Chapter 7

Legislation: uniformity, offences, and data collection

7.1 As has been noted in previous chapters, there are aspects of Australian law and policy regulating the sterilisation of persons with disabilities that are consistent across jurisdictions. All states and territories have court or tribunal-based procedures for considering applications to sterilise an adult. All have some form of test in place that can be considered a 'best interests' test. Jurisdictions have agreed to the *Protocol for Special Medical Procedures (Sterilisation)*, described in Chapter 3.

7.2 Despite these similarities, however, there are significant differences, and some weaknesses, in the current system. For example some jurisdictions have processes to consider applications for children and some do not; the guidelines endorsed by the Australian Guardianship and Administration Council are not mandatory; there is uncertainty around what constitutes 'therapeutic' cases, and therefore uncertainty about the scope of the jurisdiction of courts and tribunals; and the criteria being applied are not the same in every state or territory. Data collection and availability, as well as being poor, highlights differences across the jurisdictions.

Are sterilisation procedures happening at the same rate across Australia?

7.3 The committee sought information from all states and territories about how widespread sterilisation orders actually were. It looked at other information, where available, about the nature of cases and their outcomes.

7.4 Some of the relevant data was provided in submissions from New South Wales and Tasmania. Other jurisdictions received a letter from the committee in March or April 2013, seeking information about sterilisation procedures authorised in that jurisdiction. This text is representative of what was sought:

> The committee seeks data regarding the number of applications for sterilisation orders for adults and children with disabilities in the past decade, and the number of such orders granted during this time.
>
> The committee invites the Tribunal to provide any additional information that the Tribunal considers relevant to the terms of reference, including an analysis of the kinds of disabilities specified in the applications and whether sterilisation is for therapeutic or non-therapeutic purposes. The committee would be interested in any relevant decisions that demonstrate the approach taken by the Tribunal in adjudicating applications for sterilisation orders.[1]

7.5 The committee was grateful for the assistance of jurisdictions in helping to assemble the information, but the results of this process raised significant concerns for the committee.

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1 Committee correspondence to the ACT Civil and Administrative Tribunal, 28 March 2013.

Sterilisation cases in each jurisdiction

7.6 The Australian Capital Territory (ACT) provided an extremely detailed analysis of its case files, for which the committee is very grateful. The ACT Civil and Administrative Tribunal (ACTCAT) can make decisions regarding prescribed medical procedures for adults, and these may include abortion, sterilisation, contraception, but also transplants and some treatments for mental illness. The scope of its operation is thus slightly broader than in some other jurisdictions. The tribunal reviewed 21 years of case files, from 1992 to 2012, and identified 55 that involved contraception or sterilisation. Of these, 48 were for women and 7 for men, all but one of those for males being for medications to reduce libido. There were 13 applications for reproductive sterilisation, meaning fewer than one per year, and four of these were for therapeutic reasons. Of the remaining nine, three were for contraception and six for menstrual management; all were approved (except one which was withdrawn).[2]

7.7 The ACT was the only jurisdiction that provided detailed analysis of every relevant case. The committee looked at all the cases where sterilisation was sought and granted. In all cases, either the subject of the proposed procedure was asked their views and they were supportive, or the subject was assessed as unable to express their view. There was no case where views were sought, the person objected, but the procedure was agreed to.[3]

7.8 The New South Wales Government supplied information about applications to the Guardianship Tribunal for sterilisation of both children and adults. In the six years from July 2006 to June 2012, the Tribunal considered 39 applications for sterilisation. Eight were withdrawn; of the remaining 31, 14 were consented to and 17 were dismissed. Applications were overwhelmingly for adults: there were only 2 applications for children, one of which was withdrawn and the other consented to.[4]

7.9 The response from the Northern Territory Department of Health's Adult Guardianship office produced a surprising result. The Northern Territory scheme has jurisdiction only for adults under guardianship orders. The Northern Territory advised that there had not been a single case prior to April 2013,[5] when the committee sent its correspondence, but that in the seven weeks between the committee's letter arriving and the government finalising its response, the Local Court had received and approved three applications for the insertion of contraceptive devices. There had been no applications for permanent sterilisation.[6]

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2 Correspondence received from the Australian Capital Territory Civil and Administrative Tribunal, 12 May 2013, pp. 6–7.

3 Correspondence received from the Australian Capital Territory Civil and Administrative Tribunal, 12 May 2013, pp. 8–14.

4 New South Wales Government, *Submission 66*, p. 2.

5 The committee's letter asked for information over the preceding decade, and the committee assumes that this is the period covered by the Northern Territory's response.

6 Correspondence received from the Northern Territory Executive Office of Adult Guardianship, 21 May 2013, p. 2.

7.10 Queensland reviewed its case data for the years 2006 to 2012 inclusive. In that period, 19 applications relating to adults were received. Of those, two were ongoing, while four had been withdrawn during the process. Of the remaining 13, 11 were approved and two were dismissed. There were four applications in relation to children over the same period, of which one was withdrawn. Notably, all four involved a child who had become an adult by the time the process was concluded, and all three that proceeded to a decision were approved.[7] There appeared to be no applications involving younger children. The QCAT provided examples of its decisions (in which applicants are given letter-based codes). It observed of the three case examples: 'Both HGL and TN involved consideration of applications based on menstrual management while CEN involved consideration of methods of contraception'.[8]

7.11 The brief response from the Guardianship Board of South Australia indicated that it had received 12 applications between August 2006 and April 2013. Ten were approved.[9] The committee was not advised whether the remaining two were declined, withdrawn or were still under consideration.

7.12 Tasmania's Guardianship and Administration Board (TGAB) provided information through the Tasmanian Government's submission. It indicated that the TGAB had received around one application per annum in the last decade, for sterilisation of both children and adults. However, around half the applications were withdrawn 'when less invasive measures met the concerns of the applicants'.[10] The government's submission gave some details of four of the cases. One was refused as alternative procedures had not been adequately tried and the person was very young. The other three cases highlight the complex nature of the factors that have to be considered. In all three cases, the persons themselves wanted a sterilising procedure conducted (for very diverse reasons) but, as each had an intellectual disability that prevented them from fully understanding the consequences of the surgery, the Board had to be involved. In all three cases the Board agreed to the procedure.[11]

7.13 The Victorian Civil and Administrative Tribunal's response provided information quite different to the pattern in any other state or territory. From financial year 1999-2000 to the present there have been 1188 applications relating to adults considered by the tribunal. This extremely high figure is primarily accounted for by the fact that, prior to July 2006, applications had to be made in cases of medical research. Thus the scope of the Tribunal's responsibilities was historically different to elsewhere. Since that requirement has been removed, the Victorian tribunal has considered 102 applications in a six and a half year period. This number, however,

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7 Correspondence received from the Queensland Civil and Administrative Tribunal, 3 May 2013, pp. 3–4.

8 Correspondence received from the Queensland Civil and Administrative Tribunal, 3 May 2013, p. 4.

9 Correspondence received from the Guardianship Board South Australia, 3 May 2013.

10 Tasmanian Government, *Submission 57*, p. 2.

11 Tasmanian Government, *Submission 57*, pp. 3–4.

includes procedures for the termination of a pregnancy as well as sterilisation procedures. Data limitations meant that Victoria was unable to break the figures down any further.[12]

7.14 The State Administrative Tribunal of Western Australia responded to the committee's query, and began by noting some of the differences between Western Australia's system and that in some other states, particularly New South Wales. It indicated that there were only small numbers of applications, and that five had been considered in the last ten years. Of those five, three had been approved and two dismissed. The Tribunal supplied the statements of reasons for some of the cases, including one of those dismissed. It appeared that, in that case, one of the reasons that the person's parent had sought an order was their fear of the consequences of sexual abuse. The tribunal had rejected this as a relevant reason, and concluded '[t]he proposed procedure is not necessary from a medical or behavioural point of view and cannot be justified for menstrual management'.[13]

7.15 The Family Court of Australia, as noted in Chapter 3, has jurisdiction in a range of relevant cases, including those pertaining to children. The Chief Justice provided information to the committee in relation to cases heard by the Court. She identified 27 cases heard by the court involving 'applications to perform hysterectomies on young people with disabilities'. However almost all were during the 1990s, and there have been only two judgements on such cases in the 13 years since 2000. The committee understands that in both those cases, sterilisation was authorised.[14]

7.16 The table below summarises the very incomplete data available, excluding that from the Family Court, which is not state or territory-specific. The figures are seldom directly comparable, and can be treated as indicative only.

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12 Correspondence received from the Victorian Civil & Administrative Tribunal (VCAT), 28 May 2013.

13 AD [2007] WASAT 123, paras 100, 101.

14 The committee understands the two cases to be *Re: Angela* [2010] FamCA 98 (16 February 2010) and *Re: H* [2004] FamCA 496 (20 May 2004).

Table 7.1: The number of sterilisation applications considered by State and Territory tribunals

Jurisdiction	Time period	Applications	Withdrawn	Approved	Dismissed	Applications per unit population[15]
ACT	21 years	13	1	12	0	1.55
NSW	6 years	38	8	14	17	0.87
NT	10 years	3	0	3	0	1.50
QLD	6 years	21	5	14	2	0.76
SA	7 years	12	NK	10	NK	1.01
TAS	10 years	c. 10	c. 5	c. 3	c. 1	2.00
VIC	6.5 years	102	NK	NK	NK	2.75
WA	10 years	5	0	3	2	0.20

Notes: NK = Not known. Rates calculated using ABS 2012 state and territory population estimates. Victorian sample commences after the exclusion from tribunal jurisdiction of applications for medical research.

7.17 The apparent discrepancies in practice revealed by the preceding information are also implicit in data received from State and Territory legal aid commissions. At the committee's request, the Commonwealth Attorney-General's Department asked state and territory legal aid commissions to report on the number of child sterilisation cases that received legal aid funding.[16] The department asked the commissions two questions:

- How many special medical procedure cases has the legal aid commission funded?
- How many Independent Children's Lawyers (ICLs) have been appointed in special medical procedure cases?

7.18 The committee received the following responses, through the Attorney-General's Department:

15 (Number of applications divided by number of years), divided by jurisdiction population in millions.

16 Commonwealth Attorney-General's Department, Answers to questions on notice, 31 May 2013 (received to July 2013).

Table 7.2: Estimates of the number of Commonwealth child sterilisation cases that have received legal aid funding

LACTas (Tasmania)	Only funded one in the past 3 years that I can recall. Possibly two in the past 5.
LSCSA (South Australia)	1 ICL appointment this financial year. The parties are not in receipt of legal aid. Can't recall any other matter in the past few years.
LANSW (New South Wales)	Around 1 or 2 each year. We generally try to keep them in-house.
LAWA (Western Australia)	We have had no sterilisation cases to my knowledge for many years. We are able to advise on how many in the last 12 months but not over a longer period as we do not report against this. We have had 12 gender dysphoria cases in 2012/13 (these are classed as special medical procedures).
LAQ (Queensland)	We have had a look through our systems however we do not capture this data to a sufficient resolution to report.
VLA (Victoria)	The Victorian protocol is for an ICL to be appointed in every special medical case. We are not aware of any appointments for sterilisation matters in recent years. We have also checked our records for matters funded as "special medical procedure" and can find no reference to any sterilisation matters.
LAACT (Australian Capital Territory)	Cannot recall funding any in the past few years.
NTLAC (Northern Territory)	1 case in last 22 years.

7.19 It is difficult to interpret the data. It is at times unclear whether a commission is referring to legal aid funding for one or more of the parties to the case or for the appointment of an ICL. What is clear, however, is that each jurisdiction's approach to data management differs. At times, data was provided on the basis of supposition, prefaced with statements such as 'to my knowledge' or 'I recall'. As the number of cases that received funding were not compared with the number of cases for which a funding application was received but refused, it is also difficult to build a picture of the similarities and differences across jurisdictions. One thing does, however, stand out – there is a lack of uniformity, and a lack of data to determine the practices that exist across the Commonwealth, the states, and the territories.

7.20 Nowhere was a lack of uniformity in data and practice more starkly illustrated for the committee than in a discussion about vasectomies in young men. As has been seen above, the number of cases being considered by courts and tribunals is of the order of perhaps two dozen per annum, and that figure is likely to include some cases that lie outside the committee's terms of reference, including terminations and procedures for people with mental illness. However, the committee received evidence from Professor Sonia Grover and her colleagues at Royal Children's Hospital,

Melbourne, who had extracted Medicare data about vasectomies in boys and men aged 15 to 24. They did emphasise some qualifications on the information:

> These procedures may not be being performed in young men with disabilities, but it would be relatively uncommon for a sterilising procedure to be performed in a male of this age. Some of these procedures may for medical reasons and may be unilateral – ie not sterilising.[17]

7.21 The data however was troubling; the most recent decade of figures is below:

Table 7.3: Medicare data on vasectomies in males age 15 to 24

Year	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	**Total**
2003	9	10	22	1	0	0	2	0	**44**
2004	9	5	23	0	4	0	3	0	**44**
2005	7	7	22	0	4	1	0	1	**42**
2006	9	5	25	0	9	3	0	0	**51**
2007	10	6	20	2	5	0	4	0	**47**
2008	6	5	23	1	8	1	0	0	**44**
2009	13	1	21	1	3	0	2	0	**41**
2010	8	3	21	3	7	0	2	0	**44**
2011	4	7	15	0	1	0	2	0	**29**
2012	9	4	22	0	8	0	1	0	**44**
Total	**84**	**53**	**214**	**8**	**49**	**5**	**16**	**1**	**430**

7.22 It is possible that these represent normal vasectomies undertaken by choice, but it would be unusual to undertake this procedure at such a young age. It is possible that some of these reflect sterilising procedures being undertaken without court or tribunal authorisation. The figures for Queensland are out of all proportion to that state's population and suggest an aberrant medical practice of some kind, whether or not in connection with men with disability.

Committee view

7.23 Data on cases appeared to be very uneven, while the ability of jurisdictions to extract data regarding cases was limited and the task labour-intensive. The figures

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17 Department of Paediatric and Adolescent Gynaecology at Royal Children's Hospital, Melbourne, *Submission 69*, p. 13.

suggest a number of features that warrant attention, and some of these issues have been covered in previous chapters:

- The rate of applications varies wildly between states and territories. While the Victorian figure is known to be high because it includes abortion applications that are not counted in at least some other jurisdictions, there is still an order of magnitude range from least to most frequent, once the different population sizes of the jurisdictions are taken into account.
- There are significant differences in the frequency with which applications are withdrawn, ranging from half the applications in Tasmania, to none in Western Australia, and almost none in the ACT.
- There are even more significant differences in the rates at which applications are dismissed, ranging from a slight majority in New South Wales, to none in the ACT.

7.24 The data indicates that it cannot be assumed that Australians will receive the same outcome, and undertake the same legal journey, irrespective of where they live. Their experiences may differ significantly according to the jurisdiction in which they reside. The data available suggests that there is great scope for creating more consistent processes and outcomes across jurisdictions.

Recommendation 25

7.25 The committee recommends that data about adult and child sterilisation cases be recorded, and reported, in the same way in each jurisdiction. Data records should include the number of applications made for a special medical procedure, the kind of special medical procedures specified in the application, the categories of parties to the proceedings (for example, parents, medical experts, public advocates), and the outcome of the case.

Recommendation 26

7.26 The committee recommends that the Department of Human Services investigate the pattern of vasectomy in young males, including the apparently high number occurring in Queensland, and provide information to the Standing Council on Law and Justice if it has reason to believe the figures include sterilisations of men with disability.

The argument for uniform legislative and procedural requirements

7.27 One submitter to the inquiry, Dr Wendy Bonython, commented on the need for more consistent outcomes and processes across jurisdictions. According to Dr Bonython, given the lack of uniformity across jurisdictions '[t]he law as it currently exists with respect to sterilisation of minors is a jurisdictional disaster'.[18]

7.28 Focusing on children's cases, Dr Bonython advised that the existence of both Commonwealth and State and Territory laws regulating the sterilisation of children can lead to 'forum shopping'. While, as the Family Law Council has previously noted,

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18 Dr Wendy Bonython, *Submission 22*, p. 33; Law Institute of Victoria, *Submission 79*, p. 20.

orders of Commonwealth courts cannot be overturned by a by state or territory court or tribunal,[19] families who are dissatisfied with the outcome of a proceeding before a state or territory court or tribunal may try to circumvent the tribunal's ruling by subsequently seeking orders from the Family Court of Australia:

> Either an applicant doesn't obtain the order they sought in the Supreme Court, so tries their luck in the Family Court; or a disgruntled party, having unsuccessfully argued against the order being granted, then applies for an ex tempore injunction from the Family Court to invalidate the Supreme Court order, pending a hearing in the Family Court. It is worth emphasising that the two courts are operating in separate hierarchies, and so both are exercising original jurisdiction; argument would have to be heard de novo [from the beginning], thereby increasing delay, expense and, potentially, the trauma associated with court proceedings for all involved, including the child. This is clearly unacceptable.[20]

7.29 As Dr Bonython's advice implies, the existence of multiple jurisdictions operating under different laws creates the potential for like cases to receive different outcomes. In their submission to this inquiry, the Law Institute of Victoria noted this possibility and accordingly argued that the same criteria should apply in each jurisdiction.[21]

Standing Committee of Attorneys–General

7.30 The need for uniformity has previously been considered by the Commonwealth and the State and Territory governments. The matter was considered by the Standing Committee of Attorneys–General (SCAG) following the release of a 1997 report by the Australian Human Rights Commission, which indicated there was a high incidence of coerced or involuntary sterilisations of Australians with a disability.[22] SCAG did not publicly release the 2004 discussion paper or the 2006 draft model legislation. The documents were, however, released to 'select relevant stakeholders' for comment. The Commonwealth Attorney–General's Department advised that stakeholders included legal and medical associations, state and federal human rights commissions, health and human services, religious organisations and the judiciary.[23]

7.31 People with Disabilities Australia advised that there were concerns with the draft model legislation:

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19 Family Law Council, *Sterilisation and other medical procedures on children*, November 1994, paragraph 3.30; *P v P* (1994) 120 ALR 545.

20 Dr Wendy Bonython, *Submission 22*, p. 33.

21 Law Institute of Victoria, *Submission 79*, p. 30.

22 Commonwealth Attorney-General's Department, Answers to questions on notice, 19 April 2013 (received 14 May 2013).

23 Commonwealth Attorney-General's Department, Answers to questions on notice, 19 April 2013 (received 14 May 2013).

> While PWDA supported the development of a nationally consistent approach to the issue, we expressed our strong opposition, along with WWDA and other disability organisations to the emphasis of the SCAG on the elaboration of the circumstances and principles under which involuntary or coerced sterilisation can be authorised, rather than on prohibition of this human rights abuse.[24]

7.32 Dr Bonython also implied that the draft legislation was contentious:

> The Standing Committee of Attorneys–General have considered it. They sort of got ready to do something, and then they kind of backed away a bit and it became a bit topical. So really we are not that much further towards a consistent, transparent system than we were back when the High Court really first came to grips with it in the Marion case.[25]

7.33 While SCAG did not publicly release submissions received, a number were published on stakeholder websites and are available through a general Internet search. The submissions indicate that the object of achieving uniformity, particularly to prevent forum shopping, received support. However, there were concerns with aspects of the draft model legislation. For example, the Multicultural Disability Advocacy Association did not support the draft bill. The association was concerned that the legislation would relax safeguards already existing in New South Wales.[26] Women With Disabilities Australia opposed the draft model legislation on the grounds that it would leave open the possibility of child sterilisation:

> It was with extreme regret that, in late 2006, WWDA discovered that the Standing Committee of Attorneys-General (SCAG), had ignored WWDA's pleas to respect the fundamental human rights of women and girls with disabilities, and had proceeded to draft national, uniform legislation which sets out the procedures that jurisdictions could adopt in authorising the sterilisation of children who have an intellectual disability.[27]

7.34 The proposal for uniform legislation was removed from the SCAG agenda in 2008. As recorded in the SCAG minutes, officially the item was removed as SCAG no longer considered uniform legislation to be necessary:

> Further work and research since April 2007 has revealed that…[t]here are existing processes in place in each jurisdiction to authorise sterilisation procedures, which appear to be working adequately in light of recent

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24 People with Disabilities Australia, *Submission 49*, p. 10.

25 Dr Wendy Bonython, private capacity, *Committee Hansard*, 27 March 2013, p. 64.

26 Multicultural Disability Advocacy Association, *Comments on draft model bill*, http://www.mdaa.org.au/service/systemic/06/cidbill.html (accessed 9 July 2013).

27 Women With Disability Australia, *Systematic advocacy on the unlawful sterilisation of minors with disabilities (2003 – 2008)*, http://www.wwda.org.au/steriladv07.htm (accessed 9 July 2013).

> improvements in treatment options and education initiatives. There would be limited benefit in developing model legislation.[28]

7.35 The committee sought clarification of what work had been done since the item was removed from the SCAG agenda:

> Senator BOYCE: …In terms of the sterilisation of minors, the Standing Council of Attorneys-Generals back in 2008 said they would continue the promotion of ongoing awareness of the non-surgical alternatives to manage the menstruation and contraceptive needs of intellectually disabled people. Can you tell me what the Commonwealth is doing in this regard? The promotion of ongoing awareness, is what we are talking about.
>
> …
>
> Mr Abraham: The standing council did not make a decision to monitor ongoing activity in relation to that by the jurisdiction, so we are not in a position to indicate to the committee what the states have done.
>
> Senator BOYCE: So how would we ever know if that measure was implemented?[29]

7.36 The Attorney-General's Department agreed to review this issue further with Victoria, the lead jurisdiction on the matter. It subsequently provided further advice, confirming that there was no information about activities after 2008:

> Victoria advised they not aware of SCAG or SCLJ undertaking any further work on the recommendations from the March 2008 meeting. Victoria advise that it was up to each jurisdiction to undertake follow up action. The item did not attract any formal reporting or monitoring requirements.
>
> States and Territories had not provided examples of steps taken in their jurisdictions to promote ongoing awareness or to review their tribunals at the time of deadline for the questions on notice.[30]

7.37 The committee does note however the work of the Australian Guardianship and Administration Council at around that same time, and in response to SCAG's review of the Commonwealth, state and territory laws regulating sterilisation of persons with disabilities.[31] AGAC is made up of 'the Public Guardians, Adult Guardians and Public Advocates, the Boards and Tribunals who deliberate upon applications under guardianship and administration legislation and the State Trustees or Public Trustees'.[32] In March 2009 it agreed and released the Protocol for Special Medical Procedures (Sterilisation).

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28 Commonwealth Attorney-General's Department, Answers to questions on notice, 19 April 2013 (received 14 May 2013).

29 *Committee Hansard*, 31 May 2013, p. 9.

30 Commonwealth Attorney-General's Department, Answers to questions on notice, 19 April 2013 (received 14 June 2013)

31 Australian Guardianship and Administration Council, *Submission 28*, Attachment 1, *Protocol for Special Medical Procedures (Sterilisation)*, cl. 1.5.

32 Australian Guardianship and Administration Council, *Submission 28*, p. 1.

7.38 In response to this committee's questions, the Commonwealth Attorney–General's Department advised that the Commonwealth government has subsequently recommitted to working with the states and territories on the regulation of sterilisation of women and girls with disabilities. This commitment forms part of the 2012 National Human Rights Action Plan, released on 10 December 2012. The department further advised that discussions with State and Territory Ministers have not commenced.[33] The department advised that this initiative is in response to Recommendation 39 of the United Nations Universal Periodic Review of Australia in 2011, which recommended Australia:

> Comply with the recommendations of the Committee on the Rights of the Child and the Committee on the Elimination of All Forms of Discrimination against Women concerning the sterilization of women and girls with disabilities (Denmark); enact national legislation prohibiting the use of non-therapeutic sterilization of children, regardless of whether they have a disability, and of adults with disability without their informed and free consent (United Kingdom); repeal all legal provisions allowing sterilization of persons with disabilities without their consent and for non-therapeutic reasons (Belgium); abolish non-therapeutic sterilization of women and girls with disabilities (Germany).[34]

Uniform legislation – implications for the Family Law Act 1975

7.39 Two representatives of the legal sector, Dr Wendy Bonython and the Law Institute of Victoria, noted that legislative change may be required to address current issues with the regulation of the sterilisation of children.[35] At the Commonwealth level, the relevance of the *Family Law Act 1975* for child sterilisation cases was considered in 1994 by the Family Law Council. As explored in Chapters 3 of this report, the Family Law Act does not contain any specific provisions about child sterilisation cases. The Family Court of Australia applies the general principles regarding the best interests and the welfare of the child in Part 7 of the Act, as well as rules that the court has made to govern applications for special medical procedures.

7.40 Reporting in 1994, the Family Law Council recommended '[t]here should be a new division in the Family Law Act regulating sterilisation of young people.'[36] As Council noted, there was concern that the principles in Part 7 are of limited relevance to child sterilisation cases. Part 7 is primarily concerned with the procedures and principles for the court to apply for cases involving parental responsibility for the

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33 Commonwealth Attorney-General's Department, Answers to questions on notice, 19 April 2013 (received 14 May 2013).

34 Human Rights Council, *Report of the Working Group on the Universal Periodic Review – Australia*, 24 March 2011, paragraph 86.39, http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G11/122/90/PDF/G1112290.pdf?OpenElement (accessed 8 July 2013).

35 Dr Wendy Bonython, *Submission 22*, p. 33; Law Institute of Victoria, *Submission 79*, p. 20.

36 Family Law Council, *Sterilisation and other medical procedures on children*, 1994, Recommendation 1(a).

child and who the child will live with and spend time with. Consequently, its relevance for child sterilisation cases is questionable:

> Council…agrees that the proposed provisions on sterilisation of children should be contained in a separate division of the Family Law Act. In Council's view, the adoption of this approach will make it quite clear that distinct conditions apply in relation to sterilisation of children and a separate Act is not considered necessary to achieve this objective.

Committee view

7.41 Court or tribunal procedures must establish a robust framework for the defence of persons with disabilities. Uniform legislation would ensure that a child and an adult with disabilities receive the same protections regardless of the jurisdiction in which they reside. It is of concern to the committee that it cannot be guaranteed that a person with a disability will receive the same treatment and the same outcome irrespective of where they live. As explored in both this and previous chapters, there are marked differences in the way each jurisdiction operates. As the committee has previously noted, chief differences include the requirements and procedures to assess capacity as a threshold issue, provisions for the adult or a child to participate in proceedings, the availability of legal representation or a non-legal advocate, and the criteria considered when determining whether to grant a sterilisation order.

7.42 The committee has already made a series of recommendations to ensure a robust framework of the defence of persons with disabilities in sterilisation cases (see chapter 5). This framework would be compromised by differences across jurisdictions, and should not depend on whether an order is sought from a State or Territory tribunal or from the Family Court. Legislation, and related court and tribunal procedure, should provide a consistent defence of the rights of persons with disabilities. This safety net is compromised where like cases produce different outcomes.

7.43 Accordingly, the committee recommends that the Council of Australian Governments oversee the development of uniform model legislation. This legislation should take into account the committee's recommendations to improve court and tribunal practice and procedure, which include recommendations about the circumstances in which court or tribunal authorisation is needed, the tests courts and tribunals are to apply when considering an application for a sterilisation order, the participation of persons with disabilities in proceedings, and access to legal representation and advocacy support (see chapter 5). Based on the model legislation, a new division of the Family Law Act should be created to specifically establish the factors to be considered in child sterilisation cases as opposed to children's cases under Part 7 of the Act.

Recommendation 27

7.44 The committee recommends that the Council of Australian Governments oversee the development of uniform model legislation to regulate the sterilisation of persons with disabilities. Based on this model, a new division of the *Family Law Act 1975* (Cth) should be created.

Further proposed legislative amendment – the need for uniform offences

7.45 A broad range of submitters advocated that any regulations to prohibit, or to otherwise circumscribe, the sterilisation of persons with disabilities need to be underpinned by offences that would act as a deterrent against non-compliance.[37] Two categories of offences were proposed:

- an offence of performing a sterilisation without authorisation; and
- an offence of aiding, abetting or procuring the unauthorised sterilisation of an Australian with a disability, both within Australia and overseas.

The offence of performing a sterilisation procedure without authorisation

7.46 This category of offence would, in reality, apply exclusively to the medical profession. Such an offence, it was argued, is needed to discourage the medical profession from proceeding without requisite approvals. The offence would act as both a deterrent and a signpost that in most circumstances the medical profession does not have the authority to authorise the sterilisation of a person with a disability. The committee was provided with anecdotal evidence that the practice of sterilisation without necessary authorisations is continuing. Women with Disabilities Australia (WWDA) advised that the organisation:

> …had reports from the Tasmanian Guardianship Board to say that they are seeing an increase in applications for sterilisation procedures on women with intellectual disabilities once they turn 18 and they say that the doctors get really frustrated because they do not understand why they have to even go through the process. They said that it appears that the applications are being sought solely for the purpose of prevention of future pregnancy. I am not saying that they are being granted; I am saying that they have noticed an increase in the number of applications.[38]

7.47 Data compiled by the Australian Human Rights Commission in 1997 and 2001 was cited in support of the proposition that the medical profession is continuing to perform sterilisation procedures on persons with disabilities without proper authorisation. For example, Qld Centre for Intellectual and Developmental Disability, Queenslanders with Disabilities Network, and Qld Advocacy Inc. provided the committee with a report which, on the basis of the Australian Human Rights Commission's work, concluded that 'unauthorised sterilisations still continue to be done into the 21st century.'[39]

7.48 However, the accuracy of these concerns was disputed. Associate Professor Sonia Grover, a gynaecologist at Royal Children's Hospital, described the complex

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37 See, for example, Australian Human Rights Commission, *Submission* 5, Recommendation 4; Office of the Public Advocate, *Submission 14*, Recommendation 13; People with Disability Australia, *Submission 50*, pp. 12; 34.

38 Ms Carolyn Frohmader, Executive Director, Women With Disabilities Australia, *Committee Hansard*, 11 December 2012, p. 8.

39 Qld Centre for Intellectual and Developmental Disability, Queenslanders with Disabilities Network, and Qld Advocacy Inc., *Submission 37*, Attachment 3, p. 10.

process that would have to be undertaken in order to perform an unauthorised sterilisation without attracting suspicion, if it was being reported as a different type of operation:

> If we are going to propose that people are tying tubes in theatre—because it has to be done in the operating theatre under a general anaesthetic—and if somebody is saying, 'This woman has gone to theatre for an appendectomy but they are tying tubes instead,' then I would say: the people who work in the coding department are not in theatre; you cannot line them up and get them to tell the right story, and they are going to look for the appendectomy specimen to be able to code this as having been done as an appendectomy. Sure you could put clips on the tubes at the same time, having done the appendectomy, but that requires all the nursing staff in theatre to write down that they did not pull the clips out. So it requires a whole string of people to risk their careers. So I am not sure that there are many people who would be prepared to risk their careers or, for that matter, that a hospital would risk being closed down, presumably, if they are doing a procedure they have not got permission to do…So there may be problems but I am not sure that the size of the problem of what is happening in Australia is as big as all that.[40]

7.49 On the other hand, the committee heard evidence from a woman with a disability who had a different experience:

> Miriam: There are paediatric surgeons who are willing to do that. I have been in the presence, in a medico legal forum, only it is 20 years ago now. But the practice would continue. In 1992, we ran a medico legal forum with the High Court. We had a number of very eminent lawyers and Supreme Court and High Court judges there. In their presence were two paediatric surgeons who admitted to doing it – in the best interests of the parents. They would record it as an appendectomy. Of course that is under private health insurance. In Medicare it would be harder to follow.[41]

7.50 During the hearing at which the above evidence was received, a current health professional observed that they understood how the practice could be allowed to continue, as it would in reality be difficult for other staff to question the surgeon in theatre.[42]

7.51 It was suggested that, if occurring, unauthorised procedures may be the result of a lack of understanding of legal requirements. Ms Lesley Naik attributed any incidence of unauthorised procedures to uncertainty amongst the community about when authorisation is needed. This uncertainty, it was argued, 'raises a serious doubt

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40 Associate Professor Sonia Grover, Gynaecologist, Royal Children's Hospital *Committee Hansard*, 11 December 22, p. 4.

41 Miriam, *Proof Committee Hansard*, 30 January 2013, p. 7.

42 Woman A, *Proof Committee Hansard*, 30 January 2013, p. 7.

regarding the clarity of law in this area'.[43] Professor Grover also commented on uncertainty within the medical community about legal requirements:

> We do still get straight-out requests regarding hysterectomies. They are often from people who do not know. I get horrified when it happens. We still get doctors writing us occasional letters. I was thinking as I came in here that we have recently done a survey of GPs and paediatricians. The work has not actually been published yet. We were asking them a few questions about how comfortable GPs and paediatricians felt about fixing young women's health related problems. Of the 300 GPs and paediatricians, 12 of them mentioned hysterectomy early in the menstrual management issue for intellectually disabled young women. There is no doubt that there are gaps and there is no doubt that these families need resources. It breaks my heart to be called in late when they have struggled for years. I take my hat off to these families.[44]

Existing offences

7.52 As outlined in chapter 3 of this report, the offence of performing a sterilisation procedure without all necessary approvals already exists in a number of jurisdictions. For example, in South Australia, a medical practitioner commits an offence subject to a $10 000 fine or imprisonment two years is performing a sterilisation without the tribunal's consent. A medical practitioner does not commit an offence if the unauthorised sterilisation was performed in response to a medical emergency.[45] In the Northern Territory, proceedings for professional misconduct may be taken against a medical practitioner who performs a major medical procedure without court authorisation.[46]

7.53 In Tasmania, a person who carries out unauthorised special treatment commits an offence liable to imprisonment for a period not exceeding one year or a fine not exceeding 10 penalty units or both.[47] However, it is not an offence to carry out special medical treatment if the medical practitioner considers that, as a matter of urgency, the treatment is necessary to save the person's life or to prevent serious damage to person's health.[48] It is also an offence to purport to give consent to special medical treatment. A person who gives unlawful consent to treatment is guilty of an offence subject to a fine not exceeding 20 penalty units.[49] In New South Wales, a person who

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43 Ms Lesly Naik, *Submission 7*, pp. 2–3.

44 Associate Professor Grover, Royal Children's Hospital, *Committee Hansard*, 11 December 22, p. 4.

45 *Guardianship and Administration Act 1993*, s. 61.

46 *Adult Guardianship Act*, ss. 21(2) Note.

47 *Guardianship and Administration Act 1995*, s. 38.

48 *Guardianship and Administration Act 1995*, s. 40.

49 *Guardianship and Administration Act 1995*, s. 42.

performs an unauthorised sterilisation of a person with a disability is liable to a maximum penalty of seven years imprisonment.[50]

7.54 In the Australian Capital Territory, a medical practitioner who performs an unauthorised sterilisation does not commit an offence if he or she obtained consent for the procedure but did not know, and could not be recently expected to know, that the person who provided consent did not have the authority to do so.[51]

7.55 Dr Bonython advised that medical practitioners who perform a sterilisation procedure without appropriate approvals commit 'a trespass against the person', and therefore may also be liable to a penalty under civil law.[52] However, the value of penalties under civil law was questioned. Ms Lesley Naik submitted that civil remedies are a poor substitute for criminal sanctions:

> [C]ivil law enforcement measures are ill suited to providing a remedy for achieving deterrence in light of the barriers intellectually disabled children are likely to face in accessing justice.[53]

7.56 These examples illustrate the lack of uniformity in the existing offences. Differences affect the scope of the offences, that is, what actions and circumstances they cover, what the practitioner had to know or intend, and the penalties attached. As Ms Lesley Naik pointed out, the lack of consistency results in certain people being 'afforded less legal protection against unauthorised sterilisation' and is 'particularly unsatisfactory in light of Australia's international human rights obligations'.[54]

Offence of procuring an unauthorised sterilisation procedure within or outside Australia

7.57 WWDA gave an account of a mother who, in 2003, allegedly admitted her daughter to hospital under the mother's name in order to secure a sterilisation procedure.[55] It was submitted that these kinds of attempts to procure, or otherwise assist with the performance of, unauthorised sterilisation procedures should be subject to a criminal penalty. For example, PWDA submitted that relevant legislation should 'make it an offence to procure, or seek to procure, an involuntary or coerced sterilisation, and to assist or aid and abet such a procedure.'[56]

7.58 The committee received evidence that indicated that there is an established practice among some families of taking children outside Australia to obtain special medical procedures such as sterilisation. This may be because they are not confident

50 New South Wales Government, *Submission 66*, p. 4.

51 *Guardianship and Management of Property Act 1991*, s. 69.

52 Dr Wendy Bonython, *Submission 22*, p. 10.

53 Ms Lesly Naik, *Submission 7*, p. 8.

54 Ms Lesly Naik, *Submission 7*, p. 8.

55 Ms Frohmader, Women With Disabilities Australia, *Committee Hansard*, 11 December 2012, p. 6.

56 People with Disabilities Australia, *Submission 49*, p. 35.

of the effectiveness of Australian tribunals and courts; or because they lack the money to pay for court processes. The grandmother of a child with a disability wrote:

> We don't want to have to take M overseas to get what we know to be the best outcome for her. Travel by aircraft would cause extreme stress for her and discomfort for other passengers; however, if we must, it may have to happen.[57]

7.59 Professor Carter, the father of a woman with a moderate to severe intellectual disability, observed:

> Some—and I gave an example in our submission—have reached the stage of thinking that the only way they can get this done is to go overseas and have a hysterectomy done there. We put in an example of somebody going to New Zealand. But there are other examples. Traditionally, it has been Thailand and New Zealand. But I heard recently about somebody who went to India to get it done.[58]

7.60 Another parent stated:

> I can assure you that parents go overseas because this subject is taboo, because the court system is too complicated and too expensive. Who has $10,000 to apply to the Family Court to do something to better their child's health? If the system was more family friendly, if the system was more open, these people would not need to go overseas.[59]

7.61 The Carters also noted that there were instances where a person went overseas in order to circumvent Australian tribunal decisions:

> We are aware of instances where parents have taken their daughters to Thailand or New Zealand to have a hysterectomy because their request to have a hysterectomy performed in Australia was rejected by the Guardianship Tribunal.[60]

7.62 Accordingly, there was support for the offence of procuring, aiding or abetting an unauthorised sterilisation procedure applying not only within Australia but also to circumstances where a person with a disability is taken overseas for the purpose of obtaining an unauthorised sterilisation. The Law Institute of Victoria argued that an offence should be created:

> The LIV suggests that a clause be included in the legislation to the effect that an adult or minor with a disability from Australia whose parent, carer or guardian intends to have a forced sterilisation procedure performed must not be removed from the Commonwealth of Australia.[61]

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57 Name withheld, *Submission 10*, p. 4.

58 Professor Carter, *Committee Hansard*, 27 March 2013, p. 49.

59 Mrs Robbins, *Committee Hansard*, 27 March 2013, p. 52.

60 Dr and Mrs John and Merren Carter, *Submission 20*, p. 3.

61 Law Institute of Victoria, *Submission 79*, p. 23.

7.63 The Human Rights Commission made a similar recommendation.[62] In addition, the Law Institute of Victoria recommended that a system be put in place to allow the Australian Federal Police to put a child on the Airport Watch List as a preventative measure where necessary.[63]

7.64 Existing offences under State and Territory legislation relating to female genital mutilation (FGM) were put forward as a model that could be adopted to deter persons from taking persons with disabilities oversees for sterilisation procedures.[64] For example, the *Crimes Act 1900* (NSW) contains an offence of aiding, abetting, or procuring a person to perform an FGM act on another person. This offence carries a penalty of imprisonment for seven years.[65] This offence applies even where the action occurs outside New South Wales. It is sufficient that the person who commits the offence is usually resident in New South Wales or that the offence was committed against a New South Wales resident. The Australian Government has advised that such offences apply to attempts to remove an Australian from Australia for the purpose of procuring a FGM procedure.[66]

Committee view

7.65 The committee concludes that actions should never be taken to circumvent tribunal or court decisions, and that, as the provider of submission 10 pointed out, such actions will in any case often cause stress for all involved. The financial savings are likely to be limited, suggesting that the main motivation is fear of the courts and tribunals, or an unwillingness to abide by a tribunal decision. The solution lies in ensuring those processes are accessible and fair. Deliberately circumventing the protections that Australian law seeks to extend to people with disabilities is wrong.

7.66 The committee therefore agrees that each jurisdiction should enact offences for performing, or for procuring, an unauthorised sterilisation procedure. Consistent with legislation currently existing in some jurisdictions, it should be a defence if the medical practitioner acted in good faith or otherwise did not know, and could not be reasonably expected to know, that court or tribunal authorisation was required. The committee is concerned by anecdotal evidence that suggests that persons may be taking people with disabilities oversees for the purpose of obtaining a sterilisation procedure. Accordingly, the committee agrees that the offence of procuring or aiding and abetting an unauthorised sterilisation procedure should apply to circumstances where Australians travel overseas for this purpose. Offences relating to FGM appear to be a useful model.

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62 Australian Human Rights Commission, *Submission 5*, p. 4.

63 Law Institute of Victoria, *Submission 79*, pp. 23–24.

64 Australian Human Rights Commission, *Submission* 5, p. 13.

65 *Crimes Act 1900* (NSW), s. 45.

66 Australian Government, *Female genital mutilation*, http://www.smarttraveler.gov.au/tips/female-genital-mutilation.html (accessed 11 July 2013).

Recommendation 28

7.67 The committee recommends that each jurisdiction enact legislation prohibiting the performance or procurement of unauthorised sterilisation procedures. State and Territory legislation should also make it an offence to take, attempt to take, or to knowingly assist a person to take, a child or an adult with a disability oversees for the purpose of obtaining a sterilisation procedure.

Senator Rachel Siewert

Chair