

CHAPTER 2

Regulation of donor conception practices

2.1 This chapter provides a summary of past and present legislative and regulatory frameworks in place across Australia in relation to donor conception. It also considers concerns raised during the inquiry about the existing legislative and regulatory frameworks.

Introduction

2.2 As the Commonwealth has not enacted legislation to regulate donor conception practices, such practices are regulated by the states and territories. Only four states – Victoria, South Australia, Western Australia and New South Wales – have legislation specifically governing donor conception. In states and territories where there is no legislation regulating donor conception practices, the National Health and Medical Research Council's (NHMRC) 2007 *Ethical Guidelines on the Use of Reproductive Technology in Clinical Practice and Research* (NHMRC Guidelines)¹ apply. Clinics undertaking ART practices are accredited by the Reproductive Technology Accreditation Committee (RTAC) of the Fertility Society of Australia (Fertility Society).

2.3 As a result, there are significant differences in the approach taken throughout Australia to the practices of donor conception, the requirements for recordkeeping of donor conception practices and the provision of information to donor conceived people, the parents of donor conceived people and donors.

Commonwealth's role in regulation of donor conception

2.4 The Commonwealth's role in the regulation of donor conception practices is considered below.

Background

2.5 At a meeting of the Council of Australian Governments (COAG) in April 2002, COAG agreed that the Australian Government and state and territory governments would work towards developing uniform legislation across Australia to standardise the treatment of human cloning and regulate the use of excess ART embryos.² The *Arrangements for Nationally-Consistent Bans on Human Cloning and*

1 NMHRC, NHMRC Guidelines, <http://www.nhmrc.gov.au/files/nhmrc/file/publications/synopses/e78.pdf>, accessed 30 June 2010. These Guidelines were originally issued in 2004 and revised in 2007.

2 COAG website, 'Communiqué 5 April 2002', http://www.coag.gov.au/coag_meeting_outcomes/2002-04-05/index.cfm, accessed 30 June 2010.

Other Unacceptable Practices, and Use of Excess Assisted Reproductive Technology Embryos provide:

11. Accreditation by the Reproductive Technology Accreditation Committee (RTAC) of the Fertility Society of Australia should provide the basis for a nationally-consistent approach to the oversight of ART clinical practice in Australia, noting that compliance with the NHMRC/AHEC [Australian Health Ethics Committee] Ethical Guidelines on ART is a key requirement of RTAC accreditation.

12. Individual jurisdictions may choose to mandate RTAC accreditation in legislation or supplement requirements for RTAC accreditation with an additional layer of oversight (for example, through a system of licensing or accreditation of ART service providers).³

2.6 In January 2009, the Standing Committee of Attorneys-General (SCAG), the Australian Health Ministers' Conference and the Community and Disability Services Ministers' Conference Joint Working Group considered a national model to harmonise the regulation of surrogacy.⁴ The discussion paper for this process briefly considered donor conception:

It is important to recognise the right of a child to know their genetic heritage. The mechanism for securing appropriate access for the child and other parties to relevant information about the surrogacy arrangement and donors (such as, for example, by the establishment of a national donor information register), should be determined in a consistent manner with donor registers relating to ART generally.

It is proposed that a separate paper containing detailed proposals will be developed jointly with Australian Health Ministers' Conference and Community and Disability Services Ministers' Conference officers for consultation at a later stage.⁵

2.7 In April 2009, SCAG agreed to develop a discussion paper on a national model for the registration of donors, in consultation with Health and Community

3 COAG website, *Arrangements for Nationally-Consistent Bans on Human Cloning and Other Unacceptable Practices, and Use of Excess Assisted Reproductive Technology Embryos*, http://www.coag.gov.au/coag_meeting_outcomes/2002-04-05/docs/cloning.cfm#5, accessed 24 November 2010.

4 SCAG, the Australian Health Ministers' Conference and the Community and Disability Services Ministers' Conference Joint Working Group, *A Proposal for a National Model to Harmonise Regulation of Surrogacy*, January 2009, http://www.scag.gov.au/lawlink/SCAG/ll_scag.nsf/pages/scag_pastconsultations, accessed 11 November 2010.

5 SCAG, the Australian Health Ministers' Conference and the Community and Disability Services Ministers' Conference Joint Working Group, *A Proposal for a National Model to Harmonise Regulation of Surrogacy*, January 2009, http://www.scag.gov.au/lawlink/SCAG/ll_scag.nsf/pages/scag_pastconsultations, accessed 11 November 2010, at p. 20.

Services Ministers.⁶ However, during the course of the current inquiry, the Attorney-General's Department (Department) advised that it 'is seeking the Attorney-General's views on the involvement of Health and Community Services Ministers before the matter is placed on the SCAG agenda for any further consideration'.⁷ The issue was not discussed by SCAG at its meeting on 10 December 2010.⁸

2.8 The Department also advised that the 'working group would need to consider the existing regulatory framework and legal issues relating to donor registration'.⁹ The Department observed that, currently, there is 'no consistency in the regulatory framework for the registration and record-keeping practices relating to information about conception donors', nor in relation to 'the manner and form in which information is made available to conceived individuals'.¹⁰

Relevant Commonwealth legislation

2.9 There does not appear to be a specific head of Commonwealth legislative power which would clearly support comprehensive national legislation to regulate donor conception, and the Commonwealth has not enacted specific legislation to regulate these practices.

2.10 The Attorney-General's Department declined to provide any relevant advice to the committee with respect to whether there is a constitutional head of power which would enable it to legislate in this area:

It has been the longstanding position of the [Department], under successive governments, that it does not provide legal or constitutional advice to parliamentary committees...the Department has not in this case been involved in any substantive consideration of constitutional and international human rights law issues...The Department [is] therefore not in a position to assist the Committee on these aspects of the Committee's inquiry.¹¹

6 SCAG Communiqué, 16-17 April 2009, p. 7, http://www.scag.gov.au/lawlink/SCAG/ll_scag.nsf/pages/scag_meetingoutcomes, accessed 23 November 2010.

7 Attorney-General's Department, answer to question on notice, provided 19 November 2010, p. 2.

8 SCAG Communiqué, 10 December 2010, [http://www.scag.gov.au/lawlink/SCAG/ll_scag.nsf/vwFiles/SCAG_Communique_101210.pdf/\\$file/SCAG_Communique_101210.pdf](http://www.scag.gov.au/lawlink/SCAG/ll_scag.nsf/vwFiles/SCAG_Communique_101210.pdf/$file/SCAG_Communique_101210.pdf), accessed 13 December 2010.

9 Attorney-General's Department, answer to question on notice, provided 19 November 2010, p. 2.

10 Attorney-General's Department, answer to question on notice, provided 19 November 2010, p. 2.

11 Attorney-General's Department, answer to question on notice, provided 19 November 2010, p. 1.

2.11 While the Attorney-General's Department advised that it was not in a position to provide detailed advice on the issue, several articles in the United Nations Convention on the Rights of the Child,¹² including Article 3, Article 7.1 and Article 8.1 may be of relevance in this context.¹³

2.12 The Convention sets out the political, social, economic, cultural and civil rights of children: Article 3 requires the state to ensure that the best interests of the child are the guiding principle in actions taken in relation to children; Article 7.1 provides that each child is to be registered after birth, has the right to a name, and to know and be cared for by his or her parents; and Article 8.1 requires states to respect the right of a child to preserve his or her identity, including their nationality, name and family relations recognised by law.

Prohibition of Human Cloning for Reproduction Act 2002 (Cth) and the Research Involving Human Embryos Act 2002 (Cth)

2.13 There is, however, some Commonwealth legislation that is relevant in relation to donor conception. In late 2002, the Federal Parliament enacted the *Prohibition of Human Cloning for Reproduction Act 2002 (Cth)* and the *Research Involving Human Embryos Act 2002 (Cth)* which prohibit human cloning for reproduction and prohibit or regulate certain other practices involving human embryos, to the extent that these matters are within Commonwealth constitutional power.¹⁴ Relevantly to donor conception, the legislation prohibits the payment of 'valuable consideration' for donated oocytes, sperm or embryos. However, it permits the payment of 'reasonable expenses' incurred by the donor in connection with supplying oocytes, sperm or embryos.¹⁵

2.14 To achieve coverage of the field, the states and the Australian Capital Territory subsequently passed complementary legislation.¹⁶ To date, the Northern Territory has not passed complementary legislation.

12 [1991] ATS 4, <http://www.austlii.edu.au/au/other/dfat/treaties/1991/4.html>, accessed 19 November 2010.

13 Dr Annemarie Devereux, Attorney-General's Department, *Committee Hansard*, 29 October 2010, pp 31-32.

14 The Senate Community Affairs Legislation Committee report, *Provisions of the Research Involving Embryos and Prohibition of Human Cloning Bill 2002*, October 2002, noted that, as there was no express constitutional power to enact this legislation, the Commonwealth was relying on the corporations power, the trade and commerce power and the external affairs power, pp 96-97 at para 4.150.

15 Section 21 of the *Prohibition of Human Cloning for Reproduction Act 2002 (Cth)*.

16 *Prohibition of Human Cloning for Reproduction Act 2008 (Vic)*, *Human Cloning for Reproduction and Other Prohibited Practices Act 2003 (NSW)*, *Prohibition of Human Cloning for Reproduction Act 2003 (SA)*, *Human Reproductive Technology Act 1991 (WA)*, *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003 (Qld)*, *Human Cloning for Reproduction and Other Prohibited Practices Act 2003 (Tas)*, and *Human Cloning and Embryo Research Act 2004 (ACT)*.

Family Law Act 1975

2.15 Section 60H of the *Family Law Act 1975* (Family Law Act) addresses the status of children born as a result of assisted reproductive technologies (ART) for the purposes of that Act. The section creates a relationship of parent and child between the woman who gave birth to the child and her husband or de-facto partner at that time. This is the case even if another man is the biological father or another woman is the biological mother (under, for example, surrogacy arrangements).

2.16 In cases where a child is born after being conceived by ART procedures and there is uncertainty about that child's parentage, the Family Court of Australia or the Federal Magistrates Court may be required to consider who that child's parents are for the purposes of the Family Law Act. In a few cases, judges of the Family Court have expressed concerns about the operation of section 60H, and have suggested that this section be amended in order to clarify the role that a non-biological party or a donor of gametes may have in raising a child conceived by ART procedures (in cases where, for example, a sperm donor to a lesbian couple wishes to have contact with a child).¹⁷

NHMRC Guidelines

2.17 The National Health and Medical Research Council (NHMRC) was established under the *National Health and Medical Research Council Act 1992* (NHMRC Act). The NHMRC has a number of responsibilities, including:

- ...inquiring into and issuing guidelines and advice on a range of matters relating to individual and public health, including health ethics;
- ...advising the minister in relation to the funding of health and medical research across Australia; and
- ...advising the states in relation to its advice on matters relating to individual and public health.¹⁸

2.18 Under the NHMRC Act, the Australian Health Ethics Committee (AHEC) is the principal committee of the NHMRC. Through the AHEC, the NHMRC issues guidelines and advice on matters of ethics in health research. The NHMRC also has responsibilities under the *Prohibition of Human Cloning for Reproduction Act 2002* (Cth) and the *Research Involving Human Embryos Act 2002* (Cth).

2.19 The NHMRC Guidelines set out ethical guidelines for clinical practice and research involving ART. With respect to donor conception, the guidelines describe appropriate practices in relation to:

- providing information and counselling to participants in ART;
- record keeping;

17 See, for example, *Aldridge v Keaton* (2009) 42 FamLR 369; *Re Michael* (2009) 41 FamLR 694; *Re Mark* (2003) 31 FamLR 162; *Re Patrick* (2002) 28 FamLR 579.

18 Dr Clive Morris, NHMRC, *Committee Hansard*, 29 October 2010, p. 35.

- the rights of donor conceived people to information about their genetic parents and siblings; and
- limiting the number of people born using gametes from a single donor.¹⁹

2.20 While the NHMRC Guidelines provide guidance, they are not legally binding.²⁰ However, in some cases, the NHMRC Guidelines are given legal effect through Commonwealth or state and territory legislation, or through agreements with Commonwealth bodies which require compliance with the guidelines.²¹ In order to be an accredited ART provider, clinics providing ART services must comply with the NHMRC Guidelines.²²

Provision of information under NHMRC Guidelines

2.21 The NHMRC Guidelines specify that, in order to facilitate the exchange of information between donors, recipients and donor conceived people, clinics must have appropriate arrangements for data collection, data storage and information release.²³ Clinics are required to collect the following information from donors:

- name, any previous name, date of birth and most recent address;
- details of past medical history, family history, and any genetic test results; and
- details of physical characteristics.²⁴

2.22 The NHMRC Guidelines specify that ART clinics must provide gamete (that is, sperm or oocyte) recipients with information 'that is relevant to the care of their donor conceived offspring', including, at least, the following information:

- details of past medical history, family history and any genetic test results;
- details of the physical characteristics of the gamete donor; and
- the number and sex of people conceived using the gametes donated by the same gamete donor.²⁵

2.23 The NHMRC Guidelines state that donor conceived people are 'entitled to know their genetic parents'. Clinics must, on request, provide at least the following information to donor conceived people (but only if they are 18 years of age or have 'acquired sufficient maturity' to appreciate the significance of the request):

- details of past medical history, family history and any genetic test results;

19 NHMRC Guidelines, pp 22, 25-29, 33, 41-44 and 49-51.

20 NHMRC Guidelines, p. 15.

21 NHMRC Guidelines, p. 15.

22 NHMRC, 'Regulation of Assisted Reproductive Technology' website, www.nhmrc.gov.au/research/embryos/information/art.htm, accessed 9 September 2010.

23 NHMRC Guidelines, p. 50.

24 NHMRC Guidelines, p. 50.

25 NHMRC Guidelines, p. 28.

- identifying information about the gamete donor; and
- the number and sex of people conceived using the gametes provided by the same gamete donor, the number of families involved, and any identifying information that these siblings have consented to being released.²⁶

2.24 In relation to gamete donors, the NHMRC Guidelines state that donors are:

...entitled to some information about the recipients of their gametes and the offspring born (in particular, to prepare them for future approaches by their genetic offspring). Clinics may provide gamete donors, on request, with nonidentifying information about gamete recipients, including the number and sex of persons born.²⁷

Reproductive Technology Accreditation Committee

2.25 The Reproductive Technology Accreditation Committee (RTAC) is a committee of the Fertility Society of Australia (Fertility Society), which is the peak industry body representing the ART sector in Australia. RTAC operates an accreditation program for ART providers in all states and territories. To become an accredited ART provider, clinics must comply with the NHMRC Guidelines and the RTAC Code of Practice.²⁸ The RTAC Code of Practice sets minimum professional and laboratory standards for clinics offering fertility services.²⁹ Compliance with the RTAC Code of Practice is mandatory for clinics which provide ART treatment involving human embryos created in-vitro.³⁰

2.26 Reviews of clinics are undertaken by an independent certification body approved by the Joint Accreditation System of Australia and New Zealand (JAS-ANZ).³¹ Clinics are accredited each year on 'critical criteria' and every three years on 'practice criteria'.³²

26 NHMRC Guidelines, p. 29.

27 NHMRC Guidelines, p. 29.

28 NHMRC, 'Regulation of Assisted Reproductive Technology' website, www.nhmrc.gov.au/research/embryos/information/art.htm, accessed 9 September 2010.

29 RTAC, *Code of Practice for Assisted Reproductive Technology Units*, May 2008, www.fertilitysociety.com.au/wp-content/uploads/20080924-rtac-cop-final.pdf, accessed 1 September 2010.

30 Definition of 'accredited ART centre' in section 8 and section 11 of the *Research Involving Human Embryos Act 2002* (Cth); RTAC, *Code of Practice for Assisted Reproductive Technology Units*, p. 4.

31 Fertility Society of Australia, answer to question on notice, provided 17 November 2010, document 3 of 6, RTAC, *Code of Practice for Assisted Reproductive Technology Units*, p. 7.

32 Associate Professor Illingworth, Fertility Society, *Committee Hansard*, 3 November 2010, p. 63.

State and territory regulation of donor conception

2.27 A brief summary of relevant legislation and practices in the states and territories is provided below. Appendix 1 to this report contains a table which also includes information relating to the various state and territory legislative regimes.

Victoria

2.28 Victoria has the longest established and most comprehensive donor conception legislation of the states, with ART having been regulated there since 1988. The *Infertility (Medical Procedures) Act 1984* (Vic) (1984 Victorian Act) included requirements relating to counselling, assisted insemination and donor expenses.³³ Under that Act, information that identified any person could be released with the consent of the person about whom it related.

2.29 In 1995, the 1984 Victorian Act was replaced by the *Infertility Treatment Act 1995* (Vic) (1995 Victorian Act) which established the Infertility Treatment Authority (ITA) (which has since become the Victorian Assisted Reproductive Technology Authority (VARTA)). The 1995 Victorian Act provided more comprehensive requirements in relation to counselling, availability of information for donors and donor conceived people, as well as requirements in relation to donor registers. The 1995 Victorian Act enables donor conceived people, conceived after 1 January 1998, when they reach 18 years of age, to access information about their donor, subject to counselling requirements.

2.30 In 2008, the 1995 Victorian Act was replaced by the *Assisted Reproductive Treatment Act 2008* (Vic) (2008 Victorian Act). The 2008 Victorian Act implemented aspects of a 2004 review of the 1995 Victorian Act relating to, among other things, assisted insemination, donation of gametes, parentage and access to information.³⁴ Two of the guiding principles of the 2008 Victorian Act are that:

[t]he welfare and interests of persons born or to be born as a result of treatment procedures are paramount...[and]

Children born as a result of the use of donated gametes have a right to information about their genetic origins...³⁵

2.31 Under the 2008 Victorian Act, information (such as full name, date of birth and medical history) about donors, and women who have received treatment using donated oocytes, sperm or embryos is maintained on two registers. These registers are called the Central Register (Vic) and the Voluntary Register (Vic).

33 Victorian Assisted Reproductive Treatment Authority website, 'History of assisted reproductive treatment in Victoria', <http://www.varta.org.au/history-of-assisted-reproductive-treatment-in-vict/w1/i1003269/>, accessed 30 June 2010. The Act commenced operation in 1988.

34 Victorian Assisted Reproductive Treatment Authority website, 'History of assisted reproductive treatment in Victoria', <http://www.varta.org.au/history-of-assisted-reproductive-treatment-in-vict/w1/i1003269/>, accessed 30 June 2010.

35 Section 5 of the 2008 Victorian Act.

2.32 The registered clinic or doctor who provides the donor conception procedure is required to supply certain information to the Central Register (Vic). Information on the Central Register (Vic) is classed as either identifying or non-identifying information.³⁶ If it is the former, the registry must obtain the consent of the person to whom the information relates before releasing it, and must refer the applicant to a counselling service. If it is the latter, the registry may release it directly to the applicant. The following persons are eligible to apply for access to information held on the Central Register (Vic):

- a donor conceived person;
- a parent of a donor conceived person;
- a descendant of a donor conceived person; and
- a donor.

2.33 However, if the donation in question was given and used before 1998, no information will be provided to the donor conceived person, unless the donor has lodged their information on the Voluntary Register (Vic). If the donation was given and used between 1988 and 1997, the donor's consent is needed to provide information on the Voluntary Register (Vic) to the donor conceived person.

2.34 The following people may lodge information and apply for access to information held on the Voluntary Register (Vic):

- a donor conceived person;
- a parent of a donor conceived person;
- a relative of a donor conceived person;
- a descendant of a donor conceived person;
- a donor; and
- a relative of a donor.

2.35 Where the Voluntary Register (Vic) contains information that is requested, that information will be released if the person to whom it relates has consented to that release.

2.36 On 23 June 2010, the Victorian Legislative Council referred an inquiry into donor conception to the Victorian Parliament's Law Reform Committee. That inquiry specifically focused on legal and other issues in relation to donor conceived people being given access to identifying information about their donors and donor conceived siblings, regardless of when the donation was made. The inquiry was also reviewing

36 Identifying information is information that would directly identify a person and could include, for example, name, date of birth, address, occupation and medical histories of the person and their family. Non-identifying information could include, for example, sex, year of birth, eye and hair colour, height, weight, level of education and qualifications, marital status, number of children, nationality, culture, religion and interests.

the impacts of the transfer of the donor registers held by the ITA to the Registrar of Births, Deaths and Marriages.³⁷ The Law Reform Committee tabled an interim report on 15 September 2010, in which it made two recommendations,³⁸ but the inquiry lapsed with the prorogation of the 56th Victorian Parliament on 2 November 2010.

New South Wales

2.37 The *Assisted Reproductive Technology Act 2007* (NSW) (NSW Act) commenced on 1 January 2010 and aims to:

...assist people conceived using donated gametes (ova and sperm), to identify their donor. This legislation gives donors and their offspring the opportunity to access this information in a structured way.³⁹

2.38 One of the objects of the NSW Act is to protect the interests of:

- a person born as a result of ART treatment;
- a person providing a gamete for use in ART treatment or for research in connection with ART treatment; or
- a woman undergoing ART treatment.⁴⁰

2.39 The NSW Act establishes a central register of information about donors and donor conceived people. ART providers are required to supply both non-identifying and identifying information to the register, including:

- the donor's full name, address, date and place of birth;
- the donor's ethnicity and physical characteristics;
- any medical history or genetic test results of the donor and the donor's family that are relevant to the future health of:
 - a person undergoing ART treatment involving the use of the donated gamete;
 - any donor conceived person born as a result of that treatment; and
 - any descendants of any such donor conceived people;

37 From 1 January 2010, responsibility for the Voluntary Register and the Central Register was transferred from VARTA to the Registrar of Births, Deaths and Marriages.

38 The recommendations were that, firstly, the Victorian Government should consider as a matter of urgency whether measures should be taken to ensure that existing and unprotected donor records are preserved and, secondly, that the 57th Parliament re-refer the terms of reference to enable the committee to complete its final report: see, Victorian Parliament Law Reform Committee, *Inquiry into access by donor-conceived people to information about donors*, Interim Report, September 2010.

39 NSW Department of Health website, 'Assisted Reproductive Technology', <http://www.health.nsw.gov.au/hospitals/phc/art.asp>, accessed 15 June 2010.

40 Section 3 of the NSW Act.

- the name of each ART provider who has previously obtained a donated gamete from the donor and the date on which the gamete was obtained; and
- the sex and year of birth of any child born using oocytes or sperm provided by the donor (donors can provide updated information to the register if they choose).⁴¹

2.40 As in Victoria, the NSW register is not retrospective, and can be accessed only by people who were conceived after 1 January 2010 (or their donors).

2.41 For people conceived before 1 January 2010 (or their donors), the NSW Act establishes a voluntary register. A person is only able to access information from the voluntary register if the person to whom the information relates has consented.⁴²

South Australia

2.42 In South Australia, donor conception is regulated by the *Reproductive Technology (Clinical Practices) Act 1988* (SA) (SA Act).⁴³ Significant amendments to the SA Act commenced on 1 September 2010, and section 4A of the SA Act now provides:

[t]he welfare of any child to be born as a consequence of the provision of assisted reproductive treatment in accordance with this Act must be treated as being of paramount importance, and accepted as a fundamental principle, in respect of the operation of this Act.

2.43 Under the amended SA Act, the Minister is empowered to:

- establish a donor conception register; and
- require people to provide information for the purpose of preparing or maintaining the register.⁴⁴

2.44 However, the donor conception register will not record information about ART treatment which occurred before the amendments commenced.⁴⁵

2.45 Information required to be provided under the SA Act includes:

- the donor's full name and nominated contact address;

41 NSW Department of Health website, 'Assisted Reproductive Technology', <http://www.health.nsw.gov.au/hospitals/phc/art.asp>, accessed 15 June 2010.

42 NSW Department of Health, http://www.health.nsw.gov.au/resources/hospitals/phc/pdf/volunteer_donor_registerart_a4.pdf, accessed 26 November 2010.

43 Formerly the *Reproductive Technology Act 1988* (SA). The name was changed in 2003 when the *Reproductive Technology Act* was amended to remove the regulation of embryo research from its provisions.

44 Section 15 of the SA Act.

45 Subsection 15(8) of the SA Act.

- the full name and nominated contact address of the person to whom assisted reproductive treatment using the donor's human reproductive material was provided;
- the full name of any child born as a consequence of such assisted reproductive treatment (if known); and
- any other information required by relevant regulations.⁴⁶

2.46 Under section 16 of the SA Act, clinics and doctors are required to collect and keep information about ART procedures that is specified under the regulations. The SA regulations provide that disclosure of identifying information about a donor is permitted where the donor consents, or as required or authorised by the NHMRC Guidelines.⁴⁷

2.47 The regulations also provide that any clinical practice involving human reproductive material must be undertaken in compliance with the relevant requirements of the NHMRC Guidelines.⁴⁸

Western Australia

2.48 Commencing in 1993, the *Human Reproductive Technology Act 1991* (WA) (WA Act) regulates all ART practices in Western Australia.

2.49 One of the objects of the WA Act is to ensure:

...that the prospective welfare of any child to be born consequent upon a procedure to which this Act relates is properly taken into consideration...⁴⁹

2.50 The WA Act requires complete medical records about the donor and the treatment cycle to be made and stored in clinics. Further, the WA Act places an obligation on the Commissioner of Health to establish and maintain registers of information about all types of ART procedures, including donor conception, which must include specified information about donors and recipients. Clinics licensed under the WA Act must provide information to these registers.

2.51 The WA Act also establishes the Reproductive Technology Register. Information about all ART treatments carried out in Western Australia is included on the Reproductive Technology Register.

46 Section 15 of the SA Act.

47 Subregulation 4(4) of the *Assisted Reproductive Treatment Guidelines 2010* (SA).

48 Paragraph 8(2)(a) of the *Assisted Reproductive Treatment Regulations 2010* (SA); NHMRC Guidelines, <http://www.nhmrc.gov.au/publications/synopses/e78syn.htm>, accessed 31 August 2010.

49 Section 4 of the WA Act.

2.52 Stored information may include the donor's physical characteristics, family background, level of education, interests, and personality. However, information about donor conceived people is more limited and is not updated.⁵⁰

2.53 In terms of access to donor information in Western Australia:

...with amendments to the [WA] Act in December 2004, donor conceived persons upon reaching the age of 16 years having undertaken approved counselling have a right to access identifying information about the donor. As a result of these changes to legislation only those donors who consent to their identifying information being released to donor conceived persons upon reaching the age of 16 are able to donate human reproductive material.⁵¹

2.54 In relation to non-identifying information, the WA Act allows parties to a donation to access such information from a clinic or from the register.⁵²

2.55 As with other states that have legislated in this area, the WA Act is not retrospective. For people who were donor conceived prior to 1993 (or their donors), the only potential source of information is the clinic where the treatment was carried out.⁵³ Western Australia has also established a voluntary register to assist donor conceived people who wish to find out about their genetic origins and donors who want to know if a child has been born as a result of their donations. Identifying information on the voluntary register is only provided where the person to whom the information relates has given written consent.⁵⁴

Other states and territories

2.56 There is no specific legislation regulating donor conception in Queensland, Tasmania, the Northern Territory or the Australian Capital Territory. For the regulation of standards and practices in relation to ART, these jurisdictions rely on:

- the NHMRC Guidelines; and

50 Reproductive Technology Council website, 'Questions and answers about the donation of human reproductive material', <http://www.rtc.org.au/publications/docs/Q&A.pdf>, accessed 16 June 2010, pp 5-6.

51 Reproductive Technology Council website, 'Questions and answers about the donation of human reproductive material', <http://www.rtc.org.au/publications/docs/Q&A.pdf>, accessed 16 June 2010, p. 5.

52 Western Australia Department of Health, *Submission 126*, p. 7.

53 Reproductive Technology Council website, 'Questions and answers about the donation of human reproductive material', <http://www.rtc.org.au/publications/docs/Q&A.pdf>, accessed 16 June 2010, p. 5.

54 Department of Health (WA) website, 'Voluntary register', <http://www.voluntaryregister.health.wa.gov.au/home/>, accessed 30 June 2010.

- the certification of ART providers by the Reproductive Technology Accreditation Committee (RTAC) of the Fertility Society of Australia (Fertility Society).

Concerns about regulation of donor conception practices

2.57 During the course of the inquiry, a large number of submitters and witnesses expressed significant discontent with the current regulation of donor conception by the states and territories.⁵⁵

2.58 Three key concerns were identified, namely:

- inconsistent state and territory approaches to the information that donor conceived people, their families and donors may access;
- inadequate regulation in the states and territories where there is no specific donor conception legislation; and
- the lack of national regulation and a national framework to:
 - ensure consistency;
 - prevent donors and recipients being able to travel between states and territories to donate or access services; and
 - regulate the importation of donor gametes and embryos into Australia.

Inconsistency in approaches to availability of information

2.59 A key concern raised by submitters was the differences in access to information for donor conceived people on the basis of the state and the year in which they were conceived.⁵⁶ Monash IVF, which operates clinics in both Victoria and Queensland, stated:

[at] this point...the rights of a donor conceived person in Victoria born after 1998 compared to someone born in Queensland [are] vastly different with the Victorian person having the legal right to identifying information about their donor...

Due to changes in legislation in Victoria there are some families with donor conceived children who were born under different iterations of the

55 See, for example, Mrs Susan Hurst, *Submission 2*, p. 3; *Submission 4 (name withheld)*; Ms Zoe Brillante, *Submission 6*; Mr Adam Quinlivan, *Submission 12*, p. 2; Ms Elizabeth Lorbach, *Submission 14*; Mr Michael and Mrs Lauren Dempsey, *Submission 27*; Dr Sonia Allan, *Submission 30*, p. 3; *Submission 33 (name withheld)*, p. 2; Mr Gordon Ley, *Submission 36*; Mr Damian Adams, *Submission 38*, p. [2]; *Submission 43 (name withheld)*; Ms Kimberley Springfield, *Submission 52*; Rainbow Families Council, *Submission 73*; Ms Romana Rossi, *Submission 75*, p. 5; Mrs Elizabeth Kennelly, *Submission 80*; Ms Elizabeth Hurrell, *Submission 101*, p. 3; Monash IVF, *Submission 120*, p. 2; Mrs Caroline Lorbach and other members of the DCSG, *Committee Hansard*, 2 November 2010.

56 See, for example, Rainbow Families Council, *Submission 73*, p. 2; Monash IVF, *Submission 120*, p. 2.

legislation therefore each child/person [has] different sets of rights in terms of what information that person is entitled [to] about their genetic origins.⁵⁷

2.60 In addition, the Rainbow Families Council stated:

...some children in the one rainbow family have been conceived at different times in different clinics across different states or territories using donors with different identity-release provisions. The past practice has created a confusing and often upsetting situation for parents and their donor-conceived children when, for example, only one child has access to the identifying information about their donor while the other child does not.⁵⁸

2.61 Differences in legislation between the states and territories can result in parties accessing gametes or embryos from different states in order to take advantage of a more favourable release of information. Ms Karen Boyd – a mother of donor conceived children – explained her experience in which donors donated an embryo in one state and made it available in another state, specifically to enable the donor conceived child to access information about those donors:

[m]y son was born in 1999 and we have both non-identifying and identifying information available to us when he is 18 years old, thanks to the Victorian Registry. His embryo was conceived in NSW but his donors wanted their information available to a child if a child was born from their donation. So the embryo was made available to [us in Victoria] as Victoria at the time was the only state that had a registry available.⁵⁹

2.62 As well as variations in the amount of information able to be released depending on where and when a child was conceived, there are differences in the non-identifying information provided about donors to recipients. Solo Mums by Choice (SMC Australia) submitted:

[m]embers report great inconsistency regarding information provided about sperm donors. This ranges from a brief physical description regarding height/hair/eye colour to several pages of information relating to the donor's physical characteristics as well as medical history, interests/personality and family history. In some cases even minimal information is not provided until after a pregnancy is confirmed. It is not clear what steps clinics take to ensure that information provided by donors is accurate or complete.⁶⁰

Regulation in jurisdictions with no specific legislation

2.63 Particular concerns were expressed about the states and territories where clinics are only required to comply with the NHMRC Guidelines and the RTAC Code of Practice. The Donor Conception Support Group of Australia (DCSG) argued that

57 Monash IVF, *Submission 120*, p. 2.

58 *Submission 73*, p. 2.

59 *Submission 16*, p. 1.

60 *Submission 99*, p. 5.

the NHMRC Guidelines are insufficient, particularly because the RTAC clinic accreditation processes are not transparent. As a result, it is not clear that clinics are complying with the NHMRC Guidelines.⁶¹

2.64 One submitter advised the committee that when she conceived her child by donor conception, she was initially told that the donor was an identity-release donor but later found out, after conceiving, that the donor was a non-identity release donor.⁶² However, as noted earlier in this report, the NHMRC Guidelines do not allow for anonymous donations.⁶³

2.65 Similarly, Dr Sonia Allan, a legal academic and researcher in the area of donor conception and the use of ART, noted that there is no evidence that the NHMRC Guidelines are implemented in practice. Specifically, there is no oversight of clinics to ensure identifying information is made available to donor conceived people.⁶⁴ The DCSG has likewise argued that clinics are not making sufficient efforts to encourage past donors to place their information on voluntary registers, as required by paragraph 6.1.3 of the NHMRC Guidelines.⁶⁵

2.66 It was suggested by Miss Lauren Burns, a donor conceived person, that a way to address the apparent lack of transparency about the accreditation process would be to:

...[have] an ombudsman for assisted reproductive treatments similar to, say, the banking or insurance industries so it gives people a way that they can investigate complaints.⁶⁶

2.67 SMC Australia suggested that all clinics should be audited by a truly independent body and should be accountable to a government authority.⁶⁷

2.68 However, at the public hearing in Canberra, Dr Martyn Stafford-Bell from the Canberra Fertility Centre explained that, in his view, the NHMRC Guidelines are enforceable. This is because, if a clinic does not provide evidence of compliance, the RTAC is able to recommend to the Australian Government that the clinic's patients do not receive Medicare benefits until the clinic becomes compliant.⁶⁸ Dr Stafford-Bell contended that the NHMRC Guidelines are 'perfectly adequate', but that '[i]t is a

61 *Submission 122*, pp 111-123.

62 *Submission 54 (name withheld)*, p. 1.

63 See paragraph 6.1.4 of the NHMRC Guidelines.

64 *Submission 30*, p. 9.

65 DCSG website, 'National inquiry into donor conception practice', <http://www.dcs.org.au/legislation/inquiry.html>, accessed 30 June 2010.

66 *Committee Hansard*, 3 November 2010, at p. 13.

67 *Submission 99*, p. 3.

68 *Committee Hansard*, 29 October 2010, p. 4.

question of enforcing them'.⁶⁹ He advised the committee that he is aware of at least two clinics which have had their accreditation withdrawn or which have been sanctioned for failure to comply with the NHMRC Guidelines.⁷⁰

2.69 Dr Clive Morris from the NHMRC advised that the NHMRC Guidelines 'contain a range of requirements which are worded as 'should' or 'must', but they do not contain sanctions. It would be up to whichever body was responsible for regulation to apply sanctions'.⁷¹ He indicated that the NHMRC's role is 'not to police the [NHMRC] Guidelines' and acknowledged that the NHMRC Guidelines are not enforceable under law.⁷²

Support for uniform legislation to ensure consistency

2.70 Several submissions supported the development of uniform legislation to regulate donor conception, in order to ensure that donor conception practices and access to information for donor conceived people are consistent across Australia.⁷³ Ms Kate Dobby, who worked as the Registers Officer at the former ITA in Victoria, submitted that the fact that people are currently able to cross jurisdictions to take advantage of more favourable regulation 'makes a mockery of jurisdiction-based attempts to maintain records of donor conception and the people born' and 'dilutes any attempt by one or another jurisdiction to effectively regulate practices'.⁷⁴

2.71 The Victorian Infertility Counsellors Group similarly argued that the RTAC Code of Practice and the NHMRC Guidelines have limited capacity to ensure uniformity, because there is little scope for these bodies to monitor practices across Australia and implement consequences for non-compliance. In particular:

[a] national legislative framework would provide that extra step in ensuring that all states have a uniform approach to ensuring equitable access to treatment, protection of the rights of all parties involved in donor arrangements and a systemised approach to data collection, information provision and counselling and related support.⁷⁵

2.72 The submission from Mrs Leonie and Mr Warren Hewitt, parents of donor conceived children, indicated that the lack of consistent legislation across Australia

69 *Committee Hansard*, 29 October 2010, p. 9.

70 *Committee Hansard*, 29 October 2010, p. 10.

71 *Committee Hansard*, 29 October 2010, p. 36.

72 *Committee Hansard*, 29 October 2010, p. 39.

73 See, for example, Ms Susan Hurst, *Submission 2*, p. 3; DES Action Australia - NSW, *Submission 18*, p. [3]; Miss Narelle Grech, *Submission 107*, p. 5.

74 *Submission 103*, p. 2.

75 *Submission 68*, p. 3.

enables some donors to donate in a number of states.⁷⁶ This has resulted in one of their donor conceived children having 31 half-siblings.⁷⁷

2.73 The Canberra Fertility Centre supported the development of uniform legislation involving donor conception throughout Australia, including legislation to limit the number of families who achieve a live birth using gametes donated by a single individual.⁷⁸ However, the Centre noted that:

[t]he demand for donated gametes in Australia far exceeds the supply, and therefore we recommend that any regulatory or legislative changes regarding donor conception should take the rights and preferences of donors into consideration, in order to encourage donation, thereby allowing more Australians affected by infertility access to treatment with donor gametes.⁷⁹

2.74 Some submitters encouraged the development of national legislation based on the Victorian model.⁸⁰ The committee notes that it is also possible that the NHMRC Guidelines could be used to provide a starting point for the development of national legislation in relation to the rights of donor conceived individuals.

Commonwealth legislation

2.75 Some submitters strongly supported the Commonwealth legislating to regulate donor conception as a way to address inconsistencies between the states and territories.⁸¹ Others were concerned that having state or territory legislation, as well as federal legislation, could create a significant regulatory and compliance burden.⁸²

Support for Commonwealth legislation

2.76 Mr Damian Adams suggested that the Australian Government should legislate to ensure 'uniformity in the provision and control of the practice' of donor conception to ensure that donor conceived people across Australia are treated in the same way.⁸³

2.77 The DCSG expressed its strong support for Commonwealth action:

76 *Submission 155*, p. 1.

77 *Submission 155*, p. 1.

78 *Submission 48*, p. [1].

79 *Submission 48*, p. [2].

80 See, for example, Victorian Infertility Counsellors Group, *Submission 68*, p. 3; SMC Australia, *Submission 99*, p. 7; Monash IVF, *Submission 120*, p. 2. Miss Lauren Burns, *Submission 40*, p. 2, suggested the former ITA could be a model. However, despite the more comprehensive legislative regime in Victoria, concerns were still raised about some aspects of the Victorian legislation, particularly in relation to certain changes that occurred when ITA became VARTA: see, for example, Tonia, *Submission 7*, pp 3-4; Victorian Infertility Counsellors Group, *Submission 68*, p. 5; Public Interest Law Clearing House (PILCH), *Submission 125*, pp 9-10.

81 See, for example, Mr Damian Adams, *Submission 38*, p. [3]; DCSG, *Submission 122*, p. 137.

82 See, for example, IVF Australia, *Submission 23*, p. 1; Fertility Society, *Submission 106*, p. [14].

83 *Submission 38*, p. [3].

[t]he Federal [G]overnment has, in the past, justified their inaction in the area of donor conception by saying that it is a health matter and only the states have the jurisdiction to legislate in this area. We would put forward three points against this. Firstly, health departments are not the best place for legislation to do with donor conception. The issues that families and individuals involved in donor conception face are social [and] emotional for the most part; they deal with lack of genetic and social heritage very much like adoption. Secondly, most states have declined to do anything about donor conception, [a]nd thirdly the Federal Government has already set a [precedent] for legislating in the health area with its Prohibition of Cloning for Reproduction and Research Involving Human Embryos Acts.⁸⁴

2.78 Similarly, Ms Kylie Dempsey, who is a donor conceived person, submitted that regulation and legislation for donor conception practices is inconsistent in Australia and that this has had an effect on donor conceived people.⁸⁵ In particular, she expressed concern about the Australian Government's lack of involvement when, in her view, donor conception practices require further regulation to prevent 'heartache in its clients' and 'medical emergencies in donor conceived children who don't have medical histories of their donor'.⁸⁶

Constitutional head of power

2.79 In relation to whether a constitutional head of power exists to allow the Commonwealth to legislate in this area, Dr Sonia Allan suggested that the external affairs power could be used to 'protect existing records,...to require the...release of information to donor-conceived individuals about their genetic heritage [and to set] up a national database which would provide for consistency across the nation in relation to data retention and release'.⁸⁷ Dr Allan also noted that Australia has obligations under international treaties to protect children, and to ensure that children are not denied the right to an identity or denied the ability to have a relationship with their parents.⁸⁸

2.80 As examples, Dr Allan cited the Convention on the Rights of the Child, particularly Article 2 (to prevent discrimination against children), Article 3 (best interests of the child to be a primary consideration in all actions of the state involving the child), Article 7 (every child has a right to know and be cared for by their parents), Article 8 (every child has a right to preserve his or her identity) and Article 13 (child's right to freedom of expression). Dr Sonia Allan also drew on Article 7 (all are equal before the law and entitled to equal protection of the law) and Article 25(2) (all

84 *Submission 122*, p. 16.

85 *Submission 114*, p. 1. See also *Submission 4 (name withheld)*.

86 *Submission 114*, p. 1. See also *Submission 4 (name withheld)*.

87 Dr Sonia Allan, answer to question on notice, provided 8 November 2010, pp 1-2.

88 Dr Sonia Allan, answer to question on notice, provided 8 November 2010, pp 1-2.

children should enjoy the same social protection) of the Universal Declaration of Human Rights.⁸⁹

Concerns about further regulation of clinics

2.81 IVF Australia, which operates in New South Wales, expressed concern about the potential regulatory and compliance burden for clinics if there is both state and Commonwealth legislation regulating this area.⁹⁰

2.82 While most submissions supported further regulation of ART clinics, some submitters noted that changes to state legislation have negatively impacted upon them. These submitters were concerned that further changes may limit the ability for people to access ART services. For example, the mother of a donor conceived child in NSW commented that the introduction of the NSW Act had created difficulties in seeking to have her female partner conceive a child using sperm from the same donor.⁹¹

2.83 In addition, some evidence suggested that further regulation of fertility clinics has the potential to drive donors into unregulated spheres. One submitter noted:

[t]here are more Australian donors donating through unregulated international internet web sites than there are in Australian IVF clinics. Government regulations have totally driven donors away from regulation and monitoring. Donors on these sites are not regulated by regulations covering STD status, [f]ertility, [c]onsanguinity & contact between donors and children.⁹²

Regulation of private arrangements

2.84 A few submissions suggested that, in addition to regulating fertility clinics, there was a need to regulate private arrangements involving donor conception. This is despite perceived difficulties in relation to the regulation of private arrangements.⁹³ Dr Damien Riggs, a researcher in the field of sperm donation, suggested that it is necessary to regulate private arrangements in order to:

- ensure all parties have adequately considered the consequences of donor conception;
- provide legal protection to all parties;
- help prevent health risks arising from lack of appropriate screening of sperm; and

89 Dr Sonia Allan, answer to question on notice, provided 8 November 2010, pp 1-5.

90 *Submission 23*, p. 1.

91 Ms Zoe Brillante, *Submission 6*, p. [1]. Section 27 of the *Assisted Reproductive Technology Act 2007* (NSW) imposes limits on the number of women who may use sperm from a single donor.

92 *Submission 1 (name withheld)*, p. 1.

93 See, for example, Dr Damien Riggs, *Submission 19*, p. 1; *Submission 29 (name withheld)*, p. [2]; Ms Vanessa Ferguson, *Submission 55*, p. 3; *Submission 157 (name withheld)*, p. 2.

- ensure donor conceived individuals are able to access information about their donor.⁹⁴

2.85 In relation to the final point, Dr Riggs noted:

[w]hilst the majority of the participants in my research indicated willingness to be identified by children conceived of their donations, such willingness cannot be relied upon, and certainly not 18 or more years after the donation is made. Legislating for the recording of donor information in private arrangements in a public registry that can be accessed by donor-conceived children after the age of 18 would thus help to protect the rights of such children to access information about their genetic history at the very least.⁹⁵

Regulation of international donations

2.86 Submitters and witnesses expressed concerns about the practice of using donated gametes, particularly sperm, from overseas donors. However, there was conflicting evidence about the extent to which importation of gametes and embryos occurs in Australia.

2.87 Some submissions and witnesses suggested that donations from overseas should be banned in Australia, because the geographical barriers make it more difficult for a donor conceived person to establish a relationship with their donor.⁹⁶

2.88 For example, Mrs Caroline Lorbach of the DCSG raised objections to all overseas donations:

[w]e have a problem with semen being imported—full stop. Children have enough problems trying to find donors within this country let alone having to cope with contacting another country. It just adds yet another level of difficulty to an already serious problem.⁹⁷

2.89 Mr Richard Egan, from FamilyVoice Australia, also opposed the importation of sperm:

[i]n terms of importation from overseas, I think that has got to be stopped. It is unjust to the child to have this dad in some foreign country who in 18 years time they are going to have the alleged right to track down.⁹⁸

2.90 The Victorian Infertility Counsellors Group also suggested that the importation of gametes or embryos from overseas should be banned where

94 *Submission 19*, p. 1.

95 *Submission 19*, p. 2.

96 See, for example, Ms Myfanwy Cummerford, *Submission 63*, p. [3]; Ms Kimberly Springfield, *Committee Hansard*, 3 November 2010; Mrs Caroline Lorbach, DCSG, *Committee Hansard*, 2 November 2010, p. 12.

97 *Committee Hansard*, 2 November 2010, p. 12.

98 *Committee Hansard*, 29 October 2010, p. 20.

information about the donor cannot be provided for relevant records and if the donor cannot be counselled about, and consent to, donating within the jurisdiction where his or her donation will be used.⁹⁹

2.91 However, the Canberra Fertility Centre also noted the low level of sperm donations in Australia relative to demand, and indicated that the majority of donor treatment cycles it undertakes involves the use of donor sperm imported from overseas.¹⁰⁰ Dr Martyn Stafford-Bell advised the committee that his understanding is that most imported sperm comes from the United States of America and that 'American clinics have stricter guidelines than [Australia]'.¹⁰¹ Despite this, Dr Stafford-Bell indicated that he would not be concerned if the NHMRC Guidelines were updated to better address issues that arise when dealing with imported sperm.¹⁰²

2.92 Conversely, Mr Lyle Shelton from the Australian Christian Lobby noted his organisation's strong opposition 'to the importation of sperm and other gametes because the regulatory system in the United States, in particular, is fairly loose'.¹⁰³

2.93 Associate Professor Peter Illingworth, from the Fertility Society, advised the committee:

[i]t is not true to suggest...that the majority of donor gamete treatment in this country is through the use of imported sperm. Most clinics in Australia do not use sperm that has been imported from overseas.¹⁰⁴

2.94 Associate Professor Illingworth also suggested that there may be situations where imported sperm is of benefit. For example, there may be circumstances where the parties have a particular ethnic background and it is difficult to obtain sperm from a person with the same ethnic background:

...there are situations, particularly with ethnically diverse families, where the use of imported sperm may be the only option couples have to have a family. In deciding whether to use sperm that has been donated overseas, clinics have to weigh up the interests of the couples in front of them who [are] trying to have a family against the long-term interests of the children who have been conceived from donor gametes.¹⁰⁵

99 *Submission 68*, p. 2.

100 *Submission 48*, p. [4].

101 *Committee Hansard*, 29 October 2010, p. 10.

102 *Committee Hansard*, 29 October 2010, p. 12.

103 *Committee Hansard*, 29 October 2010, p. 45.

104 *Committee Hansard*, 3 November 2010, p. 46.

105 *Committee Hansard*, 3 November 2010, p. 46. See also the submission from Fertility First, *Submission 104*, p. 3.

Prohibition of any form of donor conception

2.95 Some submissions and witnesses were entirely opposed to the practice of donor conception. Mr Lyle Shelton, on behalf of the Australian Christian Lobby, stated that 'ART or NRT should be limited to circumstances where the biological parents [or close family members] are able to provide the gametes'.¹⁰⁶

2.96 The Australian Christian Lobby argued that self-identity problems impose such burdens on donor conceived children that donor conception should be prohibited:

[t]here should be a moratorium on all forms of donor conception and surrogacy, because by intentionally fracturing parenthood before the conception of the child, they necessarily impose intolerable burdens of identity bewilderment on the child. Such procedures are never in the best interest of the child to be conceived.¹⁰⁷

2.97 At the Melbourne public hearing, Mrs Myfanwy Cumberford, a person conceived using donor conception, stated that she does not support donor conception 'until there is an agreed legislative position where the child that comes into the world has the right to access and a relationship with their biological father'.¹⁰⁸

2.98 A former sperm donor, Mr Michael Linden, noted that, if he had the choice again, he would never have become a sperm donor 'and thereby relinquished [his] unborn children'.¹⁰⁹ He noted that he now feels cheated and at times angry that he may never meet some of the children conceived as a result of his donations:

[w]hat is most troubling about gamete donation is that it purposely severs a connection of the sort that normally informs a person's sense of identity...

...

To the parents, whether they would wish it or not, and whether they disclose to their child or not, the child will always be the donor's child. He is the father of that child. This is an inescapable biological fact and the fundamental reason why the continuing practice of donor insemination is a tragic if not a criminal mistake.¹¹⁰

106 *Committee Hansard*, 29 October 2010, p. 43.

107 *Submission 17*, p. 3.

108 *Committee Hansard*, 3 November 2010, p. 9.

109 *Submission 9*, p. [4].

110 *Submission 9*, p. [3].