CCYP
Commissioner for Children
and Young People Tasmania

Your Ref:
Our Ref: 702

27 March 2018

Ms Kate Hanslow
Tasmania Law Reform Institute
Private Bag 89
HOBART TAS 7001

By email to: KateHanslow@utas.edu.au

Dear Ms Hanslow

Re: Tasmania Law Reform Institute - Review of the *Guardianship and Administration Act 1995*

Thank you for the opportunity to provide comment in response to the *Review of the Guardianship and Administration Act 1995 (Tas)* ('the Paper'). This review is a vital mechanism by which to ensure our law appropriately reflects, protects and promotes the rights of people with disability, including children and young people, in Tasmania.

Under the *Commissioner for Children and Young People Act 2016* ('the CCYP Act'), I have responsibility for advocating for all children and young people in Tasmania generally, and for monitoring and promoting their wellbeing. Importantly, I am also required by the CCYP Act to assist in ensuring the State satisfies its national and international obligations with respect to children and young people generally.[1]

In performing a function or exercising a power under the CCYP Act, I must do so according to the principle that the wellbeing and best interests of children and young people are paramount, and must observe any relevant provisions of the United Nations *Convention on the Rights of the Child* ('the CRC').[2]

For a comprehensive discussion of the key rights under the CRC for children with disabilities, I refer you to the UN Committee on the Rights of the Child's *General Comment No 9 (2006) on the rights of children with disability.*[3]

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[1] *Commissioner for Children and Young People Act 2016* (Tas) s 8.

[2] *Commissioner for Children and Young People Act 2016* (Tas) s 3.

[3] UN Committee on the Rights of the Child, General comment No. 9 (2006): The rights of children with disabilities, 27 February 2007, CRC/C/GC/9.

The *Convention on the Rights of Persons with Disabilities* ('the CRPD') recognises that children with disabilities should have full enjoyment of all human rights and fundamental freedoms on an equal basis with other children and recalls the obligations of state parties under the CRC.[4]

While children with disabilities enjoy all of the rights set out in the CRPD, Article 7 is of specific relevance for children. It provides that:

> 1. States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.
>
> 2. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.
>
> 3. States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.

My preliminary views

Consistent with my statutory functions, this submission focuses on issues of particular importance to children and young people aged less than 18 years. However, in order to do this, it is important to understand and appreciate the application of the *Guardianship and Administration Act 1995* (Tas) ('the G&A Act') more generally.

The G&A Act establishes a framework for how substitute decisions may be made for people with disability who are unable to make their own decisions in relation to:

a) personal matters;
b) financial and property matters; and
c) consent to medical and dental treatment.

The provisions of Part 4 - *Guardianship Orders*, Part 5 - *Enduring Guardian*s and Part 7 - *Administration Orders* apply only to adults (i.e. those persons aged 18 years and above) who lack decision-making capacity because of a disability. However, Part 6 - *Consent to Medical and Dental Treatment* and its provisions also apply to a child "*with a disability who is incapable of giving consent to the carrying out of medical or dental treatment*".[5]

It is important to acknowledge that consideration of important policy issues relating to consent to medical treatment is complicated by the challenges involved in gaining a full picture of the complex legal situation as it relates specifically to children. It may, for example, be that proposals I put forward might inadvertently lead to a lessening

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[4] See the Preamble to the CRPD.

[5] *Guardianship and Administration Act 1995 s36(1).*

of protections for children with disability. As the provision of legal advice is not within my functions, I leave it to those with relevant legal expertise to identify and resolve any potential unintended consequences.

Existence of a disability as a part of the test for decision-making capacity

To some extent my comments with regard to children are informed by the substitute decision-making framework adopted for the G&A Act as a whole. For example, in Part 3 of the Paper, an option for reform put forward is to remove "*disability*" as a pre-condition for the G&A Act substitute decision-making framework applicable to adults. This approach to substitute decision-making has been adopted in other jurisdictions, such as the Northern Territory, where impaired decision-making capacity (which is defined without reference to disability) is a pre-condition for a guardianship order to be made.[6] Arguably this approach is more consistent with the principles of the CRPD and its emphasis on equality before the law for people with disability.

However, adoption of an 'impaired decision-making capacity test' would, in my opinion, raise clear questions around the need for and appropriateness of including in the G&A Act any provisions describing substitute decision-making for medical treatment for children. This is particularly so when one acknowledges that issues related to parental responsibility for children are defined and dealt with in the family law jurisdiction[7] (these matters are discussed further below).

In my respectful option, consideration of the G&A Act provisions around consent to medical treatment for children could more easily and appropriately occur in the context of debate around whether Tasmania should move to enacting separate legislation for consent to medical treatment generally. This would also provide an opportunity to consider consent to treatments beyond the normal authority of a parent or person with parental responsibility – such as sterilisation which is in a child's best interests. In this respect, I note there exists within the family law jurisdiction well-established jurisprudence around treatment decisions considered to be outside of the usual bounds of parental authority including, but not limited to, sterilisation. I am not entirely sure that the G&A Act provides the appropriate context for consideration of issues such as this in relation to children.

Interaction with the Federal Family Law jurisdiction

In some respects it is difficult to comment on the current application of the G&A Act to children and young people, or on options for reform, without a clear understanding of the way in which its provisions regarding consent to medical and dental treatment interact with the jurisdiction of the Family Court.

It is useful to recall that anyone under the age of 18 years is regarded as a "child" for the purposes of the *Family Law Act 1975* (Cth). Section 61C of the Family Law Act provides that subject to any order of the Court, each of the parents of a child who

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[6] Division 2 of the *Guardianship of Adults Act 2016* (NT).

[7] I note the particular circumstances of children who are under the guardianship of the Secretary.

has not turned 18 years of age has "parental responsibility" for that child[8]; an aspect of parental responsibility is the right and obligation to make decisions around medical and dental treatment for a child.

However, some decisions around medical treatment for children are considered to be beyond the normal authority of a parent or person with parental responsibility – and as such they require authorisation of the Family Court. For example, Court authorisation is required for surgery on a child which will result in sterilisation and which is not for the purpose of preserving life or treating and preventing grave physical illness.

There are few reported decisions of the Guardianship and Administration Board ('the Board') concerning consent to medical treatment relating to children. In the most recent of such reported cases, *NC (Medical Consent)* [2014] TASGAB 15 (21 July 2014), the Board clearly contemplates dual jurisdiction to provide consent to "special treatment" for children with that of the Family Court. Paragraphs 4, 5 and 6 of the Board's decision are set out below:

> 4. The *Guardianship and Administration Act 1995* was enacted after the High Court delivered its judgment in *Secretary, Department of Health and Community Services v. J.W.B. and S.M.B. (Marion's Case.)* [1992] HCA 15;(1992) 175 CLR 218. The Court was unanimous in that decision to the extent that:
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> > '... the authority of parents does not, in the absence of special statutory provisions, extend to authorizing surgery involving the sterilization of a profoundly intellectually disabled child for other than the conventional medical purposes of preserving life and treating and preventing grave physical illness.'
>
> 5. The legislature, in enacting this Act, were clearly responding to the terms of the High Court's decision and extended the authority to consent to a sterilisation procedure upon a child with a disability to the Guardianship and Administration Board, such that the Board holds dual jurisdiction to give such consent with the Family Court of Australia.
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> 6. Whereas the High Court decision allowed parents the authority to consent to sterilisation for 'conventional medical purposes of ... treating and preventing grave physical illness,' the legislature removed that authority in the enactment of Part 6 because the operation of that Part does not make an exception to section 38 or the definition in section 3 where the procedure is undertaken for the treatment of 'grave physical illness.' The High Court hesitated to use the terms 'therapeutic' and 'non-therapeutic' sterilisations because of the uncertainty and the lack of a clear 'dividing line' between those two concepts. It is possible that, for the same reasons, the legislature determined that application of a universal rule was preferable to attempting to delineate what was 'therapeutic' and 'non-therapeutic' in this respect [footnotes omitted].

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[8] Section 61B of the *Family Law Act 1975* (Cth) defines "parental responsibility" in relation to a child to mean all the duties, powers, responsibilities and authority that parents have, by law, in relation to children.

While the above decision concerns an application for authorisation for "special treatment" (namely sterilisation), the provisions of Part 6 also extend to "treatment other than special treatment". Section 38 of the Act provides that a person must not carry out medical or dental treatment on a person to whom Part 6 applies unless consent has been given in accordance with that Part, or is otherwise authorised by it. Significant penalties apply to persons who carry out treatment in contravention of Part 6.

The above prompts me to query whether treatment authorised by the Family Court for a child with a disability who lacks capacity would nevertheless be prohibited in Tasmania in the absence of authorisation under Part 6 of the Act. I note, for example, the *Mental Health Act 2013* (Tas) confirms its provisions do not limit the jurisdiction of the Family Court or the Supreme Court to give or refuse treatment.[9] I raise this as a potential issue, which may benefit from consideration, and potentially clarification, by the Solicitor General and/or others with relevant legal expertise.

I note the recent decision of the Full Court of the Family Court in *Re Kelvin*[10] regarding potential sterilisation arising from Stage 2 treatment for gender dysphoria. The Full Court concluded that Stage 2 treatment for young people with gender dysphoria '*can no longer be considered a medical procedure for which consent lies outside the bounds of parental authority and requires the imprimatur of the Court.*' The decision in *Re: Kelvin* is consistent with a recommendation of the UN Human Rights Committee that Australia

> [c]onsider ways to expedite access to stage two hormone treatment for gender dysphoria, including by removing the need for court authorisation in cases featuring uncontested agreement among parents or guardians, the child concerned and the medical team, provided that the treatment is provided in accordance with the relevant medical guidelines and standards of care.[11]

As is noted in the Paper at paragraph 10.8.26, Stage 2 treatment for gender dysphoria is likely to fall within the class of special treatment that currently requires consent from the Board. This is because it amounts to treatment that is reasonably likely to render a person permanently infertile. I raise this simply to demonstrate the potential for inconsistent overlap between the State and Federal jurisdictions.

On a related matter, it is important to recall the recommendation of the Senate Community Affairs References Committee in its 2013 report on its *Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia,* for development of uniform model legislation.

While I understand that applications for authority to perform sterilisation on children are becoming increasingly rare[12], there remains a question of whether involuntary

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[9] *Mental Health Act 2013 (Tas)* s 219.

[10] *Re: Kelvin* [2017] FamCAFC 258

[11] Human Rights Committee, *Concluding observations on the sixth periodic report of Australia*, 9 November 2017, CCPR/C/AUS/CO/6.

[12] Chief Justice Bryant, Submission to the *Senate Standing Committee on Community Affairs Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia*, 22 February 2013, page 3; see

sterilisation of children can ever be appropriate at all. The UN Committee on the Rights of Persons with Disabilities has expressed 'deep concern' that the Senate Committee referred to above fell short of recommending prohibition of sterilisation of children in the absence of their prior, fully informed and free consent.[13] This is not a matter which I intend to express a view on at this time.

If the G&A Act continues to apply to consent to medical treatment for children

Even if the G&A Act continues to be based on a substitute decision-making framework for which disability is a pre-condition, I have reservations around the appropriateness of continuing to include provisions describing parental responsibility regards medical treatment for children with a disability and who do not have capacity to consent. This is particularly so when one considers Article 7 of the CRPD and its focus on equality before the law.

Furthermore, it is not entirely clear to me whether a child with a disability is brought within the purview of Part 6 of the Act because they lack capacity solely due to their disability; or because of their immaturity by virtue of age and/or stage of development (ie they lack "*Gillick* competence") or both. It would appear this would benefit from clarification.

If there are no changes to the G&A Act's legislative framework governing medical treatment (including special treatment) for children with a disability who lack capacity to provide informed consent, there is, as indicated earlier in this submission, a need for expert legal consideration of the appropriateness of incorporating a section similar to section 219 of the *Mental Health Act 2013* noting section 38 of the G&A Act.[14]

Guiding principles – "best interests" and the "rights, will and preferences" of children

Promotion of the "best interests" of a person is currently a key guiding principle of the G&A Act, although I note the term is not defined. Currently, a "person responsible" (or the Board) may consent to the carrying out of various medical and dental treatments only if satisfied that a person with disability is incapable of giving consent, and that the treatment is in the person's "best interests".[15]

The CRPD has been interpreted as requiring a shift away from focusing on a person's "best interests" toward a focus on a person's "rights, will and preferences".[16]

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also the Tasmanian Government Submission to the *Senate Standing Committee on Community Affairs Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia*, Submission 57, page 2.

[13] Committee on the Rights of Persons with Disabilities, *Concluding observations on the initial report of Australia*, 21 October 2013, CRPD/C/AUS/CO/1.

[14] See *P v P* [1994] HCA 20.

[15] See sections 43 and 45 of the *Guardianship and Administration Act 1995.*

[16] Refer paragraph 2.3.1 of the Report.

The "best interests" principle nevertheless continues to have significant relevance in relation to children. Article 7 requires that "in all actions concerning children with disabilities, the best interests of the child shall be a primary consideration." The UN Committee on the Rights of Persons with Disabilities has said the following:

> 36. While article 12 of the Convention protects equality before the law for all persons, regardless of age, article 7 of the Convention recognizes the developing capacities of children and requires that "in all actions concerning children with disabilities, the best interests of the child … be a primary consideration" (para. 2) and that "their views [be] given due weight in accordance with their age and maturity" (para. 3). To comply with article 12, States parties must examine their laws to ensure that the will and preferences of children with disabilities are respected on an equal basis with other children.[17]

The decision-making capacity of individual children and young people exists across a continuum, due to a range of factors specific to each child or young person such as their age, development, the impact of disability etc. In this context, children and young people, including those with disability, require support in decision-making to a greater or a lesser extent. Regardless of decision-making capacity, a child capable of forming a view on his or her best interests must be able to give those views freely if they choose to do so, with any such views being taken into account.

The Paper provides three options at paragraph 2.5.1 for reform regarding guiding principles. If provisions regarding consent to medical treatment of children are to remain in the G&A Act I prefer the first option – that is, to redefine "best interests" taking account of Article 7 of the CRPD to give greater emphasis to ascertaining and upholding children's will, preferences and rights. This reform option balances the need to ensure the safety and protection of children, while promoting their right to have a say, and to be heard, on matters affecting them.

Including children in the hearing process

I note that the Paper raises the issue of legal representation and the potential for the use of communication intermediaries in Board proceedings. If the G&A Act is to continue to cover consent to medical treatment for children, I support the suggestion in the Report that there be further consideration of the use of intermediaries in Board proceedings and investigation of other mechanisms through which children's interests and views might be separately represented before the Board.

This issue is of particular interest to me, given that a child or young person with disability may not have the capacity to fully express their views, nor have the resources and supports to exercise her or his right of appeal, without appropriate disability and age/developmentally appropriate assistance.

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[17] UN Committee of the Rights of Persons with Disability, *General Comment No. 1 (2014) Article 12: Equal recognition before the Law*, 19 May 2014, CRPD/C/GC/1, available at: https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement

Advance Care Directives

Having regard to the principles of the CRC, particularly article 12, the views of children and young people on all matters affecting them should be given serious consideration and be taken into account. It is a natural consequence of these principles that the views of children and young people be considered in the planning and execution of future medical treatments.

Children with capacity to provide informed consent to medical treatment should, in my view, also be able to provide instructions or express preferences etc in relation to their future medical treatment. I would therefore support development of legislation to establish a clear scheme for children to make advance care directives. It would be preferable for any legislative framework regarding advanced care directives to be situated in separate legislation dealing with decisions around medical treatment generally rather than in the G&A Act.

Conclusion

Thank you again for inviting comment in response to the Paper. It is beyond the scope of this submission to respond to all of the questions posed which have the potential to impact children and young people.

I am available to discuss the matters raised above in more detail, noting that in many respects the views I express are preliminary only. I look forward to considering the views of other stakeholders and to reading the TLRI's Report.

Yours sincerely

David Clements
Interim Commissioner for Children and Young People

cc: Attorney-General and Minister for Justice
cc: Minister for Human Services
cc: Minister for Disability Services and Community Development
cc: Minister for Health