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| Towards a prohibition on deferrable Medical interventions on intersex people: |
| report on the outcomes of the legal workshop on how a prohibition could operate in the Australian Capital Territory |

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### About Equality Australia

Equality Australia is a national LGBTIQ+ organisation dedicated to achieving equality for LGBTIQ+ people.

Borne out of the successful campaign for marriage equality, and established with support from the Human Rights Law Centre, Equality Australia brings together legal, policy and communications expertise, along with thousands of supporters, to redress discrimination, disadvantage and distress experienced by LGBTIQ+ people.

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We acknowledge that our offices are on the land of the Kulin Nation and the land of the Eora Nation and we pay our respects to their traditional owners.

### Thank you

Equality Australia wishes to thank the participants who attended the workshop; the ACT Government for engaging us to conduct the legal workshop; and Clayton Utz for providing its premises, and administrative and technological support for the legal workshop. We are extremely grateful to the participants and Clayton Utz who provided their expertise and resources on a pro bono basis.

Most of all, Equality Australia thanks the intersex people who provided input on the briefing paper and case notes, and who attended our pre-workshop briefing and post-workshop debrief. Thank you to Gabriel F, a member of the ACT intersex community and LGBTIQ+ Ministerial Advisory Council, who attended the workshop and provided invaluable input based on lived experience. We sincerely hope the outcomes of this workshop help you to realise your vision for an end to harmful practices being committed against people with intersex variations.

The views expressed in this report do not, and are not intended to, constitute legal advice.

Background

In its [*Capital of Equality First Action Plan*](https://www.cmtedd.act.gov.au/__data/assets/pdf_file/0006/1438107/Capital-of-Equality-First-Action-Plan-2019-and-2020.pdf), the ACT Government committed to collaborate with intersex people, human rights organisations and healthcare professionals to form a plan on how a prohibition on deferrable medical interventions on intersex people could operate in Canberra.

As part of its broader consultations in this area, the ACT Government’s Office of LGBTIQ+ Affairs (the **Office**) engaged Equality Australia to conduct a legal workshop to analyse legal issues arising from various reform models currently being explored by the Office. The purpose of the legal workshop was to bring together various legal experts in different areas of law to provide guidance to the ACT Government on the legal implications of, and any legal constraints on, the various models, as well as any key legal issues arising from them.

### Legal workshop

Equality Australia hosted a two-hour legal workshop on Tuesday 20 April 2021. The workshop was held in person at the offices of Clayton Utz in Canberra, Sydney and Melbourne, and via videoconference. The workshop participants are listed in **Appendix 1** to this report. The workshop was also observed by representatives from the ACT Government and the office of the Victorian Commissioner for LGBTIQ+ Communities. The workshop was conducted under the Chatham House Rule.

Briefing paper and case notes

In preparation for the workshop, Equality Australia prepared a briefing paper which was distributed to participants and observers a week prior to the workshop. Drafts of the briefing paper were also provided to representatives of Intersex Human Rights Australia (**IHRA**) for their input, which was generously provided and incorporated prior to finalisation of the briefing paper. Comments on the draft briefing paper were also received from the ACT Government.

Workshop participants and observers were also provided with short case notes on the Family Court judgments in *Re Carla* [2016] FamCA 7*, Re Kaitlin* [2017] FamCA 83*,* and *Re Lesley* [2008] FamCA 1226*,* each of which involved applications for medical interventions on children with intersex variations. Representatives of IHRA were provided with the draft case notes for their input, which was generously provided and incorporated prior to the distribution of the case notes. The case notes are in **Appendix 3** to this report.

Statement from a member of the ACT intersex community

At the beginning of the workshop, a representative of the ACT intersex community was invited to give a statement to the workshop participants and observers. The representative said that people with intersex variations were a diverse population with a range of different experiences. However, there was often a common experience of medical erasure. The representative said that the voices of people with intersex variations had been expressed in the *Darlington Statement*[[1]](#footnote-1) (contained in the briefing materials provided to the participants) and that people with intersex variations want to see a legislative standard that includes criminal prohibitions and human rights protections. The representative concluded by saying that the two main principles which should guide any reform were the principles of bodily integrity and personal consent to treatment.

The representative observed the workshop and was also invited to provide any further reflections throughout the workshop. Among the reflections provided included that the medical and scientific literature regarding certain risks (such as risks of malignancy), which was sometimes used to justify surgical interventions on intersex people, was not robust. Current and clear data about such risks was not always available, with some medical literature referring to old or problematic data. Another issue was that the availability of alternatives to surgical interventions were not always sufficiently utilised or considered. The surgical option could be seen as an ‘easy fix’ when it could be just as feasible to have routine checks or ultrasounds to manage certain risks. The representative said that, from their academic medical experience, they saw a reliance on old standards and an overstating of risks.

Further information

Participants were also invited to provide any further comments or information directly to Equality Australia. Several participants did so, and those contributions have been incorporated into this report.

Participants and observers were also provided with a copy of a draft of this report for any further contributions.

The reform models and the questions

The legal workshop explored four high-level options provided by the ACT Government’s Office of LGBTIQ+ Affairs. These options represented, respectively, a criminal, human rights, non-legislative, and regulatory pathway. The criminal pathway had two sub-options. The full description of the options provided to workshop participants is included in **Appendix 2**, while a summary is provided below.

### Summary of options

Option 1: Criminal prohibitions

This option was framed as either an Option A or Option B, reinforced in each instance by criminal offences. Under Option 1A, medical interventions on the sex characteristics of a person without their personal consent would be criminally prohibited, unless a permitted exceptionapplied. Under Option 1B*,* medical interventions on the sex characteristics of a person without their personal consent would be prohibited unless an authorisation procedure had been followed.The failure to follow that procedure would amount to an offence.

These options had several possible variations, including in respect of the scope of protections and exceptions.

Under either option, the prohibition could apply to all medical interventions altering sex characteristics or only a defined category of medical interventions. The protections could also apply to all persons, only persons with intersex variations, or only children (i.e. persons under 18 years).

In respect of exceptions, either option could permit interventions in any or all of the following cases:

* in certain circumstances (e.g. medical emergencies);
* when certain processes are followed (e.g. approval is obtained through a statutory body/process);
* for certain procedures (e.g. procedures addressing the inability to urinate);
* for procedures with certain purposes (e.g. treatments affirming the child’s view as to their gender identity).

However, the exceptions would not be framed so broadly as to allow current practices to continue, and thereby circumvent the intention of the prohibition. The exceptions would also not allow procedures to be undertaken *only* with the consent of the child’s parents (although the consent of the parents could still be a prerequisite for authorising any intervention).

Option 2: Human rights protection

This option, which could be pursued in addition to Option 1, would involve creating a new human right to bodily integrity and to make decisions about one’s own body into the *Human Rights Act 2004* (ACT).

Option 3: Non-legislative standard

This option would involve a non-legislative standard applicable to ACT Government health institutions prohibiting deferrable medical interventions on intersex people without personal consent. It could establish a team based in the ACT health directorate responsible for determining whether an intervention was deferrable and notifying ACT health staff whether it could be undertaken.

Option 4: Professional disciplinary rule

This option would define certain treatments as constituting professional misconduct or unprofessional conduct by a health professional under the Health Practitioner Regulation National Law, as it is incorporated in the ACT.

### Summary of questions

The briefing paper explored a number of legal issues including the international and domestic human rights framework underpinning any potential prohibition; various legal considerations in any prohibition (including the current law on medical consent and examples of overseas prohibitions); various legal considerations in any oversight or transparency mechanisms that may reinforce a prohibition (including examples of domestic oversight mechanisms); and the interaction of any new prohibition with existing laws and systems.

From these issues, participants were asked 7 questions in the briefing paper. These questions were then explored under four general topics in the legal workshop.

1. **Models: Possibilities, strengths and limitations.** In respect of the proposed models:
   1. Are there any models which are legally impossible or could not work for legal reasons? Why?[[2]](#footnote-2)
   2. What, in your view, are the strengths and limitations of each of the models that you consider are legally possible?[[3]](#footnote-3)
   3. Are there any considerations or questions which arise for you from any of the models and how they would interact with Commonwealth or Territory laws and systems?[[4]](#footnote-4)
   4. Are any options missing?
2. **Prohibitions and exceptions.** There are several ways in which a prohibition, and any exceptions to it, may be framed.In considering the scope of any prohibition and any exceptions to it:
   1. What legal considerations, or related practical or policy considerations that flow from those legal considerations, need to be taken to account?[[5]](#footnote-5)
   2. What weight should be given to those considerations?
3. **Oversight and transparency.** Where personal consent to treatment cannot be obtained, mechanisms could be put in place to provide oversight and transparency when decisions are made to pursue interventions.In considering the scope of any oversight or transparency mechanisms, what legal considerations, or related practical or policy considerations that flow from those legal considerations, need to be taken into account?[[6]](#footnote-6)
4. **Interaction with other laws and systems.** Regardless of the model pursued, it will have to interact with existing Commonwealth, Territory and common law.
   1. What laws require consideration for their interaction with any new scheme?[[7]](#footnote-7)
   2. What are the issues and legal constraints that would require consideration if the ACT develops a legislative scheme without Commonwealth legislative amendment?[[8]](#footnote-8)

Outcomes from the discussion

# Overall themes raised by participants

## No model is legally impossible

There was consensus among the participants that none of the options were legally impossible, and that any or all of them could be legally implemented (and in fact some – particularly Options 2 and 3 – were arguably already in effect). There was also recognition that each of the models had their own strengths and challenges, although these challenges were not legal barriers which could not be overcome. These considerations are explored further below in respect of each of the options.

## Option 1 is preferred, perhaps in combination with other options

Overall, there was strong support for Option 1. There was also some support for Option 2 (although this was not universal), but not to Option 2 being pursued on its own. There was general agreement that Option 3 would be insufficient on its own. There was almost universal agreement that Option 4 would also be insufficient on its own, although one participant did not support Option 4 at all. The reasons given by participants for their views on each of the Options varied and are explored further in the sections below.

A couple of participants suggested considering an overarching scheme that used all the frameworks canvassed. Many participants saw the options as linked or capable of supporting each other. Some participants suggested that some of the options – particularly Option 2 and 3 – were already arguably in place but had not been effective in bringing about the cultural change necessary. For example, one participant said that Option 3 was practically in place already because there were already standards set by multidisciplinary medical teams at major hospitals in major cities, but that these have not been supportive of the human rights of intersex people. For the reasons set out further below, one participant opposed Option 2 and 4.

## The need for cultural change

In considering the various models, several participants agreed that there was a broader issue at play: the need for cultural change. Reflecting on the distinction made in *Marion’s* case[[9]](#footnote-9) between ‘therapeutic’ and ‘non-therapeutic’ interventions, one participant reflected on what they saw as ‘too ready an acceptance’ by the medical profession, parents and Family Court judges of the reported health risks associated with non-intervention, and thereby characterising treatments as therapeutic. This meant that interventions did not need court approval (according to the principles in *Marion’s* case).[[10]](#footnote-10)

This view was echoed by other participants, some of whom were particularly critical of the approach taken by the Family Court in previous intersex cases. One participant said that, in the history of intersex human rights before the Family Court, there had been almost blind deference to medical opinion. This participant said that the Family Court had also actively refused to appoint Independent Children’s Lawyers (**ICLs**) in intersex cases, and while ICLs were not perfect, this nonetheless evidenced a marked disdain for any contrary voice before the Family Court. This view was echoed by another participant who felt the Family Court had been captured by medical perspectives and the appointment of ICLs would not be sufficient to remedy the situation.

The broader need for cultural change underpinned some of the participants’ views on the various models. For example, several participants said that the need for a broader cultural shift supported implementing a strong criminal prohibition. One participant said that intersex advocates had been working for 25 years and had little success in getting public traction on the issue as one concerning a clear breach of human rights. To achieve this change would require criminalising procedures, and this would also serve the dual purpose of saving particular children from surgeries that are performed today. Another participant said that, while Options 3 and 4 could complement a criminal offence, neither on their own would be given sufficient gravitas before a court. A third participant said that without Option 1, none of the other options would likely be sufficient to effect the cultural change needed. However, one participant also flagged that while legal change was one way of effecting cultural change, reforms such as amending the *Human Rights Act* would not be sufficient on their own.

# Specific comments on the options

## Option 1

There was strong support for Option 1 for varied reasons, including because:

* it would offer a strong protection;
* it may be necessary to effect the needed cultural shift;
* other approaches (including Options 2 and 3, which had been implemented to a degree) had failed;
* it was more likely to be given weight by the Family Court, notwithstanding any constitutional considerations;
* it was consistent with the recommendations made by international human rights bodies for a prohibition on forced interventions.

Framing the prohibition and exceptions

A few participants noted that there would be some issues to consider in how a criminal prohibition and any exceptions should be framed.

Several participants described the need for a general prohibition with strictly ascribed exceptions. For example, one participant suggested a provision stating that a person must not undertake an intervention that modifies a person’s sex characteristics without their consent. The provision should make no allowance for defences such as the consent of parents. Another participant said that the stronger and more prescriptive the criminal prohibition, the more likely it will be interpreted narrowly.

Two participants said that an offence should not be tied to any particular diagnoses, with one of these participants noting that some clinicians contested which diagnoses were included in the definition of DSD or intersex. One of these participants also said that an offence should not be tied to any particular procedures, as legislation could not keep up with scientific advances or social values. This participant said that tying the offence to particular diagnoses or procedures would be a ‘fatal flaw’ in the legislation. This concern around keeping up with medical developments was also raised by other participants who preferred process-based exceptions under Option 1B.

The participants discussed whether a distinction between therapeutic and non-therapeutic interventions could be used as part of framing the prohibition, with non-therapeutic interventions put into one category and therapeutic interventions subject to some oversight mechanism. However, that distinction was not supported by others in the workshop. One participant said that the exception for therapeutic treatment had a poor history of efficacy to date and that, even in *Re Marion*, the judges acknowledged the distinction was not helpful but it was the best they could do.[[11]](#footnote-11) This participant said that the distinction could reintroduce psychosocial and long-term psychological rationales which are highly contested as exceptions to a prohibition. Another participant added that the distinction would enable people to circumvent or game the prohibition by arguing that they were ‘curing’ a ‘defective body’.

Reflecting on constitutional and other considerations, another participant was more attracted to framing the prohibition along the lines of Option 1B, i.e. 'don't do x without discussion with a committee', rather than as a simple prohibition with a penalty along the lines of Option 1A, i.e. ‘do x and you’re in trouble’. This participant favoured a general prohibition with an exception for urgent medical necessity (framed in terms of an urgent procedure necessary to save life), and then referral to a committee. However, the participant said that the committee’s consideration must not be allowed to revert completely to doctors and treating doctors.

Another participant said that the power to make rules as to any exceptions could in effect be delegated to an oversight entity, if that entity was the primary mechanism by which treatment absent consent would be approved or disallowed. While this would remove the decision as to which exceptions should apply from overarching democratic scrutiny, it would be preferable to setting out a huge amount of detail in the primary legislation and would allow the scheme to take account of changing medical research. Like the participant in the preceding paragraph, this participant favoured focussing on an approval process with a limited number of exceptions, with any exception for risks to physical health or fertility linked back to the notion of urgency. This participant said that terms in such exceptions were not ‘terms of art’ (that is, they did not carry particularly known or settled meanings). The risk with many exceptions is that they would be left for judges to decide. If the arbiter of those terms were a judge of the Family Court who saw these matters infrequently and did not have specific expertise, they could be particularly susceptible to experts called by certain parties. This would enlarge the scope of the exceptions. Another participant also remarked that shifting the decision-making to a special tribunal would reduce the risk of the prohibition being ‘read down’ (that is, interpreted in a way which would limit its scope or effect).

One participant said that consultation with medical professionals was needed to ensure the offence is properly framed. An exception for male circumcision was also suggested by one participant.

Oversight mechanisms

There were a range of views expressed on the potential functions, roles and processes of an oversight mechanism. This mechanism was variously described as a committee, body, entity, specialist panel or tribunal. However, a couple of participants were clear in saying the oversight mechanism should not be the Family Court.

One participant said that there were three key questions to answer in respect of any entity which is made the decision-maker or the reviewer. The first was the composition of that entity, including the forms of expertise and perspectives that were offered. The second was the way in which the entity operated. The third was the way in which its decisions could be challenged. In respect of the way in which the entity operated, this participant said that the entity needed to see enough of these matters to be able to develop a body of expertise in the way the Family Court has not been able to. As explored further below, other participants also expressed views on the way in which the entity should operate, including in respect of its functions, the way in which its decisions should be made, how evidence should be collected and analysed, and how accessible, informal or ‘family friendly’ the entity should be. In respect of pathways to challenge its decisions, this participant also said that this entity should be immune from merits review but subject to judicial review to ensure legal protocol has been followed.

In respect of the composition of the entity, several participants spoke of the need for expertise from a range of disciplines. Another participant said that it was important that the entity had the confidence of the intersex community, needed to focus on the best outcomes for intersex people and that its work was transparent. Another participant also queried whether the committee process should be a one-size fits all approach, or whether it may depend on the particular risk assessment being undertaken.

Several participants imagined the committee having a role in approving or rejecting specific medical interventions. One participant, who favoured Option 1B to Option 1A, mentioned that if the committee’s role was to undertake a risk analysis of proposed interventions, it might be informed by a range of considerations, including medical risks and other infringements to a person’s life.[[12]](#footnote-12) This participant mentioned that these incommensurable considerations were difficult to weigh up. However, another participant said that it was this difficulty – namely that these decisions were not inherently medical and involved such incommensurate questions – that meant that the decision to medically intervene can only really be answered by the person themselves. That is why they (and their organisation) strongly preferred supported decision-making rather than substituted decision-making, with the deferral of any deferrable interventions until the person could themselves provide consent. They saw the oversight mechanism as being a support body having oversight of decision-making processes, and not making decisions in every case, but some. Another participant also concurred with this view.

The principle of supported decision-making (as it may have been variously understood by participants) was supported by several participants, although one participant also warned about the potential for duress, undue influence and a lack of review in supported decision-making frameworks. This participant however emphasised that the process of obtaining consent must clearly involve the intersex person, considering their views and interests. A number of other participants also reflected on their experience in other settings, stating that a child’s wishes must be honoured and that, if there is a tribunal, it needs to be friendly to families. One participant reflected on two examples of processes which they considered to be non-affirming and potentially traumatising: the Victorian surrogacy review panel (established under section 82 of the *Assisted Reproductive Treatment Act 2008* (Vic)) and a recent Queensland Supreme Court case involving a 17-year-old transgender child where judicial authority was required for the child to be allowed in the courtroom.[[13]](#footnote-13)

Another participant said that it was important that the notion of ‘supported decision-making’ be understood consistently with the meaning given to it in the Convention on the Rights of Persons with Disabilities (**CRPD**), and noted that the term may have been used by various participants in the workshop with different understandings of what it meant. In this participant’s view, supported decision making (as understood by the CRPD) meant providing the required support to children and adults with disability to enable them to express their own will and preference, so that they were able to provide their own informed consent to medical interventions. This participant would not support an oversight mechanism that incorporated a substituted decision-making framework, as that would not comply with the CRPD nor provide protection for children or adults with disability, or intersex children and adults. Deferrable medical interventions should not be approved without the personal informed consent of the person (that is, including by an oversight mechanism).

Several participants envisaged other innovative processes for the oversight committee. One participant conceived of the oversight committee as developing into an international centre of excellence. Apart from having an ad hoc function in assessing individual cases before it, the committee process could collate data and test it by reference to international best practice. The committee could access assessments from a range of established experts and develop a body of work from its caseload to inform future practice, including developing research over the years. This broader deliberative committee process would help address a key challenge which has been seen in past decisions (such as the Family Court decision in *Re Carla*): namely, impreciseness in the medical science as to certain risks and no evidence contesting that medical evidence*.* This evidentiary challenge means that decision-makers – who are required to make decisions based on the evidence before them and who need to provide reasons for their decisions – do not have the evidence to make decisions refusing medical interventions. So, for example, when a decision-maker is confronted with uncontested evidence about germ cell malignancy and cancer risks (as arose in *Re Carla*), it is difficult for them, without evidence countering that medical evidence, to make a decision refusing to authorise surgery that would address those risks. This is because the decision-maker simply could not explain to the parents who appear before it why surgery that would address those risks should not be permitted on their child. Accordingly, unless the oversight committee has a different process for collecting and testing medical evidence, it will face the same problem which currently faces the Family Court.

Other participants also discussed the importance of considering how evidence is considered before any oversight body. Several participants advocated for a more adversarial approach – in the sense that it was necessary to have some type of contradictor, independent advocate or *amicus curiae* role – to ensure a more holistic picture of contemporary evidence is available and medical evidence would not be accepted without challenge. One participant said that the cases before the Family Court had tended to ignore substantial bodies of evidence. For example, in *Re Carla*, there was no mention that 60% of children with that particular intersex variation identify as male at puberty. This medical evidence was ignored, and unless there is a contradictor, there was a risk that only certain evidence would be presented before a decision-maker in order to avoid the prohibition. However, other participants said that the process needed to be as non-legal as possible and had to be accessible and not intimidating.

Two participants considered a potential broader role for any entity. One participant said that, as well as being a committee or tribunal, this entity could have significant infrastructure with people working to do a whole range of things. For example, there could be a person who spoke with the intersex child or person and made sure they were not under duress or improperly influenced. That person could gather evidence, offer a conciliation process,[[14]](#footnote-14) or perform a range of less formal things before the matter proceeded to any decision-making body. Another participant said the entity could perform a function in providing guidance to intersex people and their parents on different options that would positively influence and support their decision-making.

Transparency mechanisms and privacy

One participant said that it was important to remember that the ACT was a small jurisdiction. While they had no objection to mechanisms for reporting or recording information regarding treatments provided to people with intersex variations, it was important that any mechanisms could not be used to identify people (for example, to community representatives who may be involved in oversight mechanisms).

Constitutional considerations

One participant noted that there was a complex constitutional law question about how a criminal prohibition under ACT law would interrelate with Family Court orders made under federal law. In *P v P* (1994) 181 CLR 583*,* the High Court held that an order made under the *Family Law Act 1975* (Cth) to authorise medical treatment could take precedence over an order made under the *Guardianship Act 1987* (NSW).

However, this participant said that even if the Family Court could override the criminal prohibition as a matter of constitutional law, the fact that the ACT had enacted a criminal prohibition restraining treatment on children would inevitably be taken seriously by any Family Court judge. Therefore, even if the judge considered themselves not bound by the ACT law by virtue of the constitutional primacy of a federal law, a criminal prohibition would still help achieve the cultural shift necessary and go some way to ‘moving the scales’.

This view was echoed by several other participants, including another participant who also referred to the case of *Re Inaya (Special Medical Procedure)* [2007] FamCA 658 (in which the Family Court authorised a bone marrow harvest and peripheral blood collection that would otherwise have been an offence under the *Human Tissues Act 1982* (Vic)). However, this participant noted that it was likely that someone would eventually attempt to challenge a refusal to authorise treatment by the oversight entity by instead seeking authorisation through the Family Court, given that court had been hospitable in the past.

Another participant said that it was important that legal advice is sought around the scheme’s interaction with the family law system.

Extraterritoriality

Two participants noted that it was important for any offence to have extraterritorial operation (that is, that the offence could apply to acts done or proposed outside the ACT), with one participant saying it could be similar to the offence for female genital mutilation under the *Crimes Act 1900* (ACT).[[15]](#footnote-15) One of these participants said that this was because most intersex children in the ACT would be taken out of the Territory for treatment to a major hospital with a multidisciplinary team. This participant said that these teams would not respect the prohibition unless it was mandatory, and they were caught within the prohibition.

However, another participant said any offence may automatically have extraterritorial application because of section 64 of the *Criminal Code 2002* (ACT).[[16]](#footnote-16) This participant noted that the extraterritorial offences existing in respect of surrogacy in the ACT, New South Wales and Queensland had instilled fear among parents notwithstanding no one had been prosecuted under them.

Another participant noted that in the guardianship context, which prohibited the sterilisation of young women with disabilities, there could still be a compliance issue with people who ignored the prohibition or took children elsewhere for the procedure.

Children with disabilities

One participant said that the prohibition proposed in Option 1A could also capture sterilisation procedures undertaken without personal consent for children with disabilities. In their view, current court authorisation procedures had not been protective of people with disabilities, and this is an issue that requires further discussion if the offence is to be one of general application.

This participant said that they would have strong concerns if an exception to a general prohibition merely facilitated existing Family Court and Tribunal decision-making processes for the sterilisation of children with disability. In their view, terminology such as ‘medical necessity’, ‘therapeutic purposes’, and the ‘best interests of the child’ embedded assumptions in decision-making in support of sterilisation, such as assumptions based on gender and disability stereotypes and norms, assumptions about the ‘burden’ placed on parents, assumptions about presupposed psychological harms, and assumptions about the potential for sexual abuse.

Children with gender dysphoria

Several participants reflected on the situation for children with gender dysphoria (some of whom may or may not have intersex variations). One participant mentioned that a prohibition should not interfere with access to treatment for young people with gender dysphoria.

Another participant said that there may be a tension in the approach needed for authorising treatment for gender dysphoria when compared to that for treatment associated with intersex variations, in that there was a greater willingness to consider psychosocial factors for gender dysphoria while the consideration of psychosocial factors could be problematic in cases involving intersex infants.

Civil prohibitions

One participant suggested consideration of a parallel civil prohibition in addition to the criminal one (for example, one that could give rise to an action for trespass). The reason given for this was there may be less judicial reluctance to find that there has been a contravention of a civil prohibition, rather than a criminal one.

Another participant suggested there was a need to review whether any statute of limitations provisions in the ACT prevented a child from bringing a civil action in respect of past medical intervention.[[17]](#footnote-17)

Refusal of consent

One participant noted that the capacity of a person (who is *Gillick* competent) to consent or refuse treatment may still not be determinative in whether a treatment is authorised, given the *parens patriae* or welfare jurisdiction of certain courts. For example, in *X v Sydney Children’s Hospitals Network* [2013] NSWCA 320, the NSW Court of Appeal confirmed that the court could authorise a blood transfusion that a 17-year-old child (who was *Gillick* competent) had refused with the support of his parents. This meant that an intersex person who refused treatment could still have their refusal to consent questioned by a court as to whether it was in their best interests (if for example, their parents did not support their decision), notwithstanding that the views of a *Gillick* competent person would be given significant weight by a court. Another participant added that the typical cases in this area were in respect of a *Gillick* competent person who had refused treatment for anorexia or drug addictions, in addition to blood transfusions.

## Option 2

There was some support for Option 2 among the participants, although the support was not as strong as for Option 1. This was partly because some participants felt Option 2 was already in effect under existing protections contained in the *Human Rights Act 2004* (ACT), and that it would not be sufficient on its own, given it mostly applied to public authorities. While one participant felt that the right to bodily integrity could be given explicit recognition, there was not universal support for this view. One participant was opposed to Option 2 in the form proposed by the briefing paper.

Already in effect, not sufficient on its own

Several participants said that Option 2 was, in effect, already captured by the *Human Rights Act*, with one participant specifically referring to the right to protection from cruel, inhuman or degrading treatment.[[18]](#footnote-18)

Another participant said that, if you take a human rights-based approach, any measures adopted would need to be effective in the protection they provided. This participant said that while the *Human Rights Act* already offers the protection which is proposed by Option 2, this protection had not been effective in practice. In this participant’s view, the right to bodily integrity already exists but it is not being applied. Similarly, while all medical issues must already be determined in the child’s best interests, the way that phrase has been interpreted for some time has not reflected human rights law nor provided the protection to intersex children that it should have. For this reason, this participant said a strong criminal prohibition was needed with a capacity to allow treatment in some circumstances.

Another participant, who expressed attraction for Option 2, also said that changing the *Human Rights Act* would not be sufficient on its own to effect the broader cultural change needed. A further participant commented that, given the obligations in the *Human Rights Act* predominantly fall on public authorities, the obligations would not apply broadly.

Other human rights

One participant said that the proposal in Option 2 did not give enough emphasis to other human rights that are applicable to fertility issues more generally. Among those were the right to found a family and the right to decide the number and spacing of children.[[19]](#footnote-19) A full list of further relevant human rights was provided to Equality Australia by email.[[20]](#footnote-20)

Another participant, who was opposed to Option 2 as it was currently proposed, considered a broader right to health would be a better approach. Two specific reasons were relied upon for this view. The first was that different aspects of the right to bodily integrity were already encompassed within several rights in the *Human Rights Act*, such that a specific right to bodily integrity might reduce the ability of these other rights to be relied upon. This was, in effect, a statutory construction argument that a specific right could narrow the interpretation given to broader, more general rights. The second was that a right to bodily integrity was not sufficiently backed up by comparative human rights jurisprudence internationally, and therefore courts could not benefit from international understandings of how these rights work. There was a concern that ACT courts had not taken an expansive interpretation of the scope of rights in the *Human Rights Act* already, and therefore would construe a right to bodily integrity narrowly in this context. However, another participant said that the right to bodily integrity has, at least under tort law, been well developed in jurisprudence on the right to refuse medical treatment and the requirement that medical treatment be preceded, subject to exceptions, by personal consent.[[21]](#footnote-21)

## Option 3

While some participants saw Option 3 could complement other options, no participant considered that Option 3 would be sufficient on its own.

Gaps in protection

Given that Option 3 envisaged a non-legislative standard applicable to ACT Health, a couple of participants said that this left a gap in coverage in respect of medical treatment provided by the private sector. One participant said that this would mean that the private sector could effectively take over the provision of treatment to children with intersex variations in lieu of the public sector.

May be binding anyway

One participant said that, although Option 3 may be expressed as a non-legislative standard, it could still impose a legal obligation on the ACT Government, notwithstanding that it may not intend to create legal consequences or binding obligations. This person said that it could be open for a person to make the argument that there is some sort of legal obligation on the ACT Government from a public law perspective when decisions are made that affect the rights and interests of a child.

## Option 4

While some participants saw Option 4 could complement other options, most participants considered that Option 4 would not be sufficient on its own. One participant did not support Option 4.

Potential for national approach?

One participant said that one attraction of Option 4 was that it could lead a discussion at the national level with consequences outside of the Australian Capital Territory, resulting in national disciplinary rules. However, this participant also mentioned that Option 4 would be slow to implement and require agreement from the Ministerial Council[[22]](#footnote-22) overseeing the National Scheme under the Health Practitioner Regulation National Law.

Another participant, who did not support Option 4, thought that this option was not practically achievable, given the ACT could not amend a national framework by acting alone.

Adequacy of current system

One participant reflected that the Health Practitioner Regulation National Law defines ‘unsatisfactory professional conduct’ by reference to standards which reflect what is considered acceptable conduct among the medical profession. ‘Professional misconduct’ is then further defined as unsatisfactory professional conduct that is morally reprehensible. Therefore, reliance on Option 4 alone could reinforce current medical practice rather than challenge them. This participant also said that the professional disciplinary process was very slow and often hears cases about things that happened 4–5 years ago. From their experience, the only category of professional misconduct that tends to lead to the most serious consequences (such as deregistration) are improper doctor-patient relationships, such as sex between a doctor and their patient. On the other hand, clinical issues are generally dealt with at a lower level of seriousness. Accordingly, for this participant, disciplinary processes should exist alongside a general prohibition (i.e. Option 1).

However, another participant, who did not support Option 4, said that the current disciplinary frameworks were already adequate. That, if a health professional were engaging in procedures they should not be performing, there were already mechanisms in place to report and act on that behaviour. This participant emphasised that the ACT has a co-regulatory model in which the ACT Human Rights Commission has a role in addition to the national medical board. This meant there was joint decision-making and input as to what was considered professional conduct or not.

# Other themes

Commonwealth cooperation

One participant expressed pessimism about the prospects of any option which required passage of legislation through the current Commonwealth Parliament. Reflecting on the history of the federal marriage equality debate, this participant indicated that there may be opposition to addressing these issues at the federal level. This had been a driver in the decision of the Commonwealth Attorney-General to intervene in the case of *Re Kelvin* [2017] FamCA 78*,* which presenteda good opportunity to seek change through the courts rather than through parliament. However, another participant did not share that participant’s pessimism regarding the wiliness of some members of the Commonwealth Government to consider the issue.

Opportunity for improved procedure in federal family matters

One participant suggested that there may be an opportunity to improve the procedure in family law cases because of the merger between the Federal Circuit Court and Family Courts. Over the next two years, the Chief Justice of the new Federal Circuit and Family Court is empowered to write the new court rules, and draft rules had already been circulated to key stakeholders in the profession for consideration. This participant said that this presented an opportunity to seek specific procedural requirements, such as the mandatory appointment of an Independent Children’s Lawyer. This would help ensure that there is always a contradictor in such cases. While this measure alone was acknowledged as insufficient, it could nonetheless be an improvement as a temporary measure.

Appendix 1: List of participants

|  |  |
| --- | --- |
| Name | Title |
| Elizabeth Bennett | Barrister, List G Barristers |
| Susan Cochrane | National Policy Manager, Family Law at Relationship Australia |
| Graeme Edgerton | Deputy General Counsel, Australian Human Rights Commission |
| James Emmett SC | Barrister, Banco Chambers |
| Gabriel F | Representative from ACT intersex community |
| Kym Fraser | Partner, Clayton Utz |
| Stephen Page | Director, Page Provan Family and Fertility Lawyers |
| Aileen Kennedy | Lecturer, School of Law, University of New England and board member of Intersex Human Rights Australia |
| Jeremy Kirk SC | Barrister, Eleven Wentworth |
| Diane Robinson | Former President of the NSW Guardianship Tribunal and member of the Professional Standards Committee (NSW) |
| Therese Sands | Policy and Research Coordinator, Chair UN Committee on the Rights of Persons with Disabilities and former Co-CEO of People with Disability Australia (PWDA) |
| Edward Santow | Human Rights Commissioner, Australian Human Rights Commission |
| Professor John Tobin | Melbourne Law School, University of Melbourne |
| Karen Toohey | Discrimination, Health Services, and Disability & Community Services Commissioner, ACT Human Rights Commission |

Appendix 2: Models being explored by the ACT Government

## Option 1: Criminal prohibitions

The first two options involve criminal prohibitions. These options prohibit, by way of criminal offences, medical or surgical interventions on the sex characteristics of a person unless, under Option 1A, a permitted exception allows it or, under Option 1B, an authorisation procedure has been followed.

Option 1A: Criminal **offence**

Option 1A involves legislating an offence that, subject to specific exemptions, prohibits either:

* medical interventions altering the sex characteristics of a person (or alternatively, a person with intersex variations, or alternatively, a child) without personal consent; or
* the performance of defined categories of medical intervention on a person (or alternatively, a person with intersex variations, or alternatively, a child) without personal consent.

The exemptions could permit interventions in all or any of the following cases:

* in certain circumstances e.g. medical emergencies;
* when certain processes are followed e.g. approval is obtained through a statutory body/process;
* for certain procedures e.g. procedures addressing the inability to urinate;
* for procedures with certain purposes e.g. treatments affirming the child’s view as to their gender identity.

However, the exemptions would **not**:

* be framed so broadly as to allow current practices to continue, and thereby circumvent the intent of the prohibition (e.g. for example, this is considered by some stakeholders to be the case with existing legal tests of ‘medical necessity’, ‘therapeutic purposes’, ‘for the health of the child’ or ‘actions in the best interests of the child’);
* allow procedures to be undertaken *only* with the consent of the child’s parents, although the consent of the parents may still be a necessary requirement for authorising any interventions (i.e. the parents alone cannot make the decision, but neither can the decision be made without the parents’ consent).

Option 1B: Offence of failing to seek approval for treatment

Option 1B involves legislating a procedure to be followed in a class of circumstances where medical treatment altering the sex characteristics of a person (or alternatively, a person with intersex variations, or alternatively, a child) is involved without personal consent. The failure to follow that procedure would amount to an offence. Similar exemptions to Option 1A could be adopted, though framed differently.

## Option 2: Human rights protection

Option 2 involves legislating a new human right to bodily integrity and to make decisions about one’s own body into the *Human Rights Act 2004* (ACT) (for example, by amending section 10 that prohibits cruel, inhuman and degrading treatment). Option 2 could be pursued in addition to Option 1.

## Option 3: Non-legislative standard

Option 3 involves creating a non-legislative standard that is adopted by ACT Health and applied to ACT Government health institutions that prohibits deferrable medical interventions on intersex people without personal consent. It could establish a team based in ACT health directorate that is responsible for determining whether an intervention is deferrable, and if so, notifies ACT health staff that they cannot undertake it.

## Option 4: Professional disciplinary rule

Option 4 would involve defining certain treatments as constituting professional misconduct or unprofessional conduct by a health professional under the *Health Practitioner Regulation National Law (ACT) Act 2010,* as it incorporates into ACT law (with modifications) the Health Practitioner Regulation National Law.

Query also whether conduct amounting to an offence under Option 1 could amount to at least unprofessional conduct, given unprofessional conduct means conduct that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner’s professional peers.

Appendix 3: Case notes

## *Re Carla* [2016] FamCA 7

Background

* Carla (5) was born with 17 beta hydroxysteroid dehydrogenase 3 deficiency.[[23]](#footnote-23)
* Carla was born with the external appearance of a female child, but with internal male gonads.

Treatment sought

Carla’s parents, supported by the relevant government department appearing as a friend of the Court, sought:

* A gonadectomy; and
* ‘Further or other necessary and consequential procedures’, including oestrogen treatment.

Carla had already had a 'clitoral recession' (clitorectomy) and labioplasty performed by Dr B in March 2014, neither of which was subject to court consideration.

Evidence and decision

Medical evidence in favour of the gonadectomy was heard from three doctors:

* Doctor B, Carla's treating paediatric surgeon;
* Doctor C, Carla's treating paediatric endocrinologist; and
* Doctor S, Carla's treating paediatric psychiatrist.

The Court determined that the procedure was in Carla's best interests, relying on the following evidence:

* The ‘risk of tumour development in the testes’ — which, due to their internal positioning, would be difficult to monitor: [19]–[20].
* The risk that testosterone-like substances would be produced at puberty, leading to the development of male physical characteristics and leaving Carla ‘at increased risk of developing mental health problems’: [25].
* Dr S’s view that Carla identified as a female and was ‘likely to continue to’: [28].
* The medical practitioners and Carla’s parents had determined that the treatment was in Carla’s best interests: [32]–[33].
* The following alternative options were noted:
  + - Carla's gonads could be moved to the external abdominal cavity, but that would likely have adverse psychological consequences: [20].
    - Dr C reported that ‘in theory’ male puberty could be suppressed hormonally, allowing Carla the opportunity to give consent to the proposed treatment. However, Carla's pubertal development would be significantly delayed compared to her peers ‘with likely detrimental social and psychological effects’; and would additionally leave Carla exposed to the risk of tumour development: [24]–[25].
* Dr S opined that the psychological risks to Carla of not undergoing the procedure outweigh the effects of undergoing the surgery: [26].

Criticisms of the decision by IHRA[[24]](#footnote-24)

* The decision relies heavily on old data relating to cancer risks. Additionally, the data cited recommends ‘monitoring’ gonads, rather than removing them.
* The evidence in support of the treatment relied heavily on gender stereotyping and expresses attitudes towards Carla’s body and potential future sexuality: e.g. judgment refers to previous procedures that ‘enhanced’ the female appearance of Carla's genitals. There also had been no oversight of these procedures.
* The Court did not consider a well-known body of evidence that a majority of children with Carla’s variation identify as male at puberty.
* The Court gave no weight to evidence that hormonal suppressants (i.e. puberty blockers) could have been a valid option for Carla, which could have deferred the surgery until Carla could consent.
* The Court expressed the opinion that the procedure was within the power of the parents to authorise without court consent.

In the absence of an independent contradictor, the case demonstrates complicity of the court and medical systems.

## *Re Lesley* [2008] FamCA 1226

Background

* Lesley (born 2004) was born with 17 beta hydroxysteroid dehydrogenase 3 deficiency.
* Lesley was born with the appearance of a female child, but with male gonads.

Treatment sought

‘A Hospital’, supported by Lesley's parents and the Department of Child Safety, sought:

* A gonadectomy; and
* ‘Further or other necessary and consequential procedures’, including hormonal treatment.

Evidence and decision

In addition to affidavits sworn by Lesley's parents, the Court heard expert evidence from:

* Dr Z, a Fellow of the Royal Australia College of Physicians, specialist, paediatrician and endocrinologist;
* Dr X, a paediatric surgeon; and
* Dr T, a child psychiatrist not attached to the A Hospital who had been engaged principally to give independent advice to the parents.

Legal Aid argued for the appointment of an Independent Children's Lawyer, due to the lifelong and irreversible nature of the procedure and the lack of immediate urgency: [43]. The Court rejected that application and held that other options had been properly considered.

The Court decided that the proposed treatment was in Lesley’s best interests, relying on the following evidence:

* Rearing Lesley as a female child was ‘entirely appropriate from a psychological point of view’ and Dr T’s view that it was likely Lesley would continue to identify as female: [16]; [28].
* Lesley would likely face psychological and social impacts ‘whether or not the proposed surgery is performed’, but ultimately the impacts would be lesser if the surgery was performed now: [17].
* If the gonadectomy was delayed, there was a risk that Lesley would virilise in a male fashion at the onset of puberty: [18]; [27].
* Not performing the surgery would lead to an increased risk of cancer developing: [29].
* While the gonadectomy would leave Lesley infertile, Lesley would likely be infertile regardless: [31].
* The following alternatives to surgery were canvassed by Dr Z (at [40]):
  + - Take no action and allow Lesley to virilise and make a determination about her own gender, which was said to involve ‘significant risks of malignancy’ and ‘significant psychological impact’; and
    - Prescribe Lesley with testosterone blockers and replace with oestrogen, which was said to be ‘not the best course medically’.
* Counsel for the Department referred to the procedure as a sterilisation procedure, however, the Court said that the gonadectomy was not 'primarily a sterilisation procedure' in Lesley's case: [31].

Criticisms of the decision

* IHRA has noted that the cancer statistics cited by the experts (and the judge at length) appear at the top end of the range in the literature, to justify the short term removal of the gonads. IHRA also noted the reliance on the future management of psychosocial rationales.[[25]](#footnote-25)
* The Court refused the application of Legal Aid to appoint an Independent Children's Lawyer.
* The Court did not consider a well-known body of evidence that a majority of children with Lesley’s variation identify as male at puberty.
* While the Court notes Dr Z's evidence of 'alternatives to surgery', it does not appear to consider alternatives in depth or heard evidence in support of alternative options.

## *Re Kaitlin* [2017] FamCA 83

Background

* Kaitlin (16), born male with hypopituitarism,[[26]](#footnote-26) and as a result could not produce testosterone.
* Kaitlin identified as transgender in 2014, and had previously identified as female from an early age.
* Kaitlin was prescribed testosterone at 12 or 13 to commence puberty, but stopped taking it when she realised the effect it would have on her body.

Treatment sought

Kaitlin's mother (unclear what position was taken by Kaitlin’s father, listed as the respondent) sought:

* Stage two treatment for Gender Dysphoria (administration of estrogen).
* Kaitlin had not had stage one treatment (testosterone blockers), as her body could not produce testosterone.

Evidence and decision

In addition to a statement from Kaitlin and an affidavit sworn by her mother, the application was supported by evidence from medical practitioners:

* Dr W, Kaitlin's specialist paediatrician since July 2002;
* Dr N, a paediatric endocrinologist who had been treating Kaitlin since November 2014;
* Ms D, a psychologist involved in the care of Kaitlin since August 2014; and
* Dr E, a consultant psychiatrist who Kaitlin had been referred to in around July 2016.

The Court granted the application, and determined that Kaitlin was *Gillick* competent,[[27]](#footnote-27) relying on the following evidence:

* Kaitlin had a longstanding history of symptoms consistent with Gender Dysphoria;
* Kaitlin was well aware of the effects of estrogen and stage two treatment;
* Kaitlin believed that developing as a pubescent female was in her best interests, had held an unwavering desire to develop as female and had never wished to develop as male: [13].

Even if Kaitlin were not *Gillick* competent, the Court found that the evidence was unanimous in concluding that the benefits of the proposed treatment significantly outweighed any risks. Therefore, it was in Kaitlin's best interests to undergo the treatment rather than wait until turning 18: [16].

The Court made the following observation, in the context of Kaitlin requiring court approval for stage two treatment:

*… all her life, Kaitlin has taken hormones as part of a therapeutic regime to treat her pituitary disorder, the effects of which hormones were irreversible. Moreover, because her body was unable to produce, amongst many other hormones, testosterone, in order to undergo puberty at all she was required to take either testosterone or estrogen. It would seem fanciful to suggest that court authorisation was required before Kaitlin could be prescribed testosterone by Dr W in 2014. And yet the effect of that testosterone would have been to irreversibly see her develop as a pubescent male. Precisely why court authorisation for the administration of estrogen is then said to be required by Re Jamie is difficult to explain. True it is that the effects of its administration will be irreversible over time, but not in any conceptually different way to the irreversible effects of the administration of testosterone. It seems to me that this case well illustrates that the irreversibility of therapeutic treatment does not provide a sound, logical basis for requiring court authorisation for stage two treatment for Gender Dysphoria.*

Criticisms of the decision by Aileen Kennedy[[28]](#footnote-28)

* While the Court noted the weakness in the rationalisation for requiring court approval for transgender minors, it did not make any adverse comments on the fact that an intersex child had been prescribed hormone therapy without her consent and without court approval.

1. Joint statement by Australian and Aotearoa/New Zealand intersex community organisations and independent advocates, including the Androgen Insensitivity Syndrome Support Group Australia (AISSGA), Intersex Trust Aotearoa New Zealand (ITANZ), Organisation Intersex International Australia (OIIAU), Eve Black, Kylie Bond (AISSGA), Tony Briffa (OIIAU/AISSGA), Morgan Carpenter (OIRRAU/Intersex Day Project), Candice Cody (OIIAU), Alex David (OIIAU), Betsy Driver (Bodies Like Ours), Carolyn Hannaford (AISSGA), Eileen Harlow, Bonnie Hard (AISSGA), Phoebe Hart (AISSGA), Delia Leckey (ITANZ), Steph Lum (OIIAU), Mani Bruce Mitchell (ITANZ), Elise Nyhuis (AISSGA), Bronwyn O’Callaghan, Sandra Perrin (AISSGA), Cody Smith (Tranz Australia), Trace Williams (AISSGA), Imogen Yang (Bladder Exstrophy Epispadias Cloacal Exstrophy Hypospadias Australian Community – BEECHAC) and Georgie Yovanovic. [↑](#footnote-ref-1)
2. Cf Question 3 in the briefing paper. [↑](#footnote-ref-2)
3. Cf Question 4 in the briefing paper. [↑](#footnote-ref-3)
4. Cf Question 5 in the briefing paper. [↑](#footnote-ref-4)
5. Cf Question 1 in the briefing paper. [↑](#footnote-ref-5)
6. Cf Question 2 in the briefing paper. [↑](#footnote-ref-6)
7. Cf Question 6 in the briefing paper. [↑](#footnote-ref-7)
8. Cf Question 7 in the briefing paper. [↑](#footnote-ref-8)
9. *Secretary, Department of Health and Community Services v JWB and SMB* (***Marion’s Case***) (1992) 175 CLR 218; [1992] HCA 15. [↑](#footnote-ref-9)
10. *Marion’s Case,* at [48], [53] per Mason CJ, Dawson, Toohey and Gaudron JJ; at [26]–[28] per Brennan J. However, while parents and other guardians may have power to authorise ‘therapeutic’ sterilisation, their exercise of that power remains subject to supervision by the court in exercise of its *parens patriae* jurisdiction: *Marion’s Case,* at [30] per Brennan J; see also [71] per Mason CJ, Dawson, Toohey and Gaudron JJ. [↑](#footnote-ref-10)
11. *Marion’s Case,* at [48] per Mason CJ, Dawson, Toohey and Gaudron JJ; at [19] per Brennan J; see also at [11]–[14] per Deane J. [↑](#footnote-ref-11)
12. This participant did not elaborate on what was meant by such infringements on a person’s life. It may mean other consequences of the decision on a person’s autonomy, dignity or health. [↑](#footnote-ref-12)
13. *Re a declaration regarding medical treatment for “A”* [2020] QSC 389. [↑](#footnote-ref-13)
14. Conciliation is a dispute resolution process which involves the resolution of a dispute by the parties themselves through a facilitated discussion by an impartial third party who helps the parties to settle their differences. [↑](#footnote-ref-14)
15. Section 75 of the *Crimes Act 1900* (ACT) prohibits the removal of a child from the Australian Capital Territory for female genital mutilation. [↑](#footnote-ref-15)
16. Section 64 extends the geographical nexus of territory offences to those committed partly in the ACT or which have an effect in the ACT. [↑](#footnote-ref-16)
17. For example, see *Limitation Act 1985* (ACT), s 30B. [↑](#footnote-ref-17)
18. *Human Rights Act 2004* (ACT), s 10. [↑](#footnote-ref-18)
19. See e.g. Universal Declaration on Human Rights (**UDHR**), art 16; Convention on Rights of Persons with Disabilities (**CRPD**), art. 23; Convention on the Elimination of All Forms of Discrimination against Women (**CEDAW**), art. 16. [↑](#footnote-ref-19)
20. These were:

    Right to equality and non-discrimination (e.g. CEDAW art. 2, CRPD arts. 5 and 6);

    Right to health (e.g. UDHR art. 25);

    Reproductive autonomy (e.g. CESCR General Comment No. 22, CEDAW art. 12 and General Recommendation No. 24);

    Right to decide number and spacing of children (CEDAW art. 16);

    Right to found a family (e.g. UDHR art. 16; CRPD art. 23);

    Right to information (e.g. UDHR art. 19; ICCPR art. 19);

    Right to benefit from scientific progress (e.g. UDHR, art. 27; International Covenant on Economic, Social and Cultural Rights, art. 15 (b));

    Best interests of the child: Convention on the Rights of the Child (**CRC**), art 3;

    Right to an identity of the child: CRC, art 8. [↑](#footnote-ref-20)
21. See, for example, *Marion’s Case* at [10]–[11], [43], [47], [55] per Mason, Dawson, Toohey and Gaudron JJ; at [24] per McHugh J. [↑](#footnote-ref-21)
22. Comprised of the Commonwealth and all state and territory Health Ministers. [↑](#footnote-ref-22)
23. This condition occurs when a child is born genetically male (i.e. has XY chromosomes) but had minimum in-utero exposure to androgens required for the full development of male internal and external genitalia. [↑](#footnote-ref-23)
24. See Morgan Carpenter, 'The Family Court case Re: Carla (Medical procedure) [2016] FamCA 7', <https://ihra.org.au/31036/re-carla-family-court/>. [↑](#footnote-ref-24)
25. See 'The Family Court case Re: Lesley (Special Medical Procedure) [2008] FamCA 1226', <https://ihra.org.au/23090/re-lesley-special-medical-procedure/>. [↑](#footnote-ref-25)
26. A condition occurring where the pituitary gland does not produce one or more of its hormones. [↑](#footnote-ref-26)
27. Meaning she had sufficient understanding and intelligence to understand the consequences of the proposed treatment to make an informed decision: see reasons at [13]–[15]. [↑](#footnote-ref-27)
28. See Aileen Kennedy, 'Submission in response to ALRC Issues Paper 48 Review of the Family Law System', <https://www.alrc.gov.au/wp-content/uploads/2019/08/family-law-_196._aileen_kennedy.pdf>. See also IHRA's case note and views: Morgan Carpenter, 'The Family Court case Re: Kaitlin [2017] FamCA 83', <https://ihra.org.au/31368/re-kaitlin-2017-famca-83/>. [↑](#footnote-ref-28)