by a body possessing knowledge and understanding built up through experience gained in dealing with a number of cases.

(d) The Commission's view

(i) Consent should be given by an independent body

8.17 The Commission is not in favour of leaving decisions regarding the sterilisation of intellectually disabled children in the hands of parents, even though it recognises that most parents of such children are responsible and caring and devote their lives to their children in the face of formidable difficulties. Even if the law were to require that parental decisions had to be supported by medical advice, the Commission's attitude would not alter. For the reasons stated by the High Court in *Marion's Case*, and the additional reasons set out in the preceding paragraphs, the Commission is of the opinion that sterilisation decisions should be made by an independent body acting in the manner of a court or tribunal.

8.18 The Commission would see this requirement as applying to all sterilisation decisions, irrespective of whether the sterilisation was carried out for therapeutic or other reasons.¹⁸ In this respect it is departing from the decision in *Marion's Case*, which allows parental consent to remain effective in the case of therapeutic sterilisations.¹⁹ In taking this view the Commission is influenced by the considerable difficulties in applying the therapeutic/non therapeutic distinction in practice, as pointed out in particular by the medical profession.²⁰

(ii) Emergencies

8.19 In the Commission's view there should be only one exception to the requirement that consent should have to be given by an independent decision-making body. In a situation where sterilisation is urgently necessary to save the child's life or prevent serious damage to the child's health, there would be no time to obtain the necessary authorisation. In such a

¹⁷ I Kennedy *Patients, Doctors and Human Rights* in R Blackburn and J Taylor (eds) *Human Rights for the 1990s: Legal Political and Ethical Issues* (1991) 81, 102.

¹⁸ Subject to the exception dealt with at paras 8.19-8.20 below.

¹⁹ *Marion's Case* at 250. The Family Law Council provisionally proposed that sterilisation should be authorised only by a court or tribunal with appropriate jurisdiction: Family Law Council Discussion Paper para 4.16. It appears that this applies in all cases, and not just to non-therapeutic sterilisations.

²⁰ See paras 6.11-6.13 above.

situation, the prior consent of the independent decision-making body would not be required. The decision whether the case falls into this category would be one for the medical practitioner carrying out or supervising the treatment.

8.20 Legislative schemes in other jurisdictions requiring the consent of a Guardianship Board or similar body to sterilisation contain an exception for situations where sterilisation is urgently necessary because of risks to life or health. Such provisions are found in the adult guardianship legislation in Victoria and the Northern Territory,²¹ and in the South Australian legislation which applies both to adults and to children who lack the mental capacity to give effective consent.²² The legislation in New South Wales applying to intellectually disabled adults and children of 16 or over limits permitted sterilisation to cases where it is necessary to save the patient's life or prevent serious damage to the patient's health, and provides that a doctor's decision is a valid alternative to the Guardianship Board's consent in such a case.²³ Under the Commonwealth *Family Law Act 1975* as interpreted in *Marion's Case*, since sterilisation under such circumstances would be therapeutic, there would be no need to obtain court consent.²⁴ The same applies under the adult guardianship legislation in Western Australia, which only regulates non-therapeutic sterilisations.²⁵

2. THE DECISION-MAKING BODY

(a) Introduction

8.21 The Commission having proposed that sterilisation decisions should be made by an independent decision-making body, it becomes necessary to consider what is the most suitable forum for the making of the decision.

8.22 There are three existing bodies in Western Australia to which this jurisdiction could be entrusted:

²¹ *Guardianship and Administration Board Act 1986* (Vic) s 36(3); *Adult Guardianship Act 1988* (NT) s 21(1).

²² *Guardianship and Administration Act 1993* (SA) s 62.

²³ *Guardianship Act 1987* (NSW) s 37(1). The *Children (Care and Protection) Act 1987* (NSW) s 20B, which applies to children under 16, imposes similar restrictions. However, the High Court in *P v P* has held that the *Guardianship Act*, to the extent that it seeks to prohibit sterilisations which do not satisfy these criteria but have been authorised by the Family Court of Australia, is invalid.

²⁴ See para 3.27 above.

²⁵ *Guardianship and Administration Act 1990* s 56.

- (1) the Family Court of Western Australia;
- (2) the Supreme Court;
- (3) the Guardianship and Administration Board.

(b) The Family Court of Western Australia

8.23 The Family Court of Western Australia is the court which currently exercises in Western Australia the jurisdiction to deal with sterilisation applications. In so far as this is Commonwealth jurisdiction, it was conferred on the Family Court of Australia by the Commonwealth *Family Law Act 1975*, as *Marion's Case*²⁶ confirmed. In cases not covered by Commonwealth jurisdiction, the Family Court's powers are conferred by the *Western Australian Family Court Act 1975*. Following the High Court's decision in *Marion's Case*, the Family Court of Australia issued a Practice Direction with the object of providing a procedure to minimise delay and cost.²⁷ The Chief Judge of the Family Court of Western Australia issued instructions to ensure that sterilisation applications will receive expedited treatment.

8.24 There are a number of features of the Court's operation which would make it a suitable forum for considering applications for sterilisation, for example its established counselling network. However, proceedings in the Family Court, like those in other courts, are adversarial in nature.²⁸ Without specific legislation, parents and other caregivers will continue to have no alternative but to submit to the adversarial process if they wish to obtain authorisation for a sterilisation procedure to be carried out on their child. The High Court in *Marion's Case* recognised that the adversary process of a court is very often unsuitable for arriving at this kind of decision, and also that the costs and delay involved in court proceedings were a problem for parents.²⁹

²⁶ See para 4.5 above.

²⁷ Practice Direction of 15 June 1992. The Practice Direction provides for a directions hearing no later than 14 days from the date of filing of the papers in the Court and refers to the necessity of keeping costs to a minimum. See also O 23B of the *Family Law Act Rules*, dealing with special medical procedures.

²⁸ See *R v Watson; ex parte Armstrong* (1976) 136 CLR 248; A Dickey *Can Family Court Proceedings ever be Inquisitorial?* (1993) 67 ALJ 787.

²⁹ *Marion's Case* at 253.

(c) The Supreme Court

8.25 The Supreme Court is a court of general jurisdiction, and all matters are within its jurisdiction unless specifically excluded. Section 16 of the *Supreme Court Act 1935*, which sets out its jurisdiction, provides that the Court has the jurisdiction of courts of equity,³⁰ and it therefore inherited and continues to exercise the *parens patriae* jurisdiction of such courts.³¹ However, proceedings in the Supreme Court must again take the normal adversarial form.

(d) The Guardianship and Administration Board

8.26 The Guardianship and Administration Board was set up under the *Guardianship and Administration Act 1990* and commenced operation in October 1992. The Board is constituted by a judge and other members representing community and expert viewpoints. It has as its primary role the guarding of the interests of those who are not capable of making the necessary decisions for their own wellbeing, whether by reason of disability, illness or injury. The philosophy of the legislation is confirmed in the principles set out in section 4 of the *Guardianship and Administration Act*:

"(1) In the performance of its functions the Board shall observe the principles set out in subsection (2).

(2) (a) The primary concern of the Board shall be the best interests of any represented person, or of a person in respect of whom an application or a request for leave to apply is made.

(b) Every person shall be presumed to be capable of -

- (i) looking after his own health and safety;
- (ii) making reasonable judgments in respect of matters relating to his person;
- (iii) managing his own affairs; and
- (iv) making reasonable judgments in respect of matters relating to his estate,

until the contrary is proved to the satisfaction of the Board.

(c) A guardianship or administration order shall not be made if the needs of the person in respect of whom an application for such an order is made could, in the opinion of the Board, be met by other means less restrictive of the person's freedom of decision and action.

³⁰ S 16(1)(d).

³¹ See Ch 4 n 6.

(d) A plenary guardian shall not be appointed under section 43(1) if the appointment of a limited guardian under that section would be sufficient, in the opinion of the Board, to meet the needs of the person in respect of whom the application is made.

(e) An order appointing a limited guardian or an administrator for a person shall be in terms that, in the opinion of the Board, impose the least restrictions possible in the circumstances on the person's freedom of decision and action."

8.27 These principles have been described as attempting to ensure that:

- "(a) people with an intellectual disability are not deprived of medical treatment (including sterilisation operations) merely because they lack the capacity to consent;
- (b) that any medical treatment carried out is only carried out for the benefit of that person so that they are not subjected unnecessarily to medical treatment; and
- (c) to ensure that as far as possible the wishes of the person, in relation to any medical treatment, are ascertained."³²

8.28 The Guardianship and Administration Board already has jurisdiction relating to intellectually disabled adults, and in particular to consider applications for the sterilisation of such persons.³³ This jurisdiction must be exercised by the Full Board.³⁴ It thus has the opportunity of developing expertise in dealing with particular problems of disabled persons requiring protection from unwarranted surgical interventions. It will also have the substantial advantage of being less threatening to both families and the persons concerned, whilst having the benefit of a judge as chairperson.

8.29 Procedure before the Guardianship and Administration Board is less formal than a court hearing, and proceedings need not necessarily be adversarial. In determining applications seeking authority for a sterilisation procedure, the Board:

³² J Blackwood *Sterilisation of the Intellectually Disabled: The Need for Legislative Reform* (1991) 5 AJFL 138, 156. There is an uncertainty in the application of principle (c) to applications for sterilisation: see para 3.11 above.

³³ *Guardianship and Administration Act 1990* Pt 5 Div 3: see paras 3.10-3.14 above.

³⁴ Id s 56A. The Full Board means the Board constituted so as to consist of the chairperson or deputy chairperson and two other members: s 3(1). The chairperson must be a Supreme Court Judge or have been a Judge of the Supreme Court, District Court or Family Court of Western Australia: s 6(2)(a). The deputy chairperson must be or have been a legal practitioner or be a Registrar of the Supreme Court: s 6(2)(b).

". . . may, by order, consent to the sterilization of a represented person if it is satisfied that the sterilization is in the best interests of the represented person".³⁵

8.30 The submissions received by the Commission demonstrate a strong body of opinion from parents, organisations and professional groups favouring a process which will allow the determination of sterilisation questions without standard court hearings, with their attendant formality, delay and expense. Many submissions specifically urged that this jurisdiction be given to the Guardianship and Administration Board. The Public Guardian established under the *Guardianship and Administration Act*, DSC, the ACTIV Foundation and other institutional submissions³⁶ supported this alternative, as did a large number of parents of intellectually disabled children and members of the public. Although the Board has only recently been established in Western Australia, there was a high level of optimism and expectation about its potential in dealing with the similar problems of disabled adults in this area. Judged from the standpoint of an institution to which families might have recourse, the Board was considered much less threatening than a court. Very few of the submissions received favoured a court process alone as the way to deal with this question.

8.31 As compared with the Family Court, the Guardianship and Administration Board has two other advantages as a potential forum for sterilisation applications. First, it is likely that cases dealt with by the Board and refused when the person is a child may be brought before the Board when the person has become adult, at which time an order might be made. If the matter were heard initially in the Family Court, that Court would lose jurisdiction on the person's adulthood, requiring two quite separate hearings. Second, it is unlikely that there will be sufficient cases in Western Australia to enable the counselling facility of the Family Court to develop expertise in dealing with the particular problems of families caring for intellectually disabled children. Such families would be referred to other agencies. This expertise is being developed as part of the administration of the *Guardianship and Administration Act*, with the Public Guardian's Office as a focal point. That Office complements the services provided by DSC and other agencies in Western Australia.

³⁵ Id s 63(1).

³⁶ Including the Family Planning Association, the Developmental Disability Council, People with Disabilities and the Down's Syndrome Association.

(e) The Commission's view

8.32 The Commission has come to the conclusion that the constitution, the existing jurisdiction and the informal process of the Guardianship and Administration Board, plus the strong support for it in the submissions and the other points made above, make it the most suitable body for making decisions about the sterilisation of children. This jurisdiction, like the jurisdiction to hear applications for the sterilisation of adults, should be exercised only by the Full Board. If necessary, the Board could be required to provide a procedure for expediting decisions in sterilisation cases.

8.33 In making the above recommendation the Commission does not imply that neither the Family Court nor the Supreme Court is an appropriate forum for the determination of such issues; its conclusion is simply that the Guardianship and Administration Board is on balance better suited to the task in question.³⁷

³⁷ Contrast the view of the Hon Justice Nicholson, Chief Judge of the Family Court of Australia, who has criticised the development of guardianship boards and tribunals: Hon Justice Nicholson *The Medical Treatment of Minors and Intellectually Disabled Persons - United Nations Convention on the Rights of the Child, Article 23* (paper given to the First World Congress on Family Law and Children's Rights, Sydney, 4-9 July 1993) 14-15. However, Justice Nicholson's view is criticised in D Tait and others *Legal Regulation of Sterilisation: The Role of Guardianship Tribunals in NSW and Victoria* (1994) 8 AJFL 141.

Chapter 9

PROCEDURAL AND OTHER MATTERS

1. PROCEDURE BEFORE THE BOARD

9.1 Under the Commission's proposed scheme the jurisdiction to hear applications for the sterilisation of children would be given to the Guardianship and Administration Board established under the *Guardianship and Administration Act 1990*.¹ The Board in general operates informally,² and the Commission regards it as of the utmost importance that hearings dealing with the proposed sterilisation of a child should be informal and non-adversarial. The Commission notes that the Act gives the Board power to appoint a guardian,³ which avoids the necessity of taking separate proceedings for guardianship.

9.2 The Commission envisages that the procedural and other rules which govern other applications before the Board will apply to applications for the sterilisation of children with only minimal change. The Commission's proposals as to the procedure governing such applications are therefore confined to three matters of particular importance.

(a) The child should be separately represented

9.3 The Commission proposes that on an application for sterilisation of a child the child should be separately represented, either by the Public Guardian or otherwise.

9.4 The Public Guardian appointed under the *Guardianship and Administration Act* has the responsibility, at all hearings before the Board:

- "(i) to seek to advance the best interests of the represented person or person to whom the proceedings relate;

¹ See para 8.32 above.

² S 15 of the *Guardianship and Administration Act 1990* provides that the Board is to act according to the substantial merits of the case without regard to technicalities and legal forms, and is not bound by the rules of evidence. Schedule 1 Pt B para 2(2) provides that the Board shall not sit in a law court unless the chairperson is satisfied that no other suitable accommodation is available. Though hearings are in principle open, the Board has power to hold closed hearings or to exclude particular persons: id para 11. There are limitations on the publication of accounts of proceedings in the media: id para 12..

³ S 43(1).

- (ii) to present to the Board any information in his possession that is relevant to the hearing; and
- (iii) to investigate and report to the Board on any matter or question referred to him by the Board.⁴

9.5 Thus the Public Guardian would ordinarily represent the child's interests. Alternatively, the child could have other separate representation.⁵ The Commission's proposal emphasises the importance, in sterilisation proceedings, of the principle that the child should be separately represented.

(b) The child should be allowed to express views

9.6 The Commission has suggested above that where the child, even though intellectually disabled, has capacity to give informed consent, sterilisation should not take place unless such consent has been given. There are not likely to be many cases where this requirement will be satisfied. However, a child who does not have such capacity may still have at least some partial understanding of the matter and may be able to express some kind of view. The Commission proposes that in any case where the child is able to express some kind of view he or she should be given an opportunity to express it, regardless of the child's degree of immaturity or disability.

9.7 Regrettably, there will be many cases where the child is incapable of expressing any view at all and where an opportunity to express views will therefore be of no value. This was the case, for example, in *Re Marion (No 2)*⁶ and *Re L and M*⁷ where the only communication of which Marion and Sarah were capable was of the most basic kind, amounting to no more than a few words or gestures and the ability to express likes or dislikes about food.

⁴ S 97(1)(b).

⁵ In *Re L and M* (1993) 17 Fam LR 357, the child Sarah was separately represented, by order of the court. The Director General of the Department of Family Services and Aboriginal and Islander Affairs of the State of Queensland intervened in the proceedings. In *Re Marion (No 2)* (1992) 17 Fam LR 336, Marion's interests were represented by the Northern Territory Department of Health and Community Services, and the Human Rights and Equal Opportunity Commission intervened in the proceedings.

⁶ (1992) 17 Fam LR 336.

⁷ (1993) 17 Fam LR 357.

(c) The Board should have power to adjourn the proceedings

9.8 The Commission proposes that the Board, in determining an application, should have the power to adjourn the final hearing of the application for a time directed by the Board and on terms and conditions set by the Board, in order to allow for alternatives to sterilisation to be considered and tried.

9.9 The Commission is of the view that sterilisation should not be authorised unless it is justified by conditions in existence at the time of the application. Several of the court cases referred to in this Report concerned anticipated, rather than actual, problems in the care of the children concerned. In *Marion's Case*, for example, it was anticipated that she would experience difficulty because of the "hormonal fluxes" associated with her menstruation. In none of the cases referred to was the girl sexually active, and in *Marion's Case* her incapacity was such that it was unlikely she might ever choose to engage in sexual intercourse.⁸

9.10 Whereas normal prudence, care and concern require assessments of the future difficulties to be faced by an individual, and parental care of a disabled child may necessitate such an assessment, in the case of a person who is still at law a child determinations about his or her future needs and capacities must be seen as speculative.

9.11 Accordingly the Commission proposes that the Board should have power to adjourn the proceedings, in the terms set out above. A prior refusal to grant an order authorising sterilisation should be no bar to making a subsequent application for such an order, provided that there is evidence that the circumstances of the person concerned have changed to a sufficient extent to warrant further consideration of the question of sterilisation by the Board.

2. APPEALS

9.12 The *Guardianship and Administration Act 1990* provides for appeals from the Full Board of the Guardianship and Administration Board to be heard, with leave, by the Full

⁸ The judgment of Nicholson CJ in *Re Marion* (No 2) (1992) 17 Fam LR 336 contains a fuller statement of the evidence on which he came to the conclusion that sterilisation was in Marion's best interests. In particular, the judge found at 354-355 that there were no prospects for improvement in her condition and that there was no basis to defer sterilisation. Contrast *Re L and M* (1993) 17 Fam LR 357 where Warnick J found at 374 that there was no reason why Sarah, the child in question, should be sterilised immediately. Sterilisation could remain an option if circumstances changed.

Court of the Supreme Court of Western Australia.⁹ This applies to all aspects of the Board's jurisdiction, including applications for the sterilisation of adults. This appeal avenue would also be appropriate when the Board is exercising jurisdiction over applications for the sterilisation of children, and the Commission proposes that it should apply to such applications.

3. REGISTER OF STERILISATIONS

9.13 The Commission proposes that all surgical treatment of children which renders them sterile should be notified and kept on a special register maintained for that purpose by the Guardianship and Administration Board.

9.14 The Board would maintain a record of decisions relating to such surgical treatment which it approved in the normal course of its deliberations. In the case of treatment which is urgently required for a life-threatening disease or condition, notification should take place after treatment has occurred. The requirement for disclosure will provide a means of monitoring medical practice which affects fertility. It will also provide a monitoring and research resource.¹⁰

4. TRAINING

9.15 Children with intellectual disabilities will be cared for either at home or in institutions. Where parents elect to care for their child at home, they are the ones who carry the responsibility of care. There will be many problems, not the least difficult of which, in the case of girls, will be the supervision of the child's menstrual periods.

9.16 In submissions to the Commission a number of parents expressed frustration with their situation as a result of their decision to look after their child at home. They received little or no outside assistance and respite care, and had to attempt to train their own daughters in menstrual management and hygiene matters. They found it difficult to obtain information in Western Australia about ways of dealing with problems of menstrual management for children with intellectual and/or other disabilities. It is apparent that not all doctors are

⁹ *Guardianship and Administration Act 1990* ss 18(1) and 19.

¹⁰ McHugh J in his dissenting judgment advocated the development of objective standards which the courts can supervise and enforce when necessary: *Marion's Case* at 320.

equipped to provide this information to parents. Children who are institutionalised may benefit from specialist assessment of their needs and behavioural programs devised for them. Parents caring for children at home were in some cases not aware of the kinds of support that are available.

9.17 DSC provides facilities to assist the carers of intellectually disabled children. In its submission to the Commission it stated:

"With regard to menstrual management, it is standard practice for [DSC] Medical Officers to introduce this subject with parents of female clients in regular medical appointments when the child is between 8-10 years of age. Discussion of management and hygiene commences at this point with specific behavioural training programs designed by [DSC] Psychologists should this be necessary.

It should be noted however, that many families of non-English speaking background do not discuss this subject with health professionals and that in practice, menstrual management is an issue for school personnel since they inevitably face this in the practical sense. [DSC] Medical Officers believe they have the expertise to assist parents in these matters."

DSC consults on a regular basis with other service providers to ensure that there are co-ordinated and comprehensive services available.

9.18 Some families appear to be unaware of the assistance they may be entitled to. Others, on the evidence of some submissions to the Commission, were aware of the facilities made available by DSC, but had the impression that these were not readily available for children in the care of their parents. Some may have found such services wanting or may have chosen not to use them.

9.19 *Analysis of Australian Policy* recognised the difficult position of parents and the fact that parents seeking orders for sterilisation from the courts were doing so because they anticipated problems in management. It was suggested that:

"[C]omprehensive information about all menstrual and fertility management approaches and the possibility of unknown long term effects of surgical or pharmaceutical approaches, does not appear to be readily available to parents [C]ounseling which assists parents to consider their concerns and fears about their daughter's menstruation and potential to become pregnant does not appear to be integrated into service delivery Some care providers have stated that menstrual

management does not necessarily have to be complicated, time consuming or stressful."¹¹

9.20 The interviews with mothers of intellectually disabled children carried out in association with this report suggest that information and practical support for women who have disabilities and their families does not appear to be consistently available. The researchers noted that reliance on the medical profession for advice concerning menstrual management appeared to be resulting in a situation where non-medical approaches to menstrual or fertility issues are not widely known or implemented.

"The frequent access to medical advice and general lack of advice about non-medical approaches and practical support is reinforcing a perception that managing menstruation and fertility is a medical matter."¹²

9.21 The Commission finds that parents who care for their disabled children in their home bear a disproportionate burden in the upbringing and care of such children. Sterilisation of the children concerned, in some cases, is seen as a means of relieving parents of part of this burden and responsibility, but is generally undesirable for reasons already given by the Commission,¹³ and the Commission has proposed that it should be authorised only as a last resort.¹⁴ The provision of resources to provide educational and training programmes about managing fertility and the menstrual cycle that are readily accessible to parents caring for such children in their homes is a preferable course to a medical solution to the difficulties faced by parents.

9.22 There are resources available to the parents and families of the intellectually disabled to assist them in dealing with the sexuality of their children, both from government and private agencies, though the degree of assistance available from the medical profession to deal with these problems is limited. Such matters are not within the normal expertise of the medical profession yet parents and caregivers often seek assistance from their doctor in circumstances where a medical solution then becomes the option given the most consideration. The Commission finds that more effort should be directed to disseminating

¹¹ Para 2.6.

¹² G Carlson and J Wilson *Is Menstruation a Taboo? Managing Menstruation: The Mother's Perspective* (paper given at the World Congress of the International Association for the Scientific Study of Mental Deficiency, Queensland, 1992) 14.

¹³ See paras 7.43-7.65 above; see also paras 6.17-6.20 above.

¹⁴ See paras 7.66-7.71 above.

educational and training material to allow families to deal with their concerns without first seeking a medical solution.

9.23 The *Guardianship and Administration Act*¹⁵ provides that the functions of the Public Guardian include the following:

- "(d) to seek assistance for any represented person or person in respect of whom an application has been made from any government department, institution, welfare organization or the provider of any service;
- (e) to provide information and advice -
 - (i) to a proposed guardian or administrator, as to the functions of guardians and administrators; and
 - (ii) to any person, as to the operation of Part 4;¹⁶
- (f) to promote public awareness and understanding by the dissemination of information concerning -
 - (i) the provisions of this Act, including those relating to the functions of the Board, the Public Guardian and guardians and administrators; and
 - (ii) the protection of the rights of represented persons and persons who may become subject to guardianship or administration orders, and the protection of such persons from abuse and exploitation;
- (g) to promote family and community responsibility for guardianship and for that purpose to undertake, co-ordinate and support community education projects; and
- (h) to encourage the involvement of government and private bodies and individuals in achieving the objects described in paragraphs (f) and (g)."

9.24 In the Commission's view the functions of the Public Guardian should be extended to include the provision of information about sexuality, fertility and menstrual management for the intellectually disabled and the making of referrals for the development of appropriate counselling services. It therefore proposes that section 97 of the *Guardianship and Administration Act 1990* be amended to provide that the Public Guardian, as part of his or her functions, should make information concerning sexuality, fertility and menstrual management available to families and individuals concerned with the care of the intellectually disabled,

¹⁵ S 97.

¹⁶ Pt 4 deals with applications for guardianship and administration orders.

and where appropriate make referrals for the development of behavioural programmes and counselling services.¹⁷

¹⁷ Note also the recommendations in *Analysis of Australian Policy* on training: see Ch 3 n 73.

Chapter 10

APPLICATION TO ALL MINORS

1. THE ISSUES

10.1 The discussion in this Report has been primarily directed at the issue of sterilisation of intellectually disabled children, because in practice it is only in respect of intellectually disabled children that sterilisation is ever likely to be seriously considered. Requests for sterilisation by the parents of a non-intellectually disabled child, or by the child himself or herself, will be extremely rare.

10.2 Nonetheless, it is necessary for the Commission to determine whether the scheme proposed in this Report, under which applications for sterilisation may be made to the Guardianship and Administration Board, is to apply only to the intellectually disabled or to all children. The matters dealt with in this Report arise under a general reference on medical treatment for minors, in which the Commission has to consider when minors should be able to consent to medical treatment on their own behalf, when such treatment should require the consent of their parents, and whether there are cases in which treatment should be carried out without the consent of an independent arbiter such as a court.

2. THE PRESENT LAW

(a) The position in the Family Court

10.3 There is little direct guidance in *Marion's Case* on the application of the principles set out in that case to children who are not intellectually disabled. Though the majority judgment begins by dealing with the general issue of medical treatment for children,¹ its discussion of sterilisation is restricted to "circumstances such as the present", that is, cases involving intellectually disabled children.²

¹ *Marion's Case* at 236-238.

² Id 253. Though some of the reasons given by the Court for treating sterilisation as a special circumstance related to the special nature of sterilisation as such (for example its irreversibility), rather than to the particular issue of sterilisation for intellectually disabled persons, the Court expresses no final view on the sterilisation of those who are not intellectually disabled.

10.4 However, certain tentative propositions can be made about the application of the case to children who are not intellectually disabled. First, in a case involving sterilisation for therapeutic reasons, the principle that the decision is not one for the court to make must hold good. The High Court rejected any suggestion that such a decision should not be made by the parents, and it endorsed the general principle that mature minors could make decisions regarding their own medical treatment.³ It therefore seems that therapeutic sterilisation is a matter for the child to decide, if the child has the necessary capacity,⁴ and for the parents in all other cases.

10.5 Non-therapeutic sterilisation, it seems, would still be regarded as a matter for the court. The welfare jurisdiction under which the Family Court has power to authorise sterilisation for non-therapeutic reasons is not limited to the intellectually disabled, but extends to all children of a marriage. The High Court in *Marion's Case* accepted as a general principle that some decisions were not within the power of parents to make, because they could not be in the child's interests, for example cutting off a foot to allow the child to beg more effectively.⁵

10.6 The subsequent case of *Re A*,⁶ though it does not deal with sterilisation, helps to confirm the view that some medical decisions involving children who are not intellectually disabled nevertheless remain outside the limits of parental power. A was born a genetic female with an extreme degree of masculinisation because of an abnormality in the adrenal gland. She had a genetic reconstruction to give her a feminine appearance and hormone treatment to prevent the production of further male hormones by the adrenal gland. However, during her childhood, the level of hormone treatment she received was inadequate, leading to further production of male hormones and recurrent masculinisation of the external genitalia. When A was 14, her mother sought the Family Court's authorisation for medical procedures which would reassign her sex from female to male. Mushin J was satisfied on the evidence that A understood the problem and, in general terms, the way it was proposed to be resolved (by reassigning her as a male) and that A had expressed a desire that this take place.

³ See para 3.30 above.

⁴ Though Parkinson suggests that such a case could hardly ever arise: P Parkinson *Children's Rights and Doctors' Immunities: The Implications of the High Court's Decision in Re Marion* (1992) 6 AJFL 101, 118 (quoted in para 3.37 above).

⁵ *Marion's Case* at 240.

⁶ (1993) 16 Fam LR 715.

However, the judge was not satisfied that A had the capacity and maturity to appreciate fully all aspects of the matter and assess objectively the various options, as required by the general test approved by the High Court in *Marion's Case*. Furthermore, he held that the proposed treatment was not of the kind to which parents could consent on a child's behalf, but required an order of the court.

(b) The position in New South Wales and South Australia

10.7 In New South Wales, sterilisation of a child under 16 is prohibited unless such treatment is necessary as a matter of urgency to save the child's life or prevent serious damage to the child's health.⁷ This applies to all children whether intellectually disabled or not. However, a child of 16 or above who is capable of consenting to medical treatment can consent to sterilisation, and the permission of a court or similar body is not required. This is because the legislation prohibiting the sterilisation of a child of 16 or over unless it is necessary as a matter of urgency to save the patient's life or prevent serious damage to the patient's health⁸ only applies to persons who are incapable of consenting to medical treatment on their own behalf.⁹ Children of 16 or above who are not intellectually disabled, and some mildly intellectually disabled children of that age, would not come within this category. In such cases, consent to sterilisation would be governed by the ordinary rules dealing with medical treatment for minors, which in New South Wales are contained in the *Minors (Property and Contracts) Act 1970*. This provides that where medical or dental treatment is carried out with the prior consent of a minor of 14 or over, the minor's consent has the same effect as if the minor were of full age.¹⁰ However, in the case of a child under 16 the parent's consent has the same effect as if it were the consent of the minor and the minor were of full age.¹¹

10.8 In South Australia also, a child of 16 or over who has full mental capacity can consent to sterilisation without permission from any other source. In certain circumstances, the same will apply to a child under 16 who satisfies a maturity test. The provisions of the

⁷ *Children (Care and Protection) Act 1987* (NSW) s 20B: see para 3.50 above.

⁸ *Guardianship Act 1987* (NSW) s 37. However, this Act, to the extent that it seeks to prohibit sterilisations of children taking place in New South Wales unless authorised by the Guardianship Board, was ruled invalid by the High Court in *P v P* because it was inconsistent with the jurisdiction exercised by the Family Court under the *Family Law Act 1975* (Cth): see paras 4.15-4.19 above.

⁹ *Guardianship Act 1987* (NSW) s 34(1).

¹⁰ S 49(2).

¹¹ S 49(1).

Guardianship and Administration Act 1993 prohibiting sterilisation except with the consent of the Guardianship Board apply to all persons, including children, but only when they are incapable of giving effective consent by reason of mental incapacity.¹² Children who have such capacity are governed by the *Consent to Medical and Dental Procedures Act 1985*, which provides that the consent of a minor of 16 or over has the same effect as if the minor were of full age.¹³ In the case of a minor under 16, the consent of a parent is deemed to be the consent of the minor and to have the same effect as if the minor were of full age,¹⁴ but where two medical practitioners certify that the minor is capable of understanding the nature and consequences of the procedure, and that it is in the best interests of the minor's health and well-being, the minor's consent has the same effect as if the minor were of full age.¹⁵

3. THE COMMISSION'S VIEW

10.9 Since this Report deals only with sterilisation, it is not appropriate for the Commission to make recommendations relating to other kinds of medical treatment. Any question as to whether Western Australia should follow New South Wales and South Australia in enacting that children over a certain age, or who are mature, should have full capacity to make decisions concerning their own medical treatment must await the Commission's report on the more general aspects of this reference.¹⁶ The issue for the Commission is whether the consent of the Guardianship and Administration Board should be required for all non-emergency sterilisations of all children, or only the intellectually disabled.

10.10 The Commission is of the view that, under its ideal scheme, the jurisdiction of the Guardianship and Administration Board to consent to sterilisations of children should extend to all children, and not just the intellectually disabled. Sterilisation, because of its special nature, needs to be treated differently from other kinds of medical treatment.¹⁷ The scheme proposed by the Commission should therefore apply to all cases involving sterilisation of children, and not just those who are intellectually disabled. This would emphasise that sterilisation is a serious step, and that the circumstances in which it should be permitted to be carried out on a child, intellectually disabled or not intellectually disabled, are very limited.¹⁸

¹² *Guardianship and Administration Act 1993* (SA) s 58.

¹³ S 6(1).

¹⁴ S 6(4).

¹⁵ S 6(2).

¹⁶ For the Commission's provisional proposals see Discussion Paper paras 5.9-5.24.

¹⁷ See paras 8.14-8.16 above.

¹⁸ See also para 3.33 above.

10.11 The Commission is aware that in proposing that the scheme apply to all children it is imposing a limitation on the powers of non-intellectually disabled children who satisfy the common law test of maturity and are therefore able to consent to medical treatment on their own behalf,¹⁹ and that there is no equivalent limitation in New South Wales or South Australia as regards children who under the legislative provisions in those States can consent to medical treatment to the same extent as if they were of full age.²⁰ However it is disinclined to make special provision for particular categories of children to consent to one particular form of medical treatment in advance of determining that issue in relation to medical treatment generally. This it will do in the later report on this reference.

¹⁹ See para 3.30 above.

²⁰ See paras 10.7-10.8 above.

Chapter 11

SUMMARY OF THE COMMISSION'S IDEAL SCHEME

In summary form, the Commission's ideal scheme is as follows -

Whether sterilisation should be permissible

1. The legislative scheme should not seek

(a) to prohibit all sterilisations of children;

Paragraph 6.3

(b) to limit permitted sterilisations to those that are necessary to save the life of the child;

Paragraphs 6.4-6.6

(c) to limit permitted sterilisations to those that are carried out for therapeutic reasons.

Paragraphs 6.7-6.22

Prohibition on sterilisation unless permission granted by appropriate body

2. Except in a case of emergency no sterilisation would be permitted to take place in Western Australia unless permission has been granted by the decision-making body established under the proposed scheme. This would cover all sterilisations, whether sought for therapeutic reasons or otherwise.

Paragraphs 7.1-7.2

Best interests

3. The most important principle to be applied in determining whether sterilisation of a child should be permitted is whether it is in the child's best interests.

Paragraphs 7.3-7.7

4. The decision-making body should not take into account the interests or circumstances of persons other than the child, except to the extent that they have a bearing on the child's individual interests.

Paragraphs 7.8-7.13

5. If the child has capacity to give informed consent, the decision-making body should permit sterilisation only if the child has personally consented.

Paragraphs 7.14-7.19

6. Unless the decision-making body is satisfied that the sterilisation is therapeutic, it should not permit sterilisation unless it is satisfied that

- (1) there is no likelihood that the child will ever have the capacity to consent to sterilisation, and
- (2) that there is no evidence of any prior refusal by the child, being a refusal made by the child while capable of giving effective consent and which was communicated by the person to a medical practitioner.

Paragraphs 7.20-7.24

7. There should be a presumption that sterilisation is not in the child's best interests. The presumption would be rebuttable only in the following three situations:

- (1) where failure to carry out a procedure involving sterilisation is likely to result in the child's physical or mental health being seriously jeopardised, or in the suffering of pain, fear or discomfort of such severity and duration or regularity that it is not reasonable to expect the child to suffer that pain, fear or discomfort;
- (2) if -
 - (a) failure to carry out the procedure is likely to result in a real risk that a girl under 18 will become pregnant;

- (b) she does not, and never will, have any real understanding of sexual relationships, pregnancy or motherhood; and
 - (c) Allowing her to become pregnant and give birth in such circumstances is likely to cause her to suffer trauma, prior to, at the time of or after the birth, which it would not be reasonable to expect her to suffer;
- (3) if -
- (a) the child has commenced menstruation or is virtually certain to commence menstruation in the near future; and
 - (b) the procedure is necessary to avoid grave and unusual problems or suffering which are or would be involved in menstruation and which are such that, according to general community standards, it would be unfair to require the child to bear the additional burden of them.

Even if the decision-making body found that the case came within one of the above situations, it should be open to it to hold that in the light of other factors it was not in the child's best interests to be sterilised.

Paragraphs 7.25-7.65

Last resort

8. Even if sterilisation is otherwise found to be in the child's best interests, it should be permitted only as a step of last resort.

Paragraphs 7.66-7.71

Responsibility for the decision

9. All sterilisation decisions, whether or not the sterilisation is sought for therapeutic reasons, should be made by an independent body acting in the manner of a court or tribunal.

Paragraphs 8.1-8.18

10. The only exception would be where sterilisation is urgently necessary to save the life of the child or prevent serious damage to the child's health. The decision whether a case falls into this category would be one for the medical practitioner carrying out or supervising the treatment.

Paragraphs 8.19-8.20

The decision-making body

11. Jurisdiction to hear applications for the sterilisation of children should be given to the Guardianship and Administration Board. This jurisdiction, like the jurisdiction to hear applications for the sterilisation of adults, should be exercised only by the Full Board.

Paragraphs 8.21-8.33

Application to all minors

12. The jurisdiction of the Guardianship and Administration Board to consent to sterilisation should apply to the sterilisation of all children and not just the intellectually disabled.

Paragraphs 10.1-10.11

Procedural matters

13. On an application for sterilisation of a child the child should be separately represented, either by the Public Guardian or otherwise.

Paragraphs 9.3-9.5

14. In any case where the child is able to express some kind of view concerning the proposed sterilisation, he or she should be given an opportunity to express it, regardless of the child's degree of immaturity or disability.

Paragraphs 9.6-9.7

15. In determining an application, the Board should have the power to adjourn the final hearing of the application for a time directed by the Board and on terms and conditions

set by the Board, in order to allow for alternatives to sterilisation to be considered and tried.

Paragraphs 9.8-9.11

Appeals

16. The provisions of the *Guardianship and Administration Act* providing for appeals from an order of the Board to the Full Court of the Supreme Court, with leave, should apply to applications for the sterilisation of children.

Paragraph 9.12

Register of sterilisations

17. All surgical treatment of children which renders them sterile should be notified and kept on a special register maintained for that purpose by the Board.

Paragraphs 9.13-9.14

Training

18. Section 97 of the *Guardianship and Administration Act 1990* should be amended to provide that the Public Guardian, as part of his or her functions, should make information concerning sexuality, fertility and menstrual management available to families and individuals concerned with the care of the intellectually disabled, and where appropriate make referrals for the development of behavioural programmes and counselling services.

Paragraphs 9.15-9.24

PART III: DISCUSSION AND RECOMMENDATIONS

Chapter 12

DISCUSSION AND RECOMMENDATIONS

1. THE ALTERNATIVES

12.1 The High Court in *Marion's Case* identified a need for a more appropriate process for decision-making in cases involving sterilisation of children, because of the cost and delay involved in court proceedings and the unsuitability of the adversary process for arriving at decisions in such cases. The court suggested that this need could only be fulfilled by legislative reform.¹

12.2 In Part II of this Report the Commission put forward its ideal scheme for making decisions in such cases. These decisions would be made by the Guardianship and Administration Board, in accordance with stated criteria. The Board would adopt a much more informal procedure than would be possible in court proceedings.

12.3 Whether or not it is possible to implement this scheme in Western Australia depends on what action is taken by the Commonwealth. In Chapter 4 the Commission showed how decision making in matters of sterilisation involves the complex relationship between Commonwealth and State jurisdiction in matters of family law. The Commonwealth can legislate in respect of children of a marriage, though it has chosen not to do so in respect of children in State care.² States can also legislate in respect of children of a marriage, but in *P v P* the High Court confirmed that State legislation which seeks to limit the Commonwealth jurisdiction exercised by the Family Court of Australia will be invalid to the extent of its inconsistency with Commonwealth law. Only States have legislative power to deal with ex-nuptial children.

12.4 Reform is under consideration at Commonwealth level. The Family Law Council Discussion Paper outlined a number of alternatives for possible Commonwealth legislation.³

¹ *Marion's Case* at 253.

² See paras 4.7 above, 12.8 below.

³ According to para 5.01, the Commonwealth could:

- (1) retain the existing spread of jurisdictions;

The Commission's recommendations of necessity depend on what action is taken by the Commonwealth. The Commonwealth might:

- (1) Vacate the field, leaving the States free to pass comprehensive legislation on all aspects of sterilisation, in respect of all children.
- (2) Pass legislation conferring exclusive jurisdiction in matters of sterilisation, within the limits of Commonwealth power, on
 - (a) State Guardianship Boards; or
 - (b) The Family Court of Australia.

In such a situation the States would no longer have power to make laws relating to nuptial children. State laws could affect only ex-nuptial children (and children in State care, assuming that the Commonwealth continued to choose not to legislate in respect of such children).

- (3) Pass legislation under which the Family Court of Australia retained its existing jurisdiction.

This would leave the States free, as at present, to legislate with regard to nuptial children, provided the legislation was not inconsistent with Commonwealth law. The States would continue to have exclusive responsibility for ex-nuptial children and (unless the Commonwealth decided otherwise) children in care.

12.5 The same result as in (3) could be achieved if the Commonwealth did not pass any legislation. The Family Court of Australia would continue to exercise nonexclusive jurisdiction, as at present.

12.6 The alternatives described above apply not only in Western Australia, but also in the other States. Though all the States, apart from Western Australia, have referred powers

-
- (2) establish a new Specialist Tribunal;
 - (3) give existing tribunals exclusive jurisdiction; or
 - (4) give the Family Court exclusive jurisdiction.

The Specialist Tribunal alternative was in effect ruled out by the Discussion Paper as not warranted by the likely volume of claims: paras 5.06-5.07.

relating to custody, guardianship of and access to children to the Commonwealth, welfare powers have not been referred.⁴

2. A SINGLE SCHEME

12.7 The Commission's preference is for all sterilisation decisions, involving both nuptial and ex-nuptial children, to be regulated by its ideal scheme. This could happen if the Commonwealth chose to vacate the field, leaving the States free to pass comprehensive legislation.

12.8 The Commonwealth has already done this for children in care. Under section 60H of the *Family Law Act 1975*, courts having jurisdiction under that Act must not make an order, other than for maintenance, in relation to a child who is under the guardianship, or in the custody or care and control, of a person under a child welfare law.

Recommendation 1: The Commission *recommends*, as its first preference, that the Commonwealth be asked to vacate the field in matters of sterilisation, so that the Western Australian Parliament can enact the Commission's ideal scheme. Under this scheme, all sterilisation decisions would be made by the Guardianship and Administration Board. It would be competent to deal with all children, both those who were children of a marriage and those who were not. The federal jurisdiction of the Family Court of Australia under the *Family Law Act 1975*, and the jurisdiction of the Family Court of Western Australia in State matters, would be excluded.

3. EXCLUSIVE JURISDICTION CONFERRED BY COMMONWEALTH LAW

12.9 Among the alternatives for the Commonwealth identified by the Family Law Council Discussion Paper were to:

- (1) give existing Tribunals, such as State Guardianship Boards,⁵ exclusive jurisdiction in matters of sterilisation; or
- (2) give the Family Court of Australia exclusive jurisdiction.

⁴ See para 4.6 above.

⁵ There are Guardianship Boards or similar bodies in the Australian Capital Territory, New South Wales, the Northern Territory, South Australia, Victoria and Western Australia. The Queensland Law Reform Commission has discussed the possibility of introducing a similar tribunal in Queensland: see *Assisted and Substituted Decisions* (Discussion Paper No 38 1992) 36-39.

If this were done, the States would retain legislative power only in respect of ex-nuptial children and children in State care (assuming the Commonwealth continued to exempt children in State care from the provisions of the *Family Law Act*).

(a) Exclusive jurisdiction given to State Guardianship Boards

12.10 If the Commonwealth enacted legislation giving exclusive jurisdiction in matters of sterilisation to State Guardianship Boards, the options for Western Australia would be -

- (1) to enact the Commission's ideal scheme and confer jurisdiction on the Guardianship and Administration Board of Western Australia, but limited to ex-nuptial children and children in care; or
- (2) to enact legislation in Western Australia which mirrored the Commonwealth Act.

12.11 In each case, the same tribunal the Guardianship and Administration Board would exercise jurisdiction over all children, both nuptial and ex-nuptial. This is the tribunal chosen to exercise that jurisdiction under the Commission's ideal scheme, and the advantages of informality, speed and cost saving which commended themselves to the Commission would be present. Moreover, the same tribunal already has jurisdiction to deal with the sterilisation of intellectually disabled adults.

12.12 The key issue is the law to be applied in making sterilisation decisions. The advantage of the mirror legislation option is that all children, nuptial and ex-nuptial, would be dealt with according to the same criteria. Under the other option, different rules might apply to the sterilisation of ex-nuptial children. This is contrary to the present policy of the law. Reforming legislation has sought to ensure that ex-nuptial children have the same status and the same rights as children born of a marriage.⁶

⁶ See eg *Administration Act 1903* s 12A; *Property Law Act 1969* s 31A; *Wills Act 1970* ss 29-31 (implementing the Commission's report on *Succession Rights of Illegitimate Children* (Project No 3 1970); *Fatal Accidents Act 1959* s 6(3) (implementing the Commission's report on *Fatal Accidents* (Project No 66 1978)).

12.13 Much would depend on the rules contained in the Commonwealth legislation. If the criteria for decision-making or any other aspect of the Commonwealth scheme were thought to be undesirable, it would be preferable to regulate sterilisation decisions concerning ex-nuptial children according to the Commission's ideal scheme. If, however, the Commonwealth legislation is broadly acceptable and even more so, if it approximates closely to the Commission's ideal scheme the Commission *recommends* that the State should enact legislation which mirrors the Commonwealth legislation, because of the benefits of having uniform criteria applying to all children, nuptial and ex-nuptial.

Recommendation 2: If the Commonwealth enacts legislation giving exclusive jurisdiction in matters of sterilisation to State Guardianship Boards, the Commission *recommends* (provided the Commonwealth legislation is in acceptable form) that Western Australia should enact mirror legislation giving State jurisdiction in such matters to the Guardianship and Administration Board of Western Australia.

(b) Exclusive jurisdiction given to Family Court of Australia

12.14 If the Commonwealth enacted legislation giving exclusive jurisdiction in matters of sterilisation to the Family Court of Australia, there are again two options for Western Australia:

- (1) to enact the Commission's ideal scheme and confer jurisdiction on the Guardianship and Administration Board of Western Australia, but limited to ex-nuptial children and children in care; or
- (2) to enact legislation in Western Australia which mirrored the Commonwealth legislation, and give jurisdiction in such matters to the Family Court of Western Australia.

12.15 The advantages of giving jurisdiction over sterilisation decisions to the Family Court of Australia, rather than the Guardianship and Administration Board, are not readily apparent. The High Court in *Marion's Case* identified a need for a more appropriate process for decision making in cases involving sterilisation,⁷ and yet under this alternative the Family Court of Australia would retain jurisdiction and the States would be unable to offer other

⁷ See para 1.14 above.

options, except for ex-nuptial children and children in care. The Family Court of Australia may be able to modify its usual procedures to some extent, but in terms of informality and cost it would not be an adequate substitute for the Guardianship and Administration Board. The only reason for giving jurisdiction to the Family Court of Australia rather than State Guardianship Boards would be the desire to encourage nationwide uniformity of decision-making.

12.16 The question for Western Australia is whether the State should confer jurisdiction on the Guardianship and Administration Board in relation to ex-nuptial children and children in care, or confer mirror jurisdiction over those classes of children on the Family Court of Western Australia. The choice is a difficult one to make, and the difficulty would be occasioned by the failure of the Commonwealth to heed the advice of the High Court about the need for a more appropriate decision-making process. However, in the Commission's view, the latter option is to be preferred, provided the Commonwealth legislation contains broadly acceptable criteria for decision-making. The most important reason is that it would be undesirable to have a different legislative scheme for ex-nuptial children and children in care. It is also significant that, in Western Australia, the enactment of mirror legislation would have the effect of ensuring that all sterilisation decisions were taken by the same court, since the *Family Law Act* jurisdiction of the Family Court of Australia is exercised in Western Australia by the Family Court of Western Australia.⁸

Recommendation 3: If the Commonwealth enacts legislation giving exclusive jurisdiction in matters of sterilisation to the Family Court of Australia, the Commission *recommends* (provided the Commonwealth legislation is in acceptable form) that Western Australia should enact mirror legislation giving State jurisdiction in such matters to the Family Court of Western Australia.

⁸ In this respect, the Western Australian family law system, involving a specialist court which has both federal and nonfederal family law jurisdiction, may still have an advantage over the position in the other States. The reference of State powers over children made by those States to the Commonwealth was limited to custody, guardianship and access and did not include welfare powers. Jurisdiction in respect of the sterilisation of ex-nuptial children must still be exercised by State tribunals, unless the Family Court of Australia is able to exercise cross-vested jurisdiction. This it would be able to do if the State jurisdiction is exercised by the Supreme Court, but not if it has been given to a Guardianship Board or similar body; see para 4.8 above. In *Re M (an infant)* (1992) FLC 92-318, a case involving a proposal to sterilise a girl under the age of 16, the Family Court of Australia was able to exercise cross-vested jurisdiction under the (*Children Care and Protection*) Act 1987 (NSW) because under the Act that jurisdiction was exercised by the New South Wales Supreme Court. It would appear that if the child had been 16 years old and was not the child of a marriage, the Family Court would not have been able to exercise cross-vested jurisdiction, because the *Guardianship Act 1987* (NSW) confers jurisdiction to consider sterilisation issues on the Guardianship Board.

4. NON-EXCLUSIVE JURISDICTION RETAINED BY FAMILY COURT OF AUSTRALIA

12.17 The Commonwealth might elect to enact legislation under which the Family Court of Australia retained non-exclusive jurisdiction in matters of sterilisation, or it might elect not to enact any legislation at all. In either case, State tribunals could continue to exercise jurisdiction in such matters over all children.

12.18 The choice for Western Australia would be -

- (1) to give State jurisdiction (which would continue to cover all children, but in the case of children of a marriage would be coexistent with the jurisdiction of the Family Court of Australia exercised in Western Australia by the Family Court of Western Australia) to the Guardianship and Administration Board; or
- (2) to leave such jurisdiction in the hands of the Family Court of Western Australia.

12.19 It should be noted that neither of these options involves implementing the criteria for decision-making contained in the Commission's ideal scheme (unless those criteria are adopted by the Commonwealth legislation). Because of *P v P*, Western Australia could not alter the criteria to be applied by the Family Court of Western Australia exercising federal jurisdiction, and it would be undesirable if different criteria were adopted for ex-nuptial children and children in care, or for cases dealt with by the Guardianship and Administration Board.

12.20 The major advantage of the first alternative would be that in every Western Australian case involving a proposed sterilisation, the parties could have the benefit of the procedures of the Guardianship and Administration Board, with its advantages of informality, speed and cheapness. The only advantage of the second alternative would be that decisions about sterilisation of all children, nuptial and ex-nuptial, would be made by the same tribunal. This is an advantage of limited importance, especially if the procedures of the tribunal are inappropriate to the decision to be reached.

12.21 In the projected situation in which the jurisdiction conferred on the Family Court of Australia by the Commonwealth is exclusive, the Commission recommended that State jurisdiction should be given to the Family Court of Western Australia (Recommendation 3 above). Here, however, the situation is different. State law will apply to all children and not just those who are children of a marriage. Applicants in cases involving children of a marriage are likely to find the Guardianship and Administration Board a more attractive forum than the Family Court of Western Australia.

12.22 It may be objected that under the first alternative there would be a risk of forum shopping. A similar problem arose when the Federal Court of Australia was established in 1976, making it possible for many cases to be litigated in either the Federal Court or State Supreme Courts.

12.23 In the Commission's view, when the advantages and disadvantages are weighed in the balance, the benefits of being able to have matters determined by the Guardianship and Administration Board, rather than in formal court proceedings, outweigh the possible problems that may arise if the Board has overlapping jurisdiction with the Family Court of Australia.⁹

Recommendation 4: If the Commonwealth -

- (1) enacts legislation under which the Family Court of Australia retains nonexclusive jurisdiction in matters of sterilisation; or**
- (2) elects not to enact any legislation, so that the Family Court of Australia retains its current nonexclusive jurisdiction,**

⁹ One disadvantage of all the options recommended above except the Commission's first preference option (Recommendation 1) is that appeals from the court or tribunal exercising federal jurisdiction would probably go to a different court from that which would consider appeals from the court or tribunal exercising State jurisdiction. Appeals from the Family Court of Australia, and from the Family Court of Western Australia exercising federal jurisdiction, currently go to the Full Court of the Family Court of Australia: *Family Law Act 1975* (Cth) s 94; *Family Court Act 1975* s 80. Appeals from the Family Court of Western Australia exercising State jurisdiction, and from the Full Board of the Guardianship and Administration Board, currently go to the Full Court of the Supreme Court of Western Australia: *Family Court Act 1975* s 81(2a); *Guardianship and Administration Act 1990* ss 18(1) and 19. On the possible problems arising out of differing interpretations of the same rule of law by different Full Courts, see A Dickey *Family Law* (2nd ed 1990) 83-84.

the Commission *recommends* (provided the Commonwealth legislation is in acceptable form) that Western Australia enact legislation giving State jurisdiction to the Guardianship and Administration Board.

P G CREIGHTON
Chairman

P R HANDFORD

C J McLURE

25 October 1994

Appendix I

SUBMISSIONS

ACTIV Foundation Inc.
ACTIV Foundation Inc South West Regional Council
Adams, C
Advisory Council for Disability
Andruszkiewicz, Mr J
Australian Association of Special Education Inc (Western Australian Chapter)
Australian Catholics Pro-Life Association
Australian Medical Association (Western Australia)
Baker, Mr A
Biggs, Mr E
Blanchard, Mr
Booth, Mr and Mrs W
Boyes, Ms M
Brethren, The
Bruce, Ms H
Bryant, Mr A G, JP
Bureau for Disability Services
Byrne, Mrs
Calvinistic Political and Social Association
Carlson, G (Department of Social Work and Social Policy, The University of Queensland)
Carter, Mr & Mrs AR
Catchpole, Dr & Mrs B N
Caterer, Mrs V
Catholic Archdiocese of Perth¹
Children's Interest Bureau (SA)
Clune, Mr P
Cole, Ms J
Communicare
Cornell, Ms J
Country Women's Association of Western Australia (Inc)
Cowan, Hon H, MLA (Leader of the National Party of Australia (WA))
Cox, Ms V A
Coyne, P
Currell, Mrs D V
Daniels, Ms L
Deller, Dr C R
Department of Health, Tasmania
Developmental Disability Council of Western Australia (Inc)
Disability Services Commission (formerly Authority for Intellectually Handicapped)

¹ Submissions from the L J Goody Bioethics Centre, Catholic Care for Intellectually Handicapped, the Catholic Community Care Commission and Bishop R Healy were withdrawn by the Archbishop of Perth.

Persons)
Dodds, Ms I (Public Guardian, Western Australia)
Down's Syndrome Association
Down, Mr R L
Drinkwater, Ms J
Education Support Committee, Peel Education District, Ministry of Education
Eastcott, A J
Elphick, Mr D
English, Ms M J
Even, Mr and Mrs P
Family Law Practitioners' Association of Western Australia (Inc)
Family Planning Association of Western Australia (Inc)
Faulkner, Ms U
Fenton, Mrs V
French, Mr H L
Geary, Mr & Mrs J S
Gilham, Mr & Mrs L S
Gillooly, Mr M
Graham, Mrs S
Halligan, Ms P
Harvey-Harris, Mrs D
Hazell, Mr P
Hebiton, Ms M
Hunter, Ms S
Huntsman, Mrs V
Intellectual Disability Review Panel
Joyce, Mrs C
Kailis, Ms A
King Edward Memorial Hospital for Women
Longbottom, Ms M
Lynes, Ms B
Maneschi, Ms M
Mansveld, Mr J
Marshall, Mrs C
Martin, Mrs A
Martin, Mrs J
Matthews, Ms G
Mentlein, Mr R
Mogridge, Mrs
Mount Isa State Special School (Queensland)
O'Brien, Ms P A
O'Callaghan, Mrs L
Parents and Friends of the Cromane Hostel for Intellectually Handicapped People Inc
Parents of Children with Disabilities
People with Disabilities (WA) Inc
Pilbara Family Support Association Inc
Pledg Project Inc
Pridham, Mr R
Richardson, Mr and Mrs L
Right to Life Association, Western Australia
Right to Life Australia

Robertson, Ms G
Royal College of Obstetricians and Gynaecologists
Scorer, Mrs J
Sexuality Education Counselling and Consultancy Agency
Selwood, Mr M
Setches, Hon K (Minister for Community Services & Minister Responsible for Child Care,
Victoria)
Sinclair, Ms P
Smith, Ms H
St Anne's Mercy Hospital
St John of God Health Care System Inc
Stanley, Ms L
Spence, Mr G C
Toster, Ms P
Tugby, Mr R
Turner, Ms M
Urlings, Ms H
Vaughan, Ms R
Walker, Mrs R
Weir, Mr H
White, R N
Wild, Mrs P D
Women Justices' Association of Western Australia (Inc)
Woods, Mr N K

Appendix II

MEDICAL DATA

The tables on the following pages give figures, for all States and Territories, for

- * hysterectomies
- * tubal ligations
- * endometrial ablations
- * ovariectomies

performed during the years 1986-87 to 1992-93.

The figures are derived from Medicare data obtained from the Australian health Commission. The form in which they appear is based on Tables 5, 6, 7 and 8 of *Analysis of Australian Policy*, with the authors' kind permission.

TABLE 1**MEDICARE DATA – HYSTERECTOMIES* PERFORMED****

0-9 year olds									10-19 year olds							
State	86/87	87/88	88/89	89/90	90/91	91/92	92/93	Total	86/87	87/88	88/89	89/90	90/91	91/92	92/93	Total
ACT	-	-	-	-	-	-	-	0	-	4	1	-	2	1	-	8
NSW	2	4	4	1	2	1	-	14	19	6	8	8	9	6	7	63
VIC	1	2	3	3	-	1	1	11	7	1	8	7	4	-	6	33
QLD	1	1	2	-	-	1	2	7	22	15	14	18	15	9	12	105
SA	1	-	-	-	-	1	-	2	3	1	1	1	1	2	3	12
WA	1	-	1	-	-	-	-	2	1	2	2	-	3	1	3	12
TAS	1	-	-	1	-	-	-	2	2	8	3	1	3	1	1	19
NT	-	-	-	-	-	-	-	0	-	-	-	-	-	-	1	1
Aust Total	7	7	10	5	2	4	3	38	54	37	37	35	37	20	33	253

Australian Total from 1986 to 1993 for 0-19 years is 291 hysterectomies.

- * Hysterectomy - surgical removal of the uterus
 - surgical removal of the uterus and one or both fallopian tubes
 - surgical removal of uterus, one or both fallopian tubes and one or both ovaries.

** These figures include only those services which qualify for Medicare benefit and for which a claim has been processed. These figures do not include services provided by hospital doctors to public patients in public hospitals.

TABLE 2**MEDICARE DATA – TUBAL LIGATIONS* PERFORMED****

0-9 year olds									10-19 year olds							
State	86/87	87/88	88/89	89/90	90/91	91/92	92/93	Total	86/87	87/88	88/89	89/90	90/91	91/92	92/93	Total
ACT			-	-	-	-	-	0			1	-	-	1	-	2
NSW			4	2	1	3	2	12			2	3	1	18	5	29
VIC			3	3	-	4	1	11			6	8	2	12	2	30
QLD			1	2	4	2	1	10			8	3	5	27	11	54
SA			1	1	1	2	-	5			1	-	2	3	1	7
WA			2	-	-	1	2	5			1	-	-	4	-	5
TAS			-	-	2	-	-	2			2	-	-	3	1	6
NT			-	-	-	-	-	0			1	1	-	2	1	4
Aust Total			11	8	8	12	6	45			22	15	10	70	20	137

Australian Total from 1986 to 1993 for 0-19 years is 182 tubal ligations.

* Tubal ligation is the surgical closure of the fallopian tubes

** These figures include only those services which qualify for Medicare benefit and for which a claim has been processed. These figures do not include services provided by hospital doctors to public patients in public hospitals.

TABLE 3**MEDICARE DATA – ENDOMETRIAL ABLATIONS* PERFORMED****

0-9 year olds									10-19 year olds							
State	86/87	87/88	88/89	89/90	90/91	91/92	92/93	Total	86/87	87/88	88/89	89/90	90/91	91/92	92/93	Total
ACT							-								-	
NSW							-								38	
VIC							-								75	
QLD							1								40	
SA							-								10	
WA							-								16	
TAS							-								3	
NT							-								1	
Aust Total							1								183	

* Endometrial Ablation or Resection is the surgical removal of the lining of the uterus.
Endometrial ablation or resection is a relatively new procedure for menstrual elimination. Figures are only currently being received.

** These figures include only those services which qualify for Medicare benefit and for which a claim has been processed. These figures do not include services provided by hospital doctors to public patients in public hospitals.

TABLE 4**MEDICARE DATA – OVARIECTOMIES* PERFORMED****

0-9 year olds									10-19 year olds							
State	86/87	87/88	88/89	89/90	90/91	91/92	92/93	Total	86/87	87/88	88/89	89/90	90/91	91/92	92/93	Total
ACT		-	1	-	-	-	-	1		3	6	6	5	2	2	24
NSW		5	3	8	1	5	9	31		199	139	153	123	126	73	813
VIC		5	6	5	1	3	2	22		110	122	103	105	87	58	585
QLD		-	3	2	5	2	1	13		51	63	40	48	43	32	277
SA		1	1	1	-	-	1	4		36	43	225	35	26	13	178
WA		-	2	2	2	1	-	7		40	42	38	27	23	15	185
TAS		1	-	1	-	-	-	2		14	10	10	15	8	7	64
NT		-	-	-	-	-	-	0		1	-	5	2	2	3	13
Aust Total		12	16	19	9	11	13	80		454	425	380	360	317	203	2139

Australian Total from 1986 to 1993 for 0-19 years is 2219 ovariectomies.

It is not clear from the figures how many of these procedures are for sterilisation purposes.

* Ovariectomy or oophorectomy is the surgical removal of part or both ovaries, using a laparotomy procedure. It may also involve removal of one or both of the fallopian tubes (salpingectomy). These figures do not include vaginal hysterectomy with salpingectomy, oophorectomy or excision of ovarian cysts.

** These figures include only those services which qualify for Medicare benefit and for which a claim has been processed. These figures do not include services provided by hospital doctors to public patients in public hospitals.

Appendix III

THE LAW ELSEWHERE

1. INTRODUCTION

1. In countries other than Australia, the attitude of the law to the problem of consent to the sterilisation of children varies widely. In some jurisdictions, sterilisation is not permitted at all in certain circumstances. In others, court consent is required, in some or in all cases. Canada appears to be the most restrictive, and New Zealand the most liberal. The jurisdictions discussed below have been arranged according to their place in this spectrum.

2. THE CANADIAN COMMON LAW

2. The position in Canada, as laid down by the Supreme Court of Canada in *Re Eve*,¹ is that neither a court nor anyone else can authorise a non-therapeutic sterilisation on a person who is incapable of consenting to such a procedure.

3. In *Re Eve*, a mother had applied for consent to the sterilisation of her 24 year old daughter who had a mild to moderate intellectual disability. The application was denied at first instance but granted by the Full Bench of the Prince Edward Island Supreme Court. On appeal by the daughter's guardian, the decision at first instance was restored. La Forest J, delivering the judgment of the Supreme Court, held that:

"In the present case, there is no evidence to indicate that failure to perform the operation would have any detrimental effect on Eve's physical or mental health. The purposes of the operation, as far as Eve's welfare is concerned, are to protect her from possible trauma in giving birth and from the assumed difficulties she would have in fulfilling her duties as a parent. As well, one must assume from the fact that hysterectomy was ordered, that the operation was intended to relieve her of the hygienic tasks associated with menstruation."²

4. La Forest J characterised the scope of the Court's *parens patriae* jurisdiction as being limited to doing "what is necessary for the benefit and protection of persons under

¹ (1986) 31 DLR (4th) 1.

² Id 30-31.

disability".³ Referring to the Canadian Law Reform Commission's paper *Sterilization*,⁴ he concluded:

"The justifications advanced are the ones commonly proposed in support of non-therapeutic sterilization Many are demonstrably weak. The commission dismisses the argument about the trauma of birth by observing at p 60:

'For this argument to be held valid would require that it could be demonstrated that the stress of delivery was greater in the case of mentally handicapped persons than it is for others. Considering the generally known wide range of post-partum response would likely render this a difficult case to prove.'

The argument relating to fitness as a parent involves many value-loaded questions. Studies conclude that mentally incompetent parents show as much fondness and concern for their children as other people. . . . Many, it is true, may have difficulty in coping, particularly with the financial burdens involved. But this issue does not relate to the benefit of the incompetent; it is a social problem, and one moreover, that is not limited to incompetents. . . .

As far as the hygienic problems are concerned, the following view of the Law Reform Commission (at p 34) is obviously sound:

'[I]f a person requires a great deal of assistance in managing their own menstruation, they are also likely to require assistance with urinary and faecal control, problems which are much more troublesome in terms of personal hygiene.'

Apart from this, the drastic measure of subjecting a person to a hysterectomy for this purpose is clearly excessive."⁵

5. La Forest J rejected the application of the "best interests" principle and instead adopted the therapeutic/non-therapeutic distinction:⁶

"The grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilization without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of that person.

³ Id 31.

⁴ Canadian Law Reform Commission *Protection of Life: Sterilization* (Working Paper 24 1979).

⁵ (1986) 31 DLR (4th) 1, 31-32.

⁶ The House of Lords in *Re B (A Minor) (Wardship: Sterilisation)* [1988] AC 199 (para 18 below) referred to *Re Eve* but rejected the therapeutic/non-therapeutic distinction, Lord Hailsham LC at 204 saying that it was meaningless. For a contrary view see the analysis of Brennan J in *Marion's Case* at 269.

Accordingly, the procedure should never be authorized for non-therapeutic purposes under the *parens patriae* jurisdiction.⁷

3. MANITOBA: THE REPORT OF THE LAW REFORM COMMISSION

6. In 1980 the Manitoba Law Reform Commission was asked to examine whether the law should, under any circumstances, provide for substituted consent to the non-therapeutic sterilisation of people legally incompetent to consent personally. However, when in 1981 the Supreme Court of Canada granted leave to appeal in the *Eve* case, the Manitoba Commission decided to defer work on its project until the Supreme Court gave its decision, since the case was expected to clarify precedent in this area of the law. It was not until five years later that the Supreme Court published its decision.⁸ The Manitoba Commission eventually reported in 1992.

7. In their Report the Manitoba Commission said that *Eve's* case settled the common law in Canada:

"Before this case, the law had been uncertain about whether any limits existed on the ability of parents, guardians or courts to give substituted consent for non-therapeutic sterilizations of legally incompetent people."⁹

8. The Manitoba Commission described the *Eve* decision as creating a blanket prohibition on non-therapeutic sterilisation. They saw this as controversial:

⁷ (1986) 31 DLR (4th) 1, 32. As an example of therapeutic sterilisation, the court cited *Re K and Public Trustee* (1985) 19 DLR (4th) 255, where the British Columbia Court of Appeal ordered that a hysterectomy be performed on a seriously retarded girl on the ground that the operation was therapeutic. The major factor in their decision was the child's alleged phobic aversion to blood, which it was feared would seriously affect her when she began to menstruate. Note also *Re R* (SL) (1992) 104 Sask R 6, in which a Saskatchewan first instance court allowed an ex parte application by the mother of an autistic 11 year old girl for an order approving gynaecological surgery (possibly involving a total abdominal hysterectomy) on the ground that it was therapeutic.

⁸ In addition, the Manitoba Commission met delays in this project as a result of its abolition and subsequent reinstatement in 1987-1988. The Commission also decided to wait and analyse the recommendations to be made by the Alberta Law Reform Institute which issued a Report for Discussion on *Sterilization Decisions: Minors and Mentally Incompetent Adults* (Report for Discussion No 6 1988). The Institute's final Report was released in 1989: *Competence and Human Reproduction* (Report No 52 1989).

⁹ Manitoba Law Reform Commission *Sterilization and Legal Incompetence* (Report No 76 1992) 1. The Commission noted, however, that in Alberta and British Columbia until the early 1970's the law was clear because those jurisdictions had involuntary sterilisation statutes, originally based on now discredited eugenic ideas and directed primarily at people with intellectual disabilities: *The Sexual Sterilization Act 1928* (Alberta), repealed by the *Sexual Sterilization Repeal Act 1972*; *Sexual Sterilization Act 1933* (BC), repealed by the *Sexual Sterilization Repeal Act 1973*.

"Its blanket prohibition is seen by some as necessary to prevent any possible return to the shameful and still recent history of routine, almost automatic, mass involuntary sterilization of people with intellectual disabilities. Others are concerned that the blanket prohibition is too rigid and prevents a consideration of individual circumstances in those occasional cases where, in the absence of any other alternative, non-therapeutic sterilization could truly be in a person's best interests."¹⁰

9. The Manitoba Commission commented that the law in Canada as it now exists as a result of the *Eve* case could be changed by provincial legislation. A statute could give a substitute decision maker the authority to consent to a non-therapeutic sterilisation on behalf of a person legally incompetent to consent personally. The central issue of this contentious area was whether it was appropriate that legally incompetent people should ever have access to or be subject to non-therapeutic sterilisation when they did not have the legal capacity to choose this procedure personally by consent.

10. The Manitoba Commission received submissions from people with widely divergent views. There were numerous opinions expressed which were based upon strongly held but inconsistent beliefs. For example, in relation to the human rights issue posed by the question of substituted consent and sterilisation, those advocating substituted consent asserted that failure to ensure equal access to a beneficial procedure amounted to discrimination. Those opposing substituted consent asserted that it was discrimination to fail to ensure security of the person against unauthorised interference.

11. The Manitoba Commission believed that:

"Whichever set of underlying assumptions is adopted determines and colours all subsequent social and legal analyses by each side, including whether sterilization may be considered a benefit, whether there is a 'need' for legislation to address *Eve's* blanket prohibition, and whether the equality provisions of the *Charter of Rights and Freedoms* would be breached or affirmed by legislation or by its absence.

Where there exist two competing but apparently equally supportable frameworks of contradicting philosophies and underlying assumptions, any choice between them can only represent a subjective ideological decision. Such an acute ideological choice is qualitatively different from the usual 'social policy' questions handled by law reform commissions that simply require the making of a subjective choice or value judgment between competing legal solutions that nevertheless ultimately share the same fundamental framework of social assumptions and philosophy."¹¹

¹⁰ Manitoba Law Reform Commission *Sterilization and Legal Incompetence* (Report No 76 1992) 2.

¹¹ Id, Executive Summary 3.

12. The Commission concluded that it was not the most appropriate body to make such an important decision:

"For the foregoing reasons, the Manitoba Law Reform Commission does not feel in a position under these unique circumstances to recommend a subjective ideological preference for one set of underlying assumptions and premises over the other.

While the Commission has some reservations about the rigidity of *Eve's* absolute prohibition of substituted consent in this context, it nevertheless believes that such fundamental questions of ideology carrying profound human rights implications are best handled directly by the Government and Legislature. The mandate and moral authority of those elected and accountable bodies place them in the best position to provide an open and accessible atmosphere for the necessarily non-partisan exploration required by the two irreconcilable ideologies at issue here."¹²

4. ONTARIO

13. In 1992 the Ontario Parliament passed the *Substitute Decisions Act*. The Act reformed the law governing substitute decision-making for legally incompetent people in the areas of both property management and personal decisions, including consent to medical treatment.

14. However, nothing in the Act affects the law relating to giving or refusing consent on another person's behalf to sterilisation that is not medically necessary for the protection of the person's health.¹³ The common law laid down in *Re Eve* thus continues to operate in Ontario.

15. The Substitute Decisions Bill as originally introduced in 1991 provided that no substitute decision-maker could give substituted consent to a sterilisation that is not medically necessary for the protection of the person's *physical* health. As the Manitoba Law Reform Commission pointed out in its Report, the effect of this would have been to widen the prohibition established by *Eve*:

"The *Eve* decision left intact a substitute decision-maker's ability to give substituted consent to a therapeutic sterilization; the Supreme Court of Canada defined the concept of 'therapeutic' as a procedure necessary to the *physical or mental health* of a person, but excluded any consideration of social purposes. However, the corollary of Ontario's proposed statutory prohibition is that a substitute decision-maker would presumably have the authority to give substituted consent of a sterilization that is medically necessary for the protection of the person's *physical health* only. Note that

¹² Ibid. There have been no further developments in Manitoba since the Law Reform Commission's Report: information from Manitoba Law Reform Commission 18 July 1994.

¹³ *Substitute Decisions Act 1992 (Ont)* s 66(14).

Ontario excludes the availability of any sterilization based not just on factors of social purposes but also any based on factors of mental health."¹⁴

16. However, the proposed provision was not in the Act as eventually passed.

5. ENGLAND

17. There is no legislative provision in the United Kingdom specifically relating to consent to sterilisation of people with intellectual disabilities, so the common law applies. The law may be said to be more liberal than that in Canada, since it is possible to authorise a non-therapeutic sterilisation.

18. In *Re B (A Minor) (Wardship: Sterilisation)*¹⁵ the House of Lords held that a court exercising wardship jurisdiction could authorise the sterilisation of a child if it was in the child's best interests. Lord Templeman stated that decisions concerning the sterilisation of a child had to be made by a court:

"[S]terilisation of a girl under 18 should only be carried out with the leave of a High Court judge. A doctor performing a sterilisation operation with the consent of the parents might still be liable in criminal, civil or professional proceedings. A court exercising the wardship jurisdiction emanating from the Crown is the only authority which is empowered to authorise such a drastic step as sterilisation after a full and informed investigation."¹⁶

However, this statement was not concurred in by the other members of the court.

19. In the earlier case of *Re D (A Minor) (Wardship: Sterilisation)*,¹⁷ where the court was again exercising wardship jurisdiction, Heilbron J held that a decision to carry out a sterilisation operation on a child for non-therapeutic purposes was not solely within a doctor's clinical judgment, but that court consent was required. Heilbron J refused to consent to sterilisation, on the ground that:

"The type of operation proposed is one which involves the deprivation of a basic human right, namely, the right of a woman to reproduce, and, therefore, it would be, if

¹⁴ Manitoba Law Reform Commission *Sterilization and Legal Incompetence* (Report No 76 1992) 17.

¹⁵ [1988] AC 199.

¹⁶ Id 205-206.

¹⁷ [1976] Fam 185.

performed on a woman for non-therapeutic reasons and without her consent, a violation of such right."¹⁸

20. In *Re B* three members of the House of Lords endorsed this statement.¹⁹ The House of Lords has therefore supported the right to reproduce as a basic human right - something the High Court in *Marion's Case* declined to do, noting that such a right was too difficult to define.²⁰ However, these three judgments do not endorse Heilbron J's statement about the necessity for court consent.

21. In the later case of *Re F (Mental Patient; Sterilisation)*,²¹ the House of Lords decided that court authorisation was not necessary for the sterilisation of a 36 year old woman where she could not give consent, but that a doctor could carry out such treatment if it was in the best interests of the woman.²² According to Lord Brandon, the operation would be in the best interests of the woman if, but only if, it was carried out in order to save her life or to ensure improvement or prevent deterioration in her physical or mental health.²³ Four of their Lordships distinguished the case before them from similar cases involving children.²⁴ Lord Griffiths endorsed a requirement of court consent, citing Lord Templeman's statement in *Re B* quoted above and the decision in *Re D* with approval. However, Lords Brandon and Goff (who gave the other two major judgments) and Lord Bridge did not go as far as this. Lords Brandon and Goff both suggested that reference to the court was highly desirable as a matter of practice, but not necessary as a matter of law. Lord Brandon elaborated the special features of sterilisation that made it highly desirable that the court be involved:

"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

¹⁸ [1976] Fam 185, 193.

¹⁹ [1988] AC 199, 203 per Lord Hailsham LC, 205 per Lord Bridge, 211 per Lord Oliver. Lord Templeman also referred to this statement in general terms at 206.

²⁰ *Marion's Case* at 254.

²¹ [1990] 2 AC 1.

²² The Crown's *parens patriae* jurisdiction in respect of mentally disordered adults no longer existed following the revocation of the Royal Warrant in 1960, though a court could under its inherent jurisdiction make a declaration that a proposed operation was in the patient's best interests.

²³ Id 55.

²⁴ Id 51 per Lord Bridge, 54 per Lord Brandon, 69 per Lord Griffiths, 79 per Lord Goff.

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 with it, from subsequent adverse criticism or claims."²⁵

22. Commenting on this decision, the High Court of Australia in *Marion's Case* suggested that the decision in *Re F* was nevertheless consistent with the proposition that, in the case of a child, a court's consent is required.²⁶ They noted that the House of Lords decision was influenced by the particular jurisdictional framework involved, due to the revocation by Royal Warrant in 1960 of the *parens patriae* jurisdiction of the English High Court with respect to adults with mental disability. In *Re F* Lord Goff distinguished United States and Australian cases requiring court consent on this ground.²⁷ He referred to the "very full and impressive consideration of the matter" by Nicholson CJ in *Re Jane*.²⁸

23. After the decision in *Re F* the Official Solicitor published a Practice Note with respect to sterilisation applications.²⁹ The latest version³⁰ reads, in part:

"Without in any way attempting either to define or to limit the factors which may require to be taken into account in any particular case the Official Solicitor anticipates that the judge will normally require evidence clearly establishing:

- (1) that (a) the patient is incapable of making his or her own decision about sterilisation and (b) the patient is unlikely to develop sufficiently to make an informed judgment about sterilisation in the foreseeable future (in this connection it must be borne in mind (i) that the fact that a person is legally incompetent for some purposes does not mean that he or she necessarily lacks the capacity to make a decision about sterilisation and (ii) that in the case of a minor his or her youth and potential for development may make it difficult or impossible to make the relevant finding of incapacity);
- (2) that the condition which it is sought to avoid will in fact occur, eg in the case of a contraceptive sterilisation, that there is a need for contraception because (a) the patient is physically capable of procreation and (b) the patient is likely to engage in sexual activity, at the present or in the near future, under

²⁵ [1990] 2 AC 1, 56.

²⁶ *Marion's Case* at 246.

²⁷ [1990] 2 AC 1, 79.

²⁸ (1988) 12 Fam LR 662: see paras 3.22-3.24 above.

²⁹ Practice Note of 19 September 1989: [1989] 2 FLR 447, and see *Re C (Sterilisation: Mental Patient: Procedure)* [1990] 2 FLR 527. See also the subsequent Practice Note of 7 September 1990: [1990] 2 FLR 530.

³⁰ [1993] 3 All ER 222.

circumstances where there is a real danger as opposed to mere chance that pregnancy is likely to result;

- (3) that the patient will experience substantial trauma or psychological damage if the condition which it is sought to avoid should arise, eg in the case of a contraceptive sterilisation that (a) the patient (if a woman) is likely if she becomes pregnant or gives birth to experience substantial trauma or psychological damage greater than that resulting from the sterilisation itself and (b) the patient is permanently incapable of caring for a child even with reasonable assistance, eg from a future spouse in a case where the patient has or may have the capacity to marry;
- (4) that there is no practicable less intrusive alternative means of solving the anticipated problem than immediate sterilisation, in other words that (a) sterilisation is advisable at the time of the application rather than in the future, (b) the proposed method of sterilisation entails the least invasion of the patient's body, (c) sterilisation will not itself cause physical or psychological damage greater than the intended beneficial effects, (d) the current state of scientific and medical knowledge does not suggest either (i) that a reversible sterilisation procedure or other less drastic solutions to the problem sought to be avoided, eg some other contraceptive method, will shortly be available or (ii) that science is on the threshold of an advance in the treatment of the patient's disability and (e) in the case of a contraceptive sterilisation all less drastic contraceptive methods, including supervision, education and training, have proved unworkable or inapplicable."

24. Subsequent cases fill out the detail of the position regarding sterilisation of children reached in *Re B* and *Re F*. In *Re E (A Minor) (Medical Treatment)*³¹ a 17 year old girl who was severely mentally handicapped suffered from serious menorrhagia, a menstrual condition for which the only effective treatment was a hysterectomy. The operation was required for therapeutic reasons and not with the object of sterilisation. Sir Stephen Brown P held that in such a case the child's parents were in a position to give valid consent and court consent was not necessary.³² In *Re HG (Specific Issue Order: Sterilisation)*³³ by contrast, where the court was requested to sanction sterilization of an intellectually disabled 17 year old girl who was severely epileptic, because of the risk of pregnancy, which would be disastrous to her, Peter Singer QC, sitting as a Deputy Judge of the High Court, held that the court's leave was required, since the case was different from *Re E*.³⁴

³¹ [1991] 2 FLR 585.

³² Sir Stephen Brown P took the same attitude in three cases not involving sterilisation of children: *Re SG (A Patient)* (1990) 6 BMLR 95 (abortion); *F v F* (1991) 7 BMLR 135 (hysterectomy for serious menorrhagia in a severely disabled adult); *Re GF (Medical Treatment)* [1992] 1 FLR 293 (hysterectomy for mentally handicapped adult who suffered from excessively heavy periods: court declaration not necessary where doctors satisfied that operation therapeutic).

³³ [1993] 1 FLR 587.

³⁴ Note also *Re M (A Minor) (Wardship: Sterilization)* [1988] 2 FLR 497 and *Re P (A Minor) (Wardship: Sterilization)* [1989] 1 FLR 182, both wardship cases where the court authorised the carrying out of tubal

25. The English position has been commented on critically by a number of commentators.³⁵ In 1993 the Law Commission issued a Consultation Paper which provisionally proposes that legislation should be enacted providing a judicial forum for the making of decisions regarding the medical treatment of incapacitated patients,³⁶ and that certain treatment decisions, including sterilisation operations, should require the approval of that forum.³⁷

26. The Law Commission made the following comments on the present English law:³⁸

"In relation to incapacitated adults, the House of Lords in *Re F* concluded that no court could approve or disapprove proposed medical treatment and the court's role is limited to making a declaration that the particular course of action proposed is lawful. Therefore the legal question (unlike the question which would arise if there were a *parens patriae* jurisdiction) is not whether or not a particular treatment is in the person's best interests, but whether the responsible professionals have made a reasonable and bona fide decision in accordance with a respectable body of medical opinion. A declaration that a proposed course of action is lawful is adequate for some purposes. However, under the ordinary law, treatment will not be unlawful if it is in accordance with a practice accepted as proper by responsible body of medical opinion skilled in the area in question [the *Bolam*³⁹ principle]. Since there may be two or more responsible bodies of medical opinion, a court might be unable to resolve a dispute because it has to declare that it would be lawful to act as proposed by those on either side.

By contrast, the patient who has the capacity to do so, and parents or courts deciding on behalf of children, do not attempt to decide whether the treatment proposed is in accordance with a responsible body of medical opinion. They attempt to decide whether, in all the circumstances as they see them, the treatment is what seems to them to be 'best'. Recently Lord Mustill expressed reservations about the application of the *Bolam* principle to decisions concerned with an incapacitated adult's best interests which go beyond questions of diagnosis, prognosis and appraisal and are ethical, not medical.⁴⁰ In such questions, he said there was no reason why the opinions of doctors should be decisive."

ligation on an intellectually disabled minor; *Re W (Mental Patient) (Sterilisation)* [1993] 1 FLR 381, where the court granted a declaration authorising the sterilisation of a 20 year old intellectually disabled woman who suffered from severe epilepsy, because of the risk of pregnancy, which might cause her epilepsy to get worse.

³⁵ See particularly M D A Freeman *Sterilising the Mentally Handicapped* in M D A Freeman (ed) *Medicine, Ethics and the Law* (1988) 55; I Kennedy *Patients, Doctors and Human Rights* in R Blackburn and J Taylor (eds) *Human Rights for the 1990s: Legal, Political and Ethical Issues* (1991).

³⁶ Law Commission Consultation Paper para 4.4.

³⁷ Id paras 6.2-6.8.

³⁸ Id paras 4.2-4.3.

³⁹ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

⁴⁰ *Airedale NHS Trust v Bland* [1993] AC 789, 898.

In Australia, the *Bolam* principle has been overruled by the High Court in *Rogers v Whitaker*⁴¹

6. THE UNITED STATES

27. In the United States, decisions about the sterilisation of incompetent persons must be made by a court.⁴² The cases which uphold this principle have been based on the concept of a fundamental right to reproduce. In a leading case, *Re Grady*,⁴³ it was confirmed that a guardian of an incompetent person could not consent to sterilisation on that person's behalf:

"Sterilization may be said to destroy an important part of a person's social and biological identity - the ability to reproduce. It affects not only the health and welfare of the individual but the well-being of all society. Any legal discussion of sterilization must begin with an acknowledgment that the right to procreate is 'fundamental to the very existence and survival of the race'⁴⁴ . . . This right is 'a basic liberty' of which the individual is 'forever deprived' through unwanted sterilization."⁴⁵

28. The Court considered that the right to procreate, and the right of privacy which protected the right to choose procreation, sterilisation or contraception, could only be protected if a court made:

". . . the final determination whether consent to sterilization should be given on behalf of an incompetent individual. It must be the court's judgment, and not just the parents' good faith decision, that substitutes for the incompetent's consent."⁴⁶

The case of *Re Grady* was the source of criteria adopted by Nicholson CJ in *Re Jane*.⁴⁷

7. ALBERTA: PROPOSALS OF THE LAW REFORM INSTITUTE

29. The Alberta Law Reform Institute⁴⁸ has recommended a legislative response to the *Eve*⁴⁹ decision which would widen the ambit of permissible sterilisations but impose the need

⁴¹ (1992) 175 CLR 479: see para 3.7 above.

⁴² See generally R Cepko *Involuntary Sterilization of Mentally Disabled Women* (1993) 8 Berkeley Women's LJ 122. In at least 14 States the court's jurisdiction is regulated by statute: id 145-156. In other cases, courts would generally rely on the *parens patriae* jurisdiction.

⁴³ (1981 NJ) 426 A 2d 467.

⁴⁴ Citing *Skinner v State of Oklahoma* (1942) 316 US 535, 541.

⁴⁵ (1981 NJ) 426 A 2d 467, 471-472.

⁴⁶ Id 475.

⁴⁷ (1988) 12 Fam LR 662: see paras 3.22-3.24 above.

⁴⁸ Formerly the Alberta Institute of Law Research and Reform.

⁴⁹ (1986) 31 DLR (4th) 1.

for court consent as a limiting factor, thus bringing the law in Alberta very close to the position in the United States.⁵⁰ The Institute considered that there will be individual circumstances that would make contraceptive sterilisation beneficial to a legally incompetent person. The *Eve* decision was seen as discriminatory and unfair when it is recognised that contraceptive sterilisation is widely practised among the general population who regard it as personally beneficial.

30. The Institute prepared a model statute which emphasises a number of procedural protections to ensure that maximum "due process" is observed. Contraceptive sterilisation of a legally incompetent person can only occur as a last resort in the absence of all other alternatives and can never be used to benefit third parties rather than the person involved.

31. The model statute proposes that the Alberta Supreme Court should be the sole substitute decision maker, with responsibility for deciding two separate issues:

- (1) whether the person in respect of whom the application is brought is incompetent to consent personally;
- (2) if the person is incompetent, whether a sterilisation procedure is in that person's best interests.

32. The procedural protections include independent legal representation for the person in respect of whom the application is brought, a full hearing of all the issues, and mandatory expert evaluations concerning competence and the risks of sterilisation. The judge must consider a list of various factors designed to screen out cases where sterilisation is excessive or in reality serves the purposes of others.

8. QUEBEC

33. Quebec appears to be the only province in Canada where the existing law allows a court to authorise a non-therapeutic sterilisation for a legally incompetent person. A therapeutic sterilisation does not require court approval. This is the effect of a new procedure

⁵⁰ Alberta Institute of Law Research and Reform *Competence and Human Reproduction* (Report No 52 1989). See also the Report for Discussion which preceded this report: Alberta Institute of Law Research and Reform *Sterilization Decisions: Minors and Mentally Incompetent Adults* (Report for Discussion No 6 1988).

created by the revised version of the *Quebec Civil Code*, which came into force on 1 January 1993.

34. Under the new Code, an authorised substitute decision-maker may consent on behalf of a legally incompetent person to "care of any nature, whether for . . . treatment or any other act".⁵¹ Substituted consent may be given both for therapeutic and non-therapeutic procedures.

35. The substitute decision maker must act in the "sole interest" of the incompetent person, taking that person's wishes into account as far as possible, and must ensure that care is "beneficial notwithstanding the gravity and permanence of its effects, that it is advisable in the circumstances and that the risks incurred are not disproportionate to the anticipated benefit".⁵²

36. However, where a substitute decision-maker consents to care or treatment that is "not required by [the incompetent person's] state of health" (in other words, non-therapeutic), a court's authorisation is also required if the care or treatment "entails a serious risk for health and if it might cause grave and permanent effects". In a non-therapeutic situation, the court must respect any refusal by the incompetent person to undergo the treatment.

9. NEW ZEALAND

37. New Zealand has the widest power to sterilise of any of the jurisdictions under consideration. Section 25(3) of the *New Zealand Guardianship Act 1968* provides that parents of a disabled child who is otherwise unable to consent to medical treatment may consent to medical treatment on the child's behalf:

"Where the consent of any other person to any medical, surgical, or dental procedure (including a blood transfusion) to be carried out on a child is necessary or sufficient, consent may be given -

- (a) By a guardian of the child; or
- (b) If there is no guardian in New Zealand or no such guardian can be found with reasonable diligence or is capable of giving consent, by a person in New Zealand who has been acting in the place of a parent. . . ."

⁵¹ Art 11.

⁵² Art 12.

38. Such a consent would be necessary where a child is under 16⁵³ or is intellectually disabled. Sterilisation is a medical procedure falling within section 25. The decision of *Re X*⁵⁴ concerned a 15 year old girl with an alleged mental age of three months, whose parents sought hysterectomy to prevent menstruation. The evidence was that in her case, menstruation would have extremely harmful consequences. Hillyer J authorised the procedure, and noted that doctors undertaking an operation which would result in sterilisation were obliged to satisfy themselves that the parents gave informed consent and that the consent was for the benefit of the child.⁵⁵ His Honour noted that an application to the court would not be necessary if the consensus of opinion was such that there was no doubt the procedure should be performed.⁵⁶

⁵³ S 25(1) provides that a child of 16 may give consent to medical procedures as if he or she were of full age.

⁵⁴ [1991] 2 NZLR 365.

⁵⁵ Id 373.

⁵⁶ Id 374.